

COMMUNITY SERVICE PLAN 2009 RIVERSIDE HEALTH CARE SYSTEM, INC.

- *St. John's Riverside Hospital*



Andrus Pavilion

Dobbs Ferry Pavilion

ParkCare Pavilion

Malotz Skilled Nursing Pavilion

Cochran School of Nursing



CONTENTS

Introduction..... 1
Mission Statements..... 2-3
Corporate Structure..... 4
Public Participation..... 4
Service Area Defined..... 5
Hybrid Model of Care..... 6



St. John's Riverside Hospital
Andrus Pavilion
967 North Broadway
Yonkers, NY 10701

Dobbs Ferry Pavilion
128 Ashford Avenue
Dobbs Ferry, NY 10522

ParkCare Pavilion
2 Park Avenue
Yonkers, NY 10703



Michael N. Malotz Skilled Nursing Pavilion
120 Odell Avenue
Yonkers, NY 10701



Cochran School of Nursing
St. John's Riverside Hospital
967 North Broadway
Yonkers, NY 10701

INTRODUCTION

St. John's Riverside Hospital has been serving the health needs of the community since 1869. Throughout its history of growth and expansion, it has always remained committed to providing superior healthcare utilizing the most advanced technology.

St. John's is currently ending a 10-year strategic plan and will shortly embark on a new strategic planning process for another 10-year period.

In the past three years, St. John's affiliated hospital, Community Hospital at Dobbs Ferry, fought for its existence, having been named on the Berger Commission closure list.

The solution to this situation was a merger of the two facilities, where Community Hospital at Dobbs Ferry has become the Dobbs Ferry Pavilion of St. John's Riverside Hospital, thereby ensuring the existence of its emergency services.

Through discussions with New York State, it was decided that the Dobbs Ferry Pavilion of St. John's Riverside Hospital will implement a hybrid model of care.

The following community service plan will focus on the activities that St. John's Riverside Hospital and the Dobbs Ferry Pavilion of St. John's Riverside Hospital will pursue to accomplish this hybrid model of care.

Access to Quality Health Care and Chronic Disease are two of the priorities set by the New York State Department of Health Prevention Agenda Toward the Healthiest State, that will be addressed through the Hybrid Model.

Other priorities addressed at St. John's Riverside Hospital are Substance Abuse, Healthy Environment and Community Preparedness.

The description of the Hybrid Model of Care will address the service area, research and relevant statistical information, community partners and those who have participated in setting our goals and priorities.

Furthermore, the Community Service Plan will address specific plans for our Behavioral Health Services department.

MISSION STATEMENT

Riverside Health Care System Mission

St. John's Riverside Hospital, Andrus and ParkCare Pavilions, the Dobbs Ferry Pavilion of St. John's Riverside Hospital and the Michael N. Malotz Skilled Nursing Pavilion, members of Riverside Health Care System, Inc., share a vision for improving community health.

Mission Statement

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 facilities 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.

We continue to strive towards a collaborative health care network, which is the provider of choice in the Southwest portion of Westchester County. Our network provides preventive, diagnostic, ambulatory, acute, rehabilitative, skilled nursing, and psychiatric care, and alcohol and substance abuse treatment & counseling. We have initiated linkages and various types of partnerships with other health care and social service agencies in the community.

Our care is provided without regard to race, religion, citizenship, sexual orientation or financial status, conforming in all policies and practices with State and Federal regulations and the standards of the Joint Commission on Accreditation of Healthcare Organizations, (JCAHO).

Service Specific Philosophy Statements

Our St. John's ParkCare Pavilion primarily serves individuals in inner city Yonkers and is committed to meeting the needs of these patients.

Primary Care - We are committed to providing education, promoting health literacy, encouraging preventive health practices, to effectively impact upon the health conditions and status of the community. We work to broaden access to primary care and coordinate services. As a medical provider we offer extensive primary and specialty outpatient services to the medically underserved population of Southwest Yonkers.

MISSION STATEMENT

Smithers Alcoholism Treatment and Training Center and Behavioral Health Services - The Smithers Center and Behavioral Health Services Department of St. John's Riverside Hospital is a comprehensive and multi-faceted service delivery network. Programs are designed to provide a full continuum of care for those seeking chemical dependency treatment. Treatment is provided to all who seek it regardless of race/ethnicity, gender, age, religion, sexual orientation, co-existing disability and/or ability to pay.

Our mission is to provide quality and accessible services to the patients we serve while also insuring their physical and emotional well-being. Through a multi-disciplinary treatment team approach, patients are assessed and placed in levels of care that most appropriately address their individual needs and offer the best opportunity for recovery and return to an optimal level of functioning.

We strive to respond to the complex needs of those seeking our services. Treatment services include inpatient detoxification and rehabilitation, inpatient crisis services, outpatient treatment including day rehabilitation, methadone maintenance, adolescent and COA/COSA services, and jail based treatment services. We have also developed programs to serve specific special needs populations including the homeless, those affected by HIV/AIDS, the elderly and the dually diagnosed.

HIV/AIDS - The HOPE (Healthcare Opportunities Provided with Excellence) Center is dedicated to providing comprehensive care in a compassionate, professional, respectful and ethical manner to every HIV-infected patient and his or her family in Southern Westchester County. We offer excellence in HIV-related medical care, mental health services, counseling and testing, dental care and case management with special concern for the underserved and low-income individual living with HIV. Working with our clients to continually improve our care, we are open to new ideas, directions and initiatives to effectively respond to the needs of individuals living with HIV in our communities. We are leaders in the fight for the lives of those who live with this virus. We commit ourselves to this quest until HIV is eradicated.

HYI - As part of our commitment to community health, we participate in and have taken a leadership role in the Healthy Yonkers Initiative, a community wide partnership aimed at addressing community health concerns of the highest priority.

Notice to the Community

The Community Service Plan for Riverside Health Care System, Inc. is available in the Administration offices at both St. John's Riverside Hospital Andrus and Dobbs Ferry Pavilions. The 2009 CSP will also be made available through the hospital website and to our employees on our intranet. Copies can also be obtained by contacting the Public Relations office. A public service announcement will be sent to the local media.

CORPORATE STRUCTURE

Riverside Health Care System, Inc is the governing organization of St. John's Riverside Hospital, Andrus, Dobbs Ferry and ParkCare Pavilions, the Michael Malotz Skilled Nursing Pavilion, and the Cochran School of Nursing.

St. John's Riverside Hospital is a 407-bed, voluntary 501 (c) (3) tax-exempt, not-for-profit health care facility offering a full range of acute care, medical and surgical services, intensive care and emergency services, the only maternity services, 21 specialty outpatient clinics including an HIV/AIDS Clinic and 10 major outpatient and inpatient substance abuse and alcoholism treatment programs in the City of Yonkers. St. John's Andrus Pavilion is located at 967 North Broadway in the Northwest quadrant of Yonkers and the ParkCare Pavilion is located at 2 Park Avenue in the Southwest quadrant of Yonkers. The Dobbs Ferry Pavilion of St. John's Riverside Hospital is located at 128 Ashford Avenue in Dobbs Ferry, NY.

PUBLIC PARTICIPATION

We identify community needs and involve the community in the process through:

Health Information from the NYS Department of Health and the Westchester County Department of Health - Relationship building with community-based and faith-based organizations - Competitive market share data (HANYs Medstat Market Expert Data Software) - Focus Groups with community and physicians - HOPE Center's Consumer Advisory Group - Neighborhood Circles (forums in locations around Yonkers)- Annual AIDS Institute Mandated Outpatient Primary Care and Case Management

- Surveys mailed to the community - Informative sessions and discussions with employees - Consumer inpatient satisfaction surveys - Critical incidents - On-going discussion with front line employees, including new physician outreach team - Counseling and Testing Client satisfaction surveys - Reviewing and investigating any concerns identified by our customers - Involvement in the chamber of commerce, rotaries and other business organizations in our community - Healthy Yonkers Initiative through partnering organizations and work-groups - Pastoral Care Committee - Social service & civic organizations - Community leaders input through meetings and surveys - Political leader briefings - Media

SERVICE AREA DEFINED

In order for **St. John's Riverside Hospital** to meet the needs of its community, it must identify its service area and understand the health risks and needs of the population.

The St. John's service area 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%. It should also be noted that 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 needs of this community are being addressed despite the following:

- Revenue is dropping and expenses are increasing.
- Operating margins remain narrow.
- Capital spending on infrastructure and technology is increasing.

St. John's remains committed to addressing the special health needs of women, the elderly and the health disparities identified in the African-American and Hispanic populations.

Dobbs Ferry Pavilion has had over a century of direct contact with people throughout its service area.

The facility is located at 128 Ashford Avenue in Dobbs Ferry, New York. It 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. In addition, an ongoing series of programs and medical specialties attract patients from throughout the United States and various other countries. The total population of this service area is 168,589. This area is defined by a population that is largely white and affluent.

Hybrid Plan Overview

The new Dobbs Ferry division of St. John's Riverside Hospital will focus on the reduction of emergency room use and inpatient admissions for ambulatory sensitive conditions for residents of southern Westchester County. A patient centered model will be used in the delivery of health services. The project design is a **three-point** program of **integrated primary care in the emergency room, care management of chronic health conditions** and **improved access to integrated breast cancer treatment for minority populations**. Our program will give special attention to the needs of the low-income, minority and uninsured and underinsured patients in this service area.

*This plan addresses the following priorities of the **Prevention Agenda**: Access to Quality Health Care, Chronic Disease, Tobacco Use and Healthy Environment.*

The hybrid model has several aims:

1. Institute a primary care focus incorporated into the Dobbs Ferry emergency room service approach with follow-up case management in the community;
2. Prevent unnecessary admissions to the hospital and other surrounding hospitals;
3. 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";
4. 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;
5. Coordinated team care is a key element for the "Medical Home" patient-centered care approach to care for our demonstration program.

While the more intensely ill patients will be referred to SJRH, the Dobbs Ferry site will become the focus of chronic care treatment when such cases present themselves in the emergency room. Working with St. John's Riverside Hospital, patients that have been examined thoroughly and then require longer term acute care will be transported to SJRH or elsewhere for admission. Because the hospitals share common diagnostic IT capability, test results will be readily available for the admission without duplication and expedition of the patients care.

As our demonstration program progresses we will seek to link physician practices to teams of pharmacists, social workers and dieticians via phone, fax and e-mail so they can coordinate care for patients. This new approach is designed to develop effective team building and ongoing collaboration among health care providers in the region who do not work together in practice in the same locations or even the same organizations.

In our reorganized Emergency Room Demonstration Project, we will be clinically capable of treating the following admissions in our emergency department in the first year and will be expanded to other ambulatory sensitive conditions in year two.

In the first year of our program we will focus on:

- Asthma and Other COPD issues
- Diabetes Management
- Pnuemonia
- Hypertension
- Dehydration

Part I: The Hybrid Health Plan Model

A. Role of Primary Care in the New Institution

A three-member physician primary care team will be the core of the new model that will include a coordinated approach to patient management. The three primary care physicians are large volume admitting physicians who also have office space on the grounds of the hospital. Additionally two of these physicians provide home visits.

For our five chronic disease categories, Emergency Room physicians will work with both our Dobbs Ferry three-member primary care team or contact the patients' primary care provider prior to patient discharge. Patients who have had an emergency room visit who have a primary care provider will be referred, upon discharge, to that provider regardless of the geographical location of the patient. A patient without a primary care provider or a patient who may be visiting the Rivertowns area will be referred to these on premises providers. If their service was related to a chronic condition or the onset of a chronic condition, education about their disease will be provided and a thorough discussion and understanding of all the medications prescribed and the interactions in a culturally and medically literate way. Should the patient require any additional diagnostic tests, they will be recommended and booked. Our follow-up care management team will be available to assist the patient with their follow-up referrals.

Patients who are uninsured or underinsured will be referred in the same manner. The patient may also be referred to Hudson River Health Care – Valentine Lane (HRHC-VL) for a less costly option utilizing a sliding fee schedule called Health Solutions. The program is based on stated income, residency and identification within the federal guidelines.

Patients maybe uninsured, underinsured (e.g., Medicare Part A only) regardless of immigration status. Additionally, HRHC-VL has onsite managed care program representatives five days a week, who will assist patients in applying for other insurance programs. Patients will be encouraged to apply for their children within New York State guidelines regardless of immigration status. Health Solutions is accepted at all Riverside Health System facilities and affiliated facilities.

Adopting A Patient Centered Care Approach

Because the management of chronic disease differs from that of an acute illness, our team is beginning to work in an ongoing partnership with patients to ensure positive outcomes referred to as patient-focused or patient-centered care. Patient focused care includes four broad areas of intervention: **communication with patients, partnerships, health promotion, and physical care**. Its purpose is to “ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they require to make decisions and participate in their own care.”

Though our emergency room and primary physicians work together, the role of our chronic care team is essential to carrying out our plan. Finally, we anticipate that patient-focused care may have a particular role to play in the management of difficult-to-treat patients with chronic conditions, a circumstance that is particularly relevant in the Yonkers metropolitan area. These patients have more complex needs because of their disease

severity and/or social and economic factors. Evaluating these more complex needs and meeting them requires specialist services and training through our many outreach and education programs.

B. Facility Services and Program Collaboration

Service delivery on the Dobbs Ferry campus has changed as a result of its merger with SJRH. The Dobbs Ferry site is currently expanding its ambulatory surgical services and cancer programs while maintaining its emergency room capacity and short stay inpatient capability. Because of its uniqueness, this hybrid model requires new collaborations between and among the service sites of the SJRH system, its physicians and the communities that surround and use Dobbs Ferry. This hybrid model will produce savings by providing rapid diagnosis and treatment, and triaging patients more appropriately when inpatient services are required.

The Dobbs Ferry hybrid emergency room model is aimed at preventing unnecessary admissions to the hospital and at providing more cost effective care for patients in alternative settings. Working in conjunction with St. John's, patients that have been examined thoroughly and then require longer term acute care will be transported to SJRH or elsewhere for admission.

In addition to the above, our ER medical assessment unit has created a care management program for select chronic care conditions that require close contact between the Emergency Room physicians and the Primary Care Practice to ensure a safe discharge plan and self-management.

Secondly, the use of a short stay service will be linked to our expanded ambulatory surgical program and to our emergency room. Our plan maintains and strengthens services required to meet the needs of our service area and expands offerings in women's health and cancer care targeted to low income and minority women.

Third, our referred ambulatory services for diagnostic services in radiology, cancer care, nuclear medicine, and mammography will be enhanced. Expanded diagnostic capability is essential as the facility becomes more focused on ambulatory care services, cancer care and chronic care disease management.

The limited number of inpatient beds requires a decrease in Emergency Room admissions by providing rapid diagnosis and treatment, and triaging patients more appropriately when inpatient services are required. Improved emergency and early diagnostic services will be relied upon to stabilize and triage patients to appropriate services both at St. John's Riverside Hospital and other hospitals in the vicinity.

C. Dobbs Ferry Initiatives to Manage Chronic Illnesses

As it becomes economically difficult to schedule appointments with a primary care physician, more people are turning to our emergency rooms for routine treatment of chronic health problems. Those visits are driving up health care costs, creating long waiting times and tying up resources. Patients also are being referred to emergency rooms to reduce the workload at busy primary care practices. Therefore the ability to keep chronic care patients out of the emergency room and in primary care will be challenged by these other trends.

Asthma

In the Dobbs Ferry ER we will provide patients with information about emergency room alternatives for the treatment of asthma. Our outreach staff members are introducing asthma emergency room patients to a primary care doctor participating in the demonstration program. Research has found that asthma patients who had an office visit after their initial ER visit were 10% less likely to have a repeat ER visit within the month. Therefore our first benchmark statistic will be our effectiveness in reduction and elimination of return visits to the ER.

Patient-focused care has also been shown to improve adherence to medication/advice, a well-known problem in asthma. A one to one relationship between the ER physician and the primary care physician will be essential for the reduction in both ER and admissions among asthma patients. For children with asthma, frequent users of the ER for acute treatment, will be placed on and monitored for proper use of controller medications.

During the ER evaluation, severity should ideally be determined at this time, after which control becomes the central focus of asthma management. This includes four key components for achieving control of asthma: (1) assessment of severity, (2) pharmacological therapy, (3) environmental measures, and (4) patient and family education, communication, and partnership.

Educational materials will include basic facts about asthma, specific skills in symptom monitoring, the role of medications and medication administration, appropriate responses to changes in asthma severity, and environmental controls.

The number of Americans diagnosed with Asthma has more than doubled since 1985; By 2000, more than 25 million Americans had been diagnosed with this chronic condition. Vulnerable populations at highest risk of acquiring asthma include children and low-income persons. Despite the vast resources spent on treating this disease, asthmatic patients continue to experience serious consequences. Each year, asthma results in nearly 2 million visits to the emergency room and roughly 5,000 deaths. Death from asthma sparks particular concern because this outcome is almost always avoidable with timely and effective care.

Why do people die in the ER from Asthma and how do we reverse it?

Acute severe asthma accounts for almost 2 million emergency room (ER) visits, 500,000 hospital admissions, and 5,000 deaths every year. It has been estimated that the primary reason for death from asthma *is the delay in seeking medical assistance*, since most asthma deaths occur at home or in transit to the hospital. Thus our goal is to get more asthmatics into treatment that uses the Emergency Room as the initial point of service. While there is no known cause or cure for asthma, recent studies have shown that hospitalizations and emergency room visits can be reduced by as much as 78% and 73%, respectively, when the disease is properly managed. Therefore our program will consist of several elements:

1. Our treat and release program with follow-up case management to reduce the rate of return to the ER;
2. On-going case management, education and medication management using Dobbs Ferry Primary Care Physicians and Nurse Practitioner Staff;
3. Assure proper instruction in medication use
4. Community based screening and education programs.

While asthma prevalence has increased over time, hospitalization for this condition improved between 1994 and 2000. However, current admission rates still fall short of the objectives set by the U.S. Department of Health and Human Services. In its report, Healthy People 2010, the Department established target hospital rates of 77 per 100,000 population for people ages 5-65 years, and 25 per 100,000 population for children under the age of 5 years. In 2000, admission rates were 201 per 100,000 children 0-17 years of age, and 113 per 100,000 adults 18 years and older.

Admission rates have been associated with lower socioeconomic status probably related to the inability to access preventive treatment of asthma.

- Our goal is to decrease asthma admission rate by 5% in year 1 and 20% in year 2.
- A safe discharge, follow up primary care physician, and contact with the Asthma Program Director within 3 to 5 days of discharge is essential for this goal.
- Our second goal is no acute events in a year from initial contact.

Pediatric Asthma Program

Outreach and education for parents presenting to the ER for care of the asthmatic child ·
 Follow-up phone calls made w/I 24 hours to assess adherence to discharge plan ·
 Referral to follow-up care with primary care physician ·
 Referral to asthma center for specialist care and case management ·
 Follow-up within 3 months

Discharge Planning, Periodic Assessment, Monitoring, Management, and Education

Coordination between Emergency Room physician, primary care providers, nurse practitioner and Asthma Program Director is essential for this diagnosis. Our Asthma Program Director follow up includes the following:

1. Contact within 24 hours of acute event for assessment and adherence to discharge plan.
2. Educate patient/family regarding:
 - Use of asthma action plan, peak flow meter, inhaler, spacer, dry powder inhaler, and medications.
 - Medication education and follow up including access to medication if unable to afford.
 - Importance of using long-term control medication (i.e., inhaled corticosteroids)
 - Recognition and treatment of symptoms and when to seek medical attention
 - Identification and avoidance of specific triggers
 - Smoking cessation and secondhand smoke avoidance

THE PLAN

3. Assessment of environmental triggers for asthma.
4. Asthma management plan developed with patient.
5. Referral to Adult Pulmonary Clinic at HRHC-VL in association with primary care physician as indicated.
6. Request follow up contact with patient at 1 week, post acute event, 3 months, 6 months, 9 months, and 1 year for treatment in an Emergency Department and/or inpatient admission.
7. Provide ongoing assessment and asthma advice in an open dialogue
8. Smoking Status will be evaluated while in the Emergency Department. If patient smokes, there should be documented evidence that a strong recommendation for smoking cessation was presented to the patient. There should be a review of options available to the patient to assist in smoking cessation, including medications and cessation programs (e.g, NYSQUIT). For patients who smoke there should be an ongoing effort to assist them in following a smoking cessation regime. If the patient smokes during initial illness the Asthma Program Director will re-ask question at same intervals.
9. If uninsured, referral to HRHC-VL for primary care. Provide assistance in application for Health Solutions and referral to New York State programs for primary care and medication assistance.
10. Flu vaccine and pneumonia vaccine referral by primary care.
11. Continuing Care referral as indicated for home care services.
12. Dietician for weight loss as indicated.

Diabetes

As a hospital system, we must take on more responsibility for organizing and providing the medical care of people with diabetes despite insufficient resources to absorb the growing numbers of referrals and to adequately address diabetes complications. A comprehensive approach to treating diabetes and its underlying conditions, such as obesity is essential. Detecting the disease in its earliest stage is also key. When the disease is in its “pre-diabetes” stage, actions can be taken to prolong, if not prevent, its onset and avoid unnecessary hospital admissions. The Institute of Medicine has identified this disease as a priority area for improvement of health care quality. Providing high quality care for diabetes management and treatment engages the health care system at all levels. Providers need to proactively manage their disease and work toward preventing secondary complications.

St. John’s Riverside Hospital treats over 9,800 patients annually who suffer from Diabetes. As part of a new demonstration program on diabetes care, SJRH-Dobbs Ferry Diabetes Specialty Center will reopen. The American Diabetes Association will recertify it as a Center of Excellence for diabetes self-management. The new center will operate in the emergency rooms of St. John’s and Dobbs Ferry and at HRHC-VL. At present over 75% of diabetics who present at the two hospital emergency rooms are admitted for inpatient treatment. A major outcome of this demonstration will be to stem the number of admissions for diabetes within our health system.

Building on its clinical reputation, The Center will operate a comprehensive diabetes *education community partnership*.

Dobbs Ferry Pavilion has taken on a strengthened role through the integration of its Surgical Weight Loss Center. The Weight Loss Center plays a significant role in the treatment of obesity, which is the overwhelming

precursor of the form of diabetes known as type 2 diabetes. Dr. Artuso, the Director of the Weight Loss Center, performs 125 bariatric cases per year at Dobbs Ferry. Of those 125 cases, approximately 30% are diabetics. The St. John's Riverside Hospital Wound Care Program treats over 800 diabetics annually. These three centers of excellence: Diabetes Specialty Care Center at HRHC-VL and Dobbs Ferry and in the hospitals' emergency rooms, the Wound Care Program and the Surgical Weight Loss program are at the core of a new comprehensive demonstration program to affect all stages of diabetes and obesity.

The demonstration program stresses the team approach, communicating closely with the referring primary care physicians in educating family members as well as those with diabetes. The Diabetes service is designed to act as a clinical problem-solving resource for primary care and then to 'hand back' clinical care to the referring primary care team.

The SJRH program provides an integrated model of care for diabetes related illnesses and self-management education and training. The Center will use a comprehensive team approach to help people and those close to them to live better with diabetes. Our demonstration program offers education classes and individual appointments with nurse educators, nutritionists, and support groups. Self-management programs include coping with diabetes for the newly diagnosed, special skills development for blood sugar monitoring, insulin pump therapy training, weight management, diet and weekly weigh in and periodic body fat measurement and medically supervised exercise programs. A diabetes nurse practitioner and endocrinologist are available on site. At the Dobbs Ferry site, a Bariatric Coordinator for the program ensures follow up with patients who currently have or are at risk to develop diabetes.

A comprehensive outpatient wound management program is also available for our diabetic patients with neuropathy. The Wound Healing Center consists of a multidisciplinary team of health professionals who work collaboratively to ensure that patients receive the most comprehensive evaluation and treatment. Non-invasive testing may be performed to check the adequacy of circulation and determine if bone is infected. Surgical wound debridement to remove non-healthy tissue is performed at the center. Services offered by home health care nurses, nutritionists, orthotists, and physical therapists are coordinated as needed.

At the Dobbs Ferry site, we offer our patients with morbid obesity multiple avenues to achieve weight loss. We offer surgical weight loss options with all the currently available surgical techniques including laparoscopic surgery (gastric bypass surgery and gastric lap-band surgery). The benefits of laparoscopic surgery is that it is less invasive which means less pain, easier and faster recovery and improved cosmetic results. We also provide non-surgical weight loss techniques including behavior modification, dietary aids, and supplements. We estimate there are 10 new consults seen each week by Dr. Artuso with approximately 35% of those presenting with diabetes. As part of our Diabetes Demonstration called Diabetics Using Bariatric Procedures:

- q A Registered Dietician is on staff at Dobbs Ferry Pavilion for follow up with these patients.
- q There are ongoing support groups for Bariatric patients to ensure they are following the proper plan of care for diabetes.
- q By screening for following co-morbidities, we will potentially eliminate the need for inpatient admissions. The co-morbidities that are screened pre and post surgery are:

- o Diabetes
- o High Blood Pressure
- o Arthritis
- o Cardiac
- o Hypercholesterolemia
- o Hypothyroidism
- o Depression
- o Surgery
- o Respiratory
- o GERD
- o Hiatal Hernia
- o Sleep Apnea
- o Migraines

Discharge Planning, Periodic Assessment, Monitoring, Management, and Education

The need to improve diabetes services is well documented yet few clinical interventions have been shown to effectively improve patient outcomes. Because more than 80 percent of adults with diabetes receive their care from primary care physicians, the community primary care practice is a logical focal point for implementing strategies that improve care delivery. Through our demonstration collaborative, we will work with our community of providers to increase primary care interventions with proven effectiveness in treating diabetes.

Our goal is to discharge from the Emergency Room following emergent care for an acute event to a safe environment. Our outcome measurement is to reduce inpatient hospital admissions for medical conditions associated with diabetes, 5% in the first year and 15% in the second year.

St. John's provides extensive community education forums that include education seminars often targeted to seniors, Hispanics and African-Americans, health fairs for senior citizens, diabetes day programs, community based support groups, faith based organizations, healthy heart lunch programs and workshops, multiple risk screening programs. We also offer programs for physicians and other health care professionals.

- Coordination between the Emergency Room physician, primary care provider and a Certified Diabetic Educator is required.
- Follow up calls within 48 hours of acute event by a Certified Diabetic Educator for assessment of discharge plan and adherence to plan.
- Request that additional contact be made at 1 month, 3 months and 6 months intervals for reoccurrence or similar events requiring Emergency Room and/or hospitalization.
- Certified Diabetic Educator will provide education on the following:
 - Hemoglobin Alc (HbA1c) testing will be completed on all diabetic patients at least once a year or more frequently if indicated.
 - Urine Microalbumin testing will be completed on all diabetic patients at least once a year.
 - LDL and HDL testing will be completed on all diabetic patients at least once a year or more frequently if indicated.

- Blood Pressure monitoring will be completed on all diabetic patients at all routine visits.
- Smoking Status will be evaluated while in the Emergency Department. If patient smokes, there should be documented evidence that a strong recommendation for smoking cessation was presented to the patient.
- Eye Exam will be completed on all diabetic patients at least once a year or more frequently if indicated.
- Foot Exam/Screening, which should include a foot evaluation for sensor motor (monofilament), skin and soft tissues integrity, vascular sufficiency (Pedal pulses), biomechanic integrity and shoes worn. The screen should be conducted at least annually and/or more frequently as indicated. Patients who have non-healing wounds maybe referred to the Wound Care Center at St. John's Riverside Hospital. Podiatry referral to own podiatrist or HRHC-VL.
- Should the patient not have a primary care provider in the area the patient will be referred to the on-call primary care provider or to HRHC-VL.
- Referral to Continuing Care Coordinator may be required for home care services.
- Dietary referral for meal planning based on assessment.
- Immunizations - all diabetic patients should receive the influenza vaccine annually and pneumovax vaccine every five years.
- Referral as indicated to Diabetes Clinic at HRHC-VL.
- Telephone contact with primary care provider prior to discharge from Emergency Department.

DIABETES COMMUNITY OUTREACH PROGRAM

Intervention Component Description Target- target high risk patients who have been treated in the SJRH and DF ER for diabetes or a related condition. Registry - Create a registry for data collection, reporting, and support. Diabetes Coordinator- oversee changes in roles and responsibilities and enhance continuity during staff turnover and will facilitate program coordination. Notify and remind - Notify patients of targets and appointments. Remind providers at time of visit with patient-specific alerts. Primary Care Team- Our three-member team will work with the site coordinator and facilitate the intervention with colleagues. Audit and feedback - Audit and review monthly. Provide feedback to improve progress. Track -Track process measures, outcomes, and operational activity. Education -Educate and update ER staff in diabetes management techniques.

Pneumonia

Community acquired pneumonia (CAP) is pneumonia contracted outside a hospital or nursing home environment which affects 4 million Americans each year, account for more that 1 million hospital discharges. The cost of treating CAP patients is significant, \$10 billion per year with about 92 percent of this amount spent on hospital care.

Facts about CAP:

- 4 million Americans are affected each year.
- Minorities are 3 to 10 times more likely to be affected than whites.
- The elderly are 60 percent more likely to be affected than the general population.
- 1 million hospital discharges per year can be attributed to CAP.
- 90,000 persons die every year from all forms of pneumonia, including CAP.

THE PLAN

Improving treatment decisions for patient with CAP:

- The mortality rate for low-risk patients treated at home is less than 1 percent.
- The mortality rate for the more serious cases treated in a hospital each year is between 2 and 30 percent.
- The mortality rate for all cases is about 13 percent each year.
- About \$10 billion per year is spent on caring for patients with CAP.
- The average cost for an inpatient case is about \$5,700.
- The average cost for an outpatient case is about \$300.
- About \$100 million per year is spent on antimicrobial therapy for CAP outpatients

Our goal is to treat the patient with antibiotics promptly, discharging the patient to a safe environment thus decreasing unnecessary hospital admissions. One research study indicated low-risk patients preferred to be treated at home. Our outcome goal would be to decrease hospital admissions by 5% in the first year and 20% in the second year.

Discharge Planning:

- Referral to Continuing Care Coordinator as required for home care services.
- Referral to Asthma Program Director if patient has a history of Asthma/COPD.
- Assessment for safe discharge referencing the Pneumonia Severity Index (PSI)
- Coordination between the Emergency Room physician, primary care provider and a nurse practitioner.
- Follow up call within 24 hours of acute event by a nurse practitioner for assessment of discharge plan and adherence to plan.
- Request that additional contact be made at 1 month, 3 month and 6 month intervals for reoccurrence of Community Acquired Pneumonia requiring Emergency Room and/or hospitalization.
- Refer for flu and pneumonia vaccine to primary care provider.
- Smoking Status will be evaluated while in the Emergency Room.

Hypertension

Data from the National Health and Nutrition Examination Survey census bureau show that only 34% of patients with hypertension have adequate blood-pressure (BP) control; the result is that hypertensive emergencies present in roughly 27.5% of emergency room visits nationwide. Long-term effects of hypertension also are significant risk factors for hospitalization.

The goal of treatment for hypertension is to lower blood pressure and reduce the risk of complications from hypertension—specifically strokes, heart attacks, heart failure, and kidney disease. People experiencing a hypertensive emergency will have their blood pressure lowered with intravenous antihypertensive medication in ER. Following that, our goal is to provide a safe discharge for the patient with appropriate follow up in the community decreasing admissions by 5% the first years and 10% the second year.

Discharge Planning:

- Coordination between the Emergency Room physician, primary care provider and nurse practitioner is essential.
- Patient will have blood pressure rechecked within 24 hours of discharge. In the event that the patient is unable to be seen by a community provider within 24 hours, may return to the Emergency Room.
- Inform patient that interim blood pressure measurement may be done every other Wednesday (Wellness Wednesday) in the lobby of Dobbs Ferry Pavilion.
- Nurse practitioner will contact patient within 48 hours of discharge for assessment and adherence to discharge plan.
- Telephone contact will be made 48 hours for assessment and adherence to discharge plan. During telephone contact request that additional contact be made at 1 month, 3 months and 6 months intervals for reoccurrence of hypertension requiring Emergency Room and/or hospitalization.
- Nurse Practitioner will assist with the following at a minimum:
 - Referral to dietician for weight reduction/meal planning as indicated
 - Stress reduction techniques - refer to Hospital Program at St. John's Riverside Hospital.
 - Review importance of self-management, treatment adherence and follow up visits to community provider.
 - Exercise program as indicated.
 - Education of medication including adverse reactions.
 - Education of possible complication
 - Cardiovascular disease
 - CHF
 - Stroke
 - Consultation with primary provider of home blood pressure monitoring either own machine or visiting nurse.
 - Smoking Status will be evaluated while in the Emergency Room.

Dehydration

Certain populations are especially vulnerable to dehydration, including older Americans and very young children. Often, this condition can be treated in an outpatient setting. In many cases, hospital treatment may be unnecessary. However, inadequate treatment can result in serious complications including mortality.

Age may be a contributing factor to requiring an admission to the hospital. We will monitor all dehydration admissions initially but may need to re-adjust our model to a specific age group.

Our goal is to decrease dehydration admissions by 5% in the first year and 15% in the second year.

Discharge Planning:

- Patient is able to tolerate adequate p.o. fluid.
- Continuing Care Coordinator referral as need for home care services.
- Coordinate care by Emergency Room physician, primary care physician, nurse practitioner to facilitate safe discharge plan and follow up.

THE PLAN

- Nurse Practitioner will have contact with the patient in 24 hours to access the following at minimum:
 - Ability to tolerate fluids and progression to normal dietary status.
 - Refer to dietician as need for meal planning
 - Request that follow up contact be made with patient at 1 month, 3 months and 6 months intervals for reoccurrence of dehydration requiring Emergency Room visit and/or hospitalization.
 - Smoking Status will be evaluated while in the Emergency Room.
 - Referral to primary care physician for flu and pneumovax vaccine as need.
 - Education of medication including adverse reactions.
 - Assessment of discharge plan and adherence to plan.

D. Cancer Programs

Breast cancer kills more Westchester women than any other type of cancer except respiratory related cancers. Our focus is on the minority populations in Yonkers where the breast cancer incidence rates are among the highest in the state. This will be accomplished using St. John's Riverside Hospital Breast Cancer Patient Navigator program. We seek to increase access to appropriate prevention, detection and treatments for minority women with a special focus on *under-treatment among minority women* for breast cancer. Our focus is on the minority populations in Yonkers and other small cities referred to as the Rivertowns in Westchester County where the cancer incidence rates are among the highest in the state. Over 50,000 women over the age of 35 live in the City of Yonkers, approximately 25,000 of which are minorities who are typically low income, uninsured and underinsured.

Women in this population tend to put their family and extended family ahead of their own health prevention. Reaching out to this population through community-based programs e.g., Cabrini Immigration, faith based organizations and most importantly "word of mouth" from patients who have used our services will play a large role in the increasing access. The undocumented population is untrusting of the system, thus we need to build upon relationships of trust.

We will reach out to patients who are uninsured, underinsured, or who have Medicaid to encourage utilization of the Ashikari Breast Center or HRHC-VL for complete breast exam (CBE) and diagnostic services.

Patients who develop a positive diagnosis have access to the following:

- Physician to discuss treatment options
- Offered assistance to access treatment options
- If uninsured – application completed for emergency Medicaid

Our goal is to significantly improve access to and utilization of beneficial cancer interventions. Individuals who require additional cancer care services will be referred to our network of medical and surgical oncologists and to our breast cancer center of excellence, The Ashikari Breast Center. Dr. Ashikari operates one of the most active breast cancer programs in Westchester County, and it will be a major provider of treatment for women with breast cancer who participate in this program. Through our demonstration program we will:

- Reduce cancer disparities among racial and ethnic minorities.

- Maximize the quality and quantity of life of members of our community through screening, prevention and control of cancer.
- Provide cost-effective state-of-the-art cancer screening, diagnosis and treatment.
- Educate physicians, health care providers and community advocates about cancer screening, prevention and control.
- Provide community outreach for education and cancer screening.
- Provide comprehensive rehabilitative services and palliative cancer care.
- Provide emotional/physiological support services for cancer patients and their families.
- Benchmark our progress as part of our PQI program by increasing the coverage of clinical breast examinations and mammography every two years to at least 60 percent over five years of women over aged 50 in our service area;

Since 2000, with funding from the Avon and Komen Foundations and the New York State Department of Health, we established the St. John's Riverside Cancer Patient Navigation Program. Community education, cancer detection and treatment coordination, support and linkages are achieved through the patient navigator relationship. The complexity of breast health treatment and the growing demand for outpatient services requires trained professionals that can increase positive patient outcomes and patient satisfaction while containing costs. The breast health navigators serve as coordinators throughout care and assess the physical, educational, psychological and social needs of the patient. As a result of these efforts about 10,000 women annually are screened for breast cancer, of which nearly half have sought and received treatment.

Through our navigation program, we have initiated methods of communicating with our Black and Hispanic patients to overcome cultural attitudes about treatment and the efficacy of prevention services and adherence to treatment regimens. Throughout the demonstration project, they provide improved access to integrated breast cancer treatment for minority populations, have been active in providing a host of services through education and helping woman to cope with potential breast cancer diagnoses by making the process smoother and removing any barriers to treatment. Our patient navigators work closely with the radiology departments at St. John's Andrus site and the at the Dobbs Ferry site, to ensure that those patients who are identified as needing further care are linked with vital resources.

Using our existing community partnership community outreach for education and cancer screening is accomplished. We educate residents of Yonkers about the risk factors relating to breast cancer and the need for screening and follow-up. Our business membership provides access to businesses and their customers to do employee screenings and educational presentations. Our Faith Based Organizations have successfully educated and stimulated Black and Hispanic pastors to focus their congregations on changing high-risk health behaviors of poor diet, lack of exercise and smoking. Consortium members have close ties to their communities, schools, community service organizations and the target population.

Our community-based breast health partnership maximizes local resources to educate, motivate and recruit eligible women and to coordinate breast screening and follow-up services. Partnership participants include the Health Department, the American Cancer Society, human service agencies, businesses and medical care providers. Partial funding for Breast Cancer Support Groups is provided through a grant from the **NYS**

THE PLAN

Department of Health. Hospital staff is dedicated to and active in continually pursuing funding to support our initiatives through government and private funding sources.

Our Yonkers Community Breast Health Program is unique because of its inclusiveness of program elements and partnerships with community advocacy groups. Our program contains all the elements: out-reach, education, screening treatment, support services and coordination of follow-up. It does not seek to duplicate programs, but rather it seeks to build on their respective strengths and experience to discard techniques that have not worked to reach at-risk women and equally as important to maintain women in treatment when necessary. There are gaps in the system despite the number of programs that do exist. Lack of treatment is not a function of lack of options but rather a complex web of perceived and real barriers, economics, fear and cultural attitudes. By inviting those organizations closest to at-risk women and developing appropriate patient navigator programs we have successfully filled in the missing links that result in disparities among minority and low-income women whose breast cancer incidence rates and mortality rates remain at unacceptable levels.

Part II. Community Education, Community Partnerships, Health Fairs and Prevention Screenings

Real community involvement is needed to successfully change environments and prevent chronic diseases within the Yonkers and Rivertowns communities. Our approach is to bring together a diverse group of leaders from the public sector, nonprofit organizations, and private entities to design unique disease prevention and health promotion strategies that respond to our local needs and take advantage of local assets.

Our community partnership relies on a consortium of over fifty different types of healthcare and non-healthcare providers who have an established referral network and significant in-reach into their respective communities. It is called The Healthy Yonkers Initiative (HYI). The Healthy Yonkers Initiative has been in operation since early 1998. It sponsors health care and community awareness campaigns, and produces and distributes valuable health care information throughout some of the most socio-economically deprived areas in the region. We estimate our consortium members touch the lives of at least two-thirds of the minority residents of Yonkers. Our consortium through its prior education programs already know how minorities view health disparities, the risk factors underlying them, and how to attack them in a community-based participatory program. Because this consortium is already in place our chronic care and cancer education program can be implemented immediately.

Several of our HYI consortium members are qualified care management organizations that are paid from grant funds to provide patient navigator services for the cancer care patients that require follow-up and referral. Because our target communities lack access to any routine network of care through a designated provider, we designed a shared care management strategy that utilizes the existing resources of our CBOs and health care providers to join in harnessing our knowledge and experience with these patients in an organized cancer care management program.

With respect to cancer outreach to poor and minority women, The St. John's Patient Navigator Program has been adapted for broad-based community use. This unique program uses Patient Navigators to create a pathway through which individuals can navigate the complex healthcare system. The navigator builds awareness in the patient of all available services, helps clarify choices and ensures unrestricted access to all services and ensures that all follow-up efforts are completed.

Community Education/Health Fairs screenings will include but not limited to the following:

1. Access to insurances and alternatives should they not qualify for insurance (Sliding scale) children coverage with New York State Medicaid guidelines.
2. Information for free screenings/low cost program including but not limited to:
 - a. Breast Cancer
 - b. Cervical Screening
 - c. Colon Cancer
3. Children and Adult Asthma Education
4. Diabetes Prevention and Management including Dietary information
5. Outreach for education and cancer screening
6. Hypertension
7. Obesity
8. Blood Pressure Screenings
9. Breast Cancer Prevention and Information
10. Substance Abuse Programs available at Riverside Health Care System Smithers Program

We will establish additional linkage with organizations in the Rivertown:

1. Expansion of our Pediatric Asthma Program into zip codes outside of Yonkers area.
2. Faith based organizations to identify opportunities to provide services for minority and uninsured populations.
3. Partnership with Cabrini Immigration located in Dobbs Ferry who provides services to immigrants.
4. Explore any and all other opportunities for community linkage.
- 5.

Home Support Services for Elderly and Infirm

The Emergency Department will make a referral to the Continuing Care Coordinator as necessary to determine a safe discharge plan. Continuing Care will assess the patient and determine if home care services are required, making appropriate referrals to agencies to ensure a safe discharge.

The Coordinator will contact the patient within 72 hours to assess the implementation and progress of the discharge plan. A determination of whether the patient has a primary provider will be made by the Emergency Department and/or physician referral given to the patient. Should the patient require primary care services in the home setting, a referral will be made to a Dobbs Ferry Pavilion physician who provides home care services.

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.

THE PLAN

The SJRH Institute for Health Education and Research and The Cochran School of Nursing will partner with St. John's Riverside Hospital to develop curriculum and structure on-site program to promote awareness of current research and technology in health care and health care delivery; serve as a resource center for professional and non-professional groups, and the community; offers programs focusing on concepts, practices and research related to health care and the hybrid health care delivery.

Four (4) meetings per calendar year for the following corps:

Ardsley

Dobbs Ferry

Greenburgh

Hastings

Irvington

PART III. Use of Benchmarks to Track Improvements

The Dobbs Ferry Pavilion of St. John's Riverside Hospital will focus on the reduction of emergency room use and inpatient admissions for ambulatory sensitive conditions for residents of the Rivertowns community of Westchester County.

As part of its **five-year** demonstration program, the above Prevention Quality Indicators, developed by The Agency for Healthcare Research and Quality (AHRQ) will be used to track outcomes. SJRH will collaborate with community providers and be responsible for reporting on these benchmarks demonstrating improved health outcomes community wide. The data collection effort will begin with 2008 for the benchmark year for the community PQI indicators and will be benchmarked annually during the five years from June 2009 through 2012.

The following Ambulatory Sensitive Conditions will be benchmarked for the River Towns Service Area during the demonstration period for the following:

- 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

Depending on the quality of the SPARCS data available to Dobbs Ferry, we will report findings by: age, sex race and financial payer data. The goal is to measure changes in these PQI measures during the period of the demonstration. 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. SPARCS data on the above PQI indicators will include the following communities.

<i>Zip Code</i>	<i>City/Town</i>
10522	Dobbs Ferry
10706	Hastings
10533	Irvington
10502	Ardsley
10701	Yonkers
10703	Yonkers
10710	Yonkers
10705	Yonkers
10530	Hartsdale
10583	Scarsdale
10591	Tarrytown

Prevention Quality Indicators (PQIs) will be used to measure rates of reductions throughout the five-year demonstration. Specific reductions in emergency use and inpatient admissions will be set for each of the five chronic conditions using PQI measures.

Program Participant Information

In addition to PQI indicators epidemiological and statistical trends will be reported on the following during the five-year plan of the project from year 2009 through year 2014, for both St. John's Riverside Hospital and Dobbs Ferry Pavilion of St. John's. The data will be reported quarterly and include the following: age, sex, ethnicity, race and payer source.

With respect to Ambulatory Procedures and inpatient admissions, we will track what services are provided according to: patient demographics, diagnosis and outcomes.

Our goals:

- Asthma Decrease rate by 5% in year 1 2009 -2010 and by year 2 20% and maintain that rate throughout
- Pneumonia 5% in year 1 and 20% year 2 and maintain throughout
- Hypertension 5% and 10% by year 2 and maintain throughout
- Dehydration 5% and maintain the 15%
- Diabetes 5% and 15% to maintain

For Breast Cancer, our evaluation model will measure 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 referral 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 and change in Incidence Rates

THE PLAN

The HOPE Center (HIV Services)

We continue to receive funding from several sources to support our comprehensive array of HIV-related services.

Grant funding includes money from Ryan White Title I funding from the Westchester County Department of Health and the NY State Department of Health to support intensive medical case management, targeted case finding activities and treatment adherence counseling services. We continue to receive Ryan White Title II funds from the NY State Department of Health to help support our outpatient primary care services for individuals living with HIV/AIDS. We also receive support in Ryan White Title III funds from the US Department of Health and Human Services to support our Early Intervention Services.

We offer a comprehensive array of services for individuals living with HIV and their families. This includes comprehensive primary care (provided by HIV Specialists), case management, HIV-specific dental services, mental health services, adherence counseling and transportation. Using our Ryan White Title III funds we plan to open the area's only HIV-specific Pain Management Unit.

SJRH also received a grant of \$2.4 million (over five years - year 4) to provide enhanced substance abuse treatment services to individuals of color who are at-risk of HIV infection or who are HIV-infected. The grant is from the US Department of Health and Human Services' Substance Abuse Mental Health Services Administration. This grant-funded service is a cooperative venture between The HOPE Center and St. John's Behavioral Health Services. Services are co-located at New Focus Center and the Methadone Maintenance Treatment Center.

Smithers Alcoholism Treatment and Training Center

We continue to receive 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.

The Smithers Center distributes patient satisfaction surveys at least 2x a year for clients actively involved in treatment and utilizes this information to improve the services offered in all our facilities. We offer CASAC training programs to educate health care professionals about chemical dependency counseling. We also offer free workshops to the public about chemical dependency and how families can access treatment services.

All patients receive a full assessment upon entry into our treatment system. We review our aggregate data on diagnoses routinely and revise our treatment services to match patients' needs in the areas of chemical dependency, mental health problems and medical needs.

Our three year plan includes :

- Continue to expand our treatment programming to meet the needs of those patients involved in the criminal justice system.
- Continued outreach and treatment programming to meet the needs of the veterans and the military.
- Continued growth of our Smithers Training Center.

St. John's Riverside Hospital applies for and receives a number of grants to support the work it does for the community. The following is a list of grants received for the calendar year 2009.

SJRH GRANTS and Other Revenue

Award	Award	Period	Total
APPSP	\$192,000	4/1/08-3/31/09	\$ 479,980
	\$191,040	4/1/09-3/31/10	\$ 442,721
COBRA	152,175	1/1/08-12/31/08	
Greyston HIV	74,000	1/1/08-12/31/08	
NYSDOH / HRSA BioPrep DHHS/HRI	45,000	8/9/08-8/8/09	\$ 45,000
Komen Breast Cancer Foundation	74,000	4/1/08-3/31/09	
	73,000	4/1/09-3/31/10	
MHA Liaison for Disabled	35,000	1/1/09-12/31/09	\$ 35,000
NYS DOH Ovarian Cancer	18,011	10/1/08-9/31/09	\$ 60,000
Ryan White Title I	174,000	3/1/08-2/28/09	
Ryan White Title I	145,038	8/1/08-7/31/09	
Ryan White Title II	300,000	4/1/08-3/31/09	
Ryan White Title III	436,000	4/1/08-3/31/09	
SAMHSA III	436,000	9/30/08-9/29/09	
TREATMENT ADHERENCE	54,000	10/1/08-5/31/09	
Other 2008 Grants			
SAMSHA II	155,357	9/30/07-9/29/08	
Total			\$3,908,831

Riverside Health Care System, Inc.

967 North Broadway

Yonkers, New York 10701