St. John's Riverside Hospital
2013 Community Service Plan

1. **Hospital Mission Statement**:

The St. John's Riverside Hospital mission statement fully encompasses our purpose and affirms commitment to who 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, 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. **Definition and brief description of the community served**:

St. John's Riverside Hospital (SJRH) is comprised of the following entities:

- SJRH Andrus Pavilion (254 beds, general medicine, surgery, obstetrics, emergency services)
- SJRH Park Care Pavilion (141 beds, behavioral health services)
- SJRH 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 care system are widespread and diverse. 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.

With a population of 195,976, *(U.S. Census Bureau 2010)*, Yonkers is New York's 4th largest city. 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 all problems that are concentrated in southwest Yonkers.

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 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 because so many of its residents lack insurance and access to care. The NYS 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.

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, with southwest Yonkers becoming one of the major epicenters of the HIV/AIDS epidemic in New York State.

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 8/1/2013. This included 435 families and 723 children. Westchester County analyzed the communities of origin of its sheltered homeless population on 4/1/11 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 Pavilion is the only hospital located in the town of Dobbs Ferry. Its primary service areas include Dobbs Ferry, Hastings-on-Hudson, Ardsley, Irvington, Tarrytown, Elmsford, Hartsdale, Greenburgh, Yonkers, White Plains and Scarsdale. 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**:

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

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, and social media. We sought input through meetings, focus groups, interviews, surveys, health forums, educational sessions and written correspondence.

The service area assessed was Westchester County. The assessment was conducted in partnership with the Westchester County Department of Health (WCDOH). St. John's, 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 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 WCDOH Planning and Evaluation health data profile of Prevention Agenda Priority Areas, Westchester County 2013-2017; County Health Rankings www.countyhealthrankings.org/; the NYS Community Health Indicator Reports and the Westchester County Health Assessment Indicators on the NYSDOH website http://www.health.ny.gov/statistics/chac/indicators/. Following review of this data and results from the 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 St. John's '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. St. John's 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 captured through traditional compliment and complaint letters received through administration. A community health needs assessment survey was produced in Survey Monkey. The survey, available in print, was emailed to over 3,000 registered users of the SJRH website. 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.

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 to address relevant health issues.

HYI participants include: the City of Yonkers, federally-qualified Valentine Lane Family Center, Congregations Linked in Urban Strategy To Effect Renewal (CLUSTER), Community Planning Council of Yonkers, Cabrini Immigrant Services, American Health Association, The Elderly Pharmaceutical Insurance Coverage program (EPIC), Family Service Society of Yonkers, WestHab, Family Services of Westchester, Good Shepard Presbyterian Church, Greyston Foundation, Yonkers Office for the Aging, American Cancer Society, St. Joseph's Medical Center, Hebrew Home for the Aged Blind/Elder Serve, Nepperhan Community Center, Office of the County Executive: *Invest in Kids* Urban Youth Initiative, Parents As Partners, United Way, Yonkers 55 Plus, The Sharing Community, Visiting Nurse Services of Westchester, Westchester Children's Association, Westchester County Department of Health, Westchester County Department of Social Sciences, Yonkers Community Action Program, YMCA, YWCA, Yonkers Chamber of Commerce, Yonkers Police Department, Yonkers Public Library, Yonkers Municipal Housing Authority, and Hudson River Immigrant Services. 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 deliver patients 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, NYS Department of Health's AIDS Institute, HRSA, and the Tri-County Consumer Advisory Group Living Together. The HOPE Center has active planning and referral linkage agreements with the following CBOs and other local health-related organizations:

- Center Lane Youth Services (WJCS)
- Cluster Congregate Care, Good Body House
- 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 11/1/13 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 American – Greater New York
- Westchester Medical Center

St. John's 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 the 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. Throughout 2012 and 2013 we worked closely with many community-based organizations, primarily through our Healthy Yonkers Initiative; met with elected officials to seek support and advise them of our findings; employers, businesses, local governmental organizations, local health department, health care partners; media, Yonkers Public Schools and PTA Coordinating Council; FEMA 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 residents.

The role of our community outreach liaison staff is to develop closer ties between the hospital, and all of its entities, 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, and housing developments. 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.

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

Our needs were identified and prioritization of those needs was established as part of a countywide planning process facilitated by the Westchester County Department of Health's Health Planning Committee. SJRH is an active participant in the Health Planning Team. The public input process encompassed the following collaborations: WCDOH Healthy Hospital's Collaborative and Health Summit, Healthy Yonkers Initiative, St. John's Community Advisory Committee, and the Maternity and HIV partnerships. The following is a list of in-person meetings and conference calls, including a Health Summit and health provider site visits; held to involve the public, discuss findings and potential health improvement initiatives.

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. Meetings were held on the following dates: March 28, April 25, June 22, and July 27, 2012.

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

- March 21, 2012 at Yonkers City Hall
- June 21, 2012 at the Yonkers Riverfront Library
- September 20, 2012 at Saint Joseph's Medical Center
- December 20, 2012 at St. John's Riverside Hospital
- June 20, 2013 at the Yonkers Riverfront Library
- September 19, 2013 at the Chema Senior Center
- December 19, 2013 to be held at Sprain Brook Manor Nursing Home.

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

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

The meetings feature speakers who present information and facilitate discussions of community needs and resources. Recent speakers included representatives of the Westchester Hispanic Coalition, American Diabetes Association, Yonkers Fire Department, NYS Department of Labor, Yonkers Police Department, City of Yonkers, NYS Attorney General's office, Metropolitan Jewish Health Association, American Lung Association, and the 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.

Meetings held in June of 2012 and 2013 between SJRH and the **Hudson Valley Perinatal Network** gave the opportunity for a formal discussion of perinatal needs across the regions, 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. Last survey 2012. Survey currently in process for 2013. Items addressed had to do with client perception of HOPE Center services and potential areas of increased needs. Client participation in 2013 is through a random sample of HOPE's clients. In previous years this was through a convenience sample.
- 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 will be re-designed (as required) for 2014. Goals of the PI plan are in congruence with this CSP.
- Attend and participate in 10 Ryan White Part A Steering Committee meetings per year (meetings are held monthly). This group includes participation from 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)
- Four meetings with clients regarding the "Getting to Zero" (reduction in community viral load) project. (March, April May, & December 2013). These meetings were 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.
- Presentation on the "Getting to Zero" project to NY State Department of Health's AIDS Institute's Quality Improvement Committee. (October 2013)

- Numerous educational events on 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 (January – March 2013) and Hepatitis C group (every month, 2013). Input is obtained in both groups on client priorities for programming. Clients decided to discontinue Treatment Adherence Group in 2013.
- In 2013, ongoing client participation through the SAMHSA-funded TCE/HIV grant program. This included client satisfaction surveys and an internal evaluation.

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. A regional forum was held in September 2013. This regional forum played 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 discussed and identified key challenges to living healthy and addressing health issues in different regions of New York State. It provided a forum to learn directly from the Latino/Hispanic community about the issues affecting their health. The forum succeeded 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 was beneficial in designing our community action plans.

The hospital **Community Advisory Committee** has been very enthusiastic in working with the hospital to better integrate the delivery of care with the needs of our local community. The group meets quarterly and has one meeting a year 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 is solicited in that meeting and over the course of the year. Members are encouraged to share information provided in these sessions with their community groups and businesses.

In June 2012 and April 2013, 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.
- Work with schools to improve eating habits, reduce obesity, and enhance exercise opportunities.
- Provide preventive health materials to city residents on chronic disease such as diabetes, asthma, and heart disease.
- Provide education to families and the community in general about mental health/illness and substance abuse.

A **Women's Health Forum Survey** was completed in May 2012. The responses of the participants as to what additional health care education is needed was one of the key community inputs to setting the framework for assessing needs and planning educational programs for the community.

A survey of the members of the **PTA Council of Yonkers** in 2012 provided evidence of a need for parent and teacher education in the areas of health related problems such as obesity, asthma and cystic fibrosis in children.

St. John's has partnered with local **Assemblymember Shelley Mayer** to offer open forums to present 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. St. John's and the Assemblywomen co-sponsored a forum at the hospital in June 2013. The session focused on the Affordable Care Act and its impact on community residents. A significant portion of the forum was allotted to discussion of the communities' health care needs and areas for improvement in health care services.

In October, we collaborated with the **Cabrini Immigrant Services** in a session to foster non for profit collaboration. In this session participants were able to discuss some of their community needs and strategies for addressing them. As a result we will have established an open forum with this organization to provide education to the clients that will benefit from our focus on prevention initiatives.

c. Public notification of these sessions:

St. John's Riverside Hospital sends consistent notification of sessions held through our hospital website, Facebook page, 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.

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 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**:

We have identified (4) major goals in three priority areas for our Community Service Plan:

Priority: Prevent Chronic Disease

- 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.**

Priority Area: Promote Healthy Women, Infants, and Children

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

Priority Area: 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.**

Our goals were selected as part of a countywide planning process facilitated by the Westchester County Department of Health's Health Planning Team. SJRH is an active participant in the Health Planning Team. The service area assessed was Westchester County. The assessment was conducted in partnership with the Westchester County Department of Health (WCDOH). St. John's, 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 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 WCDOH Planning and Evaluation health data profile of Prevention Agenda Priority Areas, Westchester County 2013-2017; County Health Rankings

www.countyhealthrankings.org/; NYS Community Health Indicator Reports and WCDOH Health Assessment Indicators on the NYSDOH website http://www.health.ny.gov/statistics/chac/indicators/. Following review of this data and results from the myriad of community health assessments conducted by SJRH, we prioritized needs and developed a plan.

The following is a description of the collaborative process with the WCDOH, a list of meetings/ conference calls held including our Health Summit, where we reviewed current health data, identified and prioritized needs for our health improvement plans.

Westchester County 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 all sixteen Westchester County hospitals 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 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 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 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.

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*).

WCDOH 2013 MEETINGS	DATE
Health Planning with Hospitals	Thursday, January 31, 2013
Health Planning with Hospitals	Thursday, February 28, 2013
Health Planning with Hospitals	Thursday, March 28, 2013
Health Planning with Hospitals	Thursday, April 25, 2013
Health Planning with Hospitals	Thursday, May 23, 2013
Health Planning with Hospitals	Thursday, June 27, 2013
Health Planning Team Conf Call (re: August Health Summit)	Thursday, July 11, 2013
Health Planning with Hospitals	Thursday, July 25, 2013
Health Planning Summit	Thursday, August 15, 2013
Health Planning with Hospitals	Thursday, August 22, 2013
Health Planning with Hospitals	Thursday, September 26, 2013
Health Planning with Hospitals	Thursday, October 10, 2013

HEALTH PLANNING COMMITTEE

ORGANIZATION	ADDRESS	CITY, NY ZIP
Blythedale Children's Hospital	95 Bradhurst Avenue	Valhalla, NY 10595
Burke Rehabilitation Center	785 Mamaroneck Ave	White Plains, NY 10605
Hudson Valley Hospital Center	1980 Crompond Road	Cortlandt Mnr., NY 10567
Lawrence Hospital Center	55 Palmer Avenue	Bronxville, NY 10708
Mount Vernon Neighborhood Center	107 West 4th Street	Mount Vernon, NY 10550
Northern Westchester Hospital	400 East Main Street	Mount Kisco, NY 10549
Open Door Family Medical Center	165 Main Street	Ossining, NY 10562
Phelps Memorial Hospital Center	701 North Broadway	Sleepy Hollow, NY 10591
Saint Joseph's Hospital	127 South Broadway	Yonkers, NY 10701
Sound Shore Medical Center	16 Guion Place	New Rochelle, NY 10802
St. John's Riverside Hospital	967 North Broadway	Yonkers, NY 10701
St. Vincent's Hospital Westchester	275 North Street	Harrison, NY 10528
Stellaris Health Network	135 Bedford Road	Armonk, NY 10504
Westchester Medical Center	95 Grasslands Road	Valhalla, NY 10595
White Plains Hospital	Davis Ave. @ E. Post Rd	White Plains, NY 10601
Westchester County Dept. of Health	25 Moore Street	Mount Kisco, NY 10549

HEALTH SUMMIT (August 15, 2013) - STAKEHOLDERS SUMMIT MEMBERS

ORGANIZATION	ADDRESS	CITY, NY ZIP
Affinity Health Plan	2500 Halsey Street	Bronx, NY 10461
American Diabetes Association	110 Corporate Park Dr.	White Plains, NY 10604
American Heart Association	3020 Westchester Ave.	Purchase, NY 10577
American Lung Assoc. POW'R Tobacco Cessation Center	237 Mamaroneck Ave.	White Plains, NY 10605
Hagan School of Business, Iona College	715 North Avenue	New Rochelle, NY 10801
Hudson Health Plan	303 South Broadway	Tarrytown, NY 10591
Lower Hudson Valley Perinatal Network Children's Health & Research Foundation, Inc.	Westchester Medical Center - 100 Woods Road	Valhalla, NY 10595
March of Dime	1800 Mamaroneck Avenue	White Plains, NY 10605
New York Medical College School of Health Sciences and Practice	40 Sunshine Cottage Road	Valhalla, NY 10595
Pace University	1 Martine Avenue	White Plains, NY 10606
Planned Parenthood Hudson Peconic, Inc.	175 Tarrytown Road	Tarrytown, NY 10591
Power Against Tobacco	237 Mamaroneck Ave.	White Plains, NY 10605
Rye YMCA	21 Locust Avenue	Rye, NY 10580
St. Frances African Methodist Episcopal Zion Church	18 Smith Street	Port Chester, NY 10573
THINC – Taconic Health Information Network & Community	300 Westage Business Center Drive	Fishkill, NY 12524
United Way of Westchester and Putnam	366 Central Park Avenue	White Plains, NY 10606
Westchester County Dept. of Social Services	112 East Post Rd., 5th floor	White Plains, NY 10601
Westchester County Office of Women	112 East Post Road	White Plains, NY 10601
Westchester County Dept. of Senior Programs & Services	9 South First Avenue, 10th floor	Mount Vernon, NY 10550
Yonkers Public Schools	75 Riverdale Avenue	Yonkers, NY 10705

5. **Three Year Plan of Action**:

PRIORITY: 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, be 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 ED that are not needed.

Objective 1:

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

Interventions:

- Refer those with chronic diseases such as CHF, Cardiac Disease, COPD, Diabetes, and Renal Disease, who have frequent re-hospitalizations or are at risk for such. Include the caregivers for patients with dementia.

- The 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.
- (The Coaching of the patients and family members is based on the Coleman Transition Intervention) 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 AMI, CHF and Pneumonia.
- Measure readmission rate for those that refused the service.
- Analyze barriers to the success of self-management.

PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

FOCUS: Maternal and Infant Health

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

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%.

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 – Baseline 2012: Black 14%, Hispanic 10%, White 20%.

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. The table below 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.

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%**

Interventions:

- Educate staff, stakeholders, and the public at large on the benefits of breastfeeding and breastfeeding exclusively;
- Require all Maternity staff to complete the 10 Steps to Breastfeeding on-line course (24.4 CEU's);
- Promote skin to skin and breast feeding after birth;
- Encourage rooming-in with mothers;
- Give every mother the Breastfeeding Bill of Rights on admission;
- Give breast feeding referrals to every mother upon discharge;
- Make follow-up phone calls to every mother, discuss feeding, newborn care, and maternal self-care;
- Continue Certified Lactation Coordinator support pre and post delivery;
- Remove all magazines that contain coupons or advertisements for commercial formula;
- Continue practice of not placing bottles in cribs of breast feeding babies;
- Continue practice of not handing out diaper bags with commercial formula in it;
- Continue practice of not providing pacifiers for newborns;
- Utilize physician liaison staff to outreach to Pediatric and Obstetrics/Gynecology practitioners to identify what resources they need to support their patients with initiation and duration of breastfeeding;
- Participate in the state "Great Beginnings NY" Campaign;
- Collaborate with the WCDOH Health Planning Team and Health Summit partners on Breastfeeding initiative; and
- Prepare written reports showing Hospital Information System data on breastfeeding rates by type and race.

PRIORITY: 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 to HIV- related primary care; people who know their HIV status and enter care at the HOPE Center; people 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.

Interventions:

- Continue 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.

- Institute 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 Part C funded resources to re-engage any clients who are lost to follow up.

Objective 2:

Increase percentage of newly enrolled 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%).

Interventions:

- Provide the first appointment to all HIV+ clients within less than five days of the person's first contact with the HOPE Center.
- Continue existing Part C funded retention in- care efforts and ensure appointment success throughout the first year.
- Track 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 72% and the Top 10% of performers nationally average 89%).

Interventions:

- Provide targeted medication adherence support 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: 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 NYS statute.*

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.

NY1 recently reported that new legislation and healthcare initiatives designed to prevent deaths from hepatitis C-related liver disease among baby boomers now are underway in New York. Governor Andrew Cuomo signed a law that would require healthcare providers to test people born between 1945 and 1965 for hepatitis C, beginning January 1, 2014. The New York City Department of Health and Mental Hygiene also launched an initiative to educate baby boomers and physicians and to build hepatitis C testing prompts into medical records systems. CDC estimated that 75 percent of people dying from hepatitis C were baby boomers.

Dr. Ype De Jong, assistant professor of medicine at the Sanford I. Weill Medical College of Cornell University and attending physician at New York-Presbyterian Hospital Cornell Campus, stated that many hepatitis C-infected people were unaware of their infection because hepatitis C often caused few

symptoms for many years. He attributed most of his patients' hepatitis C infections to unscreened blood transfusions or intravenous drug use. Many others who had no hepatitis C risk factors still could have the virus. In all, De Jong estimated that 150,000 New Yorkers had hepatitis C. In 2012, 750 New York City residents died of hepatitis C. Deputy City Health Commissioner Dr. Jay Varma estimated that without hepatitis C testing, 10,000–20,000 more residents could die from the virus throughout the next 15 years.

De Jong expected treatments in pill form to be available within the next two years. The new drugs would be more effective in curing hepatitis C and would eliminate the debilitating side effects of interferon injections currently used to treat the virus. Barriers to hepatitis C screening and treatment included a shortage of physicians with hepatitis C expertise and challenges in communicating hepatitis C danger to people who have no symptoms. (Source: NY1.com, New York City, 11.04.13, Erin Billups, New York: Viral Hepatitis, *Officials Wage War Against Hepatitis,* 11.04.2013)

6. **Dissemination of the Plan to the public**:

Following the Community Service Plan submission to the State, the Plan will be appended to the hospital website. A press release is sent to all local media for publication that the plan is available for the public to review. All administrative offices are given a copy of the Plan 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.

7. **Maintaining Engagement**:

St. John'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. The hospital also intends to work with communities to improve living conditions of individuals through education, environmental modifications, and policy and legislative changes, to enhance the quality of life.

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's monthly conference calls with HRSA-funded agencies,
- 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.