2015 Community Service Plan

"COMMUNITY STRONG"

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

OUR MISSION

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

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

COMMUNITY STRONG

St. John's Riverside Hospital, known for its' closely integrated models of care, nationally recognized services and outcomes, and strong partners is uniquely positioned to meet the health care needs of its patients and community. We have made vast investments in technology, physicians, nurses, training, and our facilities. We established a leadership role in healthcare and technology when we introduced MAKOplasty, the first Orthopedic robotic system in Westchester, followed by the da Vinci robotic system and the first Hernia Center in Westchester. These offerings elevated St. John's Riverside Hospital by offering the latest advances in surgery. Our pursuit of excellence includes renovations to several areas of the hospital which cover updated surgical operating rooms, private maternity suites and the on-going upgrade of patient rooms to private rooms.

Since the establishment of The Cochran School of Nursing in 1893, St. John's Riverside Hospital leaders have understood and respected the value of training the next generation of nursing and medical staff. Over the past few years, Cochran has been restructured to be more competitive and produce nursing students of higher quality for modern clinical practice. Additionally, St. John's Riverside Hospital has been approved for an Internal Medicine Residency program beginning in July, 2016. These are the ways St. John's Riverside Hospital is working to secure the healthcare of our community for generations to come.

All of these investments, along with our focused medical team have improved quality scores across every area of patient care. We also continue to be recognized by the most prestigious and respected organizations in healthcare. Over the past five years, our achievements included Commission on Cancer Outstanding Achievement Award, U.S. News and World Report Best in Orthopedics, Nephrology and Urology Recognition, and our latest 2015 and 2016 Women's Choice Award for America's Best Breast Center. We are also accredited through the Accreditation Council for Graduate Medical Education which is the nation's premiere medical education organization.

It is with these world-class achievements that we are able to attract leading specialists to join our family. Progress continues and the future is bright with our commitment to the community. For more information, visit www.riversidehealth.org.

COMMUNITY SERVED

St. John's Riverside Hospital (SJRH) is an accredited, 378-bed acute care community health system comprised of the following service facilities:

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

St. John's is part of the Hudson Valley Region within Westchester County, serving community residents since 1869. SJRH provides a wide range of ambulatory care and inpatient services with over 600 medical and allied health professionals. Over 250,000 individuals are served annually within our network.

Our Andrus and Park Care Pavilions are located in and primarily serve the city of Yonkers. The Dobbs Ferry Pavilion serves the Rivertown communities of Hastings-on-Hudson, Ardsley, Dobbs Ferry and Irvington. The resident population of the city of Yonkers comprises one-third of the hospital's service area and depending on zip code accounts for between 30 to 50 percent of its admissions.

The communities served by our health system are widespread and diverse. St. John's provides convenient access to high quality acute, primary and specialty care to individuals and families living in a primary service area of twelve (12) zip codes surrounding its location. The zip codes that we most commonly provide services for are: 10701, 10703, 10704, 10705, 10706, 10710, 10502, 10503, 10522, 10523, 10530 and 10533. Five zip code areas in southwest Yonkers (10701, 10703, 10704, 10705, and 10710) have been federally defined as Medically Underserved Areas. As such, it is a key emergency medical service (EMS) participant operating in its two hospitals with 52,546 visits in 2015.

Yonkers is the largest city in Westchester and the 4th largest city in New York State, with a 2013 population of 199,766 as per the U.S. Census Bureau. 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; and accompanying its diversity, are significant inequities in health status. One in five families' lives in poverty and over one third of these families are headed by females.

St. John's ethnically diverse service area encompasses neighborhoods with large numbers of Hispanic and African-American residents, including Haitian and Dominican immigrants. Yonkers has the highest proportion of Hispanic residents in Westchester County, many of whom are recent immigrants with limited fluency in English. Puerto Ricans and Mexicans are the two largest Hispanic communities. English and Spanish are the dominant languages, although there are a significant number of residents who speak Italian, Portuguese and Arabic.

The profile of this area includes high unemployment, large numbers of high school dropouts, overcrowded housing, and families and children in poverty. Yonkers is federally designated as a high intensity drug trafficking area. There is a high rate of teen pregnancy, lack of prenatal care, vaccine preventable disease, tuberculosis, and

HIV/AIDS. The city has the highest concentration of HIV/AIDS in the country. Our substance abuse treatment and training center is New York's largest provider of substance abuse services.

The Dobbs Ferry facility is the only hospital located in the village of Dobbs Ferry, approximately 7 miles from its SJRH sister facilities in Yonkers. Its primary service areas include Dobbs Ferry, Hastings-on-Hudson, Ardsley, Irvington, Tarrytown, Elmsford, Hartsdale, Greenburgh, Scarsdale and White Plains. The total population of this service area is approximately 124,000. A population that is largely white and affluent defines this area.

ASSESSMENT OF COMMUNITY HEALTH NEEDS

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

In partnership with the Westchester County Department of Health's **Healthy Hospitals Collaborative *Prevention Agenda* Initiative** and other hospitals in our area, we identified prevention agenda priorities that we as healthcare providers would address in a three-year plan to improve community 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 and best practices. While all hospitals in Westchester County shared the same priorities, individual hospitals selected priorities that were attainable and that aligned with each agency's mission and patient service area.

St. John's surveyed the community to determine the pressing health needs of our patients and their families. Over 3,000 community members representing our primary and secondary service areas were identified to participate in an **online survey** using Survey Monkey, an online survey platform. The link to the survey is on our Facebook and website page. The survey was promoted on each nursing unit, on the facility lobby televisions and at hospital-sponsored community events. The web-based survey consisted of ten (10) questions aimed to solicit information about the community's perception of need about health concerns and access to health services. **Questionnaires** were distributed to more than (30) community-based organizations as well as **letters** to our patients. Our HIV needs assessment included staff and clients from our HOPE Center HIV/AIDS programs, Tri-County Ryan White Part A Steering Committee, New York State Department of Health's AIDS Institute, Health Resources Services Administration, and the Tri-County Consumer Advisory Group Living Together. The HOPE Center has active planning and referral linkage agreements with the many community-based organizations and other local health-related organizations.

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

(2014 to 2016) **Implementation Strategy** with activities that align with our mission and strategic goals; to address these identified areas of community health need. The next Community Health Needs Assessment will be performed in 2016. The final approved report is available to the public on the hospital's website www.riversidehealth.org.

PREVENTION AGENDA PRIORITY AREAS

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

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

Priority 1: Prevent Chronic Diseases

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

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

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

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

- Focus Area: Human Immunodeficiency Virus (HIV)
    - **Goal # 3: Increase early access to and retention in HIV care.**

- Focus Area: Hepatitis C Virus (HCV)
    - **Goal # 4: Increase and coordinate HCV prevention and treatment capacity.**

THREE YEAR PLAN OF ACTION

Priority Areas, Goals and Interventions

PRIORITY 1: PREVENT CHRONIC DISEASES

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

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

The SJRH CARE TRANSITION COACH PROGRAM was introduced in 2012 to reduce recidivism and facilitate transition from in-patient stays at Andrus Pavilion to home for patients with chronic medical conditions. 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, identify patients who would benefit from the program. The program is the first and only one in Westchester County. It is a co-jointly implemented program between the Visiting Nurse Association of Hudson Valley and St. John's Riverside Hospital. There is no charge for patient participation in the program.

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

Interventions:

- Patients with chronic diseases such as Congestive Heart Failure (CHF), Cardiac Disease, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and Renal Disease, who have frequent re-hospitalizations or are at risk for such, will be referred to the transition coach.
  The Coaching of the patients and family members is based on the Coleman Transition Intervention. Coaching begins in the hospital setting. Once the patient is discharged, the Care Transition Coach will make 1-2 home visits, usually within 24-48 hours after discharge and 1-2 weekly telephone calls for 30 days.http://evidencebasedprograms.org/1366-2/transitional-care-model-top-tier; http://www.guideline.giv/content.aspx?is=43940; http://caretransitions.org/evidence-and-adoption/.
- Focus on key factors to preventing readmission: Medication Reconciliation---compare discharge instructions with prescriptions and drugs at home; Personal Health Record---provide and teach use of booklet where patients can keep medical information and medication lists in one place; Physician Visit Within Seven Days---schedule appointment for the patient and prepare list of questions; Red Flags---teach patient to identify early warning signs that indicate need for follow-up with MD with a focus to avoid re-admission.

- Measure rate of recidivism to the Emergency Department including recidivism for Acute Myocardial Infarction (AMI), CHF and Pneumonia and readmission rate for those that refused the service.
- Analyze barriers to the success of self-management.

Objective 1:

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

Outcome: We exceeded our goal in 2015. A total of (194) patient encounters, an additional (50) patients were assessed through the SJRH Care Transition Coach Program. Participants: Black 37%, Hispanic 27%, White 31%, Other/Unknown 5%. Of the (194) patients assessed (58) received coaching visits at home.

Improvements/Action Plan: In-hospital or other setting visits prior to home visit, assistance to enhance follow-up care and communication with primary care physicians, addressing patients on Coumadin, nurse education and follow-up, program marketing, improve Meditech access, provide on-site space for coach, improve discharge medication list, increase staff education re: Care Transitions, and increase patient acceptance rate.

We continue to address the following: types of disparities race/ethnicity, income/SES, Disability, geography and age. A bilingual care transition coach screens and offers self care management and support services for high-need participants. Patients at-risk and/or in need of chronic disease intervention are identified for services with consideration of specific cultural, disability, elderly and financial needs. Culturally appropriate health education and care is offered to patients with special attention to language spoken and health literacy needs.

Challenges: Maintaining involvement of the majority of stakeholders at all stages throughout intervention implementation. Methods will be implemented to increase program awareness and outcomes among clinical providers and stakeholders.

PRIORITY 2: PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

FOCUS: Maternal and Infant Health

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

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

As the *only maternity service provider* in Yonkers, we provide obstetrical care to women referred from the Hudson River Health Care family practice prenatal clinic; Yonkers based St. Joseph's Medical Center; Planned Parenthood; local private obstetric physician offices and surrounding areas. Our breastfeeding initiative connects with a wide variety of local partners through the Hudson Valley Regional Perinatal Network for needs assessment, program planning and services evaluation. We participate in annual meetings and monthly webinars with the New York State Partnership for Patient Safety. St. John's works with the March of Dimes to distribute information on healthy moms, healthy pregnancies, and healthy babies. A St. John's lactation nurse consultant meets bi-monthly with prospective parents to provide information and education on breastfeeding. Phone calls are made post discharge and additional in-person breastfeeding assistance sessions are provided as needed. A SJRH "Warm Line" is available 24 hours, seven days a week for breastfeeding help and other services. The following partners serve as referral sources for our patients: LaLeche International, Breastfeeding Solutions and Hudson Valley Breastfeeding. We are focused on reducing racial disparities in the *breast-only* feeding rate. The program takes into consideration specific cultural needs and provides culturally appropriate and sensitive breastfeeding education.

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%.

Intervention: Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and Increase the number of Baby Friendly Hospitals in NYS.

Outcome: We exceeded our goal for patients' breastfeeding exclusively or with supplementation. Breastfeeding increased to 65% in the 1st Quarter, 72.5% in the 2nd Quarter and 75% in the 3rd and 4th Quarters of 2015.

Objective 2:

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

Outcome: The Feed Type by Race for SJRH, as reported by NYS in June 2015, is as follows: (Exclusive Breast Milk) White 15%, Black 10%, Hispanic 9%, Other 14%. Achieved 2015 Goal: The disparity gap for infants exclusively breastfed in the hospital was decreased by 1% for Blacks and by 4% for Hispanics from the 2012 disparity gap measure.

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

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

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

FOCUS: Human Immunodeficiency Virus (HIV)

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

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

Objective 1:

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

For 2015, we had 19 patients that returned to care.

Outcome: In 2015, we had (19) return people, *(14) above 2015 goal*. To date, a total of (83) return people from 2012 baseline.

Improvements/Action Plan:

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

Objective 2:

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

Interventions: Provide the first appointment to all HIV positive clients within less than five days of the person's first contact with the HOPE Center. Implemented the appointment procedures intervention 'Evidenced Informed Practice' from the NYSDOH AIDS Institute, outreach is conducted for all new patients through reminder calls, pre and post appointments.

Outcome: New Patient Retention Data (Achieved Goal)

(2014) January 1 – April 30 = 93% (30/32)
(2015) April 1 – July 31 = 100% (15/15)

Improvements /Action Plan:

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

Objective 3:

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

Interventions:

- Provide targeted medication adherence support services to all clients who are beginning or changing medication regimens. Continue access to grant funding to ensure that such services are available.
- Continue to implement the "Getting to Zero" initiative within HOPE Center to build client knowledge of and support for efforts to increase medication adherence.
- Utilize the opportunities presented through the Affordable Care Act to assist uninsured and eligible HIV-positive clients to obtain insurance services through Medicaid, Medicare or the New York State Department of Health portal. Provide opportunities for and enroll all clients who qualify for medical insurances (including Medicaid) to access these resources so that there are no interruptions of coverage that impacts their access to medications.
- Continue to obtain Ryan White Parts A, B and C funding to support the hospital's ability to provide this comprehensive continuum of HIV care, including early intervention services. Continue to seek other funding

sources for services to immigrants who are not yet qualified to access insurance coverage through Medicaid or other insurance products.

- Continue to seek and obtain annual HIV-related grant funding 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.

Outcome: Exceeded 2015 target by 6%, 85% of patients had a VL <200.

Improvements/ Action Plan: Increased linkage agreements and outreach efforts through HOPE Facebook and other media.

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

FOCUS: Hepatitis C Virus (HCV)

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

Objective:

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

Interventions:

- Implemented NYS-mandated* Hepatitis C test offering in the SJRH Emergency Department in 2014.
- Analyzed the feasibility of delivering quality, state of the art Hepatitis C treatment for mono-infected clients at the hospital's HOPE Center during 2014 and 2015 in light of the changing protocols for treatment of those living with Hepatitis C. During late 2015, we worked with NY State DOH to expand our current HCV treatment grant to allow treatment of those who are mono-infected. As of January1, 2016, our co-infection grant from NY State DOH will be modified and we will establish a linkage with the hospital's Opioid Treatment Program to begin treating their mono-infected clients.
- 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.

Outcome: In 2015, Hepatitis C Screening Question Asked = 1162; Offered and Accepted = 98; Offered and Refused = 1064 *(Hospital Information System Data).*

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