SAINT JOSEPH'S MEDICAL CENTER
COMMUNITY SERVICE PLAN
~2013 – 2017~

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COMMUNITY SERVICE PLAN
SAINT JOSEPH'S MEDICAL CENTER
YONKERS, NEW YORK
2013-2017

Saint Joseph's Medical Center (SJMC), celebrating 125 years of serving a diverse community in Southwest Yonkers, is a 194-bed acute care not for profit hospital. The Medical Center campus includes a 200-bed nursing home, Saint Joseph's Hospital Nursing Home, a Family Health Center with a teaching affiliation, adult day services, and a long-term home health care program. Off campus services, located in Harrison, New York, include St. Vincent's Psychiatric Hospital acquired in 2010. St Vincent's, a 141-bed hospital, offers mental health and addiction treatment services for children, adolescents and adults.

SJMC provides comprehensive outpatient programs and services that include the following: two large school based health programs serving Yonkers school children (primary and rehabilitative care) and a new satellite Family Medicine Practice that opened in 2013. SJMC is also a sponsor of low-income senior housing.

To better understand and address community health needs, Saint Joseph's Medical Center participated in the 2010-13 Westchester County Department of Health Community Health Assessment and the New York State Prevention Agenda. Saint Joseph's Medical Center is proud to reflect the diversity of the community in which it is located and continuously strives to respond to the ever-changing healthcare needs of the community it serves. The following pages outline the process the Medical Center undertook to determine community health needs and its action plan to address the prioritized needs.

I. MISSION STATEMENT

A. Mission Statement for Saint Joseph's Medical Center

Saint Joseph's Medical Center is a Catholic healthcare facility, sponsored by the Sisters of Charity of Saint Vincent de Paul of New York. We strive for excellence in healthcare in an atmosphere of support and shared ministry.

Our Values:

We believe in:

- Respect and compassion for others and ourselves
- Excellence in service
- The dignity of human life
- Commitment to the community

The Board of Trustees reviews the mission statement annually to reaffirm its continuing validity and appropriateness. In 2013, the Board once again reviewed and approved the mission statement and its relevance to Saint Joseph's purpose and role in the community it serves.

The Sisters of Charity of Saint Vincent de Paul founded Saint Joseph's in 1888. Saint Joseph's Medical Center is proud to reflect the diversity of the community in which it is located and strives continuously to respond to the ever-changing healthcare needs of the community it serves.

The Mission Statement was drafted by a multi-disciplinary committee of employees and was adopted by the Board of Trustees and approved by the Membership Corporation in 1990. The Mission Statement is displayed prominently throughout the Hospital and is published in Hospital publications, including The Patient Handbook.

The SJMC Mission embodies the rich traditions of these followers of Saint Elizabeth Ann Seton and Saint Vincent de Paul. Their dedication to what we now call "holistic patient care" encompasses all the needs of the sick: physical, mental, and spiritual; not only medical and nursing care, but also the education of patients so that they may prevent illness and manage chronic conditions.

While there has been no change to the Mission Statement, the inclusion of the explicit statement affirming SJMC's ***commitment to the community*** has always been one of the core elements of the SJMC's mission. Our ***commitment to the community*** is to provide preventive and evidenced based care in order to make a real, measurable difference in the health of the populations we serve.

In alignment with the New York State Health Improvement Plan, the Prevention Agenda 2013-2017 and collaboration with the Westchester County Health Department (WCHD), SJMC will focus on making sustainable and measurable differences in the health of underserved, under-resourced populations by:

- Coordinating and focusing resources on specific high prevalence/high impact problems affecting its community as identified by community input from our Community Health Needs Assessment Survey and the Westchester County Health Department Focus on Prevention Agenda (2013-2014).

- Continuing active participation by SJMC on community based health initiatives and committees that include such organizations as the YMCA R.E.A.C.H Initiative (Racial, Ethnic Approach to Community Health), HYI (Healthy Yonkers Initiative), Southwest Yonkers Livable Communities and Southwest Yonkers Communities For All Ages, Westchester American Diabetes Association Stop Diabetes and Yonkers On the Move. (Appendix A-List of Partner Initiatives)

- Reaching beyond the walls of SJMC to collaborate with community partners to develop and implement more effective broad-based plans of action to address and promote the health of the communities we serve.

II. SERVICE AREA

A. Hospital Service Area

Saint Joseph's Medical Center's service area includes the City of Yonkers and the Greater Yonkers Community. For the purposes of the Community Service Plan and Community Health Needs Assessment, we focused on our primary and secondary service areas based upon hospital admission/discharge information and responses to our community health needs assessment survey. We defined our service area as follows:

Primary Service Area: Yonkers Zip codes 10705, 10701

Secondary Service Area: Yonkers Zip codes 10703, 10704, 10710; Bronx Zip Codes 10474, 10463, 10470, 10466, 10467

B. Description of Service Area

Yonkers is 18.4 square miles with approximately 198, 449 residents according to the 2010 census. (Appendix B-Yonkers Quick Facts). The community we serve is one of the most culturally and ethnically diverse in Westchester County and New York State. During the last two decades, a demographic shift has taken place with a large influx of immigrants. The percent of non-citizen residents with no health insurance in our primary service areas in Yonkers has significantly increased. Close to 31% percent of Yonkers population is foreign-born. Immigrants from all over the world bring a great vitality to our community yet, they challenge the hospital and other local community service providers to understand and meet their unique and complex needs.

Fluency in English is very important when navigating the health care system as well as finding employment. In our community, the highest rates of linguistic isolation are among Latino Americans. Forty-two percent of those who are foreign-born speak English less than "very well."(http://www.migrationinformation.org)

The SJMC service area is defined by zip codes. We consider primary and secondary service areas as follow:

Primary Service Areas

According to the 2010 Census the estimated population in zip code 10701 is 62,939. This represents approximately 33% of the total Yonkers population and is an urban mix of high-rise apartments, older wood frame homes and a downtown business area that contains community- based not for profit organizations within the immediate area around the SJMC campus. The total land area in zip code 10701 is 4.2 square miles with one of the highest population densities in New York State. (http://www.city-data.com/zips/10701)

Zip code 10701 compared to state average: (http://www.city-data.com/zips/10701)

- African Americans population percentage above New York State average
- Hispanic population percentage above state average
- Median age below state average
- Foreign-born population percentage above state average

Educational Level of residents 25 years and older in zip code10701: (http://www.city-data.com/zips/10701)

- High school or higher: 73.1%
- Bachelor's degree or higher: 21.2%
- Graduate or professional degree: 8.3%

There is an unemployment rate of approximately 7.7%.

Zip code 10705 compared to state average: (http://www.city-data.com/zips/10701)

- Hispanic population percentage significantly above state average
- Foreign-born population percentage above state average

Challenges Based Upon Demographics

We anticipate barriers and challenges based upon the population disparities in the geographic areas we serve. These disparities are outlined in the table below sighting economic status, unemployment and poverty rate.

Approximately 40% of the patients admitted to Saint Joseph's Medical Center are on Medicaid or are uninsured (52% of Yonkers residents are on Medicaid according to the Westchester County Department of Health 2013 Regional Statistics for Yonkers). The Medical Center has over 1 million outpatient visits each year of which approximately three quarters represent Medicaid or uninsured patients. The cost of uncompensated care provided by Saint Joseph's Medical Center in 2012 was $6.6 million.

Saint Joseph's has a long history of providing care to the financially indigent and offering charity care to patients treated in the Hospital and clinics. Recently, in accordance with changes in the Public Health Law, the Hospital has expanded the provision of charity care and financial aid to include all patients in need of medically necessary care who are uninsured or have a demonstrated inability to pay.

WESTCHESTER COUNTY DEPARTMENT OF HEALTH YONKERS CITY PROFILE 2013

Employment and Income	Total	Male	Female	White	Black	Hispanic1
7.9	Unemployment Rate	7.5	7.5	7.6	6.5	9.9
Median Household Income ($)	56,816	--	--	64,572	43,130	40,819
Poverty Rate (%)	14.9	13.0	16.5	10.5	20.1	23.9

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) METHODOLOGY AND PROCESS

The CHNA was comprised of quantitative and qualitative research components and included the Westchester County Department of Health Community Health Assessment (2010-13). To augment the study, additional hospital data was reviewed and qualitative data was collected through key informant surveys, community meetings, and distribution of a health survey to over 7000 (return 236) residents in the Medical Center's service area.

Quantitative Data Review included the following data sources:

- 2013 Westchester County Health Department Community Health Assessment
- SJMC discharge information
- New York State Department of Public Health's Online Analytical Statistical Information System (OASIS)
- Centers for Disease Control and Prevention's (CDC) databases
- Healthy People 2020 objectives
- Westchester County SPARCS Data by Zip Code

III. PUBLIC PARTICIPATION

A. Participants

Community engagement and feedback were an integral part of the Community Assessment process. SJMC sought community input through surveys with key community stakeholders and inclusion of community partners in the prioritization and planning process. A community needs assessment survey process was conducted in two phases. A list of community partners is included in Appendix C.

B. Dates and Descriptions of Public Input Process

The following is a list of activities highlighting the Medical Center's CHNA process and public participation:

Phase I - May 2013-October 2013

- Identified and contacted key community stakeholders and key informants to participate in a Community Health Assessment.
- Developed a key informant pre-assessment survey. (Appendix D)
- Hosted community meetings with key stakeholders.
- Participated in Westchester County Health Department meetings.
- Contacted key community stakeholders unable to attend meeting to gather additional feedback.

Phase II: June 2013-November 2013

Phase Two provided more in-depth information regarding the leading health issues and priorities in the area, as well as the opportunity to identify potential partners for future collaborations to address the health issues identified in the community. Interviews were conducted with the following community health experts:

- Ms. Susan Stein, Director of the Westchester American Diabetes Association.
- Dr. Nadem Sayegh, Endocrinologist.
- Ms. Cheray Burnett, Vice President at Saint John's Riverside Health Care to discuss future collaboration on community health needs.

C. Public Notification of Sessions

- Developed SJMC Community Health Needs Assessment Resident Survey Tool based on input from community forums, key informant feedback, and WHCD data.
- Participated in community forums on August 14 and September 19 to identify existing community assets and resources to address community health needs.
- Disseminated SJMC Community Health Needs Assessment Resident Survey Tool to community via following outreach efforts:
    - Mass mailing via US Mail to 1000 households.
    - Mass e-mail to approximately 4,000 community members, utilizing Yonkers City Council listserve; partner e-mail distribution; e-newsletters, and websites.
    - Distributed 1,500 paper surveys at community events, senior centers, schools, housing authorities, and to high-risk groups in Municipal Housing.
    - Sent via paychecks to 657 SJMC employees and their families who live in service area.

- Conducted one-to-one surveying at the library and the Westchester Diabetes Association 2013 Walk.
- 236 surveys were completed and analyzed.

IV. ASSESSMENT AND SELECTION OF PUBLIC HEALTH PRIORITIES

Members of SJMC Community Health Assessment Committee reviewed internal and external data sources for population demographics and health needs, results of the community health needs survey data, and input from community outreach and interviews. Utilizing these sources, members prioritized needs based on the following criteria: scope of issue; severity; long-term impact; and SJMC's ability to address the need.

SJMC, with input from the Westchester County Department of Health and other community partners, selected Focus Area 3 of the New York State Prevention Agenda:

- Increase Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings.

The Impact of Chronic Disease on the Community

Unhealthy lifestyles and the growth of chronic disease are increasingly affecting individual quality of life and overall community health in southwest Yonkers. Primary input from local representatives, combined with secondary data analysis indicates an increased need for chronic disease education, prevention, and management resources in the community, particularly for underserved African American and Hispanic residents. SJMC will focus its efforts specifically on impacting residents at risk and in need of self management of diabetes and hypertension.

The results of the SJMC Community Health Needs Survey support this selection by the number of residents who indicated a diagnosis of increased risk for hypertension and diabetes, as well as the number of responses indicating the need for better screenings and more community education around these topics. From the survey SJMC conducted the response to the question "What do you feel are the 3 most important health concerns in the community", the response ranked diabetes as number 1, hypertension ranked number 2 and obesity ranked as number 3.

According to the New York State Prevention Agenda, New York State data shows that individuals with diabetes are not receiving recommended preventive services. Despite system-wide efforts to improve outcomes, 2007 data showed that only half of Medicaid managed care patients received all four clinical services as recommended by the American Diabetes Association. (See PQI Chart)

Social Determinants of Health

Health disparities exist when segments of the population experience greater barriers to accessing health care and maintaining optimal health. The Prevention Quality Indicators (PQI) table, excerpted from the Westchester County Department of Health Community Health Assessment 2010-13, illustrates the health disparities experienced by some race and ethnic groups within Yonkers.

African American/Black and Hispanic residents in Yonkers are more likely to have short and long term complications related to diabetes, as well as to have a lower limb amputation. They are also more likely to have uncontrolled diabetes (Appendix E). Similar disparities exist for other chronic diseases including

asthma and heart disease. Specifically, the rate of hypertension in African Americans/Blacks is four times the expected rate when compared to the statewide rate.

PREVENTION QUALITY INDICATORS (PQI)							
	Hospital Admissions	Admission Rate[1]	Statewide Rate	As % of Expected [2]			
				All	White[3]	Black[3]	Hispanic[3]
Diabetes-Related	469	342	283	121	79	312	130
Short-Term Complications	92	69	52	133	83	331	117
Long-Term Complications	260	188	155	121	87	299	128
Lower Limb Amputation	42	31	37	82	53	245	93
Uncontrolled	74	55	39	141	72	385	186
Circulatory-Related	1,063	746	554	135	113	283	127
Hypertension	141	102	61	168	103	469	174
ZIP Codes Included the Region for PQI 10701 10703 10704 10705 10710, representing 90.1% of the region population according to the 2000 census.							
Region admission rates are defined as hospital admissions per 100,000 population, adjusted for age and sex. The population used in such calculations is derived from the 2006 ZIP code population estimated by Claritas, a national demographic research firm. According to Claritas, the population included in this report for this region was 134,761. Expected rate is defined as the statewide rate, adjusted for age and sex unless otherwise defined. White, black, and Hispanic categories are mutually exclusive.							

V. Three Year Plan of Action

The SJMC Three Year Plan of Action reflects the organization's commitment to the community by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of the organization.

SJMC has established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation, and evaluation of community activities. These activities are integrated into SJMC's multi-year strategic and annual operating planning processes.

In support of Focus Area 3 of the New York State Prevention Agenda: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings, the SJMC Three Year Action Plan includes a strategic goal to "Optimize the impact of our commitment to community service." This goal has led to the creation of a new institutional approach for health improvement activities that focus on prevention & disease self-management.

SJMC's Three Year Action Plan long range goals, objectives, strategies and performance measures are as follows:

Goal 1

Effective health promotion, prevention and self-management to improve the health and wellness of Yonkers residents with emphasis on diabetes and hypertension.

Objectives

1. Increase community awareness about the risks, prevention and management of diabetes and hypertension.

2. Increase the number of adults with diabetes and/or hypertension who have been offered and participate in culturally relevant chronic disease self management education to learn how to manage their condition (Appendix F-Greater New York Health Care Association Prevention Toolkit).
3. Track and follow up on HbA1c testing, lipid profile, dilated eye exam, nephropathy monitoring, foot exam, BMI, and BP monitoring.

Strategies

1. Develop/identify educational messages to distribute to the community using materials from the Diabetes Association, CDC, American Heart Association and other evidenced based sources on diabetes and hypertension.
2. Use media and health communications to foster public awareness and demand.
3. Host six community education sessions per year with pre/post session quizzes to evaluate learning at the sessions.
4. Select an evidenced based self management model to pilot. (Appendix G)
5. Collaborate with the Westchester County Department of Health Initiative to train providers in proper blood pressure measurement.
6. Select appropriate incentives to ensure completion of educational self management sessions such as pedometers, health club memberships, gift cards to supermarkets and farmers market coupons.
7. Distribute Living with Diabetes information to all persons with diabetes (Multilanguage).
8. Distribute hypertension management information.
9. Include diabetes and hypertension prevention and management information in four issues of SJMC community newsletter Vital Signs.
10. Place links on SJMC website and on Facebook to current information about diabetes and hypertension.
11. Provide Diabetes Risk Assessment in English & Spanish in FHC and in the community with instructions to share results at time of provider visit.
12. Plan and implement waiting room sessions in English & Spanish on addressing factors such as activity, healthy eating and weight.
13. Convene quarterly Yonkers Diabetes Education Initiative meetings with representatives from the Westchester American Diabetes Association to work collaboratively on events to increase community awareness about diabetes and hypertension.
14. Support and promote training with YMCA for community volunteers to become community health advocates.
15. Optimize utilization of certified electronic health records in Family Health Clinics to imbed clinical/care decision support tools.
16. Establish medical home at the Medical Center's Family Health Center.
17. Provide technical assistance and quality improvement training to providers.

Performance Measures	2013 Baseline	Dec 31, 2014	Dec 31, 2015	Dec 31, 2014	Dec 31, 2017
Number of educational messages distributed to prevent/reduce chronic diseases	475	Increase by 110% to 1,000	Increase by 10% to 1,100	Increase by 10% to 1,210	Increase by 15.7% to 1,400

Performance Measures	2013 Baseline	Dec 31, 2014	Dec 31, 2015	Dec 31, 2014	Dec 31, 2017
Number of persons completing self management sessions	0	Establish initial participants at 40	Increase by 37.5% to 55	Increase by 9.0% to 60	Increase by 8.3% to 65
Percent of patients HbA1C<8 (under control)	14 %	Increase patients with HbA1C <8 by 5% to 14.7%	Increase patients with HbA1C <8 by 5% to 15.4%	Increase patients with HbA1C <8 by 5% to 16.2%	Increase patients with HbA1C <8 by 5% to 17%
Percent of patients with blood pressure <140/90 (under control)	64.22%	Increase patients with blood pressure of <140/90 by 3% to 66.14%	Increase patients with blood pressure of <140/90 by 3% to 68.13%	Increase patients with blood pressure of <140/90 by 3% to 70.17%	Increase patients with blood pressure of <140/90 by 3% to 72.28%

Discussion

The increased prevalence of chronic disease in southwest Yonkers has led SJMC to take the lead on improving the health status of its immediate service area. Between 1999 and 2009, the prevalence of diagnosed diabetes in adults in New York State (NYS) increased from 5.7% to 8.9%.
Since 2011, SJMC has expanded its efforts to prevent chronic diseases, detect them early, manage conditions before they become severe, and promote healthy living through prevention and wellness initiatives in the communities which included walking programs, stroke and diabetes prevention education programs, and establishing a medical home at its Family Health Center.

Goal 2

To improve the health & wellness of SJMC employees with an emphasis on diabetes and hypertension.

Objective

Select, implement and track effectiveness of an evidenced based employee wellness program.

Strategies

1. Sponsor an employee wellness campaign using the Stop Diabetes at Work Program (approximately 657 employees live in the targeted zip code areas and are racial and ethnically diverse representing a higher risk for hypertension and diabetes). The program will begin in May 2014 to kick off National Health & Fitness Month. The program will be offered to all employees.
2. Sponsor an employee weight loss challenge beginning December 2014.
3. Provide at work internet access for employees to track progress.
4. Host six employee Fun & Fit Nights at partner agency Yonkers YMCA starting May 2014 and each year thereafter.
5. Encourage employee participation in events such as Yonkers On The Move and Stop Diabetes Walk.

Performance Measures	2013 Baseline	Dec 31,2014	Dec 31,2015	Dec 31,2014	Dec 31,2017
Number of Employees* participating in Program each year	0	Establish initial percent of employees at 5% (60)	Increase by 25% (75)	Increase by 6.6% (80)	Increase by 6.25% (85)
Number of Employees* who reduce BMI to < 30	0	Establish initial percent of employees at 1.6% (20)**	1.6% of employees (20)**	1.6% employees (20)**	1.6% employees (20)**

*** Based on US Centers for Disease Control and Prevention (36% of adults are obese)**
****Unduplicated employees**

VI. Dissemination of Plan to the Public

Public Information

The Hospital will disseminate a written summary of the Community Service Plan to the public on an annual basis. The Plan as well as pertinent information (programs, schedules, financial data, financial assistance, announcements and updates) will be maintained and continuously updated on the Hospital's website.

We will also utilize the local media to promote our prevention initiative, feature articles on health and actively work with our partners to optimize communication to our community. Saint Joseph's Medical Center will re-convene key stake holder meetings on a regular basis (no less than twice a year).

VII. Process Used to Maintain Engagement and Track Progress

The SJMC and community partners will continue to:

- Hold meetings with internal and external stakeholders to oversee and support the prevention improvement programs and activities established.
- Track the numbers of residents, employees, and patients actively participating and/or receiving selected prevention agenda material. Promote and coordinate increased community-wide awareness regarding focus areas.
- Serve as a catalyst to engage additional partners to include the faith based community to be trained to deliver chronic disease self management programs.
- Measure and monitor quarterly outcomes of the Three Year Action Plan to determine progress in community health improvement initiatives/activities.

APPENDIX

APPENDIX A- List of Partner Initiatives

Community assets and resources available to support the Medical Center's goals includes but is not limited to the following:

- **Saint Joseph's Medical Center Stoke Center:** Provides ongoing training in the community (using evidenced based resources from the American Heart Association and the American Stroke Association) on stroke prevention which includes blood pressure monitoring and management.

- **South West Yonkers Community For All Ages**: Made possible by the United Way of Westchester & Putnam and the Helen Andrus Benedict Foundation targeting at risk under-resourced residents primarily African American and Hispanic residents. Community leadership training is conducted with graduates of all ages participating in service projects related to health like community gardens, intergenerational walks and healthy diets.

- **Westchester American Diabetes Association:** Started the Yonkers Diabetes's Education Initiative and is helping with the planning and implementation of the Stop Diabetes at Work Program at SJMC and the diabetes self- management session offered at our clinic and to the community at large.

- **Yonkers On The Move (YOM):** A community wide walking initiative implemented in 2011 to encourage residents of all ages to walk. Since its inception it has reached several thousand residents (via e-mail and regular community newspaper exposure, support from current administration), with approximately 100 residents of all ages participating in the first community walking challenge exceeding the goal of 2000 miles. Saint Joseph's employees and the community we serve are made aware of YOM via publicity of events including mailings and advertisements.

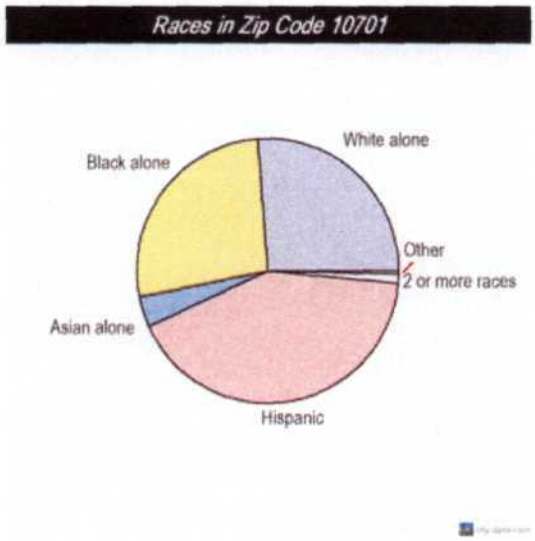
- **Yonkers YMCA R.E.A.C.H. Initiative-** The YMCA initiative, made possible by a CDC grant, promotes healthy choices and behaviors among high-risk community residents (primarily African American and Latino) of all ages in the geographic area SJMC serves. The multi-collaborative initiative partners include local businesses, housing, healthcare resources, social service agencies, the faith based community and SJMC. In addition, the initiative members are exploring ways to advocate for reducing or changing negative social determinants of health such as lack of healthy food in neighborhoods, park safety, and mentoring programs. This initiative is in the process of formulating a community resource guide that will also be mapped (on-line) to increase community awareness about locations of free or low cost physical activity opportunities, farmers markets, health education sessions etc. In addition SJMC will be using the YMCA facility to co-sponsor health activities for their staff and patients and membership at the YMCA as one of the incentives for completion of the self management sessions

APPENDIX B – Yonkers Quick Facts

Yonkers (city), New York

People QuickFacts	Yonkers	New York
Population, 2012 estimate	198,449	19,570,261
Population, 2010 (April 1) estimates base	195,979	19,378,104
Population, percent change, April 1, 2010 to July 1, 2012	1.3%	1.0%
Population, 2010	195,976	19,378,102
Persons under 5 years, percent, 2010	6.8%	6.0%
Persons under 18 years, percent, 2010	22.8%	22.3%
Persons 65 years and over, percent, 2010	14.7%	13.5%
Female persons, percent, 2010	52.6%	51.6%
White alone, percent, 2010 (a)	55.8%	65.7%
Black or African American alone, percent, 2010 (a)	18.7%	15.9%
American Indian and Alaska Native alone, percent, 2010 (a)	0.7%	0.6%
Asian alone, percent, 2010 (a)	5.9%	7.3%
Native Hawaiian and Other Pacific Islander alone, percent, 2010 (a)	0.1%	0.0%
Two or More Races, percent, 2010	4.1%	3.0%
Hispanic or Latino, percent, 2010 (b)	34.7%	17.6%
White alone, not Hispanic or Latino, percent, 2010	41.4%	58.3%
Living in same house 1 year & over, percent, 2007-2011	90.1%	88.5%
Foreign born persons, percent, 2007-2011	31.1%	21.8%
Language other than English spoken at home, percent age 5+, 2007-2011	46.0%	29.5%
High school graduate or higher, percent of persons age 25+, 2007-2011	80.7%	84.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	29.2%	32.5%
Veterans, 2007-2011	8,156	986,313
Mean travel time to work (minutes), workers age 16+, 2007-2011	32.7	31.4
Housing units, 2010	80,389	8,108,103
Homeownership rate, 2007-2011	46.9%	54.8%
Housing units in multi-unit structures, percent, 2007-2011	71.5%	50.5%
Median value of owner-occupied housing units, 2007-2011	$418,400	$301,000
Households, 2007-2011	74,242	7,215,687
Persons per household, 2007-2011	2.60	2.59
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$29,382	$31,796
Median household income, 2007-2011	$56,816	$56,951
Persons below poverty level, percent, 2007-2011	14.9%	14.5%

APPENDIX B – Yonkers Quick Facts



Median resident age

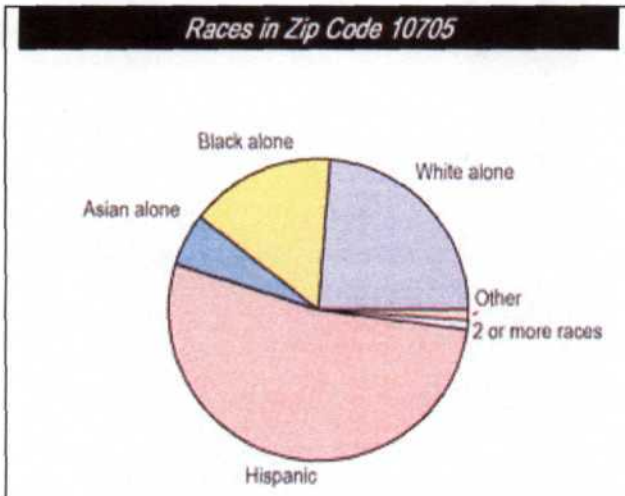
10701	33.4 years
New York median age:	38.1 years

Average household size:

10701	2.7 people
New York:	2.6 people

Average Adjusted Gross Income (AGI) in 2004: $39,166 (Individual Income Tax Returns)

10701	$39,166
New York State:	$59,519



Median resident age:

This zip code:	33.9 years
New York median age:	38.1 years

Average household size:

This zip code:	2.8 people
New York:	2.6 people

Estimated median household income in 2011:

This zip code:	$44,564
New York:	$55,246

APPENDIX C – Community Partners

Community Partner	Website	Contact
AARP Local AARP State	 www.aarp.org	Henry Doerr, President William Stoner, State Director Livable Communities
Hudson Valley Asthma Association/Westchester	www.asthma.org	Jacque Rubino
CLUSTER	www.clusterinc.org	Tony Volcheck , Executive Director, Freda Macon, Deputy Executive Director
Community Planning Council of Yonkers		Greg Arcaro, Executive Director
United Christian Assembly Mt. Carmel Baptist Church Kingdom Christian Assembly	www.yonkerschristianassembly.com www.mtcbcyonkers.org www.kbcyonkers.org	Gayle Smith, Essentials for Change- Lay Diabetes Educator Lila Barnes, RN Outreach health Ministry Thomisina Meyers, Community Outreach-Lay Diabetes Educator
Family Service Society of Yonkers	www.fssy.org	Carolyn Fluckinger, SW Yonkers Community for All Ages Gloria Jordan, Community Outreach Advocate-Volunteer
JCY-Westchester Community Partners	www.jcy-wcp.com	Janice Lubin Kirschner, Executive Director
Sarah Lawrence College	www.slc.edu	Dr. Britebart, Chair Health Advocacy
St Johns Riverside Health Care	www.riversidehealth.org	Cheray Burnett, Vice President of Development
Visiting Nurse Services of Westchester	www.vns.org	Joanne Parliament, RN Director of Community Outreach
Volunteer Center/RSVP	www.volunteer-center.org	Alisa Kestan, Executive Director
Westchester American Diabetes Association	www.diabetes.org	Susan Stein, Assistant Director
Westchester County Department of Health	www.westchestergov.com	Renee Recchia Acting Deputy Commissioner for Administration, Westchester County Department of Health
YMCA of Yonkers	www.yymca.org	Shawyn Howard, Executive Director
Yonkers Chamber of Commerce	www.yonkerschamber.com	Jeanne Martinelli
Yonkers City Council	www.yonkersny.gov	Hon. Chuck Lesnick, City Council President, Hon. Chris Johnson, Majority Leader , Hon. Wilson Terrero, Minority Leader
Yonkers Community Action Program	www.yonkerscap.org	Linda Haywood, Executive Director Susan Lensth
Municipal Housing Authority	www.mhacy.com	Paula Crawford, Assistant Director Yonkers MHA
Yonkers Office for the Aging	www.yonkersny.gov	Kathleen Moran, Director Kirsten Kodl, Assistant Director
Yonkers Office of Emergency Management	www.yonkersny.gov	Cory Hartman, Director of Yonkers Office of Emergency Management
Yonkers Parks & Recreation	www.yonkersny.gov	Steve Sansone, Assistant Deputy Director
Yonkers Public Library	www.ypl.org	Susan Thaler, Riverfront Branch & Sandy Amowya , Will Branch
Yonkers Public Schools	www.yonkerspublicschools.org www.charterschoolofeducationalexcellence.org	Cathy Hopkins, SJMC School Based Health Program Linda Bohan, Mayor's Hispanic/Latino Committee Kelley Chiarelli, Yonkers Office of Constituent Services & Yonkers Council PTA's

Saint Joseph's Medical Center

Prevention Agenda Survey
Saint Joseph's Medical Center Community Service Plan 2014-2016

Name: _____ Title: _____

Affiliation: _____ E-Mail: _____ Telephone: _____

1. In your opinion, what do you believe are the **two most important health issues** that need to be addressed in order to better serve the needs of residents of all ages in southwest Yonkers? **Please circle only two.**
   a) Asthma
   b) CVA/Stroke
   c) Diabetes
   d) Heart Disease
   e) Mental Health
   f) Substance Abuse

2. What do you feel are some of the reasons that may prevent residents from "being healthy"?
   a) Access to affordable health care/screenings
   b) Domestic Violence
   c) Economic concerns
   d) Educational barriers
   e) Lack of food sources
   f) Language barriers
   g) Safety concerns
   h) Stress
   i) Substance abuse
   j) Other_____

3. What if any health or preventive services do you think **should be offered** but as far as you know **are not**?

   a) _____
   b) _____
   c) _____

4. Please list any health and wellness services you currently offer the community.

   a) _____
   b) _____
   c) _____

5. Would you be willing to partner with Saint Joseph's Medical Center to help address health and preventive initiatives for the population you serve?
   Yes No N/A

   If yes, what would you be interested in doing? Please describe briefly.

6. The best time for future meetings is? __Early Am (8:30am) ___Afternoon ___Lunch (12pm) ___ (1pm) Evening___ (5pm)

Appendix E- Yonkers Diabetes Statistics

Number Yonkers Residents		**200,000**
Approximate # of employees with diabetes*		20,000
# of Employees x 10.0%		
Number of Diagnosed		14,600
# of People with Diabetes x 73%		
Number of Undiagnosed		5,400
# of People with Diabetes x 27%		
Approximate # of People with Pre-Diabetes*		50,000
# of Employees x 25%		
Economic Costs		
Avg. Insurance Cost - Employees with diabetes		$ 232,254,000
$5,049[1] x # of Employees with Diabetes x 2.3		
Avg. Insurance Cost - Employees with Pre-Diabetes		$ 252,450,000
$5,049[1] x Approx. Number of People with Pre-Diabetes		
Potential Cost Increase		
Scenerio A: 75% of employees with pre-diabetes develop diabetes		$ 246,138,750
Scenerio B: 50% of employees with pre-diabetes develop diabetes		$ 164,092,500
Scenerio C: 25% of employees with pre-diabetes develop diabetes		$ 82,046,250
- Lifestyle changes can delay or prevent diabetes in people with pre-diabetes		
(losing 10-15 pounds, getting 30 minutes of exercise 5 days a week)		
* Percentages for diabetes and pre-diabetes reflect the population aged 20 and older		
[1] - Based upon number provided in the Employer Health Benefits 2010 Annual Survey conducted jointly by The Kaiser Family Foundation and the Health Research and Educational Trust		

1). During the same years, the prevalence of obesity in adults increased from 17.4% to 24.6% (see Figure 2). Because obesity is a leading risk factor for diabetes,1 the increase in obesity prevalence translates to nearly one million additional New Yorkers being at higher risk for developing diabetes.2 New York State Department of Health - Division of Chronic Disease and Injury Prevention Release Date: 3/25/2011. In type 2 diabetes, focusing on glycemic control, lipid control and blood pressure control is a strategy that has been shown to be effective in preventing up to 53% of heart attacks and strokes, the leading drivers of excess mortality and costs in adults with diabetes (Gaede, 2003 [High Quality Evidence]. These may include diabetes education and other actions designed to sustain engagement of patients with their diabetes care.

New York State Department of Health - Division of Chronic Disease Prevention Release Date: 4/17/2012

Information for Action # 2012-1

Participation in diabetes self-management training promotes self-care behaviors among adults with diabetes.

Quick facts:

- In New York State (NYS), adults with diabetes who participated in diabetes self-management training (DSMT), by taking a class or course on how to manage their diabetes, were more likely to monitor their blood glucose levels daily (75.2%) than those who did not (54.1%) (see Figure 1).
- Between 2003 and 2010, participation in DSMT remained constant, with only 40% of adults with diabetes participating (see Figure 2).
- In 2009, the NYS Medicaid Program began covering DSMT as a reimbursable service for Medicaid beneficiaries diagnosed with diabetes.

Public health importance:

- The combination of DSMT and daily self-monitoring of blood glucose (SMBG) for people with diabetes has been shown to improve glycemic control (the maintenance of blood sugar levels within appropriate ranges) and reduce the risk of complications.[1]
- In 2008, NYS Medicaid program expenditures totaled approximately $4.6 billion for the nearly 307,000 beneficiaries with diabetes.[2]
- As the diabetes burden continues to increase, DSMT can play a vital role in controlling costs, improving clinical care outcomes and preventive practices, and encouraging self-care behaviors such as daily SMBG.[3]

Figure 1. Prevalence of daily SMBG among NYS adults with diabetes by DSMT* status, 2008-2010**

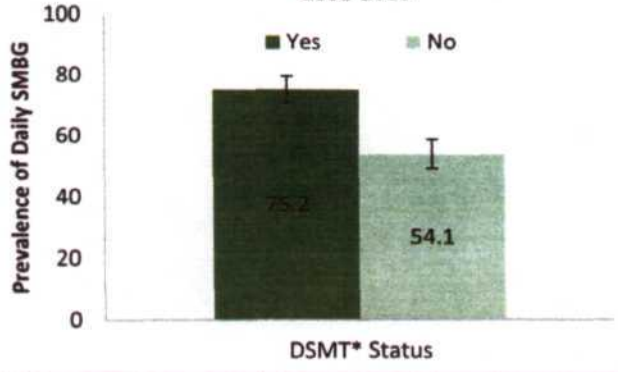
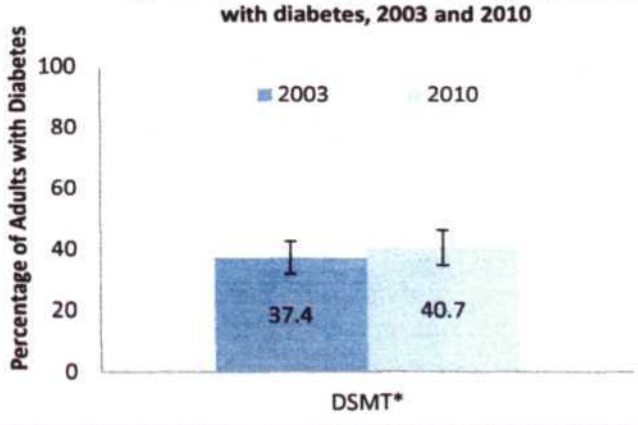


Figure 2. Prevalence of DSMT* among NYS adults with diabetes, 2003 and 2010



Data Source: NYS Behavioral Risk Factor Surveillance System.
*DSMT defined as ever having taken a course or class in how to self-manage diabetes. **Daily SMBG defined as self-monitoring blood glucose at least one or more times per day.

PUBLIC HEALTH OPPORTUNITY

Increasing provider enrollment in the NYS Medicaid DSMT benefit and promoting DSMT among people with diabetes, especially Medicaid beneficiaries, improves access to an important and effective component of diabetes care.

Contact:

For more information about the data included and their specific implications for action, please send an email to DCDIPIFA@health.state.ny.us with IFA # 2012-1 in the subject line.

References:

1. Boutati EI, Raptis SA. Self-monitoring of blood glucose as part of the integral care of type 2 diabetes. Diabetes Care, 2009;32(S2):S205-10.
2. NYS Medicaid Program, 2008.
3. Balamurugan A, Ohsfeldt R, Hughes T, Phillips M. Diabetes self-management education program for Medicaid recipients: a continuous quality improvement process. Diabetes Educator. 2006;32(6):893-900.

To access other Information for Action reports, visit the NYSDOH public website:
http://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/index.htm

Appendix G – Greater New York Prevention Chronic Diseases:

PREVENT CHRONIC DISEASES

DIABETES

Establishing a Community-Based Diabetes Self-Management Program, *Partnership for Prevention*

http://www.prevent.org/The-Community-Health-Promotion-Handbook/Diabetes-Self-Management-Education.aspx

http://www.prevent.org/

SELECTION CRITERIA

This program represents *Self-Management Education in Community Gathering Places for Adults with Type 2 Diabetes*, one of the Community Preventive Services Task Force's recommendations for Diabetes Prevention and Control.

PROGRAM TYPE

Evidence-based program.

PROGRAM DESCRIPTION

Establishing a Community-Based Diabetes Self-Management Education (DSME) Program for Adults with Type 2 Diabetes to improve Gylcemic Control—An Action Guide was developed in collaboration between Partnership for Prevention and the CDC. The Action Guide is based on Community Preventive Services Task Force recommendations on diabetes prevention and control. The *Action Guide* provides step-by-step guidance on implementing a self-management program for individuals with Type 2 Diabetes.

SETTING

Clinical setting, community center, or religious center.

TARGET POPULATION

Individuals with Type 2 Diabetes.

LENGTH OF PROGRAM

A typical program is eight weeks and includes one or two sessions per week. Follow-up phone calls may occur after the sessions conclude to problem-solve any issues that may arise later.

STAFF

- ADMINISTRATIVE STAFF: Provides logistical support for meetings and the program. This individual also makes reminder calls to participants.
- PROGRAM COORDINATOR: Oversees the planning, implementation, and evaluation of the DSME program; provides ongoing management of the program.
- FACILITATOR: Works with the program coordinator and advisory board to develop the program curriculum; delivers the DSME program; contributes to quality improvement and program review.
- ADVISORY BOARD: Ensures that the DSME program is culturally appropriate and responsive to the community; recommends program improvements.

Appendix G – Greater New York Prevention Chronic Diseases:

PREVENT CHRONIC DISEASES

DIABETES

Establishing a Community-Based Diabetes Self-Management Program, Partnership for Prevention (continued)

FRAMEWORK

Includes the following action steps:

- Conduct a community needs assessment regarding diabetes education resources
- Organize partners and stakeholders
- Form an advisory board and review the curriculum with them
- Find a location for the DSME program
- Organize staff for the program
- Begin providing classes and refine evaluation activities
- Explore methods for sustaining the program

MATERIALS

Establishing a Community-Based DSME Program for Adults with Type 2 Diabetes to Improve Glycemic Control—An Action Guide (*Partnership for Prevention*):

http://www.prevent.org/The-Community-Health-Promotion-Handbook/Diabetes-Self-Management-Education.aspx.

MEASURES

The *Action Guide* contains a section on process measures and outcome measures. The following are examples of outcome measures to consider when determining program success:

- Did participants meet their self-identified goals?
- Did targeted measures, such as weight, blood pressure, cholesterol, blood glucose level, and hemoglobin A1C, improve?
- What proportion of participants sustained behavioral improvements for one month or more?
- Do participants rate improvement in their quality of life as a result of the program?

Data to perform the evaluation may be done through participant registration and attendance records, quality-of-life assessment tools, participant satisfaction surveys, and taking physiological measures, such as weight and blood pressure, on the first and last day of class.

REFERENCES

- Partnership for Prevention. *Diabetes Self-Management Education (DSME): Establishing a Community-Based DSME Program for Adults with Type 2 Diabetes to Improve Glycemic Control—An Action Guide. The Community Health Promotion Handbook: Action Guides to Improve Community Health* (Washington, DC: Partnership for Prevention, 2008).
- Norris, S.L., et al. "Increasing Diabetes Self-Management Education in Community Settings: A Systematic Review," *American Journal of Preventive Medicine* 22, no.4S (2002): 39–66. Available at http://www.thecommunityguide.org/diabetes/dm-AJPM-evrev-incr-DSME-comm.pdf (accessed September 12, 2012).
- The Community Preventive Services Task Force, "Recommendations for Healthcare System and Self-Management Education Interventions to Reduce Morbidity and Mortality from Diabetes," *American Journal of Preventive Medicine* 22, no. 4S (2002): 10–14. Available at http://www.thecommunityguide.org/diabetes/dm-AJPM-recs.pdf (accessed September 12, 2012).
- CDC. "Diabetes Prevention and Control," *Guide to Community Preventive Services: What Works to Promote Health?* (March 2001) Available at http://www.thecommunityguide.org/diabetes/index.html (accessed September 12, 2012).