

**SAINT JOSEPH'S MEDICAL CENTER
COMMUNITY HEALTH NEEDS ASSESSMENT PLAN
~ 2013 - 2017 ~**



INTRODUCTION

Saint Joseph's Medical Center (hereafter SJMC) 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 communities it serves. Today's healthcare environment is one of challenge, change and complexity, yet through collaborative efforts and unique partnerships, SJMC strives to fulfill its mission: To provide quality healthcare services within our resource capabilities; to serve as a leader in a collaborative effort with the community in providing health education, support services and care for all residents. To better understand and address the most pressing community health needs, SJMC participated in the 2013 Westchester County Department of Health (WCDOH) Community Health Assessment New York State Prevention Agenda. (Appendix A – WCDOH Meetings). Attendance at WCDOH meetings and dialogues with community stakeholders and key informants in conjunction with a review of quantitative data, assisted the Medical Center in developing its comprehensive Community Health Needs Assessment (hereafter SJCHNA). The SJCHNA was completed by SJMC which included its psychiatric facility, St. Vincent's Hospital, located in Harrison, New York.

The following pages outline the process that SJMC undertook to determine and prioritize health needs and the development of an Implementation Strategy to address the most significant health needs of the community we serve. In addition, based upon review of primary and secondary data sources, SJMC recognized certain needs we cannot address but identified existing resources available in the community and the county which can address those needs.

The SJCHNA process enabled us to ensure that our existing internal review process and collaborations with external resources were directed appropriately toward outreach, prevention, education and wellness opportunities where the greatest positive outcomes and change in health behaviors for the residents and staff would be realized.

SJMC is committed to the residents it serves and the neighborhoods they live in. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. The assessment examined a variety of community,

household and health statistics to capture a full picture of the residents in the SJMC service area.

The purpose of the SJCHNA process was to:

- Gather information about health needs and health behaviors
- Develop a shared understanding of the results with community partners (key informants, stakeholders and residents)
- Identify the greatest health issues facing Yonkers and barriers to optimal health
- Envision and share ideas for a desirable future
- Develop health improvement initiatives that align with community need

Mission Statement

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 SJMC Mission embodies the rich traditions of the 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.

The Board of Trustees reviews the mission statement annually to reaffirm its continuing validity and appropriateness. In April 2013, the Board was informed about the IRS requirements to conduct a Community Health Needs Assessment and the relationship to the SJMC Community Service Plan (2013-2017), required by New York State Department of Health (Prevention Agenda). The Board approved SJMC Community Service Plan was submitted to the New York State Department of Health in November 2013. The SJCHNA report and Implementation Strategy was approved by the Board of Trustees in December 2013.

In alignment with the New York State Health Improvement Plan, the Prevention Agenda 2013-2017 and collaboration with the Westchester County Health Department (WCDOH), SJMC will strengthen its focus on making sustainable and measurable differences in the health of underserved and 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 (SJCHNA) and the Westchester County Department of Health Focus on Prevention Agenda (2013-2017).
- Continuing active participation by SJMC on community-based health initiatives and committees that include such organizations as the YMCA Racial, Ethnic Approach to Community Health (R.E.A.C.H) Initiative, Healthy Yonkers Initiative (HYI), Southwest Yonkers Livable Communities and Southwest Yonkers Communities For All Ages, Westchester American Diabetes Association Stop Diabetes and Yonkers On the Move. (Appendix B- Brief Description 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.

Hospital and Community Profile

SJMC's long-standing commitment to the community spans more than 125 years. SJMC is the only remaining Catholic healthcare facility in the region. We strive for excellence in healthcare in an atmosphere of support and shared ministry. This commitment has expanded and evolved through considerable thought and care in considering our communities' most pressing health needs.

Since its beginnings 125 years ago SJMC has grown from a single community hospital to a comprehensive healthcare provider, employing approximately 2,000 employees and over 100 physicians representing numerous medical specialties. SJMC services include a 194-bed acute care not-for-profit hospital that serves a diverse population in Southwest Yonkers. The Medical Center campus includes a 200-bed nursing home, Saint Joseph's Hospital Nursing Home, and a Family Health Center Clinic with a New York Medical College teaching affiliation supporting a Family Practice Residency Program.

SJMC acquired St. Vincent's Psychiatric Hospital in 2010. St Vincent's, a 138-bed hospital, offers extensive mental health and addiction treatment services for children, adolescents and adults. SJMC provides comprehensive outpatient programs and services including, 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 a certified Stroke Center and was recognized by the Joint Commission as a 2012 National Top Performer on Key Quality Measures. SJMC is investing in an electronic health record system to build integrated networks of care designed to improve the health of the community and has recently achieved a Stage 1 Meaningful Use. Our Family Health Center is in the process of developing a medical home model. SJMC's geriatric services include a low-income senior independent living facility, long-term home health care and an adult day care programs.

The Emergency Department, one of the busiest in the region, has approximately 40,000 visits per year. SJMC is expanding its cardiac and orthopedic services. Approximately 40% of the patients admitted to SJMC receive Medicaid or are uninsured. Fifty-two percent of Yonkers residents receive Medicaid according to the Westchester County

Department of Health 2013 Regional Statistics for Yonkers. The Medical Center has over one million outpatient visits each year, of which approximately three-quarters represent Medicaid or uninsured patients. The cost of uncompensated care provided by SJMC in 2012 was \$6.6 million.

List of SJMC Programs and Services

Service Site	Type of Site	Address	City/Village	Zip Code
St. Joseph's Medical Center	Hospital/Main Site	127 South Broadway	Yonkers	10701
SJMC-St. Vincent's Westchester Division	Hospital	275 North Street	Harrison	10528
Cedar Place School	School Based-Ext Clinic	20 Cedar Street	Harrison	10705
Enrico Fermi School of Performing Arts	School Based-Ext Clinic	27 Poplar Street	Yonkers	10701
E. Maria De Hostos Microsociety School	School Based-Ext Clinic	75 Morris Street	Yonkers	10705
Family Health Center & Specialty Clinic	Extension Clinic School Based-Ext	73-81 South Broadway	Yonkers	10701
Martin Luther King Jr. School	Clinic	135 Locust Hill	Yonkers	10701
Maxwell Institute of St. Vincent's	Extension Clinic	92 Yonkers Avenue	Tuckahoe	10707
Methadone Clinic I	Extension Clinic	1480 Prospect Place	Brooklyn	11213
Methadone Clinic II	Extension Clinic	21-221 Powell Street	Brooklyn	11212
Methadone Center	Extension Clinic	317 South Broadway	Yonkers	10701
Queens Opioid Treatment Program	Extension Clinic	147-18 & 147-20 Archer Avenue	Jamaica	11435
Rosemarie Ann Siragusa	Extension Clinic	60 Crescent Place	Yonkers	10704
St. Joseph's Hosp Alcohol Rehab Clinic	Extension Clinic	317 South Broadway	Yonkers	10701
St. Martin De Porres Clinic	Extension Clinic	480 Alabama Avenue	Brooklyn	11207
Saint Joseph's Family Medicine	Extension Clinic	415 South Broadway	Yonkers	10705
White Plains Satellite	Extension Clinic	199 Main Street	White Plains	10601
Health Home Care Coordination	Extension Clinic	317 South Broadway	Yonkers	10705
Health Home Care Coordination Westchester Crisis Prevention and Response Team	Hospital	275 North Street	Harrison	10528
ACT Mobile Team	Hospital	275 North Street	Harrison	10528
Sr. Anne Mary Regan Residence	Housing	18 Spring Street	Port Chester	10573
Westchester Supported Housing	Housing	275 North Street	Harrison	10528
Chait House and Residence	Housing	101 Tompkins Ave.	Staten Island	10304
Sister Mary Assisium Residence	Housing	382 Westervelt Ave.	Staten Island	10301
Austin House	Housing	20 Austin Place	Staten Island	10301
Tompkins Residence	Housing	1150 Castleton Ave.	Staten Island	10310
Immaculata Hall Residence	Housing	90-10 150th Street	Jamaica, Queens	11435
Bishop Sullivan (St. Mary's) Residence	Housing	1534 Prospect Place	Brooklyn	11213
Intensive Supportive and Supportive Apartment Programs	Housing	1216 Bay Street	Staten Island	10305
Sr. Louise Demarillac Manor	Housing	19 Hygeia Place	Staten Island	10304
Family Care	Housing	19 Hygeia Place	Staten Island	10304
Bronx/Queens Supported Housing	Housing	4419 Third Avenue	Bronx	10457
Staten Island Supported Housing	Housing	1216 Bay Street	Staten Island	10305
Brooklyn Supported Housing	Housing	1534 Prospect Place	Brooklyn	11213
Respite Care	Housing	19 Hygeia Place	Staten Island	10304

The Medical Center has traditionally served a large number of indigent and low-income patients. Many of these residents are either unemployed or underemployed, have limited literacy, are undocumented immigrants and/or have limited financial resources or no insurance. WCDOH regional data indicates that a little over one-third of Hispanics live in Yonkers (U.S. Census, 2010). According to the U.S. Census Bureau American Community Survey 2011-2012, 8.9% of the people in Westchester County were living below the Federal Poverty Level. In Yonkers, over 15% of individuals living in the SJMC primary service area report income below the poverty level.

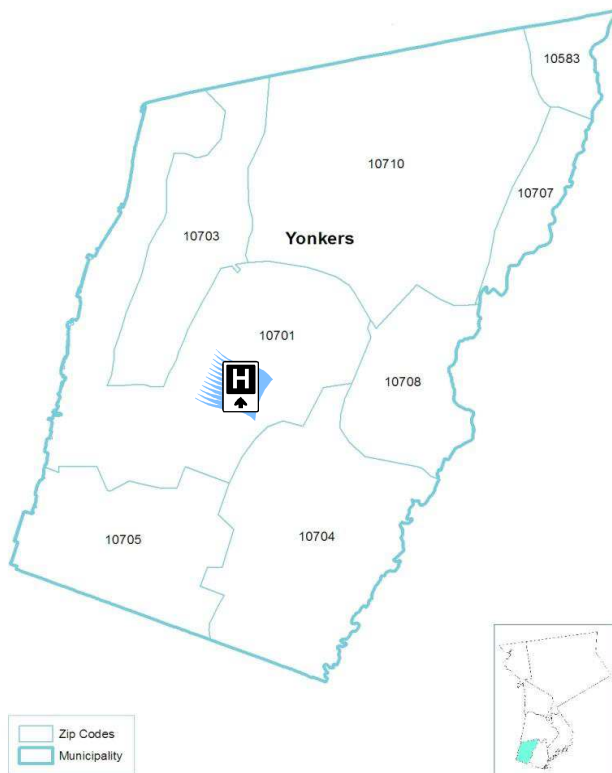
According to the Kaiser Commission on Medicaid for the Uninsured, poverty influences health negatively. Not only do uninsured adults have no regular source of health care, they are more likely to engage in risky behaviors, less likely to follow a treatment plan and more likely to be hospitalized for preventable conditions due to lack of preventive care. To address this need SJMC recently collaborated with a major tertiary care center to develop a full scope of cardiac services for people in its primary service area. The rationale for service expansion in the area of cardiovascular care included the racial, ethnic and economic/access to care issues.

Definition of the Service Area

The CHNA was conducted on behalf of SJMC and St. Vincent's Hospital (SVH). For the purposes of the CHNA, SJMC used zip codes to define the service area. Patient discharge data from SPARCS New York indicates that approximately 86% of inpatients served by the SJMC were residents of Yonkers.

St. Vincent's Hospital, Westchester (SVH) is located approximately 12 miles from SJMC. As a specialty facility, SVH provides a wide array of behavioral health services, both inpatient and outpatient to residents throughout the region including but not limited to the counties north of New York City, Nassau and Suffolk Counties, Fairfield County in Connecticut and New York City. SVH patients receiving inpatient and/or ambulatory behavioral health services reside in a widely dispersed geographic area within the region

comprised of over 300 zip codes. In 2012, more than 15% of patients treated at SVW resided in the primary service area of our main campus in Yonkers.



For purposes of the CHNA, the following Zip Codes, located in Southwest Yonkers were included in the study: 10701, 10702, 10703, 10704 and 10705.

Yonkers covers 18.42 square miles. With a population of 195,975, Yonkers has an approximate population density of 10880.3 people per square mile. (US Census 2010)

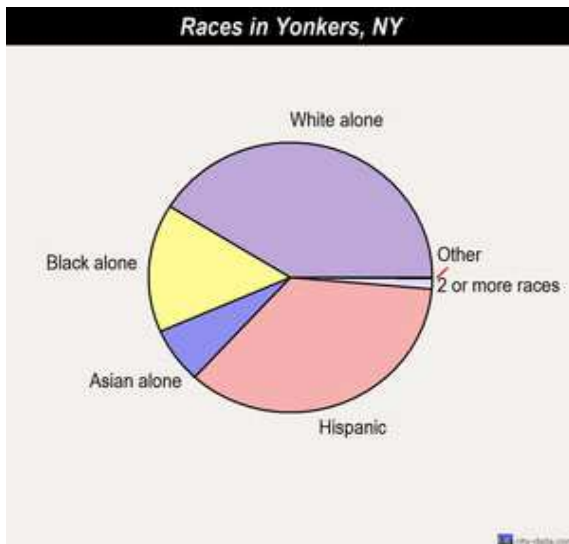
Yonkers is home to large numbers of immigrants and second-generation Americans, which can be associated with service delivery challenges. For instance, 13% of the students in the Yonkers city

schools have limited English proficiency, compared to the statewide rate of 8%. The City had an unemployment rate of 8.3% in November 2012, slightly higher than the statewide rate of 7.9%. According to 2010 Census data, the population for Yonkers was estimated at 195,979 with an estimated projection of 198,449 in 2012 representing a 1.3% increase from April 2010 to July 2012.

The highest numbers of non-English speaking residents live in zip codes 10701, 10703, 10704 and 10705. SJMC is located in zip code 10701. According to the 2010 census 54.5% of the population in Yonkers speaks English only; 46.5% report speaking a language other than English and of that number 17.9% report speaking English less than well. These statistics have implications for access to health care and social services, compliance with care received and other health indicators.

In conducting the SJCHNA, SJMC first reviewed quantitative data from Yonkers' zip codes to identify areas with populations most at risk. The data was then correlated with patient admission zip code data. It was determined that residents in zip codes 10701 and 10705 represented those most at high risk for health disparities based on race, education, poverty level and unemployment statistics.

Zip Code Demographics Yonkers, NY

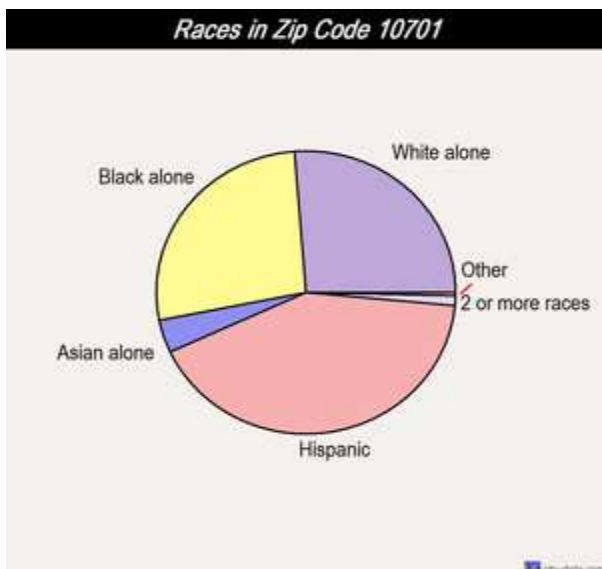


White alone - 81,293 (41.2%)
 Hispanic - 69,919 (35.4%)
 African American/Black alone - 30,369 (15.4%)
 Asian alone - 13,127 (6.7%)
 Two or more races - 2,493 (1.3%)
 American Indian alone - 105 (0.05%)
 Other race alone - 90 (0.05%)

<http://www.city-data.com/city/Yonkers-New-York>

Yonkers by Race All Zip Codes

Zip Code 10701



Residents with income below the poverty level in 2011:

10701	22.5%
NY State:	16.0%

Residents with income below 50% of the poverty level in 2011:

10701:	13.4%
NY State:	8.8%

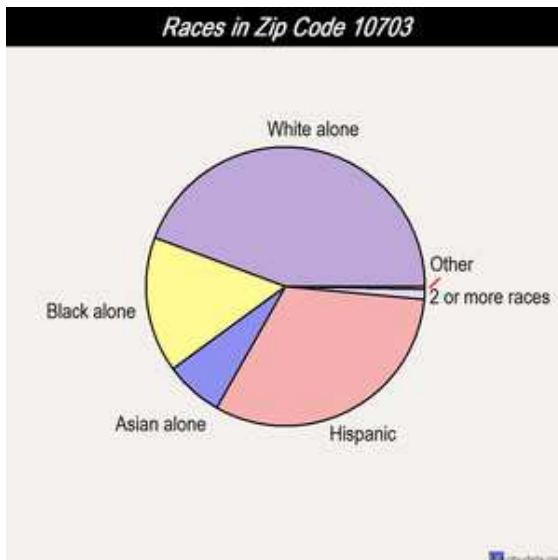
Zip code 10701 contains the majority of Yonkers community service organizations, social services, health department clinics, city government facilities and agencies. It has one major supermarket and many small businesses; it is the hub of bus and train transportation.

According to the 2010 Census, the estimated population in zip code 10701 represents approximately 34% of the total Yonkers population. The total land area in zip code 10701 is 4.2 square miles, representing one of the highest population densities in New York State. (<http://www.citydata.com/zips/10701>)

Zip Code 10701 compared to NY State average:

- African American/Black population percentage is above state average
- Hispanic population percentage is above state average
- Foreign-born population percentage is above state average
- Median age is below state average
- Percentage of population with a bachelor's degree or higher is below state average

Zip Code 10703



Residents with income below the poverty level in 2011:

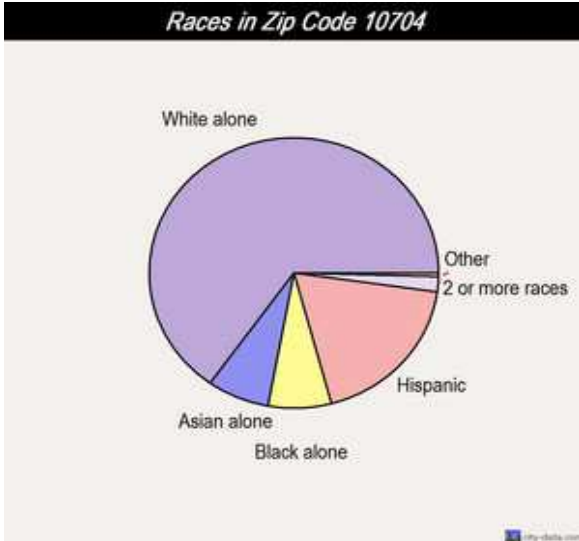
10703: 13.7%
NY State:16.0%

Zip code 10703 is primarily residential homes, parks and schools. Less residents (5.7%) report income at 50% below the poverty level account compared to NY state (8.8%).

Zip Code 10703 compared to NY State average

- Hispanic population percentage is above state average
- Unemployment rate of 7.6% is slightly below state average
- Foreign-born population is above state average

Zip Code 10704



Zip Code 10704 compared to state average:

Residents with income below the poverty level in 2011:

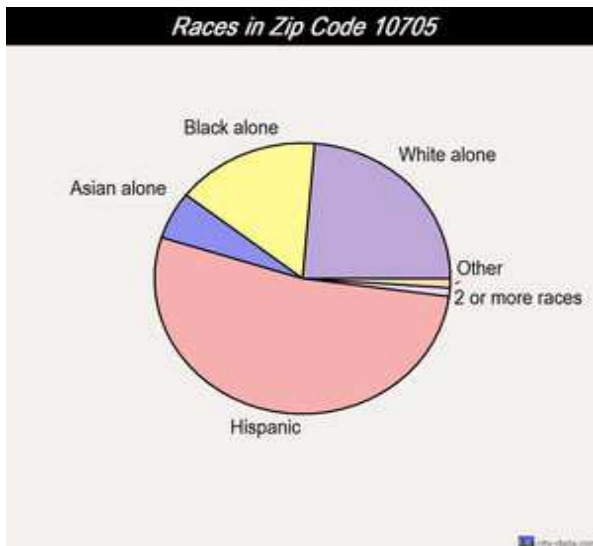
10704: 8.1%
NY State:16.0%

Residents with income below 50% of the poverty level in 2011:

10704: 4.6%
NY State:8.8%

- African American/Black population percentage is below state average.
- Foreign-born population is above state average.

Zip Code 10705



Residents with income below the poverty level in 2011:

10705: 18.5%
NY State:16.0%

Residents with income below 50% of the poverty level in 2011:

10705: 9.0%
NY State:8.8%

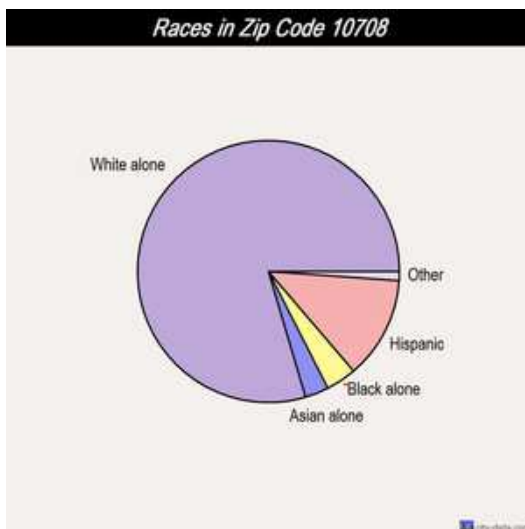
Yonkers zip code 10705 is the most densely populated urban area with approximately 17,234 people per square mile. According to the March 2012 *Cost of Living Index*, this area is 159.2 compared to the US average of 100.

The unemployment rate in 10705 is close to 8.5%, above the state average of 7.9%. Zip code 10705 contains a mix of older homes (built before 1950), small and large businesses, municipal housing and senior residences, one secondary school and several primary schools.

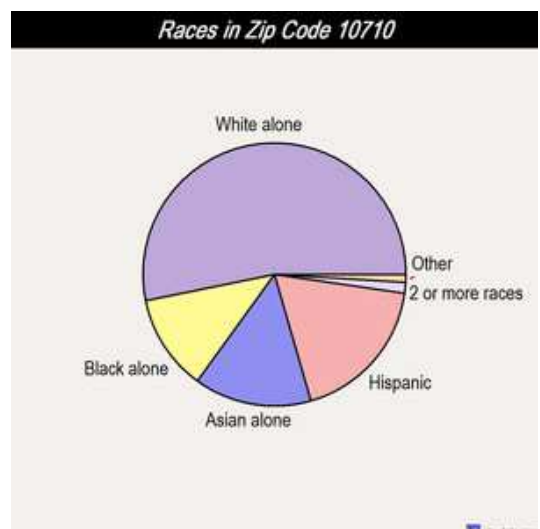
Zip Code 10705 compared to state average:

- Hispanic race percentage significantly above state average.
- Foreign-born population percentage above state average.
- Percentage of population with a bachelor's degree or higher below state average.

Zip Code 10708



Zip Code 10710



Zip codes 10708 and 10710 include predominantly white, English-speaking residents whose unemployment rates are at or slightly below the statewide unemployment rate and have a higher percentage of high school or above educational levels. Since the responses to the SJCHNA were small from these areas as can be seen in the survey response section of this report, these areas will not be addressed again. (Please note however any community education or awareness campaigns will be offered to all residents in Yonkers regardless of the zip code they reside in). Foreign born residents represent approximately 34.7% of the population with the largest group of naturalized or non citizens from Latin America.

The New York State Department of Health (DOH) website and Westchester County Department of Health Setting a Prevention Agenda meetings and literature/resources distributed at the meetings demonstrated that within our primary service zip codes, residents consistently have higher rates of inpatient admissions, incidence of chronic conditions and little participation in preventive services. When compared to statewide rates of the incidence of major diseases, the SJMC service areas breakdown included the following:

- White population comparable or better than the statewide data (for zip codes 10710, parts of 10703, 10701)
- Hispanic population scored worse in the most areas(zip codes 10701, 10704, 10703, 10705)
- Black population scored the worst for all zip codes

Yonkers Demographic Profile 2010 Census People Quick Facts

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
Persons per household, 2007-2011	2.6	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%

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, County Business Patterns, Economic Census, Survey of Business Owners, Building Permits, Census of Governments

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Age

While the median age in Yonkers is 37.6 years and the percent of residents 18 and under is 29%, the population over 65 years is rising. According to population projections the 65 plus age group, currently 14.7% of the population, is estimated to increase to over 19.46%. Older populations have an increased demand for healthcare services and an increased prevalence of chronic conditions and disability.

Median resident age:  37.6 years
New York median age:  42.4 years

Employment and Income

The table below illustrates the unemployment rate, median household income and poverty rate for Yonkers, NY. The rates are shown as an overall total, as well as by gender, race, and ethnicity.

Westchester County Department of Health Yonkers City Profile 2013





	Total Population	Male	Female	White	Black	Hispanic
Unemployment Rate	7.9	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 Needs Index

Using 2011 data from the Community Need Index (CNI), a tool developed in 2005 by Dignity Health in partnership with Truven Health, SJMC was able to pinpoint neighborhoods with significant barriers to health care access. CNI considers multiple factors that limit health care access including educational levels, housing and income.

CNI identified the severity of health disparity for our selected zip codes with one (1.0) representing less community need and five (5.0) representing more community need. According to the CNI data, there is a link between community need, access to care, and

preventable hospitalizations. A score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers. (CNI 2011) The table below shows the CNI score for Yonkers zip codes.

Zip Code	CNI Score	Population	City	County	State
 10701	4.8	64838	Yonkers	Westchester	New York
 10703	4.6	21408	Yonkers	Westchester	New York
 10704	3	30136	Yonkers	Westchester	New York
 10705	4.4	39525	Yonkers	Westchester	New York

Yonkers 2011 CNI Scores (2011 estimated data reflects increase in populations in SJMC target Zip Codes). A comparison of CNI scores to hospital utilization rates shows a strong correlation between high need and high use admission rates per 1,000 populations in these zip codes. In fact, admission rates for the neediest communities (areas shown in red) were over 60% higher than zip codes with the lowest need. The data in the table above demonstrates the zip codes with the highest need for outpatient care that could prevent or reduce the need for hospital admission for diabetes, asthma and hypertension.

The SJMC COMMUNITY HEALTH NEEDS ASSESSMENT

Background

Saint Joseph's Medical Center determined that it would be most efficient to develop their community health needs assessment by building upon relationships with existing Yonkers stakeholders such as members of the following community initiatives:

- Healthy Yonkers Initiative
- Yonkers YMCA REACH Initiative
- 55Plus/Yonkers On The Move
- Southwest Yonkers Livable Communities
- Southwest Communities For All Ages Initiative

By inviting these partners, as well as other key community leaders representing expertise in public health, underserved populations, and those with chronic disease, SJMC ensured a wide representation of community input in the development of Saint Joseph's Medical Center Community Health Needs Assessment (SJCHNA).

Methodology

The SJCHNA was comprised of both quantitative and qualitative research components, using 2010 and 2012 data. A brief outline of the methods is below and data is referenced throughout this report.

Quantitative Data: Secondary data from the following sources was reviewed and compiled for presentation at a key stakeholders meeting.

- Westchester County Health Department Assessment Project Data
- CDC New York State Behavioral Risk Factor Surveillance System
- New York State Department of Health –Division of Chronic Disease Prevention
2009-2012
- New York State Prevention Agenda 2013-2017
- Healthy People 2020

Qualitative Data: SJMC engaged key community stakeholders to solicit their input and expertise in prioritizing the needs of the community.

Phase I: Process Definition and Key Stakeholder Inclusion (May-September 2013)

- Identified and contacted key community stakeholders and key informants to participate in the SJCHNA.
- Developed a key informant pre-assessment survey (see Appendix C)
- Hosted community meetings with key stakeholders
- Participated in Westchester County Health Department meetings (See appendix A)
- Contacted key community stakeholders unable to attend meeting to gather additional feedback

Phase II: Data Collection (September 2013-December 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. Activities included the following:

- Conducted Interviews with the following community key informants:
 - Ms. Susan Stein, Director of the Westchester American Diabetes Association. Instrumental in collaborating to increase diabetes prevention and awareness information and resources to SJMC as well as the Yonkers community.
 - Dr. Nadem Sayegh, Endocrinologist.
 - Ms. Cheray Burnett, Vice President at Saint John's Riverside Health Care to discuss future collaboration and what resources we can share to meet identified needs
 - Dr. Barry Perlman(Psychiatrist), Interim Medical Director SJMC and Past President of the New York State Psychiatric Association-consulted to address the need expressed by the focus group in phase one regarding the need for

mental health and substance abuse services in the community particularly for adolescents.

- Shawyn Howard, Executive Director of Yonkers YMCA-YMCA recent recipient of a grant to reduce the incidence of poor health outcomes for Black and Hispanic residents via education and outcome based programs.
- Linda Bohan Health and Literacy Education Director, Vive School – Pathways to Success for immigrant assimilation via education
- Dr. Charles Pastor, Director Saint Joseph’s Family Health Center, a teaching clinic that is in the process of implementing a Patient Centered Medical Home Program. The FHC Health Quality Improvement was reviewed to identify trends in chronic disease outcomes
- Pam Tripodi, Administrator of SJMC Family Health Clinic
- Developed SJCHNA Resident Survey Tool based on input from community forums, key informant feedback and WHCDOH data.
- Participated in community forums on August 14, September 19, November 14 and December 12, 2013 to inform community organizations about the SJCHNA.
- Disseminated SJCHNA Resident Survey Tool to the community via the following outreach efforts:
 - Mass mailing via US Mail to 1,000 households all Yonkers zip codes
 - Mass e-mail to approximately 5,000 community members, utilizing Yonkers City Council list serve; community partner e-mail distribution lists such as Yonkers on the Move, Yonkers Office for the Aging, Yonkers YMCA; e-newsletters, and websites,
 - Distributed 1,500 paper surveys at community events, senior centers, schools, housing authorities, Vive School and to high-risk groups in Municipal Housing
 - Sent SJCHNA survey tool via paychecks to 657 SJMC employees and their families who live in SJMC service area.

- Conducted one-to-one surveying at the library in September and October 2013 and at the Westchester Diabetes Association Walk in September 2013. (More than 800 people participated in the walk; 26 completed surveys.)

SJMC sought to mitigate the limitations of the SJCHNA process by setting up outreach tables at major health fairs and in the library to ensure diversity in responses from underserved populations with language barriers, low literacy, and no access to internet.

Phase III: Prioritization (December 2013)

To prioritize the identified community health needs, the CHNA results were reviewed by SJMC with its key informants and community partners at a Stakeholder Summit. A list of organizations that participated in the Summit can be found in Appendix A. SJMC reviewed feedback from the Stakeholders Summit along with its current services and programs, resources and areas of expertise, and other existing community assets, to determine what priority needs it would address, and those for which it would play a support role in addressing.

SJMC, with input from the Westchester County DOH and other community partners, adopted **Chronic Disease Management for Diabetes and Hypertension** as its priority areas for the following three-year cycle.

Resources and Partnership Support

The following community partners were identified as assets to assist in community health improvement activities.

AARP State and Local	Westchester Heart Association
Hudson Valley Asthma Association	Westchester County Department of Health
Westchester CLUSTER	YMCA of Yonkers
Community Planning Council of Yonkers	YWCA of Yonkers
Faith Based: United Christian Assembly, Mt. Carmel Baptist Church, Kingdom Christian Assembly	Yonkers Chamber of Commerce
Family Services Society Yonkers	Yonkers City Council
JCY-Westchester Community Partners	Yonkers Community Action Program
Sarah Lawrence College	Municipal Housing Yonkers
St. John's Riverside Health Care	Yonkers Office of the Aging
Visiting Nurse Services of Westchester	Yonkers Office of Emergency Management
Volunteer Center/RSVP	Yonkers Park and Recreation
Westchester American Diabetes	Yonkers Public Library
	Yonkers Public Schools

In addition to these partners, the following initiatives will continue:

- Elected officials have agreed to support existing health promotion initiatives in connection with SJCHNA
- 2012 establishment of the Yonkers Diabetes Education Initiative cosponsored by SJMC
- 2013 hosting of the Westchester American Diabetes "Stop Diabetes" Walk in Yonkers
- In 2011 SJMC-initiated community-wide walking program for residents of all ages
- Asthma prevention program run by SJMC at five Yonkers Schools

The Impact of Chronic Disease on the Community

In an era of aging baby boomers, increased chronic disease, an epidemic prevalence of obesity, a sagging economy, an increasing number of uninsured citizens and disparate access to care, SJMC strives to maximize the use of its collective resources and develop community partnerships to meet the health needs of the communities it serves.

SJMC anticipated barriers and challenges based upon the population disparities in the geographic areas it serves. The admission rates for Diabetes and Hypertension are outlined in the table below. Approximately 40% of the patients admitted to SJMC receive Medicaid or are uninsured. Fifty-two percent of Yonkers residents receive Medicaid according to the Westchester County Department of Health 2013 Regional Statistics for Yonkers.

Unhealthy lifestyles and the growth of chronic disease are increasingly affecting 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 Black and Hispanic residents. SJMC will focus its efforts specifically on residents at risk and in need of self management of diabetes and hypertension.

The results of the SJCHNA resident survey support the priorities selected due to the number of residents who indicated a diagnosis of hypertension and diabetes, as well as the number of responses indicating the need for better screenings and more community education around these topics. Survey respondents were asked "What do you feel are the three most important health concerns in the community?" The responses ranked Diabetes as the most important health concern, Hypertension as No. 2 and obesity as No. 3.

According to the New York State Prevention Agenda, New York State data shows that individuals with diabetes do not receive the 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. The

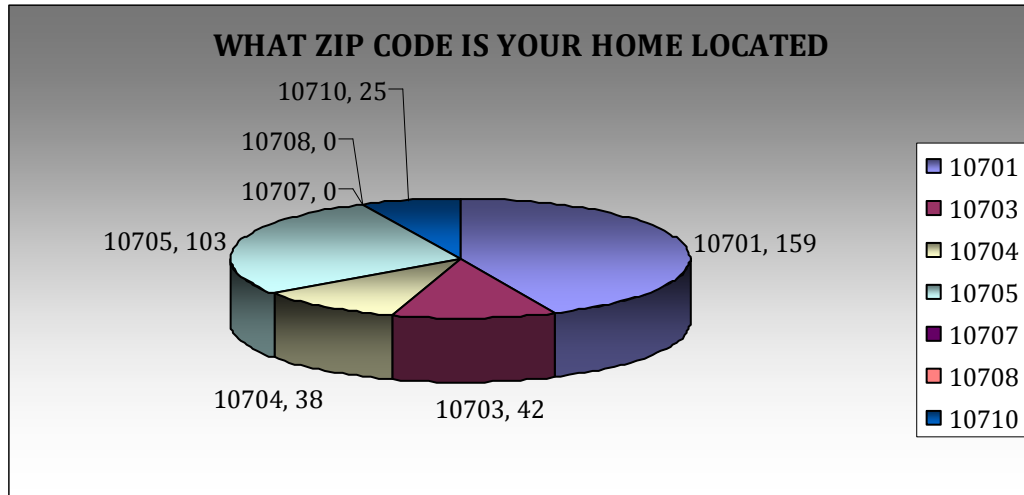
following table depicts the Prevention Quality Indicators (PQI) by diagnoses and admission rate for race and ethnicity.

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.							

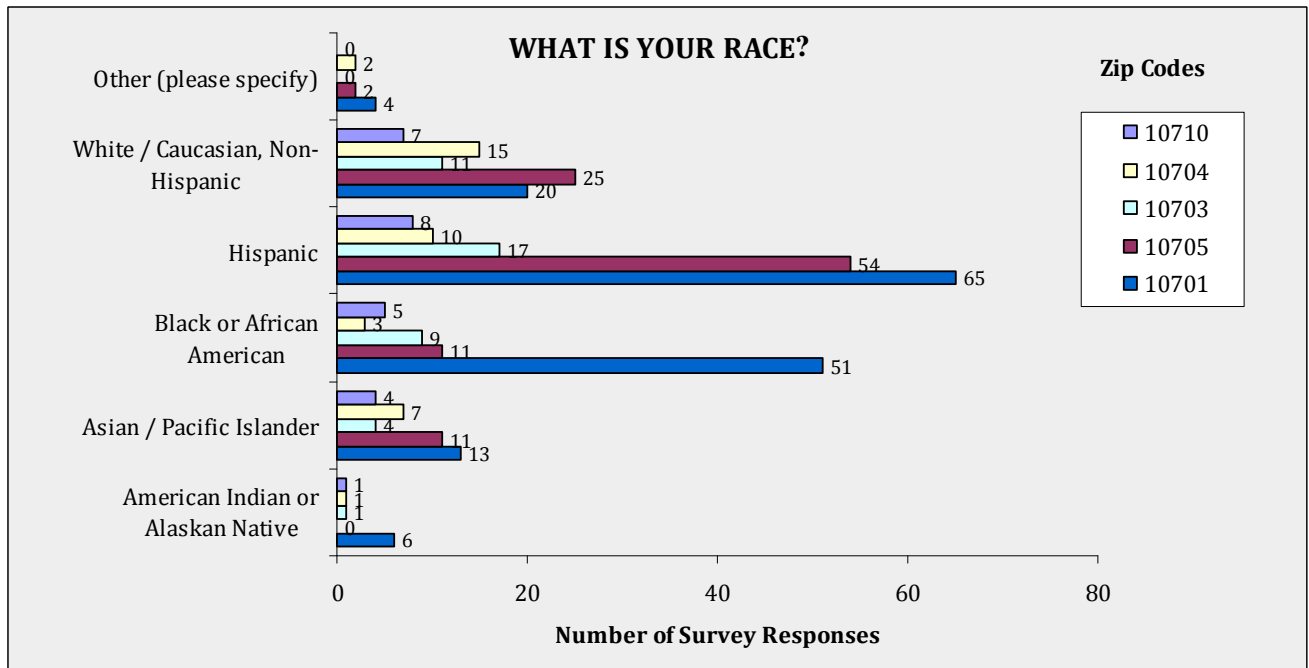
Health disparities exist when segments of the population experience greater barriers to accessing health care and maintaining optimal health. The PQI table, excerpted from the Westchester County Department of Health Community Health Assessment 2010-13, illustrates the health disparities experienced by 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.

Research Findings: SJCHNA Resident Survey

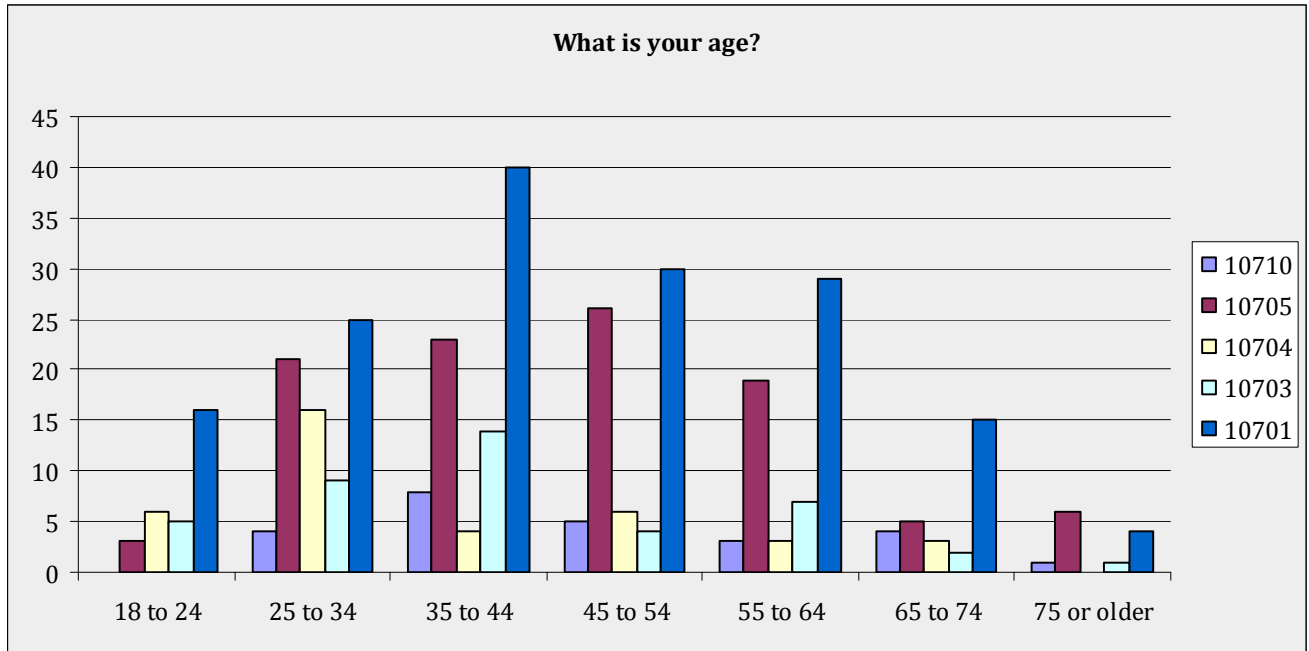
The highest number respondents of the SJCHNA Resident Survey were from zip codes 10701 and 10705.



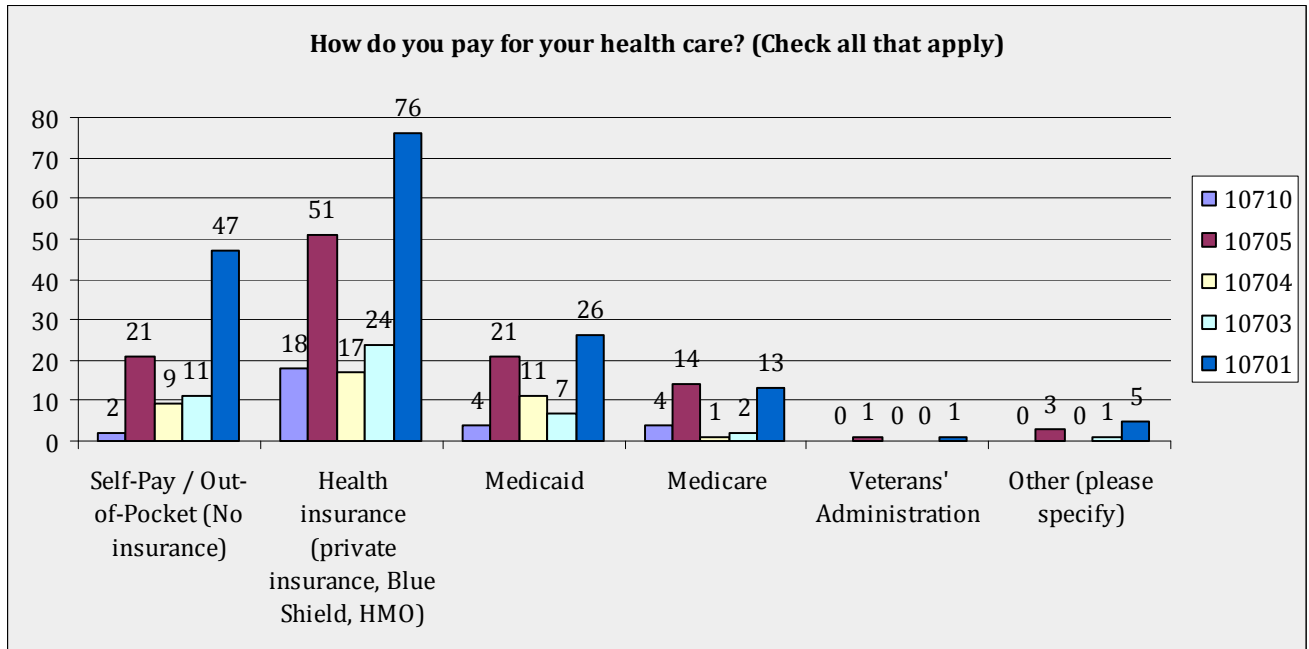
The highest number of respondents who indicated they were Black/African American or of Hispanic descent reside in zip codes 10701 and 10705.



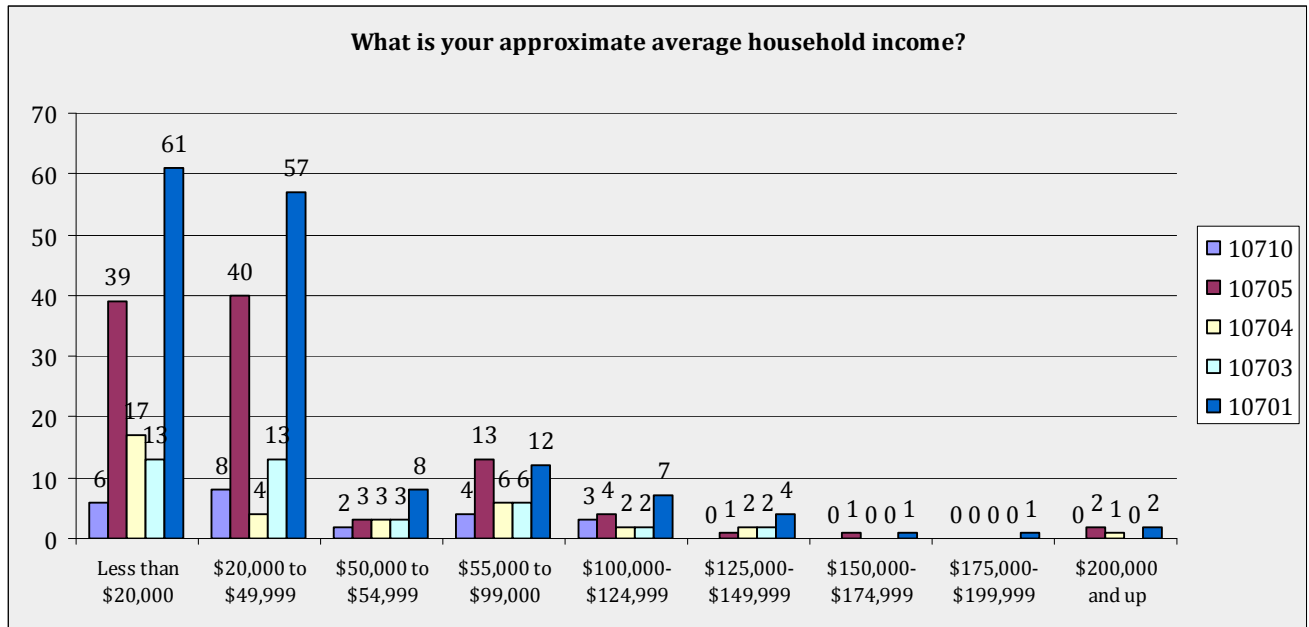
The median age of survey respondents was 35 to 44 in the majority of zip codes.



In zip codes 10701 and 10705 combined, 68 respondents reported no health insurance.



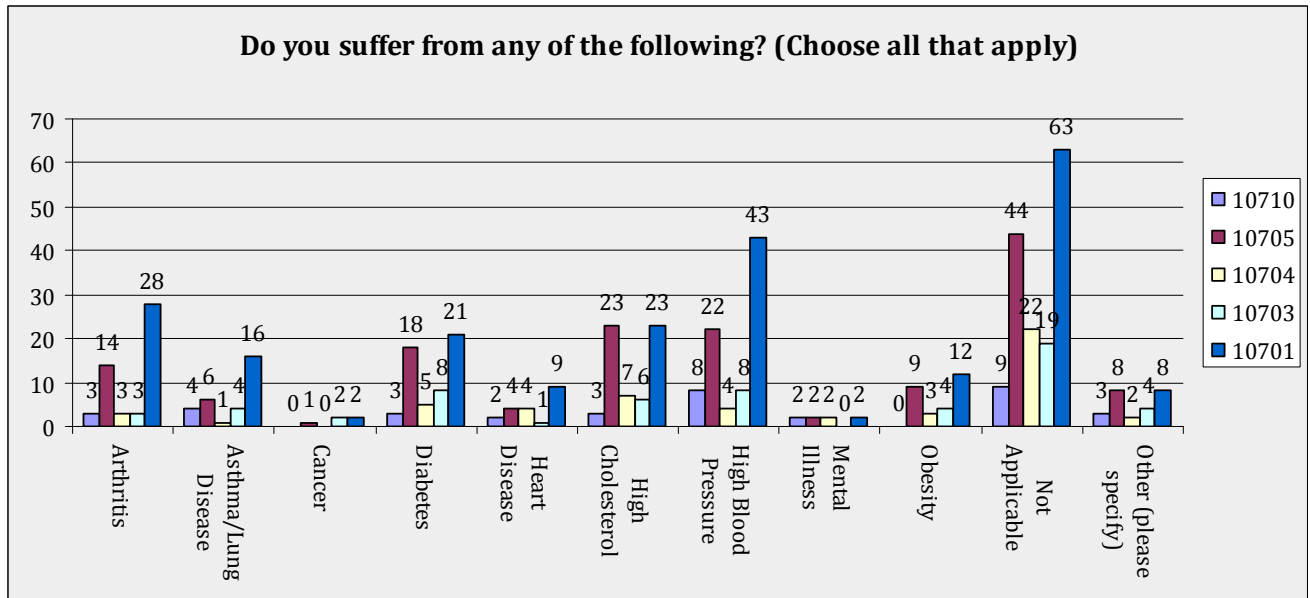
The majority of respondents in all zip codes report an annual household income of less than \$49,000.



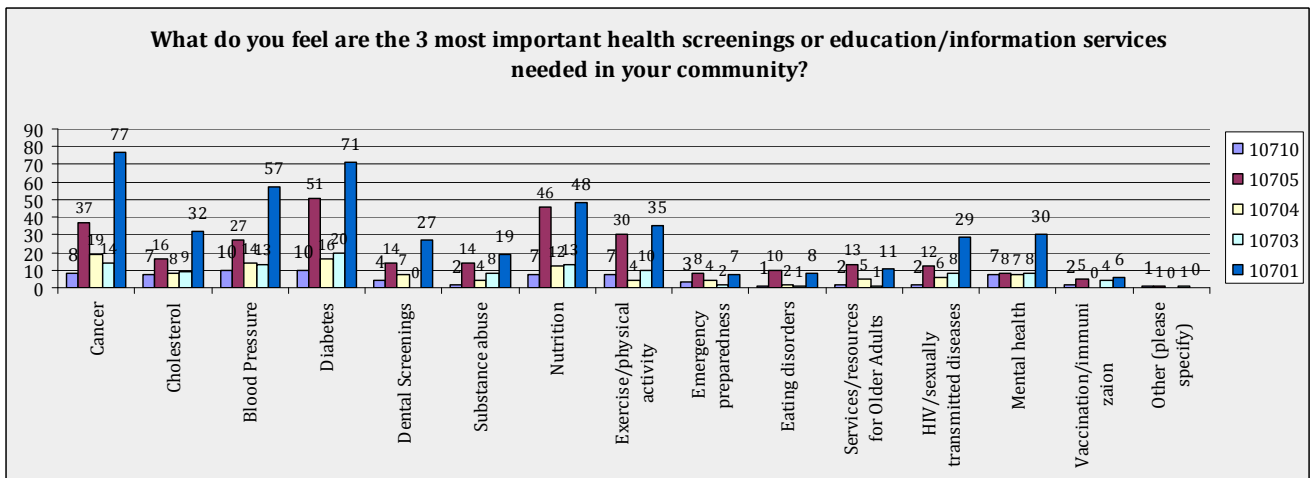
In zip codes 10701 and 10705 combined, 56 respondents had attained less than a high school diploma.

What is the highest level of school you have completed or the highest degree you have received?							
Answer Options	In what ZIP code is your home located?					Response Percent	Response Count
	10701	10703	10704	10705	10710		
Less than high school degree	36	8	6	20	2	19.7%	72
High school degree or equivalent (e.g., GED)	41	5	16	29	8	27.0%	99
Some college but no degree	29	16	4	17	6	19.7%	72
Associate degree	9	4	1	10	1	6.8%	25
Bachelor degree	26	5	8	13	6	15.8%	58
Graduate degree	17	4	3	14	2	10.9%	40
answered question							366
skipped question							1

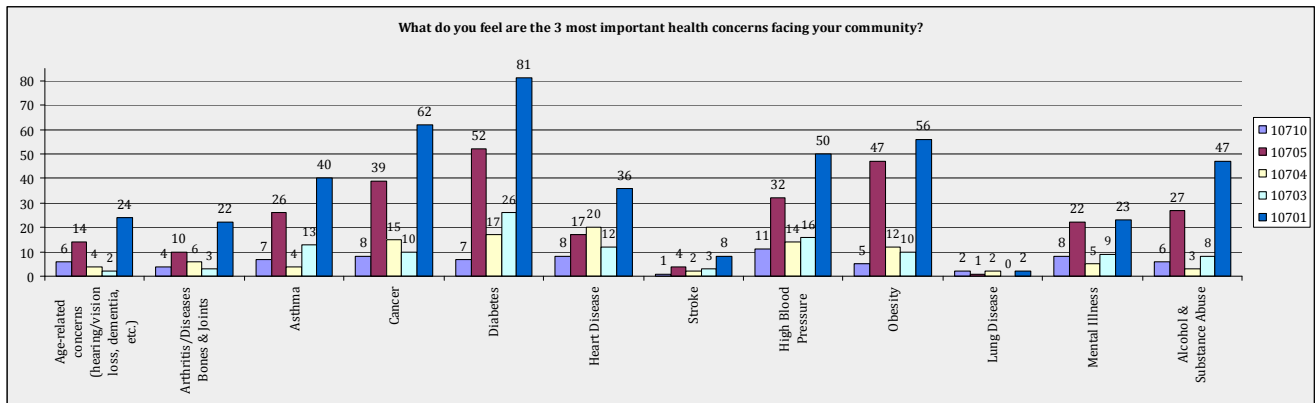
Survey respondents were also asked to report what chronic conditions they suffered from. A total of 157 respondents reported “not applicable,” assumed that they do not have any chronic conditions. The top conditions reported were high blood pressure (85); high cholesterol (62); Diabetes (55); arthritis (51); obesity (28), asthma/lung disease (22); and heart disease (20). Other conditions listed included thyroidism, Parkinson’s disease, connective tissue diseases, migraines, epilepsy and osteoporosis.



Survey respondents in zip code 10701 said the most important health screenings or education/information services needed were for Cancer (77) and Diabetes (71). Blood pressure (57) was the second highest screening requested in 10701.



Respondents in zip codes 10701 and 10705 identified Diabetes, Cancer, obesity and high blood pressure as their top health concerns in the community.



Various health needs perceived as not being met in the community are listed below from highest to lowest.

- Nutrition Education
- More General Health Education
- Exercise Classes
- Better access to food stamps and fresh fruits and vegetables
- More Cancer Services – Women’s Health
- Substance Abuse Education
- More public screenings for HIV and communicable diseases

IMPLEMENTATION STRATEGY

To improve community health related to the priority areas of diabetes and hypertension chronic disease management, SJMC created an Implementation Strategy that includes the following action items: (The full Implementation Strategy is outlined in a separate document.)

- Provide regular community-wide education and awareness programs
- Select , implement and evaluate effectiveness of disease self management programs using evidenced-based models and best practice approaches to chronic disease management to:
 - Reduce # of Emergency Department visits for non-emergency care, for those patients who participated
 - Reduce # of hospital admissions or readmissions for those patients who participated
- Document and report measurable outcomes in our Family Health Clinic Medical Home and develop on going improvement processes (e.g. reduction in weight, HgbA1C <8, Blood Pressure <140/90, reduction in BMI, increase in number of walkers/miles/steps logged)
- Participate in the Westchester County Department of Health Prevention Agenda Initiative to train health professionals on various healthcare screening (e.g. blood pressure)
- Recruit volunteers to become Chronic Care Management Program trainers offered by the Westchester County Department of Health
- Continue to identify and enroll uninsured individuals in health coverage programs
- Implement an online tool that allows hospital staff to create follow up appointments with community providers for patients post discharge or in outpatient program

BOARD APPROVAL

The SJMC Board of Trustees reviewed the CHNA Final Report and full Implementation Strategy. The Implementation Strategy was adopted by the Board in December 2013. The Final Report and Implementation Plan can be found on the SJMC website and is available in hard copy upon request.

APPENDIX

- I.* Appendix A – WCDOH Meetings
- II.* Appendix B – Brief Description of Partner Initiatives
- III.* Appendix C – Pre-assessment Survey
- IV.* Appendix D – Saint Joseph's Medical Center Community Health Needs
- V.* Appendix E – Yonkers Diabetes Statistics

APPENDIX A – WCDOH Meetings

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 11, 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

STAKEHOLDERS SUMMIT ATTENDEES

Appendix B – Brief Description of Partner Initiatives

ORGANIZATION	ADDRESS	CITY, NY ZIP
Affinity Health Plan	2500 Hasley Street	Bronx, NY 10461
American Diabetes Association	110 Corporate Park Dr.	White Plains, NY 10604
American Heart Association	3020 Westchester Avenue	Purchase, NY 10577
American Lung Association POW'R Tobacco Cessation Center	297 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 and Research Foundation, Inc.	Westchester Medical Center 100 Woods Aroda	Valhalla, NY 10595
March of Dimes	1800 Mamaroneck Avenue	White Plains, NY 1065
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 Avenue	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	300 Westage Business Center Drive	Fishkill, NY 12524
United Way of Westchester and Putnam	366 Central Park Avenue	White Plains, NY 10606
Westchester County Department of Social Services	112 East Post Road, 5 th Floor	White Plains, NY 10601
Westchester County Office of Women	112 East Post Road	White Plains, NY 10601
Westchester Count Dept. of Senior Programs	9 South First Avenue, 10 th Floor	Mount Vernon, NY 10550
Yonkers Public Schools	75 Riverdale Avenue	Yonkers, N Y 10705

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

- **Saint Joseph's Medical Center Stoke Center:** Provides ongoing training on stroke prevention, which includes blood pressure monitoring and management. The community programs used evidenced-based resources from the American Heart Association and the American Stroke Association.
- **South West Yonkers Community For All Ages:** Community leadership training is conducted with graduates of all ages participating in service projects related to health such as community gardens, intergenerational walks and healthy diets. The initiative is 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.
- **Westchester American Diabetes Association:** The Yonkers Diabetes's Education Initiative supports 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 exercise. Since its inception it has reached several thousand residents (via e-mail, community newspaper exposure, and support from SJMC administration), with approximately 100 residents of all ages participating in the first community walking challenge to exceed the goal of 2,000 miles. SJMC 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 residents) of all ages in the geographic area SJMC serves. This multi-collaborative initiative includes local businesses, housing, healthcare resources, social service agencies, various faith-based community organizations 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 use the YMCA facility to co-sponsor health activities for staff and patients with membership at the YMCA as one of the incentives for completion of the self management sessions

Appendix C - Prevention Agenda Survey

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 D - Saint Joseph's Medical Center Community Health Needs Assessment Survey

1. In what ZIP code is your home located?

- 10701
- 10703
- 10704
- 10705
- 10707
- 10708
- 10710
- Other (please specify)

2. What is your age?

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older

3. What is your gender?

- Male
- Female

4. What is your race?

- American Indian or Alaskan Native
- Asian / Pacific Islander
- Black or African American
- Other (please specify)
- Hispanic
- White / Caucasian, Non-Hispanic

5. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor degree
- Graduate degree

6. What is your approximate average household income?

- Less than \$20,000
- \$20,000 to \$49,999
- \$50,000 to \$54,999
- \$55,000 to \$99,000
- \$100,000-\$124,999
- \$125,000-\$149,999
- \$150,000-\$174,999
- \$175,000-\$199,999
- \$200,000 and up

7. How do you pay for your health care? (Check all that apply)

- Self-Pay / Out-of-Pocket (No insurance)
- Health insurance (private insurance, Blue Shield, HMO)
- Medicaid
- Medicare
- Veterans' Administration
- Other (please specify)

8. How often do you visit your healthcare provider?

- Annually
- Every few years
- Every few weeks
- Only when I am sick
- I do not have a regular healthcare provider

9. Do you suffer from any of the following? (Choose all that apply)

- Arthritis
- Asthma/Lung Disease
- Cancer
- Diabetes
- Heart Disease
- High Cholesterol
- High Blood Pressure
- Mental Illness
- Obesity
- Not Applicable
- Other (please specify)

10. If you suffer from chronic or recurring illnesses, how frequently do you see a health care provider?

- Annually
- Every few months
- Every few weeks
- Only when I have symptoms
- I do not see a health care provider
- Not Applicable

11. Are you a smoker?

- Yes
- No

12. Have you been told you are overweight?

- Yes
- No

13. If you chose Yes for Question 13 about being overweight, how many pounds are you overweight?

- 5 - 10 lbs.
- 11 - 20 lbs.
- 21 - 49 lbs.
- 50 lbs. or more
- Not applicable (answered "No" to Question 13)

14. Do you exercise at least 3 times a week?

- Yes
- No

15. How would you rate your overall health?

- Very Unhealthy
- Unhealthy
- Somewhat Healthy
- Healthy
- Very Healthy

16. What do you feel are the 3 most important health screenings or education/information services needed in your community?

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Exercise/physical activity |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Emergency preparedness |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Services/resources for Older Adults |
| <input type="checkbox"/> Dental Screenings | <input type="checkbox"/> HIV/sexually transmitted diseases |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Vaccination/immunization |
| <input type="checkbox"/> Other (please specify) | |

17. Where do you get the most of your health-related information? Check all that apply.

- Books / Magazines
- Family / Friends
- Health care provider Doctor / Nurse
- Health Department
- Hospital
- Internet
- Library
- Newspaper
- Radio
- Social Media Sites (Facebook, Youtube)
- Television
- Do not know where to get information
- Other (please specify)

18. What health services do you routinely use outside of the Yonkers area?

- Specialty Hospital
- Clinics
- Disease Specific Specialists (Cardiologists, Endocrinologists, Oncologists, etc.)
- None
- Other (please specify)

19. What do you feel are the 3 most important health concerns facing your community?

- Age-related concerns (hearing/vision loss, dementia, etc.)
- Arthritis/Diseases Bones & Joints
- Asthma
- Cancer
- Diabetes
- Heart Disease

- Stroke
- High Blood Pressure
- Obesity
- Lung Disease
- Mental Illness
- Alcohol & Substance Abuse

Other (please specify)

20. What factors have influenced your decision to use St. Joseph's Services?

- Location
- Hours of operation
- Other (please specify)
- Doctor's recommendation
- Do not use

21. In your opinion, what health needs are not met in your community?

Appendix E- Yonkers Diabetes Statistics

Number of Yonkers Residents		200,000
Approximate # of people with diabetes*		20,000
<i># of Persons x 10.0%</i>		
Number of Diagnosed		14,600
<i># of People with Diabetes x 73%</i>		
Number of Undiagnosed		5,400
<i># of People with Diabetes x 27%</i>		
Approximate # of People with Pre-Diabetes*		50,000
<i># of Persons x 25%</i>		
Economic Costs		
Avg. Insurance Cost – People with diabetes		\$ 232,254,000
<i>\$5,049¹ x # of Persons with Diabetes x 2.3</i>		
Avg. Insurance Cost - People with Pre-Diabetes		\$ 252,450,000
<i>\$5,049¹ x Approx. Number of People with Pre-Diabetes</i>		
Potential Cost Increase		
Scenerio A: 75% of people with pre-diabetes develop diabetes		\$ 246,138,750
Scenerio B: 50% of people with pre-diabetes develop diabetes		\$ 164,092,500
Scenerio C: 25% of people 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		

Note: 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, the increase in obesity prevalence translates to nearly one million additional New Yorkers being at higher risk for developing diabetes. (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). Prevention initiatives include diabetes education and other actions designed to sustain engagement of patients with their diabetes care.