V. COMMUNITY HEALTH NEEDS IDENTIFICATION

a. Needs Prioritization Process and Criteria

Our priorities were selected as part of a countywide planning process facilitated by the Westchester County Department of Health’s Health Planning Team (See Appendix E for list of team members). SJRH is an active participant in the Health Planning Team. The service area assessed was Westchester County. The NYS Prevention Agenda 2013-2017 assisted in guiding our collaboration in development of our plan around community health improvement priorities that are consistent with the population health principles embodied in federal and state health care reform. Following review of this data and results from the myriad of community health assessments conducted by SJRH, we prioritized needs and developed a plan.
The following is a description of the collaborative process with the WCDOH, a list of meetings/conference calls held including our Health Summit, where we reviewed current health data, identified and prioritized needs for our health improvement plans.

**Westchester County Department of Health – Health Planning Team**

“*Working together toward a healthier Westchester*” **January – October 2013**

In January 2013, St. John’s Riverside Hospital along with other area hospitals and health centers partnered with the Westchester County Department of Health to work together on assessing community needs, identifying at least two local priorities, one of which should address a health disparity, and developing a plan to address the identified priorities.

To help support and coordinate this collaboration, the Westchester County Department of Health (WCDOH) invited sixteen Westchester County hospitals and health centers to attend a kick-off meeting on January 31, 2013. In addition, the three Federally Qualified Health Centers were also invited to attend. The meeting was held at the Westchester County Department of Health (10 County Center Road in White Plains).

At the first meeting Sherlita Amler, MD, Westchester County Commissioner of Health, welcomed all participants to the meeting. WCDOH provided a brief team overview of the prior planning process and the new requirements for both the health department and the hospitals specific to the development of community health assessments and community health improvement plans. The Health Planning Team supported working collaboratively on this project and during the past ten months we demonstrated our commitment by attendance at monthly meetings, participating in two conference calls and hosting a Health Summit entitled “Working Together Toward a Healthier Westchester” (See Appendix G for a list of Summit participants). In addition, the team has shared information, resources and updates through email and phone calls.

The team met monthly and conducted an extensive review of all the health indicators contained in the Prevention Agenda (See Appendix F for list of health planning team meeting dates). For each indicator, the team reviewed whether the County was below, meeting or exceeding the state established targets/goals, the estimated number of people affected by each indicator (when available), the County’s overall ranking for the indicator compared to other New York Counties, and the performance range within the State. The team often requested the Westchester County Department of Health to provide additional reports/analysis, including data at a sub-County level to allow a more complete understanding of the problem.
The team developed an agency profile that was distributed to community partners. The profile requested each agency to provide general agency information, such as hours of operations, office locations and service areas, as well as to include current activities, training and policies in place to support the selected priorities and any new activities planned. The team also invited community partners to a half-day summit that was devoted to sharing current activities/programs and to discuss what could be done to address the selected health priorities.

i. Needs Addressed and Not Addressed in Plan

As a result of a myriad of methods utilized to assess the needs of our community, we addressed the top ranked needs as indicated through our surveys and review of data with the WCDOH. Priority needs in chronic disease prevention, specifically addressing diabetes, obesity, cancer and hypertension will be addressed with the WCDOH Health Planning Team and the SJRH Care Transition Coach Program. Although the rate of mothers exclusively breastfeeding in Westchester County exceeded New York State averages, the WCDOH Health Planning Team agreed that significant improvement could be made when compared to other counties in the region. Other priority areas selected, HIV and Hepatitis C Virus were critical need areas to be addressed as indicated from service area data and community feedback. Following a thorough review of the data, the priorities selected included consideration of priorities that were attainable and that aligned with each agency’s mission and service area. With the diversity and the number of hospitals in the County, it was quite challenging for the team to select its priorities especially when for a number of indicators the data revealed only certain parts of the County being impacted.

b. Priority Need Areas Identified

Southwest Yonkers and Westchester County data were compared for the purpose of addressing the needs in our service area. After careful deliberation and discussion, the following two priorities were selected by the WCDOH Health Planning Team:

1. Increasing Breastfeeding
   (Priority Area: Promote Healthy Women, Infants and Children)

   PERCENTAGE OF INFANTS WHO WERE EXCLUSIVELY BREASTFED IN THE HOSPITAL AFTER BIRTH BY REGION, WESTCHESTER COUNTY, 2008-2010

   Southwest Yonkers had 34.6 percent of infants who were exclusively breastfed in the hospital as compared to 54.2 percent of infants in Westchester County (Appendix I).

2. Decreasing the Percentage of Blacks and Hispanics Dying Prematurely from Heart-related deaths
   (Priority Area: Prevent Chronic Diseases)

   Black and Hispanic Westchester residents have disproportionately high rates of premature death, before age 65 (Appendix I). Compared to White non-Hispanic residents, in Westchester the life span of Black non-Hispanics is 10 years less and the life span of Hispanics is 16.5 years less (Appendix K).
PERCENTAGE OF PREMATURE DEATHS (BEFORE AGE 65) AND AVERAGE AGE OF DEATH BY RACE IN WESTCHESTER COUNTY, 2008-2010

<table>
<thead>
<tr>
<th></th>
<th>% of Premature Death</th>
<th>Average Age of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanics</td>
<td>46.9%</td>
<td>62.6</td>
</tr>
<tr>
<td>Black non-Hispanics</td>
<td>36.7%</td>
<td>69.1</td>
</tr>
<tr>
<td>White non-Hispanics</td>
<td>16.3%</td>
<td>79.1</td>
</tr>
<tr>
<td>Other</td>
<td>40.3%</td>
<td>65.9</td>
</tr>
<tr>
<td>Total</td>
<td>22.0%</td>
<td>77.2</td>
</tr>
</tbody>
</table>

DISPARITIES IN PREMATURE DEATH RATES BY RACE AND ETHNICITY, 2008-2010

<table>
<thead>
<tr>
<th></th>
<th>New York State</th>
<th>Westchester County</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of premature death (before age 65 years)</td>
<td>24.3</td>
<td>20.0</td>
<td>21.8</td>
</tr>
<tr>
<td>Ratio of Black non-Hispanics to White non-Hispanics</td>
<td>2.12</td>
<td>2.48</td>
<td>1.87</td>
</tr>
<tr>
<td>Ratio of Hispanics to White non-Hispanics</td>
<td>2.14</td>
<td>3.16</td>
<td>1.8</td>
</tr>
</tbody>
</table>


The overall rate of premature death in Westchester is lower than in New York State as a whole, but our racial and ethnic disparities are greater than the statewide averages.

More than 50% of respondents to the SJRH Community Health Needs Assessment Survey administered via Survey Monkey (November/December 2013) indicated chronic diseases as the most important health issue facing our community today.
Identification of four (4) major goals in three (3) prevention priority areas for our Plan:

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

Priority 1: Prevent Chronic Diseases

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

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

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

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

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

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