VI. IMPLEMENTATION STRATEGY (Three-Year Plan of Action)

a. Priority Areas, Goals and Interventions

**PRIORITY 1: PREVENT CHRONIC DISEASES**

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

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

The SJRH CARE TRANSITION COACH PROGRAM was introduced in 2012 to reduce recidivism and facilitate transition from in-patient stays at Andrus Pavilion to home for patients with chronic medical condition. This patient-centered and home visiting program addresses the needs of the patients who are not provided sufficient primary care options in our medically underserved area of Yonkers. Nurses and Case Managers, in collaboration with the Care Transition Coach who is a Spanish speaking registered nurse, identifies patients who would benefit from the program. The program is the first and only one in Westchester County. It is a co-jointly implemented program between the Visiting Nurse Association of Hudson Valley and St. John’s Riverside Hospital. There is no charge for patient participation in the program.

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

**Objective 1:**

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

- Patients with chronic diseases such as Congestive Heart Failure (CHF), Cardiac Disease, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and Renal Disease, who have frequent re-hospitalizations or are at risk for such, will be referred to the transition coach. Includes the caregivers for patients with dementia.

The Coaching of the patients and family members is based on the Coleman Transition Intervention. Coaching begins in the hospital setting. Once the patient is discharged, the Care Transition Coach will make 1-2 home visits, usually within 24-48 hours after discharge and 1-2 weekly telephone calls for 30 days.

- Coach will focus on key factors to preventing readmission: Medication Reconciliation---compare discharge instructions with prescriptions and drugs at home; Personal Health Record---provide and teach use of booklet where patients can keep medical information and medication lists in one place; Physician Visit Within Seven Days---schedule appointment for the patient and prepare list of questions; Red Flags---teach patient to identify early warning signs that indicate need for follow-up with MD with a focus to avoid re-admission.

- Measure rate of recidivism to the Emergency Department including recidivism for Acute Myocardial Infarction (AMI), CHF and Pneumonia.

- Measure readmission rate for those that refused the service.

- Analyze barriers to the success of self-management.
PRIORITY 2: PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

FOCUS: Maternal and Infant Health

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

Objective 1:

Increase the percentage of SJRH-born infants breastfed in the hospital by 10% to 64% (By 2% in 2014, 4% in 2015, 4% in 2016) – Baseline 2012: 54%.

Objective 2:

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

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

The SJRH Health System encourages mothers to breastfeed their infants. In 2012 we made progress, increasing the number of new mothers who did breastfeed their infants at least some of the time from 44% in 2011 to 54% in 2012. We are focused on reducing racial disparities in the breast-only feeding rate. Table 2 shows that our African-American patients in 2011 and 2012 were less likely to give their children the health benefits of exclusively breastfeeding as compared to White patients. Hispanic patients exclusively breastfeeding from 2011 to 2012 decreased by 50%. In 2011 the percentage of Black mothers at SJRH who breast-fed solely was 11% as compared to whites at 22%, 2012 14% as compared to 20% and Hispanic mothers only 10% as compared to 20% of White mothers.
Table 2: Feeding type by Race at St. John's Riverside Hospital (Source: EBC)

<table>
<thead>
<tr>
<th></th>
<th>Raw Numbers</th>
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<th>Percentages</th>
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<tbody>
<tr>
<td></td>
<td>Breast Milk Only</td>
<td>Formula Only</td>
<td>Breast Milk and Formula</td>
<td>Total</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>2011</td>
<td>Black</td>
<td>37</td>
<td>181</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>73</td>
<td>141</td>
<td>118</td>
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<tr>
<td></td>
<td>Hispanic</td>
<td>178</td>
<td>224</td>
<td>411</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>14</td>
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<tr>
<td></td>
<td>Year Total</td>
<td>302</td>
<td>575</td>
<td>698</td>
</tr>
<tr>
<td>2012</td>
<td>Black</td>
<td>43</td>
<td>114</td>
<td>144</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>57</td>
<td>100</td>
<td>123</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>77</td>
<td>233</td>
<td>449</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>9</td>
<td>25</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Year Total</td>
<td>186</td>
<td>472</td>
<td>772</td>
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**Interventions:**

- Educate staff, stakeholders, and the public at large on the benefits of breastfeeding and breastfeeding exclusively;
- Require all Maternity Department staff to complete the 10 Steps to Breastfeeding on-line course;
- Promote skin to skin and breast feeding after birth;
- Encourage rooming-in with mothers;
- Give every mother the Breastfeeding Bill of Rights on admission;
- Give breastfeeding referrals to every mother upon discharge;
- Make follow-up phone calls to every mother, discuss feeding, newborn care, and maternal self-care;
- Continue Certified Lactation Coordinator support pre and post delivery;
- Remove all magazines that contain coupons or advertisements for commercial formula;
- Continue practice of not placing bottles in cribs of breast feeding babies, handing out diaper bags with commercial formula in it, providing pacifiers for newborns;
- Utilize physician liaison staff to outreach to Pediatric and Obstetrics/Gynecology practitioners to identify what resources they need to support their patients with initiation and duration of breastfeeding;
- Participate in the State “Great Beginnings NY” Campaign;
- Collaborate with the WCDOH Health Planning Team and Health Summit partners on Breastfeeding initiative;
- Prepare written reports showing Hospital Information System data on breastfeeding rates by type and race.
PRIORITY 3: PREVENT HIV, STDs, VACCINE-PREVENTABLE DISEASES, AND HEALTH CARE-ASSOCIATED INFECTIONS

FOCUS: Human Immunodeficiency Virus (HIV)

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

St. John’s Riverside Hospital is the only NY State Designated AIDS Center in Yonkers and provides Yonkers’ only dedicated and comprehensive HIV-related primary care services. Our program currently provides 334 HIV-positive individuals with a comprehensive array of services including primary HIV-related health care, comprehensive care management/care coordination, dental care, treatment adherence services, and psychiatric and social work services.

Objective 1:

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

Interventions:

- Continue existing linkage agreements and outreach efforts to community partners to ensure that HOPE continues as the primary referral source for HIV-related primary care in Yonkers, NY, particularly the zip codes of 10701, 10703 and 10705.

- Institute more use of social media, particularly Facebook, to enhance at-risk community’s knowledge of the resource.

In keeping with the goals of the Department of Health and Human Service’s HIV/AIDS Bureau, continue HOPE Center’s existing efforts to outreach and provide early intake into HIV primary care for individuals newly diagnosed with the virus and continue to use the Ryan White Part C funded resources to re-engage any clients who are lost to follow up.
Objective 2:

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

Interventions:

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

Objective 3:

Increase percentage of clients receiving HIV primary care services through HOPE Center who obtain viral load suppression by 5% to 81% in 2016 (By 2% in 2014, 1% in 2015 and 2% in 2016) – Baseline as of October 2013: 76% (National average is 72% and the Top 10% of performers nationally average 89%).

Interventions:

- Provide targeted medication adherence support services to all clients who are beginning or changing medication regimens. Continue access to grant funding to ensure that such services are available.
- Continue to implement the “Getting to Zero” initiative within HOPE Center to build client knowledge of and support for efforts to increase medication adherence.
- Utilize the opportunities presented through the Affordable Care Act to assist uninsured and eligible HIV-positive clients to obtain insurance services through Medicaid, Medicare or the New York State Department of Health portal. Provide opportunities for and enroll all clients who qualify for medical insurances (including Medicaid) to access these resources so that there are no interruptions of coverage that impacts their access to medications.
- Continue to obtain Ryan White Parts A, B and C funding to support the hospital’s ability to provide this comprehensive continuum of HIV care, including early intervention services. Continue to seek other funding sources for services to immigrants who are not yet qualified to access insurance coverage through Medicaid or other insurance products.
- Continue to seek and obtain at least $976,000 in HIV-related grant funding per year to provide a continuum of HIV-related care services for people in Yonkers, N.Y.
- Continue to meet all grant goals and objectives (programmatic and fiscal) in order to assure good standing on all federal, state and county grants.
- Apply for new opportunities for direct care HIV-related funding as these become available.
PRIORITY 3: PREVENT HIV, STDs, VACCINE-PREVENTABLE DISEASES, AND HEALTH CARE-ASSOCIATED INFECTIONS

FOCUS: Hepatitis C Virus (HCV)

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

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

Interventions:
- Implement NYS-mandated* Hepatitis C testing in the SJRH Emergency Department by 2014.
- Analyze the feasibility of delivering quality, state of the art Hepatitis C treatment for mono-infected clients at the hospital’s HOPE Center by July 2014. (Note: HOPE Center currently has a state grant for the treatment of those living with HIV and Hepatitis C. If not feasible, to begin the treatment of those who live only with Hepatitis C, we will set up a referral network of providers of this treatment by July 2014).
- For those receiving Hepatitis C treatment at HOPE Center, continue the existing linkage with community agencies offering linkage to expanded access to insurance under the Affordable Care Act to enhance public access to Hepatitis C treatment, including the new, highly-effective medications.

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

Dr. Ype De Jong, assistant professor of medicine at the Sanford I. Weill Medical College of Cornell University and attending physician at New York-Presbyterian Hospital Cornell Campus, stated that many hepatitis C-infected people were unaware of their infection because hepatitis C often caused few symptoms for many years. He attributed most of his patients’ hepatitis C infections to unscreened blood transfusions or intravenous drug use. Many others who had no hepatitis C risk factors still could have the virus. In all, De Jong estimated that 150,000 New Yorkers had hepatitis C. In 2012, 750 New York City residents died of hepatitis C. Deputy City Health
Commissioner Dr. Jay Varma estimated that without hepatitis C testing, 10,000–20,000 more residents could die from the virus throughout the next 15 years.

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

b. Community Health Needs Assessment and Strategic Plan Commitment

St. John’s Riverside Hospital is committed to the ongoing assessment of our community health needs, maintaining engagement with its community partners and implementation of health priorities initiative through the followings methods.

SJRH sends consistent notification of health education sessions, forums, and planning meetings held through our hospital website, Facebook page, targeted mailings and printed materials posted throughout our three main campuses. A community outreach team distributes information daily to our private practice physician offices. Notification of our patient satisfaction survey is sent by a third party provider. Our community health needs assessment survey, also available in print, is emailed to the community via Survey Monkey, and links to all surveys are posted on Facebook and the website homepage. Notifications for Speakers’ Bureau events are relayed face to face during actual sessions and by select mailings to community members.

Our Healthy Yonkers Initiative (HYI) holds regularly scheduled monthly meetings. The schedule of upcoming meetings is announced during the meetings, handouts are distributed, and email reminders are sent out. Agendas are used to notify committee members of topics that will be discussed at the meeting and members are welcome to propose additional items for presentation or discussion. The HYI partnership is an open forum where committee members take the opportunity to invite their clientele and other community residents that may benefit from the discussion. Several of the HYI subcommittees have volunteers that help to support our efforts. Their participation in other circles, i.e. the Yonkers public schools, helps us to expand and increase our reach into the local community.

A variety of key stakeholders facilitates and publicizes HIV/AIDS planning meetings. The Westchester County Department of Health facilitates Ryan White Part A Steering Committee meetings. Living Together facilitates Tri-County Consumer Advisory Group meetings. The NYS Department of Health’s AIDS Institute facilitates Quality Improvement Committee meetings.
The U.S. Department of Health and Human Service, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau convenes monthly conference calls with its funded agencies. SJRH’s HOPE Center conducts our annual consumer satisfaction survey, follow-up informant interviews, and focus groups. Our HOPE Center also convenes our Performance Improvement, “Getting to Zero”, Treatment Adherence, and other ad hoc group meetings. Notifications of meetings are through flyers to all of HOPE’s clients.

SJRH’s strategy to achieve these goals is to make appropriate resource allocation decisions so that institutional resources are expended in certain identified directions. With the combined efforts of the hospital, the community, and its leadership, finances for needed healthcare services can be provided to the population.

As part of its ongoing commitment to addressing the identified health priorities, the WCDOH Health Planning Team is planning to continue meeting to review progress in implementing the improvement plans developed by each agency, to work together, when applicable, on planned activities, to discuss barriers to implementation and consider new strategies that could be adopted. The Team is also planning to regularly convene the attendees from the health summit to provide input and support on project implementation.

SJRH will maintain its' close ties to our local partners by continuing to be actively involved in the following local planning and coordinating groups:

- Westchester County Department of Health’s Health Planning Team,
- Healthy Yonkers Initiative,
- Tri-County Ryan White Part A Steering Committee,
- NYS Department of Health’s AIDS Institute Quality Improvement Committee,
- U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau,
- Tri-County Consumer Advisory Group (Living Together),
- Hudson Valley Regional Perinatal Network, and the
- Community Planning Council of Yonkers.

We are enthusiastic about and fully support a major new collaboration in Yonkers that specifically focuses on overcoming racial and ethnic health disparities. Earlier this year the Yonkers Family YMCA was one of 14 YMCAs in the nation chosen by YMCA-USA to implement a CDC-funded Racial and Ethnic Approaches to Community Health (REACH) project designed to reduce health disparities in Yonkers’ African-Americans and Hispanics communities.
Yonkers’ REACH program, called Yonkers Healthy Connections for L-Y-F-E, is being led by the Yonkers Family YMCA and the City of Yonkers. There has been a powerful surge of community support for this effort and over 60 organizations already have agreed to participate. SJRH will be actively participating in this REACH program. We will work with its key leaders in our newly formed Community Outreach Advisory Committee focused on addressing the health needs of the minority population. It includes the woman who organized and leads Yonkers REACH. She’s the YMCA CEO, a young Black minister, a countywide leader in minority health, and a powerhouse organizer. It also includes REACH’s lead African-American and Hispanic Health Coaches as well as the African-American female CEOs of two of Yonkers’ leading minority-controlled agencies, the Yonkers Community Action Program and the YWCA of Yonkers.

Our Community Outreach Advisory Committee also includes the African-American woman who serves as Coordinator of Residential Programs for the Municipal Housing Authority for the City of Yonkers (MHACY). MHACY is Yonkers’ largest housing provider for low and moderate income families. It is the second largest public housing authority in the New York metropolitan area, second only to New York City itself. MHACY has 19 developments with 2,047 conventional public housing apartments and a Section 8 Program with an additional 2,600 scattered-site apartments.

St. John’s has ongoing partnerships and collaborations at the community level to assist with the identification of local health priorities and the planning and implementation of strategies for local health improvement. These alliances will contribute to improving the health status of our service area and reducing health disparities through increased emphasis on prevention. SJRH community representatives will be instrumental in serving as leaders to effectively engage community members in community action planning activities and identify potential diverse individuals and stakeholders, that will work together to address health related disparities in the region.

SJRH will establish a hospital committee which will meet quarterly and assume responsibility for the implementation and execution of this plan, including, but not limited to: monitoring and evaluating data, activities, and outcomes; identifying/recruiting critical stakeholders to participate on the committee; and reviewing existing and new evidenced-based interventions that could be adopted.