ST. JOHN'S EPISCOPAL HOSPITAL

EPISCOPAL HEALTH SERVICES INC.

# Community Health Needs Assessment and Community Service Plan (2016 Update)

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# Community Health Improvement Plan and Implementation Strategy
# The Rockaway Community, Queens, New York
# 2014-2017

St. John's Episcopal Hospital (hereafter referred to as "St. John's" or "The Hospital" is a 257 licensed bed acute care hospital located in Far Rockaway, New York, which is sponsored by the Episcopal Diocese of Long Island.

What follows is the result of a comprehensive Community Health Needs Assessment (CHNA) for the local hospital community.

This report fulfills the requirements of the new Federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring non-profit hospitals to conduct CHNAs every three years. The CHNA process undertaken by the Hospital utilized extensive input from entities that represent the broad interests of the community. In addition, this document satisfies the requirements set forth by the New York State Department of Health (DOH) relative to the preparation of a three year Community Service Plan. The overlapping nature of these requirements enabled the Hospital to complete one comprehensive document.

The Community Health Needs Assessment was developed based on several sources of local, state and national data, with input from community members and public health experts. Data pointed to underlying behaviors and risk factors that lead to chronic disease and mental health as needed areas of improvement.

When developing our improvement plan, our team utilized New York State Prevention Agenda for 2013 not only for organizing priorities and measures, but for examples of evidence based implementation strategies. We selected priorities based on our identified needs from the CHNA.

## Summary

During 2012–2013, a Community Health Needs Assessment was compiled by St. John's. During the assessment process and for the purposes of this report, the assessment team worked in collaboration with various community organizations, health care providers and the general public to develop this assessment. Team members met on a regular basis to review and discuss statistical data from a variety of sources. Information discussed at meetings was shared with hospital leadership, community organizations and with the general public.

**Mission Statement for St. John's Episcopal Hospital**

**MISSION**: St. John's Episcopal Hospital in partnership with our community provides exceptional healthcare and education programs in an academic setting across the continuum of care. We deliver high quality, value based services with cultural sensitivity to the faiths and traditions of those we serve.

**VISION**: St. John's Episcopal Hospital will build an effective coalition aimed at achieving improved community health status in a financially stable environment, with emphasis on serving the needs of our patients and families, while training the physicians and healthcare providers of tomorrow

**VALUES**: **ICARE**: **I**-Innovation **C**-Compassion **A**- Accountability **R**- Respect **E**- Empathy

## Service Area and Community Health Needs Assessment

**Hospital Service Area: A Rapidly Growing Population**

St. John's Episcopal Hospital is a 257-bed community teaching hospital. It is the only hospital on the Rockaway Peninsula since the recent closure of the nearest hospital, Peninsula Hospital Center (closed 2012), and Long Beach Hospital, which was shuttered due to Superstorm Sandy.

As per the 2010 Census the population of the Rockaway peninsula was 123,332. The population is projected to increase to over 130,000 people by the year 2020.

**St. John's Episcopal Hospital**
**Utilization Statistics**
**2015**

| | |
|---|---|
| Discharges | 8,896 |
| Inpatient Days | 60,674 |
| Emergency Service Visits | 43,203 |
| Ambulatory Surgery Visits | 2,799 |
| Other Ambulatory Visits* | 71,244 |
| Employed FTEs | 1,333 |

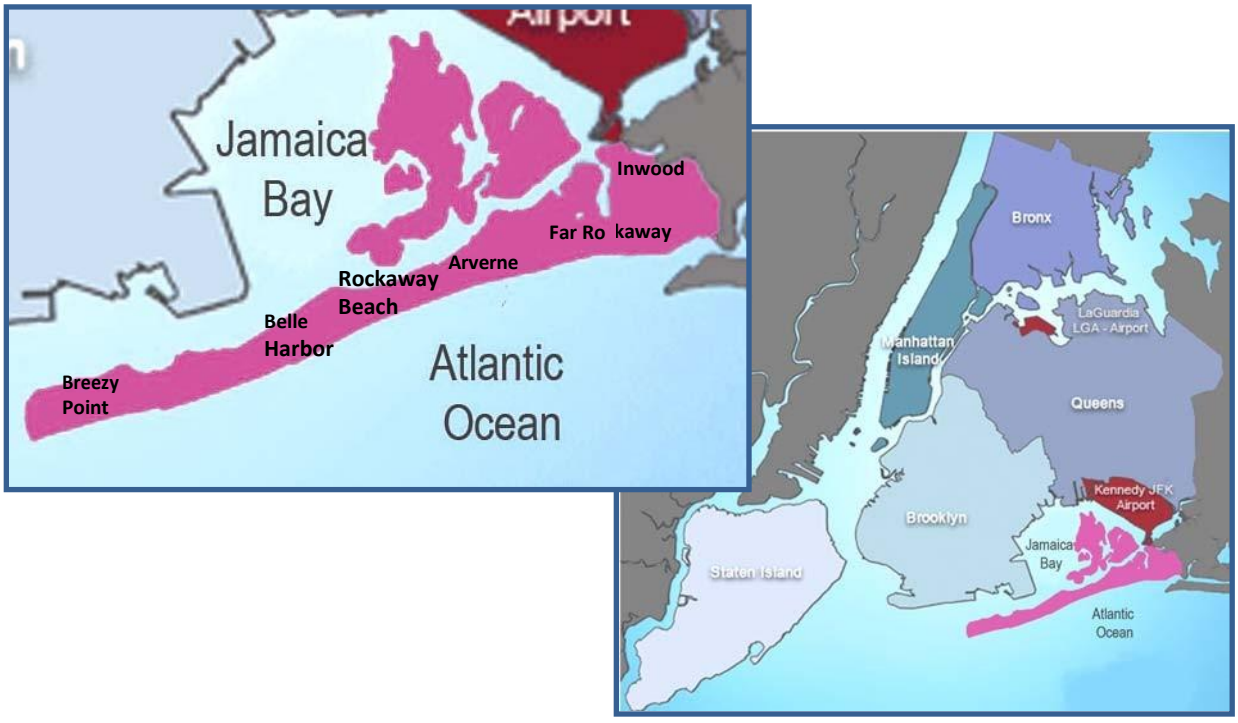
*Excludes Referred Ambulatory in 2015 stats

## Description of the Community

**Definition of the Community Served**

The Rockaway Peninsula is a narrow strip of land bordered by the Atlantic Ocean and Jamaica Bay and is a part of Queens County, New York City and also borders Nassau County on Long Island. Superstorm Sandy had a devastating impact on the Rockaway Peninsula. Much of the community was without gas and electric for weeks following the storm. Homes and businesses were in ruin, some claimed by the sea, others by fire, entire blocks in Belle Harbor and Rockaway Park were engulfed in flames, a considerable portion of Breezy Point literally burned to the ground. Debris and sand were everywhere, including the inside of homes. Cars that had been flooded were scattered throughout the streets of the community. The rebuilding has been extremely slow, and is an ongoing process, with many displaced residents having still not returned to their homes. Many nursing homes and adult homes - sources of admissions to the Hospital, as well as other local businesses never reopened. Transportation between the peninsula and the mainland is a long time commitment for residents as the peninsula is connected to New York City by two toll bridges, the Marine Park Bridge and the Cross Bay Bridge, and by the "A" subway line of the New York City Metropolitan Transit Authority, which was out of commission until late summer 2013.

### Figure 1: Rockaway Peninsula in Relation to New York



**Demographics of the Community Served**

**Table 1: Total Service Area: Population 2010 To 2017**

| Area | 2010 | 2017 (Projected) | 2010 -2017 Projected Change | 2010– 2017 Projected % Change |
|---|---|---|---|---|
| **Rockaways** | 123,332 | 128,629 | 5,297 | 4.2% |
| **Queens** | 2,230,722 | 2,261,557 | 30,835 | 1.4% |
| **NYC** | 8,175,133 | 8,372,276 | 197,143 | 2.4% |

Source: © 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc.

St. John's has served the community for more than 100 years. As a not-for-profit faith-based institution that is deeply aware of the community's geographic isolation and vulnerabilities, it is deeply committed to continuing to serve the community well into the future. It is also committed to improving the health of the community and continuing to offer a wide range of services, as well as community outreach and health education.

While "community" can be defined in many ways, the Hospital defined its Service Area as the 5 zip codes from which approximately 70% discharges came. By this determination, the Hospital's Service Area is defined in the following table.

**Table 2: Market Share Discharges by Zip Code for 2015**

| Zip Code | Area | Total Patients | SJEH Patients | Percentage of Population |
|---|---|---|---|---|
| **11096** | Inwood | 1,085 | 218 | 20.1% |
| **11691** | Far Rockaway | 10,738 | 5,033 | 46.9% |
| **11692** | Arverne | 3,108 | 1,179 | 37.9% |
| **11693** | Rockaway Beach | 1,722 | 608 | 35.3% |
| **11694** | Belle Harbor | 3,442 | 872 | 25.4% |
| **Grand Total** | | **20,095** | **7,910** | **39.4%** |

Source: Source: © 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc

**Service Area by Age – Predominantly Younger – and Older**

In Hospital's Service Area (the "Service Area") almost 30% of the population is under the age of 20, a significantly higher percentage than in Queens County and all of New York City.

On the other end of the age spectrum, primarily due to the prevalence of nursing homes and adult homes, the percentage of the senior population is also higher than in Queens and all of New York City. The senior population in the Rockaways is expected to grow to be nearly 20% of the total population over the next 25 years.

**Table 3: Population by Age**

| ZIP | Total Pop. | 0 – 14 Years | 15 – 19 Years | 20-24 Years | 25-44 Years | 45- 64 Years | 65+ Years |
|---|---|---|---|---|---|---|---|
| 11096 | 8,344 | 21.40% | 8.50% | 7.80% | 27.20% | 23.50% | 11.60% |
| 11691 | 60,035 | 24.50% | 8.10% | 7.40% | 25.70% | 21.90% | 12.30% |
| 11692 | 18,540 | 23.80% | 8.20% | 7.70% | 27.50% | 22.90% | 9.90% |
| 11693 | 11,916 | 18.70% | 7.50% | 6.30% | 27.00% | 28.90% | 11.60% |
| 11694 | 20,408 | 16.20% | 6.10% | 5.00% | 23.00% | 31.60% | 18.00% |
| 11697 | 4,079 | 15.70% | 5.40% | 4.20% | 18.10% | 32.40% | 24.20% |
| Total Service Area | 123,332 | 22.00% | 7.70% | 6.80% | 25.50% | 24.80% | 13.20% |
| Queens | 2,230,722 | 16.90% | 6.20% | 7.20% | 30.90% | 25.70% | 12.90% |
| NYC | 8,175,133 | 17.80% | 6.60% | 7.90% | 31.10% | 24.40% | 12.10% |

Source: © 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc

**Service Area by Median Income and Education – High Percentage below the Federal Poverty Level**

The Service Area has a higher percentage of individuals below the Federal Poverty Level (FPL) than the rest of Queens and New York City. It also has a lower Median Household Income and a slightly higher percentage of high school graduates than the other parts of Queens and New York City.

**Table 4: Service Area by Median Income and Education**

| ZIP | Total Pop. | Under age 18 | Above age 65 | Individuals Below FPL | Median Household Income | Public Assistance or Food Stamps | HS Grad (Age 25+) |
|---|---|---|---|---|---|---|---|
| 11096 | 8,344 | 26.50% | 11.60% | 13.50% | $54,803 | 11.50% | 35.10% |
| 11691 | 60,035 | 29.50% | 12.30% | 26.00% | $38,415 | 33.30% | 29.70% |
| 11692 | 18,540 | 28.60% | 10.00% | 28.00% | $36,875 | 29.70% | 35.10% |
| 11693 | 11,916 | 23.50% | 11.60% | 16.00% | $50,443 | 18.50% | 35.10% |
| 11694 | 20,408 | 20.10% | 18.00% | 6.10% | $73,196 | 6.70% | 23.90% |
| 11697 | 4,079 | 19.60% | 24.10% | 1.90% | $86,941 | 3.20% | 26.40% |
| Total Service Area | 123,332 | 26.70% | 13.20% | 20.40% | $47,811 | 23.40% | 30.10% |
| Queens | 2,230,722 | 20.60% | 12.90% | 13.70% | $56,406 | 12.60% | 28.00% |
| NYC | 8,175,133 | 21.60% | 12.10% | 19.40% | $51,270 | 18.10% | 25.00% |

Source: © 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc

**Race, Ethnicity and Foreign Born**

The percentage of the Service Area population who are deemed to be minorities is 65.4%, with African Americans comprising 38% of the population. A large population of Hispanics resides in the zip code 11096, which is Inwood and is the most northeast boundary of the Service Area.

These numbers are significant since minority populations tend to display an unequal proportion of illness due to, among other things, access to health related information and primary health care. It also highlights the need to address disparities of disease in the Hospital's Service Area.

**Table 5: Race, Ethnicity and Foreign Born**

| ZIP | Total Pop. | White | African American | Asian | Hispanic (any race) | Other | Foreign-born |
|---|---|---|---|---|---|---|---|
| 11096 | 8,344 | 25.70% | 25.60% | 2.50% | 44.10% | 2.10% | 34.00% |
| 11691 | 60,035 | 22.40% | 47.10% | 1.90% | 25.20% | 3.40% | 34.30% |
| 11692 | 18,540 | 10.30% | 61.90% | 2.80% | 22.00% | 3.00% | 25.40% |
| 11693 | 11,916 | 47.40% | 27.60% | 3.00% | 19.10% | 2.90% | 18.50% |
| 11694 | 20,408 | 76.00% | 7.90% | 2.50% | 12.30% | 1.30% | 15.20% |
| 11697 | 4,079 | 96.60% | 0.10% | 0.60% | 2.20% | 0.50% | 0.90% |
| Total Service Area | 123,332 | 34.60% | 38.00% | 2.20% | 22.50% | 2.70% | 27.00% |
| Queens | 2,230,722 | 27.70% | 17.70% | 22.80% | 27.50% | 4.30% | 47.80% |
| NYC | 8,175,133 | 33.30% | 22.80% | 12.60% | 28.60% | 2.70% | 36.80% |

Source: http://www.census.gov/2010census/popmap/ipmtext.php

## Data

Data used for this Community Health Needs Assessment was sourced from internal data as well as state and local resources including:

- Hospitalization Data: Statewide Panning and Research Cooperative Systems (SPARCS) files, based on hospital discharges
- 2013 County Health Rankings (www.countyhealthranking.org)
- New York City Department of Health and Mental Hygiene (www.nyc.gov/health)
    - Your Neighborhood (www.nyc.gov/htnl/data/your-neighborhood.shtml)
    - NYC Community Health Survey (www.nyc.gov/html/doh/html/data/survey.shtml)
    - Interactive Data Tools (www.nyc.gov/html/doh/html/data/interactive-tools.shtml)
- New York State Department of Health (www.health.ny.gov)
    - Prevention Quality Indicators (https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.maps)
    - Community Health Data Sets (www.health.ny.gov.gov/statistics/chac/indicators)
    - Community Health Assessment Clearinghouse (www.nyhealth.gov/statistics/chac)

## Health of the Service Area

After reviewing the County Health Rankings for the State of New York, Queens County ranks 19 out of the 62 counties for health outcomes. A telephonic assessment conducted by New York City Community Health Survey shows that 1 in 4 residents of the Rockaways considers themselves to be in poor or fair health. It also shows that 21% of Queens County residents do not have health insurance coverage, which is higher than the statewide rate of 14%. Lack of health insurance is a significant barrier to accessing health care. The ratio of population to primary care physician is significantly higher in Queens (1,512:1) than statewide (1,222:1).

**Preventative Quality Indicators (PQI) of Service Area compared to Queens and New York City**

**Table 6: PQI of Service Area vs. Queens and NYC**

| | NY State Rate (per 100,000) | As a % of Statewide Rate Service Area | As a % of Statewide Rate Queens County | As a % of Statewide Rate New York City |
|---|---|---|---|---|
| **All Acute** | 526 | 139% | 90% | 101% |
| **All Circulatory** | 456 | 131% | 95% | 119% |
| **All Diabetes** | 224 | 218% | 107% | 144% |
| **All Respiratory** | 357 | 187% | 82% | 122% |
| **All Conditions** | 1,563 | 158% | 92% | 192% |

Source: Prevention Quality Indicators (https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.maps)

**Table 7: PQI Admissions as % of Expected by Race/Ethnicity for Service Area**

| | NY State Rate (per 100,000) | White | Hispanic | African-American | Asian | Other |
|---|---|---|---|---|---|---|
| **All Acute** | **526** | **113%** | **134%** | **196%** | **n/a** | **n/a** |
| **All Circulatory** | **456** | **67%** | **118%** | **301%** | **n/a** | **n/a** |
| **All Diabetes** | **224** | **106%** | **245%** | **376%** | **n/a** | **n/a** |
| **All Respiratory** | **357** | **150%** | **169%** | **270%** | **n/a** | **n/a** |
| **All Conditions** | **1,563** | **106%** | **156%** | **271%** | **53%** | **171%** |

Source: Prevention Quality Indicators (https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.maps)

## Comparison of PQI Statistics between NYS, NYC, Queens County and Service Area

1) **Cardiovascular Disease**
   a) The death rate from heart disease in the Rockaways is 449/100,000 population. This is 78% higher than the Queens rate (253/100,000 population) and 59% higher than the New York City rate (283/100,000 population).
   b) 35.5% of residents have been told by a health care provider that they have high blood pressure (versus 30% in Queens and 29% in NYC).

2) **Obesity and Diabetes**
   a) More than 65% of the residents of the Rockaways reported that they were overweight or obese in the New York State Department of Health/Mental Health 2011 Community Survey (versus 55% Queens and 58% NYC).
   b) In 2007, 286 residents of the Rockaways died from diabetes mellitus (28/100,000 population) which is more than 2 times higher than the Queens rate of 12.7/100,000 population and 1/35 times higher than the NYC rate and nearly 2 times higher than the NYS rate.

3) **Cancer**
   a) The cancer death rate of the Rockaways (150/100,000) is 16% higher than the Queens rate (129/100,000) and 14% higher than the NYC rate (175/100,000).
   b) The age adjusted rate for females, 50 years and older with breast cancer, is higher for the Rockaways (316.3/100,000) than in Queens (278.3/100,000) and NYC (289.2/100,000)
   c) Prevalence of other types of cancer is higher in the Service Area as well.

4) **Respiratory Disease**
   a) The asthma-related hospital admission rate in the Rockaways is higher than Queens for all age groups and significantly higher than NYC for the pediatric population (age 0-14 years).
   b) The asthma Emergency Department (ED) visit rate per 10,000 of the population is high for specific ZIP Codes within the Service Area, with a rate of 167.1 for Far Rockaway (11691), 288.7 for Arverne (11692) and 148.9 for Rockaway Beach (11693), all significantly higher than the Queens rate of 81.5 and the NYC rate of 131.5.
   c) The Chronic Obstructive Pulmonary Disease (COPD) specific PQI rate for the Service Area is more than 2 times higher than the Queens, NYC and NYS rates.

5) **Maternal Child Health**
   a) There are 3 important measures relative to maternal and infant health: 1) early prenatal care (care initiated in the 1$^{st}$ trimester); 2) low birth weight, which

increases the risk for many health problems; and 3) infant mortality (death of babies under 1 year of age).

b) The Service Area has worse outcomes than Queens and NYC for these 3 indicators.
c) Other indicators of maternal and infant health are preterm birth and neonatal death (death within 28 days of birth). Again the Service Area has worse outcomes than Queens and NYC.
d) The birth rate of females between the ages of 15 and 19 for the Service Area is 23/1,000, which is significantly higher than the Queens rate of 15/1,000 and slightly higher than the NYC rate of 21/1,000.
e) Pregnant teens are more likely to have babies with low birth weight than older women and have a higher percentage of having reduced or no prenatal care.

**6) Mental Health**

a) A hospital admission for mental health problems is the 6th leading cause of hospitalizations in NYC.
b) 22.3% of adults in the Rockaways (approximately 19,000 people) report that they have either received counseling and/or took prescription medication for a mental health problem. This is higher than adults in Queens (12.5%) and NYC (15.2%) overall.
c) Queens has a lower use rate for all types of mental health services than NYC and NYS.

**7) Chemical Dependence and Substance Abuse**

a) 7.4% of adults in the Rockaways indicate that they are heavy drinkers, defined as consuming an average of more than 2 drinks a day for men and 1 drink a day for women, compared to 3.1% of Queens adults and 5.3% of NYC adults.
b) New York City Department of Health and Mental Hygiene ("NYCDOH/MH) estimates that approximately 11.5% of the adults in NYC have substance abuse (alcohol and/or drug) disorders. Using that estimate, one can estimate that approximately 10,390 adults in the Service Area suffer from a substance abuse disorder.

**8) HIV/AIDS and Communicable Diseases**

a) In the 2011 NYC Community Health Survey, NYC DOH/MH estimated that 31.4% of the residents of the Rockaways have had an HIV test (in the past 12 months, or ever, compared to 22.2% for Queens and 32.2% for NYC.
b) The residents of the Rockaways and Queens exhibit higher rates of HIV/AIDS compared to NYC.
c) Residents of the Rockaways have higher rates of STD such as Chlamydia, Gonorrhea and late latent syphilis than Queens County overall and was comparable to the NYC rates.
d) NYC NYCDOH/MH has designated Arverne as being in the top quintile of all NYC areas for Hepatitis C, HIV and Gonorrhea.

## PUBLIC PARTICIPATION

To advance the goals of the New York State Prevention Agenda 2013-2017 and Healthy People 2020 in its Service Area, St. John's Episcopal Hospital reached out and partnered with numerous community-based organizations and other stakeholders to identify community health needs and develop plans to address these needs. The participating organizations included:

### Participating Organizations

- St. John's Episcopal Hospital Community Advisory Board
- Joseph P. Addabbo Family Health Center
- NAACP of Rockaway
- Rockaway Beach Channel Long Term Recovery
- Rockaway United
- Community Board 14
- Deerfield Area Civic Association
- Rockaway Development and Revitalization Corp.
- Visiting Nurse Service of New York
- Rockaway Manor Home Care
- Queens County Perinatal Council
- Doctors of the World
- SCO Family of Services
- Met Council
- Queens Public Library
- Lucille Rose Day Care
- Safe Space
- Rockaway Beach Civic Association
- New York State Assemblyman Phillip Goldfeder

**Community Meetings: Sampling Public Opinion**

Two initial community meetings were held, to gather input from the public on the health concerns of the community, the application of the New York State Department of Health Prevention Agenda 2013-2017 to their community and their views of health data gathered by the Hospital. At those meetings, participants were then asked to give their opinion on the two highest priorities in the Rockaways. In this manner, a sampling of the community opinion was conducted.

The meetings were held on:

- July 9, 2013 at 6 pm at the Peninsula Preparatory Charter School – 34 attendees
- July 16, 2013 at 6 pm at the Knights of Columbus Rockaway Council #2672 – 55 attendees

The meetings were publicized through a variety of ways, including four full-page color advertisements in the local newspapers, the "Wave", the "Rockaway Pointer", and the "Five Towns Jewish Press"; a community email blast; social media; and St. John's website.

**Coalition Meetings: Ongoing Community Health Task Force**

Following the public Community Meetings, two subsequent meetings were held. Representatives of Community-Based Organizations who had attended the public meetings were contacted by email and telephone. At this meeting the health priorities public opinion sampling, combined action on these priorities, and the need for continued meetings on a quarterly basis were discussed.

These meetings were held at St. John's on:

- Monday, August 12, 2013 at 6 pm
- Thursday, August 22, 2013 at 6 pm

Discussion at these meetings also included: the need for additional mental health services with more of a personal touch; the Hospital's crowded Emergency Room; coordination of services; education and the need for more teen services; dialysis services on the Rockaways; need for diabetes services; need for participation of elected officials; need for trauma services on the Rockaways; more primary care; need for urgent care on the west end of the peninsula; concern with closure of mental health services; requests for copies of the data presented.

## Selection of Public Health Priorities

The Hospital convened the aforementioned open meetings to present the draft Community Health Needs Assessment and, based on the data, gather public input on the selection of health priorities for the community. The sampling showed that the community was most concerned about Chronic Disease, especially diabetes, high blood pressure, Mental Health and Substance Abuse.

Two subsequent Rockaway Health Task Force meetings, composed of representatives of community-based organizations that had attended the public meetings, were held. At

those meetings, the results of the community sampling were presented and adopted as the top health priorities for the three-year plan. The Task Force plans to meet on a quarterly basis to review data, learn about the progress of the identified activities, and continue to exchange of information on the status of healthcare in the Rockaways.

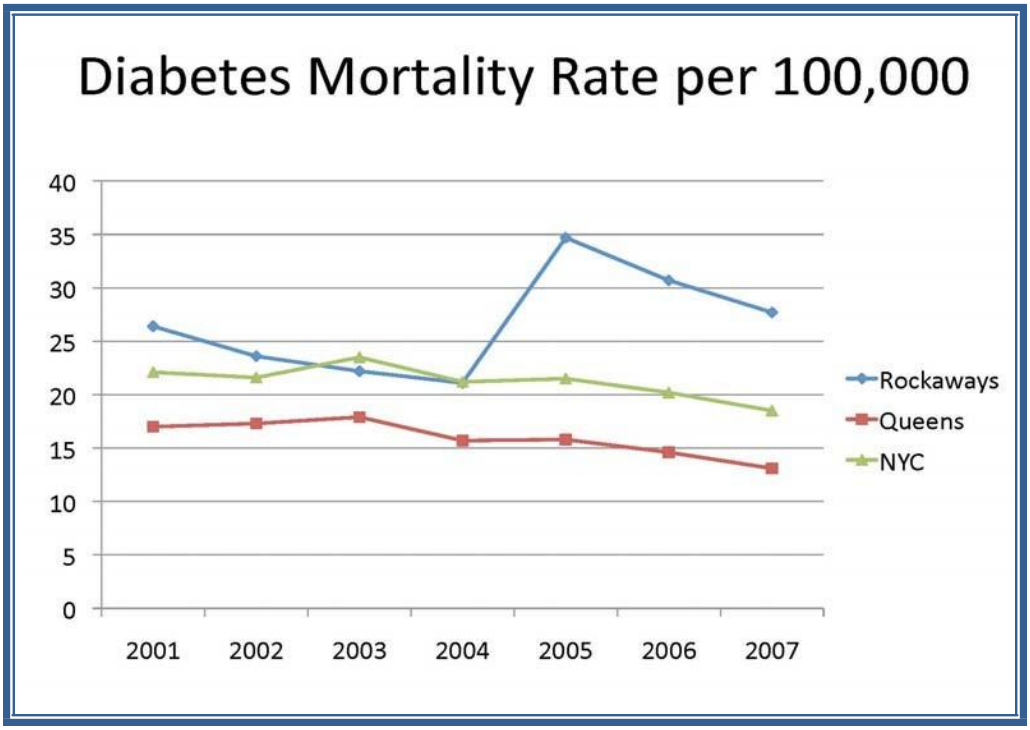
**Promote Mental Health and Prevent Substance Abuse** is a new priority for St. John's Episcopal Hospital.

- 7.4% of adults in the Rockaways indicate that they are heavy drinkers, defined as an average of more than 2 drinks a day for men and 1 drink a day for women, compared to 3.1% of Queens adults and 5.3% of New York City adults.
- NYC DOH/MH estimates that approximately 11.5% of the adults in New York City have substance abuse (alcohol and/or drug) disorders). Using that estimate one can estimate that approximately 10,390 adults in the Service Area suffer from a substance abuse disorder.

The program will adopt the PHQ-9 depression screening tool, and brief intervention and referral to treatment (SBIRT) for alcohol and drug use tool within all primary care settings. It will address New York State Goal 2.1 "Prevent Excessive Alcohol Consumption by Adults." The SBIRT model is designed for use in health clinics or emergency departments (EDs). Adults visiting a participating health clinic or ED for medical care are screened for substance use by social workers who have been trained to deliver the intervention. Patients with a positive screening result are engaged by interventionists with the Brief Negotiated Interview (BNI), a semiscripted, motivational interviewing counseling session. It is in conjunction with the Take Care NYC community health intervention.

Current screenings indicate that one-third of patients assessed fall into the moderate category, indicating need for further assessment.

**Prevent Chronic Disease -** this has been a priority at St. John's for a number of years. However the focus on diabetes and obesity prevention (a former focus of St. John's) represents a new evidence-based program that will address a prevalent disease with a very high mortality rate in the community, especially when compared to the rest of Queens and New York City. It was also inspired by the National Diabetes Prevention Program for overweight and obese adults with pre-diabetes and the participation of the New York City Department of Health.




The need to create a program for early intervention and risk reduction is important:

- The prevalence of Type 1 Diabetes in Americans under age 20 rose by 23 percent between 2001 and 2009. *(*SEARCH for Diabetes in Youth data by the Centers for Disease Control and Prevention and the National Institutes of Health.)

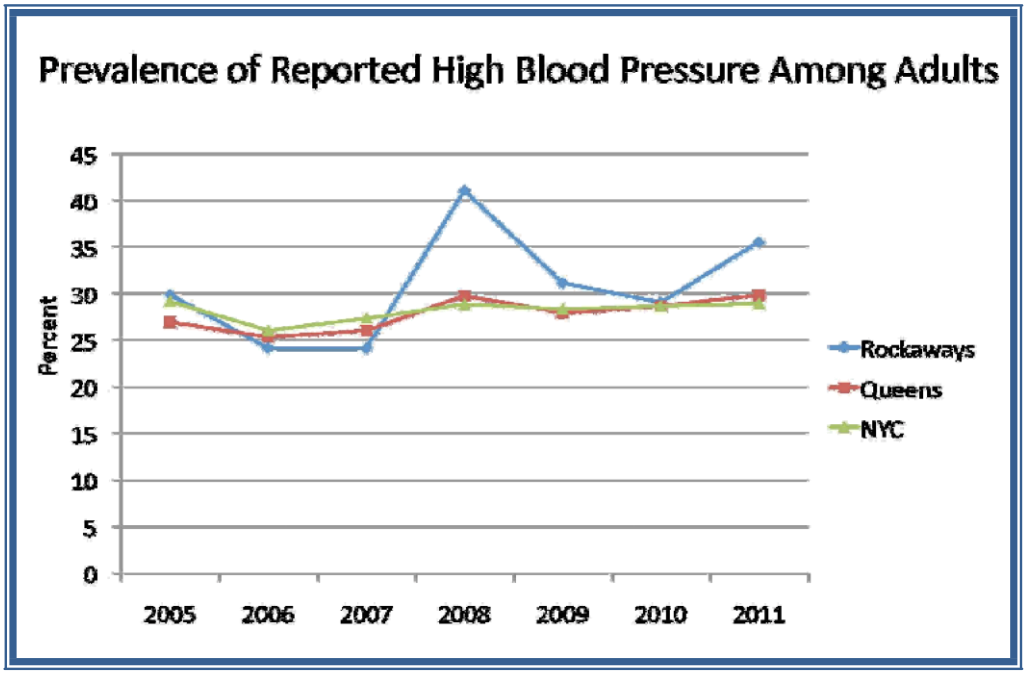
- The rate of Type 1 Diabetes incidence among children under age 14 is estimated to increase by three percent annually worldwide.

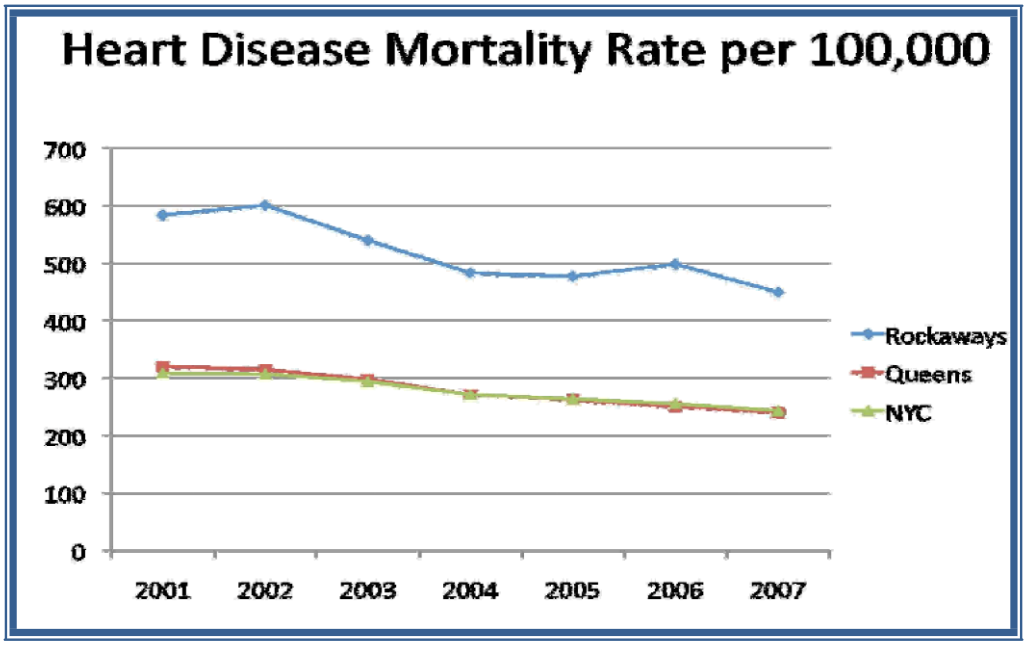
This priority also addresses two disparities both are which are present in the Service Area: that Hispanics and Blacks are more likely to be obese; and that obesity varies in schools located in low income neighborhoods (NYC Vital Signs, October 2012).

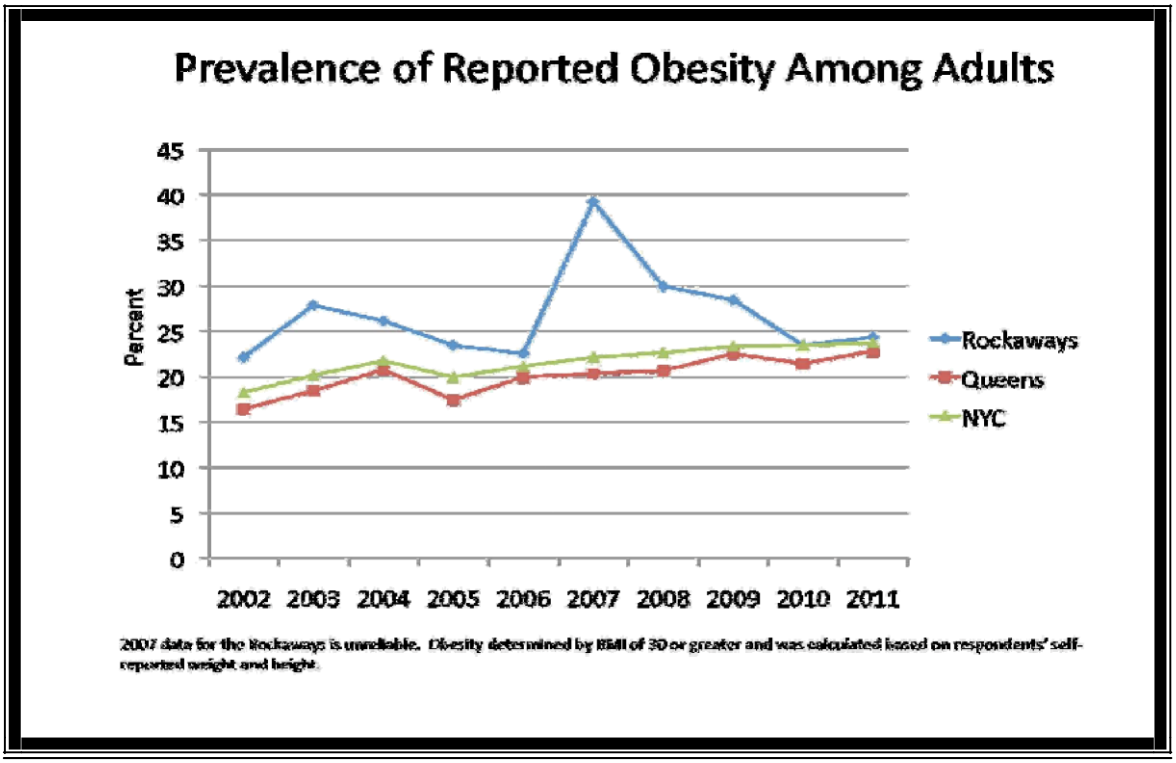
It was decided to embark on a totally new risk reduction intervention program that would address an adolescent population who were old enough to understand and take steps to adopt a healthy lifestyle that would involve the schools and the community.

It also draws upon the expertise of the Hospital and staff, the local high schools and other resources of the Rockaways.

**Prevent Chronic Disease Goal #3.1: Increase screening rates for cardiovascular disease especially among disparate populations.** This priority, returned from prior years, continues to be an important one at St. John's Episcopal Hospital.






The program will shift the past screenings for high blood pressure that were conducted on a more random basis to the Take Care NYC "Keep on Track: A Community-Based Blood Pressure Monitoring Program" and will be a part of a citywide initiative.

This program will provide consistent blood pressure screening, an ability to capture data which will be accessible by community participants, utilize the Hospital's residency program, as well as train community volunteers to continue the program into the future.

Keep on Track has been used by more than 100 community-based organizations, with 60 currently participating across New York City.

**Prevent Chronic Disease Goal #1.1 Create Community Environments that promote healthy food and beverage choices.**

St. John's Episcopal Hospital has submitted application for a continuing grant as part of Southwest Airlines'-sponsored Heart of the Community Grant. Our proposed program features the hospital as the community "health hub," and start/finish for community organizations to form peer to peer mentorships in monitoring each other's daily steps toward increased physical activity, with a goal of 10,000 steps per day.

Obesity and diabetes-related complications disproportionately affect St. John's Episcopal's diverse patient population, and overwhelm its emergency department. The U.S. Center for Disease Control (CDC) quantifies the most successful programs in combating prediabetes / diabetes are those that increase daily physical activity and reduce body mass. Lowering body mass index (BMI) by as little as 7% can reduce the incidence of diabetes onset by 50%.

## Details of Implementation Strategy

A. As part of St. John's Episcopal's grant proposal, the hospital would issue free pedometers to all participants registered in the walking program, which begins at SJEH and continues two blocks east to the Boardwalk along the Atlantic Beach and the Rockaway Peninsula's 7 miles of oceanfront public spaces. Walkers will submit their starting weight and BMI measurement, and chart monthly progress.

**B. Community-based Diabetes Program:**

**Engaging high school students at risk for developing type 2 diabetes and enrolling them in an evidence based, risk-reduction, lifestyle modification program via coordination of local hospital services, school staff, and community/business partnerships.**

**Background:**

In the past 30 years, the incidence of adolescent obesity has tripled in the United States. Between 1980 and 2010, the percentage of adolescents (aged 12-19) who were classified as obese increased from 5% to 18% (www.cdc.gov/HealthyYouth/obesity/facts.htm). Obese adolescents are at risk for both immediate and long term health problems. They are more likely to have pre- diabetes, a condition in which blood glucose levels do not meet the criteria for diabetes, yet are elevated above normal and indicate a high risk for development of type 2 diabetes (T2DM). Pre-diabetes is also a risk factor for development of cardiovascular disease. Having a family history of T2DM in a first or second degree relative, specific racial/ethnic attributes (e.g. Native American, African American, Hispanic/Latino, Asian American, and Pacific Islander), having signs or conditions associated with insulin resistance, or having a mother with gestational diabetes during the child's gestation augments this risk (ADA Clinical Practice Recommendations, 2010). Progression from pre-diabetes to T2DM may be prevented, or its onset delayed, with systematic lifestyle modification, including caloric intake reduction and regular daily exercise, with an aim to lose greater than 7% body weight. Lifestyle management alone has been demonstrated to reduce the incidence of diabetes by as much as 58% in low risk patients (Endocrine Practice 2011; 17(Supplement 2) 14-15).

St. John's Episcopal Hospital recently performed an assessment of the demographics and health care priorities of the Rockaway community. Based upon the NYSDOH/MH 2011 Community Survey, over 65% of the residents reported that they were either overweight or obese. Diabetes was identified as a leading chronic health condition in this community, largely due to the burden of illness among its ethnic minorities. 65.4% of the Service Area population self-identified as either African American (38%) or Hispanic (22.5%). With 20.4% of the Service Area falling below the federal poverty level and a significant number of residents lacking access to health care services to identify and manage their diabetes, the Service Area mortality rate from this condition is more than double the rate in Queens and 1.34 times higher than the overall NYC rate.

The community demographic assessment further identified that the pediatric percentage exceeds that of Queens and NYC. Given the health assessment of the adult population, their children have both an environmental and genetic propensity for obesity and the development of diabetes. Therefore, aggressive efforts to manage childhood obesity and to identify children with early defects in insulin secretion and/or action (i.e. pre-diabetes) have been proposed to try to reduce the adult health care burden (Students with Diabetes: A Resource Guide for Wisconsin Schools and Families 2010).

The national epidemic of obesity has been linked directly to poor dietary choices and physical inactivity (www.bridgingthegapresearch.org) Schools provide an opportune setting for identifying at-risk adolescents and for educating them about lifelong healthy behaviors to combat the health risks of obesity. A partnership between the health care providers of the Hospital (endocrinologists, primary care physicians, certified diabetes educators, nutritionists) the administrators, nurses, and parent organizations of the local high school(s), pharmaceutical companies, community organizations (e.g. Police Athletic League (P.A.L.)), and local businesses (e.g. fitness clubs, eating establishments, grocery stores) is suggested to combat the health care risks of obesity among our high school aged pediatric population.

**Three Year Action Plan:**

1) Promoting Healthy Lifestyle Behaviors in Obese High School Students:
    1. Participation in recommended amount of physical activity
    2. Healthy food choices and portions
    3. Improved health literacy and promotion of self-efficacy among high school students

**C. Prevent Chronic Disease Goal #3.1: Increase screening rates for cardiovascular disease especially among disparate populations. This priority, maintained from prior years, continues to be an important one at St. John's Episcopal Hospital.**

Keep On Track: A Community-Based Blood Pressure Monitoring Program

Prevent Chronic Disease Goal #3.1: Increase screening rates for cardiovascular disease especially among disparate populations. This priority, maintained from prior years, continues to be an important one at St. John's Episcopal Hospital.

The program will shift the past screenings for high blood pressure that were conducted on a more random basis to the Take Care NYC "Keep on Track: A Community-Based Blood Pressure Monitoring Program" and will be a part of the citywide initiative.

This program will provide consistent blood pressure screening, an ability to capture

data which will be accessible by community participants, utilize the Hospital's residency program, as well as train community volunteers to continue the program into the future.

Keep on Track has been used by more than 100 community-based organizations, with 60 currently participating across New York City.

The community partners that will be contacted will be primarily churches and synagogues with a steady consistent congregation who will serve as a patient and volunteer base. Also the Joseph P. Addabbo Family Health Center will serve as one of the health centers for referrals and follow up, as will the Belle Harbor Family Practice and Lawrence Medical Practice of St. John's.

Among the churches and synagogues that will be contacted initially are:

i. St. Francis de Sales
ii. Congregation Kneseth Israel
iii. Macedonia Baptist Church
iv. St. Mary's Star of the Sea

During Year 1, the program at the individual sites will be staffed by residents of the Family Practice and Internal Medicine programs, who will establish a steady consistent blood pressure monitoring and enrollment of screeners. Year 2 will see the identification and training of volunteers from among the congregants. They will take over the screenings with oversight by the doctors. Year 3 will expand the program to additional sites.

The NYC Department of Health Keep On Track program will help to provide: web-based software; provide literature; train volunteers; and provide blood pressure monitors.

Through the NYCDOH computer program the blood pressures will be tracked annually. Goals will be:

- Lowering blood pressure rates of overall participants
- Increase numbers of participants as well as participating churches / synagogues
- Increase numbers of referrals
- Increase numbers of patients going to doctors consistently
- Increase number of participating users of the Community Health Dashboard.
- The doctor in charge of the specific site will receive feedback about the Keep On Track program and may make modifications to the program.

D. Additionally, St. John's Episcopal Hospital is a safety net provider within the Nassau Queens PPS (NQP) under DSRIP and a partner of the Catholic Health Services of Long Island hub, and is committed to NQP-selected ambulatory projects 3.b.i and 3.c.i, i.e. Evidence based strategies for disease management in high risk/affected populations DSRIP, the Delivery System Reform Incentive program, is a five year NYS initiative, intended to reinvest federal savings generated by the Medicaid Reform Team into innovative changes in the delivery of care to Medicaid recipients.

The objective of projects 3.b.i and 3.c.i is to improve the management of cardiovascular disease and diabetes using evidence based strategies and patient educational material in the ambulatory and community care settings. Hospital owned and community based primary care practices will be transformed into Level 3 Patient Centered Medical Homes with standardized treatment protocols for managing hypertension and diabetes, and a data-driven methodology to improve patient outcomes based on measurement efforts. The projects align with the Million Hearts Campaign, a national initiative to prevent one million heart attacks and strokes by 2017 through cardiovascular disease prevention by focusing on blood pressure control, cholesterol management, smoking cessation, and aspirin use for people at risk. It advocates the use of home blood pressure monitoring and support and facilitating access to blood pressure checks without copayment or advance appointments. The diabetes project focuses on the identification of eligible patients within primary care practices with diabetes and risk stratification based on comorbidities and conditions (chronic kidney disease, coronary artery disease, insulin use and polypharmacy). High risk patients will be assigned a care coordinator and ADA standards/National Diabetes Education Program tools will assist providers in meeting clinical benchmarks for the disease. Secondarily, diabetic patients will be empowered to achieve self-management practices. The goal is to decrease rates of diabetes-related complications, potentially preventable ED visits, and avoidable hospital admissions. (NQP PPS resources).

Other practice milestones within the above projects include:

- Electronic medical record connectivity to local RHIO's and SHIN-NY.
- Use of the EHR to prompt providers to complete the 5 A's of tobacco control with referral to the NYS Quitline, if indicated.
- Developing care coordination teams including nursing staff, pharmacists, dieticians, and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self management
- Providing opportunities for follow-up blood pressure checks without a copayment or advance appointment
- Ensuring that all practice staff are using correct blood pressure measurement technique and equipment
  Identifying patients who have repeated blood pressure readings but no diagnosis of hypertension and schedule them for a visit
- Documenting patient driven self-management goals in the medical record and reviewing at least with self-management goal with patient at each visit
- Follow-up with referrals to community based programs to document participation and behavioral and health status changes

- Developing and implementing protocols for home blood pressure monitoring with follow-up support
- Implementation of the Standard Model for chronic diseases, an educational program aimed at empowering patient with cardiovascular disease to achieve self-management practices and lifestyle change.

## E. Promote Mental Health and Prevent Substance Abuse

To complete the Community Health Needs Assessment/Community Service Plan and address the New York State's Prevention Agenda Priority Area entitled "Promote Mental Health and Prevent Substance Abuse" which was selected as a result of several community stake holder meetings, we are proposing the following initiatives:

In order to meet the stated goal of promoting mental health and preventing substance abuse, licensed clinicians and case managers will utilize the screening tool known as the Screening Brief Intervention and Referral to Treatment (SBIRT). During the first year of the project, patients referred to the outpatient mental health programs, will be screened during the intake evaluation at the Department of Psychiatry's Community Mental Health Center ("CMHC"), Wellness and Recovery Center ("WRC"), and two On-Site Mental Health Clinics located in community based Adult Homes and at the three unique programs that provide services to seriously mentally ill children and adolescents – Home Based Crisis Intervention, Blended Case Management and Family Resource Center. Clinicians providing services will include LCSW Social Workers at the CMHC, WRC, Adult Home Clinics, and ambulatory care clinics, and non-licensed case managers at the three programs for seriously mentally ill children and adolescents.

We have been approached by the New York City Department of Health and Mental Hygiene regarding our entering into a partnership which identified 16 evidenced- based community health interventions that advance both the New York State Prevention Agenda 2013-2017 and the DOHMH Take Care New York 2016 priorities. We have initiated discussions with Dr. Louis Cuoco, Director of the Office of Program Initiatives and Community Liaison, NYC DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment, regarding the Community Health Initiative number 16 described as "Adopt screening, brief intervention and referral to treatment (SBIRT) for alcohol and drug use in outpatient and emergency department settings. This initiative is identical to the New York State Prevention Agenda Priority Area of "Promoting Mental Health and Preventing Substance Abuse" that we have adopted to address in the Hospital's CHA/CHIP. In our initial conference, Dr. Cuoco described the City's SBIRT efforts in the NYC Sexually Transmitted Disease (STD) Clinics, including the goals of SBIRT and how this methodology could be effectively implemented in both outpatient mental health, ambulatory care and emergency department settings. Currently, we are screening for

alcohol and substance misuse in our outpatient mental health programs including the Community Mental Health Center, and on-site Adult Home mental health clinics and providing appropriate intervention or referrals for treatment if needed.

In terms of patient contacts, during 2016 we screened 490 patients at the Community Mental Health Center, 116 at the Wellness and Recovery Center, 182 at Surfside Adult Home Mental Health Clinic, and 365 patients at the HBCI/BCM/FRC Programs. The majority of patients with positive screens were referred for substance abuse treatment within the respective programs.

Under DSRIP, St. John's is committed to the NQP projects 3.a.i (Integration of Primary Care and Behavioral Health Services) and 3.a.ii (Behavioral Health Community Crisis Stabilization Services). (Nassau Queens PPS resources)

The immediate project 3.a.i goal is to integrate/co-locate behavioral health services within hospital primary care practices, screen all patients for depression and substance use annually, with evidence based tools (PHQ-9, AUDIT-C, and CRAFFT), connect patients with the integrated/co-located professional to provide interventions for behavioral health concerns when the individual screens are positive, arrange for shared documentation to ensure communication about the patient is easily accessible and readily available, and carry out "warm handoffs" and referrals to additional mental health and substance abuse resources/providers for more intensive treatment when indicated. Long term deliverables include diabetes monitoring for patients with co-occurring diabetes and schizophrenia, diabetes screening for patients on anti-psychotic medication, cardiovascular monitoring for patients with cardiovascular disease and schizophrenia, antidepressant medication management, adherence to antipsychotic medications for patients with schizophrenia, initiation of alcohol and other drug dependence treatment and engagement, follow-up care for children prescribed ADHD medication, screening for clinical depression and follow-up, follow-up after hospitalization for mental illness within 7 and 30 days, and avoidance of potentially preventable ED visits.

St. John's is participating with its NQP partners and the Catholic Health Services hub in project 3.a.ii, which entails providing readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of crisis. The plan is to create a single source of specialty expert care management for behaviorally complex patients, observation monitoring in a safe location, and ready access to inpatient psychiatric stabilization, if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness (NQP resources).

## Needs that Were Not Addressed

The Hospital recognizes there is a need to address all identified health concerns. Due to limitations in staffing and resources, the Hospital focused its efforts on those priorities that appeared to be of the most need and had the staffing and resources to commit to a plan of implementation. HIV and AIDS services are currently offered at the Joseph P. Addabbo Family Health Center.

The community health priorities that the Hospital identified in its health needs assessment but does not intend to meet are:

a. Cancer
b. Respiratory Disease
c. HIV and AIDS
d. Maternal Child Health

## Financial Aid Program

In accordance with its charitable and religious mission, in May 2013, St. John's expanded the Financial Assistance Program's qualification parameters from 300% of the Federal Poverty Guideline to 400%. This change brings the Assistance Program to a total of eight (8) levels, facilitating more opportunities for patients to qualify for assistance.

In 2012, St. John's provided $1.9m in Total Financial Assistance, which was a 200% increase over the amount provided in 2011.

In order to ensure full community access to the Program, the Hospital has dedicated staff available onsite, during normal business hours, to facilitate providing information about and/or enrolling patients in the Program.

Consistent with industry best practices, St. John's continues to fully integrate its Financial Assistance Policy with its overall insurance eligibility, verification and collection processes.

## Changes Impacting Community Health/Provision of Charity Care/ Access to Care

The Hospital, like many hospitals in the region, is experiencing reduced volume and decreased reimbursement for services. While this trend has resulted in losses, St. John's has not significantly changed the way financial assistance is determined or how access to care is granted. As discussed above, the Hospital actually made potentially more patients eligible for financial assistance by increasing the range to 400% of the federal poverty limit. The Hospital continues to see patients regardless of their ability to pay for necessary medical services and is cognizant of the needs of patients and their families.

## Dissemination of the Report to the Public

The Community Health Needs Assessment and the Community Service Plan will be posted on the Hospital's website, www.ehs.org and paper copies will be made available upon request.

## Engagement Process with Local Partners

All current members of the assessment team are committed to this process and will continue to meet on a regular basis. Beyond the federal requirements, the State of New York requires progress reporting on the measures outlined in the Community Service Plan, so the team will continue to meet to track progress and develop reports.

St. John's Episcopal Hospital will work closely on the projects with a number of community health partners, including schools, educators, businesses and local health clinics over the three- year implementation period.

The Rockaway Health Task Force, which is composed of a larger number of community-based organizations throughout the Service Area, of which the Hospital is a member, plans to meet quarterly to discuss local health concerns as well as implementation updates.