ST. JOHN'S EPISCOPAL HOSPITAL

EPISCOPAL HEALTH SERVICES INC.

Community Health Needs Assessment and Community Service Plan (2020-2023)

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Community Health Improvement Plan and Implementation Strategy the Rockaway Community, Queens, New York 2019-2024

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 is 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 the New York State Prevention Agenda for 2019 – 2024, for not only organizing priorities and measures but for examples of evidence-based implementation strategies. We selected priorities based on our identified needs from the CHNA

Summary

2018–2019, a Community Health Needs Assessment compiled by St. John's was completed. 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 public to develop this assessment. The information discussed at meetings was shared with hospital leadership, community organizations and the community.

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 closure of Peninsula Hospital Center (closed 2012), and Long Beach Hospital, which was shuttered due to Superstorm Sandy.

The total population of the Rockaway Peninsula is estimated to be 133,051, with an estimated 125,622 people in the SJEH catchment area.

St. John's Episcopal Hospital Utilization Statistics 2018

Discharges*	7,760
Inpatient days	56,566
Emergency Services Visits	46,549
Ambulatory Surgery Visits	2,564
Other Ambulatory Visits	74,117
Employed FTEs	1,412

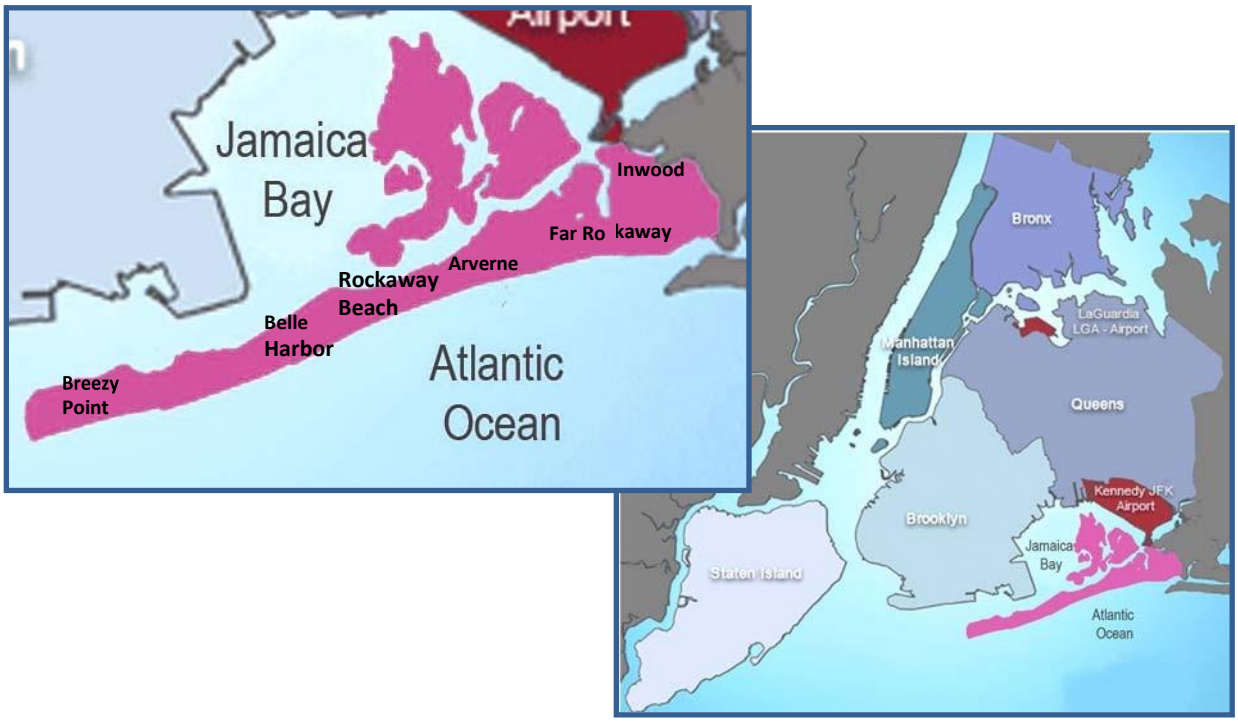
*Excludes newborn discharges.

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, is a part of Queens County, New York City, and 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. The rebuilding has been extremely slow, and today still an ongoing process, with many displaced residents having not returned to their homes. 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.

Figure 1: Rockaway Peninsula in Relation to New York



Demographics of the Community Served

Table 1: Catchment Area Demographics

City	Median Household Income	Distance from SJEH	Population	Race & Ethnicity	Median Age	Under 18 yrs.	45-69 yrs.
Far Rockaway (11691)	$42,434	0	65,356	43.5% Black; 27.7% Hispanic; 24.6% White	31.9	19,869 (30.4%)	17,384 (26.6%)
Inwood (11096)	$53,875	2	8,609	45.1% Hispanic; 27.2% White; 25.1% Black	35.1	2,160 (25.1%)	2,454 (28.5%)
Arverne (11692)	$45,816	2.7	18,540	55.3% Black; 26.2% Hispanic 9.3% White	33.9	**5,303 (28.6%)**	5,525 (29.8%)
Rockaway Beach (11693)	$57,443	6.5	12,709	46.3% White; 27.9% Hispanic; 18.2% Black	38.5	5,524 (24.5%)	4,360 (34.3%)
Belle Harbor/Rockaway Park (11694)	**$77,547**	6	**20,408**	75.4% White; 13.8% Hispanic; 6% Black	49	3,960 (19.4%)	**8,123 (39.8%)**

[Source: https://factfinder.census.gov]

St. John's has served the community for over 110 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.

Table 2: Catchment Area SJEH Inpatient Admission Data 2014 through Q3 2017

Catchment Area SJEH Inpatient Admission Data 2014 through Q3 2017

City	Grand Total Admissions by Zip Code	SJEH Admissions	SJEH Market Share	% of Admissions in Zip Code Not Captured by SJEH
Far Rockaway (11691)	40,414	25,451	34.81%	65.19%
Inwood (11096)	3,650	669	18.33%	81.67%
Arverne (11692)	11,232	3,834	34.13%	65.87%
Rockaway Beach (11693)	5,879	1,802	30.65%	69.35%
Belle Harbor/Rockaway Park (11694)	11,947	3,030	25.36%	74.6%

[Source: SPARCS 2017/3M 360 Encompass Health]

Table 3: Service Area by Age

City	Population	Median Age	Under 18 years	20-39 years	40-64 years	65-84 years
Far Rockaway	65,356	31.9	30%	28%	27%	11%
Inwood	8,609	35	25%	30%	30%	10%
Arverne	18,540	33.9	29%	27%	31%	10%
Rockaway Beach	12,709	38.5	25%	25%	36%	12%
Belle Harbor	20,408	49	19%	20%	38%	18%

Source: https://factfinder.census.gov/

Table 4: Racial Makeup of Total Catchment Area

City	Far Rockaway (11691)	Inwood (11096)	Arverne (11692)	Rockaway Beach (11693)	Belle Harbor (11694)	Totals	Percent Makeup of Catchment Area
Population Total	65,356	8,609	18,540	12,709	20,408	125,622	N/A
Hispanic	18,104	2,342	4,857	3,546	2,816	31,665	25%
Black	28,429	2,161	10,253	2,313	1,224	44,380	35%
White	16,077	3,883	1,724	5,884	15,388	42,956	34%

Source: https://factfinder.census.gov/

The percentage of the Service Area population who are deemed minorities is 60%, with those classified as Black comprising the largest percentage of the population at 35%, followed by 34% White, and 25% Hispanic. 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.

Data

Data used for this Community Health Needs Assessment was sourced from internal data as well as state and local resources including the Statewide Planning and Research Cooperative Systems (SPARCS), 3M 360 Encompass Health Analytics Suite, and factfinder.census.gov.

Health of the Service Area

1) Childhood Obesity

Twenty-three percent of Rockaway and Broad Channel children in grades K through 8 have obesity. This is similar to the citywide rate of one in five. [Source: NYC Health: Rockaway and Broad Channel Community Health Profile 2018]

2) Obesity, Diabetes, and Hypertension

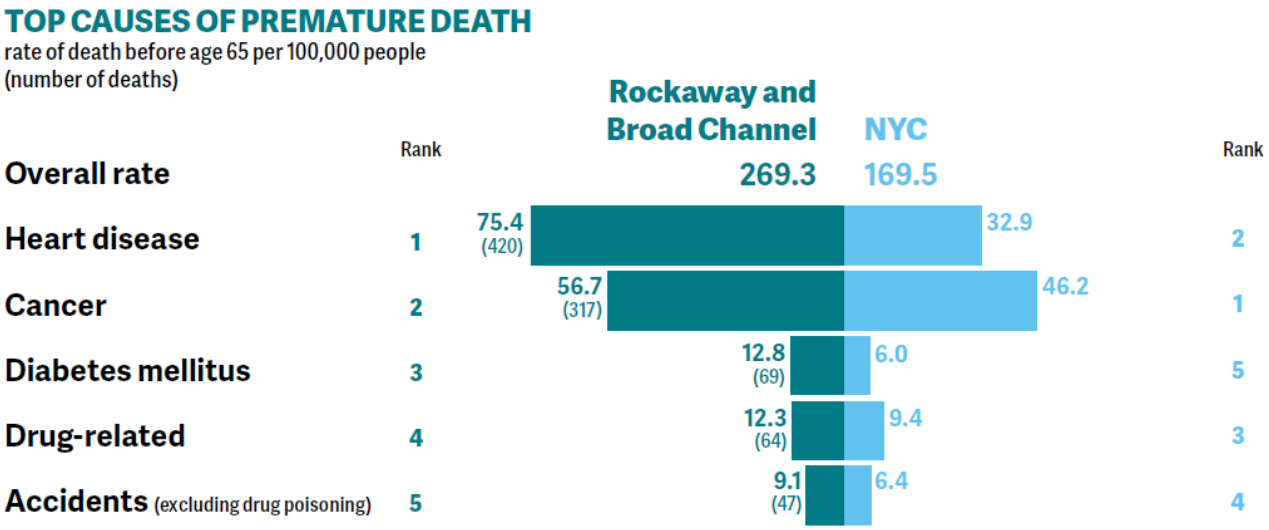
OBESITY, DIABETES AND HYPERTENSION (percent of adults)

	Rockaway and Broad Channel	Queens	NYC
Obesity	32%	22%	24%
Diabetes	15%	11%	11%
Hypertension	34%	28%	28%

Source: NYC DOHMH, Community Health Survey, 2015-2016

3) Premature Death

Cancer and heart disease are the leading causes of premature death (death before the age of 65) in Rockaway and Broad Channel, similar to the rest of NYC. However, Rockaway and Broad Channel residents die prematurely at a higher rate. Lung cancer, breast cancer (among women) and colorectal cancer are the three leading causes of cancer-related premature death in Rockaway and Broad Channel. [Source: NYC Health: Rockaway and Broad Channel Community Health Profile 2018]



3) Cancer

The rates for the following 14 cancers in the Rockaways are higher than New York City rates:

1. Oral cavity and pharynx
2. Esophagus
3. Colorectal
4. Colon excluding rectum
5. Rectum & recto sigmoid
6. Pancreas
7. Larynx
8. Lung and bronchus
9. Melanoma of the skin
10. Urinary bladder (incl. in situ)
11. Hodgkin lymphoma
12. Corpus uterus and NOS (Cancer of Uterus - not specified)
13. Ovary
14. Prostate

Additionally, the cancer rate for All Invasive Malignant Tumors is 6.57% higher in the Rockaways at 471.7 than it is for New York City at 442.6. Invasive cancer refers to cancer that spread beyond the layer of tissue in which it developed and is growing into surrounding, healthy tissues. [Note: Cancer rate per 100,000 Population].

4) Behavioral Health

Per SPARCS data, Behavioral Health Services account for the most outpatient medical visits for Rockaway residents. In 2018, SJEH saw 31,054 behavioral health visits.

PUBLIC PARTICIPATION

To advance the goals of the New York State Prevention Agenda 2019-2024, St. John's Episcopal Hospital reached out and collaborated 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 Committee
- Joseph P. Addabbo Family Health Center
- NAACP of Rockaway
- Community Board 14
- Deerfield Area Civic Association
- Rockaway Development and Revitalization Corp.
- Visiting Nurse Service of New York
- Queens Public Library
- Lucille Rose Day Care
- Rockaway Beach Civic Association
- BreezyPoint Resident Association
- FRANC
- ROCKAWAY YMCA
- Bayswater Civic Association
- Hatzalah
- Achiezer
- New York State Assembly member Stacey Pheffer-Amato
- New York State Assembly member Michele Titus
- New York State Senator Joseph Addabbo Jr.
- New York State Senator James Sanders Jr.
- New York City Councilmember Donovan Richards Jr.

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 was conducted.

The meetings were held on:

- March 27, 2017, at 8 pm at the Bayswater Civic Association – 55 attendees
- April 25, 2018, at 7 pm at the St. John's Episcopal Hospital – 25 attendees

The meetings were publicized through a variety of ways, including advertisements in the local newspapers, and the community email blast; social media; and snail mail flyers.

Community Advisory Meetings: Ongoing Community Health Task Force
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 the following dates at 7 pm:

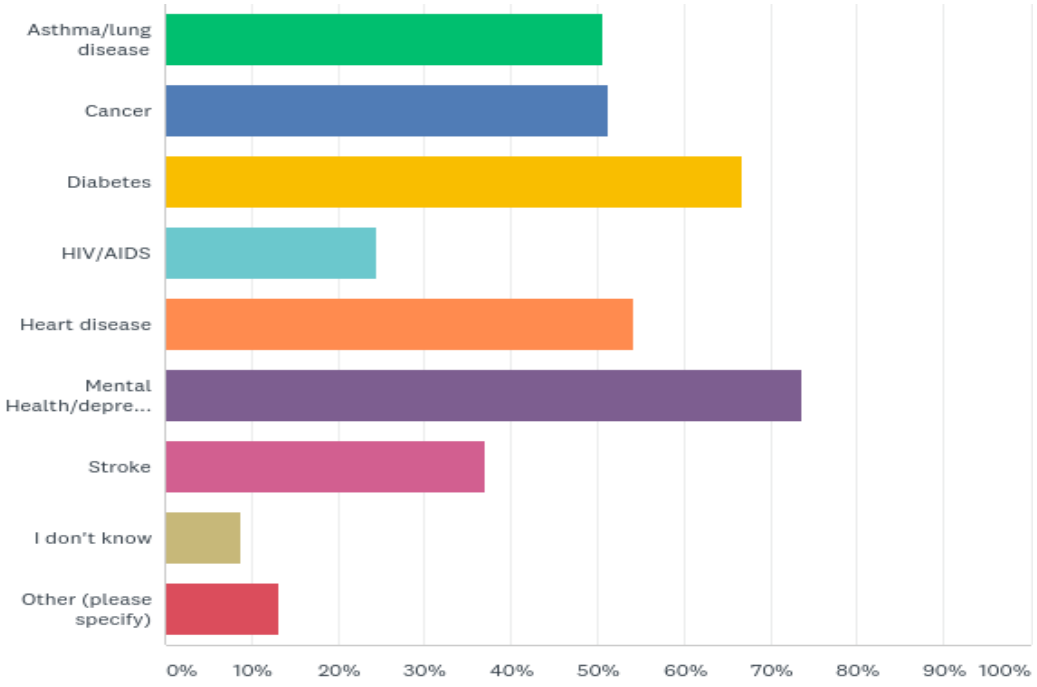
- Wednesday, January 10, 2018
- Wednesday, March 7, 2018
- Wednesday, July 11, 2018
- Wednesday, October 17, 2018

Discussions 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 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;

Selection of Public Health Priorities

The Hospital convened the aforementioned open meetings and presented the draft Community Health Needs Assessment and, based on the data, gathered 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.

Community Health Needs Assessment Survey



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 information on the status of healthcare in the Rockaways.

I. Mental and Substance Use Disorders Prevention

Mental health and substance due disorders are often driven by socioeconomic conditions, exposure to living in communities with violence, and poor physical health status. As previously discussed, the Rockaway Peninsula has a higher than average percentage of individuals living below the poverty line, higher levels of crime (as reported by the NYPD crime stats) and higher rates of cardiovascular disease and diabetes when compared to the rest of Queens and to New York City. It is not surprising then that 22.3 % of adults reported that they received counseling for or took medication for mental health issues, also significantly higher than the rest of Queens and New York City. In addition, while effective identification and treatment for people with current mental health and/or substance use disorders is required, as Rockaway demographics are increasingly younger, prevention of the onset of these disorders must also be a priority.

a. Goal 2.1 Prevent underage drinking and excessive alcohol consumption by adults

St. John's Episcopal Hospital has established a collaborative care model in its three primary care settings. Annually, all patients age 13 and older, are screened using evidenced based screening tools (AUDIT -C, DAST, CRAFFT) for substance and alcohol use disorders. All patients who screen positive are provided with a warm handoff from the primary care physician to the behaviorist for further assessment and intervention using the SBIRT intervention. The primary care physician and the behaviorist work together with the patient to move the patient toward recognition of the impact of excessive use and assist the patient in accessing treatment. The primary care EMR assists in ensuring that all patients have annual screening and those patients who screen

positive and receive the SBIRT intervention have outcomes tracked and monitored. However, the foundation for excessive alcohol and substance use is often rooted in childhood trauma.
Trauma can be the result of an acute traumatic incident or sustained over a period with exposure to living in communities with high levels of violence, poverty or with high rates of drug and alcohol use. Identifying and addressing these traumas for children and adults can reduce the long-term risk of the development of an alcohol or substance use disorder. Using the training modules developed by the Center for Practice Innovations (*https://practiceinnovations.org*), St. John's will provide training for our behavioral clinical staff in the primary care settings and in our New York State OMH licensed clinics on trauma-informed care and motivational interviewing and offer evidenced-based interventions to adults and adolescents presenting with or at risk for alcohol and substance use disorders.

b. Goal 2.2 Prevent opioid and other substance misuse and deaths

The co-occurrence of mental health and substance use disorders is long established but it was often difficult for patients to find an effective treatment for both disorders from the same provider. St. John's Episcopal Hospital operates two outpatient New York State Office of Mental Health Outpatient clinics. The number of patients presenting with co-occurring substance use disorders has increased in part due to the use of evidence-based screening tools at admission. Our mental health clinics are committed to expanding our capacity to provide treatment for co-occurring disorders at our mental health clinics. We are at the beginning stages of our participation with a NYSOMH initiative to build this capacity statewide and have committed to implementation of the 5 Best Practices for Article 31 clinics; (1) Clinics will use standardized OUD specific screens for all patients at intake, (2) Clinics will prescribe Naloxone to clients with OUD, (3) Clinics will provide or refer patients with OUD to a Mediation Assisted Treatment provider, (4) Clinics will have waivered Buprenorphine provider (5) Clinics will prescribe Buprenorphine, Naltrexone/ Vivitrol)

c. Goal 2.5 Prevent suicides

St. John's Episcopal Hospital is committed to identifying and treating individuals at risk for suicide. The Zero Suicide initiative promotes a system-wide, comprehensive approach to screening for and treating suicidal thoughts and behaviors. Our primary care and mental health clinics have a comprehensive policy and process in place to screen assess and intervene with suicidal patients. This process includes screening all individuals at the point of entry, screening annually (primary care) and throughout treatment (mental health clinics), use of the C-SSRS evidenced-based screening and assessment tool across the continuum, and a clinical workforce trained in suicide safety planning. Warm handoffs for patients who screen positive from the primary care provider to a co-located behaviorist is established at the primary care clinics. Strengthening the current model of care is a priority in our outpatient sites.

In the next phase, all behavioral clinical staff will complete Center for Practice Innovations training on the NYS Zero Suicide Model as well as on evidenced based clinical interventions for patients who are at risk for suicide. Competencies around provision of suicide interventions will be established to ensure a confident and competent workforce. Ongoing monitoring and oversight of the treatment provided to patients at higher risk for suicide includes quality assurance activities such as chart reviews, ongoing competency assessments and data collection regarding high-risk cases and outcomes.

d. Goal 2.6 Reduce the mortality gap between those living with serious mental illness and the general population

The Rockaway Peninsula has slightly higher rates of tobacco use than other areas of the city and this is likely correlated with the higher rates of psychiatric illness on the peninsula. In New York State, the smoking rate for people with a mental health disorder is 33.7% as compared to 14.3 % for the rest of the population. Tobacco use is a prime contributor to the 25 year shortened life expectancy for the psychiatrically ill population. As the Nassau Queens PPS Community Needs Assessment, I 2014 indicated that the Rockaway Peninsula did not have any smoking cessation programs widely available. This past year, our behavioral health clinics joined the New York City Tobacco Cessation Training and Technical Assistance Center and the New York City Department of

Health and Mental Hygiene and had all clinical staff, including physicians, complete three days of in person training on tobacco dependence, evidenced based cessation interventions and medication assisted treatment all focused on patients with co-occurring behavioral health diagnosis.

This is an ongoing collaborative project with technical assistance being provided by DOHMH and the Center for Practice Innovations. All patients receive screening and assessment for tobacco use and nicotine addiction and are offered treatment by trained staff as well as medication assistance. CPI, both to ensure that newly hired staff develop the same clinical skill set as current staff and to provide annual refresher training on motivational interviewing and updates on medication-assisted treatment, will provide ongoing training. The next year we will be working with our EMR provider to develop a tracking mechanism for collecting data about current tobacco/ nicotine rates of use, medication compliance for patients prescribed MAT and overall outcomes of interventions (patients who are able to achieve remission- short and long term).

II. **Prevent Chronic Disease**

The Rockaway Peninsula is a geographically isolated area of Queens with a shortage of primary care providers, many of which left the peninsula after Superstorm Sandy. VNSNY received a $1.4M social services block grant from NYS after the storm, to create the Rockaway Wellness Partnership, a health-coaching program involving nurses, social workers, and community health workers, to facilitate access to primary care and promote wellness. Residents within the 11691, 11692, and 11693 zip codes were enrolled in the program. 234 comprehensive health assessments were performed on enrolled clients, helping to identify the following top needs of the community residents:

- Linkages to a primary health provider
- Legal and immigration issues
- Job opportunities
- Medication Management
- Diabetic counseling
- Counseling around depression.

Specific to chronic disease, 49% of respondents rated their health as fair or poor, of those with hypertension, 24% admitted not taking their medications and 27% said that their hypertension symptoms were under control only some of the time or not at all, of those with diabetes, 38% said their diabetes symptoms were under control only some of the time or not at all and of those with heart disease, 24% responded that their heart disease symptoms were under control only some of the time or not at all. Sixteen percent of respondents were taking six or more medications

Beginning in August of 2014, a partnership between Catholic Health Services of Long Island, NuHealth, and North Shore-LI Health was formalized into the Nassau Queens Performing Provider System (NQP) under the DSRIP (Delivery System Reform Incentive Payment program), to fundamentally restructure the healthcare delivery system for Medicaid, dually eligible, and uninsured patients in Eastern Queens and Nassau County. The Nassau-Eastern Queens Community Needs Assessment (CNA) process was launched to survey NYS Prevention Agenda priorities, goals, and barriers to health, strategies, and demographic information throughout communities in its service areas. Surveys reached a broad spectrum of community residents and health care provider sites, within the Rockaway peninsula, as an identified NQP hot spot area. A total of 17 Eastern Queens and Rockaways Stakeholder Forums were conducted, with specific Rockaway forums on 10/22/14 and 10/28/14. Participants of those forums included Visiting Nurse Services of NY, 1199 SEIU Funds, FEGS Health and Human Services, Catholic Charities, AIDS Center of Queens County, St. John's Episcopal Hospital (including several hospital social workers), and the 101st Precinct. The following is feedback, from Providers *to Patients* session from those Rockaway forums, related specifically to chronic disease:

What is not working?

1. There are too many overlapping and disconnected chronic disease management programs
2. Younger people are more difficult to engage with on chronic care disease management, specifically, that "asthmatic kids are a good population for smoking education and [we need to] make sure they don't initiate, because they already have issues".
3. Health literacy (and literacy in general) needs to be taken into account when communicating chronic disease management and educational interventions, including consideration of cultural competency (e.g. health workers should not assume a person can read in their native language).
4. Oncology needs to be treated as a chronic disease, including the integration of survivorship programs, population screenings, and continued recommended screenings of other cancers by the PCP.
5. Patient characteristics, which act as barriers to communication across providers, include a patient's level of social support, education level, language, and culture.
6. Provider awareness of where to send patients with chronic illness for support and education is lacking.
7. Medical Homes lack the resources to coordinate chronic disease management.

What is needed?

1. Chronic disease self-management providers need to partner with primary and subspecialty care
2. Greater number of referrals to home care (e.g. telehealth)
3. Environmental management and smoke-free residential buildings
4. Incentives for chronic disease education and symptom management
5. Intensive education programs which use teach-back or reciprocal learning to teach disease management
6. Working in the framework of patient-centered goals of care; patient-focused results help reinforce chronic care management
7. A population health level approach to healthy eating
8. Secure funding for chronic disease management and prevention
9. Integration of chronic disease management and prevention in schools and referral to community-based programs (e.g. senior centers) from primary care.
10. Peer level coordination (i.e. health coaches) for patients with chronic disease
11. Educating the patient on cultural competence

What would it take?

1. Get practitioners to use evidence-based guidelines for treating chronic illness in order to provide continuity of messaging between settings (e.g. asthma is a chronic disease, not a series of acute episodes)
2. Addressing disparities in the community, including regional disparities and racial/ethnic disparities
3. A diverse workforce to accommodate cultural differences in health care engagement.
4. A family-level approach to chronic disease management and prevention
5. Enhanced, regular communication between community care providers.

The most recent NYC Community Health Profiles 2018, Queens Community District 14, identified an adult obesity rate of 32% in the Rockaway and Broad Channel region, which is higher than that of Queens (22%) and New York City (24%). Since obesity has been linked to the onset of diabetes, hypertension, and other health conditions, it was not unexpected that the same report demonstrated a higher adult rate of diabetes (15%), compared to the remainder of Queens (11%) and New York City (11%), and higher adult rate of hypertension (34%), compared to the remainder of Queens (28%) and New York City (28%).

In response to the above community needs assessment, St. John's Episcopal Hospital will be working on:

a. Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer.

St. John's Episcopal Hospital has become a credentialed provider of the NYS Department of Health Cancer Services Program and will be implementing free breast, cervical, and colorectal cancer screenings, diagnostic follow-up services and referrals to treatment for uninsured and underinsured women and men who are at or below 250% of the Federal Poverty Level (FPL) and meet other program requirements. The intent is to improve access to age and sex appropriate high quality cancer screening, early detection, and management of priority populations that are disproportionately burdened by the increased risk of cancer (e.g. rarely or never screened for cervical cancer) or are medically un- or under-insured (having experienced prior barriers to services due to sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, socioeconomic status, cultural isolation, low literacy, and language). Furthermore, as a contracted provider, SJEH will provide education to targeted populations and providers, to promote the importance of early detection and garner community support for the initiative.

b. Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity

The Department of Population Health at St. John's Episcopal Hospital has embarked on an aggressive mobile health outreach project, using a branded hospital vehicle that is stationed at strategic locations within the community, at or near community based organizations, high foot traffic areas (shopping centers, beach entrances, transit depots) local churches, schools, and at community events, holiday celebrations, and health fairs. The van offers free blood pressure screening by SJEH nurses, family practice residents, and attending physicians and nutrition education from a registered dietician and certified diabetes educator. Health coaches make follow-up appointments and appropriate linkages to hospital based primary care practices (for patients without a primary care physician) and other clinical services when required. Community residents, identified with elevated blood pressure, are contacted after the event by the health coach, to assure an appropriate follow-up appointment is made with their medical provider.

In phase 2 of the project, the hospital will have the capability to offer random glucose and Cholesterol screening to community residents and be able to calculate their ten (10) year cardiovascular risk and make an assessment of their glucose control. Patients will be referred to the hospital's Diabetes Wellness Program and Diabetes Self-Management Education Services if indicated.

c. Goal 4.3 Promote the use of evidence-based care to manage chronic diseases

Plans are in development to provide evidence-based asthma education to elementary-aged students and their families at local elementary schools in the Rockaways. The program will be a collaborative effort of the departments of pediatrics, ambulatory care, and population health, with the goal of improving asthma self-management skills and environmental trigger awareness/reduction in this age group, in order to reduce the frequency of avoidable emergency room visits and school absences.

To support the effort of our pediatric asthma specialist and team of general pediatricians, the Department of Population Health's health coaches and ED navigators are being trained by the American Lung Association-Asthma Educator Institute in asthma self-management education. In addition, a specialty home care program (through Catholic Health Services of Long Island), focusing on pediatric asthma, is available to our providers in the emergency room, pediatrics clinic, and community for referral of high utilizing and high risk patients, to assess their home environment and patient/family skills in medication administration.

Goal 4.4: Improve self-management skills for individuals with chronic conditions

In 2017, St John's Episcopal Hospital and IPRO, the not-for profit Medicare Quality Improvement Organization for New York, agreed to collaborate on the Centers for Medicare and Medicaid Services 11th Statement of Work on projects including 1) disseminating Diabetes Self-Management Education Services (DSMES) to Medicare

beneficiaries with diabetes or prediabetes (including dually eligible Medicare and Medicaid beneficiaries), and 2) developing sustainable strategies for continued DSMES efforts beyond IPRO's contract cycle. Under this agreement, IPRO provided Peer education training and certification for SJEH health coaches and ED navigators to become certified educators and to co-lead and facilitate chronic disease (CDSMP) and diabetes self-management education services (DSMP) workshops throughout the Rockaways. IPRO covered the cost of the initial licensing fee for use of the Stanford DSMP curriculum and provided class resources, teaching tools, and patient education materials. Workshops were scheduled at the main hospital and at community based organizations throughout the peninsula, including Neponsit Adult Day Health Care Program, Seagirt Adult Day Care, Ocean Bay Development Corporation, Redfern Housing Tenants Association, and the 40's Housing Tenants Association. We anticipate a renewal of the agreement with IPRO to continue these workshops for future CMS payment cycles.

In addition, IPRO provided technical assistance to St John's Episcopal Hospital leadership, to establish a hospital based service that was accredited on November 1, 2018, as a Diabetes Education Accreditation Program, and eligible to receive Medicare reimbursement for Diabetes Self-Management Training. The Diabetes Self-Management Education Services team at SJEH consists of three (3) certified diabetes educators, including a registered dietician and clinical pharmacist. Workshops utilize the American Association of Diabetes Educators (AADE) "Diabetes Education Curriculum", which is based on the AADE7 Self Care Behaviors (Healthy Eating, Being Active, Taking Medications, Monitoring, Problem Solving, Healthy Coping, and Reducing Risks). Workshops are advertised to community providers, as well as directly to the public through social media efforts. A plan is underway to expand the program to the employees of St. John's Episcopal Hospital, many of which have prediabetes and diabetes, live in the surrounding communities, and can become peer champions of the program and support healthy lifestyle choices within the hospital and at home.

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 in addition to St. John's partnership with other community-based organizations that address this issue.

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 (5) levels, facilitating more opportunities for patients to qualify for assistance.

In 2018, St. John's provided $2.3m in Total Financial Assistance, as compared to $2.5M in 2017.

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 committee 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 community-based organizations, educators, businesses and local health clinics over the three- year implementation period.

The Community Advisory Committee, which is composed of a larger number of community-, based organizations, local residents and elected official representatives throughout the Service Area, plans to meet quarterly to discuss local health concerns as well as implementation updates.