

WINTHROP-UNIVERSITY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN 2016



Your Health Means Everything.™

Winthrop-University Hospital
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Adopted by the Board of Directors November 8, 2016

IMPLEMENTATION STRATEGY

I. MISSION STATEMENT

It is the mission of Winthrop-University Hospital to provide high-quality, safe, culturally competent, and comprehensive healthcare services in a teaching and research environment which improve the health and well-being of the residents of Nassau County and contiguous county areas...based on a profound commitment to an enduring guiding principle – “Your Health Means Everything.”

ABOUT WINTHROP-UNIVERSITY HOSPITAL

Founded in 1896 by a group of local physicians and concerned citizens, Winthrop, Long Island’s first voluntary hospital, is a 591-bed university-affiliated medical center offering inpatient and outpatient programs and services to address every stage of life. What’s more, its newly renovated 7,500-square-foot Trauma Center – the only facility in Nassau County with full adult and pediatric capabilities – was recently certified as an adult Level 1 Trauma Center by the American College of Surgeons.

Consistently recognized for providing quality patient care, Winthrop’s awards, recognitions and accreditations are many, including recent national recognition for excellence in nursing from the American Nurses Credentialing Center’s (ANCC) Magnet Recognition Program® – the highest recognition that a hospital can earn in the area of nursing excellence. Winthrop was also the first hospital on Long Island to be awarded Baby Friendly® Designation – a global program launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1991, to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding.

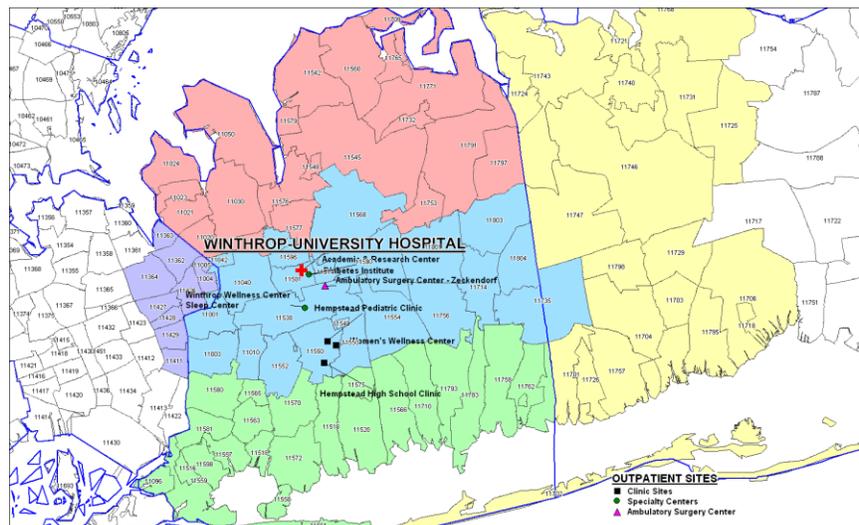
A leader and innovator in many specialty areas, Winthrop is home to the very first Diabetes Education Program in New York State and was the first major teaching hospital in New York State to earn The Joint Commission's Gold Seal of Approval™ for its Advanced Inpatient Diabetes Care. Additionally, Winthrop’s Breast Health Center was the first in Nassau County to earn certification by the National Accreditation Program for Breast Centers (NAPBC).

Winthrop opened the Research and Academic Center in February of 2015, a 95,000 square-foot, five-story facility that houses laboratories, academic lecture halls, and clinics which facilitate bench-to-bedside research, cross-fertilization of ideas, and access to the most current information available.

Winthrop is currently projected to spend \$5.9 million on unsubsidized research in 2016; our 2017 budgeted unsubsidized expense has been increased to \$6.4 million. We recently increased our research staff by approximately 25% and hired a new director of the Diabetes and Obesity Research Center, along with additional graduate PhD students, technicians, and volunteer doctors to do research on diabetes, obesity-related conditions and cardiovascular disease.

II. COMMUNITY SERVED

The Hospital’s primary/core service area has historically been Nassau County, specifically, Core Areas A, B, and C (See map below). Based on an analysis of our patient population, 80.9% of discharges come from these areas.



Within Core Areas A, B and C, there are “select communities,” i.e., communities that experience health disparities. They include Elmont (11003), Inwood (11096), Freeport (11520), Glen Cove (11542), Uniondale (11553), Long Beach (11561, and Roosevelt (11575), Hempstead (11550) and Westbury (11590). Winthrop’s inpatient population for these communities totals 35% of our population from Core Areas A, B & C. Significant attention was paid to communities with health disparities.

III. IMPLEMENTATION STRATEGY PROCESS

Selection of initiatives is data-driven, supported by research and discussions with community partners. Disparities will be addressed by partnering with community-based organizations in select communities to hold culturally relevant chronic disease management educational programs. A bilingual nurse is now on the team, who will be able to communicate effectively with participants. To address disparities, Winthrop will focus on Hempstead and Westbury, two

communities that account for approximately 25% of our inpatients from select communities. Because of the collaborative efforts that exist in Nassau County, other hospitals will focus on the select communities geographically closest to them.

Implementation strategy was developed by the following committee members, who reviewed data and discussed the most effective way possible to utilize evidenced-based programs and resources that the hospital is able to commit to this initiative. They included:

- Joseph Greco, MD, Medical Director
- Virginia Peragallo-Dittko, Administrative Director of the Diabetes Institute
- Ed Keating, Senior Vice President, Marketing, Advertising & PR
- Diane Bachor, Vice President, DSRIP
- Karen Tripmacher, Director, Community Education & Health Benefit
- Denise Portalatin, Manager, Community Outreach

The strategy was then discussed with community partners and approved by the Board of Directors.

IV: PRIORITIZED LIST OF SIGNIFICANT HEALTH NEEDS IDENTIFIED IN CHNA

The prioritization process included discussion with community partners, including both the Long Island Health Collaborative and Winthrop's Community Cultural Advisory Committee, internal discussions with Winthrop Senior Administration and review with the Board of Directors, an examination of resources, and a determination of the feasibility of possible interventions. Winthrop ranked priorities based on the burden, scope and urgency of the health need across the service area, health disparities in select communities, resources, and the importance the community placed on addressing the needs. The following is a prioritized list. A complete work plan is attached.

1. Chronic Disease Self-Management Education – will be addressed through the following programs.

- Stanford Program for Chronic Conditions – a six-week, evidenced-based chronic disease management initiative. Classes are facilitated by an RN and a peer leader from the community. Staff with needs to be trained through QTAC (Quality & Technical Assistance Center of New York). This program will be piloted in the Hospital, and then brought out into both the community-at-large and communities with health disparities.
- CDC Diabetes prevention program – evidenced-based and successfully offered at the Diabetes Education Center at no charge to participants. The program involves a one year commitment, with 16 weekly visits, followed by monthly

visits for the remainder of the year. *Note: Winthrop's program has the highest enrollment in all of NYS. These statistics are monitored by QTAC –NY. QTAC supports public, private, health and community-based partners to disseminate and deliver a series of evidence-based self-management programs that improve the health, wellness and quality of life in communities within and beyond New York State.*

- Tai Chi – evidenced-based for arthritis and fall prevention, it is also proven to be an excellent strategy to relieve stress and improve mental health. It's an 8-week program, twice a week. This program was piloted during January of 2016, and was enthusiastically received by the community. Since then, six programs have been offered – four at the Welcome Center and two at the Yes We Can Community Center in Westbury, a community with health disparities. Close to 100 people have participated. Demand for more classes is high. We will continue to offer this both at the hospital and in the community. We are also looking to have our bilingual nurse trained to offer this program

2. Obesity

- Head Start Partnership, 5-2-1-0 program. Obesity is at higher levels in communities with health disparities. The CDC has recommended early childhood intervention as a strategy to combat obesity.

With this program, children are weighed twice a year, and families are provided with information about the healthy lifestyle program (5 servings of fruits and vegetables, no more than 2 hours of screen time, one hour of exercise and zero sugary drinks.) Each child receives a packet of information, where they have the opportunity to chart their progress each day, but coloring in forms that monitor their consumption of fruits and vegetables, screen time and exercise.

Since the “buy-in” of the family is important, the program is explained at a parent meeting and parents are also offered a support group if interested. The program was piloted in Westbury and Hempstead locations during 2016. Freeport is interested as well.

- The 5-2-1-0 program is also utilized at Winthrop's Hempstead Pediatric clinic, where children are monitored for obesity for the past three years. Outcomes are tracked by that office.
- Baby Friendly Hospital – Breastfeeding is an evidenced-based obesity intervention. Winthrop currently tracks the number of women who choose to breastfeed when their child is born, and the number of women who attend support groups. We will continue to educate prospective and new mothers about the benefits of breastfeeding.

3. Cancer – Division of Cancer Services in working to increase cancer screenings in the community

- Cancer Services is working on the “80% by 2018” pledge to increase colorectal cancer screenings (80% of the eligible population screened by 2018)
- Breast Health Center is working to increase screenings in communities with health disparities

4. Injury Prevention – Falls continue to be problematic within our community. We will concentrate on offering Tai-Chi and will also provide lectures offering fall-prevention tips on as-needed basis.

5. Mental Health – Winthrop has expanded its psychiatric division and maintains a strong referral system. We are in the stages of investigating Mental Health stress management initiatives that will be introduced to the community at educational programs. Since Mental Health is being included as an “overlay” within interventions offered by collaborative partners, Winthrop will seek to continually address this issue, but due to limited resources, will not address this formally as one of our initiatives.

Please note that the issue of mental health is also being addressed community-wide by: Nassau/Queens Performing Provider System (PPS) New York State Delivery System Reform Incentive Payment (DSRIP) program, project 3.a.i. *Integration of primary care and behavioral health services.*

6. Women & Children’s Health – a constant focus at Winthrop. The issues of pediatric asthma and low birth weight babies will continue to be addressed, but due to limited resources, will not prioritize this formally as one of our initiatives.

Note: Winthrop is also involved with the Long Island Health Collaborative, a group of approximately 100 committed partners who aim to improve the health of communities across Long Island. By using the collective impact model, we hope to enhance the quality of work being pursued by individual organizations. Members are entrenched in Nassau County communities and are able to engage community members in improvement strategies. Brief goals and objectives for our work with the Collaborative are included in the attached work plan.

V. BOARD APPROVAL

The Implementation Strategy was adopted and approved by the Board of Directors on November 8, 2016.

Please see attached for complete work plan.

CHNA – 2016 Implementation Plan

Work Plan Chart

Goal	Outcome Objectives	Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
Chronic Disease - Increase the percentage of individuals taking the NDPP in communities with health disparities to 32% of enrollees	<p><i>Short Term – Educate at-risk individuals about prevention</i></p> <p><i>Intermediate – Change behavior</i></p> <p><i>Long Term – Reduce the number of individuals with Diabetes</i></p>	<p><i>National Diabetes Prevention Program</i></p> <p><i>Director of Diabetes Education Center will meet with community physicians in Westbury & Hempstead to promote the free program and increase referrals</i></p>	<p><i># of participants in the program</i></p> <p><i>Post-evaluation forms</i></p>	<p><i>Community physicians refer patients based on blood test results</i></p>	<p><i>Winthrop will help physicians identify & diagnose pre-diabetes and provide a brochure for patients to facilitate onboarding</i></p>	<p><i>2017 to 2019 cycle</i></p>	<p><i>Yes</i></p>
Increase percentage of adults with arthritis, asthma, cardiovascular disease or diabetes who have taken a course or class to learn how to self-manage their condition. (New program – will develop baseline)	<p><i>Short Term – Arrange training for staff and peer leaders in Stanford program</i></p> <p><i>Intermediate – Offer classes at hospital and in community</i></p> <p><i>Long Term – # of Participants who develop an action plan</i></p>	<p><i>Stanford Program for Chronic Conditions</i></p>	<p><i># of individuals in program</i></p> <p><i># of individuals who develop an action plan</i></p> <p><i># of programs offered</i></p>	<p><i>Recruit participants in communities with health disparities</i></p>	<p><i>Meeting space - “Yes We Can” Community Center in Westbury</i></p> <p><i>Hispanic Counseling Center</i></p> <p><i>St. Brigid’s Church</i></p> <p><i>Hempstead Hispanic Civic Association</i></p>	<p><i>2017 – 2019 cycle</i></p>	<p><i>Yes– programs will also be offered in communities with health disparities</i></p>
Cancer - Increase the # of individuals screened for colorectal cancer	<p><i>Short Term – Identify barriers to colorectal screening</i></p> <p><i>Intermediate –</i></p>	<p><i>80% by 2018 Colorectal Cancer Screening Initiative</i></p> <p><i>Reach out to</i></p>	<p><i># of community organizations contacted</i></p> <p><i># of public</i></p>	<p><i>Community Partners will provide outreach to foster the program. Community</i></p>	<p><i>Volunteering time to raise awareness</i></p> <p><i>Physicians will</i></p>	<p><i>2017 – 2019 cycle</i></p>	<p><i>Yes – outreach will be made to communities with health disparities</i></p>

	<p>Overcome challenges of barriers to screenings & Increase cancer screening awareness</p> <p>Long Term 80% of targeted population will be screened for colon cancer</p>	<p>community partners to discuss barriers to screening</p> <p>Promote screening awareness through public education</p> <p>Develop a direct access process for colorectal cancer screening</p>	<p>educational programs/events attended</p> <p># of community members counseled and referred for screening</p> <p># of individuals screened</p>	<p>physicians will support the program by encouraging participation and sharing knowledge with patients about the importance of screening.</p> <p>Physicians will refer patients for screening</p>	<p>share their expertise</p>		
<p>To increase the # of women screened for breast cancer according to clinical guidelines.</p> <p>To improve the quality of breast cancer screening and diagnostic follow-up among age-appropriate patient populations.</p>	<p>Short Term - Expand current outreach into the community to target women in underserved populations who have not been screened.</p> <p>Intermediate – Patient navigators will work with referred patients, discuss barriers to accessing care, assist with resolving barriers</p> <p>Long term – Increase the number of women who will be up-to-date with breast cancer screening guidelines</p>	<p>NAPBC (Nationally Accreditation Program for Breast Centers) Patient Navigation Initiative</p> <p>Contact community partners to formalize referral relationships</p> <p>Develop workflows for patients to navigate the system</p> <p>Develop workflows for patients who are uninsured or underinsured; get financial assistance when qualified</p>	<p># of women contacted</p> <p>% of women who need screening</p> <p>% of women who go for the screening</p>	<p>Community partners will refer women to patient navigator for initial screening to see they are appropriate for a mammogram</p>	<p>New program – TBD</p> <p>NYS Department of Health Grant - NAPBC Patient Navigation Project</p>	<p>800 by 2017 800 by 2018</p>	<p>Yes – initiative focuses on communities with health disparities</p>

<p>Obesity - Prevent childhood obesity through early childhood care and schools</p>	<p>Short Term - Increase family knowledge of healthy lifestyle</p> <p>Intermediate - Change health behaviors</p> <p>Long Term - Improve health</p>	<p>5-2-1-0 Program</p> <p>Provide 5-2-1-0 take-home packets</p> <p>Offer support group/educational meetings to parents of overweight children</p>	<p>Number of children weighed & provided with information packet</p> <p># of parents at parent meetings and/or support groups</p> <p>% of children who are obese</p>	<p>Community outreach – school obtains parental consent</p> <p>Head Start reinforces healthy lifestyle with children</p>	<p>Staff - Children are weighed at Head Start Schools in Hempstead & Westbury</p> <p>Meeting space for parental support groups</p> <p>-</p>	<p>2017-2019 cycle</p>	<p>Yes</p>
<p>Expand the role of health service providers in obesity prevention</p>	<p>Short Term - Promote obesity awareness</p> <p>Intermediate - Change health behaviors</p> <p>Long Term - Improve health</p>	<p>Identify children who are obese</p> <p>Provide counseling to improve lifestyle behaviors</p> <p>Implement no-juice campaign</p>	<p>Track counseling rate of 5-2-1-0</p> <p>Track no juice educational documentation rate for toddlers</p>	<p>Hospital Program – clinic in community with health disparities</p> <p>Parents are encouraged to partner with providers</p>	<p>Hospital Resources – staff to track rates</p>	<p>2017-2019 Cycle</p>	<p>Yes</p>
<p>Increase the percentage of infants who are exclusively breastfed</p>	<p>Short term - Exclusive breastfeeding</p> <p>Intermediate – Longer duration of breastfeeding</p> <p>Long Term - Better health for women and children</p>	<p>Baby Friendly® Hospital</p> <p>Raise awareness about the benefits of breastfeeding</p> <p>Refer moms to supportive services for breastfeeding</p>	<p>Percentage of women who exclusively breastfeed upon leaving the hospital</p>	<p>Internationally Board Certified Lactation Consultant Community physicians support women to be successful in breastfeeding goals</p> <p>WIC –Women, Infants & Children support moms in breastfeeding</p>	<p>Educational materials for women</p>	<p>Increase percentage to 53% by 2018</p>	<p>Yes – all women who give birth at Winthrop are included</p>

<p>Prevent Falls</p> <p>Promote Mental Health & Wellness</p>	<p>Short term - improve moment</p> <p>Intermediate – better balance and stress reduction</p> <p>Long Term – promote empowerment and general well-being</p>	<p>Tai Chi for Arthritis</p>	<p># of participants</p> <p>Post-program evaluation forms</p>	<p>Community partners will promote program</p>	<p>Space at CBO's to offer program</p>	<p>2017-2019 cycle</p>	<p>Yes – programs will be offered in the broad community, as well as communities with health disparities.</p>
<p>Long Island Health Collaborative Goals</p> <p>Increase community awareness of Mental Health/Substance Abuse</p>	<p>Short term - Identify strategies, meet regularly to address the need for increased awareness and focus on Mental Health and Substance abuse</p> <p>Intermediate - Promote initiatives to community partners</p> <p>Long Term – provide support in raising awareness about mental health</p>	<p>Participate in Evidence-Based Mental Health First Aid USA™ training program for community members and front line healthcare workforce</p> <p>Provide stress management information at all hospital programs/events</p> <p>Provide community programs on stress management</p>		<p>Interventions, supportive linkages will be passed on by Winthrop community-based partners</p>		<p>2017-2019 Cycle</p>	<p>Yes</p>

<p>Long Island Health Collaborative Goals Leverage partnerships and achieve collective impact among LIHC community-partner network</p>	<p>Short term - Communicate with partners to understand what activities are occurring within which communities</p> <p>Intermediate - Identify potential partnerships and introduce compatible partners</p> <p>Long Term - Align objectives with organizations currently engaged in built environments</p>	<p>LIHC will assess resource availability through network of community-partners</p> <p>LIHC will promote collective impact strategies by leveraging existing resources and identifying partnerships</p> <p>Support Complete Streets Policy work</p>	<p>LIHC will develop efficient surveys and polls which will capture information about parallel projects within Nassau County Communities.</p> <p>LIHC will manage and ongoing involvement in partnerships with continued effort to identify partnership and streamline activities</p> <p>LIHC will work closely with Local Health Departments and organizations engaged in Complete Street work, identify opportunities for partnership or support</p>	<p>Winthrop will attend meetings and participate in projects dedicated to improving the health of the community</p>	<p>Staffing</p>	<p>2017-2019 Cycle</p>	<p>Yes</p>
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