

# WINTHROP-UNIVERSITY HOSPITAL

## COMMUNITY NEED ASSESSMENT

### 2016



Your Health Means Everything.™

Winthrop-University Hospital  
259 First Street  
Mineola, NY 11501  
[www.winthrop.org](http://www.winthrop.org)  
1-866-WINTHROP



*Approved by the Board of Directors November 7, 2016*

## **INTRODUCTION**

A provision of the Affordable Care Act requires that not-for-profit hospitals conduct and publish a Community Health Needs Assessment (CHNA) once every three years to assess community needs and adopt an Implementation Strategy to meet those needs. Progress on addressing these needs is reported annually through the IRS Schedule H Form 990. To complete the CHNA and produce the most effective assessment possible, Winthrop-University Hospital participated in the collaborative assessment that was conducted by The Long Island Population Health Improvement Program (LIPHIP).

The core of the LIPHIP is an extensive workgroup of committed partners who work together to improve the health of all Long Islanders. This workgroup, called the Long Island Health Collaborative (LIHC), consists of the two county health departments, all hospitals on Long Island, physician leaders, representatives from nursing and mid-level provider associations, dozens of community-based health and social service organizations, academic institutions, health plans, local municipalities, and many other sectors. The LIHC convenes on a monthly basis and is utilizing the collective impact model, the structured approach for bringing people and groups in a community together to achieve social change.

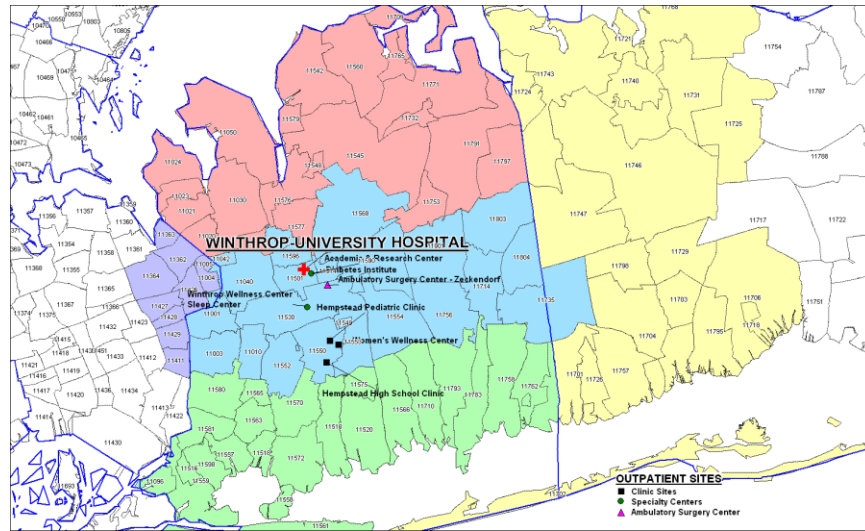
In 2015, the Long Island Health Collaborative was awarded the Population Health Improvement program (PHIP) grant by the New York State Department of Health. The PHIP is a data-driven entity, pledged to pursue the New York State of Health's Prevention Agenda, making the program a natural driver for the Community Health Needs Assessment cycle. For information about the LIHC and a list of members, please visit [www.lihealthcollab.org/](http://www.lihealthcollab.org/) Winthrop has been extensively involved in this initiative since its inception in 2013.

The following report provides insight into the Winthrop-University Hospital community, the assessment process, the findings for Nassau County, and a prioritization of the significant health needs for Winthrop's service area. Please note that although community members had the opportunity to provide written comments on our 2013 CHNA through our website or by calling our office, none were provided.

## **I. COMMUNITY SERVED**

Winthrop's service area is defined geographically and by patient population. 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 (see table 1). The assessment concentrated on our primary service area. Our secondary service area, Suffolk County and Eastern Queens, respectively, Areas D and E, is

considered in the Hospital’s strategic planning process for purposes of establishing new programs and services, but was not included in the assessment.



**Blue: Core A; Green: Core B; Pink: Core C; Purple: Core D; Yellow: Core E**

*Table 1*

Discharge Data 2015 (excluding normal newborns)		
Core Areas	Total	% of Total
A	16,984	53.68%
B	7,144	22.58%
C	1,215	3.84%
<b>Nassau Total</b>	<b>25,343</b>	<b>80.09%</b>
D	1,671	5.28%
E	455	1.44%
Other	4,084	12.9%
<b>TOTAL</b>	<b>31,724</b>	<b>100%</b>

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). Thirty-five percent of our patients from Core Areas A, B & C (see Table 2) come from select communities, with 27.6% from Core Area A alone. Significant attention was paid to communities with health disparities.

Table 2

<b>Discharge Data 2015 – Select Communities</b> (excluding normal newborns)				
<b>Core Areas</b>	<b>Total Select Communities</b>	<b>% of Total Select Communities</b>	<b>WUH Total</b>	<b>% of WUH Total Select Communities</b>
<b>A</b>	7,000	78.6%	16,984	27.6%
B	1,657	18.6%	7,144	6.5%
C	249	2.8%	1,215	.9%
<b>TOTAL</b>	<b>8,906</b>	<b>100%</b>	<b>25,343</b>	<b>35%</b>

## **NASSAU COUNTY – AN OVERVIEW**

Nassau County is unique in that it presents complex polarity, representing a wide range of both healthy and sick community members from opposite ends of the health continuum. Data presented within this report will demonstrate the existence of vast health disparities stemming from a wide range of socioeconomic factors. Our findings indicate the reality of the linkage of health disparities to a variety of social factors including race, ethnicity, gender, language, age, disabilities, and financial security, among others. Elimination of such disparities is a priority throughout the Long Island region, as the bridging of gaps and services will ultimately improve health outcomes and quality of life for community members.

### **DEMOGRAPHICS**

The United States Census Bureau American Fact Finder estimates Nassau County’s population as of July 1, 2015, as 1,361,350 people. The median age of residents is 41.3; 90.3% are high school graduates or have achieved higher education, and the median household income is \$98,401, with an estimated 6.3% living below poverty level.<sup>1</sup> The unemployment rate is 4.8%, compared with the New York State ranking of 6.3% - an improvement of approximately 2% from 2013. Race is reported as: White alone, 63.7%; Hispanic or Latino of any race, 15.4%; Black or African American, 10.8%; and approximately 8.2% are Asian.<sup>2</sup>

According to data culled by the NYS DSRIP project in 2016, approximately 223,494 individuals are unique Medicaid enrollees. Of these, 38% are Hispanic; 26% are white; 20% are black and

<sup>1</sup> [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml)

<sup>2</sup> <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

9% are Asian/Pacific Islanders. The Hispanic population comprises the largest group of Medicaid enrollees in Nassau County, specifically females between the ages of 1-71 and 18-44.<sup>3</sup>

A “snapshot” of Nassau County from estimated 2016 data from County Health Ranking and Roadmaps from the University of Wisconsin Population Health Institute – factors that drive health – provides the following information. Nassau County is ranked as number 1 in New York State for Health Factors and number 2 in Health Outcomes. This is an improvement from our 2013 CHNA which reported health outcomes at number 8. Health Behaviors are ranked at 2, an improvement from number 3. Approximately 10% of the population is uninsured, compared to 12% in NYS; this is an improvement from 12% reported in 2013. Primary care physician rates continue to be solid – about 680 patients to one doctor, compared to 1,200 patients to one doctor in NYS.<sup>4</sup>

## II. THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

The following is a summary of the assessment process that was conducted by the Long Island Population Health Improvement Program (LIPHIP). The assessment was conducted throughout both Nassau and Suffolk counties. For the purposes of this report, we will only include data from Nassau County. Complete results of the assessment can be found at [www.lihealthcollab.org/data-resources.aspx](http://www.lihealthcollab.org/data-resources.aspx)

The LIPHIP, which led the assessment, is organized by the Nassau-Suffolk Hospital Council (NSHC), the membership association for all hospitals on Long Island. The staff is comprised of a Senior Director, Program Manager, Data Analyst, and Communications Specialist. This team provided administration, consensus-building, collection, reporting and analysis of data. Public health officials from the Nassau County Department of Health and Suffolk County Department of Health, along with representatives from all hospitals located on Long Island, appointed the LIPHIP as the workgroup lead for collecting data to propel the Community Health Needs Assessment Cycle 2016-2018.

The strategy for the assessment was developed by the following individuals who were Advisory Committee Members and Program Facilitators:

- Harriet Gourdine-Adams, Chief Officer for Care Coordination, Tri Care Systems DBA LIAAC
- Celina Cabello, Epidemiologist, Nassau County Department of Health
- Laurel Janssen-Breen\*, Associate Professor, Assistant Chair, Department of Nursing, St. Joseph’s College
- Tavora Buchman, Director, Quality Improvement, Epidemiology and Research, Director, Tuberculosis Control, Nassau County Department of Health
- Elizabeth Cohn, Director, Center for Health Innovation, Adelphi University

---

<sup>3</sup> Nassau Queens PPS Community Need Assessment, December 2014, pg. 3

<sup>4</sup> <http://www.countyhealthrankings.org/app/new-york/2016/rankings/nassau/county/outcomes/overall/snapshot>

- Nancy Copperman, Assistant Vice President, Public Health and Community Partnerships, Strategic Planning, Northwell Health, Nassau-Queens PPS
- Linda Efferen, Medical Director, Suffolk Care Collaborative
- Amy Hammock\*, Assistant Professor, Department of Family, Population and Preventative Medicine, Stony Brook Medicine
- Chris Hendriks, Vice President, Public & External Affairs, Catholic Health Services of Long Island
- Grace Kelly Mc-Govern, Public Relations Director, Suffolk County Department of Health
- John J. Perkins Jr. EPIC Physician Co-Champion, St. Charles Hospital Rehabilitation Liaison
- Matt Tannenbaum, Nutrition Intern, Northwell Health
- Karen Tripmacher, Director, Community Education and Health Benefit, Winthrop University Hospital
- Althea Williams, Senior Manager, Provider and Community Engagement, Suffolk Care Collaborative

LIHC member organizations, Adelphi University and St. Joseph’s College provided meeting space and served as the host for the summit events for community-based organizations.

\* Amy Hammock and Laurel Janssen-Breen hold expertise in facilitation skills and qualitative analysis, serving as valuable key-leaders during the facilitator training for LIHC members.

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey, qualitative data from the Nassau County Community-Based Organization Summit Event, and the LIHC Wellness survey. Secondary, publicly-available data sets have been reviewed to determine change in health status and emerging issues within Nassau County. Sources of secondary data include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), NYS Cancer Registry, and New York State Vital Statistics.

## **INITIAL DATA FINDINGS**

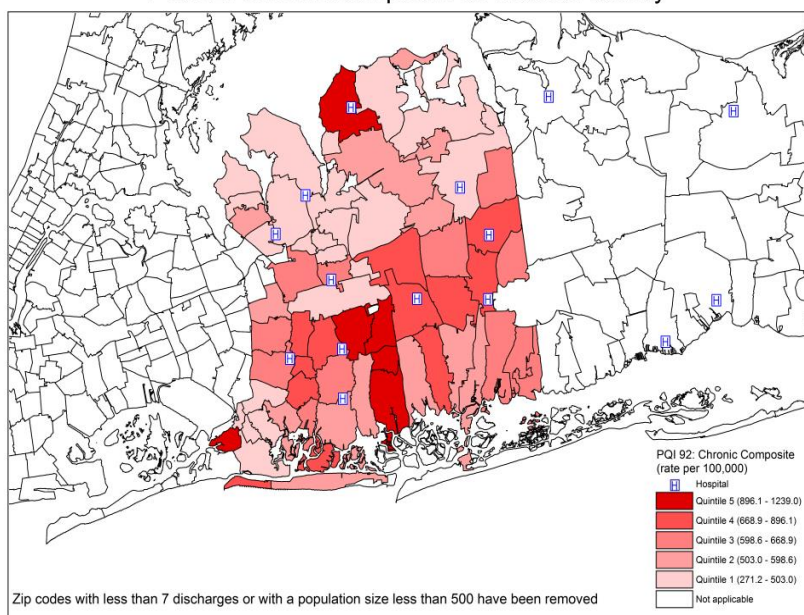
### *Prevention Quality Indicators*

Prevention Quality Indicators (PQI), are defined by the Agency for Health Research and Quality\* (AHRQ) and can be useful when examining preventable admissions. Using SPARCS data, the LIPHIP created a visual representation of preventable admissions related to Chronic Disease at the zip code level.

PQI 92 is defined as a composite of chronic conditions per 100,000 adult population. Conditions, identified by ICD-9 code, included in PQI 92 are: Short and long-term complications, Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, Heart Failure, Angina, Uncontrolled Diabetes and Lower-Extremity Amputations among patients with Diabetes.



PQI 92: Chronic Composite for Nassau County\*



\*COPD, Hypertension, Heart Failure, Asthma, and Diabetes: Short-Term, Long-Term, Uncontrolled Lower Extremity Amputation

The above map demonstrates the zip codes in Nassau County representing the most significant number of preventable cases per 100,000 adult population.\* Quintile 5 represents 896.1-1239.0 per 100,000 adult cases, and can be identified by dark red coloring. This quintile demonstrates within which zip codes the largest pockets of potentially preventable hospital visits related to chronic disease fall. As displayed within the PQI Chronic Composite for Nassau County, there is notable occurrence of Chronic Disease among a majority of communities, particularly those connected to low socioeconomic status. These zip codes are 11550 (Hempstead) and 11590 (Westbury), two communities within Winthrop’s Core Service Area A that experience health disparities.

\*Source: Agency for Healthcare Research and Quality-Prevention Indicators/www.qualityindicators.ahrq.gov/modeules/pqu\_resources.aspx)

### *Prevention Agenda Dashboard*

The Prevention Agenda 2013-2018 is New York State’s Health Improvement Plan designed to improve health outcomes and reduce health disparities within five public health priority areas: Chronic Disease Prevention, Healthy and Safe Environment, Prevention of HIV/STD, Vaccine Preventable Disease and Health-care Associated Infections, Promote Health Women, Infants and Children, and Promote Mental Health and Prevent Substance Abuse.

The New York State Prevention Agenda Dashboard is an interactive visual presentation of the most recent Prevention Agenda tracking indicator data at state and county levels. It serves as a

key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2018 objectives.

Within the Dashboard, review of 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System demonstrates that 19.8% of adults in Nassau County are obese. Although obesity rates in Nassau are lower than New York State, obesity remains an issue that is closely related to chronic conditions including heart disease, stroke, type 2 diabetes, and other leading causes of preventable conditions highlighted above in PQI 92, the Chronic Disease Composite for Nassau County.

### **III. COMMUNITY INPUT**

To collect input from community members and measure the community perspective as to the biggest health issues in Nassau County, the LIHC developed a regional survey called the Long Island Community Health Assessment Survey. It was translated into certified Spanish language and large print copies were available to those living with vision impairment. Distribution and promotion of this survey occurred throughout a wide range of social service locations including hospital websites and educational programs, social media outlets, doctor's offices, health departments, libraries, schools, insurance enrollment sites, community-based organizations, and more. These surveys were available online and in paper format. The survey is available in Appendix 1.

The broad interests of the community are also reflected in the second part of the assessment which was accomplished qualitatively, through a facilitated summit of community-based organizations (CBOs) that occurred on February 2, 2016. Representatives from CBOs shared valuable information about the health issues faced by their clients, barriers to care and other issues recognized as the social determinants of health -- citing poverty, housing, job losses and food insecurities as problematic. The community-based organizations who participated in the summit are listed under the Summit Event description in the Methodology section below.

### **METHODOLOGY**

#### ***INDIVIDUAL SURVEYS***

Surveys were distributed by LIHC members and were collected between January and November 1, 2016. Nassau County had a total of 2,335 respondents, which means our responses have a confidence level of 95% and a confidence interval of 2.03. We had a response of 672 surveys from select communities, meaning a confidence interval of 3.78 with a confidence level of 95%. These values are based on the 2010 census for Nassau County.

The following is a brief description of survey demographics:



- Gender – 72% Female, 28% male
- Household income – 50% over \$75,000; 16.5% \$50,000-\$74,999; 13% \$20,000-\$34,999; 11% below \$19,999; 9.5% \$35,000-49,999
- Age – 27% over 65; 32% 55 – 64; 18% 45-54; 13% 35-44; 14% 25-34; 6% 18-24
- 11% self-employed;
- Insurance – 92% Insured; 8% Uninsured
- Race – 77% White/Caucasian (18.2% identified as Hispanic or Latino); 13% African American; 7% Asian, 3% Multi-racial\*
- Education – 57% College graduate or above; 21% some college or technical school; 16% high school graduate; 6% some high school or below

Surveys were distributed by paper and electronically through Survey Monkey to community members. The electronic version placed rules on certain questions; for questions 1-5 an individual could select 3 choices and each question was mandatory. Although the rules were written on the paper survey, people did not follow them. The paper surveys were sorted into a “rules” and “no rules” pile. The “rules” surveys were entered into the Survey Monkey collector while the “no rules” were entered into a separate, closed survey where any number of answers could be selected and others could be skipped.

#### **Analysis Results:**

1. When asked ***what the biggest ongoing health concerns in the community where you live:***
  - Nassau County Respondents felt that Cancer, Drug and Alcohol Abuse and Obesity/Weight Loss were the top three concerns.
    - In Nassau, these three choices represented 43% of the total responses.
    - Select communities cited Cancer, Diabetes and Drug and Alcohol Abuse. This represented 40% of the total responses.
2. When asked ***what the biggest ongoing health concerns for yourself:***
  - Nassau County respondents felt that Heart Disease and Stroke, Cancer, and Obesity/Weight Loss were the top three concerns.
    - In Nassau, these three choices represented roughly 43% of the total responses.
    - Select communities cited obesity/weight loss, diabetes and Cancer as top concerns, accounting for 39% of the total responses.

3. The next question sought to **identify potential barriers that people face when getting medical treatment:**
  - Nassau County respondents felt that No Insurance, being Unable to Pay Co-pays or Deductibles, and Fear were the most significant barriers.
    - These choices received roughly 55% of the total responses in Nassau.
  - Select communities identified No Insurance, being Unable to Pay Co-pays or Deductibles, and being unable to understand the need to see a doctor as significant. This accounted for 54.8% of responses.
  
4. When asked **what was most needed to improve the health of your community:**
  - Healthier Food Choices, Clean Air & Water, and Weight Loss Programs were chosen by Nassau County community members, accounting for 42% of the total responses.
    - Healthier food choices, Job Opportunities, and Clean Air & Water were top concerns for select communities, accounting for 38.37% of the total responses.
  
5. For the final question, people were asked **what health screenings or education services are needed in your community:**
  - Nassau County respondents felt that the Blood Pressure, Cancer, and Diabetes, services were most needed, representing 27% of the total respondents.
    - Select communities cited Diabetes, Blood Pressure and Nutrition, representing 27% of the responses.

Questions 1 & 2 helped determine the highest area of concern for community residents. Chronic Disease was a highly rated in both Nassau County and the select communities, so this quickly identified as a significant health need.

Questions 3, 4 & 5 addressed factors related to the social determinants of health, and were helpful in guiding the summit questions.

#### **SUMMIT EVENT**

To measure professional expertise from representatives working directly within the community setting, the LIPHIP planned the Nassau County summit event during which qualitative data was collected. Representatives from a comprehensive network of organizations were invited to participate during the events. Participating organizations emphasized the importance of an

opportunity to network and share expertise among counterpart agencies as a value-added benefit during events.

### *Summary of Event Details*

- Facilitated discussion format
- NYS Prevention Agenda – framework for project development and analysis
- Included high-priority concerns related to health equity, disparities and barriers to care
- Primary data collection tool - a script
- Court reporters captured conversations
- ATLAS TI qualitative Data software used to guide and structure analysis process

Data collected during facilitated discussion summit events was analyzed, interpreted and is presented under the *Summary of Findings* section below. Aspects covered include identifying priority areas according to the New York State Department of Health Prevention Agenda 2013-2017, reoccurring themes outside of the Prevention Agenda parameters, health disparities, barriers to care, and novel recommendations for improving services and programs.

### *Event Planning and Structure*

Two members of the Advisory Committee participated as key leaders, selected due to their extensive background in qualitative research and facilitation skills. These key leaders, Dr. Laurel Janssen-Breen, Associate Professor, St. Joseph's College and Amy Hammock, Assistant Professor, Stony Brook University, presented an interactive, hands-on curriculum and training for LIHC members who volunteered to take the role of facilitators during the events.

Seating assignment of participants at facilitated discussion tables was randomized, with seven to 12 participants seated at a table. After permission was granted by participants, they were guided through scripted-facilitated discussion by a trained facilitator. Discussions were recorded and transcribed by certified court reporters.

### *Data Collection Tool*

A script for facilitators was developed and used as our primary data collection tool. Adapted from the Nassau County Department of Health's Key Informant Interview script in 2013, this tool was revised to meet a facilitated discussion format. Questions were composed to evoke an inherent response at first and then expanded upon to encourage digging deeper to obtain a more focused response. Questions pertained to health problems and concerns, health disparities, barriers to care, available services, and opportunities for improvement. A copy of the script is available in Appendix 2.

Court reporters were positioned at each table during the event to accurately capture conversations. Post-event, transcripts were transcribed and provided in Microsoft Office Word document Format.

**The Nassau County Summit Event was hosted by Adelphi University, Garden City, NY, on February 2, 2016.** The following is a list of organizations who participated in the summit. This list encompasses community-based organizations who represent low-income, minority populations or medically underserved individuals.

<b>Organization</b>	<b>Title of Participating Representative</b>
<b>Adelphi University, Health Studies, School of Education</b> Garden City, NY	1. Program Director and Associate Professor, Health Studies 2. Assistant Professor
<b>Adelphi University, Breast Cancer Hotline and Support Program</b> Garden City, NY	1. Director 2. Bilingual Outreach Coordinator
<b>American Red Cross</b> New York, NY	1. Disaster Health Services Regional Advisor
<b>Angela's House</b> Hauppauge, NY	1. Supervisor of Case Management
<b>Coordinating Agency for Spanish Americans (CASA)</b> Hempstead, NY	1. Administrative Aide
<b>Catholic Health Services of Long Island Catholic Home Care, Good Shepherd Hospice</b> Farmingdale, NY	1. Account Manager
<b>Coloki Inc. The Freeport Trailer</b> Merrick, NY	1. Executive Director
<b>Community Care HHS</b> Hicksville, NY	1. Account Executive 2. Public Relations Representative
<b>Cornell Cooperative Extension</b> Jericho, NY	1. Regional Program Director 2. Nutrition Educator (2)
<b>Docs for Tots</b> Melville, NY	1. Project Director
<b>EAC Network</b> Hempstead, NY	1. Division Director
<b>The Epilepsy Foundation of Long Island, a Division of EPIC Long Island</b> East Meadow, NY	1. Community Education Coordinator
<b>Family and Children's Association</b> Mineola, NY	1. Vice President and Chief Operating Officer 2. Assistant Vice President, Senior Programs 3. Assistant Vice President, Preventive Services
<b>Family First Home Companions</b> Bohemia, NY	1. Director of Marketing

<b>Fidelis Care</b> Westbury, NY	1. Community Relations Specialist
<b>Girls Incorporated of Long Island</b> Deer Park, NY	1. Operations Manager
<b>Hispanic Counseling Center</b> Hempstead, NY	1. Therapist
<b>LI Cares</b> Hauppauge, NY	1. Nutrition Resource Manager 2. Chief Network Officer
<b>Life Trusts</b> Cedarhurst, NY	1. Trust Outreach
<b>Long Island Crisis Center</b> Bellmore, NY	1. Supervising Social Worker
<b>Memory &amp; Music</b> Mineola, NY	1. Northeast Regional Director
<b>Mental Health Association of Nassau County</b> Hempstead, NY	1. Community Health Educator 2. Director of Education and Training
<b>MOMMAS House</b> Wantagh, NY	1. Executive Director
<b>National Aging in Place Council</b> Long Island, NY	1. CEO, The Crisis Planner
<b>Nassau University Medical Center</b> <i>Federally Qualified Health Center</i> East Meadow, NY	1. Community Outreach Coordinator (2)
<b>Nassau University Medical Center</b> <i>Pediatric Specialty Clinic</i> East Meadow, NY	1. MD, PGY-3
<b>New York City Poison Control Center</b> New York, NY	1. Health Educator
<b>Department of Services for the Aging</b> <i>North Hempstead's Project Independence</i> Town of North Hempstead, NY	1. Deputy Commissioner
<b>Northwell Health Long Island Jewish Medical Center,</b> <i>Reproductive Health Education Center</i> New Hyde Park, NY	1. Health Educator
<b>Northwell Health Glen Cove Hospital,</b> <i>Family Medicine Ambulatory Care Center</i> Glen Cove, NY	1. Outreach Coordinator
<b>Options for Community Living, Inc.</b> Smithtown, NY	1. Executive Director
<b>Planned Parenthood of Nassau County</b> Hempstead, NY	1. Sexuality Educator 2. Family Planning Benefits Coordinator
<b>PULSE of Long Island</b> Wantagh, NY	1. President
<b>Right at Home Long Island,</b> <i>Homecare &amp; Assistance</i> Hicksville, NY	1. Owner
<b>Society of St. Vincent de Paul</b>	1. Program Support Associate

Bethpage, NY	
<b>The American Cancer Society</b> Hauppauge, NY	1. Health Systems Manager, Primary Care
<b>United Way of Long Island</b> Deer Park, NY	1. Vice President, Community Impact
<b>Utopia Homecare</b> Kings Park, NY	1. Certified Senior Advisor, Age in Place Specialist

## Summary of Findings

### *Data Analysis*

ATLAS TI Qualitative Data Analysis software was used to guide and structure analysis process. Members of the Qualitative Analysis team discussed strategy and logistics of project from beginning to completion of report. Alyssa Dahl, Principal Research Analyst, served as the lead analyst on the project, during which she offered expertise on strategy, direction, running qualitative data through Atlas TI software, producing meaningful synthesis of data elements and assisting in the description of the team’s methodology. The complete team is:

### *Analysis team:*

- Dr. Laurel Janssen-Breen, Associate Professor Assistant Chair, St. Joseph’s College
- Michael Corcoran, Data Analyst, Population Health Improvement Program
- Alyssa Dahl, Principal Research Analyst, Data Gen Healthcare Analytics
- Janine Logan, Senior Director, Nassau-Suffolk Hospital Council, Population Health Improvement Program
- Kate McCale, Director of Quality and Education, Rochester Regional Healthcare Association, Nassau-Suffolk Hospital Council
- Sarah Ravenhall, Program Manager, Population Health Improvement Program
- Kim Whitehead, Communications Specialist, Population Health Improvement Program

The *Distinct* and *Cumulative* Prevention Areas by ranking tables, displayed below, outline the New York State Prevention Agenda Priority Areas ranked in order from highest to lowest rate of marked significance of concern among participants.

**Summit participants reported Chronic Disease as the most significant health problem seen within the communities they serve in Nassau County.** In looking at distinct Prevention Agenda Categories, 26.1% of quotations indicated Chronic Disease being a priority area. Cumulatively 42.5% of quotations in Nassau were identified as being inclusive of one or more Chronic Disease keywords.

Within the Chronic Disease Priority Area, ***Chronic Disease Management*** and ***Obesity/Nutrition*** were the most frequently mentioned focal areas. Of the total number of quotes by County, 10.2% of quotations included “Chronic Disease Management” as a topic of importance. Obesity/Nutrition was a focal area of 9.8% in Nassau.



**Mental Health and Substance Abuse** emerged closely as a second-ranking Priority Area. Analysis shows 2.1% quotations in Nassau indicate Mental Health as a priority. Cumulatively, 36.9% of the total number of quotes included Mental Health and Substance Abuse as a priority area.

*Distinct Prevention Areas by Ranking*

Distinct Prevention Areas by Ranking reflects the number of quotations where the focus area is mentioned at least once and counted once, divided by the total number of Nassau County quotes.

Example of Quotation: “Chronic Disease is a problem for the community I serve. Many of our members are troubled with obesity and tobacco use.” This quote is coded once for chronic disease.

Rank	Nassau	%*
1	Chronic Disease	26.1%
2	Mental Health	23.0%
3	Healthy and Safe Environment	20.1%
4	Healthy Women, Infants and Children	19.1%
5	HIV, STD and Vaccine Preventable Disease and Health-Care Associated Infections	6.2%

\*Distinct number of quotations with Nassau County code and priority area code/total number of quotes applicable to Nassau County.

*Cumulative Prevention Areas by Ranking*

Cumulative Prevention Areas reflects the number of focus areas mentioned within one of the priority areas per quote, divided by the total number of Nassau County quotes.

Example of Quotation “Chronic Disease is a problem for the community I serve. Many of our members are trouble with obesity and tobacco use.” This quote is coded twice for Chronic Disease because obesity and tobacco use are two separate focus areas.

Rank	Nassau	%*
1	Chronic Disease	42.5%
2	Mental Health	36.9%
3	Healthy and Safe Environment	26.6%
4	Healthy Women, Infants and Children	24.9%
5	HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections	8.1%

\*Cumulative number of focus area quotations with Nassau county code and total number of quotes applicable to Nassau County.

Summit discussions also addressed disparities, barriers to care, and other social determinants of health. The following is a brief description of some of the highlights.

*Disparities* among the senior population were of high importance to summit participants, with 17% of quotations in Nassau County being coded under this topic. Other disparities included special population disparities, age, language, race, gender-identity-orientation disparities, and religious disparities.

*Barriers to care* were discussed frequently during the summit event, with a majority of conversation surrounding this topic. The top three emerging focus areas included: access, financial and insurance barriers. Access barriers included themes related to access to care, housing and transportation. Financial barriers included affordability, barriers to funding, financial burdens, pay scales and poverty. Insurance barriers include keywords related to emergency Medicaid, high deductibles, insurance policies, pending Medicaid, uninsured, undocumented, and copayments.

*Additional Services and Programs* -The summit also revealed additional services and programs needed to improve the health of Nassau County Residents. Four themes emerged: Service Expansion & Improvement, more Community and Bridging of Services, Policy and Financial assistance. Service Expansion & Improvement accounted for 21.4% of quotations addressed which included extended provide hours, screenings for social determinants of health, health literacy and more. Community and bridging services was mentioned in 13.1% of quotations. This included developing resource centers, family-centered advocacy and partnering with faith-based organizations.

For the complete report, please refer to the Appendix 3.

## **COLLABORATIVE DETERMINATION OF PRIORITIES**

Results of both the Key-Informant Interviews and the Individual Surveys were shared with the workgroup on March 22, 2016.

- Community-wide survey results:
  - Representative of demographics in the county
  - Obesity, Chronic Disease (Cancer, Cardiovascular Disease) and Mental Health emerged as priorities
- Summit Results
  - Chronic disease reported
  - Obesity ranked as a risk factor
  - Mental Health reported as important

Nassau County Attendees included:

Organization	Title
--------------	-------

Catholic Health Services	Vice President, Public and External Affairs.
LIPHIP	1. Data Analyst
Nassau County Department of Health	1. Epidemiologist
Nassau-Suffolk Hospital Council	1. Senior Director, Communications & Population Health 2. Program Manager – PHIP 3. Communication Specialist
Northwell Health	Assistant Vice President, Public Health and Community Partnerships
South Nassau Communities Hospital	Director of Education
St. Francis Hospital	Director, Rehabilitation & Community Services
Winthrop-University Hospital	Director, Community Education & Health Benefit

After discussion, it was determined that the following priorities and objects were identified as significant needs and that each hospital would address these issues by implementing their own programs. They are:

1. Preventive Care and Management of Chronic Disease in both Clinical and Community Settings
2. Reduce Obesity in Children and Adults
3. The group also agreed that Mental Health should be highlighted as an area of overlay within all intervention strategies

**RESULTS SHARED WITH WINTHROP’S COMMUNITY CULTURAL ADVISORY COMMITTEE**

Winthrop engaged local community partners in a discussion on August 5, 2016 to share the results of the assessment and discuss solutions. These results were also shared via e-mail with those who could not attend. This group of partners, Winthrop’s Community Cultural Advisory Committee, represents local communities who are low-income, have minority populations, and who experience health disparities. Concerns and possible ways to address needs were also discussed at the following two meetings with our local partners on September 30 and December 1, 2016.

- Discussions determined that obesity and knowledge about chronic disease prevention/management are the most crucial conditions to be addressed – in particular, asthma and diabetes
- Concerns were also raised about mental health issues, drugs and alcohol abuse
- During all discussions, it was agreed that Winthrop needs to go into the community, during weekends or other appropriate times when the underserved are available. Our partners

believed that educational classes would be attended by members of the community, if held at appropriate times

- Participating agencies offered to partner with us to provide space to offer classes on chronic disease management

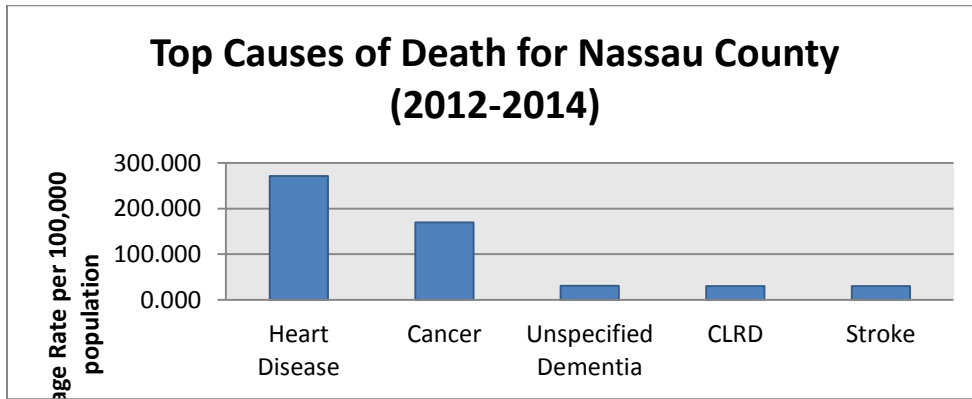
Members of Winthrop’s Community Cultural Advisory Committee:

<b>Agency</b>	<b>Representative</b>
CASA Nassau County Coordinating Agency for Spanish Americans	Administrative Aide
Community Physician	Hempstead Location
Cornell University Cooperative Extension Nassau County	Nutrition Program Director
EOC of Nassau County, Inc.	Program Director, Head Start Director, Family Development Center
Girl Scouts of Nassau County, Inc.	Fund Development Officer
Hempstead Hispanic Civic Association, Inc.	Executive Director
Hempstead NAACP AHEAD Foundation	Community Advocate
Hispanic Brotherhood of Rockville Centre	1. Executive Director 2. Co-Director
Hispanic Counseling Center	CEO Program Coordinator
LI Asthma Coalition	Director
LI Minority Aids Coalition	CEO
Nassau BOCES	Teen & Parenting Program
Nassau County Department of Health	Commissioner
Nassau County Perinatal Services	Educator
North Shore Child & Family Guidance	Director of the Leeds Place
Noticia (Hispanic newspaper)	Publisher
Project Independence	Deputy Commissions, Dept. of Services for the Aging, Town of North Hempstead
SHIP/AHEC	Community Advocate
St. Brigid’s Casa Mary Johanna	Immigration Ministry Representative

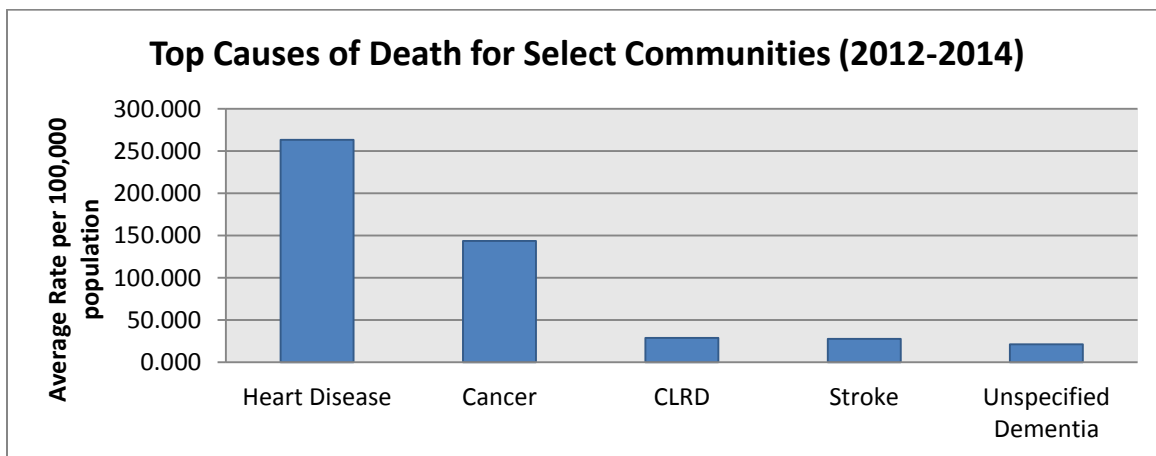
#### **IV. PRIORITIZED SIGNIFICANT COMMUNITY HEALTH ISSUES**

In addition to the collaborative assessment which identified the prevalence of preventable hospital admissions and the concerns of the community, Winthrop reviewed the top causes of death in Nassau County from 2012 – 2014 (see below). They were: heart disease, cancer,

unspecified dementia, CLRD (chronic lower respiratory disease, i.e., asthma, COPD), and stroke. This is slightly different from our CHNA of 2013, with the inclusion of a new cause – unspecified dementia.



The top causes of death in Nassau County in select communities during the same time period were slightly different (see below). They were heart disease, cancer, CLRD, stroke and unspecified dementia.

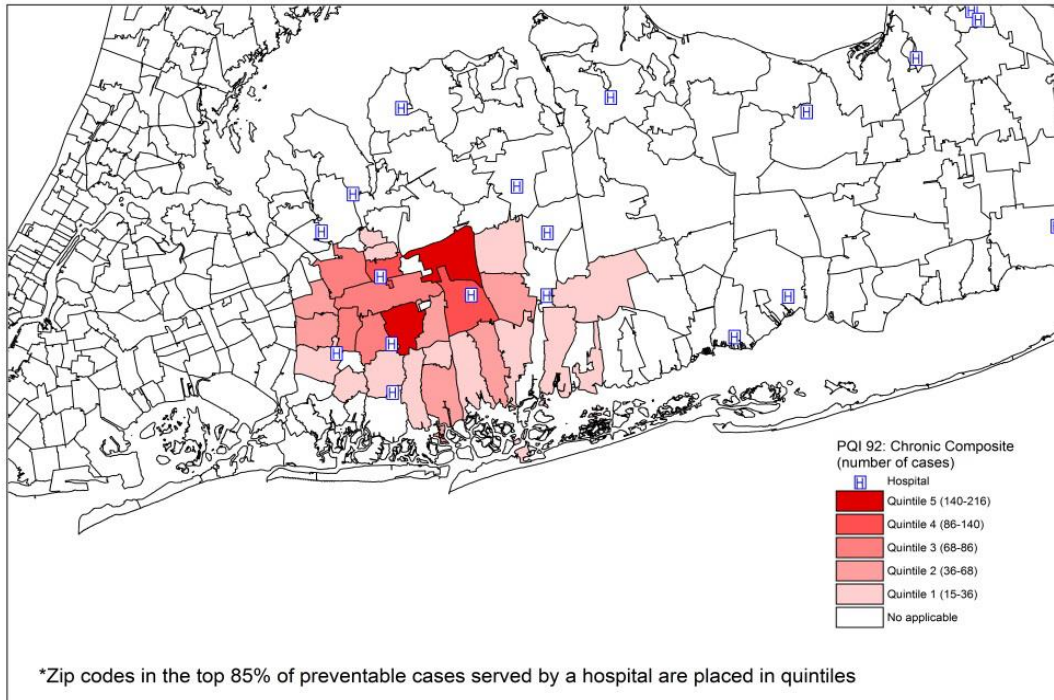


These statistics support the concerns that emerged during our assessment. The health conditions cited as the leading cause of death are categorized as chronic conditions and obesity is widely identified as a contributing risk factor. According to the Center for Disease Control, chronic diseases are responsible for 7 of 10 deaths each year, and treating people with chronic disease accounts for 86% of our nation’s health care costs.<sup>5</sup>

<sup>5</sup> <https://www.cdc.gov/chronicdisease/>

Winthrop also reviewed the map below (PQI 92), created based on SPARCS data from Winthrop, which demonstrates that the highest rates of preventable admissions came from Hempstead and Westbury, two select communities that are within our core Service Area A. This finding emphasized the need for the prevention and management of disease in these zip codes that are in close proximity to the Hospital.

PQI 92: Chronic Composite for Winthrop-University Hospital\*



\*COPD, Hypertension, Heart Failure, Asthma, and Diabetes: Short-Term, Long-Term, Uncontrolled Lower Extremity Amputation

Note: Highest rates – Hempstead & Westbury

In addition to the significant needs identified by collaborative partners citing the prevention and management of chronic disease, reducing obesity and addressing mental health and substance abuse, Winthrop determined the following additional areas of need:

- Cancer Prevention/Awareness – Cited as a top concern among community members; education is needed about prevention and screening.
- Healthy & Safe Environment – Ranked as the third concern in both the community survey and summit. One of the aspects of this category is fall prevention. The CDC cites falls as costly and a leading cause of death and disability.<sup>6</sup> The Prevention Agenda Dashboard also identified the rate of hospitalizations due to falls per 10,000 seniors aged, 65+ as 222.5 According to SPARCS data as of January, 2016, there is no significant change, therefore, intervention is still needed.

<sup>6</sup> <https://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html>



[https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?\\_program=/EBI/P/HIG/apps/dashboard/pa\\_dashboard](https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/P/HIG/apps/dashboard/pa_dashboard)

- Women and children’s health – The category of Healthy Women, Infants and Children was highlighted during the summit and in the surveys. Children’s health issues were inclusive of well child visits; child neglect; safe childcare options; developmental delays and dental problems for children. “Maternity/Mother” covers issues related to breastfeeding; reproductive care; young mother’s and utilization of preventive health services for mothers.

## **PRIORITIZATION**

The following criteria were utilized in determining the prioritization of needs:

- SPARCS data (201-12-2014), NYSODH Vital Statistics, NYS Cancer Registry and the NYSDOH Surveillance System
- Winthrop’s Admissions Data, in particular PQI (Prevention Quality Indicators)
- The severity of the public health need
- Perceptions of the community identified in community survey & CBO Summit
- Resources – both hospital and community-based
- Health disparities within our core market area
- New York State Prevention Agenda priorities
- Priorities of Healthy People 2020

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.

## **RANKING**

1. Prevention and management of chronic disease
2. Reduce obesity in children and adults
3. Cancer Prevention & Screening
4. Healthy & Safe Environment (Fall Prevention)
5. Mental Health and Substance Abuse
6. Women & Children’s Health

## **V. POTENTIALLY AVAILABLE RESOURCES**

In addition to the resources that Winthrop is planning to commit, such as staffing, space and materials, Nassau County has a number of available resources to help meet community needs. Our County boasts 12 hospitals (including Winthrop), an adequate number of primary care physicians, five federally qualified health care centers in areas of high need, and numerous community-based organizations. Community members can access resources at [www.hitesite.org/](http://www.hitesite.org/), [www.211.org/](http://www.211.org/) and of course, at <https://www.winthrop.org/community-programs>

During this assessment, the collaborative effort also identified a number of potentially available resources that are posted on our website and are identified as Appendix 4.

## **VI. EVALUATION OF IMPACT**

Our CHNA of 2013 identified the same priorities as our current assessment, specifically prevention and management of chronic disease, obesity, fall prevention, and women and children's health. The following is a brief description of Winthrop's actions that were taken to address the most significant health needs identified in our prior CHNA.

As mentioned earlier in the introduction, these health concerns are also being addressed by hospital community partners in the Long Island Health Collaborative. By using the collective impact model to enhance the quality of work being pursued in Population Health efforts, it is hoped that public awareness and education will help motivate individuals to make the changes necessary to develop a healthy lifestyle and improve outcomes. Leading a healthy lifestyle (e.g., avoiding tobacco use, being physically active and eating well) reduces the risk for these diseases.

The following is a brief description of programs that were implemented and an evaluation of their impact.

### **PREVENTING CHRONIC DISEASE – NATIONAL DIABETES PREVENTION PROGRAM**

Winthrop offered the National Diabetes Prevention Program at no cost at the Diabetes Education Center. It is important to note that approximately 28% of participants were from communities with health disparities.

Participation involves a commitment for one year and includes classes held weekly during the first six months. It then transitions to every other week and then monthly during the second six months of the year.

During 2014, **Winthrop offered five new diabetes prevention classes during the day and evening that were staggered throughout the year. A total of 106 individuals participated.**

During 2015, **seven new diabetes prevention classes** were started. Classes offered in the day and evening were staggered throughout the year with two classes starting in the Winter, two classes in the Summer and three classes in the Fall. Participation totaled **254 individuals.**

Six new diabetes prevention classes were started in 2016 – a total of **242 individuals** participated in the Diabetes Prevention Program

Percentage of sessions with weight documented during months 1 to 12 100%

Percentage of sessions with physical activity documented during months 1 to 12. 70%

**Evaluation of Impact** - In 2016, we transitioned to completed QTAC participant satisfaction surveys.

Results are as follows:

*Months 1 to 6 – 25 surveys*

*Months 7 to 12 – 21 surveys*

<b><i>I know more about lifestyle changes like diet and exercise that are recommended for my health condition.</i></b>		
Months 1-6 Participant Satisfaction Survey	84% strongly agree	16% agree
Months 7-12 Participant Satisfaction Survey	95% strongly agree	5% agree

<b><i>I have been able to maintain the lifestyle changes for my health that I have made.</i></b>			
Months 1-6 Participant Satisfaction Survey	52% strongly agree	48% agree	
Months 7-12 Participant Satisfaction Survey	62% strongly agree	29% agree	9% disagree

<b><i>I now have a better understanding of how to manage my health and/or physical activity.</i></b>		
Months 1-6 Participant Satisfaction Survey	80% strongly agree	20% agree
Months 7-12 Participant Satisfaction Survey	86% strongly agree	14% agree

In addition to the above statistics, during 2015 one group found the support so helpful that they decided to continue their group on their own after the class ended. They named themselves the “DiaBEATers,” and get together regularly to exchange healthy recipes, enjoy a healthy meal out or even take a tour of a local grocery store to learn about nutritious food options. They feel it helps them stay “focused and motivated.”

## **ASTHMA**

To reduce pediatric hospital admissions from asthma, Winthrop partnered with the Long Island Asthma Coalition in 2013 to implement the BREATHE program: **B**ringing **R**esources for **E**ffective **A**sthma **T**reatment through **H**ealth **E**ducation. The initial population of focus was children in the Hempstead Pediatric Clinic – a community with health disparities that showed the area of highest need. Children having emergency department visits or being admitted to the hospital were followed by Home care nurses, who assessed homes for asthma triggers and taught families about asthma management. This is now expanded to all asthma ER visits or hospital admissions for children in Nassau County. Referrals to the program come from doctor's offices, the ER or in-patient hospital admissions.

**Evaluation of Impact** - Initial aim was to reduce asthma emergency department visits and hospitalizations by 25% in one year. BREATHE Winthrop Outcomes – Pediatric Patients Admitted May 2013 to April 2014, a reduction of 89% in hospitalizations – which surpassed expectations. The program is continuing.

## **OBESITY – NUTRITION AND HEALTHY WEIGHT**

The identification and counseling of children who are obese (BMI  $\geq$ 95%) was implemented in 2013 in the WUH Hempstead Pediatric Clinic, an area suffering health disparities. The Clinic utilizes the 5-2-1-0 program as a way of teaching parents and children a healthy lifestyle. The plan incorporates five servings of fruits and vegetables, no more than two hours of screen time (including TV and IPADS), one hour of exercise and zero sugary drinks. The objective is to teach children the basics of a healthy lifestyle; the intended goal is to achieve a long-term positive impact on their health.

Through this program, primary care providers are encouraged to consistently document Body Mass Index (BMI), provide lifestyle counseling, and develop individual care plans and follow-up measures.

Parents whose children are obese (BMI  $\geq$ 95%) are asked to bring their child back within three months for a follow-up visit. Children nine years old and over who are still obese (BMI  $\geq$ 95%) are sent for lab work which includes cholesterol and liver function testing. Children with abnormal results are then referred to an endocrinologist or a gastroenterologist.

Original tracking measures identified in the 2013 plan were to “increase the number of care plans and obesity folders distributed to 25%.” An evaluation of tracking methods in 2014 determined a more effective measure: “Documentation of counseling rate and follow-up rate.” During 2015, the tracking measure was revised to “documentation of counseling rate” as we lacked resources to continue the follow-up mailings.

During 2014, the counseling documentation rate was 96%; up 17% from 2013. Follow-up rate with parents = 30%; 14% increase from 2013.

During 2015, counseling documentation rate was 91%; 5% drop due to staffing.

During 2016, counseling documentation rate was 90%.

**Evaluation of Impact** – Obesity rates continue to rise. Winthrop will continue the program, but will include a no-juice campaign, documenting the counseling rate for parents of toddlers and “no juice. Since a number of four-year-olds are obese, It is hoped that early intervention via counseling at six months of age will help reduce the rate of obesity in children.

### **PREVENT CHILDHOOD OBESITY THROUGH EARLY CHILD-CARE AND SCHOOLS -**

During 2014, Winthrop collaborated with the Head Start communities located in Hempstead and Westbury to bring the 5-2-1-0 program to their families. The plan included giving each child a packet of information about the program to share with their parents, documenting BMI's and providing nutritional counseling for families of children identified as having an unhealthy weight. The healthy lifestyle program was introduced at Head Start parent meetings.

During 2015, agreements were in place with Head Start and Winthrop, detailing the program and objectives. Plans were revised to invite **all** parents to participate in a workshop that would offer nutritional counseling and support to parents of children who are identified as having BMIs that are considered “high” or “very high.”

The program was implemented in 2016. Each child received a packet of information about the program, including sheets where they track their food and activity level by coloring in the appropriate boxes. To date, 238 children were measured in Hempstead and 16.5% were in the high range; 18.9% in the very high range. In Westbury, 212 children were measured; 15.5% of children were in the high range and 19.3% were in the very high range.

**Evaluation of Impact** – This is a new intervention. Administrators at both Hempstead and Westbury locations have praised the partnership and would like us to expand to other Head Start locations. More parental “buy-in” is needed. Although we offered nutritional counseling in the form of support groups, parents did not respond. Going forward, we hope to attend parent meetings in the spring and fall to explain the program more fully and encourage participation.

## **PROMOTE EXCLUSIVE BREASTFEEDING**

Since breastfed infants are less likely to develop medical problems such as childhood obesity, respiratory and gastrointestinal infections and are at lower risk for childhood cancers, asthma and Sudden Infant Death Syndrome (SIDS), a strategy identified in 2013 was to achieve Baby Friendly Designation and improve percentage of newborns who only receive breast milk when discharged from the Hospital.

In 2014, Winthrop was awarded Baby-Friendly Designation by Baby-Friendly, USA; 45% of babies were only receiving breast milk when discharged from Winthrop, an increase of 5% from 2013. During 2015, 47% of babies were only receiving breast milk when discharged; during 2016, 50% of babies were only receiving breast milk when discharged from Winthrop.

**Evaluation of Impact** – In addition to the above, Winthrop offers a breastfeeding support group, led by a lactation consultant. Over 110 different women attended the support group during 2016.

## **NUTRITION AND HEALTHY WEIGHT (OBESITY) -CHRONIC CONDITIONS**

### **PROMOTE CHRONIC DISEASE SELF-MANAGEMENT AND PREVENT OBESITY**

In the 2013 CHNA, Winthrop created and implemented “Active Living,” A four-part free-of-charge series that addresses chronic condition management and the benefits of a healthy lifestyle through nutrition, exercise and stress management.

During 2014, Winthrop implemented three pilot sessions at the Hospital’s Welcome Center; **63 people attended three sessions**. In 2015, the program expanded into the community. Two four-week sessions were held at the Hospital’s Welcome Center and one was held at the Yes We Can Center in Westbury, a community with health disparities. One more was held at the Westbury Library. A total of **64 people attended four sessions**. Due to limited resources of staff and space, we were only able to offer one program during 2016.

**Evaluation of Impact** – Participants are given a Wellness Survey, both pre- and post-program. Based on results, the Active Living program is influencing the health behaviors of its participants in a positive way. To start, more than 75% of the participants completed at least 3 of the 4 parts. After attending the program, no matter how many parts of the series were completed, the participants scored 10% more positive on the Nutrition section and nearly 7% on the Exercise section. We have recently hired a new community nurse educator and look forward to holding more sessions in the future.



## **HEALTHY & SAFE ENVIRONMENT - FALL PREVENTION**

Winthrop's robust Fall Prevention Program for seniors includes a beginner four-part fall prevention workshop, followed by exercise classes to improve balance, flexibility and strength.

A total of **69 beginner workshop, four-week series** were held during 2014, 2015 and 2016. Forty-seven of these were held at the Hospital's Welcome Center, and 22 were held at out in the community. A total of 810 individuals participated in these classes.

**Evaluation of Impact** – Participants fill in post-satisfaction forms. They acknowledge that the classes have given them more confidence, make them more aware of their posture, have made modifications at home, see the eye doctor once a year, and review their medications. Feedback from the workshops inspired Winthrop to develop the exercise classes as a reinforcement to improve balance, flexibility and strength. Since their inception, approximately 140 follow-up exercise classes have been held. People noticed that the program helped create an awareness of what to do to prevent a fall.

**TAI CHI FOR ARTHRITIS** – evidenced-based for arthritis and fall prevention, it is also proven to be an excellent strategy to relieve stress and improve mental health. Winthrop implemented this eight-week twice-a-week program in January of 2016. 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. Approximately 200 people have participated.

**Evaluation of Impact** – The response to the program has been tremendous, with community members calling and requesting classes. Anonymous post-evaluation forms are collected as part of the program and submitted to QTAC-NY (Quality & Technical Assistance Center of NY) for evaluation. Here is a summary of the report:

- 93% of participants experienced a reduced fear of falling.
- 90% would recommend the program to a friend or relative
- 89% continued to do exercises they learned in the program
- 53% reported that they are "very sure" they can become steadier on their feet. Another 50% feel sure they

*Follow-Up Workshop Participant Evaluation* – In addition to the above, Winthrop distributes a post-satisfaction form to individuals who return for the "refresher" portion of the workshop. This form collects information regarding the impact the program has on participants over a longer period. The following is a short summary:

- 75% indicated that they felt more self-confident performing daily activities
- 72.3% indicated that they were stronger and more flexible
- 68.4% indicated that their balance improved
- 67.1% indicated that their posture has improved.

## **WOMEN'S HEALTH**

Winthrop's **Women's Wellness Center in Hempstead** addresses the health disparities of this select community. They offer a wide variety of obstetrical and gynecological services, as well as on-site risk assessment, smoking cessation support, genetic counseling, nutritional counseling along with gestational diabetes education. Additional services include: psychosocial counseling, depression screening at each visit, postpartum depression screening and referrals, bereavement counseling, education on domestic relationship abuse/sexual abuse, assessment of living conditions and cultural diversity.

To meet the needs of the community, the site features a Medicaid Enrollment Specialist for uninsured patients; Charity Care Application and self-pay rates are available as well. They participate with NYS Medicaid and most Medicaid Managed Care HMO plans.

Evaluation of Impact - During 2016, the Center averaged 2200 **visits per month** with a total of 26,000 **encounters**. This is a 47% **increase** from 2015. **Financial services** department met with over 375 patients at the Center during this time period; this does not include those already enrolled in Medicaid services. There are more patients insured now; no appointment is needed for Medicaid enrollment.

#### **CHILDREN'S HEALTH SERVICES - ASTHMA**

**The Winthrop Hempstead Pediatric Clinic**, a Patient-Centered Medical Home since 2014, draws patients primarily from the Hempstead community but also serves children, from newborn to age 21, from the surrounding neighborhoods experiencing health disparities (Elmont, Freeport, Uniondale and Roosevelt). In 2015, a total of **17,481** patients were treated at the facility, **an increase of 6%** from 2014.

The practice focuses on four important conditions: obesity, asthma, 18-month well-check and the first month of life.

**Evaluation of Impact** - Statistics and quality monthly meetings review the impact of asthma education on the patient population.

**The Hempstead High School Health Center (HHHC)** is a school-based Health Center in a community with health disparities. During the end of the school year, June 2016, there were over **3,970** visits to the Center by approximately **1,304** students. Comprehensive preventive, episodic and confidential healthcare was provided. Winthrop includes specific programs needed by the school's population; asthma is a priority:

- An **Asthma Management Program** monitors and tracks students with asthma. It includes quarterly asthma workshops. This effort is particularly significant in

Hempstead, where asthma rates are nearly double those of adjacent neighborhoods. Both staff nurses in the HHHC are certified asthma educators. Collaboration with primary care physicians in the community facilitates treatment that meets current medical standards, trains high school nurses and staff about asthma, offers access to medications and assists with obtaining health insurance for uninsured students. There is a noticeable difference among students with asthma, in that fewer students are presenting at the clinic with difficulties.

## **VII. CONCLUSION**

Our assessment revealed that Nassau County continues to experience difficulties with obesity and chronic disease management, and that there is an increased need for mental health services. Communities with health disparities still exist. Because of this, Winthrop will continue to work with community partners to improve outcomes by stressing the importance of a healthy lifestyle, seeking appropriate clinical services and treatment, and improving access to care.