South Nassau®
COMMUNITIES HOSPITAL

Community Service Plan
Update 2018

South Nassau County CSP
2018 Update

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Priority	Focus Area	Goal	Objectives	Disparities	Interventions/ Strategies/Activities	Family of Measures	2018 Progress to Date	Implementation Partner (Please select one partner from the dropdown list per row)	Partner Role(s)	Strengths
Priority 1: Prevent Chronic Diseases: Reduce Obesity in Children and Adults	Reduce obesity in children and adults	~~Create community environments that promote and support healthy food and beverage choices and physical activity. Decrease the incidence of obesity in those communities identified as being at risk.~~	~~Engage community members in physical activity. Encourage all SNCH departments to promote this campaign with staff and patients.~~	Not addressing disparity	~~Encourage participation in the "Are You Ready, Feet?™ walking initiative. Rack cards and brochures to be distributed at community events. Refer the community to the website where lists of indoor/outdoor walking venues, walking clubs, and upcoming events are posted. Disseminate the walking initiative information at SNCH department meetings. Provide nutritional information on meals served in the employee cafeteria to support healthier choices.~~	~~Analysis of registration data by zip code. Evaluation of the food choices available to employees at the hospital cafeteria.~~	Zip code analysis of registration data in the hospital's catchment area does not indicate interest in participation via the website portal. Healthy food choices including vegan, vegetarian and mindful options are available in the employee cafeteria daily. However, it is not possible to determine how many healthy choices are consumed each week. **This program will be discontinued due to the reasons outlined above, however, the "Are You Ready, Feet?" brochures will continue to be be distributed at all community functions.**			
Priority 1: Prevent Chronic Diseases: Reduce Obesity in Children and Adults	Reduce obesity in children and adults	Decrease the incidence of obesity in school districts.	To increase consumption of fruits and vegetables and decrease intake of sugar and fat. To increase physical activity and decrease screen time.	Not addressing disparity	Conduct the "5-2-1-0 Numbers to Live By" program for school aged children in local schools. South Nassau's Family Medicine Center will monitor pediatric counseling regarding nutrition and physical activity and promote the 5-2-1-0 program.	Post-presentation survey questions were designed to address lesson content. Number of students educated Number of students who took the survey. Percentage of pediatric patients counseled	This program was presented in 4 elementary school in 2018 with a total attendance of 306. Of those, 191 students took the post-education survey (62%): 86% agreed to eat more fruits & vegetables 45% pledged to substitute one high sugar snack or drink with a healthier choice 60% reported that they would attempt to be more physically active. Family Medicine Center data: Q1: 82% counseled for nutrition 75% counseled for physical activity Q2: 75% counseled for nutrition 77% counseled for physical activity Q3: 65% counseled for nutrition 69% counseled for physical activity	K-12 School	Informational Transactional	Cooperation of the school's staff and enthusiastic engagement of the students. Parents are counseled and educated with the child during the Family Medicine Center visit.
Priority 1: Prevent Chronic Diseases: Reduce Obesity in Children and Adults	Reduce obesity in children and adults	Increase the percentage of infants who are exclusively breastfed.	Better health for women and children.	Not addressing disparity	Baby Friendly® Hospital accreditation Raises awareness about the benefits of breastfeeding. Educates and supports the breastfeeding experience.	Percentage of women who exclusively breastfeed upon discharge, and at 3 & 6 months follow-up.	**Q1** - exclusive breastfeeding at: Discharge: 46.2% 3 months: 62.5% 6 months: 34.8% **Q2** - exclusive breastfeeding at: DIscharge: 44.5% 3 months:54.0% 6 months: 28% **Q3** - exclusive breastfeeding at: Discharge: 50.6% 3 months: 51.6% 6 months: 22.6%	Hospital	Informational	Certified lactation consultants provide expertise and suport on breastfeeding.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	Promote evidence-based care for those with or at-risk for cardiovascular disease.	Incorporate a team-based care intervention using a multidisciplinary approach to help improve blood pressure control.	Not addressing disparity	"Evidence shows team-based care increases the proprtion of patients with controlled blood pressure and reduces systolic and diastolic blood pressure ...studies included in the systematic review primarily used teams in which nurses and pharmacists collaborated with primary care providers, patients, and other professionals." (www.communityguide.com) The Cardiac Wellness program is a multidisciplinary approach consisting of a Physician/Nurse Practitioner, Registered Nurse, Pharmacist, and Dietician. The patients with the diagnosis of heart failure are given an appointment to the Wellness Program within 7 days of discharge. The goal of having heart failure clients in the program is to reinforce education, assist with managing their diagnosis, medications, dietary needs, and self-management tools to avoid readmissions. These clients receive 1:1 time with each discipline according to their needs.	Number of visits to SNCH's Cardiac Wellness Program. Number of attendees at community educational events. Number of community blood pressures taken.	The number of visits to the Cardiac Wellness program totaled 76 for January through October 2018. Within 30 days of discharge, there were no patients re-hospitalized for the diagnosis of Heart failure. 4 community educational events on heart health and hypertension occurred with 85 attendees. 17 community blood pressure screening events occurred reaching 980 participants. Of those 980 blood pressure results: 225 (23%) were Stage 2 or above (≥ 140/90). Of those, 99 (44%) consented to a 4-week follow-up phone call; 58 (59%) of whom had followed-up with their primary care provider.	Hospital	Informational	Individualized 1:1 education and follow-up. Multidisciplinary team approach tailored to the multifaceted needs of each patient.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	Promote evidence-based care for those with or at-risk for cardiovascular disease.	Implement self-measured blood pressure monitoring interventions.	Not addressing disparity	"Comprehensive telehealth interventions to supplement the care of adults with chronic diseases...significantly inproved diet quality and sodium intake." (www.communityguide.com) Telehealth monitoring has been shown to reduce rehospitalizations in heart failure patients. Patients in this program are continually educated regarding the signs & symptoms of heart failure with a strong focus on daily weigh-ins. Daily weight & vital signs are reviewed by a Registered Nurse. Any change in status is reported to the physician with the goal of early detection & intervention thus avoiding a return to the ER or a readmission.	Number of patients who participated in SNCH's Telehealth Monitoring Program. Readmission rates for those enrolled in the telehealth program.	A total of 685 patients participated in the program from January through September 2018. Readmission rates within 30 days: Q1: 9.7% Q2: 6.1% Q3: 6.6% The overall average for readmission rates of the 685 patients in the telehealth program in 2018 was 7.4% for those 9 months.	Hospital	Informational	Individualized 1:1 education and follow-up Early detection & intervention leads to improved outcomes.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	~~To raise awareness about risk factors, including the importance of screening, through education and prevention; to mitigate the complications associated with chronic disease~~	~~Promote the reduction of chronic disease risk factors through participation in SNCH's annual Health and Wellness Fair~~	Not addressing disparity	~~Promote SNCH's Annual Health and Wellness Fair where 8 different health screenings will be offered: BMI, Asthma, Sleep Assessment, Balance Testing, Cholesterol, PSA, Blood Pressure, and Head & Neck Cancer.~~	~~Number of attendees availing themselves of screening and educational opportunities~~	**The hospital reassessed our 1 time event of an annual on-campus health fair. In 2018, in an effort to reach more communities, we participated in community-based health fairs. A total of 6 health fairs resulted in 605 screenings which included Blood Pressure, BMI, Balance, PSA, Sleep, Skin Cancer, Cholesterol and Head & Neck Cancer.**	Community-based organizations	Informational Transactional	Participating in community-based health fairs allows for more meaningful collaborations with community partners and provides increased accessibilty to residents of those communities.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	~~To raise awareness about colorectal cancer risk factors and the importance of screening.~~	~~Provide educational programs and screening opportunities.~~	Not addressing disparity	~~South Nassau will support the 80% by 2018 - Colorectal Cancer Screening Initiative.~~	~~Number of community programs provided. Number of community members who attended educational presentations.~~	**Program not successful, little to no interest in this topic.** **Difficult to obtain colonoscopy data.**			

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Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	To increase the number of women screened for breast cancer according to clinical guidelines.	Conduct outreach into the community to target women in underserved populations who have not been screened.	Disparity addressed: Lack of access to health care. This strategy addresses women who are uninsured or underinsured.	NAPBC (National Accreditation Program for Breast Cancer) Patient Navigation Initiative. Identify and work with elected officials to act as champions to promote breast cancer no-cost mammogram events.	Number of women contacted. Number of women screened. Number of women who participated in "No Cost Mammogram" community event.	A total of 1,163 women were contacted between October 1, 2017 and September 30, 2018. Of this number, 676 were screened (58%). In contrast, between September 2016 and September 2017, 874 women were contacted and 358 (42%) were screened. This reflects a 16% increase, meeting the goal of the Patient Navigation Initiative to increase breast cancer screening rates. One No-Cost Mammogram event, sponsored by a local elected official, was conducted at the hospital. 46 women availed themselves of this opportunity.	Hospital	Informational	Patient Navigators educate and engage the community regarding the NAPBC program. Those lacking insurance, the underserved, and those never having had a mammography are encouraged to register for screenings.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	To raise awareness about prostate cancer updates and the importance of screening.	Provide educational programs and screening opportunities.	Not addressing disparity	Identify and work with elected officials to act as champions to promote prostate cancer educational and screening events.	Number of community programs provided. Number of community members in attendance. Number of men screened.	A total of 3 community lectures were held with 49 in attendance. A total of 7 screenings were provided to 103 men resulting in 7 (6.8%) elevated results. All men with elevated results were sent certified letters encouraging them to follow-up with their PCP or urologist.	Hospital	Informational	Hospital urologist provides lectures and oversight to program. Staff flexibility and availability for various screening venues.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	Promote tobacco use cessation.	Provide smoking cessation classes.	Not addressing disparity	Offer 5-week smoking cessation programs. Refer class participants to SNCH's Early Lung Cancer Action Project (ELCAP) lung cancer screening program.	Number of attendees at programs. Rate of smoke-free status at 3 month follow-up phone call. Number of participants screened in the ELCAP program.	A total of 29 attendees participated in the 5-week smoking cessation program offered bi-annually. 1 (3.4%) reported being smoke-free at the 3 month follow-up phone call. Newly offered in 2018, a monthly 90-minute smoking cessation workshop increased the oportunity for patients to begin the smoke-free journey. A total of 9 people attended and 2 (22%) reported being smokefree at the 3-month follow-up phone call. For 2018, the ELCAP program reported a total of 167 participants. Of the 167 screened, 21 (12.5%) were referred for further evaluation.	Hospital	Informational	Trained hospital staff conducts classes. COPD Coordinator educates inpatients and encourages them to attend the classes upon discharge. The addition of the 90-minute monthly workshops gives participants the oppportunity to begin the smoke free process and the flexibility to attend one-time instead of 5 weeks. ELCAP program staff are eager to accommodate referred participants from the cessation classes.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	Promote evidence-based care for the prevention and management of DM. Support Human Resources' efforts to increase awareness of the 2018 Diabetes Prevention Program for employees.	Promote SNCH's Diabetes Education Center (DEC). Increase knowledge of those with diabetes regarding selfcare and minimizing the effects of diabetes.	Not addressing disparity	Literature and brochures will be distributed at community events. Conduct Diabetes self-management programs and workshops.	Number of patient visits to the DEC. Completion rate for Diabetes Prevention Program (DPP).	Patient visits to the DEC for quarters 1,2, and 3 totaled 1,625. Q2 had a 12% increase in volume from Q1, and Q3 had a 31.4% increase in volume from Q2. The Diabetes Prevention Program (DPP) commenced January 2018 with preliminary recognition by the CDC and with the goal of receiving full recognition by 2020. The completion rate for this program has been 50% which is in line with the CDC retention rate. A Diabetes Expo consisting of lectures and various vendors was held at the hospital and reached 78 attendees.	Hospital	Informational	Diabetes Education Program accredited by the AADE. Trained staff offer a variety of programs and support to all participants. Classes incorporating diabetes management tools & strategies are mandatory for all participants and are offered during the day & evening.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	Promote mental health & wellness, and prevent falls.	Improve movement, balance, and general well-being.	Not addressing disparity	"Stepping On" Program. Tai Chi for Arthritis	Number of participants and fall rate data for Stepping On participants. Number of participants in the Tai Chi for Better Balance program. Enrollment rate 2017 vs 2018 for Tai Chi.	From January through October 31, 2018 there were 18 "Stepping On" programs conducted with 147 participants. The participation in 2018 reflected a 54% increase in participation rate from 2017. A sample of those who completed the class from January through April, (76 participants), reported having fallen within the 3 months prior to starting the class which is a 46% fall rate. The post-class survey reflected that 12% had had a new fall after the class which reflects a 34% fall improvement rate. From January through October 31, 2018, 7 Tai Chi for Better Balance programs were conducted resulting in 132 attendees. Comparing the 39 attendees from 2017 reflects a 30% increase in participation.	Hospital	Informational	Trauma nurse and physical therapist co-teach the programs. The classes are scheduled frequently and there is strong interest from the community.
Priority #2: Increase Preventive Care and Management of Chronic Disease	Increase Preventive Care and Management of Chronic Disease	Promote evidence-based programs that engage community members in wellness campaigns.	Increase knowledge of Diabetes and Heart Failure regarding self-management to mitigate complications.	Not addressing disparity	Via the EMR, Medicare patients with the diagnosis of DM and an A1C of ≥ 8 will be contacted for follow up and education through the NYMP-ACO. Medicare patients discharged with the diagnosis of Heart Failure will be called by NYMP-ACO RN to discuss discharge instructions, medications, and self-management with an emphasis on weight monitoring for 12 weeks.	DM: number of patients attempted to be reached by phone, Number of patients actually reached, and number of patients agreeing to educational follow-up. HF: number of patients consenting to follow-up by a NYMP-ACO RN. Percentage of patients weighing themselves at initial follow-up call, week 4, and week 8.	Diabetes Update: April 2018 snapshot: # of qualifying patients NYMP-ACO attempted to call: 156 # of patients reached: 63 (40%) # of patients receiving education and a self-management monitoring tool: 24 (15%). Heart Failure Update: April/May 2018 data: 51/76 (67%) of patients discharged with the diagnosis of Heart Failure consented for follow-up by a NYMP-ACO RN At the initial call 54% reported weighing themselves < 3 days/wk At week 4, 36% reported weighing themselves < 3 days/wk At week 8, 17% reported weighing themselves < 3 days/wk Thus, reaching the goal of weighing oneself ≥ 4 days/week	Hospital	Informational	THE NYMP-ACO has a wide-reaching net connecting regularly with 57 community-based practices. The ACO's data analytics department identifies gaps in care which can be addressed. Care Coordinator RNs promote and educate on disease-specific self-management.
		Raise awareness regarding the many health & wellness events offered to the community.	To increase the community's perception of SNCH as their partner in health by advertising educational programs and screening events through social media reach.	Not addressing disparity	Collaborate with the Department of External Affairs to advertise events such as Narcan Training, Memory Screenings, Skin Cancer Screenings, and Prostate Cancer Screenings via mailings, flyers, Public Service Announcements, and social media sites.	Number of recorded hits to SNCH website for upcoming community events. Number of "Likes" to Facebook posts for upcoming community events.	In 2018, the numbers below reflect a total of "Hits" to the website and Facebook "Likes". Breast Cancer Day - 433 Breastfeeding Symposium - 656 Diabetes Awareness - 355 Narcan Training - 591 Smoking Cessation - 809 Long Beach SNCH Fair - 582	Hospital	Informational	External Affairs staff has access to various media outlets. Hospital-sponsored events are advertised through email blasts, print distribution, SNCH website, and Facebook postings.