UNITED HEALTH SERVICES HOSPITALS

COMMUNITY SERVICE PLAN
2015 Update

Three Year Plan of Action

Prevent Chronic Disease:

1. Reduce rate of hospitalization for diabetes

Strategy Objective: By year end 2015, increase the access to diabetes preventive care and identify the pre-diabetic population and develop a case management plan of action specific to population need.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- Promote and expand the need of diabetes self-management practices such as self-blood glucose monitoring and self-foot exams.
- Increase outpatient diabetes management by health care providers such as A1c, foot exams and eye exams.
- In conjunction with the UHS Diabetes Center, support education to all community members regarding all aspects of diabetes from dietary education to lifestyle modifications.

Goals and Performance Measures

- Track the rate of hospitalization for diabetic conditions such as acute ketoacidosis, hyperosmolarity, coma and chronic renal, eye, neurological, circulatory.
- Track the Homoglobin A1c tests performed for readings below 6.5 or below.

2015 Progress Report

- **Certified Diabetes Nurse Educators provided individual and group counseling to over 1,000 patients. This includes individual sessions; meal planning; meter class; and incorporating nutritional management into lifestyle.**
- **The on-going Diabetes Self-Management Education Program which is scheduled once a month provides education on nutrition; meal planning and carbohydrate counting; blood glucose monitoring; prevention of complications/decreasing risks associated with diabetes; physical activity; diabetes disease process and treatment options; and living with diabetes.**
- **Stay Healthy Nurses made 204 outreaches to patients in our Population Management Diabetes program.**

2. Reduce the readmission rate for patients with Congestive Heart Failure (CHF)

Strategy Objective: The 30 day readmission rate to the hospital for patients with CHF that were seen by the Cardiac Navigator was 6.5%.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- Provide Cardiac Navigator follow up on all patients referred to program.
- Provide telephonic education to all CHF disease management patients from UHSH facilities.
- Follow all CHF discharge patients for three months to ensure compliance to all provider post-discharge instructions.

Goals and Performance Measures

- Cardiac navigator to follow all CHF patients referred to her.
- UHS Stay Healthy nurses to contact patients with CHF to provide assistance in dietary needs, medication education, provider follow-up appointment reminders and a resource for further communication.
- Review the overall 30-day readmission rate for CHF.

2015 Progress Report

- **Cardiac Navigator and Stay Healthy Nurses completed 1,656 interactions, (calls, hospital visits, and/or home visits) to patients to review patient's understanding of diet, exercise plan, symptoms, medications, etc.**

3. Increase access to a comprehensive array of cancer care services

Strategy Objective: Provide health screenings and educational programs to prevent cancer.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- Provide access to state-of-the-art equipment and a full range of cancer services.
- In conjunction with the American Cancer Society's Road to Recovery Program, coordinate free rides for patients to and from treatment services.
- Provide education programs such as Tea with Ruth, Mugs for Men and support groups such as Lymphedema support group and Breast Cancer support group.
- Educate the community about the array of complex medical treatment options and the broad range of services for cancer care.

Goals and Performance Measures

- Enrollment in various on-going programs and support groups.
- Track the number of screenings (breast, cervical, prostate etc.)

2015 Progress Report

- **UHS Cancer Nurse Navigator works with Cancer care team, which includes a physical therapist, social worker and dietician to offer patients undergoing treatment a full option of services to help them navigate through the care process and into survivorship. Over 3,386 calls were made to patients during 2015 by our Cancer Nurse Navigator and Stay Healthy Nurses.**
- **The existing support groups (Lymphedema, Tea with Ruth, Mugs for Men, Best Bites, A La Carte, Breast Cancer) continued throughout 2015. We had 283 patients registered in 2015. UHS continues to collaborate with the community and health plans on ways to promote screening and prevention measures via health fairs and the media.**
- **Worked with Rural Health Network to help arrange rides for patients receiving treatment.**

4. Reduce Obesity in Children and Adults

Strategy Objective: Prevent childhood and adult obesity through intervention in early childhood and increased physical activity.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- Introduced programs such as Small Steps in 2 schools (Benjamin Franklin and Greene) that promotes increasing physical activity, consuming fruits and vegetables and decreasing screen time.
- Provide education on behavior modifications and meal portion sizes to children through Stay Healthy Kids.
- Collaborate with health care providers by providing them with obesity information/guidelines and encourage compliance to NYS guidelines.
- Collaborate with community partners to promote areas of physical activity.

Goals and Performance Measures

- By year end 2015, increase the number of school districts participating in the Small Steps program from 3 to 5.
- By year end 2015, increase the number of children who attend Stay Healthy Kids Club.
- Perform random chart audits to document health care provider compliance. (50 per month per pediatric office)

2015 Progress Report

- **UHS Childhood Obesity Nurses, via the New York State grant, developed provider alliances with 8 key provider sites (both UHS and non-UHS) to provide tools to share with children and parents, on nutrition, exercise, reduction of screen time, etc. Tracked patient data on 4 of these provider sites by reviewing 50 patient wellness visits, or all if less than 50, on a monthly basis. Patient height/weight, BMI, BP on children >3 yrs/ of age, provider documentation of patient counseling on nutrition, exercise, decreased screen time, etc; as well as all community referrals made for patient on these topics.**
- **Worked with local schools to promote childhood wellness tools that were distributed at school functions and health fairs.**
- **Also, collaborated with community partners to develop consistent messaging for children and adults, on Childhood Obesity prevention measures, including the encouragement of Breastfeeding over bottle.**
- **UHS Stay Healthy developed an Adult Weight Management & Wellness Program to begin January 2015. We had 335 people registered for the program in 2015.**
- **The existing Stay Healthy Kids Program was revamped for 2015, to focus more on wellness strategies for all children regardless of BMI and will now include children with providers in or outside the UHS provider network. We had 51 interactions with children and family members in 2015 for this program.**

5. Reduce Tobacco Use

Strategy Objective: Promote Tobacco cessation by youth, young adults, especially among low socioeconomic adult population.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- Increase the number of primary care providers promoting tobacco cessation in five counties.
- Utilize Tobacco Cessation Program by offering free weekly cessation classes and strategies to cut tobacco dependence.
- Utilize the pre-admission testing (PAT) process to reach the community as all qualified patients who go through PAT, receive a tobacco cessation redemption coupon.

Goals and Performance Measures

- Track the contacts made to health care providers to reach 20 new providers every year.

- Track the usage/redemption rate of coupons that can be used to obtain nicotine replacement therapies.

2015 Progress Report

- **UHS offers free weekly cessation classes that include strategies to cut tobacco dependence. We had 210 people registered for Tobacco Cessation Classes. All UHS inpatients, outpatients and visitors can request a tobacco cessation packet which includes a coupon for free NRT. Over 1,000 packets were given out in 2015.**
- **All provider offices address tobacco use with each patient and refer patients to New York State quit line or classes.**
- **UHS Stay Healthy Nurses provided 63 outreach calls to patients in 2015.**
- **A low density CT Lung screening program started in October 2015. Stay Healthy Nurses completed 27 screenings, 11 of which signed up for our Tobacco Cessation Program.**
- **UHS Hospitals remain Tobacco free campuses.**

Promote Healthy Women, Infants and Children

1. Increase Breastfeeding

Strategy Objective: By year end 2015, increase the percentage of women at UHSH to initiate breast-feeding and increase the number of infants who are breast-fed.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- Discuss and offer literature about breast-feeding at pre-natal visits and skin-to-skin immediately after birth.
- All mothers contacted 3 to 5 days of discharge and offered guidance and support in any breast-feeding strategies and (if needed) equipment rental.
- Free lactation consultant services made available to all mothers.

Goals and Performance Measures

- Track the mothers contacted by year-end 2015 and continue periodic contact for two years upon discharge.
- Decrease formula usage by mothers.
- Track enrollment in pre-natal classes and breast-feeding courses.

2015 Progress Report

- **UHS Stay Healthy nurses worked in conjunction with the Broome County Health Department and Mother's and Babies and completed outreach to 2 UHS provider sites to introduce "breastfeeding friendly" office policy.**
- **Our UHS Lactation Consultant provided consultant services to 71 breastfeeding mothers in 2015. Stay Healthy nurses made over 1,000 calls to new moms in 2015.**
- **Additional Stay Healthy nurse was certified as a "Lactation Counselor". UHS continues to provide free Lactation services at the Stay Healthy center with a Certified International Lactation Consultant. Stay Healthy center provides on-site private space for breastfeeding mothers and their babies.**

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Promote a Healthy and Safe Environment

1. Improve outdoor Air Quality

Strategy Objective: Reduce exposure to community of harmful effects of tobacco and exposure to harmful effects of second-hand smoking.

Goals and Objectives, Improvement Strategies and Performance measures (with measureable and time-framed targets over the three year period):

Tactics

- All UHSH facilities to be tobacco-free.
- All UHSH facilities to adopt policies that prohibit smoking on all hospital grounds and within 15 feet of the property lines.

Goals and Performance Measures

- Increase availability of the "Survival Pack" which includes a coupon for free NRT (nicotine replacement therapy) gum.
- Track the "Survival Pack" participation by employees, family members and visitors.

2015 Progress Report

- **UHS has adopted a tobacco free policy to prohibit smoking on all hospital grounds within 15 feet of property lines.**
- **Over 750 "Survival Packs" were given out to employees, visitors and family members in 2015.**
- **210 registered for Tobacco Cessation classes at the Stay Healthy Center.**