WINTHROP-UNIVERSITY HOSPITAL
CHNA IMPLEMENTATION PLAN
2014 – 2016

Your Health Means Everything™

Adopted and Approved by the Board of Directors.
Winthrop’s CHNA identified public health priorities that are aligned with national, state and community health concerns. Our CHNA also identified data indicating that living a healthy lifestyle (e.g., avoiding tobacco use, being physically active and eating well) greatly reduces a person’s risk for developing chronic disease. Our goal is to not only improve access to care, but also to encourage individuals to make the behavioral changes needed to lead a healthy lifestyle through an approach that encompasses health interventions and education, public outreach, and strong community partnerships.

Our Implementation Plan is aligned with Winthrop’s mission to provide high-quality, safe, culturally competent, and comprehensive healthcare services in a teaching and research environment, which improve the health and well-being of the residents of Nassau County and contiguous county areas...based on a profound commitment to an enduring guiding principle – “Your Health Means Everything.” The Plan is a dynamic document that will be continually reviewed according to the quality improvement measurement standards of the Hospital, PDSA (Plan, Do, Study, Act), and revised as needed according to changes in community need or resources.

The most pressing needs of the community identified by our CHNA are reducing obesity and the prevention and management of chronic disease (diabetes, asthma, cardiovascular disease and stroke, cancer). Other needs we will address include perinatal outcomes in select communities, unintentional injuries, i.e., the high risk of falls among seniors, and oral health.

Mental Health and Substance Abuse were also identified as a significant health problem by our community. We have limited resources in this field and cannot currently address this need. However, we do have a referral system in place.

It should be noted that obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer – some of the leading causes of preventable death. Therefore, it was determined that Winthrop may make the most significant impact on public health by addressing obesity and the most prevalent, preventable chronic conditions in our community that are mentioned above.

The following is a summary of specific programs, goals and objectives. Programs have been developed according to the feasibility of impact, resources and priority of need. These outreach objectives will be supported by other hospital-based and outreach activities that will be implemented as needed. For convenience, a chart outlining specific programs is attached.

**Priority 1 – Obesity – Nutrition and Healthy Weight**

The evidence supporting significant health risks associated with obesity is compelling: obesity and overweight are the second leading cause of preventable death in the United States and may soon overtake tobacco as the leading cause of death. By the year 2050, obesity is predicted to shorten life expectancy in the US by two to five years.
A. **Obesity Screenings in Primary Care Provider Offices**

**Goal:** Identify children who are obese; reduce BMI’s

**Objective:** By December 31, 2016, reduce the percentage of children who are obese in the Winthrop Hempstead Practice (community with health disparities) by 3%

**Baseline Data Source:** Electronic Medical Records (EMR)

**Performance Measures:** BMI’s

**Data Source for Outcome Measures:** EMRs, provider feedback. Data will be evaluated bi-annually

**Strategy: 5-2-1-0 Program** The program encourages primary care providers to consistently document BMI, provide lifestyle counseling, develop individual care plans and follow-up measures.

During 2013, the identification and counseling of children who are obese (BMI =/>95%) was implemented in the Hempstead Pediatric Clinic, an area suffering health disparities. Children are measured for obesity at every well-child visit beginning at age two. Those who are identified as being obese receive a folder with informational sheets, resources and a personal “goal tracker” that encourages documentation (by coloring for age-appropriate children) the number of fruits and vegetables, screen time, physical activity and sugary drinks they have each day. They also receive a visual chart, developed by a nutritionist, to clarify portion sizes.

Parents 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 =/>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.

**Year 2014 – Hempstead Practice**

- *Increase the number of individual Care Plans and Obesity Folders distributed to 25%*
- *Current compliance on part of parents to return for follow-up with their obesity folder is poor – Increase compliance rate to 25% of patients*
- *Current compliance rate of obtaining labs is poor – Increase compliance rate to 25%*

**Year 2015 – Hempstead Practice**

- *Increase number of Care Plans and Obesity Folders distributed by 5%*
- *Increase compliance rate of parents returning for follow-up appointment by 3%*
- *Increase compliance of parents who obtain labs by 5% from year one*

**Year 2016 – Hempstead Practice**

- *Increase number of Care Plans and Obesity Folders distributed by 10%*
- *Increase compliance rate of parents returning for follow-up appointment by 5% (from year one)*
- *Increase compliance of parents who obtain lab work by 10%*
B. CHILDHOOD OBESITY SCREENINGS IN THE COMMUNITY

Goal: Identify children who are obese (BMI =/>95%) in communities with health disparities; provide appropriate nutritional counseling

Objective: By December 31, 2016, increase the number of children screened by Winthrop at preschool/ childcare centers in communities with health disparities by 20%; provide nutritional counseling based on 5-2-1-0 program

Baseline Data: Will be gathered in first year; will include number of children screened, BMIs, and number of participants with BMI =/>95% whose families receive nutritional counseling packets

Outcome Measures: Number of children screened, number of children with BMI =/>95%; BMIs at follow-up visits; number of children returning with completed nutritional counseling packets

Data Source for Outcome Measures: BMI Measurement; provider feedback. Data will be evaluated bi-annually.

Strategy: Bring the 5-2-1-0 Program to the Community (Promising Practice Program)
Winthrop will collaborate with its community partners in areas experiencing health disparities, document BMI’s, and provide nutritional counseling for families of children identified as being obese

Year 2014 – Obtain baseline statistics. Pilot obesity screenings and counseling at two early childhood centers in communities experiencing health disparities; healthcare team return in two months for follow-up visits
Year 2015 – Based on pilot data, evaluate successes and barriers; increase screenings in the community and follow-up visits by 10%
Year 2016 – Continued expansion of program in community; increase screenings and follow-up visits by 10%

C. BABY-FRIENDLY HOSPITAL

Goal: Increase the number of babies only receiving breast milk when discharged from Winthrop

Objective: By December 31, 2016, 60% of healthy newborns discharged from Winthrop will only receive breast milk

Baseline Data: Medical records (on paper)

Outcome Measures: Number of babies leaving the hospital who are breastfed

Data source for Outcome Measures: Medical records (on paper)
Strategy (Evidenced-based program)
Winthrop is on a 4-D pathway seeking Baby-Friendly Designation. The pathway phases are: Discovery, Development, Dissemination and Designation. Winthrop has implemented the 10-step process:

1. Written breastfeeding policy
2. Training healthcare staff in skills necessary to implement
3. Inform all pregnant women about breastfeeding benefits
4. Help mom initiate breastfeeding
5. Show mothers how to breastfeed
6. Give newborn infants no food or drink other than breast milk, unless medically indicated
7. Practice “rooming in”
8. Encourage breastfeeding on demand
9. Give no pacifiers or artificial nipples
10. Foster the establishment of breastfeeding support groups

Year 2014 – 50% exclusivity
Year 2015 – 55% exclusivity
Year 2016 – 60% exclusivity

INTERVENTION ADDRESSING CHRONIC CONDITION MANAGEMENT AND HEALTHY WEIGHT (OBESITY)

A. “ACTIVE LIVING” - Winthrop program based on “A New Leaf...Choices for Healthy Living” intervention program

Goal: Senior Program - To increase general knowledge about chronic disease management and encourage a healthy lifestyle that supports the prevention/maintenance of chronic conditions

Objective: Targeting the older community, by December 31, 2016, increase by at least 10% the number of adults who have taken a course to promote chronic disease management and the importance of a healthy lifestyle

Baseline Data: Will be obtained first year
Outcome Measures: Number of individuals who attend and complete program
Outcome Date Source: Pre- and post-surveys

Strategy: Targeting the above priorities, as well as the newly developed Healthy People 2020 initiative, “Health-Related Quality of Life (HRQoL),”¹ Winthrop will develop and implement its own program for addressing both general chronic disease and weight management.

“Active Living,” will be offered in four sessions and encompass: General Management of Chronic Conditions, Stress Management, Nutrition, and Exercise. Developed by the Director of Winthrop’s Center for Chronic Conditions and Nurse Navigator from the Center, a registered dietician, physical therapist, a social worker experienced with chronic disease management and registered nurse educators, the program will target older adults with the goal of increasing their knowledge about managing their conditions, improving their weight and balance, and ultimately, reducing healthcare costs.

Year 2014 – Develop and implement three pilot sessions at Winthrop
Year 2015 – Evaluate effectiveness and make changes as needed; expand into communities
Year 2016 – Continued expansion into communities with health disparities, based on pilot data

**PRIORITY AREA 2 - PREVENTING AND MANAGING CHRONIC DISEASE – DIABETES**

Winthrop historically has been a leader in diabetes care. Our Diabetes Education Center, the first diabetes education program in New York State to be accredited by the American Diabetes Association, has been serving as a resource for members of the community since 1970. Research into the causes and treatment of diabetes has been ongoing and will continue to be a focus in the Research and Academic Center currently under construction.

Hospitalization from Type 2 Diabetes occurs more than twice as often in the select communities than it does in the rest of Nassau County. Given the significant health disparity in select communities, the potential complications that lead to heart disease, stroke, eye problems, amputations and more, the emphasis the public placed on diabetes in our assessment and Winthrop’s expertise in the area of diabetes management, the Hospital has chosen to prioritize and place greater emphasis on addressing diabetes case findings, prevention and management.

**A. NATIONAL DIABETES PREVENTION PROGRAM**

*Goal:* Promote culturally relevant chronic disease self-management education

*Objective:* By December 31, 2016 initiate the National Diabetes Prevention Program and increase by at least 5% each year the number of adults who have participated in at least nine of the core sessions (they must either meet the diagnostic criteria for pre-diabetes or have risk factors to participate)

*Baseline Data:* Number of attendees, number of sessions attended; weight and physical activity minutes along with demographic data will be collected first year

*Outcome Measures:* The National Diabetes Prevention Program outcome measures include number of attendees, number of sessions attended, weight and physical activity minutes along with demographic data.
Data source for Outcome Measures: Actual participants who start the program and complete at least nine sessions; data will be collected every session

Strategy: Evidenced-Based The National Diabetes Prevention Program is a 16-week core program, followed by a once per month post-core program for eight months.

2014 – Scale-up Winthrop’s existing diabetes prevention program to the National Diabetes Prevention Program. We will offer two core program groups and one post-core program during calendar year 2014.
2015 – Completion of the second post-core and launch of the Spanish-speaking version.
2016 – Continued expansion into communities with health disparities, based on pilot data.

B. DIABETES CASE FINDING & EDUCATION IN HEMPSTEAD (SELECT COMMUNITY WITH HEALTH DISPARITY)

Goal: Increase screening rates for diabetes
Objective: By December 31, 2016, increase the number of adults 18 years and older who have been identified as being at risk for diabetes in a health disparate community by 5% over three years
Goal: Promote culturally relevant chronic disease self-management and education
Objective: By December 31, 2016, over three years, link at least 25% of those identified as at-risk with culturally relevant patient education services

Baseline Data: Will be collected in the first year; will include number of participants
Outcome measures: The number of people who are identified and attend culturally relevant patient education services
Data Source for Outcome Measures: We will document the number of participants in all programs along with post-program satisfaction surveys of those who attend the American Diabetes Association classes.

Strategy: Partnering with The Hispanic Counseling Center and the American Diabetes Association, Winthrop will utilize its “mobile health” trailer and Spanish-speaking staff to participate in case finding in Hempstead, a select community. Blood pressure and cholesterol results obtained at the screening will be used in the My Health Advisor website to not only assign risk, but also to demonstrate the impact on risk of changes in metabolic parameters.

Those participants who present with established diabetes will be referred to the Hispanic Counseling Center which currently hosts classes presented by the American Diabetes Association. The Hispanic Counseling Center serves a diverse population throughout Nassau County.

Year 2014 –Patients who present with established diabetes will be able to attend the American Diabetes Association’s classes that are being offered through the Por Tu Familia and Vivir con
Diabetes Tipo 2 programs. Those who are identified through My Health Advisor as high-risk for type 2 diabetes will be given diabetes prevention guidelines and Spanish-language literature. Year 2015 – Because there are formidable barriers that interfere with community screening linking diabetes diagnostic testing, education and treatment, year 2015 will serve to identify strategies addressing these barriers. In addition, the diabetes prevention program (mentioned above) will be developed for the Spanish-speaking population. Year 2016 – Using the data that we obtain in year two, evaluate data and re-evaluate program based on cultural implications

**C. PROMOTING CULTURALLY RELEVANT DIABETES EDUCATION TARGETING SOUTH ASIAN INDIAN COMMUNITY**

**Goal:** Promote culturally relevant chronic disease self-management education  
**Objective:** By December 31, 2016, increase by at least 5% the number of South Asian Indian-American adults with diabetes who have taken a diabetes self-management course  

**Baseline Data:** Diabetes Education Center statistics  
**Outcome Measures:** Number of individuals who attended outreach initiatives.  
**Outcome Date Source:** Post-surveys from all who attend the program.

**Strategy:** The South Asian Indian community has a high prevalence of diabetes. Winthrop will target this population through community outreach to provide diabetes education.

Year 2014 – Winthrop will build new relationships and work to increase participation in Winthrop’s Diabetes Education Center established courses.  
Year 2015 – Engage the South Asian Indian population to explore culturally relevant avenues for reinforcing diabetes-specific messages.  
Year 2016 – Support the sustainable infrastructure through clinical – community linkages.

**PRIORITY AREA 3 - ASTHMA**

Asthma poses a health disparity in select communities in Nassau County. Interventions that focus on proper management can impact healthcare costs and the long-term effects on Nassau County’s fourth leading cause of death (chronic obstructive lung disease).

**Goal:** Promote asthma self-management  
**Objective:** Targeting select communities, by December 31, 2016, increase by at least 20% the number of participants who have attended a workshop addressing asthma management

**Baseline Data:** Will be obtained first year  
**Outcome Measures:** Number of participants attending sessions  
**Outcome Date Source:** Post-surveys
Strategy: Winthrop will partner with community churches and community-based organizations to provide educational workshops.

Year 2014 – Partner with two community churches
Year 2015 – Increase presence in the community by 10%
Year 2016 – Increase presence in the community by 20% from year one

PRIORITY AREA 4 – CARDIOVASCULAR DISEASE, INCLUDING STROKE

Heart disease is the number one killer of adults both nationally and within Nassau County. Interventions such as cholesterol screenings, public education, and the benefits of a healthy lifestyle will be addressed by the Hospital.

Goal: To reduce risk of cardiovascular disease and stroke by educating the community about current guidelines and identifying at-risk patients

Objective One: By December 31, 2016, increase by 10% the number of adults who have been screened for cardiac risk
Objective Two: By December 31, 2016, increase by 20% the number of participants who attend a seminar about guidelines.

Baseline Data: Will be obtained first year
Outcome Measures: Number of participants attending sessions or screened
Outcome Date Source: Consent forms; post-surveys

Strategy: Winthrop will partner with community- and faith-based organizations to provide assessment and education. Assessment will consist of a blood pressure reading, BMI and cholesterol. Winthrop will also hold hospital- and community-based educational programs.

Objective one:
Year One: Partner with two community-based or faith-based organizations
Year Two: Increase number screened by 5%
Year Three: Increase number screened by 10%

Objective two:
Year One: Hold two hospital-based programs
Year Two: Expand into community – increase attendance by 10%
Year Three: Continued expansion – increase attendance by 20% from year one

PRIORITY AREA 5 – PERINATAL OUTCOMES

Perinatal outcomes in select communities are poor. Winthrop’s Women’s Wellness Clinic in Hempstead improves access to care and has prioritized this disparity. The Hospital is
also involved in the Nassau County Perinatal Network, a coalition that works to help women be healthy before, during and after pregnancy.

A. NASSAU COUNTY PERINATAL NETWORK COLLABORATION

Goal: To address poor perinatal outcomes in Nassau County by promoting education and improving access to care for at-risk mothers
Objective: Engage childbearing women to obtain health insurance and connect them with proper prenatal care.

Baseline Data: Will be obtained first year
Outcome Measures: Metrics will be developed, new collaboration
Outcome Data Source: To be determined after collaborative meetings

Strategy: Collaboration with the Nassau County Perinatal Network, a coalition comprised of the Nassau County Department of Health, Long Island Hospitals, and more. The coalition works to help women be healthy before, during and after pregnancy. Mary Lynne Brassil, RN, Perinatal Clinical Nurse Specialist at Winthrop, is the chair of the Nassau County Perinatal Network.

The task force is currently addressing perinatal outcomes in communities with health disparities, in addition to creating a safety net for women in Nassau County who are at risk for a Perinatal Mood and Anxiety Disorder.

Year 2014: Engage faith-based leaders to develop community support; evaluate NYC’s “Yes We Can” program for Nassau County community
Year 2015: Train community-based leaders to educate women
Year 2016: Evaluate and grow program

B. PERINATUAL OUTCOMES WINTHROP WOMEN’S WELLNESS CENTER - HEMPSTEAD

Goal: Improve perinatal outcomes for Nassau County
Objective: By December, 2016, the rate of women delivering under 39 weeks will be improved by 5%
Objective: By December, 2016, the rate of low birth weight babies (≤ 5 lbs.) will be reduced by 5%

Baseline Data: Will be developed first year
Outcome Measures: Number of babies with low birth weights
Number of babies carried to term at Hempstead & High Risk Clinic

Outcome Data Source: EMRS
Strategy: Winthrop’s Women’s Wellness Clinic in Hempstead improves access to quality care. Pregnant women are provided with educational materials consisting of a comprehensive, educational Baby Basics Book and planner with scheduled appointments. The clinic also offers monthly educational classes for pregnant moms. All women suspected of being at-risk are sent to the high-risk practice at Maternal Fetal Medicine. Outcomes are tracked.

Year 2014: Continue to engage women in prenatal counseling and support outreach initiatives; provide appropriate medical intervention
Year 2015: Continue public education outreach within the community; provide appropriate medical intervention
Year 2016: Evaluation of strategies to address barriers and continued monitoring of program

**Priority Area 6 – Cancer**

Prostate, Lung, Breast and Colon Cancer have the highest incidence of occurrence in Nassau County. Winthrop will work with community partners on public education efforts that will help individuals recognize risk factors and seek appropriate screenings.

**A. Hospital- and Community-Based Education**

*Goal:* To Increase knowledge about reducing risk factors and the importance of screenings
*Objective:* December 31, 2016, increase by 10% the number of adults who have attended programs addressing risk-factor education and prevention

*Baseline Data:* Will be obtained first year
*Outcome Measures:* Number of participants at sessions; attendee satisfaction survey
*Outcome Date Source:* Post-surveys

Strategy: Offer hospital-based programs each year addressing the risk factors/prevention of cancer. Winthrop will also partner with faith-based/community based-organizations to provide education in communities.

*Year 2014 –* Provide two hospital-based programs
*Year 2015 –* Continue with hospital-based programs, expand further into community. Increase number of participants 5%
*Year 2016 –* Evaluate programs; increase number of participants by 10% from year one

**B. “A Teen’s Guide to Breast Health”**

*Goal:* To improve the rate of early detection in breast cancer among women
*Objective:* Teens will be educated about breast health, risk factors and the importance of early detection
Strategy: Winthrop will target the teen community and provide education about breast health, breast cancer risk factors, and importance of self-examination and screenings through a presentation “A Teen’s Guide to Breast Health.” Partnerships will be built with schools. Program will be provided by a Breast Cancer Nurse Navigator.

Baseline Data: Will be obtained first year
Outcome Measures: Number of schools visited and participants who attend session
Outcome Data Source: Pre- and Post-surveys

Year 2014 – Develop partnerships with schools; provide at least one high school lecture
Year 2015 – Increase number of teens reached by at least 5%
Year 2016 – Increase number of teens reached by 10% from year one

C: TOBACCO CESSATION

Goal: Reduce the risk for cancer and other chronic diseases related to tobacco
Objective: By December 2016, increase the number of participants in our tobacco cessation classes by 10%

Baseline Data: Number of attendees in 2013: 56
Outcome Measures: Number of attendees
Outcome Data Source: Post-surveys and follow-up

Strategy: The Tobacco Cessation program consists of a four-week series that addresses behavior modification techniques, positive reinforcement, relaxation techniques, Information on use of nicotine replacement therapies and group support.

Year 2014 – Conduct one session in a select community
Year 2015 – Provide two sessions in select communities; increase participation by 10%
Years 2016 – Increase public participation by 20% from year one

PRIORITY AREA 7 – UNINTENTIONAL INJURIES (FALLS)

Goal: Reduce the rate of falls among seniors, by providing prevention strategies and exercises to improve balance
Objective: By December 2016, increase the number of adults who have taken a fall prevention or exercise class by 5%

Baseline Data: During 2013, 1100 participants in 57 fall prevention classes
Outcome Measures: number of participants who attend sessions
Outcome Data Source: Post-survey
**Strategy:** Winthrop currently has a robust community-based fall prevention program, offering education about risk reduction and fall prevention strategies. This includes, but is not limited to, risk assessments, exercises to enhance balance, and environmental modifications. The program has grown significantly from 360 participants the first year to 1100 in 2013, the fourth year. We will continue to grow and expand the program.

Year 2014: Provide programs at new two community-based locations
Year 2015: Review program and expand into community
Years 2016: Continued expansion

**PRIORITY AREA 8 – ORAL HEALTH**

Oral health is considered to be a “public health opportunity” by the New York State Department of Health, due to its link with diabetes. The action notes: “Because chronic periodontal inflammation has been identified as a potential risk factor for poor glycemic control, routine dental care may help prevent complications from diabetes.” This will be addressed through education and free screenings.

Goal: To promote oral health for children and adults
Objectives: By December 2016, increase the number of participants who have been screened/referred for follow-up by 10%

*Baseline data:* Will be obtained first year
*Outcome Measures:* Number of participants
*Outcome Data Source:* Consent Forms

**Strategy:** The Winthrop-University Hospital Center for Family Dental Medicine is a full-service, state-of-the-art dental facility developed to serve the community’s patients and allow Dentists to complete their residency in a hospital environment. *Winthrop developed the program to target communities with health disparities.*

Year 2014: Conduct screenings & education in one school and one Head Start Program in a select community; conduct one adult screening
Year 2015: Conduct screenings and education at two schools in communities with health disparities and two Head Start Programs; conduct two adult community screenings
Year 2016: Continued expansion into the community

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COLLABORATIVE WELLNESS EFFORTS

THE LONG ISLAND HEALTH COLLABORATIVE

In addition to the measures indicated above, Winthrop is actively involved with the Long Island Health Collaborative, an initiative that is moving forward with a three-pronged approach to reducing obesity and the prevention and management of chronic disease. It encompasses programming, policy, and public outreach.

Programming

Each member of the collaborative is to collect data on their programs through a pre- and post-assessment to determine participants’ change in health behaviors adopted or learned. Program offerings are not homogenous, nor are the communities served by these institutions – some serve predominately elderly populations, others poorer communities, etc. Each member will develop its own programs, but in the end, all collaborative members are working toward the same overarching goals.

- **Walking** – we will link with organizational-sponsored walks on LI for 2014 and use the activity of walking (which is cost-free, neutral and feasible for all populations) to promote healthy living behaviors and thus affect positive change in the incidence of chronic disease over time. We will ask our walk partners to provide us with data on either steps walked or numbers of participants. This approach will be repeated in 2015 and 2016.

- **Policy** – while we continue to promote walking as a healthy behavior and one way to lose weight, keep blood pressure under control, etc., we will work with the regional state transportation office to ensure more of our communities are safe and walkable. We realize this change will take years.

- **Public Outreach** – we are overlaying our programming and policy efforts with a public awareness campaign that promotes LIHC, healthier lifestyles and better chronic disease management. The campaign’s centerpiece will be an easily navigable website that connects the user with programs, services, and resources in the local communities.

IDENTIFIED NEED NOT CURRENTLY BEING ADDRESSED

MENTAL HEALTH AND ADDRESSING SUBSTANCE ABUSE

REFERRALS TO COMMUNITY RESOURCES

Winthrop has a solid referral base for community members in need of assistance.
The Hospital has a protocol in place for evaluating patients with evidence of behavioral abnormalities who enter the Emergency Department. Evaluated by the Attending Physician, patients with non-psychiatric conditions are diagnosed and treated as appropriate. These patients are provided with a list of community resources for further help.

For patients requiring further evaluation, psychiatric consultation is requested by the Emergency Department Attending Physician when appropriate. The Attending Physician, in conjunction with the Psychiatric consultant, will make a decision regarding the hospitalization of psychiatric patients. Two different forms of hospitalization are available – involuntary and voluntary.

Patients seeking voluntary hospitalization are aided by a social worker in finding proper placement.

Patients who require involuntary hospitalization must be evaluated by at least two physicians who agree that the patient meets one of the following criteria for involuntary admission:

- a. Patient is suicidal
- b. Patient is homicidal
- c. Patient is incapable of caring for himself or herself.

All patients who require psychiatric hospitalization must be transferred to another institution that has the appropriate facilities to treat the individual.

**SUBSTANCE ABUSE**

Winthrop has licensed social workers specializing in substance abuse treatment who assist patients with referrals. Acutely intoxicated individuals or those suffering from an overdose that are brought to the Emergency Department or admitted to the Hospital are provided with a consult and assisted with services. Patients who are admitted for another condition, but who are struggling with substance abuse, can request services for referrals and will receive support while hospitalized at Winthrop.

Individuals in the community who need assistance with substance abuse and do not require an emergency room visit can call (516) 663-2796. They will be provided with community referrals over the phone.