Stony Brook Southampton Hospital

Community Service Plan 2014-17

Southampton Hospital Mission Statement:

The Mission of Southampton Hospital is to provide and ensure the highest quality of healthcare services for its entire community.

Description of the community served:

Southampton's Service area extends from Montauk to the East to Westhampton Beach to the West and the Southern area of Riverhead in the center of the East End of Long Island. The service area accounts for approximately eight-five (85) percent of total admissions to the Hospital and includes the following zip codes: Amagansett (11930); East Hampton (11937); Bridgehampton (11932); Southampton (11968); Hampton Bays (11946); Sag Harbor (11963); Sagaponack (11962); Montauk (11954); Riverhead (11901); East Quogue (11942); Quogue (11959); Remsenburg (11960); Water Mill (11976); Westhampton Beach (11978); and Westhampton (11977). In addition, the Hospital's service area is home to the Shinnecock Nation. Since April of 1995, Southampton Hospital has worked with the Nation to provide services at the Shinnecock Indian Health Clinic through a contract with the NYS Department of Health. On an annual basis, the Clinic provides approximately 2,000 medical and 800 dental visits for eligible members of the Shinnecock Nation. Southampton Hospital's service area has a year-round population of approximately 115,536 residents. The population in the Hospital's service area, a resort destination, more than doubles during the summer season when tourists and seasonal residents from all over the world come to the South Fork of Long Island.

Demographics: While the South Fork has a significant second-home population, many of whom use Southampton Hospital for various services, we are addressing only the year-round population for the purpose of this plan.

2010 US Census:

Total Population	**Town of Southampton**	**Town of East Hampton**
	56,790	**21,547**

Ethnicity/Race	**Town of Southampton**	**Town of East Hampton**
(all are "alone")		
White (alone)	**72.5%**	**67.9%**
Black/African American	**4.9%**	**3.2%**
American Indian	**.2%**	**.2%**
Asian	**1.1%**	**1.3%**
Hispanic/Latino	**19.9%**	**26.4%**
Median Household Income	**$78,815**	**$74,849**
Average Age	**44.9 years**	**47.3 years**

Assessment and Selection of Prevention Agenda Priorities

Assessment:

1) Community Needs Assessment through Suffolk County Community Health Needs Assessments (CHNAs) - A summary report (April 2013) by Jane Corrarino, MD, Suffolk County Department of Health, provided relevant public health data from the NYS Department of Health Prevention Agenda.
2) Needs Assessment – Public Participation

   As a member of Nassau/Suffolk Hospital Council (NSHC), Southampton Hospital is participating in the Long Island Health Collaborative (LIHC), a group organized by NSHC that includes representatives from 23 member hospitals, the Suffolk and Nassau County Health Departments, Long Island colleges and universities, school systems and various other agencies, including the YWMCA of Long Island, Western Suffolk BOCES, Asthma Coalition of Long Island, among others.

- In preparation for submitting our individual Community Service Plans, the LIHC members met monthly, February-October 2013, to assess community health needs, review the results of a community survey, select prevention agenda priorities based on those results, discuss methods of data collection, and eventual analysis of our efforts.
- At Southampton Hospital, a group that included our VP/Quality Assurance, Director of Rehabilitation Services, Cardiac Nurse Manager, Coordinator of Wellness Institute Services, and our Diabetes Educator met regularly to discuss local health needs in relation to the work being done at LIHC meetings.
- The group re-worked a Suffolk County Health Department's (SCDOH) draft survey to give it a Community Based Organization (CBO) focus in order to seek input from the communities served and to engage these potential partners in implementation of the Community Health Improvement Plan. With input from the member hospitals, The Nassau-Suffolk Hospital Council created a master list of CBO contacts including school districts, BOCES, Patchogue Community Development Agency, South Fork Community Health Initiative, Catholic Charities, Cornell Cooperative Extension, American Lung Association, LI Youth Mentoring, LI Men's Center, chambers of commerce, fire departments, volunteer ambulance groups, libraries, civic associations, and senior centers.
- The uniform survey was sent collectively to approximately 200 CBOs via Survey Monkey. The SCDOH distributed the same survey to about 100 additional contacts and each organization also sent the survey to its local CBO contacts. Duplicate surveys were eliminated from the tabulations. 102 unique responses were received for a response rate of 35%.

Prevention Agenda Priorities:

The selection of our priorities was informed by the results from the CBO survey, the health issues addressed in the Suffolk County Community Health Assessment 2014-2017 and the priorities set forth in the NYS Department of Health Prevention Agenda 2013-17. LICH members reached a consensus and selected Prevent Chronic Disease, with the focus areas of Reduce

Obesity and Reduce the Risk for Diabetes. In addition, Southampton Hospital chose another priority of concern to our local community, Prevention of Mental Health Illness.

PREVENT CHRONIC DISEASE

Focus Area 1: Reduce obesity in children and adults ***(NYS Prevention Agenda Focus Area)***

Obesity and overweight are currently the second leading preventable causes of death in the US. According to the Suffolk County, NY Student Weight Status Category Reporting System 2010-2012, 17.5% of children and adolescents in the County are categorized as obese. In the County Health Rankings & Roadmaps (Robert Wood Johnson Foundation) 25% of Suffolk County adults were overweight or obese. Rates of obesity in Suffolk County are recognized as a major public health challenge and the number one public health nutrition problem. 23% of County residents are physically inactive, a number that is remarkable considering 90% of Suffolk County residents report having access to physical activity options. According to the Youth Risk behavior Surveillance System (YRBSS), 73% of New York State high schools students drank a can, bottle or glass of sugar-sweetened soda during the seven days before the survey, 21.4% drank one or more per day, and 14.3% drank two or more per day. In addition almost half of students did not meet minimum standards for physical activity. These children and their parents are in need of counseling and education to decrease their mortality rate and risk for chronic, life-threatening disease.

- **Purpose:** Reduce obesity by modifying behaviors through education and access to primary healthcare.
- **Audience:** school-age children and their parents in the Town of Southampton.
- **Objectives:** modify behavioral risks by 1) encouraging and increasing physical activity, 2) encouraging healthy over unhealthy food choices through nutritional counseling programs and coordination with the school district, and 3) achieve a weight loss of 5-10% of the participant's initial weight.
- **Action:**

1. Disseminate information about the consequences of obesity at community outreach events (lectures, school health fairs, library programs), in external communications

(monthly Hospital e-newsletter to 5,000+ contacts, Patch.com blog, Facebook, Twitter) and to inpatients through the admitting process and the Hospital's Dietary Services Department.

2. Implement "Rethink the Drink" program in 2014. Reduce or eliminate sugar-sweetened beverages in Hospital vending machines and in the cafeteria (open to the public as well as Hospital staff), replacing them with water, seltzer, and milk. Educate staff to standardize the message that the healthy beverage program represents. Communicate the message to the community in the Hospital's monthly e-newsletter, signage at the point-of-sale, social media, and the Hospital's internal monthly "Fast Facts" and quarterly "Pulse" newsletter.
3. Increase availability of healthy foods in Hospital vending machines and in the cafeteria.
4. Expand the role of the Hospital's Wellness Institute through programs for the QuarterBackers (Hospital supporters who are local business owners).
5. "Take the Stairs" (rather than the elevator) program for Hospital staff.
6. Continue "Hypnosis for Weight Loss" program for adults.
7. Partner with nutrition and physical activity programs in Southampton High School with female athletes and their families as the target group. After school and evening programs will include nutrition, mindfulness training, yoga/Tai Chi/Pilates.
8. Partner with community-organized annual walking events (Ellen's Run, Joe Koziarz Run, Hamptons Marathon, Bariatric Surgery Walk, LI2Day Walk, American Heart Association).

- **Outcome measurement:**

1. Weekly health log will quantify data over the 6-week period and track progress for follow up assessment.
2. Weekly clinical evaluations will further track progress and customize program for individuals.
3. Assessment/questionnaire along with BMI screening and waist circumference measurements will quantify data for participation.

Focus Area 2: Reduce risk for Diabetes ***(NYS Prevention Agenda Focus Area)***

Diabetes is the seventh leading cause of death based on US death certificates in 2007 and is suspected to be underreported. According to the Suffolk County Health Needs Assessment Report, two of the risk factors for the development of diabetes (type 2) include physical inactivity and overweight/obesity.

- **Purpose:** Increase access to high quality chronic disease preventative care and management in both clinical and community settings and assess risk of diabetes in advance of diagnosis.
- **Audience:** adults who are at risk and are patients of medical practices in the Town of Southampton.
- **Objectives:** 1) educate patients on risk factors, 2) alert patients already at risk, 3) provide methods for self-management to improve blood sugar control, increase insulin sensitivity, reduce triglyceride levels, increase "good" HDL cholesterol levels, and lower blood pressure, and 4) improve post-intervention measures.
- **Action:**

1. Southampton Hospital's ADA-certified program "Living with Diabetes," coordinated by a certified Diabetes Educator, enables patients to self-manage the disease through nutrition, exercise, medication, and blood glucose level monitoring.
2. Assist patients with coping mechanisms for stress and in making psychosocial adjustments.
3. Educate participants on how to detect and prevent chronic complications.
4. Provide free monthly lecture programs, individual and group counseling sessions, and educational materials.
5. Encourage participation in exercise and nutrition programs available at the Hospital's Ed & Phyllis Davis Wellness Institute.

- **Data collection:**

1. Participants will complete the Hospital's "Health Survey" (addendum) at the beginning of their participation in the program.

2. Results will be measured at completion of the program and post-program to determine if participant's were able to sustain their behavioral changes.
3. Data will be collected by our ADA-certified Diabetes Educator.

- **Outcome measurement:**

1. Weekly health log will quantify data over a 6-week period and track progress for follow-up assessment.
2. Weekly clinical evaluations will further track progress and customize programs for individual participants.
3. Results of Assessment Questionnaire along with glucose screenings will provide data to measure outcomes for participants.

Focus Area 3: Prevention of mental illness ***(NYS Prevention Agenda Focus Area: Promote Mental, Emotional and Behavioral Health)***

- **Purpose:** to reduce a growing number of suicides in Long Island's East End communities
- **Audience:** school-age children and adults
- **Objectives:** 1) identify the mental health service gaps in our communities, 2) better serve the Shinnecock Nation (Hospital off-site clinic for medical and dental services is located on the Shinnecock Reservation) and Latino populations, and 3) work with school districts to provide better psychiatric care for troubled teens.
- **Action:**
    1. Develop a central website and possible referral center to provide information about locally available services and providers
    2. Work with Suffolk County and HRHCare to offer mental health services at the new Federally Qualified Health Care Center on Southampton Hospital's campus
    3. Support collaboration with mental health professional members of East End Clinical Connection
    4. Develop bilingual public awareness campaign and educational materials
    5. Assess the feasibility of child mental health clinic in conjunction with the school districts to provide badly need psychiatric care for school age children

6. Look for non-traditional outreach opportunities for reaching areas where service disparities are particularly acute; these would include churches and health fairs
7. Continue efforts to strengthen access to services for the Shinnecock Nation, a community at high risk for alcohol and substance abuse
8. Develop opportunities to educate and promote mental health wellness through our growing list of services at our Phyllis & Ed Davis Wellness Institute
9. Investigate funding sources to embed mental health resources, including social workers in primary care settings to broaden outreach in areas where freestanding mental health services may be impractical or unfeasible
10. Form an advisory committee of Latino community leaders to identify greater opportunities to outreach and serve our growing Spanish speaking communities

- **Assessment of community need:**

  In 2013 Southampton Hospital began an assessment of mental health services by partnering with the East End Clinical Connection (EECC), a voluntary association of approximately 70 mental health providers including psychiatrists, psychologists, and social workers, who practice primarily in the communities of the South Fork of Long Island. This effort began as a result of community feedback about a growing shortage of mental health services for individuals in our communities. Additional feedback came from our elected officials NYS Senator Kenneth LaValle and NYS Assemblyman Fred Thiele) and Stony Brook University Hospital, Suffolk County's only tertiary care provider.

- **Outreach:**

  In addition to working with the EECC providers, outreach included over 27 different community leaders and organizations in order to learn more about the needs and service gaps in the mental health services arena. The formal assessment consisted of in-person interviews. We have gleaned a great deal of preliminary information from this effort. In particular, we identified glaring needs for care of childhood mental health issues and noted a large disparity in the availability of services for our growing Latino communities. The assessment revealed:

  1. A major gap in the availability of bilingual mental health service providers.

2. Services are unevenly distributed among the various communities of the South Fork with a growing shortage the further east one travels.
3. Long waiting lists
4. A severe shortage of providers willing to accept most insurance plans.
5. A lack of a central clearing house for mental health referrals and information.
6. Quite simply, community residents, especially in disadvantaged communities do not know where to turn for assistance.

This phase of our mental health study is still in process as we are seeking feedback from other sources including local schools with regard to the pediatric population and from our elected officials. We also need to link the identified lack of services with other health disparity issues. However, from local experience and national literature, we already know that health issues such as substance abuse, noncompliance with medical treatments, high hospitalizations, obesity and general poor health correlate very strongly with untreated mental health illnesses. For this reason we believe, even without further assessment, that we should take action to address growing mental health care disparities in our South Fork communities.

- **Outcome measurement:** since we are beginning to develop this initiative, we will be working with our mental health professionals to collect baseline data. We will work with those partners—Suffolk County, Stony Brook University, EECC and HRHCare—to develop an assessment tool to measure the success of our outreach efforts. Unfortunately, we have been unable to obtain reliable data about existing service utilization for mental health programs in our communities. For this reason it is difficult to benchmark current service disparities in a hard and quantifiable manner. However, through continued community outreach we will seek to measure the success of our efforts. In addition we are investigating innovative programs offered in other underserved communities to learn and then model best practices.

Long Island Health Collaborative

The LIHC is a cooperative effort between all Long Island hospitals, Suffolk and Nassau County Departments of Health, community organizations and colleges to support and develop projects to improve the health and well-being of the Long Island population. The group will focus on obesity, and chronic disease prevention and management. Southampton Hospital will support the work of clinical partners on the East End in the area of mental health.

Along with our local community partners, Southampton Hospital will work with Long Island Health Collaborative to help NYS meet its own Prevention Agenda goals for 2014-2017.

The approach is three-fold:

1. Programming – members of the collaborative will collect data on each of their programs through pre- and post-assessment to determine behavior modification results. We will promote walking (cost-free, neutral and feasible for all populations) to achieve a healthy lifestyle and link with organizational sponsored walks in 2014.
2. Policy – promote safer, more pedestrian-friendly communities; support "Complete Streets" policy as one way to combat obesity.
3. Public Outreach – a public awareness campaign will engage Long Islanders in embracing a healthier lifestyle and promote knowledge of and access to preventive and chronic disease management programs. The campaign's centerpiece is the Long Island Health Collaborative's easily-navigable website that is expected to go-live during the first quarter of 2014, and will connect the user with programs, services, and resources in their local communities.

Data Collection:

1. Walking program – our walk partners will be asked to help us in collecting data on steps walked or numbers of participants that will enable us to create a baseline for comparison with subsequent years. Disabled community will be included.
2. Universal assessment tool – pre- and post-assessment tool will be used by all organizations in each of their programs for the priorities selected as a method to follow

each participant's progress and change in healthy behavior as a result of the programs. The criteria for using this metric with any program includes: three or more educational sessions as part of a chronic disease management or wellness program, pre-program assessment, immediate post-program assessment, and follow-up assessments at 3 and/or 6 months.

3. Data pre- and post-assessment will be provided to our academic partner, SUNY Stony Brook for analysis.

Program Sustainability:

- Overall program effectiveness will be assessed quarterly and reviewed for strengths and weaknesses by Southampton Hospital's clinical staff with oversight for programs.
- Patient progress will be followed monthly with adjustments made as necessary to insure goals are met.
- Southampton Hospital will continue its community partnerships to forward our goals to reduce obesity, reduce the risk for diabetes.
- Southampton Hospital will continue to collaborate with LICH members to benefit from their successes and findings.

SOUTHAMPTON HOSPITAL

Outreach Program

Diabetic Assessment Survey

Name:_____ **Sex:** ☐ Male ☐ Female **Age**:_____

Phone Number:__( )_____ **Email:** _____

Race/Ethnicity: ☐ Asian ☐ African American ☐ Native American ☐ Caucasian ☐ Hispanic/Latino

Primary Language: _____

Reason for participating in this program:_____

Please help us learn about your lifestyle, feelings about health, and how you manage your health. This information will help us improve our health and wellness programming for you, your family and the community. There are no right or wrong answers.

1. Would you say that your general health is: ☐ EXCELLENT ☐ VERY GOOD ☐ FAIR ☐ POOR

2. I know what my sugar level/ HgA1C should be. ☐ YES ☐ NO
3. I can find a health care provider who gives me good advice about managing diabetes. ☐ YES ☐ NO

4. During the past 3 months have you done any of the following to maintain or improve your health:
   Thought about changing eating habits to maintain or improve diabetes……☐YES ☐NO

   Changed eating habits to maintain or improve diabetes……☐YES ☐NO

   Seen a doctor for diabetes management…… ☐YES ☐NO

In a typical week:	Always	Often	Sometimes (2 days)	Rarely	Never

	(6-7days)	(3-5 days)		(1 day)	(0)
I take oral diabetic medications					
I take insulin or injectable diabetic medications					
I take my medication as it is prescribed.					
I have other health conditions					
I feel that I get support from my family and friends regarding my diabetes					
I feel like a get support from my health care practitioner regarding my diabetes					
I am knowledgeable regarding my diabetes					
I plan my meals ahead of time					
I use my meal plan….					
I am compliant with my dietary restrictions					
I do my own food shopping					
I do my own cooking					
I exercise for at least 20 minutes on a daily basis					
I eat out at fast food or restaurants					
I drink alcohol					
I check my blood sugars					
My blood sugar ranges are below 180 on a regular basis					
My blood sugar ranges are below 130 on a regular basis					
How frequently do you have a low blood sugar reaction?					
I can tell when my blood sugar is too					

high					
I have my eyes checked yearly					
I have my feet checked by a physician annually					
I perform self checks of my feet monthly					
I have my HgA1C checked every 3 months					
I have had previous diabetic Imanagement instruction					
I feel like I can manage my diabetes well					
I feel good about my general health					
My diabetes interferes with other aspects of my life					
My stress level is high					
I have some control over whether I get diabetic complications or not					
I struggle with making changes in my life to care for my diabetes					

SOUTHAMPTON HOSPITAL

Outreach Program - Health Survey/Obesity

For Children & Families

Name:_____ **Sex:** ☐ Male ☐ Female **Age**:_____

Phone Number: (_____)_____ **Email:**_____

Race/Ethnicity: ☐ Asian ☐ African American ☐ Native American ☐ Caucasian ☐ Hispanic/Latino

Primary Language:_____

Reason for participating in this program:_____

Please help us learn about your lifestyle, feelings about health, and how you manage your health. This information will help us improve our health and wellness programming for you, your family and the community. There are no right or wrong answers.

5. Would you say that your general health is: : ☐ EXCELLENT ☐ VERY GOOD ☐ FAIR ☐ POOR

6. I know what my healthy Body Mass Index (BMI) or weight for my height (BMI) should be. ☐ YES ☐ NO
7. I can find a health care provider who gives me good advice about how to stay healthy. ☐ YES ☐ NO

8. During the past 3 months have you done any of the following to maintain or improve your health:
   - Thought about changing eating habits t o maintain or improve health……..☐YES ☐NO
   - Changed eating habits to maintain or improve health……..☐YES ☐NO
   - Thought about participating in physical activities or exercise to maintain or improve health…☐YES ☐NO
   - Participated in physical activities or exercise to maintain or improve health…… ☐YES ☐NO

In a typical week:	Always (6-7days)	Often (3-5 days)	Sometimes (2 days)	Rarely (1 day)	Never (0)
How often do you purchase/eat Fast Food or processed foods?					
How often are your meals preplanned?					
How often do you plan a menu for 2-3 days at a time?					
Do you shop for groceries with a list of ingredients needed for specific meals?					
How often do you feel that a busy schedule prevents you from preparing frequent family meals?					
How often do you exercise?					
I find healthy foods that are within my budget					
I eat 2 or more servings of vegetables every day					
I eat low fat and low cholesterol foods (for example low fat dairy, lean meats, chicken, fish)					
I think about what is a healthy BMI or weight to be healthy					
I eat foods high in fiber (for example whole grains and beans)					
I read nutrition labels to see what foods are good for me					
I drink regular soda and sweetened beverages.					
I drink at least 4 glasses of water every day					
I do things to help me relax					
I feel lonely					
I do things that make me feel good about myself					
I feel bored					
I talk to friends and family about the things that are bothering me					
I change things in my life to reduce my stress					
I do physical activity for more than 20 minutes per day					
I fit exercise into my regular routine					
I find ways to exercise that I enjoy					
I find places for me to exercise in the community					

I take steps to be safe exercising (protective gear, reflective clothing)					
I do stretching exercises.					
I know where to get information on how to take care of my health					
I watch for changes in my body's condition (weight, breathing, sores, sleep changes, etc)					
When I have a health problem, I call my doctor or nurse.					
I use medication correctly					
I use tobacco products					
I have more than 1 alcoholic drink per day or more than 8 per week					
I get help from others when I need it					