Brookhaven Memorial Hospital Medical Center

2016 - 2018 Community Service Plan

Community Health Needs Assessment and Improvement Plan:

Brookhaven Memorial Hospital Medical Center (BMHMC) is a voluntary, not-for-profit community hospital in Patchogue, Suffolk County, New York. Brookhaven has maintained a commitment to providing access to quality health care since its founding in 1956. Brookhaven has grown from a 100-bed hospital founded to meet the needs of the Village of Patchogue, to a Medical Center with an operating license for 306 beds that serves the lives of more than 375,000 people living in 28 different communities.

The 2016-18 Community Service Plan will provide an overview of the Medical Center, its cooperation with the Long Island Health Collaborative, Suffolk County Department of Health, Nassau Suffolk Hospital Council and the hospitals of Suffolk County to develop a systematic approach to developing plans for providing access to care for the community for the upcoming years.

Mission Statement

It is our mission is to deliver accessible, high-quality health services in a focused caring and teaching environment while providing health advocacy for the community and people we serve.

Vision
BMHMC will be our community's healthcare provider of choice.

- We will be renowned for compassionate care, exceptional service, and medical excellence.
- Our clinical teams will deliver extraordinary care.
- We will continue to be independently committed to our Community.
- We will be the leading destination for Community patients and hospital employees alike.

Core Values

- Quality - performing at the highest level of expertise to produce the best outcomes
- Compassion - treating others with concern, interest, and caring
- Integrity - honesty in all of our actions and interactions
- Dignity- treating others with respect and courtesy
- Responsibility and Accountability - owning one's action and their consequences.

We provide care through a 306-bed acute-care hospital that's part of a multidisciplinary, multi-campus, state-of-the-art healthcare complex, designed to meet the evolving needs of the 28 Suffolk County communities we serve. BMHMC is in the process opening a state-of-the-art cardiac care center (Knapp Cardiac Care Center) that will further enhance the services and meet the needs of our community. In addition, Brookhaven has recently acquired the former John J. Foley Nursing Rehabilitation Center from the County of Suffolk. Renovation work and enhancements are planned for 2017. The center will operate much needed services to the community.

While much has changed since we first opened our doors to the community in 1956, our patient-centered approach to healthcare remains as strong as ever. Today, we are home to some of the finest

centers for specialized care along with a Level III Trauma Center/Emergency Room, two Community Behavioral / Chemical Dependency Health Centers in cooperation with Hudson River Health, and more. The Medical Center also was the first in the county to establish a Certified Home Health Care Department, a Hospice and an outpatient Hemodialysis unit and is a leader in health education throughout the community.

Community Served

We serve the needs of 28 towns and villages in Suffolk County. The Medical Center's primary and secondary service area census is 375,000 persons. It includes Brookhaven (one of the fastest growing towns in New York), and expands from west to east from Sayville to Moriches and north to Coram and Selden. Currently the highest number of hospital visits originate from the town of Patchogue, which is ethnically diverse and includes a high number of minorities. The individual median income that on average is 25 percent less than other Suffolk County residents. Census data notes an unemployment rate for the 28 communities of 6.73% with several areas over 10% including Brookhaven, West Sayville, and Mastic Beach. The poverty rate for our community is at 7.69% which is well above State and County averages with several communities with rates in excess of 10 percent including Bellport at 16.9%, Mastic Beach at 17.5%, Mastic at 13.2%, Patchogue at 12.4% and Yaphank at 11.1%. While the County has areas of wealth, the population served by the Medical Center contains 7 out of 10 communities with the lowest median income in Suffolk County. Approximately 102,000 individuals in Suffolk County live below the federal poverty level. With 28,800 living in our catchment area that approximates 28% of the total.

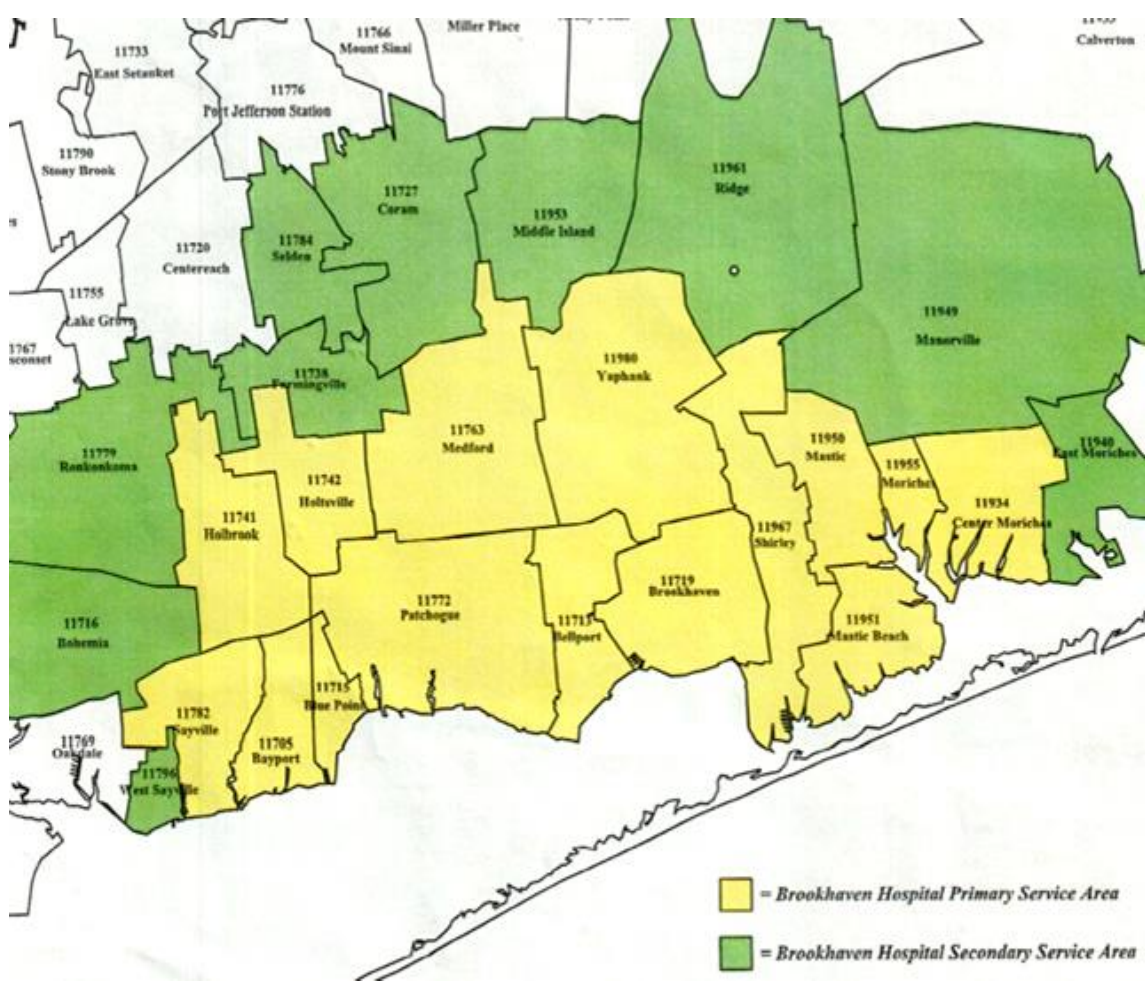
COUNTY/STATE DEMOGRAPHICS

Population	Suffolk County	New York State
2015	1,501,587	19,795,791
2010	1,493,346	19,378,110
% Change	0.5%	2.2%
Persons Under 5 Years	5.8%	6.0%
Persons Under 18 Years	24.0%	21.0%
Persons 65 Years and Over	15.6%	15.0%
Female Persons	50.8%	51.4%
White Alone	84.9%	70.1%
Black or African American Alone	8.4%	17.6%
American Indian/Alaska Native Alone	0.6%	1.0%
Asian Alone	4.2%	8.8%
Native Hawaiian/Other Pacific Islander Alone	0.1%	0.1%
Two or More Races	1.8%	2.4%
Hispanic or Latino	16.5%	18.8%
White Alone (Not Hispanic or Latino)	68.6%	56.0%
Living in Same House 1 Year and Over	93.2%	89.0%
Foreign Born Persons	15.1%	22.5%
Language Other Than English Spoken At Home	22.0%	30.4%
High School Graduate (% of persons 25 years +)	89.9%	85.6%
Bachelor's Degree or Higher (% of persons 25 years +)	34.0%	34.2%
Veterans	74,323	828,526
Mean Travel Time To Work (minutes, workers age 16+)	31.4%	32.3%
Housing Units (2008-2012*)	570,670	8,206,739
Homeownership Rate (2008-2012*)	80.1%	54.5%
Housing Units in Multi Unit Structures	14.2%	50.5%
Median Value of Owner Occupied Units	375,100	283,400
Households	493,849	7,262,279

Persons Per Household	2.98	2.63
Per Capita Money Income	37,634	33,236
Median Household Income	88,663	59,269
Persons Below Poverty Level	7.8% ¥	15.4% ¥

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits

Brookhaven ‘s Primary and Secondary market area’s



Public Participation

BMHMC has established a leadership position in health promotion, prevention and education throughout the community. Regional health planning is accomplished through a number of Agency contacts including the Suffolk County Department of Health, Mental Health Agencies and the New York State Department of Health. Brookhaven Memorial Hospital Medical Center is dedicated to

communicating with key staff and community members, as the Hospital prepares to plan for the future health care needs of the people we serve.

Brookhaven Memorial Hospital Medical Center was founded by a community focused Board of Directors and continues with more than 25 members from the community who serve on the governing Board.

In addition, the Medical Center established an Advisory Council to receive further input to the needs of the community's residents. There are more than 30 members on the Advisory Council. Members are typically active in other areas of the community and including: civic leaders, members of the clergy, school representatives, public health advocates, business leaders and service club members.

In 2013, Brookhaven along with all Long Island Hospitals and both County Departments of Health on Long Island convened to work collaboratively on the community health needs assessment. Over time, this syndicate grew into an expansive membership of academic partners, community-based organizations, physicians and other community leaders who hold a vested interest in improving community health and supporting the NYS Department of Health Prevention Agenda. Designated The Long Island Health Collaborative, this multi-disciplinary entity has been meeting monthly to work collectively toward improving health outcomes for Long Islanders.

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. Data analysis efforts were coordinated through the Population Health Improvement Program, with the PHIP serving as the centralized data return and analysis hub.

As directed by the data results, community partners selected Chronic Disease as the Priority Area with a focus on (1) Obesity and (2) Preventive Care and Management for the 2016-2018 cycle. The group also agreed that Mental Health should be highlighted as an area of overlay within all intervention strategies. This area, Mental Health, is being addressed through attestation and visible commitment to the DSRIP. There are four PPS Domain projects (4.a.i, 4.a.ii, 4.a.iii) aligned with addressing these issues.

Priorities selected in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate Mental Health throughout Intervention Strategies. Mental health has been highlighted as a focus area of growing need, which will be addressed by the Nassau Queens Performing Provider System and Suffolk Care Collaborative, DSRIP Performing Provider Systems as they integrate Domain 4 projects.

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey, Qualitative Data from Community-Based Organization Summit events and the LIHC Wellness survey. Secondary, publically-available data sets have been reviewed to determine change in health status and emerging issues within Suffolk 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), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics.

The broad community was engaged in assessment efforts through distribution and completion of the Prevention Agenda Community-Member Survey (Appendix). This tool was developed in consensus by community partners from the Long Island Health Collaborative and designed using the Prevention

Agenda framework. Available in both online and hard copy format, this survey was translated into certified Latin American-Spanish language. LIHC community partners have displayed an exemplary commitment to distributing and promoting the survey to a diverse-range of community members at a variety of locations.

Distribution and promotion of this survey is occurring throughout a wide-range of social service locations including hospitals, doctor's offices, health departments, libraries, schools, insurance enrollment sites, community-based organizations and beyond. Long Island Health Collaborative member organizations are spearheading community engagement strategies by ensuring that their front-line service departments are handing surveys out to community members. In addition, Brookhaven promoted the survey through social media efforts, posted links on their website and distributed surveys at health Center, Health fairs and other consumer-oriented events.

With funding secured through the Population Health Improvement Plan, the Long Island Health Collaborative has been leading initiatives focused on decreasing rates of Chronic Disease, specifically those diseases related to obesity and preventive care and management. Initiatives geared to address health disparities and barriers to care are vital to improving health outcomes in Suffolk County. Selected initiatives are supported and implemented by way of the LIHC network and discussed transparently at monthly Long Island Health Collaborative meetings. Long Island Health Collaborative sub-workgroups provide a focused-expertise and strategizing efforts surrounding the development of specific interventions, strategies and activities. LIHC sub-workgroup areas include: Public Education, Outreach and Community Engagement; Academia; Data; Nutrition and Wellness and Cultural Competency and Health Literacy. Sub-workgroup membership is growing continually, which adds to the high level of partnership and diversity of project efforts. Selection of initiatives is data-driven, supported by research and data in alignment with the Population Health Improvement Program's commitment to utilizing evidence-based strategies. PHIP-led initiatives support the NYS Prevention Agenda areas and include:

"Are You Ready, Feet?™" physical activity/walkability campaign and walking portal

Physician-driven Recommendation for Walking Program

Evidence-Based Stanford Programs

Mental Health First Aid USA™ Training, Evidence-based Program

LIHC Wellness Survey to measure program efficiency

Complete Streets Community and Policy Work

Leverage PHIP resources to support two synergistic programs: Creating Healthy Schools and Communities, funded by NYS DOH and Eat Smart New York, funded by USDA

The LIPHIP short-term plan for evaluation will begin with extensive qualitative data collection and analysis. We are particularly interested in the degree to which member organizations are collaborating and direct feedback from community members and member organizations. Process measures include:

- Progress and involvement of various PHIP projects resulting from collaboration and member engagement
- Feedback from partner organizations regarding the benefit of PHIP structure and how PHIP funding has impacted the health landscape

- Primary concerns and community needs voiced by community members via Community Survey
- Areas of need identified by community based organizations during Summit Events
- Emergence of policies supporting collaboration to improve population health and well-being
- Quality of partnership between NYS reform initiatives including DSRIP, SHIP, Prevention Agenda and SHINY

Specific quantitative measures will be analyzed to assess the reach of our various projects within the communities on Long Island.

- Number and organizations from various health sectors that participate and attend LIPHIP meetings and projects
- Reach of organizations and community members through social media, website and additional communications strategies
- How many community members participate in the LIPHIP walking program “Are you ready, feet?™” and subsequent data surrounding adaptation of healthy behavior
- Impact of programs that address healthy eating, physical activity, physiological well-being and responsible health practices through evaluation of LIHC wellness survey portal data
- Analysis of results from Prevention Agenda Community Member Survey and second quarter update
- Growth in number of evidence-based Stanford programs being conducted as a result of link between HRH Care, RSVP and LIPHIP
- Improvement in preventable admission and preventable visit data utilizing 3M software
- Hot spotting to identify areas of greater socio-economic need in the Long Island region

Community Outreach has long been a mainstay for Brookhaven Memorial Hospital Medical Center. Brookhaven's outreach program participates in community health fairs, with senior and community centers, as well as civic associations throughout the region. BMHMC is also an active member of eight Chambers of Commerce in the community. Membership with these chambers affords Brookhaven the opportunity to learn of the needs of the workforce and business leaders in the community. Brookhaven has a strong presence in the civic and service Clubs,(e.g. Kiwanis, Rotary Club, Lions,) houses of worship, the YMCA and Boys and Girls Club, local government health and social service programs, the social service agencies, senior living communities and public libraries.

Through its **Emergency Management** program, Brookhaven Memorial Hospital Medical Center communicates on a regular basis with the 28 voluntary EMS, EMT and Fire Departments in its service area. These volunteer departments provide an invaluable service to the community. As the 911 responders in the community, they are intimately familiar with the needs of the community. Through regular dialogue, Brookhaven learns of the unmet needs in the community and is able to assess its ability to meet those needs or provide connections to available services.

BMHMC provides a wide variety of programs and services in our community. The most encompassing of these is its county-wide recognized Home Health Agency. Our certified Home Health Care is a successful means of providing high-quality healthcare services. The need for service will be determined by the patient's physician, in consultation with the professional nurse coordinator, the patient and the family. These services bring to your home the same professional care you receive at the hospital.

These services may:

- Shorten or prevent an inpatient stays in the hospital
- Provide a smooth transition from the hospital to the home
- Prevent or delay placement in a nursing facility
- Help reduce the stress on the patient and family

Home Care makes it possible for patients to continue their recuperation at home with the availability of services provided by skilled professionals. It is also available to individuals who have not been recently hospitalized if they still meet the eligibility criteria.

Home Care also provides a **Telehealth** program for its home care patients. Telemonitoring involves collecting and sending biometric and symptom data from patients' homes to nurse care coordinators. Daily readings enable nurses and physicians to intervene early, resolving health problems before they become crises. Nurses also counsel patients, teaching them to live successfully with chronic diseases. Tele-monitoring improves quality of care and health, and reduces the cost of care.

Tele-monitoring functions through several mechanisms. First, it gives clinicians insight into a patient's condition when the patient is at home, without a lengthy phone call or home visit. Blood pressure, temperature, weight, blood glucose, blood oxygen, self- reported symptoms and other biometric data can be measured by patients at home and uploaded automatically. If a patient's health is deteriorating, our clinicians know about it early, often early enough for a home or office visit instead of a trip to the ER or a hospital admission.

In addition to improving the transition from hospital to home, it helps people with chronic diseases such as diabetes become better patients. When readings are outside an acceptable range, care coordinators help patients understand how their health behaviors- skipping a few pills, eating a high salt meal, etc.-create the adverse readings that threaten their health. Telehealth offers powerful 'teachable moments' to show patients how their self-care behaviors affect their health.

Our **Behavioral Health Home Care Program** can support those in the community with Behavioral Health illnesses are unable to transport themselves to community agencies. In addition the program is able to care for patients with co-morbidities, such as a Behavioral Health disorder and Diabetes. There can often be high levels of non-compliance in this patient population. Through this program we can provide home visits by a Registered Nurse, Nutritional Therapist, Social Worker and Physical and Occupational Therapy if needed.

Given the high prevalence of Diabetes in Suffolk County, Brookhaven has a specialized Diabetes Wellness Program that provides education, support groups, wellness and prevention classes for the community without cost.

Assessment and Selection

The community health assessment covers Suffolk County, New York. Suffolk County's service area is situated east of the Nassau County Border, extending through the eastern forks of Long Island. It comprises ten towns: Babylon, Huntington, Islip, Smithtown, Brookhaven, Southampton, Riverhead, East Hampton, Shelter Island and Southold. Suffolk County is an area of growing diversity, cultures and population characteristics.

Data presented within this report demonstrates 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 bridging of gaps and services will ultimately improve health outcomes and quality of life for community members. As noted previously the socioeconomic environment of our catchment area shows unemployment and poverty rates well above the Long Island and Suffolk County averages. The Mastic beach area has an unemployment rate of 10.8%, Poverty rate of 17.5% and 17.8% of their residence are receiving cash public assistance and or food stamps. Bellport is another community in need with unemployment at 6.1% but the poverty level is at 16.9% and Household assistance need is at 11.64%. The Brookhaven Bellport Primary Care Center was opened to support the needs of this community and we are working with community groups, the Boys and Girls Club as well as many area churches and organizations to publicize our presence. Plans are being developed to establish a similar facility in the Shirley/Mastic area.

The Long Island Health Collaborative in conjunction with numerous participating health care facilities and providers support the New York State's Prevention Agenda. The data obtained and reviewed supports the agenda.

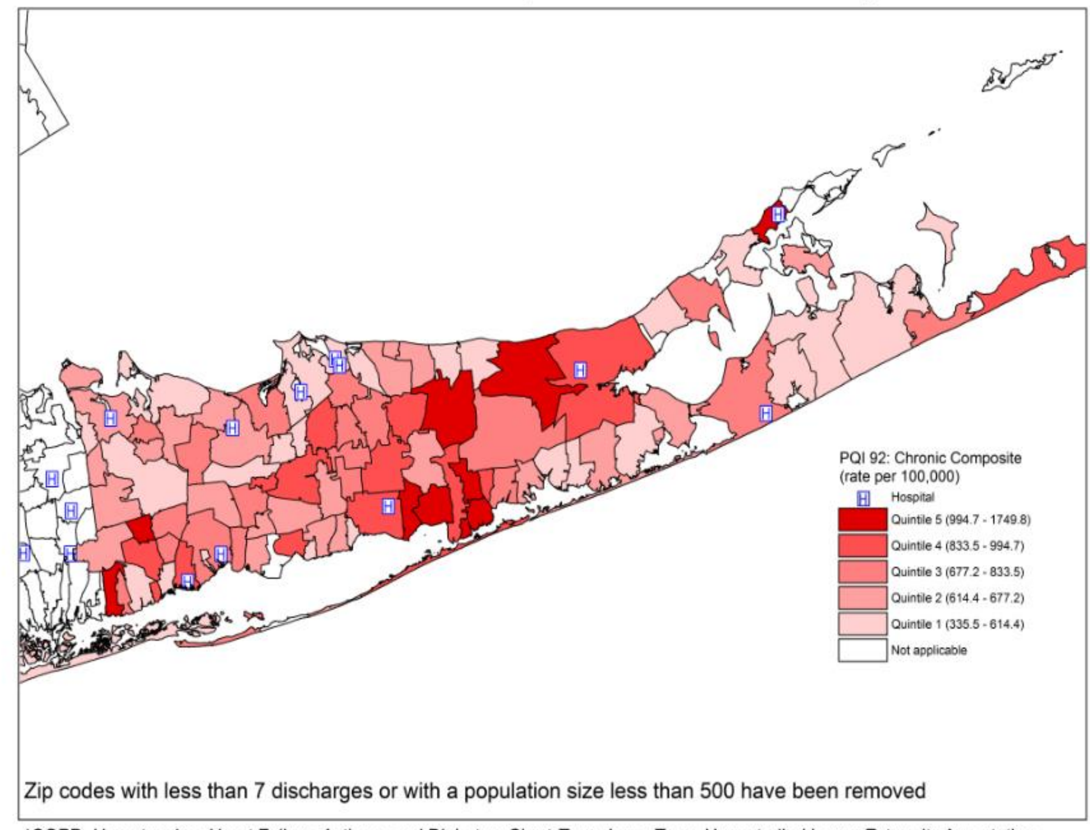
The Prevention Agenda 2013-2018 is New York State's Health Improvement plan purposed to improve health outcomes and reduce health disparities within five priority areas: Chronic Disease Prevention, Healthy and Safe Environment, Prevention of HIV/STD, Vaccine Preventable Disease and Healthcare-Associated Infections, Promote Healthy Women, Infants and Children and Promote mental health and prevention substance abuse.

Chronic Disease

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.

Figure 1 demonstrates the zip codes in Suffolk County representing the most significant number of preventable cases per 100,000 adult population. Quintile 5 represents 994.7-1749.8 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 hospitals visits related to Chronic Disease fall. As displayed within the PQI Chronic Composite for Suffolk County, there is a notable occurrence of Chronic Disease among a majority of communities, particularly those connected to low socioeconomic status.

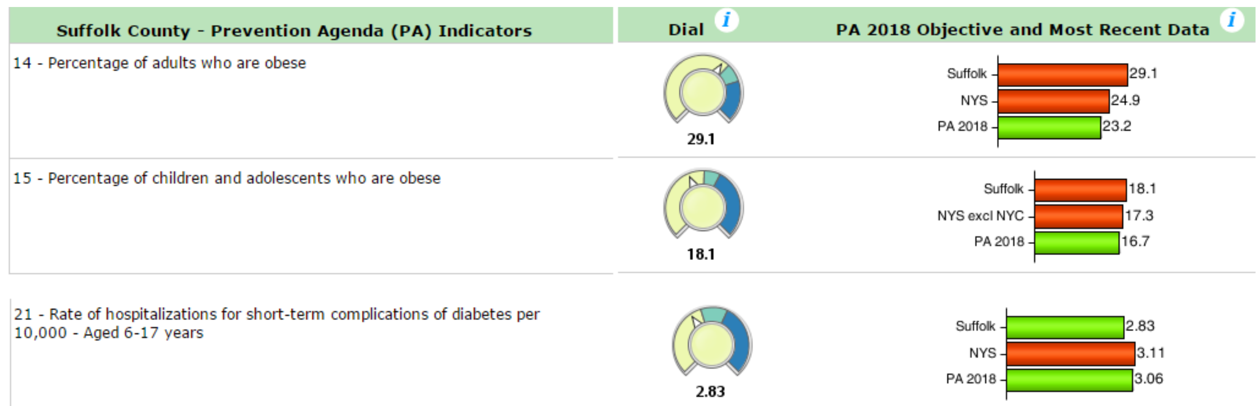
PQI 92: Chronic Composite for Suffolk County*



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

Within the dashboard, review of 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System, demonstrates 29.1% of adults in Suffolk County are obese. Obesity rates are higher than figures reported by New York State, 24.9% and the Prevention Agenda Goal of 23.2%. The Long Island Health Collaborative felt interventions should be focused on decreasing chronic disease as a whole, while focusing on obesity, prevention and care management.

Rate of hospitalizations for short-term complication of diabetes reflects 2.83 per 10,000 for adults in Suffolk County and 3.11 in New York State. Although this indicator is below the Prevention Agenda Goal of 3.06%, Long Island Health Collaborative emphasized a need for focus on high utilizing pockets within the County with further room for improvement



Suffolk County - Prevention Agenda (PA) Indicators	Dial	PA 2018 Objective and Most Recent Data
14 - Percentage of adults who are obese	29.1	Suffolk 29.1; NYS 24.9; PA 2018 23.2
15 - Percentage of children and adolescents who are obese	18.1	Suffolk 18.1; NYS excl NYC 17.3; PA 2018 16.7
21 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	2.83	Suffolk 2.83; NYS 3.11; PA 2018 3.06

Through the work of dedicated volunteers who serve as member of the Board Directors and the Advisory Council, BMHMC provides significant benefit to the community. Board and Council members annually donate an estimated 4,300 hours of service. They were integrally involved in the selection of the public health priorities.

Long Island Community Health Assessment Survey

To collect input from community members, and measure the community-perspective as to the biggest health issues in Suffolk County, the LIHC developed a regional survey called the Long Island Community Health Assessment Survey. This survey was distributed via survey monkey and hard copy formats. The survey was written with adherence to Culturally and Linguistically Appropriate Standards (CLAS). It was translated into certified Spanish language and large print copies were available to those living with vision impairment. Survey distribution began among LIHC members in January 2016, with 3,910 surveys collected from Suffolk County residents. Based upon the total population of Suffolk County, survey totals assume a confidence level of 95% and confidence interval of 1.57. Initial analysis took place in March 2016, a secondary analysis took place in June 2016, and a third analysis took place in November 2016. LIHC members have played an integral role in ensuring surveys are distributed while maintaining validity and reliability among responses. To view a copy of the Long Island Community Health Assessment Survey, see Appendix.

Long Island Community Health Assessment Surveys were distributed both by paper, and electronically through Survey Monkey, to community members. On March 21st 2016, June 2nd 2016, and November 1st 2016, the PHIP data analyst downloaded results from each of the Survey Monkey collectors.

Data Findings by Survey Question:

When asked what the biggest ongoing health concerns in the community where you live are:

1. Suffolk County respondents felt that Drugs and Alcohol Abuse, Cancer, and Obesity/Weight Loss were the top three concerns. These three choices represented roughly 46% of the total responses.

2. When asked what the biggest ongoing health concerns for yourself are:

Suffolk County respondents felt that Obesity/Weight Loss, Women's Health and Wellness, and Cancer were the top three concerns. These three choices represented roughly 40% of the total responses.

Findings from Questions 1 and 2 of the Long Island Community Health Assessment Survey served as one data-driver for selection of the priority areas for the 2016-2018 Community Health Needs Assessments. An additional focus of this survey tool explored barriers to care, community needs and education or health services.

The next question sought to identify potential barriers that people face when getting medical treatment:

3. Suffolk County respondents felt that No Insurance, Inability to pay co-pays or deductibles, and fear were the most significant barriers. These choices received roughly 55% of the total responses.

4. When asked what was most needed to improve the health of your community:
   Suffolk County respondents felt that Drug and Alcohol Rehabilitation Services, Healthier Food Choices, and Job Opportunities were most needed. These choices accounted for 40% of the total responses.

5. When asked what health screenings or education services are needed in your community:
   Suffolk County respondents felt that Drug and Alcohol, Mental Health/Depression, and Exercise/Physical Activity services were most needed.

Summary of Findings

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 Suffolk County. In looking at distinct Prevention Agenda Categories, 30.9% of quotations indicated Chronic Disease being a priority area.

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 Suffolk County quotes.

e.g. "*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.

PA Rank	Suffolk	%*
1	Chronic Disease	30.9%
2	Mental Health	29.9%
3	Healthy and Safe Environment	25.4%
4	Healthy Women, Infants and Children	13.2%
5	HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections	9.4%

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

Within the Priority Area of Chronic Disease, Chronic Disease Management and Obesity/Nutrition were the most frequently prioritized focal areas. Of the total number of quotes by County, 10.2% of quotations included “Chronic Disease Management” and “Obesity/Nutrition” equally, as topics of importance.

Chronic Disease	
Focus Area	%*
Chronic Disease Management	10.2%
Obesity/Nutrition	10.2%
Chronic Disease Prevention	7.9%
Diabetes	5.2%
Cancer	4.0%
Other Chronic Conditions	3.9%
Cardiovascular	3.8%
Respiratory	3.6%
Smoking/Tobacco	3.3%

*** Number of quotations with Suffolk county code and focus area code/total number of quotes applicable to Suffolk County**

The Priority Area of Mental Health and Substance Abuse emerged closely as a second-ranking topic of importance. Qualitative analysis demonstrated, 29.9% of quotations indicating Mental Health as an area of concern in Suffolk County. Cumulatively, 47.9% of quotations included Mental Health and Substance Abuse as an area of concern within communities served in Suffolk County.

Upon further breakdown of the focus areas within the overarching priority area of Mental Health and Substance Abuse, “Mental Health Issues”, including behavioral, developmental, poor mental health, emerged at the forefront with 18.1% of quotations in Suffolk County. A second focus area, “substance abuse”, appeared with 11.3% of quotations containing related key words.

Mental Health and Substance Abuse	
Focus Area	%*
Mental Health Issues	18.1%
Substance Abuse	11.3%
Susceptible Populations	7.4%
Attitudes	4.1%
Anxiety, Mood Disorders, and Associated Emotions	2.9%
Treatment and Recovery	2.7%
Eating Disorders	0.9%
Suicide	0.4%

*** Number of quotations with Suffolk county code and focus area code/total number of quotes applicable to Suffolk County**

For the 2016-2018 cycle, community partners selected ***Chronic Disease*** as the Priority Area with a focus on (1) Obesity and (2) Preventive Care and Management. The group also agreed that Mental Health should be highlighted as an area of overlay within all intervention strategies. This area, Mental Health, is being addressed through attestation and visible commitment to the DSRIP, PPS Domain 4 projects (4.a.i, 4.a.ii, 4.a.iii). Priorities selected in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate Mental Health throughout Intervention Strategies. Mental health has been highlighted as a focus area of growing need, which will be addressed by the Suffolk Care Collaborative (PPS) as they work on Domain 4 projects.

Domain 4 projects with a focus on mental health include:

- Project 4.a.i Promote mental, emotional and behavioral (MED) well-being in communities
- Project 4.a.ii Prevent substance abuse and other mental emotional disorders
- Project 4.a.iii Strengthen mental health and substance abuse infrastructure across systems
- Project 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health

Hospital partners are fully attested and active participants in DSRIP project and deliverables, thus fully supporting the emphasis being placed on improving outcomes related to Mental Health.

Through our assessment efforts, BMHMC has learned some very salient facts and this led to a 23.4% of pregnant women in WIC were pre-pregnancy obese (BMI 30 or higher). 26% of individuals in Suffolk County are obese. In the US at large, 25% of individuals are obese.

Diabetes

- Diabetes is one of the leading causes of death in New York State, (excluding New York City), according to the New York State Department of Health's Vital Statistics
- Diabetes mortality rates are 14% of all deaths in Suffolk County and are the highest in the region
- Diabetes hospitalization rates in Suffolk County are also highest in the region at 15.9%
- Suffolk County has 29.1% of its population classified as obese. This exceeds both the State at 24.9% and the country at 23.2%
- The rate of hospitalization for short term complications due to diabetes per 10,000 increased to 4.83.
- 6.3% of Suffolk County residents are at risk for pre-mature death due to diabetes.

Drug Abuse

- The prevalence of heroin use is increasing, due to its low cost and ease of accessibility
- In 2016 Our Emergency Room has noted a significant increase in drug related visits.
- In Suffolk County, drug related admissions increased by 9% from 2013 to 2014. As such, BMHMC has identified a strong need for community education, prevention and treatment services to quell this rising epidemic.
- According to the Substance Abuse and Mental Health Services Administration, SAMSHA the number of people aged 12 and older who have used heroin increased from 373,000 in 2007 to 669,000 in 2012.

As per information obtained from SAMSHA, Heroin is a highly addictive narcotic, with users representing a variety of ages, races and other backgrounds. Fatal overdose, the contraction of Hepatitis C and/or HIV and addiction and dependence are among a plethora of negative side effects

that can result from heroin use. In addition to physical danger, heroin use threatens a user's social ties - often straining family bonds, friendships and professional relationships.

Brookhaven's Three-Year Plan of Action

The focus of BMHMC's Community Service Plan is to provide resources and services to at-risk members of the community and employees of BMHMC who are dealing with Chronic Diseases / obesity, diabetes, mental health, substance abuse and other health related issues. BMHMC will be reaching out to a wide variety of organizations within the community to offer educational programs as well as services to assist in living healthier lives and making better health choices.

Priority 1: Obesity, Including Co-morbidities of Diabetes and Heart Health

Goal: Create community environments that promote and support healthy food and beverage choices and physical activity and to engage community members in regional physical activities and wellness campaigns.

Action Plan:

- Increase community, employee and partner engagement.
- Identify individuals at risk for chronic disease, such as COPD, Diabetes and Heart disease through community health events, community meetings, Hospital visits and free screenings
- Create educational materials and/or classes on nutrition, benefits of increased physical activity, BMI, etc.
- Improve the health of the employee community within BMHMC
- Establish walking and running groups for employees and community members
- Provide BMI screenings and integrate a focus on obesity and nutrition
- Partner with community organizations, including Suffolk County, Town of Brookhaven, YMCA, Bellport boys and Girls club for annual health related events
- Promote Brookhaven Bariatrics for those struggling with weight loss
- Work with the Long Island Health Collaborative (LIHC) by attending regional meetings, accessing the inventory of services, and utilizing the universal screening tool as appropriate

Evaluation: Programs will be evaluated on a monthly basis by the number of participants who attend. Educational material, health counseling and referral to medical evaluation will be offered to those who attend.

Priority 2: Increase access to high quality chronic disease preventive care and management for Diabetes and other chronic care conditions in both clinical and community settings.

Goal: Promote culturally relevant self-management education and tools for diabetes and other chronic conditions

Action Plan:

- Enhance services and provide education classes for the community though Brookhaven's Diabetes Wellness Program
- Expand access to free screenings for blood pressure
- Coordinate with clinicians to establish a process to monitor and remind patients about preventative and follow up care
- Partner with community organizations to develop healthy food alternatives
- Promote medical home/team based care to clinicians in the community

- Identify high risk patients and monitor out of hospital experiences to improve patient outcomes through lung cancer screening program, Breast cancer coalition and coordination with Suffolk Care Coalition programs

Evaluation: Programs will be evaluated on a monthly basis by the number of participants who attend. Free educational class will be offered along with educational material to be distributed.

Priority 3: Promote Mental Health and Prevent Substance Abuse

Goal: Promote mental, emotional and behavioral well-being in communities and reducing drug abuse.

Action Plan:

- Educate the community through health forums and free lectures on mental, emotional and behavioral well-being and substance abuse
- Partner with community agencies (such as Suffolk County Department of Health/Division of Community Mental Hygiene Services) and other providers to afford access to treatment of Chemical Dependency problems
- Provide mental health and chemical dependency services in our Brookhaven Outpatient programs
- Provide education on identification and treatment options for individuals with mental health and substance use issues to Emergency Room staff and Community clinicians
- Coordinate expansion of Alcohol and Drug rehabilitation through the renovation of the former John J. Foley Nursing Rehabilitation Center
- Identify potential substance abuse patients through use of the Emergency Room screening tool, Screening Brief intervention and referral to treatment, SBIRT tool.
- Implement the Opiate abuse prevention program at the Emergency room to provide Narcan Opiate overdose kits to those in need.
- Brookhaven Family Medicine has become an NCQA Certified Patient Centered Medical Home and will continue to identify and recognize early symptoms of mental illness and substance abuse through the use of evidence based tools. This Integrated care model will enable easy access to the services needed.

Evaluation: Programs will be evaluated on a monthly basis by the number of participants who attend. Free educational class will be offered along with educational material to be distributed.

Organizational and Community Health Programs

The following entities will collaborate with BMHMC to assist with attainment of goals and objectives of the public health priorities:

BMHMC - Diabetes Wellness Center

In partnership with The New York State Diabetes Prevention Program (NYS DPP), BMHMC hosts free education programs provided by the Suffolk County Department of Health Services. Pre-diabetes is a serious health condition that can lead to diabetes, heart disease, and stroke. Most people with pre-diabetes don't know that they have the condition.

In 2006, BMHMC developed the Diabetes Wellness Center with the support of the Suffolk County Lions Diabetes Education Foundation sclionsdiabetes.org and Lions International. The Center has a Diabetes Self-Management Education Program and offers a series of educational programs "*Living Well While Managing Your Diabetes*" for those learning to manage with diabetes in their life.

The classes are held at the Brookhaven Diabetes Wellness Center located at 33 Medford Ave, Patchogue, NY 11772. For more information please call 631.687.4188.

The BOCES - Bellport Academic Center is located within the BMHMC services area. BMHMC has a contractual relationship to provide health care services to the students at the Center. Educational material about diabetes, obesity, mental health and substance abuse will be distributed to the students as a component of BMHMC's outreach program and this Community Service Plan.

BMHMC - Bellport Primary Care Center

BMHMC has opened a primary care center in Bellport which is close to the main hospital. This new primary care center will have a strong focus on prevention and education, especially in the areas of diabetes, hypertension, tobacco cessation, obesity, mental health and substance abuse, women's health and cardiovascular education.

Located in close proximity to the BPPC is a new Boys and Girls Club facility. BPPC and the Club intend to collaborate to provide better health and lifestyle choices for the residents of the community.

Community-Based Patient Advisory Council

BMHMC realizes the tremendous value of having a community-based Patient Advisory Council (PAC). In 2014, BMHMC selected a diverse group of community members who can provide us information and feedback about the programs and services offered.

Brookhaven Breast Cancer Survivorship Coalition

BMHMC recognizes the impact that Breast cancer can have on not just the patient but the family and is working with community members to support those in need and to educate the public on the impact and issues of Breast Cancer

Knapp Cardiac Care Wellness program

This program offers free blood pressure screenings, art classes, walking and exercise classes, and educational seminars to support heart health

Mental Health Family Education

For Family and Friends of people struggling with mental illness and or substance abuse meets twice a month.

Other Programs

Annually, Brookhaven offers a free of charge wellness event for the community. This year BMHMC collaborated with the Patchogue YMCA and the Boys & Girls Club of Bellport to provide more than 300 people an interactive experience. Utilizing educational games and creative stations including CPR and AED demonstrations we were able to educate and inform the community about healthy lifestyle choices. Also included were physical activities for adults and children including bounce houses and obstacle courses along with Zumba instruction, all promoting movement to improve health.

Brookhaven Hospital offers a variety of medical lectures through our Knapp Cardiac Care Center, Breast Cancer Survivorship Coalition and Diabetes Wellness Center on a monthly basis. Topics have included healthy lifestyles, cooking demonstrations with healthy recipes provided,

depression screening and treatment, diabetes wellness and prevention of diabetes, managing heart disease, to name a few. Most of the presenters are members of the BMHMC medical staff, or closely affiliated with it. Additional resources about all BMHMC programs, support groups and community events are always made available to the community at the same time. The lectures are free to the public.

Additional Community Health Programs

In addition to the many programs and services offered by BMHMC, there are many other community programs to help achieve better health. Some organizations that we currently work with are:

- Boys & Girls Club of Bellport
- The Diabetes Resource Coalition of Long Island
- YMCA of Patchogue
- BOCES
- Cornell University Cooperative Extension of Suffolk County
- St. Joseph College
- Bellport and Patchogue Head Start
- Bellport
- Hudson River Health Center Patchogue and Shirley
- Bellport Hagerman East Patchogue Alliance
- School Districts
- Service Clubs
- House of Worship
- Local Libraries
- NPF Organizations
- Mental Health Agencies
- Substance abuse agencies
- Nursing Homes and Assisted Living

We will also partner with the Long Island Health Collaborative (LIHC) which is a working group of hospital members, local health department personnel, representatives from social service organizations, public health specialists from colleges, and others who form the core of health and human service for all Long Islanders. In addition, we are working with the Suffolk Care Collaborative to impact population health through our participation in the Delivery System Reform Incentive Payment program, DSRIP.

Member organizations include:

Hospitals, Hospital Association and Hospital Systems	Website
Brookhaven Memorial Hospital Medical Center	www.brookhavenhospital.org
Catholic Health Services of Long Island	www.chsli.org
Eastern Long Island Hospital	www.elih.org

Glen Cove Hospital	www.northwell.edu
Good Samaritan Hospital Medical Center	www.goodsamaritan.chsli.org
Huntington Hospital	www.northwell.edu
Long Island Jewish Valley Stream	www.northwell.edu
John T. Mather Memorial Hospital	www.matherhospital.org
Mercy Medical Center	www.mercymedicalcenter.org
Nassau-Suffolk Hospital Council	www.nshc.org
Nassau University Medical Center	www.numc.edu
North Shore University Hospital	www.northwell.edu
Northwell Health System	www.northwell.edu
Peconic Bay Medical Center	www.pbmchealth.org
Plainview Hospital	www.northwell.edu
St. Catherine of Siena Medical Center	www.stcatherines.chsli.org
St. Charles Hospital	www.stcharles.chsli.org
St. Francis Hospital	www.stfrancis.chsli.org
St. Joseph Hospital	www.stjoseph.chsli.org
Southampton Hospital	www.southamptonhospital.org
South Nassau Communities Hospital	www.southnassau.org
South Oaks Hospital	www.south-oaks.org
Southside Hospital	www.northwell.edu

Stony Brook University Hospital	www.stonybrookmedicine.edu
Syosset Hospital	www.northwell.edu
Veterans Affairs Medical Center	www.northport.va.gov
Winthrop University Hospital	www.winthrop.org

Local County Health Departments	Website
Nassau County Department of Health	www.nassaucountyny.gov
Suffolk County Department of Health Services	www.suffolkcountyny.gov

Medical Societies and Associations	Website
Long Island Dietetic Association	www.eatrightli.org
Nassau County Medical Society	www.nassaucountymedicalsociety.org
New York State Nurses Association	www.nysna.org
New York State Podiatric Medical Association	www.nyspma.org
Suffolk County Medical Society	www.scms-sam.org

Community-Based Organizations	Website
Adelphi New York Statewide Breast Cancer Hotline and Support Program	www.breast-cancer.adelphi.edu
Alzheimer's Association, Long Island Chapter	www.alz.org
American Cancer Society	www.cancer.org
American Foundation for Suicide Prevention	www.afsp.org
American Heart Association	www.heart.org

American Lung Association of the Northeast	www.lung.org
Association for Mental Health and Wellness	www.mentalhealthandwellness.org
Asthma Coalition of Long Island	www.asthmacommunitynetwork.org
Attentive Care Services	www.attentivecareservices.com
Caring People	www.caringpeopleinc.com
Community Growth Center	www.communitygrowthcenter.org
Cornell Cooperative Extension - Suffolk County	www.ccesuffolk.org
Epilepsy Foundation of Long Island	www.efli.org
Evolve Wellness	www.evolvewellness.net
Family & Children's Association	www.familyandchildrens.org
Family First Home Companions	www.familyfirsthomecompanions.com
Federation of Organizations	www.fedoforg.org
Girls Inc. LI	www.girlsincli.org
Health and Welfare Council of Long Island	www.hwcli.com
Health Education Project / 1199 SEIU	www.healthcareeducationproject.org
Hispanic Counseling Center	www.hispaniccounseling.org
Hudson River Healthcare	www.hrhcare.org
Life Trusts	www.lifetrusts.org
Long Island Association	www.longislandassociation.org
Long Island Association of AIDS Care	www.liaac.org

Long Island Council of Churches	www.liccny.org
Make the Road NY	www.maketheroad.org
Maurer Foundation	www.maurerfoundation.org
Mental Health Association of Nassau County	www.mhanc.org
Music and Memory	www.musicandmemory.org
New York City Poison Control	www.nyc.gov
Options for Community Living	www.optionscl.org
Pederson-Krag Center	www.pederson-krag.org
People Care Inc.	www.peoplecare.com
Pulse of NY	www.pulseofny.org
Retired Senior Volunteer Program	www.rsvpsuffolk.org
RotaCare	www.rotacareny.org
SDC Nutrition PC	www.call4nutrition.com
Smithtown Youth Bureau	www.smithtownny.gov
Society of St. Vincent de Paul Long Island	www.svdpli.org
State Parks LI Regional Office	www.nysparks.com
Sustainable Long Island	www.sustainableli.org
The Crisis Center	www.thecrisisplanner.com
Thursday's Child	www.thursdayschildofli.org
TriCare Systems	www.tricaresystems.org

United Way of Long Island	www.unitedwayli.org
YMCA of LI	www.ymcali.org
School and Colleges	**Website**
Adelphi University	www.adelphi.edu
Farmingdale State College	www.farmingdale.edu
Hofstra University	www.hofstra.edu
Molloy College	www.molloy.edu
St. Joseph's College	www.sjcny.edu/long-island
Stony Brook University	www.stonybrook.edu
Western Suffolk BOCES Creating Healthy Schools and Communities, NYS DOH	www.wsboces.org
Performing Provider Systems (DSRIP PPS)	**Website**
Nassau Queens PPS	www.nassauqueenspps.org
Suffolk Care Collaborative	www.suffolkcare.org
Insurers	**Website**
1199SEIU/Health Education Project	www.1199seiu.org
Fidelis Care	www.fideliscare.org

Dissemination of CSP to the Public

Through the use of professional independent research community surveys and focus groups, we will garner interest and report findings back to the community. The community surveys and focus groups will help to identify the perceived needs and concerns of the community.

Our community agencies and partners will also distribute our CSP to their participants. For a complete copy of this Community Service Plan please contact the External Relations office at 631.654.7708.