Community Service Plan 2014-17
Annual Update 2016

Prevention Agenda Priorities and Overview

The selection of our priorities for 2014-17 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. Long Island Health Collaborative (LICH) members reached a consensus and selected Prevent Chronic Disease, with the focus areas of Reduce Obesity and Reduce the Risk for Diabetes. In response to a growing need for assessable mental healthcare on Long Island's South Fork, Southampton Hospital chose an additional priority, Prevention of Mental Illness.

The following report provides an update on the programs we have continued to follow this past year, the progress we are making, and considerations for 2017. Between our three Focus Areas—obesity, diabetes, and mental illness—there are shared interventions and useful crossover opportunities that we are continuing to incorporate.

PREVENT CHRONIC DISEASE

Focus Area 1: Reduce obesity in Children and Adults *(NYS Prevention Agenda Focus Area)*

- **Target Population:** school age children and their parents, Hospital staff
- **Key Partners:** Wellness Foundation/East Hampton, and Southampton School District (Long Island, NY)

Fit Kids Program

The Fit Kids program continues to focus on raising awareness of health and wellness focused on school-aged children between 10-15 years of age. Our model has been implemented in the Southampton and Tuckahoe School districts, and we are expanding the program to offer it in the Hampton Bays School district as well. Our model currently runs on a 4-6 week time frame with education focusing on exercise and health promotion. We are continuing to use a Likert scale to measure the students' perception of their health from a nutrition, exercise and mental health standpoint. One barrier to measuring results is that not all of the same students return their surveys, making the pre- and post-data slightly skewed. Many of the surveys are incomplete since students have very limited time to complete the survey and participate in the

class, we tried on previous occasions to send the surveys home with the students but the return rate was too low.

Starting in 2016 Southampton Hospital Wellness Institute along with the East Hampton Wellness Foundation started a train-the-trainer program and offered small grants to all participating schools. We coordinated a day-long program to train teachers, student representatives, and other school staff (nurse, athletic directors, etc.) on increasing activity, increasing nutrition, and leading by example for their students. We thought that by training the teachers who are the role models and the leaders within the school that we could use the "trickle down" theory to promote wellness in the classroom. Topics included brain breaks, extra recess, using non-food items as a reward, limiting classroom celebrations to healthier foods, and much more. There was a coordinated effort lead by both Southampton Hospital and the Foundation to have all resources in the community attend and represent their services at the program. We had 10 different organizations come to showcase what they are doing in various areas on the East End for the childrens' health and wellness. This collaborative program served as an excellent resource and networking event for the school administrators, teachers, support staff and students.

All participants were awarded a grant to apply to wellness programs in their schools. We are currently planning the next conference as this is now become an annual event. We are in the process of choosing schools to report and present how they used their Wellness Grant funding. Our hope is that other schools can network and brainstorm ideas to promote Wellness. This conference not only promotes health and wellness within the schools but makes this a community-wide effort that has expanded beyond the South Fork to include the North Fork as well. Last year we had over 15 different schools participate in this program and are expecting it to grow to over 20 schools in 2017.

Southampton Hospital's Nutrition Services

The Hospital's Nutrition Services Department plays a key role within the Hospital in promoting Health and Wellness through our programs on Healthy Eating for Patient and in the Meeting House Café. Our menus promote whole grains, super foods, berries, yogurt, fiber, fruits, and vegetables. To achieve the balance of good nutrition and great flavor, we serve menus that adhere to the principles of the award-winning food style of Conscious Cuisine®. We start by selecting fresh seasonal fruits and vegetables, as well as Certified Humane cage-free eggs, and poultry-raised without the routine use of antibiotics. We make a conscious effort to deliver food and its promise of comforting flavor and balanced nutrition.

Our Patient Menus Highlights these items: Whole Grains: Whole grain foods are a great source of fiber that helps to reduce cholesterol, stabilize blood sugar, reduce risk of heart disease and aid in maintaining a healthy weight. Super Foods: Cinnamon has one of highest antioxidant levels of any spice; you'll find as many antioxidants (disease fighting properties) in 1 teaspoon of cinnamon as in a full cup of pomegranate juice or 1/2 cup of blueberries. Berries: Strawberries, blueberries and raspberries offer a variety of antioxidants (disease fighting properties), anti-inflammatory compounds and fiber. An excellent source of vitamin C (an immune boosting vitamin), they provide 141% of the recommended daily allowance (RDA) per cup. Yogurt: Yogurt is naturally rich in protein and calcium. A probiotic, it will stimulate the immune system and promote intestinal health.

Ed & Phyllis Davis Wellness Institute Programs for the Community and Hospital Staff:

Our goal is to promote wellness through Functional Medicine/ Anti-Aging Medicine by promoting certain foods to help heal the body and prevent chronic disease. Educational topics for our monthly Nutrition Talks and Cooking Demonstrations include "Cleaning up Your Diet," "Rainbow of Fruits," "Vegetables That Promote Increased intake of Antioxidants/Phytochemicals," Cardiovascular Health," "Nutrition Wellness," "Packing a Fun and Satisfying Lunch." "Adding Healthy Spices to Meals," "Taming Inflammation in the Body," "The Microbiome," and "Use of Probiotics and Prebiotics." We discuss whole foods, fresh cooking , eliminating processed foods and foods containing preservatives and additives, choosing a moderate amount of lean protein, healthy fat choices, whole grains and incorporating fruits and vegetables into meals and exploring plant-based meals. These presentations are free to the public and well-attended.

In the Hospital's Meeting House Café

Convenient for Hospital staff, physicians, and visitors, the Café features a monthly Seasonal Food Table where super foods, seasonal fruits and vegetables are featured along with food sampling to encourage visitors and staff to try new things. Super foods are included in our salad bar, "Outtakes" salads, smoothies, soups, desserts and entrees, and recipes for incorporating these super foods are also provided. Our Executive Chef and Clinical Dietitian also offer Quarterly Cooking Demonstration Promoting Healthy foods and cooking Ideas. Also offered are FIT food items low in cholesterol and sodium, no trans fats, Flexatarian items, ancient grains, vegan, and vegetarian items. "Impulse" items are displayed close to the cash register (water, fresh fruits, nuts and snack foods (less than 200 calories and 200 mg sodium).

East End Farm-to-School Program Grants

The Southampton School District will receive a $94,863 grant for the farm-to-school program in 2017. School cafeterias in schools in Southampton, Bridgehampton, and Tuckahoe will benefit from the program which stresses health and wellness through access to healthy, locally grown produce. More locally grown specialty crops will be integrated in school meal programs. The East End of Long Island has a rich agricultural history and is the perfect place to create partnerships between farms and schools with the goal of increasing the volume and variety of local crops making it into school meal programs.

Community Outreach Focus on Healthy Choices and Health Consequences of Obesity

- Southampton Hospital has a robust community outreach program that includes presentations by physicians, registered dieticians and other clinicians that take place in area libraries, YMCA, Senior Centers, school health fairs, cancer support groups, and meetings of local organizations. 2016 topics included: Healthy Transition: Start with Nutrition, Heart Health Awareness, Healthy Eyes: Healthy Vision. Topics for early 2017 include Cleaning Up Your Diet by Weaning Yourself Off Of Sugar and Processed Foods, and Food as Medicine.

- Monthly E-Newsletter is sent to 7,000+ subscribers. Nutrition and exercise topics are included along with other Hospital news.

- Social Media: Nutrition tips are posted periodically on Facebook and Twitter, with links to related content on the Southampton Hospital website. Social media users can engage with content and receive feedback from Southampton Hospital marketing staff to find services to manage their healthcare concerns.

- "Nutrition for the Whole Family" was a program in the Hospital's Summer Wellness Series.

- We partner with the Wellness Foundation, a nonprofit organization based in East Hampton, NY that promotes healthy living by educating, supporting and inspiring children and adults to adopt healthy lifestyles. Their 6-week "Wellness Challenge" takes place in the Hospital's Parrish Memorial Hall and typically attracts 25+ adult participants each session.

- Nutritional Counseling services are featured on the Southampton Hospital website under Hospital Services with information about these programs and contact information.

- We also partner annually with community-organized annual walking events including Ellen's Run, Hamptons Marathon, Hamptons Half-Marathon, Bariatric Surgery Walk, LI2Day Walk, and American Heart Association.

- We continue to monitor the content of Hospital vending machines and options in the Meeting House Lane Café to reduce consumption of sugary beverages and unhealthy snacks. Only healthy refreshments are provided at Hospital meetings.

Focus Area 2: Diabetes Self-Management Education and Support Program (DSME/S)

Target Population: Patients with diabetes, pre-diabetes and gestational diabetes and their family members invited to participate in the out-patient DSME/S program

Key Partners: American Diabetes Association/Education Recognition Program (ADA/ERP), Community Physicians, Diabetes Advisory Committee members

Diabetes self-management education and support (DSME/S) provides the foundation to help people with diabetes navigate daily decisions and activities and has been shown to improve health outcomes. DSME/S has been shown to be cost effective by reducing hospital admissions and re-admissions as well as estimated lifetime health care cost related to lowering diabetes complications. It is the position of the American Diabetes Association (ADA) that all individuals with diabetes receive DSME/S at diagnosis and as needed for optimal care thereafter. The goals are ultimately to improve patient experience of care and education, to improve the health of individuals and populations, and to reduce diabetes associated per capita health care cost

Intervention Strategies

The strategies of DSME/S program are based on ADA standards of care which include a number of evidence-based guidelines that result in good diabetes outcomes.

- All participants are provided a self-assessment questionnaire on their diabetes management to guide the healthcare practitioner in assessing the patient to determine an individualized education and support plan

- Nutrition assessment is conducted to identify nutrition related problems, their causes and significance. Purpose is to identify a specific nutrition problem that can be resolved or improved through nutrition intervention, i.e. diet high in simple carbohydrates. Nutrition intervention provides specific planning and implementing individualized meals and snacks

- The benefits of exercise on blood glucose levels and health is addressed. An individual exercise regimen is worked out between patient and clinician for patient to incorporate into lifestyle. This provides a learning experience for patients to create a plan of physical activity if participant desires.

- Patients are instructed on monitoring blood glucose, identifying blood glucose targets, and interpret the results for self-management decision making. Updated lab results, A1C, glucose, BMP and lipid panel are reviewed when available

- Educate patients on the prevention detection and treatment of both acute and chronic complications of poorly controlled diabetes. Review sick-day management, hypoglycemia and hyperglycemia.

- Aid the patient in strategies to promote health and change behavior. Identify appropriate screenings, schedules and personal care plans.

- Review safe use of medications, the side effects of medicines on diabetes, and the timing of medications with regard to meals and exercise.

Reporting period CQI 2015-2016

- Program outcomes: CQI project in place for DSME program to improve/lower A1C of DSME participants to <7%

- 33/36 participants had an initial A1C

- 21 Participants had A1C >7 at start of program

- On 6-month follow up, 16 participant had updated A1C, 16/16 <7%, 100% improvement

- On one-year follow-up, 12 participants had updated A1C, 12/12 <7%, 100% improvement

Next Step: Implement Support Plans

- Living with Diabetes monthly classes are given in the Wellness Center. The material includes current content areas necessary for meeting the National Standards for Diabetes Self-Management Education and Support to achieve and maintain our recognition from the American Diabetes Education Recognition Program (ADA/ERP).

- Classes include PowerPoint presentations, updated handouts, Q&A and guest speakers who have current knowledge and experience with topics presented.

- Encourage the use of technology by providing participants with appropriate Internet resources and phone apps as needed.

- Patient follow-up visits include re-assessment of their needs, a follow-up education plan, clinical goal setting and prioritizing, a review of any barriers to learning or adherence to self-management, i.e. lack of funds for food or transportation.

- Review topics, learning objectives and behavioral changes. Encourage family participation. A follow-up plan for ongoing support will be developed by patient and clinician.

- Provide emotional support, refer to mental health or other professionals if needed.

- Information sharing with other health care providers at the Hospital's Cardiac Rehabilitation Center.

- The DSME/S program meets the ADA/ERP standards of care with the Diabetes Advisory Committee bi-yearly meetings. The goal is to have input from both internal providers (MD, RD, RN, CNO, Pharmacy, PT, Cardiac) and external input, i.e. patient–consumer advocate to assure that the program is patient-centered and responsive to the needs of the community.

Next Steps: **CQ1 2016-2017**

- Medicare requirement for MNT services has been ordered.
- For CQI reporting, program outcomes will monitor Provider Referral Forms are provided to meet Medicare standards for reimbursement.
- Public Relations: Southampton Hospital's DSME/S program will continue to reach out to the community at local event and health fairs, give free lectures and presentations to community groups and public libraries, provide Southampton Hospital employees with information on diabetes for Annual America Diabetes Month in November, and participate in the Hospital's outreach booth at the Hampton Classic in August 2017.

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

South Fork Behavioral Health Update

For the past decade, the East End towns of East Hampton and Southampton have seen a dramatic change in demographics with school districts finding that 40 percent or greater of the student bodies are now from Hispanic families. This clash of cultures has exacerbated issues related to behavioral health for the entire population, especially children. In the past five years

we saw completed suicides of three youth and a significant increase in the number of mental health crises being experienced by youth and requiring school districts to respond. Due to a number of factors including geography and the high cost of establishing practices in this expensive region, the East End has long needed additional behavioral health services and is now experiencing a crisis that threatens the stability of the small school systems and the communities in general.

Over the past three years, a coalition of clinical providers, school districts, social service agencies, and community advocates have collaborated on a joint effort to improve access to behavioral services for at-risk individuals. The coalition has enjoyed the strong support of the area's elected officials with particular leadership provided by our New York State Assemblyman Fred Thiele and Senator Ken LaValle. Both Assemblyman Thiele and Senator LaValle were successful in obtaining New York State grants to launch and support the efforts of the Coalition. Additionally, the County of Suffolk, the Towns of East Hampton and Southampton as well as several school districts have provided funding for this initiative.

The group assembled in Southampton Hospital's Parrish Hall in several large meetings and planning sessions over a series of months and years to develop a plan for meeting our communities' behavioral health challenges. Dubbed the South Fork Behavioral Coalition, the group developed a three-phase effort with an initial focus on at-risk children and adolescents. We identified opportunities to expand access through partnership with the school districts and Family Service League. Initial results have been very positive particularly in the East Hampton School District which volunteered to serve as the pilot site for these efforts. Initial statistics are attached in the Appendix below and clearly indicate the positive outcomes of the collaboration.

With two years of progress under our belts the Coalition will now focus on expanding its efforts. Following is an update of the progress made against the initial plan and highlight areas where work remains. During the coming two-year period, we recommend continued efforts in the following areas:

- **School Access Program Funding** – Continue NYS support for the School-based Access Program linking the local school districts to Family Service League for early intervention, crisis management and treatment. The early successes in East Hampton should be replicated in the surrounding school districts and efforts made to insure all districts are aware of and utilizing the program.

- **Adult Services Mental Health Resources** – Work with key local providers and the Suffolk Care Collaborative to expand the availability of psychiatric social workers and Nurse Practitioners in existing primary care practices.

- **Expanded Psychiatrist Resources** – Build on the forthcoming new partnership between Southampton Hospital and Stony Brook Medicine and continue efforts with Stony Brook's Department of Psychiatry to recruit additional Psychiatrists and/or Nurse Practitioners to the currently under-served communities of the South Fork. This effort will include efforts to expand Stony Brook's overall teaching programs and behavioral footprint in the region.

- **Referral and Coordination Services** – Plan and develop a community referral and coordination service to link providers with a helpline.

Current Status of Initial Health Proposal

A three-phase approach was originally developed to address the South Fork's behavioral health needs. The first phase established a crisis service that provides resources to the South Fork area to address immediate behavioral health needs, particularly those of the adolescent community. It also established Family Service League as the point of contact for crisis intervention. The second phase included expansion of the crisis services through community collaboration. The third phase, not yet implemented, was designed to build on the first two phases by tapping support of Stony Brook's psychiatric residency program. Many of the proposals included the envisioned the use of telepsychiatry capabilities. Telepsychiatry has been deemed by the American Psychiatric Association as "one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas." We offer in the following pages a progress report of the current implementation status of each of the phases of our original plan.

Phase One: Establish a Crisis Service

Proposal 1: Increase Child and Adolescent Psychiatric services and prescribing hours.

It is proposed that one full-time equivalent psychiatrist, preferably a child psychiatrist, be hired to provide services located at Family Service League's East Hampton and Westhampton Mental Health Clinics. This proposal includes the implementation of telepsychiatry capabilities. **Status**: Stony Brook, Southampton Hospital and Family Service League have agreed to share a full-time psychiatrist. Unfortunately to date, we have been unable to recruit. Several candidates have been interviewed, but none actually accepted a position. Current consideration is to shift to physician extender such as a Nurse Practitioner, until a psychiatrist becomes available. In the meantime, Southampton Hospital has recruited a full-time Psychiatric Nurse Practitioner to support the patients seen in its Meeting House Lane Medical practices. It is anticipated that a portion of salary and benefits may eventually be offset through Medicaid and other insurance

revenue, depending on final program design and population served. **Required support**: $200,000.

Proposal 2: Increase clinical staff at various locations.

It is proposed that two full-time equivalent social workers be hired through Family Service League (FSL) to provide services at locations to be determined in conjunction with the school superintendents and according to space availability. **Status:** With NYS support, Family Service League has added the additional support and implemented a crisis line with the school systems for early intervention. East Hampton Schools have made the most referrals to the program (98 since inception) followed by Sag Harbor School District (41). Additionally, Hampton Bays and Southampton School Districts have been participating and all schools have embraced the program and provided extremely positive feedback with regard to meeting the goals of the initiative. FSL is currently working with Bridgehampton School District to potentially include them. As with proposal #1, it is anticipated that a portion of salary and benefits may eventually be offset through Medicaid and other insurance revenue, depending on final program design and population served. **Required support:** $120,000

Phase Two: Expand Crisis Service

Proposal 1: Embed specialized staff in Hudson River Health Care (HRH) sites.

It is proposed that a Licensed Clinical Social Worker, community health workers, and Americorp staff be hired and placed in Hudson River Health Care sites. Supervision will be shared by the site practice manager and physicians. **Status:** HRH has added a social worker to its health center located on the Southampton Hospital campus. The social worker is bilingual and very valuable to the patient population served by HRH.

Proposal 2: Establish a Community Behavioral Healthcare Collaborative.

It is proposed that a Program Coordinator and ancillary staff be hired to collaborate with school districts and community based organizations and resources to ensure cross collaboration in dealing with community behavioral health issues. The Program Coordinator and staff will serve as the point of contact for the schools and community for crisis intervention. The collaborations can be established through the development of Memorandums of Understanding (MOUs) and/or Memorandums of Agreement (MOAs), depending on the type of collaboration. **Status:** This program has been implemented by Family Service League and outreach continues with the schools with very good results to date. Two major family support programs have been initiated; one in the Springs School District and the other in the Montauk School District. Each site has provided a family support and educational program. In addition, each site has had a bilingual case manager present to assist families with concrete service

needs. A bilingual social worker has been present to provide crisis intervention and short-term counseling. In addition, the social worker provides a 'bridge' to formal mental health services at FSL's East Hampton clinic, when needed. This social worker has also facilitated a bi-weekly support group for young adults who've been involved in substance abuse or have mental health concerns, including suicide attempts or ideation. The group, known as "Chat and Chill," has an average attendance of 15 young adults from various south fork areas and takes place at locations in Montauk. In addition, SafeTALK, a research supported program to help community members identify when youth or adults they know might be expressing self-injurious remarks or indicating evidence of depression, is in place. FSL has facilitated a SafeTALK workshop for faculty and parents at the Montauk School and then had three of the Community Behavioral Health Collaborative staff, as well as other South Fork professionals become trainers in SafeTALK. The trained staff will be offering workshops throughout the south fork. **Required support:** $150,000

Proposal 4: Implement peer and family support, education and advocacy.

It is proposed to hire one full-time equivalent Peer Family Support Specialist, one part-time Peer Family Support Specialist and to support a Program Director/Supervisor for two hours per week to establish and operate peer and family support and education groups. Such groups will augment the crisis service and help identify behavioral health issues prior to the onset of more serious or acute episodes. **Status:** See above.

Phase Three: Enhance Embedded Support through Linkage to Teaching Program

Proposal 1: Deploy Stony Brook Medicine psychiatrists to Southampton Hospital and other sites.

It is proposed that the behavioral health infrastructure established through implementation of Phases One and Two be enhanced and supplemented through Stony Brook University's psychiatric residency program. **Outcome:** Implementation of this proposal expands opportunities for psychiatric clinical residencies to the South Fork area, as well as making additional behavioral health resources available to the area. **Required support:** $80,000

Stony Brook will support the portion of the psychiatric residents' salaries that is reimbursed through Medicaid and commercial insurance; support is requested for the net deficit.

Status: Southampton Hospital has embedded a Psychiatric Nurse Practitioner in its Meeting House Lane primary care practices. The practitioner's schedule is already quite full and we anticipate the need for additional support. As noted above we have not been successful to date recruiting an additional psychiatrist. Until we have additional faculty presence, we are unable to expand the residency program to our local practices.

Proposal 2: Enhance Behavioral Health Mobile Service Capabilities

It is proposed that mobile teams can be enhanced to provide behavioral health services in the community. This proposal expands the target population beyond children and adolescents to include elderly, adult non-English speaking, uninsured, and individuals with serious and persistent mental illness (SPMI).

Outcome: It is estimated that implementation of this proposal could achieve a 25 percent reduction and/or diversion of psychiatric inpatient utilization and increase linkage to existing local providers and those hired during Phase one. **Required support:** $90,000 to $150,000 for staffing to support the expansion of mobile behavioral health services such as a team of social workers. **Status:** This service has not yet been implemented and currently in discussion to coordinate with Suffolk Care Collaborative (DSRIP).

Appendix: East Hampton Union Free School District

2014-2015	60 referrals to FSL	12 hospitalizations
2015-2016	40 referrals to FSL	7 hospitalizations

Please note these numbers do not include Springs, Amagansett and Montauk K-8 schools.

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