NYU Winthrop Hospital

Community Service Plan
and
Community Health Needs Assessment

2019-2021

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APPENDIX

NYU WINTRHOP HOSPITAL
COMMUNITY SERVICE PLAN
2019-2021

Nassau County Department of Health
Lawrence E. Eisenstein, MD, MPH, FACP, Commissioner of Health
200 County Seat Drive, North Entrance
Mineola, NY 11501
(516) 742-6154

Catholic Health Services of Long Island

Mercy Medical Center	1000 N Village Ave, Rockville Centre, NY 11571
St. Francis Hospital	100 Port Washington Blvd, Roslyn, NY 11576
St. Joseph Hospital	4295 Hempstead Turnpike, Bethpage, NY 11714

Northwell Health System

Glen Cove Hospital	101 St. Andrews Lane, Glen Cove, NY 11542
Long Island Jewish Valley Stream	900 Franklin Ave, Valley Stream, NY 11580
North Shore University Hospital	300 Community Drive, Manhasset, NY 11030
Plainview Hospital	888 Old Country Road, Plainview NY 11803
Syosset Hospital	221 Jericho Turnpike, Syosset NY 11791

Nassau University Medical Center	2201 Hempstead Turnpike, East Meadow, NY 11554
South Nassau Communities Hospital	1 Healthy Way, Oceanside, NY 11572
NYU Winthrop Hospital	259 First Street, Mineola, NY 11501

LIHC is a coalition funded by the New York State Department of Health through the Population Health Improvement Program (PHIP) grant. The LIHC is overseen by the Nassau-Suffolk Hospital Council. The LIHC provided oversight and management of the Community Health Needs Assessment processes, including data collection and analysis.

NYU WINTHROP HOSPITAL
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EXECUTIVE SUMMARY

SELECTION OF PRIORITIES

In 2019, NYU Winthrop Hospital joined with members of the Long Island Health Collaborative to review extensive data sets selected from primary and secondary sources to identify and confirm Prevention Agenda priorities for the 2019-2021 Community Service Plan cycle. Data analysis efforts were coordinated through the Long Island Population Health Improvement Program (LIPHIP), who served as the centralized data return and analysis hub. As directed by the data results, community partners selected: **(1) Prevent Chronic Disease:** *Focus Area 4: Chronic Disease Preventive Care and Management* and **(2) Promote Well-Being and Prevent Mental and Substance Use Disorders**: *Focus Area 2: Mental and Substance Use Disorders Prevention.*

Priorities selected in 2019 remain unchanged from the 2016 selection; however, for 2019, a specific priority regarding mental health and substance use was selected, as opposed to placing an overarching emphasis on these two issues as was done in the previous cycle.

DATA

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey *(See Appendix B*) and the results from focus groups and key community-based organization leader interviews. The latter results were compiled in the report – *Focus Groups and In-Depth Interviews*. *(See Appendix C)*

Secondary, publically available data sets include Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, Prevention Quality Indicators (PQI), Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS), New York State Community Health Indicator Reports (CHIRS), and New York State Vital Statistics.

PARTNERSHIPS

NYU Winthrop Hospital participates in the Long Island Health Collaborative activities. This includes review of all data collected and analyzed by the LIHC, with Nassau County Department of Health input and consultation offered when appropriate. The hospital relies upon the LIHC to disseminate information about the importance of proper nutrition and physical activity among the public in an effort to assist Nassau residents in better managing their chronic diseases and/or preventing the onset of chronic diseases. These efforts, along with process and outcome measures, are defined in the Prevention Agenda Work Plan *(See Appendix F)*.

NYU Winthrop Hospital participates in the LIHC's bi-monthly stakeholder meetings and avails itself of LIHC's extensive network.

Finally, the Hospital's local partners from the NYU Winthrop Community Cultural Advisory Committee meet quarterly to discuss health needs and seek solutions. Several of our partners, the Hispanic Counseling Center, the Yes We Can community center in Westbury, the Hempstead Hispanic Civic Association, and St. Brigid's Church in Westbury, have offered to partner with us to encourage community participation and provide space for educational programs so that they may be conveniently located for their clients.

COMMUNITY ENGAGEMENT

The broad community was engaged in assessment efforts through distribution and completion of the Long Island Community Health Assessment survey. 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 partners distributed and promoted the survey to a diverse range of community members, from January 1, 2018 through December 31, 2018 at a variety of locations, including hospitals, doctor's

offices, health departments, libraries, school, insurance enrollment sites, community-based organizations and more. In addition, member organizations promoted the survey through social media efforts, posting links on their website and distributing surveys at health fairs and other events.

Community engagement continues through monthly meetings with the Long Island Health Collaborative to discuss evidenced-based programming, public outreach initiatives and changes in health trends. Local community partners are kept up-to-date through quarterly meetings of NYU Winthrop's Community Cultural Advisory Committee. NYU Winthrop maintains a survey on its website that requests input from the community on current health concerns. Evaluation forms at community programs are utilized as a method of feedback from community members. Social media platforms, Facebook and Twitter, keep the Hospital and the community connected.

INTERVENTIONS/STRATEGIES/ACTIVITIES

Selection of initiatives is data-driven, supported by research and discussions with community partners, including NYU Winthrop's Community Cultural Advisory Committee, and senior leadership within the Hospital. Disparities will be addressed by collaborating with community-based organizations in select communities to hold culturally relevant chronic disease management educational programs. Our initiatives support the NYS Prevention Agenda areas and include:

- Evidenced-based programming:
    - Stanford Program for Chronic Disease Management
    - Tai-Chi for Arthritis
    - Breastfeeding Initiative – Baby-Friendly® Hospital
    - 5-2-1-0 Healthy Lifestyle Program
- Increased efforts to raise participation in breast cancer and colorectal cancer screenings
- Promote Tobacco Cessation
- Promote Vaping Cessation

- Mental Health and Substance Abuse –will be addressed through public education and stress management techniques
- Continued support of Long Island Health Collaborative *Are You Ready, Feet?™* physical activity/walkability campaign and walking portal

PROGRESS

Progress will be tracked through quantitative data collection and analysis. The Prevention Agenda Work Plan is a dynamic document that will be continually reviewed according to the quality improvement measurement standards of the Hospital, PDSA (Plan, Do, Study, Act), and revised as needed according to changes in community need or resources. Process measures include:

- Number of students and parents participating in the 5-2-1-0 program in Nassau County; # of post evaluations
- Documented counseling rates of parents of children with unhealthy weights NYU Winthrop Pediatric Clinic in Hempstead.
- Number of participants in an evidence-based chronic disease prevention programs, including the Stanford Chronic Disease Self-Management Program and CDC Diabetes Prevention Program
- Number of individuals who develop an action plan for self-management; # of post evaluations
- Increase number of self-reported lowered A1c levels and blood pressure reading
- Number of participants who report no incidents of falls in 12 months post Tai Chi program; Number of participants in Tai Chi; post evaluation forms
- Number of students participating or in attendance in a vaping cessation afterschool program, presentation and/or workshop; # of post evaluations
- Number of individuals referred for smoking cessation programs; # attending

DEMOGRAPHICS

Nassau County

Nassau County sits east of the borough of Queens and west of Suffolk County. It is comprised of two cities (Long Beach and Glen Cove) and three townships (Hempstead, North Hempstead, and Oyster Bay). Total population: 1,363,069 (48.5% male; 51.5% female); those aged 65+ comprise 16.8% of the population and those aged 35 to 64 comprise 41.1% if the population. In terms of income, the median is $105,744; 26.5% of the population earn less than $74, 999 with about a third of that group earning less than $34,999 annually.

The region is predominately white at 68.9% with 11.5% Black/African American, and 9.1% Asian. Hispanic or Latino represent 16.4% of the population. The percentage of the population (5 years and over) that speak a language other than English is 28%. Of those who speak a language other than English, 42% report they speak English "less than very well." In terms of education, for those age 25 and over, 23.3% are high school graduates, 24.3% hold a bachelor degree, and 20% hold a graduate professional diploma. The percentage of people with health insurance is 94%.[1]

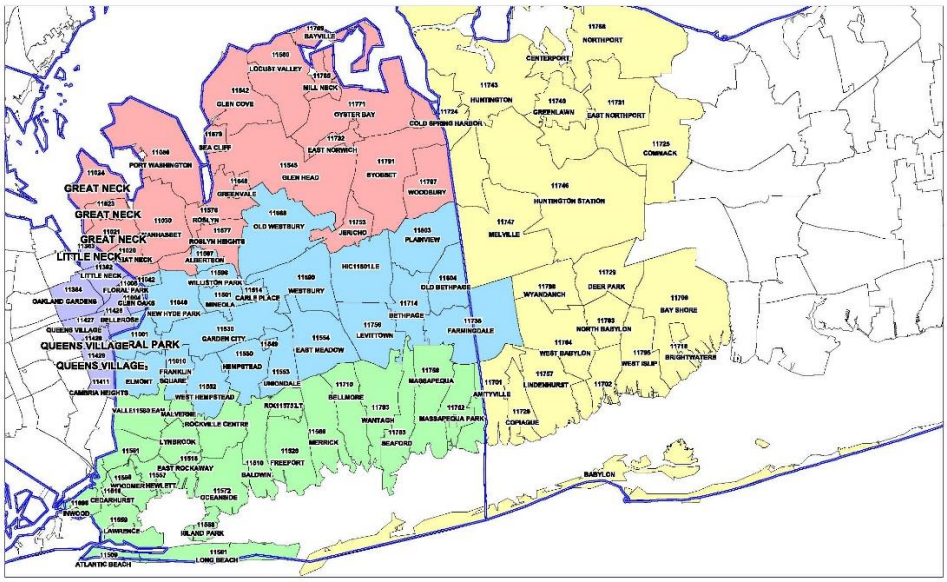
A "snapshot" of Nassau County from 2019 County Health Rankings & Roadmaps from the University of Wisconsin Population Health Institute – factors that drive health – rank Nassau County as number 2 in New York State for Health outcomes, and number 1 for Health Factors. Based on health factors, including socioeconomic determinants, health behaviors, clinical care and physical environment, Health Behaviors are ranked at 1, an improvement from number 2 reported in our 2016 assessment. Approximately 5% of the population is uninsured, an improvement of 5% reported in 2016. Primary care physician rates improved; about 700 patients to one doctor, compared to 1,200 to one in NYS[2] .

Nassau County is unique in that it presents complex polarity, representing a wide range of both healthy and sick community members from opposite ends of the health spectrum. There are eight communities in which a variety of socioeconomic factors lead to vast health disparities. These communities, identified by the Nassau County Department of Health, are known as "select communities" and include: Elmont (11003), Inwood (11096), Freeport (11520), Glen Cove (11542), Uniondale (11553), Roosevelt (11575), Hempstead (11550), and Westbury (11590).

[1] https://www.census.gov/quickfacts/nassaucountynewyork
[2] http://www.countyhealthrankings.org/app/new-york/2019/rankings/nassau/county/outcomes/overall/snapshot

NYU Winthrop's Service Area

NYU Winthrop's service area is defined geographically and by patient population. The Hospital's primary/core service area has historically been Nassau County, specifically Core Areas A, B and C (see map below). The secondary service area, represented by Areas D and E, is also considered in the Hospital's strategic planning process for purposes of establishing new programs and services. Based on an analysis of our patient populations (See Table 1 below), Care Areas A, B & C account for 77.81% of discharges.



***Blue**: Core A; **Green**: Core B; **Pink**: Core C; **Purple**: Core D; **Yellow**: Core E*

Table 1

Discharge Data 2018 (excluding normal newborns)		
Core Areas	**Total**	**% of Total**
A	17,934	51.65%
B	7,833	22.56%
C	1,181	3.40%
Nassau Total	**26,948**	**77.61%**
D	2,268	6.53%
E	574	1.65%
Other	4,931	14.20%
TOTAL	**34,721**	**100%**

Nearly 33% of NYU Winthrop patients come from select communities in Core Areas A, B & C (see Table 2), with a higher percentage of patients from select communities coming from Core Area A – 40.76%. Two of these communities, Hempstead (11550) and Westbury (11501) are geographically close to the hospital and represent 63% of residents from select communities admitted to the hospital (3,250 patients from Hempstead; 2,135 from Westbury).

Table 2

Discharge Data 2018

Core Areas	Total Select Communities	NYUWUH Patient Total	% of NYUWIN Total Select Communities
A	7,109	17,443	40.76%
B	1,279	7,502	17.05%
C	170	1,125	15.12%
TOTAL	**8,558**	**26,070**	**32.83%**

PUBLIC PARTICIPATION

To collect input from community members and measure the community perspective as to the biggest health issues in Nassau County, we utilized an ongoing regional survey called the Long Island Community Health Assessment Survey. This survey is available online via a Survey Monkey link and is available to residents at public events, workshops, educational programs, interventions, etc., which are offered by LIHC partners. It is also distributed among Health,

social media outlets, libraries, schools, insurance enrollment sites, community-based organizations and more. A certified translation of the survey is available in the following languages: Spanish, Polish, and Haitian Creole. Large print copies are also available to those living with vision impairment. It is also available on the NYU Winthrop website under "community health."

To assist with delving into the health concerns experienced by the underserved communities relating to the Social Determinants of Health, the LIPHIP contracted with EurekaFacts to conduct a qualitative research study. The study consisted of focus groups with Long Island residents who indicated difficulty in accessing healthcare in the previous year, and interviews with leaders of community-based organizations who serve these populations.

In addition, NYU Winthrop maintains an ongoing dialogue with the community. The Hospital meets with local community partners from underserved areas quarterly, to keep abreast of health needs within the community, share ideas and discuss solutions. This group, NYU Winthrop's Community Cultural Advisory Council, represents local communities who are low-income, have minority populations and experience health disparities. Their participation in this initiative helps to keep the hospital abreast of ongoing and emerging issues.

Health concerns of the community are also revealed through post-satisfaction surveys from more than 25 hospital-based lectures each year and requests from outside organizations for speakers on specific topics. Interaction with the public at the NYU Winthrop Welcome Center, which serves as the site of several health education programs and support groups, provides further insight. Staff here also documents calls to the 1-866-WINTHROP number; queries reflecting health concerns are reviewed when planning programs.

Although the 2016 CHNA is posted on our website and written comments were solicited, none was received.

PROCESS & METHODS USED TO CONDUCT THE CHNA

Data analysis efforts were coordinated through the Population Health Improvement Program, with the PHIP serving as the centralized data return and analysis hub. Two cluster groups were formed, the CHNA workgroup and the Data Advisory Group. Key members included the Commissioners of the both the Nassau and Suffolk Departments of Health, epidemiologists, Nassau-Suffolk Hospital Council representatives, and Long Island hospital representatives. A list of members of these workgroups is in Appendix A.

DATA SOURCES

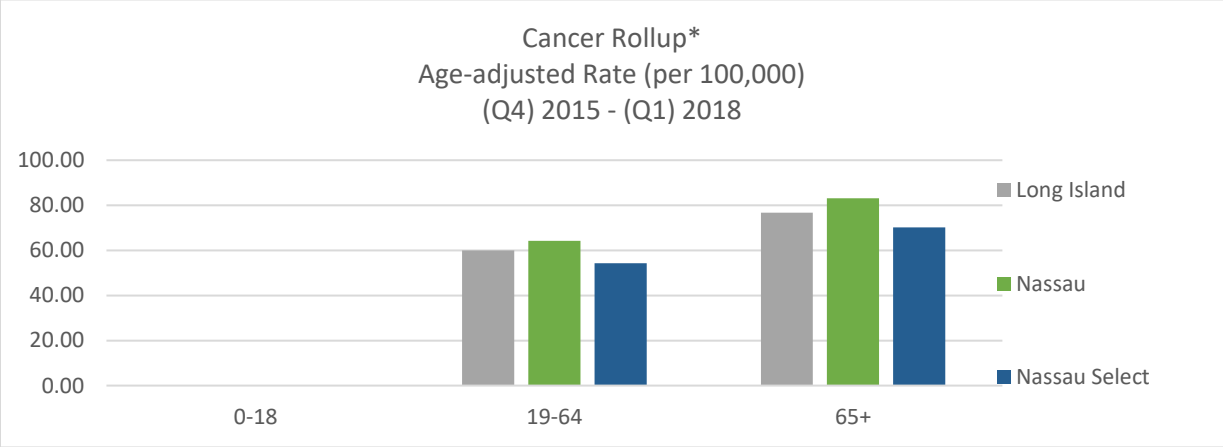
Primary data sources: Long Island and Eastern Queens Community Health Assessment Survey (CHAS) (Appendix B) and the results from focus groups and key community-based organization leader interviews. The latter results were compiled in the report – Focus Groups and In-Depth Interviews (See Appendix C).

Secondary data sources: Publically-available data sets were reviewed to determine change in health status and emerging issues within Nassau County. Sources of secondary data: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda Dashboard, Prevention Quality Indicators (PQI), Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS), New York State Community Health Indicator Reports (CHIRS), and New York State Vital Statistics.

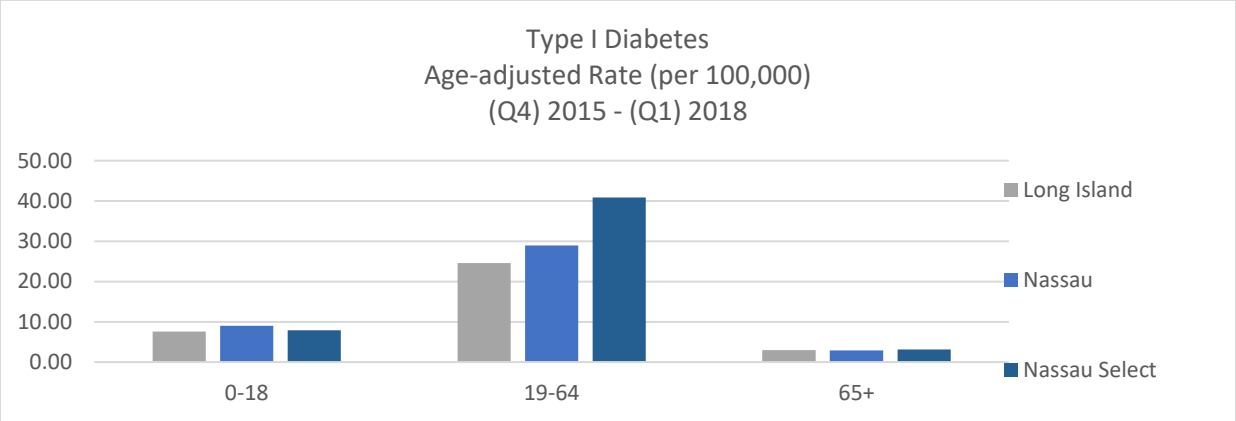
Data Depiction of Health Status of Community

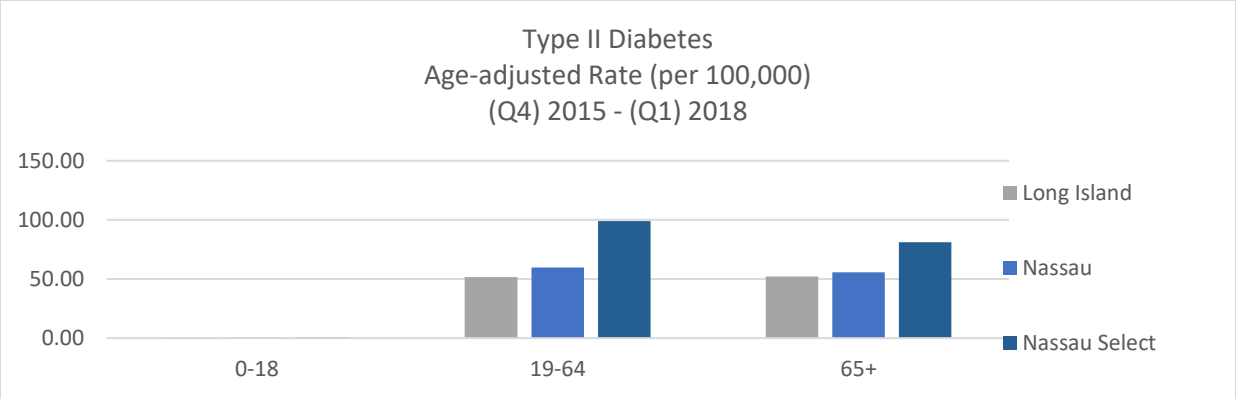
The following bar charts illustrate the prevalence of chronic disease on Long Island. Please see the SPARCS data on all cancers, types 1 & 2 diabetes, heart disease, and chronic obstructive pulmonary disease/asthma.

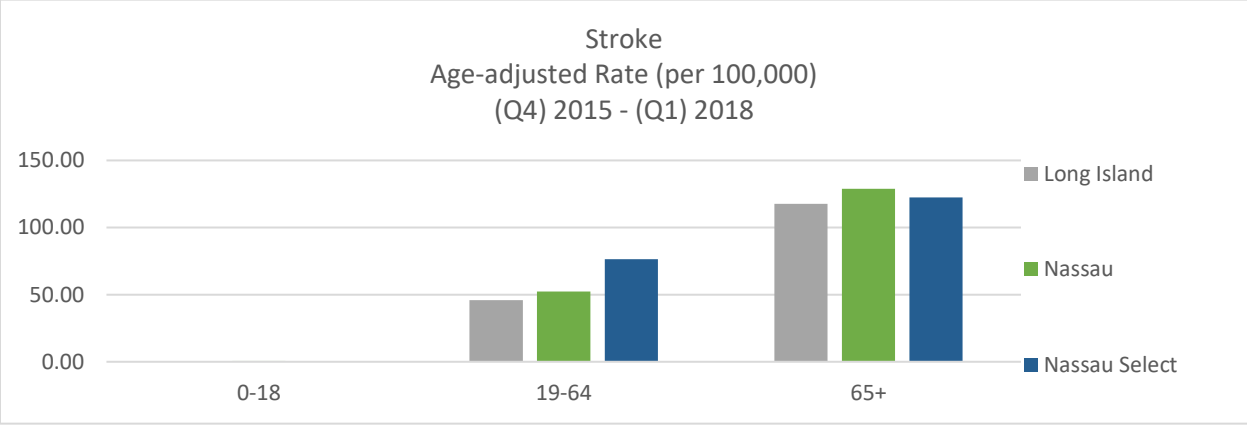
Please note the similar statistics between the 19-64 and 65+ age groups for cancer.

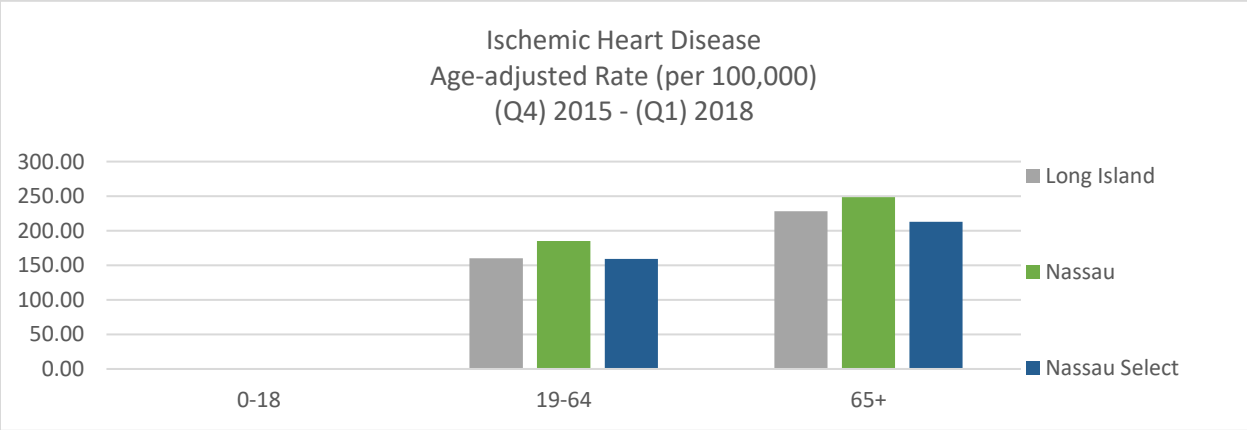


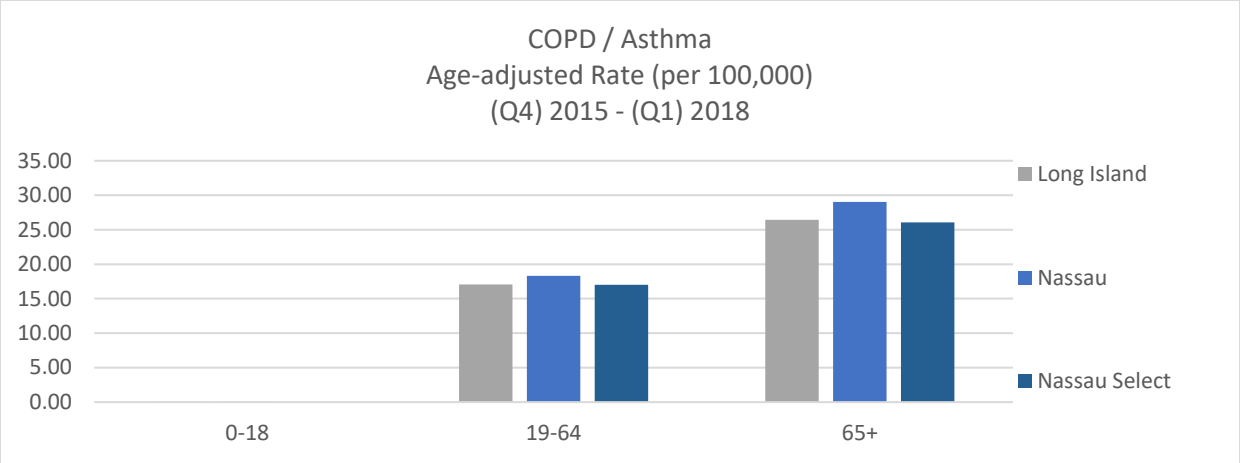
Note the higher rate of diabetes Type I among the 19 to 64 age group, especially in select communities.



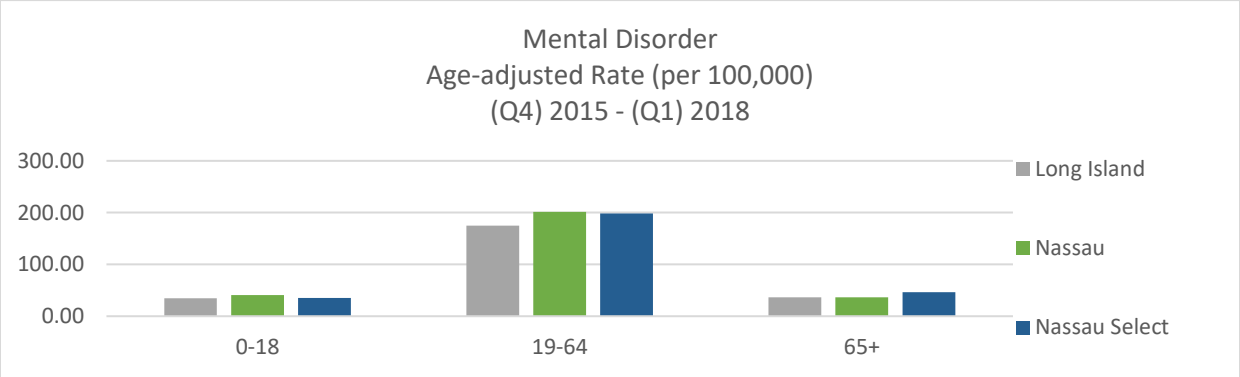

Type II Diabetes
Age-adjusted Rate (per 100,000)
(Q4) 2015 - (Q1) 2018
150.00
100.00
50.00
0.00
0-18
19-64
65+
Long Island
Nassau
Nassau Select

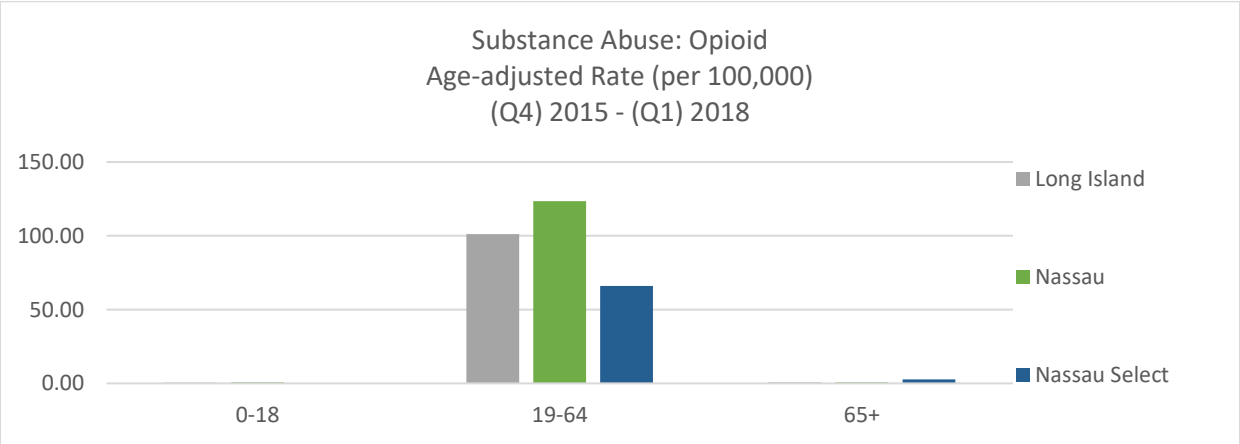

Stroke
Age-adjusted Rate (per 100,000)
(Q4) 2015 - (Q1) 2018
150.00
100.00
50.00
0.00
0-18
19-64
65+
Long Island
Nassau
Nassau Select

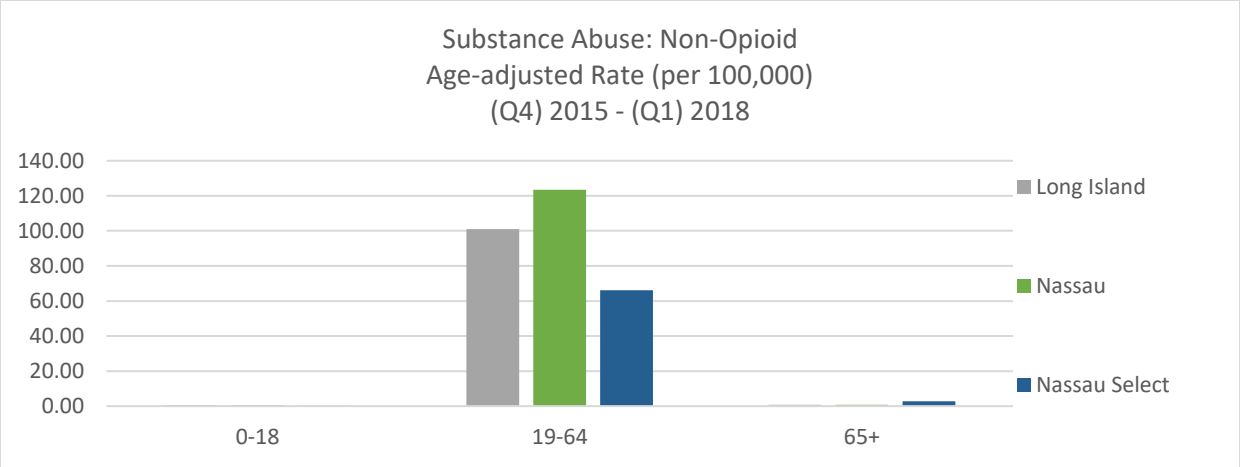

Ischemic Heart Disease
Age-adjusted Rate (per 100,000)
(Q4) 2015 - (Q1) 2018
300.00
250.00
200.00
150.00
100.00
50.00
0.00
0-18
19-64
65+
Long Island
Nassau
Nassau Select



The following bar charts illustrate the issue with mental health and substance misuse. It is especially difficult among the 19-64 years of age group. Abuse of opioids and non-opioids is occurring at about twice the rate among the overall Nassau Population compared to the select communities.





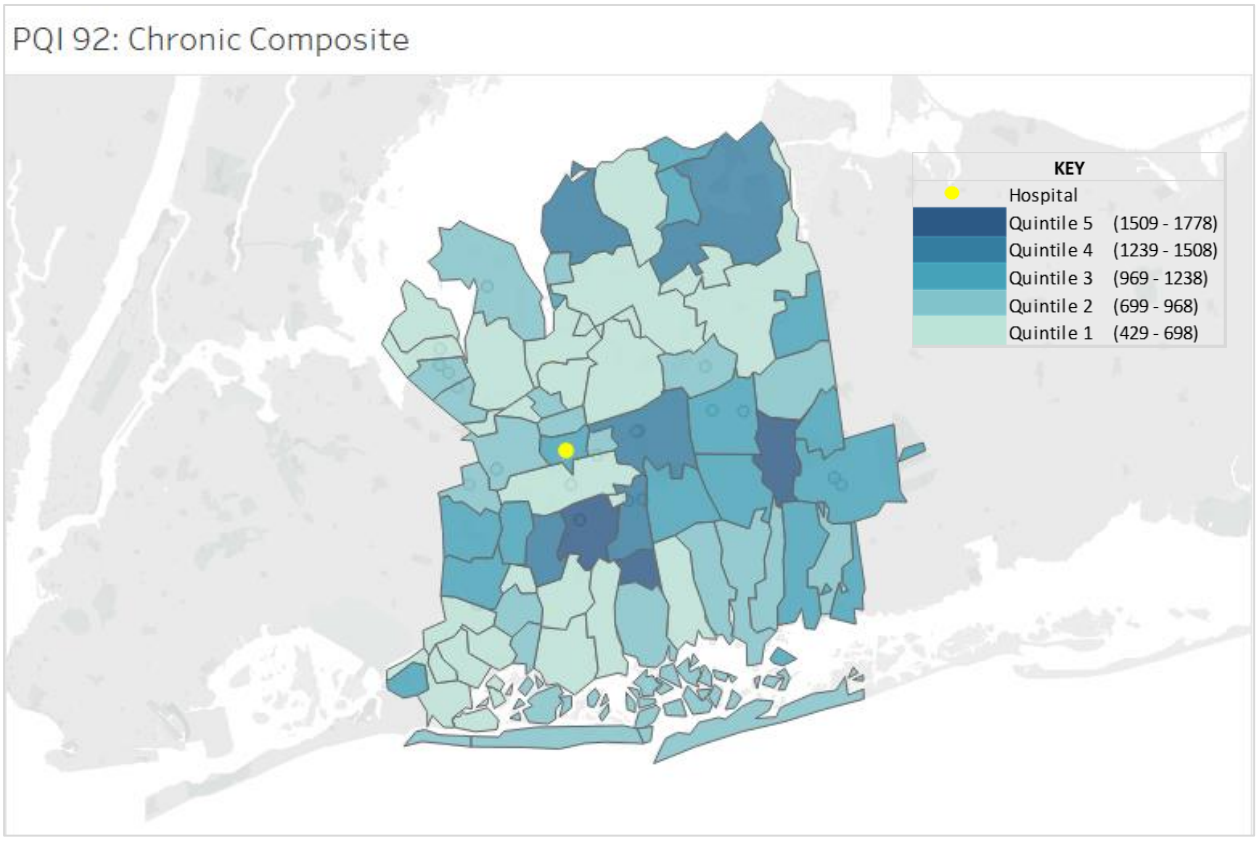


PREVENTION QUALITY INDICATORS

Chronic conditions, if treated early and properly in the community, prevent hospital admissions. PQI 92 is defined as a composite of chronic conditions per 100,000 adult population. Conditions included in PQI 92 are: diabetes with short and long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive Pulmonary Disease, asthma, hypertension, heart failure, or angina without a cardiac procedure. Time period for map below is **January 1 – December 31, 2017**.

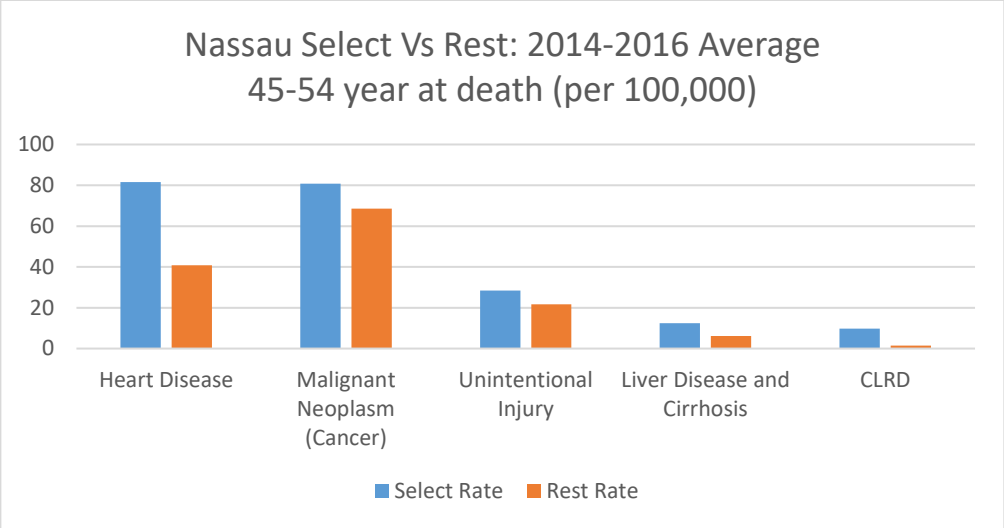
The Agency for Healthcare Research and Quality draws the indicators from SPARCS data. The map below shows the areas in Nassau County representing the most significant numbers of preventable cases per 100,000 of the adult population. Quintile 5 represents 1509 – 1778 per 100,000 adult cases. As displayed within the PQI Chronic Composite for Nassau County, there is notable occurrence of chronic disease among a majority of communities, particularly among those connected to low economic status.

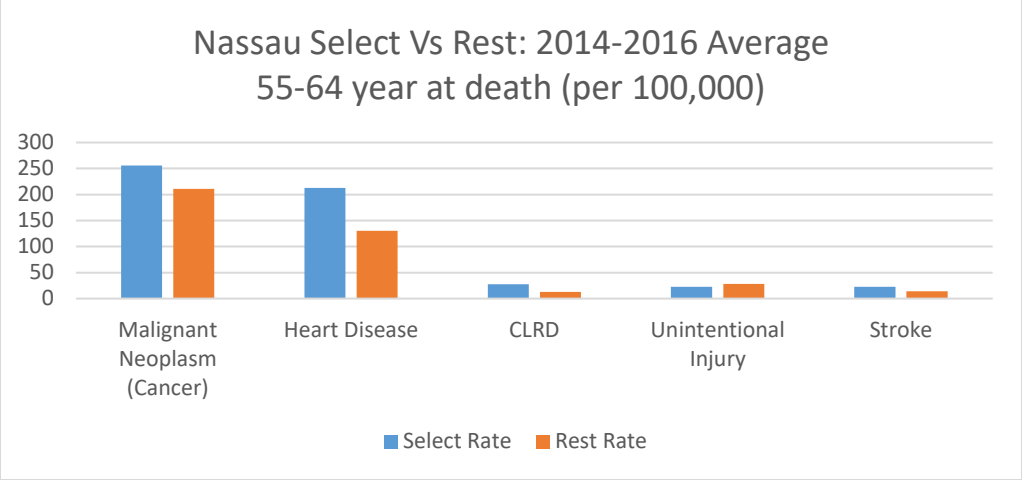
The yellow dot indicates NYU Winthrop Hospital. Please note that one of the select communities in quintile 5 is in close proximity to the hospital. This is Hempstead, previously highlighted under NYU Winthrop's Core Area A service area as having a high admissions rate:

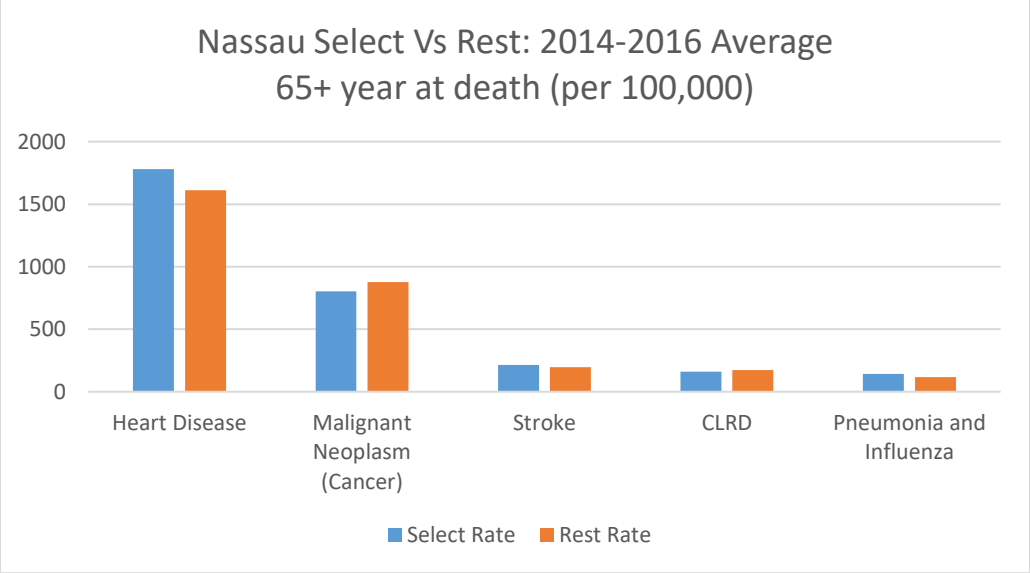


Vital Statistics Data

To gain a better understanding of the long-term effects of disease on communities with health disparities, we reviewed the causes of death according to age groups and separated select communities from the rest of Nassau County. For the purposes of this report, we are only highlighting ages 45 and above. Prior to that age group, 0 to 17 identifies the perinatal period as the highest cause of death; ages 18-24, 25-34 and 35-44 identify unintentional injuries.


Nassau Select Vs Rest: 2014-2016 Average
45-54 year at death (per 100,000)
100
80
60
40
20
0
Heart Disease
Malignant Neoplasm (Cancer)
Unintentional Injury
Liver Disease and Cirrhosis
CLRD
Select Rate
Rest Rate


Nassau Select Vs Rest: 2014-2016 Average
55-64 year at death (per 100,000)
300
250
200
150
100
50
0
Malignant Neoplasm (Cancer)
Heart Disease
CLRD
Unintentional Injury
Stroke
Select Rate
Rest Rate


Nassau Select Vs Rest: 2014-2016 Average
65+ year at death (per 100,000)
2000
1500
1000
500
0
Heart Disease
Malignant Neoplasm (Cancer)
Stroke
CLRD
Pneumonia and Influenza
Select Rate
Rest Rate

METHODOLOGY

The Community Health Needs Assessment Survey

A barometer of the perception of health needs and barriers experienced by individuals and communities – provides a snapshot in time of the main health challenges facing communities.

Surveys were distributed by paper and electronically, though Survey Monkey, to community members. The electronic version placed rules on certain questions: for questions 1-5, and individual could chose as many responses as they'd like. Although rules were written on the paper survey, people often did not follow them. Surveys were download on December 18 2018. Weights were added to the surveys which did not follow the rules, i.e., for each of the questions that had more than three responses. No weight was applied to the questions with less than three responses because they had the option to select more and chose not to.

1644 surveys were collected between January 1 and December 31, 2018. For a full version of the spreadsheet that includes interactive tables to analyze results based on demographic factors, visit: https://www.lihealthcollab.or/data-resources.aspx

The following tables highlight the most relevant questions on the survey. Questions 1 & 2 helped determine the highest area of concern for community residents. Chronic disease was highly rated in Nassau County and the select communities, so this quickly identified as a significant health need. Questions 3, 4 and 5 addressed factors related to the social determinants of health.

1. What are the biggest ongoing health concerns in the community where you live?

2018 Rank	Concern	Percentage
1	Cancer	17.08%
2	Dugs & Alcohol Abuse	14.72%
3	Diabetes	12.88%
4	Heart disease & stroke	11.23%
5	Obesity, Weight Loss Issues	9.49%

2. What are the biggest ongoing health concerns for yourself?

2018 Rank	Concern	Percentage
1	Heart disease & stroke	17.9%
2	Cancer	14.56%
3	Obesity/Weight Loss issues	13.77%
4	Diabetes	13.26%
5	Women's Health & Wellness	13%

3. Potential barriers People face when getting medical treatment:

2018 Rank		Percentage
1	No insurance	20.8%
2	Unable to pay co-pays/deductibles	16%
3	Fear	14.1%
4	Don't Understand Need to see a Doctor	13.14%
5	There are no barriers	10.99%

4. What is most needed to improve the health of the community?

2018 Rank		Percentage
1	Insurance	20.8%
2	Unable to pay co-pays/deductibles	16%
3	Fear	14.1%
4	Don't Understand Need to see a Doctor	13.14%
5	There are no barriers	10.99%

5 .What health screenings or education services are needed in your community?

2018 Rank		Percentage
1	Blood Pressure	12%
2	Diabetes	9.62%
3	Cancer	9.26%
4	Cholesterol	8.47%
5	Mental Health/Depression	8.33%

<u>Focus Groups and In-Depth Analysis Report</u>

The LIHC contracted with EurekaFacts to conduct a qualitative research study to assist in the CHNA process and selection of NYS Prevention Agenda priorities for the 2019-2021 cycle. The objective was to understand the health concerns through the lens of the Social Determinants of Health. The study consisted of the following: four two-hour focus groups with LI residents who indicated difficulty in accessing healthcare the previous year, and 15-minute in-depth interviews with 26 leaders of health-related community organizations who serve these populations. Twelve in-depth interviews of Long Island residents lasting half an hour each were also added as an insufficient number of participants attended two of the four focus groups.

Focus groups were held during the week of January 28 through February 1, 2019. Nassau representation was held in Freeport and Elmont; Suffolk groups were held in Wyandanch and Riverhead.

The in-depth interviews of CBOs were conducted from January 7 until February 13, 2019. Sixteen were from Nassau County and 10 from Suffolk; many organizations are active in both counties. Nineteen interviews explicitly discussed Nassau County and locations therein. All five social determinants of health and both counties received full representation. The CBOs are distributed roughly across the five Social Determinants of Health, as can be seen in the table below. A list of the organizations who participated is in Appendix D.

CBO Focus for Interview	Nassau	Suffolk	Total
Neighborhood and Built Environment	2	2	4
Health and Health Care	5	3	8
Social and Community Context	3	1	4
Economic Stability	3	1	4
Education	3	3	6
Total	16	10	26

Twelve in-depth interviews were held from February 12 through February 20, 2019. There were three men and nine women; the sample was split evenly between Nassau and Suffolk. Five of the six participants in Nassau County came from Hempstead and one from Elmont.

BRIEF DESCRIPTION OF REPORTED SOCIAL DETERMINANTS OF HEALTH RISK FACTORS

1) Neighborhood and Built Environment – concerns about pollution leading to cancer, water safety, access to healthy food were expressed. Many participants indicated difficulty n accessing and affording healthy food, which could potentially lead to chronic diseases such as diabetes and obesity. Gang violence was also a significant concern, particularly the exposure of drug and gang violence on children, which could potentially lead them to model violent behavior. Several participants indicated that afterschool activities could help children from getting involved with gang violence.

2) Health and health Care – Access to health and health literacy were major themes among participants. Two of the largest concerns were the affordability of health insurance and lack of knowledge about health insurance; the lack of knowledge results in not knowing the benefits of different health insurances relevant to their conditions. Participants also mentioned healthcare disparity, which is associated with the issue of affordability. Health literacy – knowledge of prevention of disease, healthy diet and how to seek help were commonly mentioned concerns. Participants said that some people do not know why they are sick and how they can seek help to make the situation better.

3) Social, Family, and Community Context – Education, lack of parental involvement (sometimes due to their own health issues or other poverty-related challenges), incarceration and racism were among the leading concerns. Participants also expressed

concerns about the adverse effects of social media, including addiction to social media, lack of face-to-face interaction, and cyberbullying of children.

4) Economic Stability - Unemployment, poverty, homelessness, lack of affordable housing and access to healthy food were among the leading concerns. One participant stated: "I think that lack thereof, poverty causes mental health problems…You're probably not going to be seeking healthcare and trying to go to a doctor if you don't have a house.

5) Education – Concerns included poor school systems, education quality and illiteracy, as well as a lack of adequate health education about disease, treatment options, healthy food and providers. Most participants believe illiteracy has a cause and effect relationship with poverty or low income.

Analysis of responses from focus group participants and interviews with community-based organization leaders support the results of the quantitative data analyses. The chart below ranks the top five specific health concerns within the Prevention Agenda Priorities by the number of times it was referenced when asked about the highest priorities to be addressed.

Ranking	**Specific Health Concern**	**Number of References**	**Prevention Agenda Priority**
1	Mental Health	13	Promote well-being and Prevent Substance Use Disorders
2	Violence	12	Promote a Healthy and Safe Environment
3.	Substance use disorders	9	Promote well-being and prevent mental & substance Use disorders
4	Diabetes	7	Prevent Chronic diseases
5	Cancer	6	Prevent Chronic Diseases

Looking more broadly, the number of times that the **Prevention Agenda Priorities** were referenced while discussing the highest priority health concerns yielded the following ranking:

Ranking	**Priority**	**Number of References**
1	Promote well-being and prevent mental and substance use disorders	23
2	Promote a Healthy and Safe Environment	20
3	Prevent Chronic Diseases	18
4	Prevent Communicable Diseases	7
5	Promote Healthy Women, Infants & Children	2

SELECTION OF PUBLIC HEALTH PRIORITIES

On March 27, 2018, the LIHC distributed results of all its data analyses to LIHC CHNA workgroup participants. Large data files were posted on google drive. Workgroup participants were asked to review all the quantitative and qualitative data in advance of the Priority Selection Meeting.

That meeting took place on Friday, March 29, 2018 at 9:30 a.m. at the offices of the Nassau-Suffolk Hospital Council in Hauppauge, NY. The LIHC's data analyst walked participants through screen shots of the relevant findings. Participants also viewed the Prevention Agenda dashboard, diving deep into the goals, objectives, and recommended interventions for each priority. Present at the meeting either in-person or via phone were representatives from each of the two local health departments on Long Island and representatives from each of Long Island's hospitals/health systems, as well as staff of the LIHC.

Attendees discussed the results and based the selection of priorities on the following criteria:

- The overwhelming evidence presented by the data, especially the first two questions of the survey.
- The activities/strategies/interventions currently in place throughout the region
- The feasibility of achieving momentum and success with a chosen priority, taking into account the diversity of partners and community members served

After an official vote, the priorities aligned with the NYS Prevention Agenda were selected unanimously:

- Chronic Disease Preventive Care and Management
- Promote Well-Being & Prevent Mental & Substance Use Disorders

The **health disparity** in which partners are focusing their efforts rests on the inequities experienced by those in low-income neighborhoods. As such, low-income – one social determinant of health – precludes members from low-income communities from accessing preventive and/or medical care due to their difficulty to afford co-payments/deductibles (if insured) or care at all if they are uninsured. Additionally, financially-stressed individuals have difficulty affording nutritious foods, leaving them more vulnerable to poorer chronic disease management outcomes, since nutrition and diet play a pivotal role in almost every chronic disease.

NYU Winthrop's Community Cultural Advisory Council (CCAC)

At the April 3, 2019 meeting of the CCAC, the results of the collaborative community needs assessment were shared with community partners. Health concerns and possible ways to address needs were discussed.

- Discussions determined that education about chronic disease prevention is still needed
- Concerns were also raised about mental health issues, drugs and alcohol abuse

- Health literacy and patient navigation services were reported to be crucial

Members of the CCAC at that meeting included:

Agency	Representative
EOC of Nassau County	Health Manager
Family & Children's Association	Assistant VP Senior & Adult Services
Girl Scouts of Nassau County	Fund Development Officer
Hempstead Hispanic Civic Association, Inc.	Executive Director
Hispanic Brotherhood of Rockville Centre	Executive Director Co-Director
Hispanic Counseling Center	CEO Program Coordinator
LI Asthma Coalition	Director
Nassau BOCES	Teen & parenting Program
Nassau County Coordinator Agency for Spanish Americans (CASA)	Director
Nassau County Dept. of Health	Commissioner, NC Department of Health
North Shore Child & Family Guidance	Director of the Leeds Place
Noticia (Spanish Newspaper)	Publisher/Co-Owner
Project independence	Deputy Commissioner, Department of Services for the Aging
SHIP/AHEC	Community Advocate
St. Brigid's Church (Westbury)	Immigration Ministry

In addition to the two significant needs identified by collaborative partners 1) The prevention and management of chronic disease and 2) To promote well-being and Prevent Mental and Substance Use Disorders, NYU Winthrop is highlighting the following additional areas of need:

- Healthy & Safe Environment – Fall prevention continues to be an issue of concern among the aging population of Long Island
- Improvement of health literacy –many people don't understand the importance of a healthy lifestyle, or how to access resources when needed
- Birth-related disparities – there is a greater disparity among Black women, as opposed to White or Hispanic. A lower percentage of Black women receive adequate prenatal care than white women: 79.7% to 89%; Hispanic rates are 81.6%. The disparity continues with premature births (13.4% Black, 8.5% white and 8.8% Hispanic) and low birthweight births (12.5% Black and 7.0% white, 7.1% Hispanic).[3]

[3] https:///www.health.ny.gov/statistics/community/minority/county/nassau.htm

- Healthy Foods - the lack of healthy food affordability, convenient options, transportation, as well as time to prepare healthy food were significant challenges

PRIORITIZATION

The following criteria were utilized in determining the prioritization of needs:

- SPARCS data (2015-Q1 2018); NYSDOH Vital Statistics (2014-2016); Prevention Quality Indicators PQI 92 Chronic Composite, Nassau County 2017
- New York State Prevention Agenda Dashboard & Priorities
- Nassau County Health Indicators by Race/Ethnicity, 2014-2016
- NYU Winthrop's Admission Data
- Health disparities within our core market area
- The severity of the public health need
- Perceptions of the community identified in community survey, focus-group and in-depth interviews
- Resources – both hospital and community-based

The prioritization process included discussion with community partners, internal discussions with the Hospital's Senior Administration and review with the Board of Directors, an examination of resources, and a determination of the feasibility of possible interventions. Priorities were ranked based on the burden, scope and urgency of the health need across the service area, health disparities in select communities, resources, and the importance the community placed on addressing the needs.

RANKING

1. Prevention & Management of Chronic disease
2. Mental & Substance Use Disorders Prevention
3. Improvement of Health Literacy
4. Improvement of birth-related disparities
5. Healthy foods – improve access and educate about convenient options

INFORMATION GAPS

Although the qualitative report indicated that certain health concerns dominated across Long Island, it should be noted the report was not specifically separated by county to clarify the ranking of priorities according to Nassau County residents. This, however, was mitigated by conversations with our Community Cultural Advisory Council members. Also, although vast attempts were made, it was difficult to obtain a better number of surveys from communities with health disparities.

EXISTING FACILITIES AND RESOURCES

In addition to the resources that Winthrop is planning to commit, such as staffing, space and materials, Nassau County has a number of available resources to help meet community needs. Our County boasts 12 hospitals (including Winthrop), an adequate number of primary care physicians, five federally qualified health care centers in areas of high need, and numerous community-based organizations. Community members can access resources at our website, www.nyuwinthrop.org. Resources can also be accessed at www.**hites**ite.org/ and www.**211**.org/; these sites exist in real-time and are routinely updated. They help connect community members and health/social services providers with social determinants of health services.

A summary of assets and resources within Nassau County that can be mobilized and employed to address the health issues identified is maintained by the vast network of Long Island Health Collaborative. The LIHC actively promotes relevant resource databases listed on the LIHC website that are available for public use. They invite consumers and health/social service providers to provide feedback on resources to ensure the most timely and comprehensive representation as possible. The website is: https://www.lihealthcollab.org/healthy-resources

EVALUATION OF IMPACT – ACTIONS TAKEN SINCE 2016

Our 2016 CHNA identified the significant health needs of the prevention and management of chronic disease and a reduction in obesity. These were addressed collaboratively by Hospital and community partners in the Long Island Health Collaborative. Since the targeted objectives addressed lifestyle changes to improve outcomes, it was hoped that through the collective impact model, public awareness and education would help motivate individuals to make the changes necessary to adopt a healthy lifestyle. Additional public health priorities we addressed were fall prevention and an increase in cancer screenings.

Programs are evaluated by pre- and post- evaluation forms, community demand, and outcomes. The following is a brief summary of actions taken since 2016 to address these concerns.

CHRONIC DISEASE MANAGEMENT & PREVENTION

The **CDC evidenced-based National Diabetes Prevention** program, offered at our Diabetes Education Center, has received positive feedback. Since 2016, more than 300 individuals participated in the one-year program and approximately 80% were motivated to change behavior. An average of 33% were from communities with health disparities.

A summary of a review of post-evaluation surveys includes the following:

"I know more about lifestyle changes" – 94% strongly agree, 6% agree
"Able to maintain lifestyle changes" 45% strongly agree; 58% agree; 6% disagree;

"Better understanding of physical activity – 90% strongly agree, 19% agree; 1% disagree

The Stanford Program for Chronic Disease Management, challenging to implement because of changes in staffing and training schedules, began classes out in the community in 2018. As of this date, three programs were held in our core service area, with one of them being a community with health disparities. Feedback has been positive, with 90% of individuals making an action plan to control their health. Participants' comments also indicated the following:

"I eat healthier." "I exercise more." "I learned to keep a medical journal."

Tai Chi – evidenced-based for arthritis and fall prevention, it is also proven to be an excellent strategy to relieve stress and improve mental health. Our Tai-Chi program is offered twice a week, for 8 weeks. Approximately 150 individuals have participated in the program. Demand is high. Post-satisfaction surveys indicate an increased feeling of wellness, improved energy, posture and confidence. Sample comments:

"*The program is a morale booster." "It releases tension." "It makes me relax." "I have less anxiety, learned how to walk without losing my balance, and feel better after the class."*

OBESITY

NYU Winthrop utilizes the **5-2-1-0 healthy lifestyle program** in obesity prevention, both out in the community at Head Start and in the NYU Winthrop clinic. Challenges are the same for both locations; parents are often reluctant to understand that their child is obese. Consistent, culturally relevant messaging continues to address this.

Head Start Partnership – During 2017 and 2018, we serviced two locations in Hempstead and Westbury. All children are weighed and given a packed of information about the program. Parents receive a follow-up letter about their child's BMII and are offered healthy lifestyle education through a workshop, but no parents have participated. Our relationship with Head Start is positive, despite the fact that the overall obesity rates are not showing a positive change.

Stats were measured for the same children who participated in the program during the school year. Change is difficult to assess, given the varying growth rates of children. However, measures were as follows:

Westbury
Fall 2016 to Summer 2017 – a 12% reduction in obesity
Fall 2017 to Summer 2018 – No change in Obesity rate – 22.4% of children are obese, however, there was a reduction in the High rate of obesity of 5%

Hempstead
Fall 2016 to Summer 2017 – No reduction in obesity – 24% of children are obese
Fall 2017 to summer 2018 – A 2% reduction in obesity; 24.3% of children are obese

In 2019, Head Start requested that we bring the program to two more sites: Freeport and Roosevelt. Consistent messaging continues at Head Start, to both parents and children. NYU Winthrop staff also attends parent meetings to cultivate the relationship and promote wellness.

Hempstead Children's Health Clinic – The 5-2-10- program is explained to families. Children who are obese are referred to an endocrinologist, who is now in the practice one or two Saturdays a month to provide easier access for parents.

Currently, approximately 22% of the children within the practice are obese. There has been a 90% counseling rate for all parents; 100% of those who are obese receive 5-2-1-0 counseling. Those with a BMI of 95% or more received special dietary counseling and surveillance. Compliance rate of families for those requested to return for 3-month follow-up visit for obesity was 44%. Again, parents are resistant and do not want to hear that their child is unhealthy. This challenge continues to be addressed with consistent, culturally relevant messaging to parents.

The obesity rate at the Hempstead Children's Clinic is similar to the rate at Head Start, at approximately 22%.

Breastfeeding is an evidenced-based obesity intervention. NYU Winthrop, A Baby Friendly Hospital, tracks the number of women who choose to breastfeed when their child is born, and the number of women who attend support groups. Our records show that from January 2017 to April 2019, an average of 41% of women were exclusively breastfeeding upon discharge. Approximately 5 to 15 mothers attend support groups with their babies each week. To date, 166 women have attended support groups.

This past year, the Hospital developed a new program called LATCH hour. It is for women who are having issues with the LATCH for infants up to 4 weeks old; 15 new mothers participated as of April 2019.

Cancer Screenings – the Division of Cancer Services worked to increase the following cancer screenings in the community:

- Colon Cancer – NYU Winthrop committed to the "80% by 2018" American Cancer Society pledge to increase colorectal cancer screenings (80% of the eligible population screened

by 2018). An important component of the 2016 goal was to overcome challenges and barriers to screening and increase cancer screening awareness. NYU Winthrop worked with community organizations to encourage participation among their clients, and also held hospital-based program to promote cancer awareness.

A common barrier was insurance. NYU Winthrop had several meeting with insurance experts, who educated staff about accessing insurance, so staff could in turn, educate the community. The impact of this initiative was revealed in the most recent Oncology Nurse Navigator Program Patient Satisfaction survey:

- 2015 – 25% of those surveyed required information and/or education regarding insurance plans and coverage
- 2018 – 15% of those surveyed required information and/or education – a 10% improvement

As of the end of 2018, 2008 screening colonoscopies were completed.

- Breast Cancer – NYU Winthrop participated in the National Accreditation Program for Breast Centers (NAPBC) Patient Navigation Initiative. A patient navigator assisted women with making appointments for a screening mammography. The navigator, who speaks five languages, identifies and addresses any barriers to care on a case-by-case basis. Procedures are in place to get financial assistance for screening.

  This program targeting the underserved. NYU Winthrop collaborates with CBO's and churches in select communities to promote the initiative.

NAPBC Program	**2017**	**2018**	**Jan to April 2019**
# of Women Contacted	686	991	522
In Need of Screening	87%	51%	67%
Complete Screenings	47%	75%	42%

Fall Prevention – NYU Winthrop has offered a four-part series on fall prevention for several years. Approximately 200 individuals have participated since our CHNA OF 2016. The series addresses fall prevention tips, and exercises that improve balance, flexibility and strength. Post-satisfaction surveys indicate an increase in an awareness of environment, limitations, possible home modifications and physician visits to check eyesight and review medications.

The program was revamped in early 2019 to implement a cognitive component. The goal is to connect mind and body to gain optimal health status in the individual. This has been well received, with requests from participants for more classes.

As mentioned above, the Tai Chi program that is offered also targets fall prevention. A six-month follow-up survey of the classes offered in 2018 revealed that **no one** has experienced a fall.

ASSETS AND RESOURCES

A summary of assets and resources that can be mobilized and employed to address the health issues identified begins with the vast network overseen by the Long Island Health Collaborative. The list below reflects partners with whom the LIHC currently engages throughout the counties of Nassau and Suffolk. A full list of LIHC participants is in Appendix E.

- 23 hospitals/systems
- 2 county health departments
- 110+ community-based and social service organizations
- 111 libraries
- 5 major academic institutions
- 100+ food pantries
- 2 school districts
- 4 Headstart programs

We assessed available resources via the participant list maintained by the LIHC, the United Way's 2-1-1 database, the Health Information Tool for Empowerment (HITE) database, New York State Department of Parks and Recreation website, Suffolk County Department of Parks and Recreation website, Nassau County Department of Parks and Recreation website, New York State Department of Agriculture website, Nassau-Suffolk Hospital Council member list, Nassau and Suffolk Cooperative Library System directory, Nassau and Suffolk Counties Superintendent Associations, Suffolk Care Collaborative (Suffolk County's Performing Provider System), NQP PPS (Nassau County's Performing Provider System), Diocese of Rockville Centre Parish Listing, New York Jewish Guide Synagogue listing, Long Island Council of Churches.

The LIHC actively promotes the use of 2-1-1 and HITE among community members and health/social service providers who connect individuals with social determinant of health services. The 2-1-1 and HITE site exist in real-time and are routinely updated. Links to these databases and other relevant resource databases are listed on the LIHC website and are available for public use. We invite consumers and health/social service providers to provide feedback on resources to ensure the most timely and comprehensive representation as possible.

COMMUNITY SERVICE PLAN

METHODOLOGY FOR SELECTION OF PRIORITIES

On March 27, 2018, the LIHC distributed results of all its data analyses to all LIHC participants. Large data files were posted on google drive. LIHC participants were asked to review all the quantitative and qualitative data in advance of the Priority Selection Meeting. That meeting took place on Friday, March 29, 2018 at 9:30 a.m. at the offices of the Nassau-Suffolk Hospital Council in Hauppauge, NY. The LIHC's data analyst walked participants through screen shots of the relevant findings. Participants also viewed the Prevention Agenda dashboard, diving deep into the goals, objectives, and recommended interventions for each priority. Present at the meeting either in-person or via phone were representatives from each of the two local health departments on Long Island and representatives from each of Long Island's hospitals/health systems, as well as staff of the LIHC. Attendees discussed the results and based the selection of priorities on the following criteria:

- The overwhelming evidence presented by the data, especially the first two questions of the CHAS
- The activities/strategies/interventions currently in place throughout the region
- The feasibility of achieving momentum and success with a chosen priority, taking into account the diversity of partners and community members served

After an official vote, the priorities were selected unanimously.

As directed by the data results, community partners selected **Prevent Chronic Disease** as a priority area with a focus on *Chronic Disease Preventive Care and Management* and **Promote Well-Being and Prevent Mental and Substance Use Disorders** as a priority area with a focus on *Mental and Substance Use Disorders Prevention* for the 2019-2021 cycle.

Priorities selected in 2019 remain unchanged from the 2016 selection; however, for 2019, a specific priority regarding mental health and substance use was selected, as opposed to placing an overarching emphasis on these two issues as was done in the previous cycle.

GOALS, OBJECTIVES, INTERVENTIONS, STRATEGIES AND ACTIVITIES

Please refer to Appendix F for the work plan.

MAINTAINING ENGAGEMENT OF LOCAL PARTNERS

- Community engagement continues through monthly meetings with the Long Island Health Collaborative to discuss evidenced-based programming, public outreach initiatives and changes in health trends.

- Local community partners are kept up-to-date through quarterly meetings of NYU Winthrop's Community Cultural Advisory Committee.

- The Long Island Community Health Assessment survey is located on NYU Winthrop's website that requests input from the community on current health concerns.

- Evaluation forms at community programs are utilized as a method of feedback from community members. Those forms also request ideas for new programs.

- Social media platforms - Facebook, Twitter, Instagram and YouTube – keep the Hospital and the community connected.

Progress will be tracked though quantitative and qualitative data collection and analysis. The plan is a dynamic document that will be continually reviewed according to the quality improvement measurement standards of the Hospital, PDSA (Plan, Do, Study, Act) and revised as needed according to changes in community need or resources.

Progress will also be tracked monthly using the Community Benefit Inventory Database as a way for NYU Winthrop to measure its impact on the community.

DISSEMINATION TO THE PUBLIC

The Executive Summary is posted on the NYU Winthrop Hospital website, and accessed under the Community Health section on the main page. It may be viewed and printed in hard copy. The website address is https://www.nyuwinthrop.org/community-health/community-service-plan/. A complete copy of this report may be requested by anyone by contacting the NYU Winthrop Welcome Center at 1-866-946-8476.