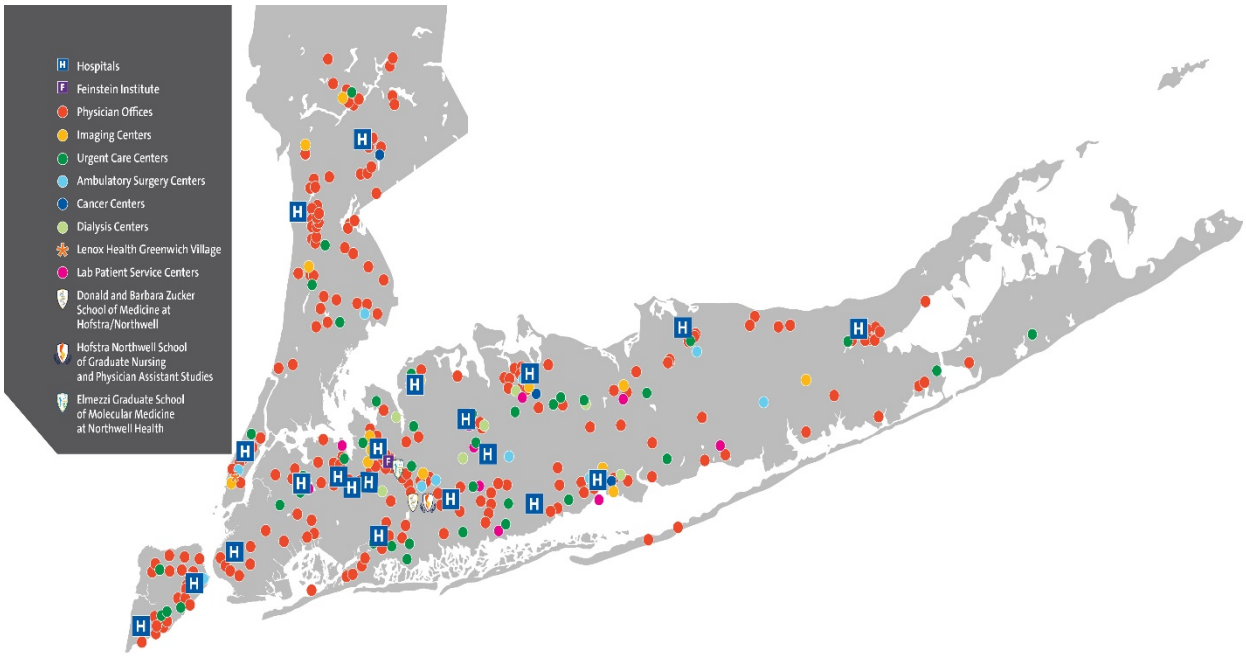
Northwell Health NYSDOH Community Service Plan 2019-2021 Summary Report



County Service Area:

Nassau County, New York County, Queens County, Richmond County, Suffolk County and Westchester County

Northwell Health Contact:
Edward Fraser, Vice President Community Relations
(efraser@northwell.edu)
2000 Marcus Avenue
New Hyde Park, NY 11042

A. Executive Summary

1. 2019-2021 Northwell Health New York Prevention Agenda Priorities:

To improve the health of the community, Northwell Health as a result of the CHNA process and approved by the Committee on Community Health of the Northwell Health Board of Trustees, has selected the following NYSDOH Priority Agenda Priority Areas, focus areas and goals for the service area of the health system:

PRIORITY AREA: Prevent Chronic Disease

FOCUS AREA: Healthy Eating and Food Security

- Increase access to healthy affordable foods and beverages
- Increase skills and knowledge to support healthy food and beverage choices
- Increase food security

- FOCUS AREA: Physical Activity
  - Promote school, childcare and worksite environments that support physical activity for people of all ages and abilities

- FOCUS AREA: Tobacco Prevention
  - Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
  - Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including low SES, frequent mental distress/substance use disorder; LGBT; and disability

- FOCUS AREA: Preventative Care and Management
  - Increase cancer screening rates for breast, cervical and colorectal cancer
  - Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
  - Promote the use of evidence-based care to manage chronic diseases
  - Improve self-management skills for individuals with chronic diseases

PRIORITY AREA: Promote Well-Being and Prevent Mental and Substance Use Disorders

- FOCUS AREA: Promote Well Being

- Strengthen opportunities to build well-being and resilience across the lifespan
- Facilitate supportive environments that promote respect and dignity for all ages

- FOCUS AREA: Prevent Mental and Substance Use Disorders
  - Prevent opioid and other substance misuse and deaths
  - Reduce Prevalence of major depressive disorders

The NYSDOH Prevention Agenda Dashboard Improve Heath Status and Reduce Health Disparities objective that Northwell will be focusing on is *Age-adjusted preventable hospitalization rate per 10,000 - Aged 18+ years* in addition to a focus on low income populations with health disparities.

2. Data sources used to identify and confirm chosen NYSDOH Priorities

The 2019-2021 Northwell Health NYDSOH Prevention Agenda Priorities remain similar to the 2016-2019 NYDSOH Prevention Agenda Priorities. As a result of the increasing evidence of the impact of social determinants of health on health outcomes and disparities, Northwell Health expanded the community needs assessment to include both primary and secondary data analysis and mapping of determinants of health for each county in the Northwell Health service area. The determinants of health encompass the range of personal, social, economic, and environmental factors that influence health status. The determinants of health reach beyond the boundaries of traditional health care to include Centers for Disease Control and Prevention[1] (CDC) categories of policymaking; social factors; health services; individual behavior and biology and genetics.

Primary Analysis

The CHNA stakeholders determined that in addition to census, hospitalization and vital statistics data, the assessment should include the "voice of the community" (e.g. the community's perception of need). This assessment included individual and community health priorities, barriers to accessing

[1] Centers for Disease Control and Prevention (CDC). "Social Determinants of Health: Know What Affects Health." Oct. 2015.

health care and strategies to improve the individual's and community's health. Social determinants of health which impact wellness were included in the assessment. To collect and analyze primary data, Northwell Health partnered with local health departments, area hospitals/health systems and community–based organizations in each of the six counties in our service area, as well as the Long Island Health Collaborative (LIHC), recipient of the NYSDOH Population Health Improvement Program, which focuses on health in Nassau and Suffolk Counties, the Health and Welfare Council of Long Island, a regional umbrella organization for health and human service providers and the Human Services Council which is a network of human service organizations representing over 200,000 staff providing services such as housing, childcare, elder care, food pantries and mental health counseling to vulnerable New York City community members.

Secondary Analysis

Since the Northwell Health service area includes, Nassau, New York, Queens, Richmond, Suffolk, and Westchester counties, secondary community health data collection, assessment and NYSDOH Priority Agenda Item selection was performed by county. Sources of included SPARCS data[2] (version 2016), NYSDOH Vital Statistics, NYS Cancer Registry, the NYSDOH Surveillance System, New York State DOH Prevention Agenda Dashboard, New York State Community Indicator Reports, New York State Opioid Data Dashboard, New York City Neighborhood Health Atlas, Behavioral Health Risk Factor Surveillance System, NYCDOHMH EpiQuery data set, Policy Map, Northwell Health TSI Reporting and Analytics and U.S Census data. Data were age-adjusted (direct standardization of rates) based on 2010 U.S. standard population. A mapping of Prevention Quality Indicators (PQIs) quintiles was also used as part of the health data analysis. PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for

[2] 2017 SPARCS data set was recalled by the NYSDOH for further analysis leaving the 2016 data set as the most recent at the time of this assessment but a 2 year analysis of 2015 and 2016 was not possible due to the use of IDC 9 codes in 2015 and the use of IDC 10 codes in 2016. Therefore, with guidance from the NYSDOH the PQI analysis was performed using the combined 2013-2014 data sets.

"ambulatory care sensitive conditions." These are conditions for which quality community health and outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. With high-quality, population health and community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community combined with data on race, ethnicity and social determinants of health.

The community health needs assessment included primary and secondary data analysis and mapping of determinants of health for each county in the Northwell Health service area. The determinants of health encompass the range of personal, social, economic, and environmental factors that influence health status. The determinants of health reach beyond the boundaries of traditional health care to include sectors such as education, housing, and environment and it is the interrelationships among them that determine individual and population health. According to the Centers for Disease Control and Prevention[1] (CDC) we can identify the determinants of health in several categories, including (1) Policymaking, (2) Social Factors, (3) Health Services, (4) Individual Behavior, and (5) Biology and Genetics.

3. *Community and Local Health Department Community Health Needs Assessment and Implementation Plan Partners and Broad community Engagement*

Northwell Health began the Community Health Needs Assessment (CHNA) process in January 2019. As an integrated health care system, the Office of Community Relations was the lead corporate office that planned, coordinated and reported the CHNA in collaboration with internal and external

stakeholders for Northwell Health. System stakeholders included senior leadership, the Committee on Community Health of the Northwell Board of Trustees, executive directors and staff of Northwell hospitals, Office of Strategic Planning, Office of Government and Community Affairs and corporate service lines. External stakeholders included representatives from county health departments, area hospitals, academia, business, government agencies and community based organizations with an emphasis on those who serve communities with health disparities. A series of internal and external stakeholder meetings were held to discuss the process including: the CHNA methodology; recruitment of community, academic and government partners; secondary data analysis; primary data collection from external stakeholders; evaluation of primary data; identification of health system and community resources; identification of NYSDOH Priority Agenda items and development of the implementation plan. The Committee on Community Health of the Northwell Board of Trustees was updated on the CHNA process during its quarterly meetings, provided feedback on the process including the selection of the NYSDOH Priority Agenda items and approved the recommended NYSDOH Priority Agenda items and the implementation plan for Northwell Health as the governing body of community health of the Northwell Board of Trustees.

Northwell Health and its service area stakeholders agreed that quantitative and qualitative data should be collected from community organizations and the population-at-large in the forms of community member and community-based organization/provider surveys, facilitated focus groups and community-based organization summits with each county service area partners choosing the preferred method for their communities. External stakeholders were presented the data analysis and provided feedback in the selection of the Northwell NYSDOH Prevention Agenda Priorities and Focus Areas as well as identifying disparities and social determinants of health which were impacting the health of their communities and potential cross sectional strategies to address these issues. Area health coalitions from all 5 service area counties including the lead health departments and other community-based organizations, schools, national/regional health organizations and

academia are included as partners in the Northwell Health 2019-2021 Community Service Plan. Their roles include partnering in community outreach, education, engagement, delivery of evidence-based interventions, providing social services related to identified social determinant of health needs, advocacy and policy formation.

4. Specific Evidence-based Interventions/Strategies/Activities Utilized to Address the Identified NYSDOH Prevention Agenda Priorities and Health Disparities selected from NYSDOH suggested Interventions[3]

To address the selected NYSDOH Prevention Agenda Priorities and Focus Areas related to chronic disease, behavioral health and health disparities, Northwell Health incorporated the following evidence- based interventions into its 2019-2021 Community Service Plan:

1. Stanford Chronic Disease Self-Management Program (CDSMP)
2. National Diabetes Prevention Program
3. Mobile Community Cancer Screenings including mammography
4. 5 "A's" Tobacco Cessation Counseling
5. Family Connects Durham/International (Nurse home visiting program for parents of newborns)
6. EMR based Social Determinant of Health Inpatient Screening and NOW POW Electronic Referral Platform
7. Health Information Technology for Measurement, Registry Development, Patient Alerts, Bi-Directional Referrals
8. Anchor Institution Strategies
9. Food as Health & Food Rescue Programs Hospital based CBO Food Security Interventions
10. Breast Feeding Friendly Hospitals, Worksites, Primary Care and Women's Health Practices, Baby Café'sUSA
11. Healthy Vending Guidelines & Work Site Wellness Policy Implementation
12. Healthy Corner Store Initiative

[3] NYSDOH Prevention Agenda Action Plans https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/chr.htm Accessed November 2019

13. Stepping On

14. Tai Chi

15. Project Fit America

16. Mental Health First Aid Certification Course

17. Naloxone Overdose Reversal Training

18. Stop the Bleed

19. SBIRT Behavioral Health Screens

5. Implementation Plan Evaluation and Process Outcomes

Northwell Health's Implementation Plan's evaluation measures include performance measures related to the 2019-2024 NYSDOH Prevention Agenda Objectives and health system SMART objectives related to the NYSDOH Prevention Agenda Objectives. In addition, short term metrics such as changes in engagement, behaviors, social determinant of health status (i.e. food security) have been identified to track activities related to the long term indicators.

A. Community Health Needs Assessment

The Northwell Community Health Needs Assessment (CHNA) is found in the accompanying document titled *Northwell Health 2019 Community Health Needs Assessment* that addresses the NYSDOH 2019-2021 CHNA and CHIP and CSP Guidance sections:

1. Description of the community being addressed

2. Identification of the main health challenges facing this community and discussion of contributing causes of health challenges, including the broad determinants of health.

3. A succinct summary of the assets and resources that can be mobilized and employed to address the health issues identified.

C. Community Service Plan

The Northwell Community Service Plan is found in the accompanying document titled *Northwell Health 2019-2021 Community Service Plan* which utilizes the NYSDOH required template.