Suffolk County

Community Health Assessment and Improvement Plan

2019-2021

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CHIP created based on priorities set by the Long Island Health Collaborative (LIHC)
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Participating Hospitals Listed in Appendix

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The Long Island Health Collaborative (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 Assessment processes, including data collection and analysis. Participating hospitals and hospital systems included the following:

Catholic Health Services of Long Island

Good Samaritan Hospital Medical Center	1000 Montauk Hwy, West Islip, NY 11795
St. Catherine of Siena Medical Center	50 NY-25A, Smithtown, NY 11787
St. Charles Hospital	200 Belle Terre Rd, Port Jefferson, NY 11777

Northwell Health System

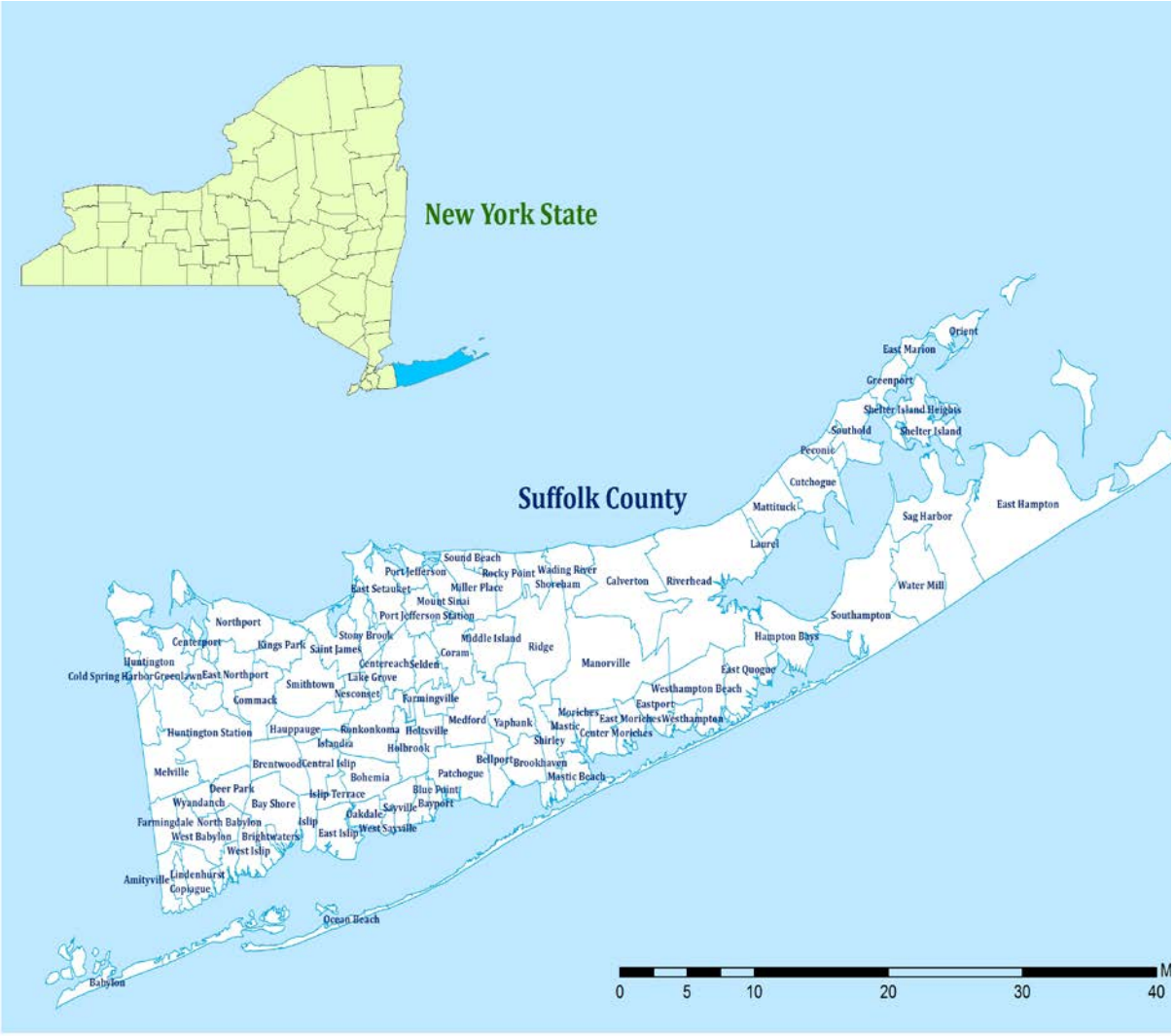
Huntington Hospital	270 Park Ave, Huntington, NY 11743
Mather Hospital	75 N. Country Rd., Port Jefferson, NY 11777
Peconic Bay Medical Center	1300 Roanoke Ave, Riverhead, NY 11901
Southside Hospital	301 E. Main Street, Bay Shore, NY 11706

Stony Brook Medicine

Stony Brook Southampton Hospitals	240 Meeting House Ln, Southampton, NY 11968
Stony Brook University Hospital	101 Nicolls Rd, Stony Brook, NY 11794
Eastern Long Island Hospital	201 Manor Pl, Greenport, NY 11944

Long Island Community Hospital	101 Hospital Road, Patchogue, NY 11772
Veterans Affairs Medical Center	79 Middleville Rd, Northport, NY 11768

The Suffolk County Community Health Assessment and Improvement Plan was created in collaboration with community agencies based on priorities determined by the "Long Island Health Collaborative," established in January 2013. The Long Island Health Collaborative (LIHC), funded by the New York State Department of Health's Population Health Improvement Program, was developed by hospitals and the Health Departments of Suffolk and Nassau Counties with the assistance of The Nassau-Suffolk Hospital Council to develop and implement a Community Health Assessment and Improvement Plan (CHA-CHIP). Representatives throughout SCDHS contributed to the development of the goals and objectives. The objective of the CHIP was to partner with community agencies and develop and monitor programs to improve the quality of health of the community.



SUFFOLK COUNTY

COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN 2019-2021

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Executive Summary

Executive Summary

The Prevention Agenda priorities for the 2019-2021 period selected by the Long Island Health Collaborative (LIHC) and adopted by the Suffolk County Department of Health Services (SCDHS) include:

1. **Prevent Chronic Disease**
   Focus Area 4: Chronic Disease Preventive Care and Management

2. **Promote Well-Being and Prevent Mental and Substance Use Disorders**
   Focus Area 2: Mental and Substance Use Disorders Prevention

To identify and confirm Prevention Agenda priorities for the 2019-2021 Community Health Assessment cycle, members of the Long Island Health Collaborative reviewed extensive data sets, with coordination of data collection and analysis through the Long Island Health Collaborative.

Primary data sources included: The Long Island and Eastern Queens Community Health Assessment Survey (CHAS) *(Appendix A*) and the results from focus groups and key community-based organization leader interviews. The latter results, compiled in the report – *Focus Groups and In-Depth Interviews*, are summarized in the Primary Data Sources section of this document.

Secondary data sources included: Publically available data sets, including: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, Prevention Quality Indicators (PQI), New York State Behavioral Risk Factor Surveillance System (BRFSS), New York State Extended Behavioral Risk Factor

Surveillance System (eBRFSS), New York State Community Health Indicator Reports (CHIRS) and New York State Vital Statistics.

Local Partners and Community Involvement

SCDHS participates in the LIHC activities. This includes a collaborative review of all data collected and analyzed by the LIHC, with SCDHS' input and consultation offered when appropriate. SCDHS also relies upon the LIHC to assist in disseminating information about the importance of proper nutrition and physical activity among the general public in an effort to assist Suffolk residents in better managing their chronic diseases and/or preventing the onset of chronic diseases. Additionally, the various Divisions and Programs within SCDHS have ongoing relationships with various community based organizations, schools, and hospitals where collaboration on the implementation of the Community Health Improvement Plan takes place. These efforts, along with process and outcome measures, are defined in the work plan, outlined in the Community Health Improvement Plan (CHIP) section of this document. Finally, SCDHS participates in the LIHC's bi-monthly stakeholder meetings and avails itself of LIHC's extensive network (*Appendix B*).

The engagement of the broader community, for assessment processes, is achieved through the LIHC's and its partners' ongoing distribution of the Long Island Community Health Assessment Survey (CHAS). This survey is offered online via a Survey Monkey link and is available to residents at public events, workshops, educational programs, and interventions offered by LIHC partners. Additionally, it is distributed among physician offices, hospital waiting areas, libraries, schools, federally qualified health centers, insurance enrollment sites, and other public venues. The LIHC aggressively promotes the

survey through social media and asks LIHC participants to post the survey link on each of their websites. CHAS Results are analyzed twice a year, and findings are shared with all LIHC participants and the media, and are posted on the LIHC website. The community is also engaged through focus groups in low-income areas and key informant interviews with leaders of community-based organizations (CBOs).

Improvement activities engage the broader community through the LIHC and established partnerships that SCDHS divisions and programs have with community agencies, health systems, federally qualified health centers, hospitals, and programs.

Evidence Based Interventions

Community health improvement interventions in the priority areas include:

- Health promotion activities of the LIHC:
  - Chronic disease self-management education workshop series (Stanford model)
  - Are You Ready Feet?™ walking campaign and portal
  - Cultural Competency Health Literacy training
  - Awareness Campaign (Live Better) via social media and traditional media platforms
- SCDHS Community Health Improvement Projects
  - Expand access to the National Diabetes Prevention Program
  - Increase and expand the number of Tai Chi for Arthritis courses offered in Suffolk County
  - Provide high school students with a peer education electronic

vaping product prevention and refusal skills training

- Provide opioid overdose trainings and naloxone kit distribution to community members
- Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine
- Strengthen access and delivery of suicide care
- Increase access and delivery of cancer screening
- Increase awareness and knowledge regarding cancer screening

PROGRESS MONITORING:

A variety of process and outcome measures specific to each intervention will be utilized to monitor progress toward the objectives of each project, with annual reporting to New York State Department of Health. These measures are outlined in the Community Health Improvement Plan section of this document. The Long Island Health Collaborative meets bimonthly and will have regular updates on the status of projects. The broad membership with hospitals, health departments and community-based organizations will allow for community input into the projects, as well as community awareness of the projects' status. Additionally, reporting on progress to the Suffolk County Department of Health Services Commissioner will take place regularly. Resultant modification of activities as indicated will take place to ensure continued quality and effectiveness of the interventions.

Community Health Assessment and Improvement Plan

COMMUNITY SERVED

Suffolk County, occupying the eastern end of Long Island, has a land area of 912.2 square miles. Suffolk County's service area is situated east of the Nassau County border, extending through the eastern forks of Long Island. It comprises ten towns: Babylon, Huntington, Islip, Smithtown, Brookhaven, Southampton, Riverhead, East Hampton, Shelter Island and Southold. Suffolk County is an area of growing diversity, cultures and population characteristics. As of July 1, 2018, the U.S. Census Bureau 2018 Vintage Population Estimates program, estimates the total population of Suffolk County to be 1,481,093, which represents a decrease from April 2010 of 0.8%. Of this estimated total Suffolk County population, 5.4% of the population are under 5 years, 21.1% are under 18 years and individuals aged 65 years and older constitute 16.9% of the total population, with a median age of 41.8 years. As of July 1, 2018, females make up an estimated 50.8% of the County's population.

As of July 1, 2018, the US Census Bureau Vintage 2018 Population estimates that 19.8% of the population is Hispanic/Latino, 67.2% of the population is non-Hispanic White, 8.7% is African American/Black, 4.2% is Asian, 0.6% is American Indian and Alaskan Native, 0.1% is Native Hawaiian and other Pacific Islander and 2.0% are two or more races. Suffolk County is also home to two Indian reservations, the Shinnecock Reservation in Southampton as well as the Poospatuck Reservation, Unkechaug Nation in Shirley.

According to the US Census Bureau, 2013-2017 American Community Survey (ACS) 5-year estimates, 15.6% of Suffolk County residents were foreign-born. Furthermore, for

the 2013-2017ACS 5-year estimates, the percentage of the population (five years and over) that speaks a language other than English is 22.7%. Of those who speak a language other than English, 40.3% report they speak English "less than very well." Educational attainment refers to the highest level of education a person has completed. According to the 2013-2017 ACS 5-year estimates, among those Suffolk County residents age 25 and over, 28.4% of the county's residents have an educational attainment of a high school or high-school equivalent diploma, 19.1% a bachelor degree, and 15.8% a graduate professional diploma.

According to the ACS 5-year estimates for 2013 to 2017, the unemployment rate in Suffolk for those aged 16 and older was 5.4% countywide: 5.0% for whites, 8.2% for African Americans, 5.0% for Asians, 16.4% for American Indian and Alaskan Native, 3.7% for Native Hawaiian and Other Pacific Islander and 5.9% for Hispanics. Median household income was $92,838 with a per capita income in the past 12 months (in 2017 dollars) of $40,277. The percent of persons in poverty was estimated to be 7%. For 2013-2017, there were 576,873 housing units in Suffolk County, with 85.2% occupied housing units. Of those occupied housing units, 80.3% of housing units were owner-occupied, while 19.7% of housing units were renter-occupied. For 2013-2017, the median value of an owner-occupied housing unit was $379,400, and the median gross rent was $1646.

According to the ACS 5-year estimates, between 2013 and 2017, 6.1% of Suffolk County residents under 65 years of age had a disability and the percentage of the civilian noninstitutionalized population with health insurance was 93.5%.

Suffolk County's medical needs are served by thirteen hospitals, ten Hudson River Health Care (HRHCare) community health centers (federally qualified health care centers) located throughout the county, as well as multiple health care systems functioning within the

county, including their affiliated primary and specialty care practices. The Suffolk County Department of Health Services is affiliated with eight of the HRHCare health centers. The age-adjusted percentage of adults who have a regular health care provider in Suffolk is 82.2% compared to 82.6% for New York State, according to the 2016 NYS Expanded BRFSS data. Additionally, the age-adjusted percent of adults in Suffolk County who did not receive medical care because of cost was 12.4%, compared to 11.5% for New York State, according to the 2016 NYS Expanded BRFSS data.

In order to identify areas at risk for health outcomes due to social determinants of health, nine measures obtained from the United States Census Bureau's American Community Survey, using the FactFinder tool were reviewed and used to identify twenty zip codes in each measure that had the least optimal results. The nine measures included:

1. Among individuals 25 years or older, percent High School Graduate or higher;
2. Among individuals 25 years or older, percent Bachelor's Degree;
3. Percentage of households with limited English speaking;
4. Among individuals 16 years and older, unemployment rate;
5. Percent below poverty level;
6. Percent of households receiving cash public assistance in the past 12 months;
7. Percent of households receiving food stamps/SNAP in the past 12 months;
8. Median income; and
9. Percent foreign born.

There were 107 zip codes in Suffolk County that were used for this analysis. Five zip codes in Suffolk County were excluded from the analysis due to lack of reporting on the American Community Survey website. For each of the nine US Census measures, the

Suffolk County zip codes were assigned a ranking number, such that the one with the least optimal result was assigned the number one (1) and then the most optimal result was assigned 107. These values were added for all nine measures for each zip code to create sum ranking with lower scores representing less optimal results.

In addition, another ranking was performed, counting the number of times when a zip code fell into the least optimal 20 zip codes for a particular US census measure. Since there were nine measures, values for this count ranking ranged from zero (0) to nine (9).

Among the zip codes, those that were in the least optimal twenty for both the sum ranking and count ranking, as described above were categorized as "Identified Zip Codes." There were a total of seventeen Identified Zip Codes, and they included the following:

Town	**ZIP**
Amityville	11701
West Babylon	11704
Bay Shore	11706
Bellport	11713
Brentwood	11717
Central Islip	11722
Copiague	11726
Lindenhurst	11757
Patchogue	11772
Wyandanch	11798
Riverhead	11901
Calverton	11933
Greenport	11944
Mastic	11950
Mastic Beach	11951
Ridge	11961
Shirley	11967

COLLABORATIVE PROCESS TO DETERMINE PREVENTION AGENDA PRIORITIES

In 2013, hospitals and both county departments of health on Long Island convened to work collaboratively on the community health needs assessment. Over time, this Collaborative grew into an expansive membership of academic partners, community-based organizations, physicians, health plans, schools and libraries, local municipalities and other community partners who held a vested interest in improving community health and supporting the New York State Department of Health (NYSDOH) Prevention Agenda. Designated the *Long Island Health Collaborative*, this multi-disciplinary entity now meets bi-monthly to work collectively toward improving health outcomes for Long Islanders.

Since 2015, the LIHC has received its funding from the NYSDOH Population Health Improvement Program (PHIP) grant. A primary responsibility of the LIHC is data collection and analysis, which is manifested in the supervision of the Community Health Needs Assessment process for the Long Island region.

One of the roles of the LIHC is to choose the priorities for the New York State's Prevention Agenda for the Long Island Region. Since 2013, LIHC's work on the NYS Prevention Agenda focused on chronic disease prevention and treatment, with an emphasis on reducing obesity in adults and children. It also addressed the need for better coordinated mental health/substance abuse treatment and prevention services.

In 2019, members of the Long Island Health Collaborative (membership is listed in the pages that follow) reviewed extensive data sets selected from both primary and secondary data sources to identify and confirm Prevention Agenda priorities for the 2019-2021 Community Health Needs Assessment Cycle. Data analysis efforts were coordinated through

the Population Health Improvement Program (PHIP), with the PHIP serving as the centralized data return and analysis hub.

COMMUNITY HEALTH ASSESSMENT

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey (CHAS) and the qualitative data from Focus Groups and Key Informant Interviews with Community-Based Organization Leaders. Secondary, publically-available data sets were reviewed to determine changes in health status and emerging issues within Suffolk County. Sources of secondary data include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard (PA), New York State Maternal and Child Health dashboard (MCH), County Health Rankings, New York State Behavioral Risk Factor Surveillance System (BRFSS), New York State Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics. The data findings are as follows.

PRIMARY DATA SOURCES:

Long Island Community Health Assessment Survey (CHAS)

Surveys to determine the perception of health needs and barriers experienced by individuals and communities were distributed by paper and electronically, through Survey Monkey, to community members from January 1, 2018 through December 31, 2018 with 810 surveys collected in Suffolk County. 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. The survey results are summarized below:

Table 1. Biggest ongoing health concerns in individual community

2018 Rank	Suffolk County	Percentage
1	Drugs and Alcohol Abuse	22.45%
2	Cancer	16.68%
3	Mental Health, Depression, Suicide	12.05%
4	Heart Disease and Stroke	10.14%
5	Obesity, Weight Loss Issues	8.20%
	Sum of Column Percentages	**69.52%**

Table 2. Biggest ongoing health Concern for oneself

2018 Rank	Suffolk County	Percentage
1	Heart Disease and Stroke	18.57%
2	Obesity, Weight Loss Issues	14.94%
3	Cancer	14.19%
4	Women's Health and Wellness	12.63%
5	Diabetes	8.14%
	Sum of Column Percentages	**68.47%**

Table 3. Potential barriers people face when getting medical treatment

2018 Rank	Suffolk County	Percentage
1	No Insurance	20.18%
2	Fear	17.52%
3	Unable to Pay Co-pays or Deductibles	16.16%
4	There are No Barriers	14.70%
5	Don't Understand the Need to See a Doctor	11.13%
	Sum of Column Percentages	**79.69%**

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

2018 Rank	Suffolk County	Percentage
1	Healthier Food Choices	15.26%
2	Drug and Alcohol Rehabilitation Services	14.71%
3	Clean Air and Water	12.11%
4	Mental Health Services	11.75%
5	Job Opportunities	9.87%
	Sum of Column Percentages	**63.70%**

Table 5. Necessary Health Screenings and Education Services

2018 Rank	Suffolk County	Percentage
1	Drug and Alcohol	14.07%
2	Mental Health/Depression	10.74%
3	Importance of Routine Well Checkups	8.61%
4	Exercise/Physical Activity	8.01%
5	Cancer	7.99%
	Sum of Column Percentages	**49.42%**

Table 6. Sources of Health Information

2018 Rank	Suffolk County	Percentage
1	Doctor/Health Professional	42.74%
2	Internet	20.62%
3	Family or Friends	8.62%
4	Newspaper/Magazines	5.65%
5	Television	4.76%
	Sum of Column Percentages	**82.39%**

Focus Groups and Key Informant Interviews with Community Based Organization (CBO) Leaders

The research firm Eureka Facts Inc. conducted the focus groups and CBO interviews, interpreted the results, and produced the report. The study consisted of several phases of data

collection: four two-hour focus groups with Long Island residents who indicated difficulty in accessing healthcare in the previous year, and 15-minute in-depth interviews with 26 leaders of health-related community-based organizations (CBOs) who served these populations. Twelve in-depth interviews of Long Island residents lasting half an hour each were also added, as insufficient numbers of participants attended two of the four focus groups.

The result revealed key challenges within the New York State Prevention Agenda priority areas of Prevention of Chronic Diseases, Promotion of a Healthy and Safe Environment, and Promotion of Well-Being and Prevention of Mental and Substance Use Disorders. Numerous concerns within these areas were expressed, including cancer, diabetes, violence, access to healthy food and mental health. In addition to discussing the services provided by their community based organizations, the CBO leaders acknowledged numerous structural challenges in play. Health education and addressing these structural barriers were noted as opportunities to improve community health.

Based on the number of times a topic was referenced during this portion of the discussion, the top five most commonly referenced specific health concerns were ranked as follows:

Table 7: Ranking 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 Mental and Substance Use Disorders
2	Violence	12	Promote a Healthy and Safe Environment
3	Substance use disorders	9	Promote Well-being and Prevent Mental and 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 yields the following ranking:

Table 8: Ranking the Prevention Agenda Priorities by the number of times it was referenced when asked about the highest priorities to be addressed.

Ranking	Prevention Agenda 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, and Children	2

Discussion with participants in the focus groups and in-depth interviews included the ways that each of the Social Determinants of Health[i] impacted community health outcomes. Residents and CBO leaders agreed that economic stability had a significant

influence on health outcomes, in terms of accessible transportation and financial insecurity. Access to affordable insurance and healthcare were agreed upon as significant challenges for health and healthcare. Long Island residents also suggested that additional outreach and health education would help people connect to available resources and address barriers to engaging in care such as fear or stigma. With regard to the Neighborhood and Built Environment, residents discussed structural challenges such as lack of affordable housing or access to health food options. Long Island residents also discussed the negative impact of incarceration on individuals and their families in social, family, and community context. Residents placed less emphasis on the importance of education (specifically early childhood education or primary or secondary education) as compared to other social determinants of health.

SECONDARY DATA SOURCES:

Prevention Quality Indicators and Chronic Disease Conditions

Prevention Quality Indicators (PQI), are defined by the Agency for Health Research and Quality* (AHRQ) and can be useful when examining preventable admissions. Using 2014 SPARCS data, the PHIP created a visual representation of preventable admissions related to Chronic Disease at the zip code level (Figure 1).

PQI 92 is defined as a composite of chronic conditions per 100,000 adult population. Conditions, identified by ICD-9 code, included in PQI 92 are: Short and Long-term complications, Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, Heart Failure, Angina, Uncontrolled Diabetes and Lower-Extremity Amputations among patients with Diabetes.

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

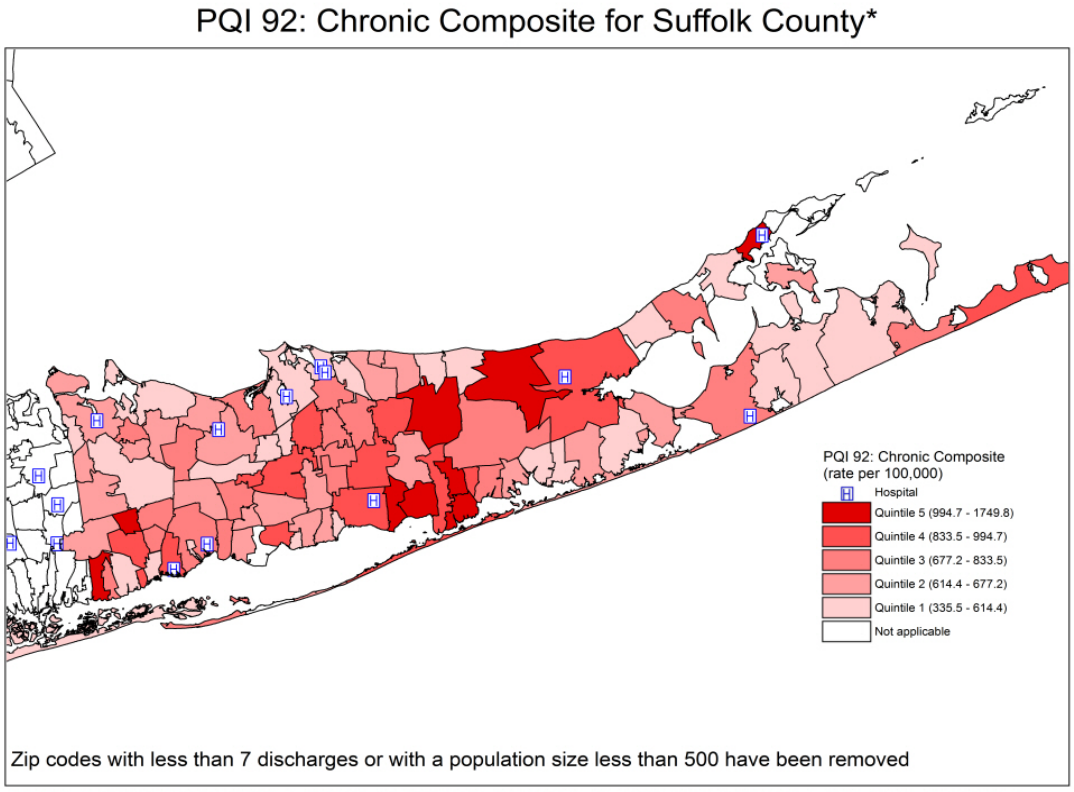


Figure 1: Map of preventable admissions related to Chronic Disease at the zip code level in Suffolk County. *Source: Agency for Healthcare Research and Quality – Prevention Quality Indicators (http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspm) / (Based on 2014 SPARCS data); this figure is the most recent visual representation at the time of development of this document.

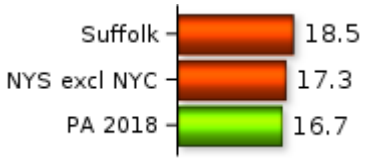
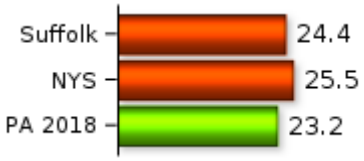
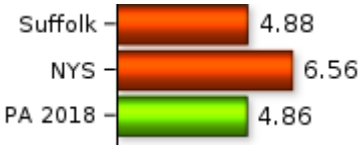
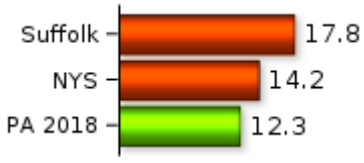
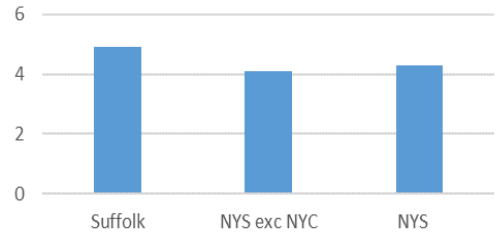
Prevention Agenda Dashboard and Chronic Disease Prevention Indicators

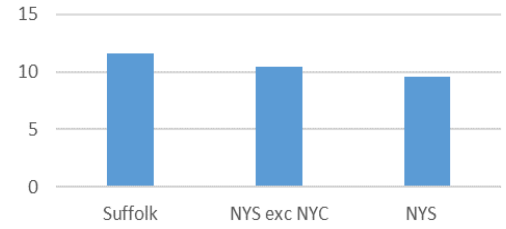
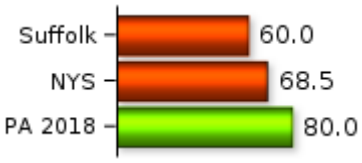
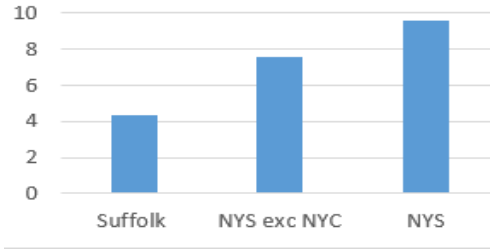
The Prevention Agenda 2019-2024, New York State's health improvement plan is the blueprint for state and local action to improve health outcomes and reduce health disparities within five priority areas: Prevent Chronic Disease, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants and Children, Promote Well-Being and Prevent Mental Health and Substance Use disorders, and Prevent Communicable Diseases.

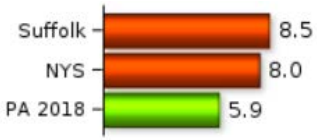
The New York State Prevention Agenda Dashboard (2013-2018), the New York State Maternal and Child Health Dashboard 2020, and the New York State Behavioral Risk Factor Surveillance System 2016 were reviewed to identify areas of importance for Suffolk County that correspond to the New York State Prevention Agenda's priorities. Depicted in Table 9 below are the key areas that have not met the Prevention Agenda, Maternal Child Health Dashboard, and BRFSS benchmarks or that have not improved since the last measurement period.

While there were some measures within each of the Prevention Agenda Priority categories where Suffolk County scored lower than the Prevention Agenda goals, the categories of Chronic Disease and Mental Health/Substance Abuse were targeted for CHIP projects in Suffolk County. These categories aligned with priorities identified in the Primary Source data (Long Island Community Health Assessment Survey and Focus Groups/Key Informant Interviews).

Table 9. Prevention Agenda – Suffolk County Key Findings

Prevention	Health Indicators	Difference from Goal	Data
Prevent Chronic Diseases	Percentage of children and adolescents who are obese	1.8% above PA goal 	PA (2014-2016 SWSCRS)
	Percentage of adults who are obese	1.2% above PA goal 	PA (2016 BRFSS)
	Rate of hospitalizations for short-term complications of diabetes per 10,000 – Aged 18+ years	0.4% above PA goal 	PA (2012-2014 SPARCS)
	Percentage of cigarette smoking among adults	5.5% above PA goal 	PA (2016 BRFSS)
	Percentage of adults who use e-cigarettes	0.6% above NYS (Suffolk 4.9, NYS excluding NYC 4.1, NYS 4.3) 	2016 BRFSS

	Percentage of adults with current asthma	2.0% above NYS (Suffolk 11.6, NYS excluding NYC, 10.4, NYS 9.6) 	2016 BRFSS
	Percentage of adults who received a colorectal cancer screening based on the most recent guidelines – Aged 50-75 years	20% below PA goal 	PA (2016 BRFSS)
	Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines	8.5% below NYS (Suffolk 71.2, NYS excluding NYC 79.2, NYS 79.7) 	2016 BRFSS
	Percentage of adults who have taken a course or class to learn how to manage their chronic disease or condition	5.2% below NYS (Suffolk 4.3, NYS excluding NYC 7.5, NYS 9.5) 	2016 BRFSS
Promote Mental Health and Prevent Substance Abuse	Newborns with withdrawal syndrome and/or affected by narcotics via placenta or breast milk, rate per 1,000 delivery hospitalizations/newborn discharges	88.5% above MCH goal 	MCH (SPARCS 2014)

	Age-adjusted suicide death rate per 100,000 population	44.1% above PA goal 	PA (2014-2016 VS)

PA = NYSDOH Prevention Agenda Dashboard; MCH = NYSDOH Maternal and Child Health Dashboard; BRFSS=Behavioral Risk Factor Surveillance System; SWSCRS = Student Weight Status Category Reporting System; SPARCS = Statewide Planning and Research Cooperative System; VS= NYS Vital Statistics. Percent change formula was used to calculate values for all non-percentage variables. For percentage variables, simple subtraction was used to calculate the percent difference.

Life Expectancy and Death Rates

According to the Institute for Health Metrics and Evaluation (IHME) at the University of Washington, the average life expectancy in Suffolk County in 2014 was 82.5 years for females and 78.6 years for males, compared to 82.5 years for females in New York State and 78.1 years for males in New York State. Between 1980 and 2014, female life expectancy increased by 6.9% and male life expectancy increased by 10.8%.

From the same source, age-standardized all-cause mortality in 2014 in Suffolk County was 604.3 deaths/100,000 individuals for females and 822.5 deaths/100,000 individuals for males, compared to 588.6 deaths/100,000 individuals for females in New York State and 819.4 deaths/100,000 individuals for males. According to the New York State Department of Health Leading Causes of Death report for 2016, the top causes of death in Suffolk County included Heart Disease (174.8 per 100,000), Cancer (146.5 per 100,000), and Unintentional Injury (51.2 per 100,000), Chronic Lung and Respiratory Disease (28.7 per 100,000), and Stroke (24.9 per 100,000).

Cancer

Between 2013 to 2015, according to Cancer Registry Data, Suffolk County has higher rates of all cancer incidence, age-adjusted all cancer incidence, all cancer mortality, and age-adjusted all cancer mortality than the rest of New York State, as seen in the New York State Community Health Indicator Report (CHIRS) figures shown below.

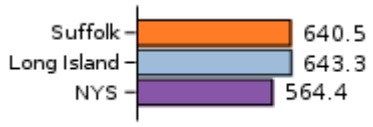
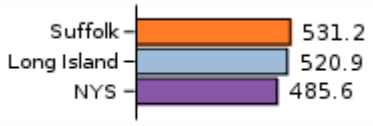
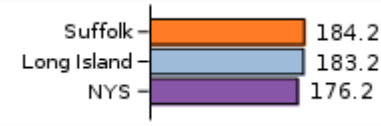
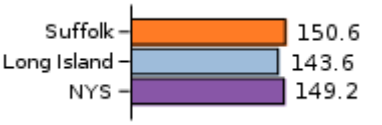
All cancer incidence rate per 100,000	
Age-adjusted all cancer incidence rate per 100,000	
All cancer mortality rate per 100,000	
Age-adjusted all cancer mortality rate per 100,000	

Figure 2: Comparison of all cancer incidence and mortality rates (inlcuding age-adjusted rates) in Suffolk County vs. Long Island vs. New York State, for 2013-2015. Source: New York State Community Health Indicator Report, Cancer Registry Data as of May, 2018

Similarly, during this same time period, with regard to specific cancers, Suffolk County has higher rates of lung and ovarian cancer incidence and mortality than New York State, as shown below.

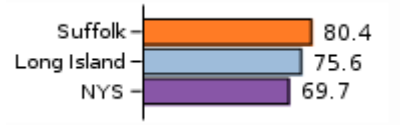
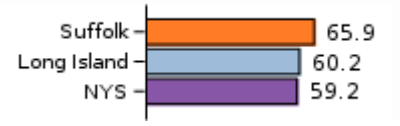
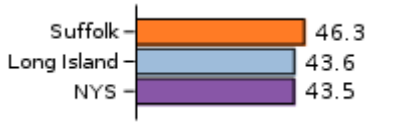
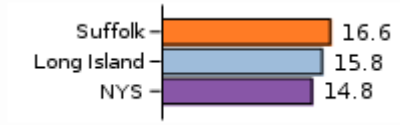
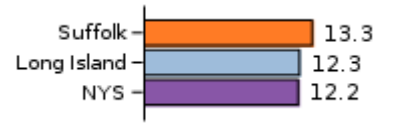
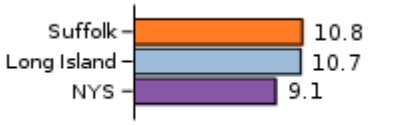
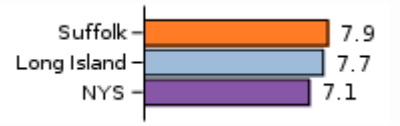
Lung and bronchus cancer incidence rate per 100,000	
Age-adjusted lung and bronchus cancer incidence rate per 100,000	
Lung and bronchus cancer mortality rate per 100,000	
Age-adjusted lung and bronchus cancer mortality rate per 100,000	
Ovarian cancer incidence rate per 100,000	
Age-adjusted ovarian cancer incidence rate per 100,000	
Ovarian cancer mortality rate per 100,000	
Age-adjusted ovarian cancer mortality rate per 100,000	

Figure 3: Comparison of 2013-2015 incidence and mortality rates (inlcuding age-adjusted rates) in Suffolk County vs. Long Island vs. New York State, for lung and bronchus cancer and ovarian cancer. Source: New York State Community Health Indicator Report, Cancer Registry Data as of May, 2018

In addition to cancer incidence and mortality statistics, another important measure is compliance with recommended cancer screening guidelines. On these screening activities, Suffolk County has room for improvement. Currently, the United States Preventive Services Task Force recommends that women between the ages of 50 and 74

receive a screening mammogram every 2 years. Between October 1, 2014 and December 31, 2016, the percentage of women in Suffolk County who had a screening mammogram was 63.4%, compared to 71.2% of all women in New York State. This indicates a need for better screening for breast cancer in Suffolk County.

Increased screening for colorectal cancer is also needed in Suffolk County. According to the 2016 NYS Behavioral Risk Factor Surveillance System, 60% of Suffolk County adults aged 50-75 have received colorectal cancer screening based on the most recent guidelines compared to 68.5% of NYS adults aged 50-75; this percentage is also substantially less than the 2018 NYS Prevention Agenda goal of 80%.

Cardiovascular Disease

In addition to cancer, cardiovascular disease is another major chronic illness burden in Suffolk County. Cardiovascular disease is a broad category of illness that includes coronary heart disease, heart attack, congestive heart failure, and stroke. Vital Statistics show that in several cardiovascular measures, Suffolk County's performance has worsened. For example, as seen below, Suffolk County has a lower cardiovascular mortality rate than New York State; however, since 2012, the cardiovascular mortality rate in Suffolk County has been increasing. In addition to overall mortality, the rate of cardiovascular disease premature death in Suffolk County individuals aged 35 to 64 has also been increasing, from 263.3 deaths per 100,000 individuals in 2012 to 280.6 deaths per 100,000 individuals in 2016, as seen in the figure below. Similarly, the cardiovascular disease pre-transport mortality rate has also increased substantially in Suffolk County from 132.5 deaths per 100,000 individuals in 2011 to 158.9 deaths per 100,000 individuals in 2016.

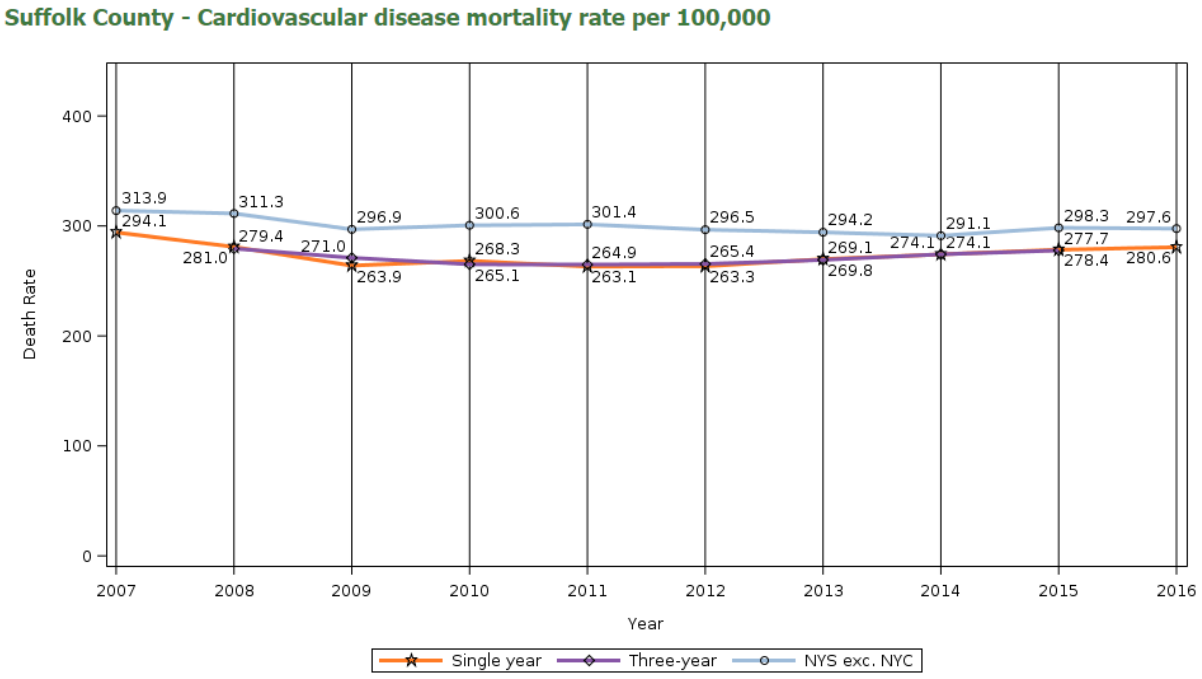


Figure 4: Trend in cardiovascular disease mortality rates in Suffolk County vs. New York State without New York City, for 2007-2016. Source: New York State Community Health Indicator Reports, Vital Statistics as of May 2018

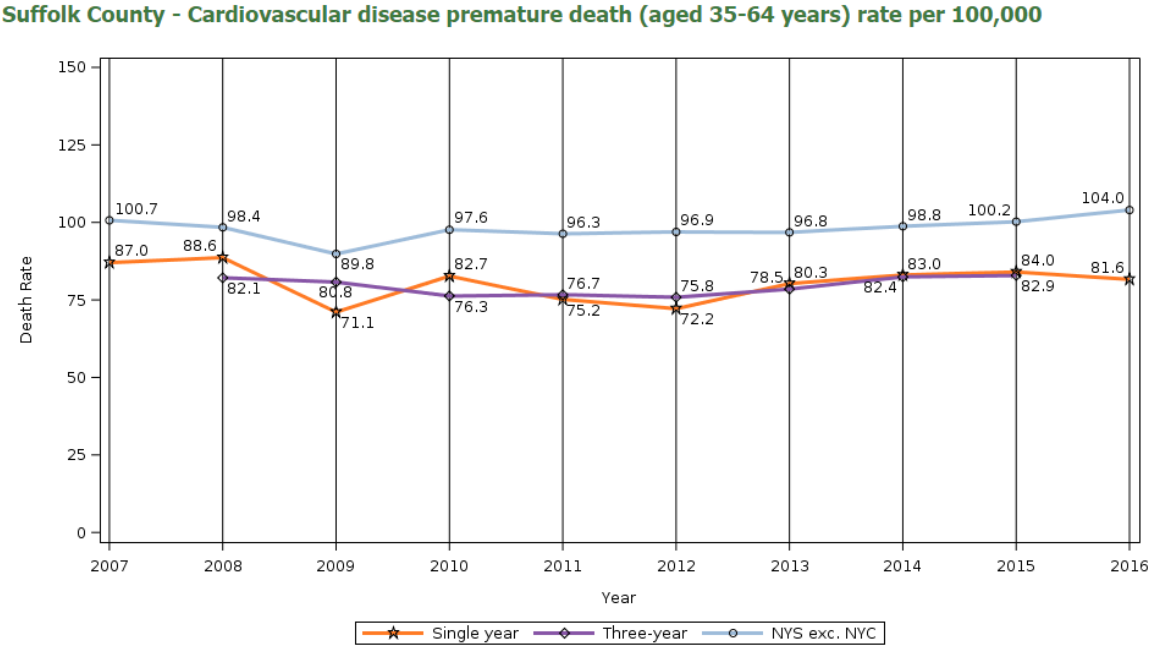


Figure 5: Trend in cardiovascular disease premature death rates in Suffolk County vs. New York State without New York City, for 2007-2016. Source: New York State Community Health Indicator Reports, Vital Statistics as of May 2018

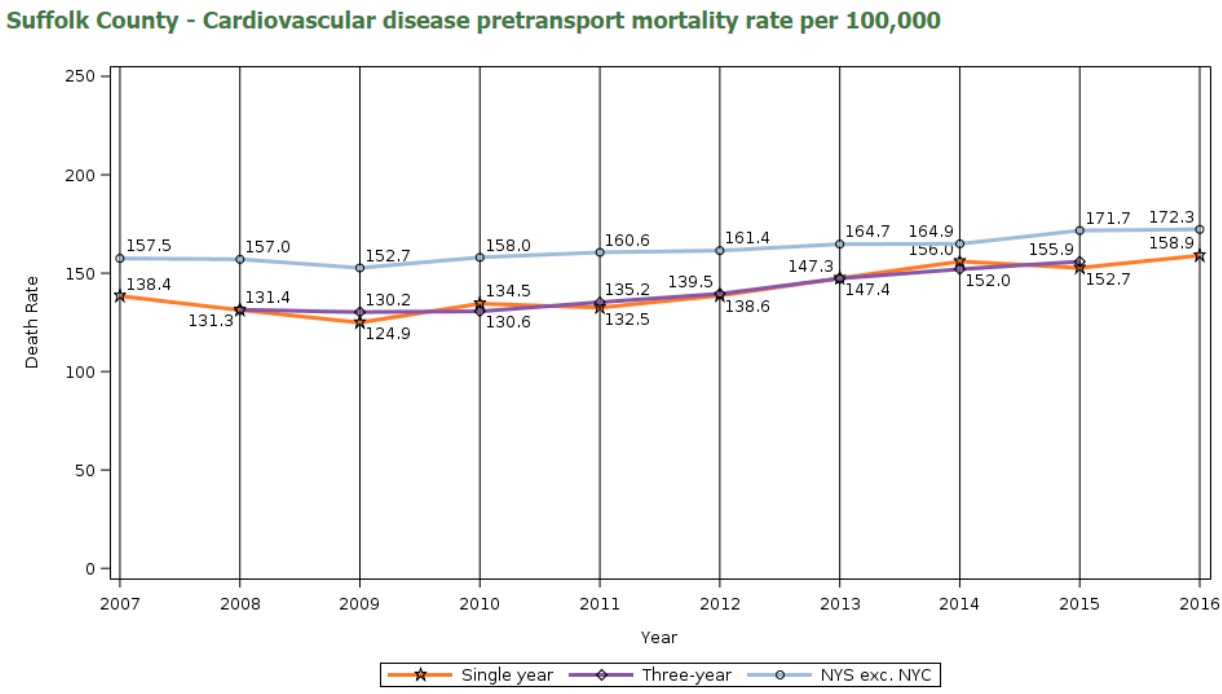
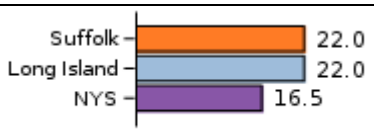
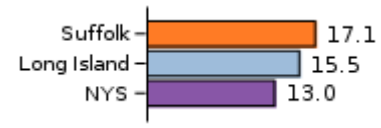


Figure 6: Trend in cardiovascular disease pretransport mortality rate in Suffolk County vs. New York State without New York City. Source: New York State Community Health Indicator Reports, Vital Statistics as of May 2018

Among the various types of cardiovascular disease, congestive heart failure, in particular, is a major concern in Suffolk County that needs to be addressed. Suffolk County performs worse than New York State in various measures of congestive heart failure mortality, measured by 3-year average between 2014 and 2016, as shown in the figure below.

Congestive heart failure mortality rate per 100,000	
Age-adjusted congestive heart failure mortality rate per 100,000	

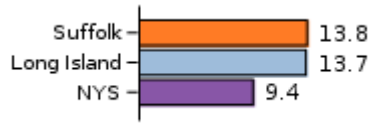
Congestive heart failure pre-transport mortality rate per 100,000	

Figure 7: Comparison of congestive heart failure mortality (including age-adjusted rates) and congestive heart failure pretransport mortality rate in Suffolk County vs. New York State vs. Long Island, for 2014-2016. Source: New York State Community Health Indicator Reports, Vital Statistics as of May 2018.

Obesity

Obesity is a risk factor for many chronic illnesses, including diabetes and heart disease, among others. Suffolk County has room for improvement among obesity indicators, as seen in the figures below. Between 2014 and 2016, the percentage of Suffolk County children and adolescents who were obese was 18.5%, 1.8 percentage points above the 2018 New York State Prevention Agenda goal and 1.2 percentage points above New York State, excluding New York City. Similarly, the percentage of Suffolk County adults who are obese is 1.2 percentage points above the New York State Prevention Agenda 2018 goal.

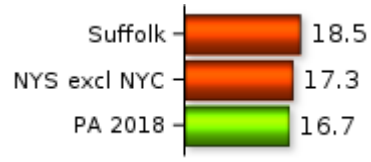
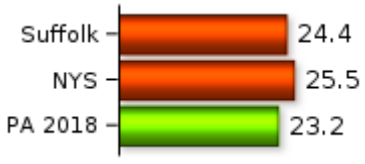
Percentage of children and adolescents who are obese	1.8% above PA goal 	PA (2014-2016 SWSCRS)
Percentage of adults who are obese	1.2% above PA goal 	PA (2016 BRFSS)

Figure 8: Comparison of percentage of children and adolescent who are obese, for 2014-2016, and percentage of adults who are obese, for 2016, in Suffolk County vs. New York State without New York City vs. Prevention Agenda 2018 Goal. Source: New York State Prevention Agenda Dashboard, Student Weight Status Category Reporting System (SWSCRS) data as of May 2017, 2016 NYS Behavioral Risk Factor Surveillance System as of February 2018.

A map of the distribution of the percentage of children and adolescents who are obese by school district for school years 2014-2016 (see figure 9 below), shows pockets where the percentages of children and adolescent who are obese (21.5 %+) is higher compared to the overall of Suffolk County (18.5%). Furthermore, some of these pockets fall within Identified Zip Codes.

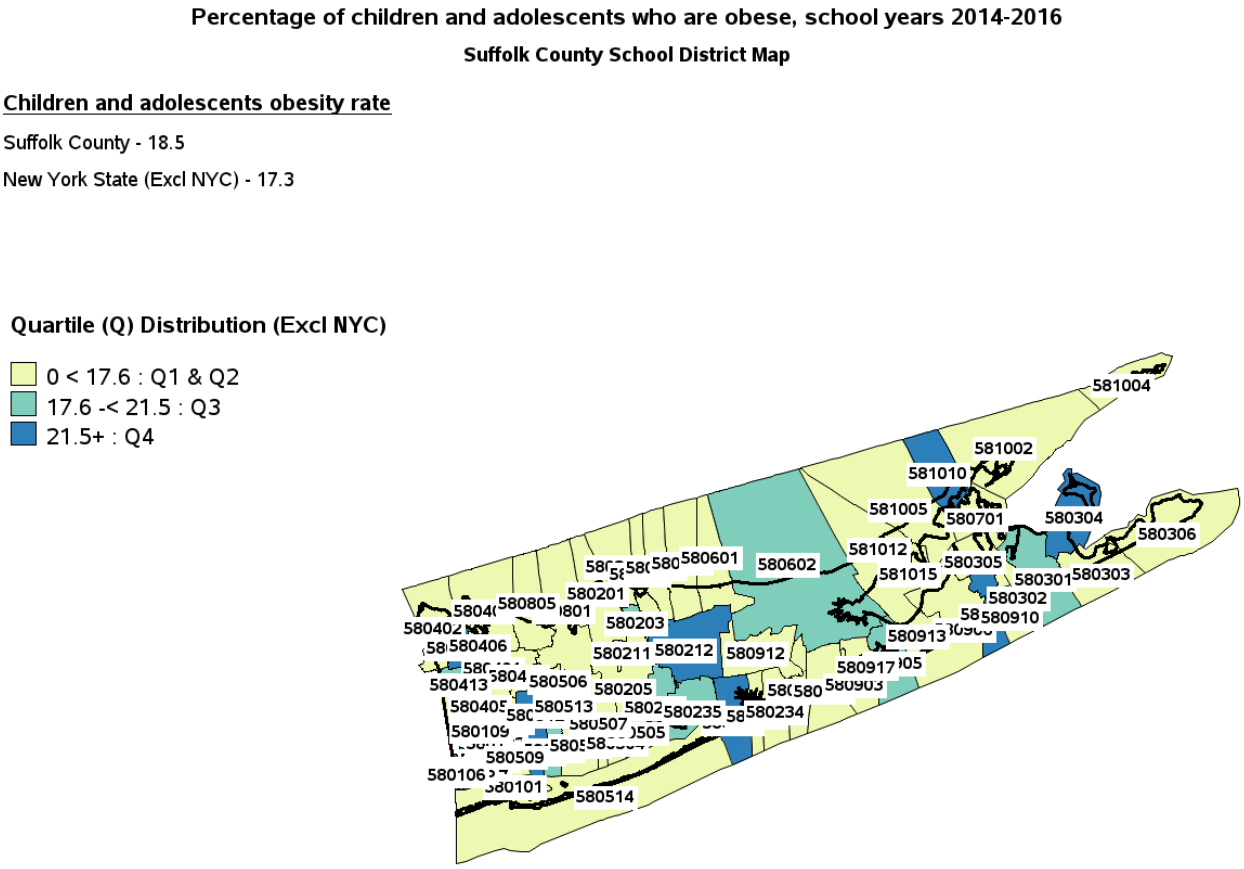


Figure 9: Map of the percentage of children and adolescents who are obese, by Suffolk County School District, for school years 2014-2016. Source: NYS Prevention Agenda Dashboard, Student Weight Status Category Reporting System (SWSCRS) data as of May 2017.

Diabetes Mellitus

The rate of hospitalizations for short-term complications of diabetes reflects 4.88 per 10,000 for adults, 18 years and older, in Suffolk County and 6.56 in New York State. Although this indicator is only slightly above the Prevention Agenda Goal of 4.86, the rate has been on an upward trend (see the figures below).

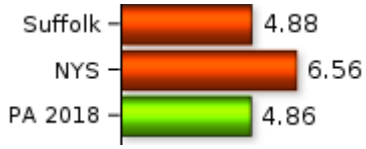
Rate of hospitalizations for short-term complications of diabetes per 10,000 – Aged 18+ years	0.4% above PA goal 	PA (SPARCS 2016)

Figure 10: Comparison of hospitalization rates for short-term complications of diabetes (Aged 18+years), for 2012-2014 in Suffolk County vs. New York State vs. Prevention Agenda 2018 Goals, 2012-2014, Source: New York State Prevention Agenda Dashboard, SPARCS data as of August 2016

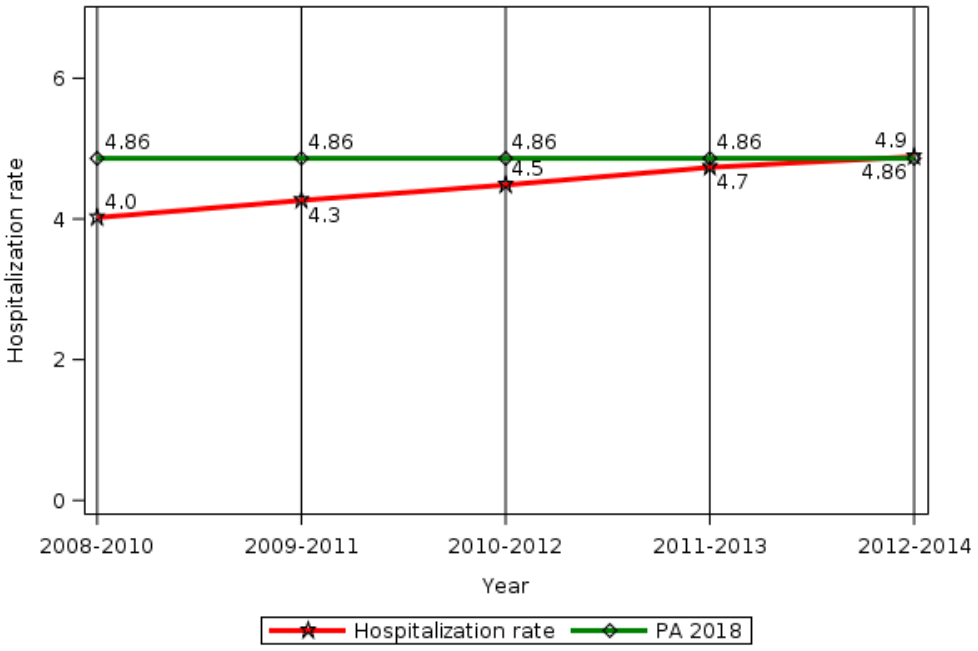


Figure 11: Trend in hospitalization rates per 10,000, for short-term complications of diabetes (aged 18+ years), for 2008-2014, in Suffolk County. Source: New York State Prevention Agenda Dashboard, SPARCS data as of August 2016.

Respiratory Illnesses

Various indicators also demonstrate that respiratory illnesses are a major health issue in Suffolk County. The prevalence of cigarette smoking among adults in Suffolk County is higher than the 2018 Prevention Agenda goal and the overall prevalence in New York State; a similar trend is seen with regards to e-cigarette use, where the percentage of Suffolk County adults who use e-cigarettes is higher than that of New York State. Furthermore, according to BRFSS, the percentage of adults in Suffolk County who currently have asthma is higher than that of New York State.

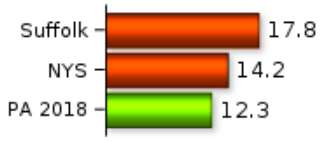
Percentage of cigarette smoking among adults	5.5% above PA goal 	PA (2016 BRFSS)
Percentage of adults who use e-cigarettes	0.6% above NYS (Suffolk 4.9, NYS excluding NYC 4.1, NYS 4.3) 	2016 BRFSS
Percentage of adults with current asthma	2.0% above NYS (Suffolk 11.6, NYS excluding NYC, 10.4, NYS 9.6) 	2016 BRFSS

Figure 12: Comparison of percentage of cigarette smoking among adults, for 2016, in Suffolk County vs. New York State vs. Prevention Agenda 2018 Goals. Comparison of percentage of adults, for 2016, who use e-cigarettes and percentage of adults with current asthma, for 2016, in Suffolk County vs. New York State with and without New York City. Source: New York State Prevention Agenda Dashboard, BRFSS as of February 2018

Mental Health/Substance Abuse

With regard to substance abuse indicators, Suffolk County has a number of areas where improvement is needed. As seen in the table below, a dramatically higher proportion of newborn children in Suffolk County are suffering from narcotic withdrawal syndrome or other effects of narcotics via placenta or breast milk, compared to the Maternal and Child Health (MCH) 2020 goal and New York State's rate. Furthermore, the rate of newborns who have withdrawal syndrome or who suffer from narcotics has been increasing since 2008, with an especially dramatic increase starting in 2012 (see figures below).

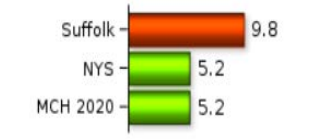
Newborns with withdrawal syndrome and/or affected by narcotics via placenta or breast milk, rate per 1,000 delivery hospitalizations/newborn discharges	88.5% above MCH goal 

Figure 13: Comparison of rate of newborns with withdrawal syndrome and/or affected by narcotics via placenta or breast milk, for 2014, in Suffolk County vs. New York State vs. New York State Maternal and Child Health 2020 Goals. Source: New York State Maternal and Child Health Dashboard, SPARCS as of August 2017

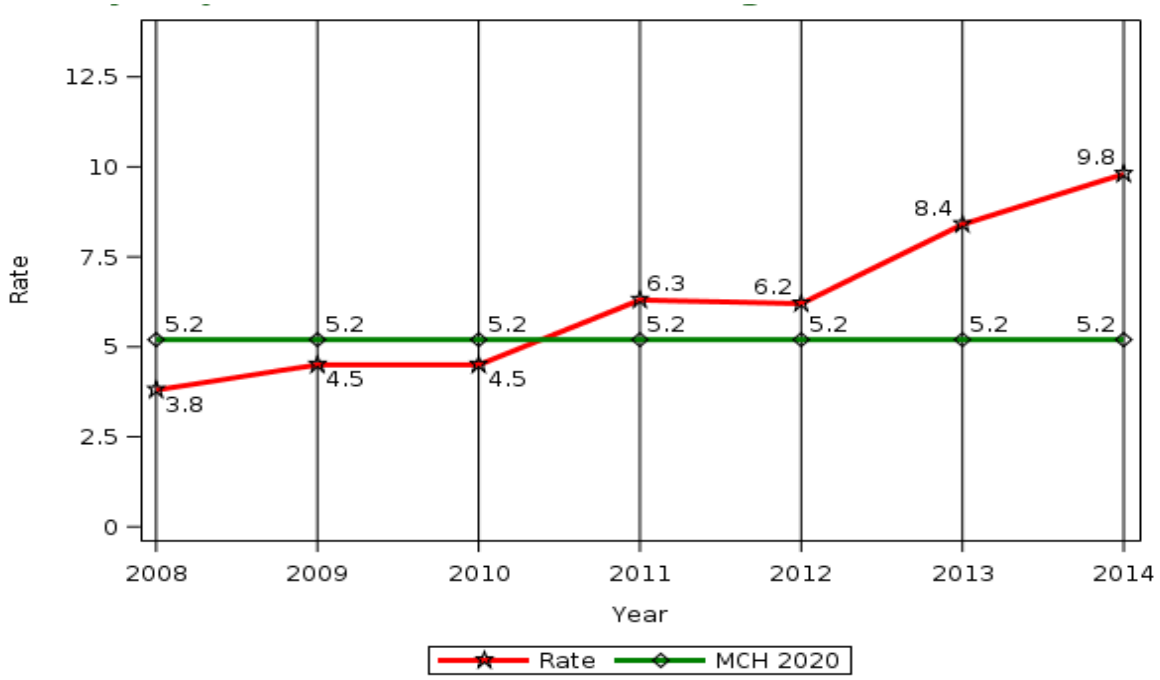


Figure 14. Trend in rates of newborn with withdrawal syndrome and/or affected by narcotics via placenta or breast milk, per 1,000 delivery hospitalizations/newborn discharge, in Suffolk County, for 2008-2014. Source: New York State Maternal and Child Health Dashboard, SPARCS as of August 2017.

According to 2016 Vital Statistics data, Suffolk County has a higher crude overdose deaths (involving any opioid) rate compared to Long Island and NYS (see figure 15). Suffolk County also had a significant increase in the crude overdose death (involving any opioid) rate from 2015 to 2016 (see figure16). Upon review of 2016 SPARCS data, Suffolk County had a higher age-adjusted hospitalization rate for opioid abuse/dependence, compared to New York State with and without New York City (see table 10 and figure 17 below). Even though, the difference is not statistically significant, it is important to continue to monitor the direction of this rate, in light of the opioid epidemic.

Overdose deaths involving any opioid, crude rate per 100,000 population	

Figure 15: Comparison of crude overdose deaths involving any opioid in Suffolk County vs. Long Island vs. NYS, for 2016. Source: Vital Statistics Data as of May 2018

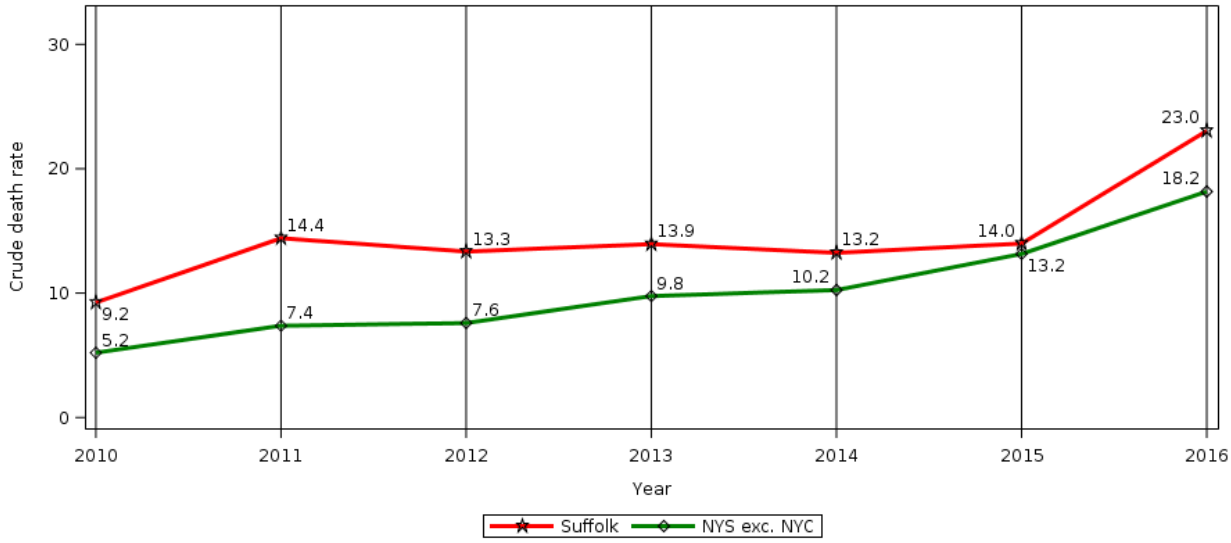


Figure 16: Trend in overdose deaths involving any opioid, crude rate per 100,000 population, in Suffolk County vs. NYS without NYC, for 2010-2016. Source: Vital Statistics Data as of May 2018

Table 10: Comparison of age-adjusted hospitalization rates of Opioid Abuse/Dependence, for 2016, in Suffolk County vs. New York State with and without New York City. Source: SPARCS 2016

Location	Age-adjusted Hospitalization Rates of Opioid Abuse/Dependence, 2016
Suffolk County	145.53 per 100,000 population
New York State (NYS)	111.41 per 100,000 population
NYS excluding New York City (NYC)	104.52 per 100,000 population

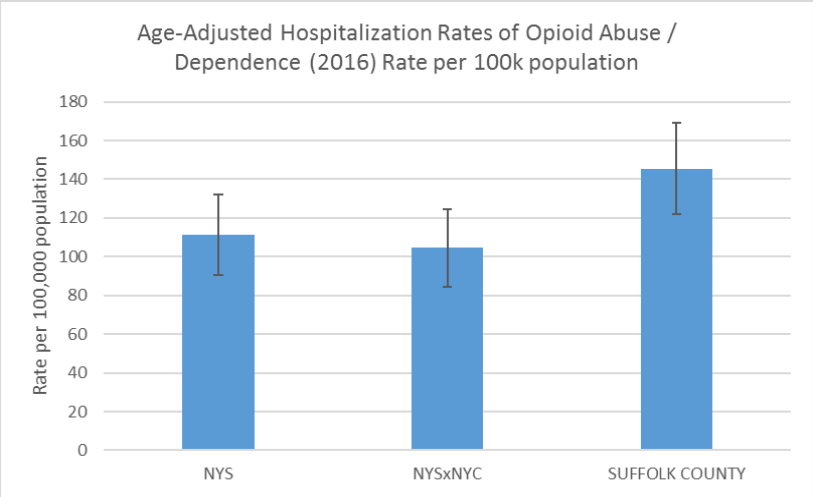


Figure 17: Comparison of age-adjusted hospitalization rates of Opioid Abuse/Dependence, for 2016, in Suffolk County vs. New York State with and without New York City. Source: SPARCS 2016

In addition to opiate abuse, alcohol abuse is another major health issue facing Suffolk County. New York State Department of Motor Vehicles Data indicates that Suffolk County suffers from a substantially higher rate of alcohol-related motor vehicle injuries and deaths than New York State. Furthermore, suicide is another mental health concern for Suffolk County; the age-adjusted suicide death rate in Suffolk County is 44.1% above the NYS 2018 Prevention Agenda goal.

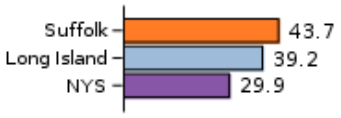
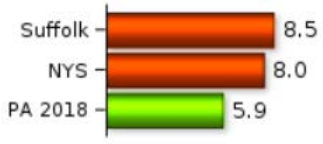
Alcohol related motor vehicle injuries and deaths per 100,000	46.2 percent above NYS rate 	2014-2016 NYS Department of Motor Vehicles
Age-adjusted suicide death rate per 100,000 population	44.1% above PA goal 	PA (2014-2016 Vital Statistics Records)

Figure 18: Comparison of rates of alcohol related motor vehicle injuries and deaths in Suffolk County vs. New York State vs. Long Island, Source: NYS Department of Motor Vehicles Data as of June 2018. Comparison of rates of age-adjusted suicide death in Suffolk County vs. NYS vs. NYS Prevention Agenda 2018 Goal. Source: NYS Prevention Agenda Dashboard, Vital Statistics Records data as of May 2018

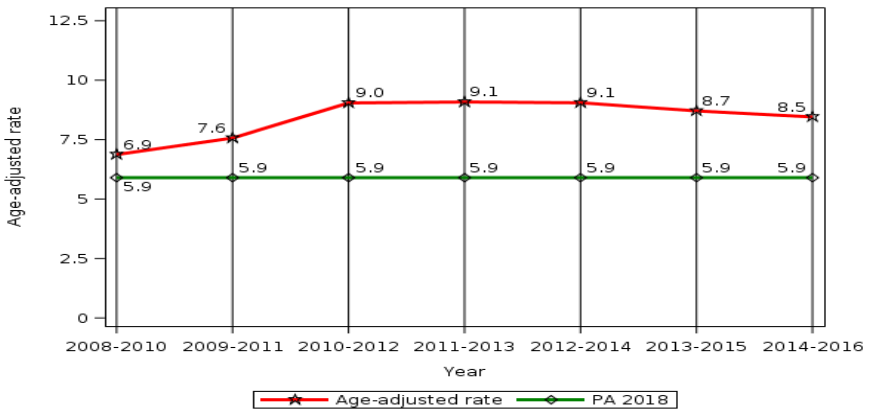


Figure 19: Trend in age-adjusted suicide death rate (per 100,000) in Suffolk County, for 2008-2016. Source: New York State Prevention Agenda Dashboard, Vital Statistics Records data as of May 2018

Main Challenges/Social Determinants of Health

In terms of social determinants of health, evidence of Suffolk's status include a 2019 ranking of 16th in New York State out of 62 counties for health outcomes. This is based on data between 2010 and 2018 from the CDC, U.S. Census, and other sources and determined from a Robert Wood Johnson Foundation and the University of Wisconsin Health Population Institute study. As depicted below in Table 11, Suffolk County ranked 33 out of 62 counties in clinical care.

Table 11. Suffolk County health outcome rankings out of 62 counties in New York State for 2019

Health Outcomes	Rank (out of 62)
Overall Health Outcomes	16
Length of Life	17
Quality of Life	16
Health Factors	8
Health Behaviors	5
Clinical Care	33
Social & Economic Factors	4
Physical Environment	38

Of the Clinical Care health factors, as shown in Table 12, the rate of preventable hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees was found to be slightly worse than that of New York State. Although the mammography screening rate was the same as New York State's, there is much room for improvement as the screening rate was 41% in this age group.

Table12. Suffolk County's clinical care health factors compared to that of the New York State for 2019 County Health Rankings.

Clinical Care Health Factors	Suffolk	NYS	Difference
Uninsured	6%	7%	1% less
Primary care physicians (PCP)	1,360:1	1,200:1	160 more people per PCP
Dentists	1,210:1	1,230:1	20 less people per dentist
Mental health providers	400:1	370:1	30 more people per Mental Health Provider
Preventable hospital stays	4,238 per 100,000 Medicare enrollees	4,141 per 100,000 Medicare enrollees	**97 more**
Flu Vaccinations (% among fee for service Medicare enrollees)	49%	46%	3% more
Mammography screening among female Medicare enrollees ages 65-74	41%	41%	same

Of note, there is 1 primary care physician for every 1360 Suffolk County residents, compared to 1 primary care physician for every 1,200 New York State residents. Similarly, there is 1 mental health provider for every 400 Suffolk County residents, compared to 1 mental health provider for every 370 New York State residents. Access to care in Suffolk

County may be impeded by the broad geographical area and limited public transportation, as compared to more metropolitan areas.

The County Health Ranking of 38 for Physical Environment was largely related to the high percentage of individuals that drive alone to work and have a long commute. This might be expected, given the large geographic area of the County.

Assets and Resources to Address Health Issues in Suffolk County

Suffolk County has various institutional resources to address health disparities, including the Suffolk County Department of Health Services, the Long Island Health Collaborative, Suffolk Care Collaborative, HRHCare clinics, thirteen hospitals, the Cornell Cooperative Extension of Suffolk County, the Suffolk County Medical Society, and many community based organizations. Most of these participate in the Long Island Health Collaborative and are involved in addressing the priority issues identified by the Collaborative.

Suffolk County Department of Health Services

The Suffolk County Department of Health Services is a large and well-functioning health department with a wide range of programming to address all aspects of public health, including the LIHC priority areas of chronic disease and mental health/substance use. Divisions of SCDHS that address chronic disease include the Patient Care Services Division, the Office of Health Education, and Bureau of Public Health Nursing. Additionally, the Department chairs the Suffolk County Cancer Prevention and Health Promotion Coalition that works to provide education and outreach to County residents regarding healthy lifestyles and environmental risk factors in order to prevent cancer and other

chronic diseases. The Department is affiliated with nine federally qualified community health centers located throughout Suffolk County. The Department's Patient Advocate Unit coordinates the medical care of patients with chronic illnesses. The Office of Health Education helps to prevent and address chronic illnesses through various initiatives, including school based youth and adult smoking cessation programs and support groups; a tobacco enforcement unit; and a robust Diabetes Prevention Program.

Unique to SCDHS is its Division of Community Mental Hygiene Services. This division plays an instrumental role in addressing mental health and substance abuse issues in Suffolk County. Its various programs and services include mental health clinics, an opioid treatment program and abuse prevention resources, opioid overdose prevention classes (providing Naloxone training), adult and child single point of access program to provide referrals for mental health services, and single point of access program for housing.

Long Island Health Collaborative

Since 2013, the Long Island Health Collaborative (LIHC) has been a valued stakeholder in the Community Health Assessment and Improvement process for both health departments and local hospitals. The LIHC provides resources, data, and guidance to assist various hospitals and healthcare organizations in the drafting and implementation of their Community Health Assessment Plans. In addition, LIHC itself has undertaken various initiatives that address the chosen Prevention Agenda priorities in Suffolk County. These have included programming to promote walking and increased activity, provision of information related to chronic disease prevention via website, and collaboration with local

community based organizations to increase access to evidence based programs to prevent and reduce the burden of chronic disease and reduce disparities in health outcomes, focusing on addressing the social determinants of health and cultural competency and health literacy.

Suffolk Care Collaborative

The Suffolk Care Collaborative is the lead organization in Suffolk County for implementing the New York State Delivery System Reform Incentive Payment (DSRIP), an initiative that was started to provide better care to uninsured patients and patients with Medicaid. Goals of the Suffolk Care Collaborative include reducing avoidable emergency room visits and hospital admissions, empowering patients to improve their self-care, and increasing access to community resources. Specifically, the Suffolk Care Collaborative is currently involved in 11 initiatives with the goal of achieving the Institute for Health Care Improvement triple aim: improving patient health outcomes, improving the patient experience of care and patient satisfaction, and reducing health care costs.

Federally Qualified Health Centers

Key community resources in Suffolk County include Federally Qualified Health Centers (FQHCs) that provide primary and preventive health care services, behavioral health and dental services to County residents, regardless of insurance status. Within Suffolk, these include Hudson River Health Care (HRHCare) health centers and Long Island Select Healthcare, Inc. HRHCare operates several centers in Suffolk County, and each year provides services to about 225,000 patients. The Suffolk County Department of Health Services (SCDHS) is strategically affiliated with eight of these HRHCare health centers.

Long Island Select Healthcare, Inc. is another FQHC that provides services in several locations in Suffolk County.

Hospitals

In addition to the HRHCare centers, there are several hospitals located throughout Suffolk County that provide medical and mental health care for Suffolk County residents: Brookhaven Memorial Hospital Medical Center, Brunswick Hospital Medical Center, Eastern Long Island Hospital, Good Samaritan Hospital Medical Center, Huntington Hospital, John T. Mather Memorial Hospital, Northport Veterans Affairs Medical Center, South Oaks Mental Hospital, Southampton Hospital, Southside Hospital, St. Catherine of Siena Medical Center, St. Charles Hospital and Rehabilitation Center, and Stony Brook University Medical Center. In addition to providing inpatient, emergency, and outpatient hospital services, these hospitals are engaged in various health education and community outreach initiatives, such health sciences enrichment programs to encourage ethnic minority students to pursue careers in the health sciences. Many of these hospitals participate in the LIHC and perform their own Community Health Needs Assessment and have Community Health Improvement plans that align with the Prevention Agenda Priorities.

Cornell Cooperative Extension of Suffolk County

The goal of the Cornell Cooperative Extension is to provide information to New York State residents about evidence-supported, research-based best agricultural practices. In addition to providing information on sustainable agriculture and horticulture, the Cornell Cooperative Extension of Suffolk County also engages in educational efforts with regards to

nutrition and wellness, diabetes management, parenting, environmental protection, and marine restoration.

Suffolk County Medical Society

Another important institution in Suffolk County that works to improve the health of residents is the Suffolk County Medical Society. The Suffolk County Medical Society is a professional association of Suffolk County physicians that engages in medical education efforts and advocacy for physicians and patients through conversation with legislators, public interest groups, and managed care organizations. The Suffolk Academy of Medicine, a part of the Suffolk County Medical Society, is responsible for continuing medical education for Suffolk County physicians and medical providers so that residents receive healthcare that adheres to best practices.

Collaborative Process for Choosing Priority Areas

On March 27, 2019, 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, 2019 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.

For the 2019-2021 cycle, community partners selected ***Prevent Chronic Disease*** as our first priority area with a focus on preventive care and management and ***Promote Well-Being and Prevent Mental and Substance Use Disorders*** as our second priority area with a focus on preventing mental and substance use disorders. Furthermore, as Suffolk County has room for improvement regarding obesity, cigarette and e-cigarette use, and in line with LIHC-based and SCDHS-based interventions, physical activity and tobacco prevention were additional areas of focus.

The tables in the next section outline the Community Health Improvement Plan for the two priority areas.

COMMUNITY HEALTH IMPROVEMENT PLAN

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.4 - In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**
Interventions/Strategies/Activities:	Long Island Health Collaborative (LIHC): Evidence-based Stanford Chronic Disease Self-Management education/workshop series
Objectives:	4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition.
Process/Outcome Measure:	Outcome Measures: Prevention Agenda Indicators: 1. (18) Percentage of adults who are obese 2. (18.1) Percentage of adults aged 18 years and older with an annual household income less than $25,000 who are obese Process Measures: 1. Number of workshops; 2. number of adults with full completion; 3. Change in knowledge via customized pre and post survey
Implementation Partner	Long Island Health Collaborative (LIHC)
Partner Resources	Community Based Organizations
Partner Role	Partner: LIHC, which is coordinating the CDSME workshops.
By When	Workshops completed by March 2020
Will Action Address Disparity?	Yes. Addresses reducing obesity among low-income adults.

Reference:	https://www.cdc.gov/arthritis/marketing-support/1-2-3-approach/docs/pdf/provider_fact_sheet_cdsmp.pdf Centers for Disease Control and Prevention. Sorting Through the Evidence for the Arthritis Self-Management Program and the Chronic Disease Self-Management Program: Executive Summary of ASMP/CDSMP Meta-Analyses. May 2011. www.cdc.gov/arthritis/docs/ASMP-executivesummary.pdf

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.4 - In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**
Interventions/Strategies/Activities:	Long Island Health Collaborative (LIHC): Cultural Competency Health Literary train the trainer program designed by the LIHC and the regions two Performing Provider Systems
Objectives:	4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition
Process/Outcome Measures:	Outcome Measures: Prevention Agenda Indicator (2.1) Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics Process Measures: 1. Number of healthcare workforce members completing CCHL training; 2. Number of times CCHL curriculum content included in organizations' new employee orientation sessions
Implementation Partner	Long Island Health Collaborative (LIHC)
Partner Resources	Community Based Organizations
Partner Role	Partner: LIHC, which oversees and manages the CCHL training program.
By When	CCHL training offerings completed by March 2020

Will Action Address Disparity?	Yes, addresses improving health literacy of low-literate adults with chronic conditions so they can better take care of themselves
Reference:	https://www.lihealthcollab.org/member-resources/cchl

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.3 - Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**
Interventions/Strategies/Activities:	Long Island Health Collaborative: Live Better - a multi-faceted public information/awareness campaign using social media and traditional media channels. LIHC is developing and managing the campaign on behalf of all LIHC participants.
Objectives:	4.3.1 Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)
Process/Outcome measures	Outcome Measures: Prevention Agenda Indicator (18) Percentage of adults who are obese; (31) Percentage of adult health plan members with diabetes, who have blood glucose in good control - Commercial Managed Care. Process Measures**.** Number of chronic disease video views; number of clicks Live Better page; number of social media mentions about Live Better; number earned media placements
Implementation Partner	Long Island Health Collaborative
Partner Resources	Media
Partner Role	Campaign developed and managed by the LIHC on behalf of all LIHC participants.
By When	Campaign is ongoing and will conclude March 2020.
Will Action Address Disparity?	Yes, intervention to promote better self-care among low-income adults who suffer from any chronic condition, with an emphasis on diabetes.
Reference:	https://www.lihealthcollab.org/healthy-resources/livebetter

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 2. Physical Activity**
Goal:	**Goal 2.2 - Promote school, child care and worksite environments that increase physical activity**
Intervention/Strategies/Activities:	Long Island Health Collaborative: Are You Ready, Feet?™ walking program (Walking is an evidence-based activity with proven physical and mental health benefits.)
Objectives:	1.2 Decrease the percentage of children with obesity (among public school students in NYS exclusive of NYC)
Process/Outcome measures	Outcome Measures. Prevention Agenda Indicator: (20) Percentage of children and adolescents who are obese Process Measures: Number of children participating; number of total steps walked
Implementation Partner	K-12 schools
Partner Resources	Hospital
Partner Role	Hospital
By When	School-based challenges completed by January 2020
Will Action Address Disparity?	Yes. Addresses reducing obesity among low-income children
Reference:	https://www.lihealthcollab.org/sign-up

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**
Intervention/Strategies/Activities:	SCDHS Health Education- Provide Diabetes Prevention programs for Suffolk County residents at risk for developing diabetes: 1. Expand access to the National Diabetes Prevention Program (DPP), to provide Diabetes Prevention programs for residents at risk for developing diabetes, by: • Facilitating DPP community programs • Facilitating an annual Master DPP training
Objectives:	1. Increase participant's knowledge and promote behaviors that improve healthy dietary and physical activity patterns.
Process/Outcome Measures:	<u>Process Measures:</u> 1. Number of year-long classes offered 2. Number of participants of year-long classes <u>Outcome Measures:</u> 1. Change in participants' knowledge of healthy diet and physical activity 2. Number of participants who report they will use the knowledge and behaviors learned in the classes 3. Number of participants who achieve weight loss goals 4. Number of participants who achieve physical activity goals
Implementation Partner	Temple University , College of Public Health
Partner Resources	1. Temple University, College of Public Health. 2. A.M.E. 3. Suffolk Care Collaborative. 4. Community based agencies.

Partner Role	1. Temple University oversees statistical program data and organization certification. 2. A.M.E. provides site for Master DPP training. 3. Suffolk Care Collaborative provides funding support for Master Training. 4. Community agencies provide outreach and location for DPP training.
By When	Classes will be ongoing.
Will Action Address Disparity?	N/A, DPP programs will be offered to all Suffolk County residents who meet the criteria for pre-diabetes. Health Care Providers will be encouraged to refer all those at risk for Diabetes to a DPP program.
Reference:	National Diabetes Prevention Program.

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**
Intervention/Strategies/Activities:	SCDHS Health Education - Provide Tai Chi for Arthritis classes to Suffolk County residents: 1. Increase and expand the numbers of Tai Chi for Arthritis courses offered in Suffolk County.
Objectives:	1. Increase the number of adults with arthritis who take a course to manage their chronic condition.
Process/Outcome Measures:	<u>Process Measures:</u> 1. Number of Tai Chi for Arthritis classes offered. 2. Number and diversity of geographical locations where Tai Chi for Arthritis classes are offered.

	3. Percentage of participants attending a minimum of 11 of the 16 Tai Chi for Arthritis classes at current locations. 4. Percentage of participants attending a minimum of 11 of the 16 Tai Chi for Arthritis classes at additional locations. <u>Outcome Measures:</u> 1. Number of participants who sign up for additional/continuation of Tai Chi for Arthritis classes at current locations 2. Number of participants who sign up for additional/continuation of Tai Chi for Arthritis classes at additional locations 3. Number of participants who report they will continue to use Tai Chi outside of class after attending Tai Chi for Arthritis classes
Implementation Partner	New York State Falls Programs
Partner Resources	1. Regional Falls Prevention Coordinator. 2. Community based agencies.
Partner Role	1. Provide outreach, marketing and site for class.
By When	Beginning fall 2019 and ongoing until 2024.
Will Action Address Disparity?	N/A, Programs will be offered to all older adults living in Suffolk County. Health Care Providers will be encouraged to refer all those at risk to a Suffolk County Tai Chi Program.
Reference:	Tai Chi for Arthritis New York State Falls Prevention Program.

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 3. Tobacco Prevention**
Goal:	**Goal 3.1 Prevent initiation of tobacco use**
Intervention/Strategies/Activities:	SCDHS Health Education - Provide high school students with a peer education electronic vaping product prevention and refusal skills training: 1. High school peer educators will be trained to use a variety of SEL based and peer norming strategies, which will address the electronic vaping product epidemic. 2. High school peer educators will provide age appropriate SEL based and peer norming prevention lessons about electronic vaping products to their peers and younger students.
Objectives:	1. Increase the number of High school students that will be able to identify risk factors associated with vaping after peer education training. 2. Increase the number of High school students that will be well practiced in peer education group presentation skills after peer education training. 3. Increase the number of High school students and younger students that will be able to recognize the tobacco industry‘s youth targeted advertisements and product placement after being trained by High School peer educators.
Process/Outcome measures	<u>Process Measures:</u> 1. Number of participating school districts 2. Number of peer education trainings offered to high school students at participating school districts 3. Number of high school students participating in peer education trainings. <u>Outcome Measures:</u> 1. Number of trained high school peer educators 2. Number of trained high school peer educators who report they will present to peers and younger students 3. Change in high school educators’ ability to identify risk factors associated with vaping and peer education group presentation skills after peer education training 4. Number of peers and younger students trained by the high school peer educators

	5. Change in peer and younger students' ability to recognize tobacco industry's youth targeted advertisements and product placements after peer educator training
Implementation Partner	Suffolk County School Districts
Partner Resources	1. School Administrators, Social Workers, Advisors, Teachers, Health Coordinators, Guidance Counselors.
Partner Role	1. School districts will: • Identify all candidates for the peer educator's training. • Oversee school-related administrative needs. • Provide training location. • Schedule the classes that peer educators will teach. • Provide transportation for peer educators.
By When	1. Trainings start Fall 2019 – Spring 2020 school year, and will continue each school year
Will Action Address Disparity?	N/A, peer education training will be offered to all high school students and peer education will be offered to all peer and younger students
Reference:	1. NYS Education Department: Social-Emotional Learning, Essential for Learning, Essential for Life 8/2018 2. Durlak, Weissber, Dymicki, Taylor & Schellinger, 2011. The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development, 82, 405-432.

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.1 Increase Cancer Screening Rates**
Intervention/Strategies/Activities:	Suffolk County Cancer Prevention and Health Promotion Coalition -Work with employee medical insurance providers to put systems in place for employee reminders and work with health care providers to put systems in place for patient reminders: 1a. Work with county employee medical insurance provider and labor relations to establish a notification system to employees turning 50, informing them of the importance of colorectal cancer screening. 1b. Develop employee reminder letter and provide educational information 2. Outreach to health clinics and providers, especially those that care for families with income less than $25,000, using county's reminder process as an example
Objectives	1. Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening 2. Increase the percentage of adults who receive a colorectal cancer screening (adults with annual household income less than $25,000)
Process/Outcome measures	<u>Process Measures:</u> 1. Number of colorectal cancer screening reminders sent out to employees 2. Number of clinics and providers who have been contacted to discuss implementing reminder system 3. Number of clinics and providers (including clinics/providers who serve low income household) who implemented reminder system <u>Outcome Measure:</u> 1. Number of employees who receive colorectal cancer screening 2. Number of patients of clinics and providers (including clinics/providers who serve low income household) who implemented reminder system, who receive colorectal cancer screening
Implementation Partner	*Local Health Department, Employee Benefit Unit, Community Based Organizations*
Partner Resources *(who are the partners)*	1. Suffolk County Department of Health Services **2.** Suffolk County Cancer Prevention and Health Promotion Coalition

	3. Suffolk County Cancer Services Program 4. Suffolk County Employee Medical Health Plan
Partner Role *(what will partners do?)*	1. SCDHS: prepare reminder materials **2.** SC CPHPC: advisory **3.** SC CSP: conduct outreach with health care providers 4. EMHP: negotiate with medical plan administrators
By When	Year 1: County reminder system in place Year 2: Outreach to local providers to establish screening reminder system Year 3: Follow up with providers
Will Action Address Disparity?	Yes, addresses improving colorectal cancer screening among adults with an annual household income less than $25,000
Reference	The Community Guide

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.1 Increase Cancer Screening Rates**
Intervention/Strategies/Activities:	Suffolk County Cancer Prevention and Health Promotion Coalition-Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings: 1. Schedule community based educational programs and mobile mammography van visit to East End of Suffolk County where access to breast cancer screening is limited. Targeted population will be African American women and women with an annual household income less than $25,000.
Objectives	1. Increase the percentage of women with an annual household income less than $25,000

	who receive a breast cancer screening
Process/Outcome measures	Process Measures: 1. Number of community-based education programs offered 2. Number of participants of community-based education programs 3. Number of participants of community-based education programs who are African American women and women with an annual household income less than $25,000. 4. Number of mammography van visits offered 5. Number of participants of mammography van visits 6. Number of participants of mammography van visits who are African American women and women with an annual household income less than $25,000. Outcome Measures: 1. Change in participant's knowledge/awareness of breast cancer screening after community-based education program (including African American women and women with an annual household income less than $25,000). 2. Number of participants reporting that they will get breast cancer screening after community-based education program 3. Number of African American women and women with an annual household income less than $25,000 reporting they will get breast cancer screening after community-based education program 4. Number of women who receive breast cancer screening 5. Number of African American women and women with an annual household income less than $25,000 who receive breast cancer screening 6. Number of women who receive mammography screening in the van 7. Number of African American women and women with an annual household income less than $25,000 who receive mammography screening in the van
Implementation Partner	Local Health Department, Cancer Services Program, Community Based Organizations
Partner Resources (who are the partners)	1. Suffolk County Department of Health Services 2. Suffolk County Cancer Prevention and Health Promotion Coalition 3. Suffolk County Cancer Services Program

	4. The Witness Project 5. Stony Brook Cancer Center 6. Bridgehampton Child Care and Recreational Center 7. Coalition for Women's Cancers at Stony Brook Southampton Hospital
Partner Role (what will partners do?)	1. SCDHS, SC CSP, Witness Project: arrange logistics for mobile mammography van 2. SC CPHPC: Provide guidance 3. Stony Brook Cancer Center: Provide mobile mammography van 4. Bridgehampton Child Care and Recreational Center will do outreach to get women from hard to reach communities, signed up for programs and screenings 5. Coalition for Women's Cancers at Stony Brook Southampton Hospital will work to get time slots and transportation if needed, to the Cancer Center so that women from underserved communities can be screened
By When	Year 1: Identify host location and requirements for reserving the mobile mammography van Year 2: Hold screening and educational event Year 3: Evaluate effectiveness
Will Action Address Disparity?	Yes, addresses improving breast cancer screening among African American women and women with an annual household income less than $25,000
Reference	The Community Guide

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.1 Increase Cancer Screening Rates**
Intervention/Strategies/Activities:	Suffolk County Cancer Prevention and Health Promotion Coalition-Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand: 1- Identify and/or develop small media outreach materials, such as bookmarks, Suffolk

	County AMA journal letters ensuring availability of materials for minority populations. 2- Disseminate small media at health clinics and group education events, targeting areas with disparate populations.
Objectives	1. Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening 2. Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening 3. Increase the percentage of adults aged 50-75 who receive a colorectal cancer screening 4. Increase the percentage of adults who receive a colorectal cancer screening (adults with annual household income less than $25,000)
Process/Outcome measures	<u>Process Measures:</u> 1. Number of health clinics that are distributing small media outreach materials 2. Number of group education events that are distributing small media outreach materials 3.Number of small media outreach materials distributed at health clinics 4. Number of small media outreach materials distributed at group education events <u>Outcome Measures:</u> 1. Change in knowledge and awareness about the need for cancer screening among those county residents (including residents with annual household income less than $25,000) who receive small media outreach material at health clinics 2. Number of county residents and (including residents with annual household income less than $25,000) who received small media outreach materials in health clinics report that they will receive cancer screening 3. Change in knowledge and awareness about the need for cancer screening among those county residents and (including residents with annual household income less than $25,000) who receive small media outreach material at group education events 4. Number of county residents and (including residents with annual household income less than $25,000) who received small media outreach materials at group education events report that they will receive cancer screening 5. Number of county residents (including residents with annual household income less than

	$25,000) who comply with cancer screening guidelines
Implementation Partner	Local Health Department, Cancer Services Program, Community Based Organizations, health clinics and hospitals
Partner Resources (who are the partners)	1. Suffolk County Department of Health Services 2. Suffolk County Cancer Prevention and Health Promotion Coalition 3. Suffolk County Cancer Services Program 4. Stony Brook Cancer Center 5. Local health clinics and hospitals
Partner Role (what will partners do?)	1. SCDHS, SC CPHPC: Identify or develop small media outreach materials 2. SC CSP: distribute small media during group educational events 3. Stony Brook Cancer Center and other hospitals, health clinics: distribute small media
By When	Year 1: Identify and or develop small media outreach material Year 1,2,3: Identify opportunities, and work with partners to distribute small media
Will Action Address Disparity?	Yes, addresses improving cancer screening among adults and women with annual household income less than $25,000
Reference	The Community Guide

PREVENTION AGENDA PRIORITY AREA:	**PREVENT CHRONIC DISEASES**
Focus Area:	**Focus Area 4. Preventive Care and Management**
Goal:	**Goal 4.1 Increase Cancer Screening Rates**
Intervention:	Suffolk County Cancer Prevention and Health Promotion Coalition-Conduct group education: 1. Conduct group education sessions in libraries, businesses and educational facilities 2. Migrant/Seasonal worker population will be targeted for group education sessions.
Objectives	1. Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening 2. Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening 3. Increase the percentage of adults aged 50-75 who receive a colorectal cancer screening 4. Increase the percentage of adults who receive a colorectal cancer screening (adults with annual household income less than $25,000)
Process/Outcome measures	<u>Process Measures:</u> 1. Number of group education sessions offered in libraries 2. Number of participants 3. Number of group education sessions offered in businesses 4. Number of participants 5. Number of group education sessions offered in educational facilities 6. Number of participants <u>Outcome Measures:</u> 1. Change in knowledge and awareness of cancer screening after group education session in libraries including participants with annual household income less than $25,000 2. Number of participants who are referred to a health care provider for cancer screening after group education in libraries including participants with annual household income less than $25,000 3. Change in knowledge and awareness of cancer screening after group education session in businesses including participants with annual household income less than $25,000 4. Number of participants who are referred to a health care provider for cancer screening, after group

	education in businesses including participants with annual household income less than $25,000 5. Change in knowledge and awareness of cancer screening after group education session in educational facilities including participants with annual household income less than $25,000 6. Number of participants who are referred to a health care provider for cancer screening, after group education in educational facilities including participants with annual household income less than $25,000 7.Number of participants who comply with cancer screening guidelines including participants with annual household income less than $25,000
Implementation Partner	Local Health Department, Cancer Services Program, Community Based Organizations
Partner Resources (who are the partners)	1. Suffolk County Department of Health Services 2. Suffolk County Cancer Services Program 3. Suffolk County Cancer Prevention and Health Promotion Coalition
Partner Role (what will partners do?)	1. SCDHS: provide guidance, participate as speakers in events 2. SC CSP: outreach with health care providers, speak at group education events 3. SC CPHPC: provide guidance and input
By When	Year 1: Identify organizations and venues appropriate for hosting group education session, including migrant/seasonal worker populations, begin conducting events Year 2&3: Conduct group education sessions
Will Action Address Disparity?	Yes, addresses improving cancer screening among migrant/seasonal worker populations
Reference	The Community Guide

PREVENTION AGENDA PRIORITY AREA:	**Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area:	**Focus Area 2. Prevent Mental and Substance Use Disorders**
Goal:	**Goal 2.2 - Prevent opioid and other substance misuse and deaths.**
Intervention/Strategies/Activities:	Long Island Health Collaborative (LIHC) - Promotion of all programs, events, education offered by collaborative members that speak to the prevention of mental and substance use disorders. Posts in LIHC weekly communications newsletter, social media postings, cross promotion of member events, programs on all media platforms.
Objectives:	2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population
Process/Outcome measures	Outcome Measures. Prevention Agenda Indicator (59) Percentage of adolescents (youth aged 12-17 years) reporting non-medical use of pain relievers in the past year; (60) Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month Process Measures. Number of SUD/mental health-related programs, events included in LIHC weekly email communication; number of SUD/mental-health related posts on LIHC social media platforms.
Implementation Partner	LIHC
Partner Resources	Media, collaborative participants
Partner Role	Media, collaborative participants
By When	Ongoing and will conclude March 2020
Will Action Address Disparity?	N/A Opioid epidemic spans all socieoeconomic categories
Reference:	https://www.lihealthcollab.org/

PREVENTION AGENDA PRIORITY AREA:	**Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area:	**Focus Area 2. Prevent Mental and Substance Use Disorders**
Goal:	**Goal 2.2 - Prevent opioid overdose.**
Intervention/Strategies/Activities:	SCDHS Health Education - Provide opioid overdose trainings and naloxone kit distribution to community members: 1. Conduct opioid overdose workshops using Power Point, video and role play response skills. 2. Practice the protocol for administering the naloxone. 3. Review steps for requesting replacement naloxone kit.
Objectives:	1. Increase the number of community members that will be able to recognize signs of an opioid overdose. 2. Increase the number of community members that are equipped with naloxone medication and possess the skills necessary for its use.
Process/Outcome measures	<u>Process Measures:</u> 1. Number of opioid overdose workshops offered 2. Number of participants of workshops. <u>Outcome Measures:</u> 1. Number of naloxone kits distributed to participants of workshops 2. Number of replacement of the Naloxone kits and reasons for replacements, among participants of workshops 3. Number of kits used for overdose prevention, among participants of workshops
Implementation Partner	Suffolk County Department of Health Services – Division of EMS
Partner Resources	1. Fire Stations, Treatment Centers, Schools, & Community based agencies. 2. Public Officials and Coalitions.
Partner Role	1. Implementation Partner provides naloxone kits and data management. 2. All other partners provide promotion, outreach and training location.
By When	1. Program is ongoing. 2. Data is collected and reported annually.

	3. Programs are assessed on an annual basis. 4. Continuation of program will be based on need.
Will Action Address Disparity?	N/A opioid overdose workshops are provided to all family and community members most likely to be first responders in an overdose situation.
Reference:	New York State's Opioid Overdose Prevention Program.

PREVENTION AGENDA PRIORITY AREA:	**Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area:	**Focus Area 2. Prevent Mental and Substance Use Disorders**
Goal:	**Goal 2.2 Prevent opioid and other substance misuse and deaths**
Intervention/Strategies/Activities:	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine: SCDHS Community Mental Hygiene Division - 1. Increase the number of MAT providers via free waiver trainings and a Learning Collaborative established by the Suffolk County MAT Workgroup. 2. Provide Compassion Fatigue training to first responders to increase self-awareness and addiction education.
Objectives	1. (2.2.2) Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.8 per 1,000 population.
Process/Outcome measures	<u>Process Measures:</u> 1. Number of free waiver trainings offered 2. Number of providers attending free waiver trainings 3. Number of Compassion Fatigue training offered to first responders 4. Number of first-responders attending training <u>Outcome Measures:</u> 1. Number of providers that attended training that complete full waiver

	2. Number of fully waivered providers that prescribe buprenorphine for SUD
Implementation Partner	*Local and State partners; Community Based Agencies; Hospital Systems in Suffolk County; Greater New York Hospital Association; LGU Subcommittees and Workgroups*
Partner Resources *(who are the partners)*	1. New York State Department of Health 2. OASAS 3. Suffolk County Department of Health 4. LICADD (Compassion Fatigue training) 5. Various Community Based Agencies (treatment resources) 6. Northwell Health, Catholic Health Services of Long Island, Long Island Community Hospital, and Eastern Long Island Hospital. 7. Suffolk County Medical Examiner's Office
Partner Role *(what will partners do?)*	1 Participate in Learning Collaborative and other trainings. 2. Promote participation in waiver training and waiver completion. 3. Collaborate on and support the development and maintenance of the provider resource list. 4. Supply Technology 5. Provide trainings / technical assistance 6. Overdose Data collection
By When	*Goal progress to be updated annually.*
Will Action Address Disparity?	N/A, All individuals impacted by opioid use or at risk for opioid use will qualify for the above regardless of race, gender, sexual orientation, etc. The only exclusionary criteria being absence of opioid use or risk for opioid use.
Reference	Evidence base: - Larochelle, M. R., et al. (2018). "Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study." Ann Intern Med, 169(3): 137-145. - Sordo, L., et al. (2017). "Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-analysis of Cohort Studies." BMJ; 357: j1550. - FDA Drug Safety Communication: FDA Urges Caution about Withholding Opioid Addiction Medications from Patients Taking Benzodiazepines or CNS Depressants: Careful Medication Management Can Reduce Risks Resources:

	- SAMHSA TIP 63: Medications for Opioid Use Disorder - Facing Addiction in America: The Surgeon General's Spotlight on Opioids - Increasing Access to Medication-Assisted Treatment of Opioid Abuse in Rural Primary Care Practices. Content last reviewed July 2018. Agency for Healthcare Research and Quality, Rockville, MD. - New York State. You Don't Have to be Alone in Addiction - NYSDOH. Buprenorphine - OASAS. Addiction Medications

PREVENTION AGENDA PRIORITY AREA:	**Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area:	**Focus Area 2. Prevent Mental and Substance Use Disorders**
Goal:	**Goal 2.5 Prevent suicides**
Intervention/Strategies/Activities:	2.5.2 Strengthen access and delivery of suicide care - Zero Suicide: Zero Suicide is a commitment to comprehensive suicide safer care in health & behavioral health care systems: SCDHS Community Mental Hygiene Division - 1. Increase availability of non-hospital based crisis services, including the recent opening of a 24 hour crisis stabilization center. 2. Increase accessibility to Mobile Crisis Team services. 3. Promote ongoing trainings in suicide prevention. 4. Provision of Crisis Intervention Team training. 5. Improve competency of law enforcement officers in successfully managing interactions with individuals experiencing behavioral health crises.
Outcome Objectives	1 2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.
Process/Outcome measures	<u>Process Measures:</u> 1. Number of non-hospital based crisis services (including 24-hr crisis stabilization center) offered/available 2. Number of persons using the non-hospital based crisis services (including 24-hour crisis stabilization center) offered

	3. Number of persons using Mobile Crisis team services offered 4. Number of suicide prevention training offered 5. Number of participants 6. Number of Crisis Intervention Team training offered 7. Number of participants <u>Outcome Measure:</u> 1. Number of persons using non-hospital based crisis services (including 24-hour stabilization center) that had counseling/treatment/follow-up appointment started and set up 2. Number of persons using non-hospital based crisis services (including 24-hr stabilization center) referred to CPEP. 3. Number of persons using Mobile Crisis services that had counseling/treatment/follow-up appointment started and set up 4. Number of persons using Mobile Crisis services referred to CPEP 5. Number of suicide-related deaths via use of ME reports
Implementation Partner	*Local and State Partners, Community Based Agencies, LGU Subcommittees and Workgroups*
Partner Resources *(who are the partners)*	1. Office of Mental Health 2. SC Medical Examiner's Office 3. Various Community Based Organizations 4. Veteran Suicide Prevention : Mayors Challenge "Have You Served"
Partner Role *(what will partners do?)*	1 Funding and Regulatory guidance / CQI innovators 2. Training 3. Participation monitoring (prevention trainings/MH Sub Committee, etc.) 4. Data Collection 5. Awareness campaign
By When	*Goal progress to be updated annually.*
Will Action Address Disparity?	N/A All individuals impacted by suicide risk will qualify for the above regardless of race, gender, sexual orientation, etc. The only exclusionary criteria being absence of suicide risk.
Reference	Zero Suicide

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

Focus Area:	**Focus Area 2. Prevent Mental and Substance Use Disorders**
Goal:	Goal 2.5 - Prevent Suicides among identified high-risk groups.
Intervention/Strategies/Activities:	SCDHS Health Education - Provide high school students with a peer education suicide awareness and prevention skills training: 1. High school students will participate in social emotional learning (SEL) skill development and peer norming activities. 2. High school peer educators will implement similar SEL and peer norming lessons to their peers and younger students.
Objectives:	1. Increase the number of High school students that will be able to identify signs and symptoms of a person in crisis and where to secure help. 2. Increase the number of High school students that will be well practiced in peer education presentation skills. 3. Increase the number of high school students trained as peer educators who will provide lessons to peers and younger students.
Process/Outcome measures	<u>Process Measures:</u> 1. Number of participating school districts 2. Number of peer educator trainings offered to high school students at participating school districts 3. Number of high school students participating in peer-education training <u>Outcome Measures:</u> 1. Number of trained high school peer educators 2. Number of trained high school peer educators who report they will present to peers and younger students 3. Change in ability of high school peer educators to identify signs and symptoms of a person in crisis and where to secure help and peer education skills after peer education training 4. Number of peers and younger students trained by the high school peer educators. 5. Change in peers and younger students' ability to identify signs and symptoms of a person in crisis and where to secure help, after peer education lessons.
Implementation Partner	Suffolk County School Districts

Partner Resources	1. School teachers, advisors, social workers, guidance counselors, school psychologists, health coordinators and administrators.
Partner Role (what will partners do?)	1. School districts will: • Identify all candidates for peer education training. • Oversee all school administrative needs. • Provide training location. • Schedule the classes that peer educators will teach. • Provide transportation for all peer educators.
By When	Trainings start Fall 2019-2020 school year, and continue each school year.
Will Action Address Disparity?	N/A, peer education training will be offered to all high school students and peer education will be offered to all peer and younger students.
Reference:	1. NYS Education Department: Social-Emotional Learning, Essential for Learning, Essential for Life 8/2018 2. Durlak, Weissber, Dymicki, Taylor & Schellinger, 2011. The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development, 82, 405-432.

Plans for Sustaining Partnerships and Tracking Progress

Long Island Health Collaborative Partnerships and Sustainability

The Long Island Health Collaborative (LIHC) first convened in 2013, with membership and partner-engagement gaining exponentially over time. Funding was awarded through the New York State Department of Health, which has allowed the LIHC to maintain engagement with community-partners in improving chronic health disease management and access to care, plan and implement health promotion initiatives, provide critical information and data, and bring counterpart organizations to the table during monthly meetings.

As strategies are implemented, progress will be measured on an ongoing basis. Baseline data from the Long Island Community Member Survey will allow for strategic decision making based upon the effectiveness of strategies and improvements in outcomes. Strategic direction and project oversight is guided by the Population Health Improvement program (PHIP) Steering Committee members, who are presented with outcome data on a quarterly basis. Mid-course modifications will be identified and implemented in response to data evaluation strategies.

Dissemination and Transparency

Health Communication Strategies and Transparency are two key roles of the LIHC PHIP. The LIHC website is designed to engage consumers and provide transparency in population health initiatives and data analysis efforts. Working documents developed by

the LIHC are available to the public as they are posted on the LIHC website. The Suffolk County Executive Summary will be publically available through the consumer facing portion of the Long Island Health Collaborative website at: http://www.lihealthcollab.org. Copies of the executive summary will also be printed and distributed at any community forum events.

Suffolk County Department of Health Services Partnerships and Sustainability

The Divisions of the SCDHS maintain additional ongoing collaborations with community based organizations beyond those of the LIHC. Program areas will work with these agencies to accomplish the goals in each action area. Continued participation in the LIHC will provide easy access to increase collaboration as needed. In addition, Divisions such as the Community Mental Hygiene Division have State agency contacts that assist in the support and maintenance of programming within the Department.

The process measures outlined in each action description will be used to determine effectiveness of the effort and modifications in the plans will be made, depending on the results. SCDHS has been developing its Performance Management Program over the past several years and these initiatives will be incorporated into that program. Quality improvement principles will be used as part of the action assessments.

Dissemination and Transparency

SCDHS provides information on programming to the community through its Divisions, its Public Information Officer, the LIHC, and other public venues. The Department maintains social media communications via Website, Twitter, and Facebook.

Additionally, press releases, email notifications, and other communications methods will be used, appropriate to the actions in the Community Health Improvement Plan. The SCDHS Community Health Assessment & Improvement Plan for 2019-2021 will be posted on the Department's website (https://www.suffolkcountyny.gov/health).

Internal reporting on progress of the action plan within SCDHS through various staff meetings will provide an opportunity to share ideas for improvement, request additional internal support, and assist with "getting the word out" on availability of programming to the public.

APPENDICES

Appendix A: LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY

Your opinion is important to us!

The purpose of this survey is to get your opinion about health issues that are important in your community. Together, the County Departments of Health and hospitals throughout Long Island will use the results of this survey and other information to help target health programs in your community. Please complete only one survey per adult 18 years or older. Your survey responses are anonymous. Thank you for your participation.

1. What are the biggest ongoing health concerns in THE COMMUNITY WHERE YOU LIVE? (Please check up to 3)

- ☐ Asthma/lung disease
- ☐ Cancer
- ☐ Child health & wellness
- ☐ Diabetes
- ☐ Drugs & alcohol abuse
- ☐ Environmental hazards
- ☐ Heart disease & stroke
- ☐ HIV/AIDS & Sexually Transmitted Diseases (STDs)
- ☐ Mental health depression/suicide
- ☐ Obesity/weight loss issues
- ☐ Safety
- ☐ Vaccine preventable diseases
- ☐ Women's health & wellness
- ☐ Other (please specify) _____

2. What are the biggest ongoing health concerns for YOURSELF? (Please check up to 3)

- ☐ Asthma/lung disease
- ☐ Cancer
- ☐ Child health & wellness
- ☐ Diabetes
- ☐ Drugs & alcohol abuse
- ☐ Environmental hazards
- ☐ Heart disease & stroke
- ☐ HIV/AIDS & Sexually Transmitted Diseases (STDs)
- ☐ Mental health depression/suicide
- ☐ Obesity/weight loss issues
- ☐ Safety
- ☐ Vaccine preventable diseases
- ☐ Women's health & wellness
- ☐ Other (please specify) _____

3. What prevents people in your community from getting medical treatment? (Please check up to 3)

- ☐ Cultural/religious beliefs
- ☐ Don't know how to find doctors
- ☐ Don't understand need to see a doctor
- ☐ Fear (e.g. not ready to face/discuss health problem)
- ☐ Lack of availability of doctors
- ☐ Language barriers
- ☐ No insurance
- ☐ Transportation
- ☐ Unable to pay co-pays/deductibles
- ☐ There are no barriers
- ☐ Other (please specify) _____

4. Which of the following is MOST needed to improve the health of your community? (Please check up to 3)

- ☐ Clean air & water
- ☐ Drug & alcohol rehabilitation services
- ☐ Healthier food choices
- ☐ Job opportunities
- ☐ Safe worksites
- ☐ Mental health services
- ☐ Recreation facilities
- ☐ Safe childcare options
- ☐ Safe places to walk/play
- ☐ Smoking cessation programs
- ☐ Transportation
- ☐ Weight loss programs
- ☐ Other (please specify) _____

5. What health screenings or education/information services are needed in your community? (Please check up to 3)

- ☐ Blood pressure
- ☐ Cancer
- ☐ Cholesterol
- ☐ Dental screenings
- ☐ Diabetes
- ☐ Disease outbreak information
- ☐ Drug and alcohol
- ☐ Eating disorders
- ☐ Emergency preparedness
- ☐ Exercise/physical activity
- ☐ Heart disease
- ☐ HIV/AIDS & Sexually Transmitted Diseases (STDs)
- ☐ Importance of routine well checkups
- ☐ Mental health/depression
- ☐ Nutrition
- ☐ Prenatal care
- ☐ Suicide prevention
- ☐ Vaccination/immunizations
- ☐ Other (please specify) _____

6. Where do you and your family get most of your health information? (Check all that apply)

☐ Doctor/health professional	☐ Library	☐ Social Media (Facebook, Twitter, etc.)
☐ Family or friends	☐ Newspaper/magazines	☐ Television
☐ Health Department	☐ Radio	☐ Worksite
☐ Hospital	☐ Religious organization	☐ Other (please specify)
☐ Internet	☐ School/college	_____

For statistical purposes only, please complete the following:

I identify as: ☐ Male ☐ Female ☐ Other

What is your age? _____

ZIP code where you live: _____ **Town where you live**: _____

What race do you consider yourself?

☐ White/Caucasian	☐ Native American	☐ Multi-racial
☐ Black/African American	☐ Asian/Pacific Islander	☐ Other (please specify)
		_____

Are you Hispanic or Latino? ☐ Yes ☐ No

What language do you speak when you are at home (select all that apply)

☐ English	☐ Portuguese	☐ Spanish	☐ Italian	☐ Farsi	☐ Polish
☐ Chinese	☐ Korean	☐ Hindi	☐ Haitian Creole	☐ French Creole	☐ Other

What is your annual <u>household</u> income from all sources?

☐ $0-$19,999	☐ $20,000 to $34,999	☐ $35,000 to $49,999
☐ $50,000 to $74,999	☐ $75,000 to $125,000	☐ Over $125,000

What is your highest level of education?

☐ K-8 grade	☐ Technical school	☐ Graduate school
☐ Some high school	☐ Some college	☐ Doctorate
☐ High school graduate	☐ College graduate	☐ Other (please specify)
		_____

What is your current employment status?

☐ Employed for wages	☐ Self-employed	☐ Out of work and looking for work
☐ Student	☐ Retired	☐ Out of work, but not currently looking
☐ Military		

Do you currently have health insurance? ☐ Yes ☐ No ☐ No, but I did in the past

Do you have a smart phone? ☐ Yes ☐ No

If you have health concerns or difficulty accessing care, please call the Long Island Health Collaborative for available resources at: **631-257-6957.**	Please return this completed survey to: LIHC Nassau-Suffolk Hospital Council 1383 Veterans Memorial Highway, Suite 26 Hauppauge, NY 11788 Or you may fax completed survey to 631-435-2343	All non-profit hospitals on Long Island offer financial assistance for emergency and medically necessary care to individuals who are unable to pay for all or a portion of their care. To obtain information on financial assistance offered at each Long Island hospital, please visit the individual hospital's website.

LONG ISLAND Health COLLABORATIVE

connecting you to better health

The Long Island Health Collaborative (LIHC) . . . your local hospitals, county health departments, health and welfare organizations, and colleges working together to improve the health of all Long Islanders.

Appendix B: LIHC Member List

Hospitals, Hospital Association and Hospital Systems	Website
Catholic Health Services of Long Island	www.chsli.org
Cohen's Children Medical Center	www.childrenshospital.northwell.edu
Eastern Long Island Hospital	www.elih.org
Glen Cove Hospital	www.northwell.edu
Good Samaritan Hospital Medical Center	www.goodsamaritan.chsli.org
Huntington Hospital	www.northwell.edu
Long Island Community Hospital	www.licommunityhospital.org
Long Island Jewish Valley Stream	www.northwell.edu
Mather Memorial Hospital	www.matherhospital.org
Mercy Medical Center	www.mercymedicalcenter.org
Nassau-Suffolk Hospital Council	www.nshc.org
Nassau University Medical Center	www.numc.edu
North Shore University Hospital	www.northwell.edu
Northern Metropolitan Hospital Association	www.normet.org
Northwell Health System	www.northwell.edu
NYU Winthrop Hospital	www.winthrop.org
Peconic Bay Medical Center	www.pbmchealth.org

Plainview Hospital	www.northwell.edu
St. Catherine of Siena Medical Center	www.stcatherines.chsli.org
St. Charles Hospital	www.stcharles.chsli.org
St. Francis Hospital	www.stfrancis.chsli.org
St. Joseph Hospital	www.stjoseph.chsli.org
St. Mary's Healthcare System for Children	www.stmaryskids.org
Southampton Hospital	www.southamptonhospital.org
South Nassau Communities Hospital	www.southnassau.org
South Oaks Hospital	www.south-oaks.org
Southside Hospital	www.northwell.edu
Stony Brook University Hospital	www.stonybrookmedicine.edu
Syosset Hospital	www.northwell.edu

Health Departments	***Website***
Nassau County Department of Health	www.nassaucountyny.gov
Suffolk County Department of Health Services	www.suffolkcountyny.gov
New York State Department of Health	www.health.ny.gov

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

Community-Based Organizations	***Website***
Adelphi New York Statewide Breast Cancer Hotline and Support Program	www.breast-cancer.adelphi.edu
All Ability Wellness	www.allabilitywellness.com
Alzheimer's Association, Long Island Chapter	www.alz.org

American Cancer Society	**www.cancer.org**
American Diabetes Association	**www.diabetes.org**
American Foundation for Suicide Prevention	**www.afsp.org**
American Heart Association	**www.heart.org**
American Lung Association of the Northeast	**www.lung.org**
Arbors Assisted Living	**www.thearborsassistedliving.com**
Association for Mental Health and Wellness	**www.mentalhealthandwellness.org**
Asthma Coalition of Long Island	**www.asthmacommunitynetwork.org**
Attentive Care Services	**www.attentivecareservices.com**
CARECEN	**www.carecenny.org**
Caring People	**www.caringpeopleinc.com**
Car-Less Long Island	**www.litransportationalliance.org**
Catholic Charities, Diocese of Rockville Centre	**www.catholiccharities.cc**
Cold Spring Hills Adult Day Care for Nursing and Rehab	**www.coldspringhills.net**
Community Growth Center	**www.communitygrowthcenter.org**
Community Housing Innovations	**www.chigrants.org**
Cornell Cooperative Extension - Suffolk County	**www.ccesuffolk.org**
Docs for Tots	**www.docsfortots.org**
EAC, Inc. (Empower, Assist, Care)	**www.eac-network.org**
Economic Opportunity Council of Suffolk, Inc.	**www.eoc-suffolk.com**
EPIC Long Island	**www.epicli.org**
Epilepsy Foundation of Long Island	**www.efli.org**
Evolve Wellness	**www.evolvewellness.net**
Family & Children's Association	**www.familyandchildrens.org**
Family First Home Companions	**www.familyfirsthomecompanions.com**
Family Service League	**www.fsl-li.org**
Federation of Organizations	**www.fedoforg.org**
Girls Inc. LI	**www.girlsincli.org**

Harmony Cafe	**www.harmonycafeli.org**
Health and Welfare Council of Long Island	**www.hwcli.com**
Health Education Project / 1199 SEIU	**www.healthcareeducationproject.org**
Hispanic Counseling Center	**www.hispaniccounseling.org**
Hudson River Healthcare	**www.hrhcare.org**
Island Harvest	**www.islandharvest.org**
JDRF Long Island	**www.jdrf.org**
Life Trusts	**www.lifetrusts.org**
LiveOn NY	**www.liveonny.org**
Long Island Association	**www.longislandassociation.org**
Long Island Association of AIDS Care	**www.liaac.org**
Long Island Family Caregivers Coalition	**www.familyfirsthomecompanions.com**
Long Island Regional Planning Consortium	**www.clmhd.org**
Long Island Regional Planning Council	**www.lirpc.org**
Long Island Council of Churches	**www.liccny.org**
Long Island Select healthcare, Inc.	**www.lishcare.org**
Make the Road NY	**www.maketheroad.org**
Maria Regina Skilled Nursing Facility	**www.mariareginaresidence.org**
Maurer Foundation	**www.maurerfoundation.org**
Mental Health Association of Nassau County	**www.mhanc.org**
Music and Memory	**www.musicandmemory.org**
NADAP	**www.nadap.org**
National Aging in Place Council	**www.ageinplace.org**
Nassau Region PTA	**www.nassaupta.com**
National Eating Disorder Association	**www.nationaleatingdisorders.org**
National Health Care Associates	**www.nathealthcare.com**
New Horizon Counseling Center	**www.nhcc.us**
New York City Poison Control	**www.nyc.gov**

New York Coalition for Transportation Safety	**www.nycts.org**
NutriSense	**www.nutri-sense.com**
Options for Community Living	**www.optionscl.org**
People Care Inc.	**www.peoplecare.com**
Prevention Resource Center	**www.liprc.org**
Project Safety Net NY	**www.projectsafetynet.org**
PSYCH-K	**www.psych-k.com**
The Pulse Center for Patient Safety Education & Advocacy	**www.pulsecenterforpatientsafety.org**
Retired Senior Volunteer Program	**www.rsvpsuffolk.org**
Riverhead Free Library	**www.riverheadlibrary.org**
Roosevelt Community Revitalization Group	**www.rcrgli.org**
RotaCare	**www.rotacareny.org**
Sayville Project	**www.socialwelfare.stonybrookmedicine.edu/sayvilleproject**
SCO Family Services	**www.sco.org**
SDC Nutrition PC	**www.call4nutrition.com**
Self Help Community Service, Inc.	**www.selfhelp.net**
Services for the Underserved	**www.sus.org**
Smithtown Youth Bureau	**www.smithtownny.gov**
Society of St. Vincent de Paul Long Island	**www.svdpli.org**
State Parks LI Regional Office	**www.nysparks.com**
Suffolk Independent Living Organization	**www.siloinc.org**
Sustainable Long Island	**www.sustainableli.org**
The Crisis Center	**www.thecrisisplanner.com**
Thursday's Child	**www.thursdayschildofli.org**
Town of Smithtown Horizons Counseling and Education Center	**www.smithtownny.gov**
TriCare Systems	**www.tricaresystems.org**
United Lifeline	**www.unitedlifeline.com**
United Way of Long Island	**www.unitedwayli.org**
Urban League of Long Island	**www.urbanleaguelongisland.org**

Victory Recovery Partners	www.victoryrp.com
Visiting Nurse Services & Hospice of Suffolk	www.visitingnurseservice.org
YMCA of LI	www.ymcali.org

School and Colleges	***Website***
Adelphi University	www.adelphi.edu
Farmingdale State College	www.farmingdale.edu
Hofstra University	www.hofstra.edu
Molloy College	www.molloy.edu
Nassau Community College	www.ncc.edu
St. Joseph's College	www.sjcny.edu/long-island
Stony Brook University	www.stonybrook.edu
SUNY Old Westbury	www.oldwestbury.edu
Western Suffolk BOCES Healthy Schools NY	www.wsboces.org

Performing Provider Systems (DSRIP PPS)	***Website***
Nassau Queens PPS	www.nassauqueenspps.org
Suffolk Care Collaborative	www.suffolkcare.org

Insurers	***Website***
1199SEIU/Health Education Project	www.1199seiu.org
EmblemHealth	www.emblemhealth.com
Fidelis Care	www.fideliscare.org
United Healthcare	www.unitedhealthcare.com

Regional Health Information Organizations	***Website***
Healthix Inc.	www.healthix.org
New York Care Information Gateway	www.nycig.org

Businesses and Chambers	Website
Air Quality Solutions	www.iaqguy.com
Custom Computer Specialists	www.customonline.com
Feldman, Kramer & Monaco, P.C.	www.fkmlaw.com
Greater Westhampton Chamber of Commerce	www.westhamptonchamber.org
Honeywell Smart GRID Solutions	www.honeywellsmartgrid.com
LIFE, Inc. Pooled Trusts	www.lifetrusts.org
Marcum	www.marcumllp.com
PSEG of Long Island	www.psegliny.com
TeK Systems	www.teksystems.com
Temp Positions	www.tempositions.com
Time to Play Foundation	www.timetoplay.com
Wisselman & Associates	www.lawjaw.com
WSHU Public Radio (NPR News & Classical Radio)	www.wshu.org

Municipal Partners	Website
Nassau Library System (54 Member libraries)	www.nassaulibrary.org
New York State Association of County Health Officials	www.nysacho.org
New York State Department of Parks and Recreation	www.nyparks.com
NYC Poison Control Center	www1.nyc.gov
Suffolk County Legislature	www.legis.suffolkcountyny.gov
Suffolk Library System (57 Member libraries)	www.portal.suffolklibrarysystem.org
Town of Babylon	www.townofbabylon.com

Acknowledgements:

Special thanks are due to the contributing staff of the Suffolk County Department of Health Services, the Nassau-Suffolk Hospital Council (NSHC), including Janine Logan, Director of Communications at NSHC, Kimberly Whitehead, Pascal Fils-Aime, Paul Love, Katie Feerick, and of the Population Health Improvement Program (PHIP) the Nassau County Department of Health and all of the collaborative member organizations and other partners. In addition, thanks are due to the contributions of the Preventive Medicine Residents of the State University of New York at Stony Brook, Dr. Sujoy Gayen, and Dr. Hanjo Kwon-Anderson.

[i] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health