COMMUNITY SERVICE PLAN & IMPLEMENTATION PLAN

Peconic Bay Medical Center
2022–2024

Peconic Bay Medical Center
Northwell Health®

Mission Statement

We are a team of nearly 1,500 caring professionals working together to address the full range of health and wellness needs of the people of the East End. We strive to be the health care provider of choice for our communities.

Who We Are

As a not-for-profit 144-bed community hospital, we serve as the primary resource for advanced health care services for the 250,000+ residents of the Riverhead area, eastern central Suffolk County, and Long Island's North Fork. Peconic Bay Medical Center (PBMC) serves our community with an Interventional Cardiac Catheterization Laboratory Suite, Level III Trauma Center, and New York State-Designated Primary Stroke Center. As a facility focused on providing a comprehensive continuum of care for our patients, we are committed to providing an ever-growing range of leading-edge services and resources focused on the health care needs of every community member through every stage of life.

PBMC was awarded a disease-specific certification for heart failure care (2021). PBMC also received a coveted four-star rating from the U.S. Centers for Medicare and Medicaid Services (CMS) in its annual hospital rankings.

PBMC offers the following patient services: stroke, joint replacement and bariatric surgery. In addition to community-based services, the hospital operates a 5-star-rated nursing and rehabilitation center, a palliative care center, advanced cardiac care, and rehabilitation, the first hospital-based Caregivers Center on Long Island, and an advanced ambulatory and urgent care campus in Manorville.

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About Northwell Health

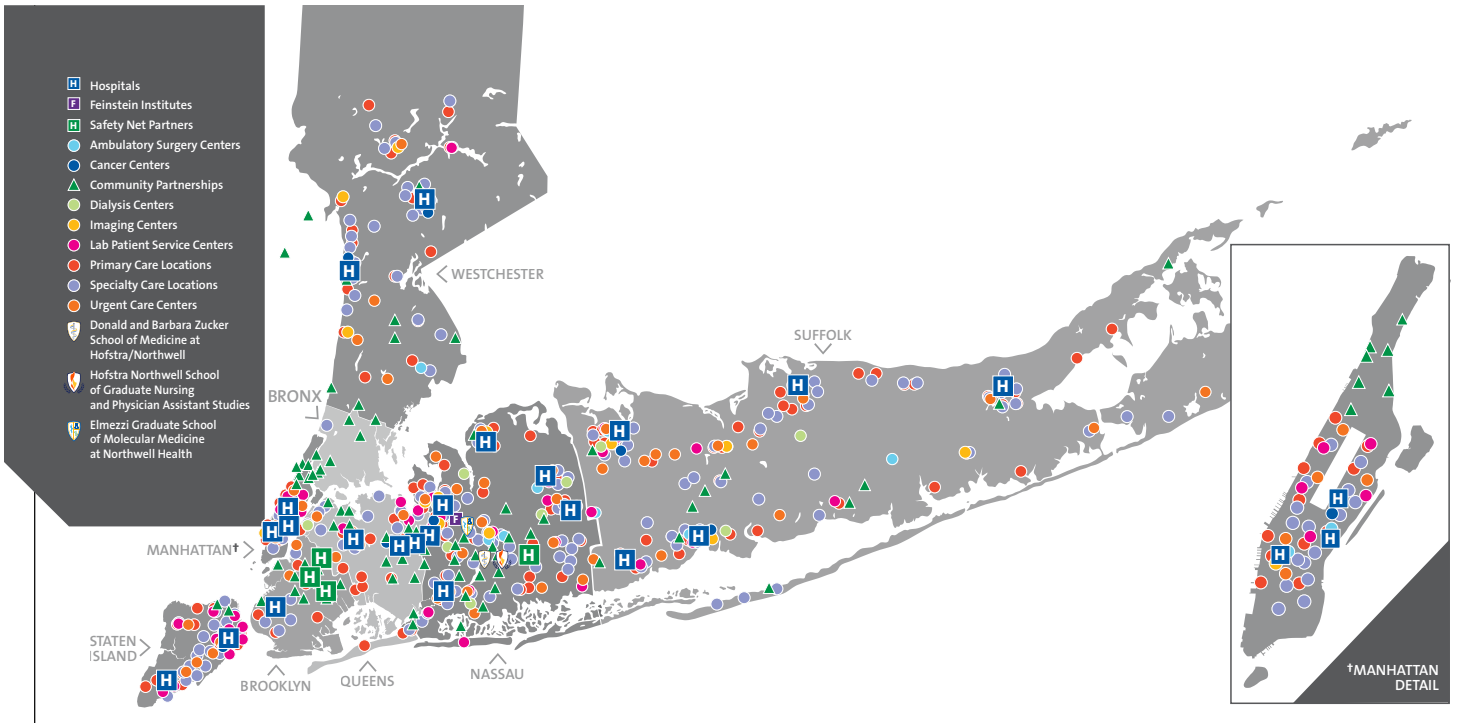
Northwell Health, New York State's largest health care provider, cares for over two million people annually in the New York metropolitan region. Northwell operates 21 hospitals across 13 campuses and 830 outpatient facilities and has more than 16,600 affiliated physicians on its medical staff, 4,200+ of which are members of Northwell's multi-specialty physicians' group. Northwell is also home to the Feinstein Institutes for Medical Research, and we train the next generation of medical professionals at the innovative Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, and the Hofstra Northwell School of Nursing and Physician Assistant Studies.

Northwell has a long standing commitment to providing exceptional care and investing in our most vulnerable and underrepresented communities. We have developed an extensive network of community partnerships to impact the health and well-being of the diverse communities we serve.

Our goal is to measurably improve health and wellness in the communities we serve and to provide the highest quality of care for all regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, gender identity, sexual orientation, religion, disability, geographic location or socioeconomic status. Northwell's integrated community and population health strategy includes data-driven approaches to screening for and addressing non-medical factors (social determinants of health). In doing so, our mission is to empower the communities we serve to eliminate disparities and create sustainable change. This mission is aligned with the Surgeon General's National Prevention Strategy, which we believe is fundamental to raising health for all.

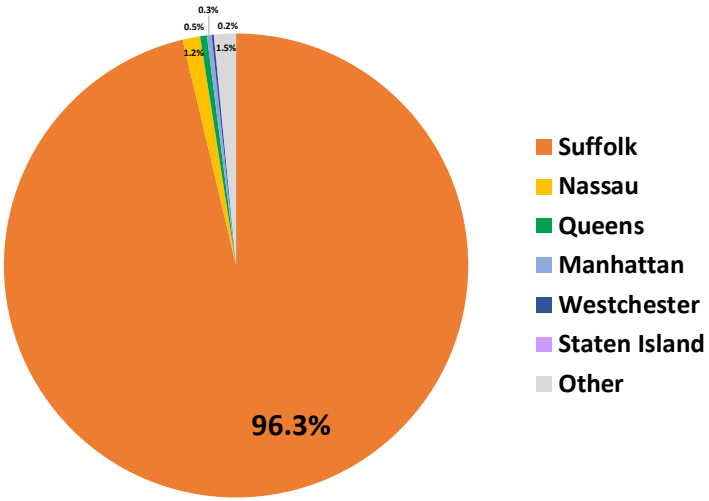
Our Service Area

Northwell's service area includes the following counties: Queens, Nassau, Suffolk, Manhattan, Westchester, and Staten Island. It serves a population of 8 million residents, over forty-one percent of the total population of New York State. According to the U.S. Census, the population of the service area grew by 2.3% between 2010 and 2020; faster than the 1.5% growth of New York State overall. Nearly a fifth of the service area residents are under 18 years old, and over 16% of the population is over 65 years old. Northwell's service area contains some of the most racially, ethnic, and linguistically diverse communities in the nation which spans urban, suburban, and rural settings where the health of its 8 million residents is impacted by a broad range of social determinants of health. Over 4 in 10 residents are from communities of color. The service area is also characterized by a higher density of foreign-born residents (29.5%), compared to the overall state (22.4%). Economic factors such as poverty and access to care underpin the health of our residents. A tenth of the population lives below the poverty line. Over 20% of our residents receive Medicaid health insurance coverage, while over 5% of our residents remain uninsured.

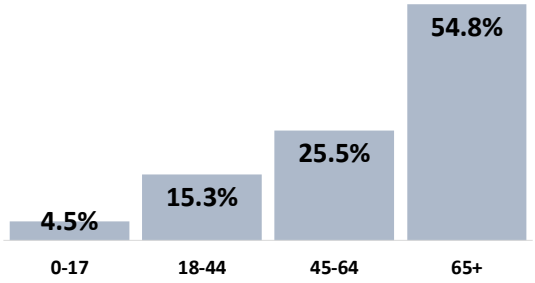


Serving the Community

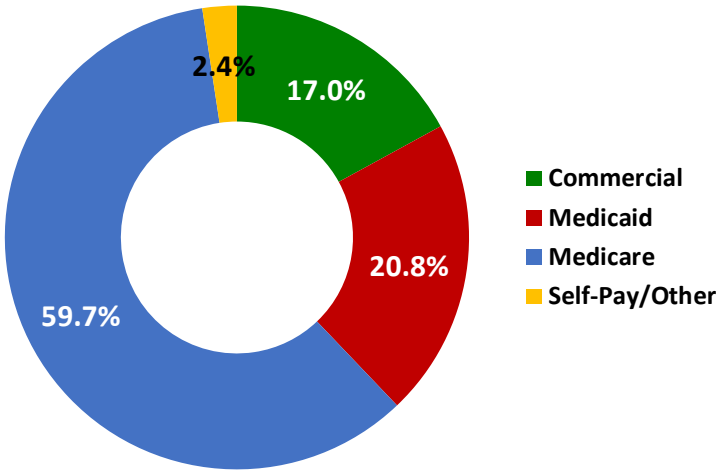
Inpatient Origin



Age Distribution



Payor Composition



Top 10 Languages Spoken at Home

1. English
2. Spanish
3. American Sign
4. Urdu
5. Polish
6. French
7. Russian
8. Albanian
9. Arabic
10. Italian

Source: NYSDOH SPARCS 2021; Prepared by the Office of Strategic Planning at Northwell Health/jc; Peconic Bay Medical Center

CHNA 2022 — Methodology and Significant Health Needs Identified

Our CHNA process consisted of a series of efforts to solicit input from leaders representing the interests of the communities we serve. As part of an integrated health system, the Office of Community and Population Health established the Northwell Health CHNA 2022 Steering Committee to serve as the platform of stakeholders and experts to plan, coordinate, and report the CHNA to our leadership and strategic partners. The committee agreed that the needs assessment should be based on both qualitative and quantitative data, collected from community organizations and the population at large, as well as through in-depth analyses of publicly available data on health indicators and outcomes.

Our primary analysis for our needs assessment included a series of focus group discussions (FGDs) across our health system's six-county service area. The FGDs were held with 82 leaders from governmental, non-profit, community- and faith-based organizations, who exist to meet the needs of the underserved and marginalized populations within our communities. We also collaborated with the Greater New York Hospital Association (GNYHA) and member organizations (i.e. hospitals and health systems) to design and distribute a community health survey to garner feedback from our members themselves.

Our efforts resulted in nearly 12,000 respondents within our overall service area. The primary analysis of our assessment ensured that we include the "voice of our communities," meeting them where they are and identifying their significant and unmet health needs. We then supplemented our primary analysis with an extensive secondary analysis of publicly available community and public health data, across several data sources, to build a more robust picture of health outcomes and trends in our communities.

Our efforts resulted in our identification of three major significant health needs:

- **Disruptions in care for chronic conditions**
- **Worsening mental health and substance use disorders**
- **A greater need for women and children's care**

Prevention Agenda 2019-2024: New York State's Health Improvement Plan

Peconic Bay Medical Center as part of Northwell Health, aligns its mission with the US Surgeon General's National Prevention Strategy (NPS) to realize the benefits of prevention for healthier communities. The NPS provides evidence-based recommendations for improving health and wellness and addressing leading causes of disability and death. The framework of the NPS is defined by its four strategic directions and seven priorities shown below:

NEW YORK STATE PREVENTION AGENDA

Source: Adapted from National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

STRATEGIC DIRECTIONS:

- Healthy and Safe Community Environments
- Clinical and Community Preventive Services
- Empowered People
- Elimination of Health Disparities

PRIORITIES:

- Tobacco Free Living
- Preventing Drug Abuse and Excessive Alcohol Use
- Healthy Eating
- Active Living
- Injury and Violence Free Living
- Reproductive and Sexual Health
- Mental and Emotional Well-Being

In alignment with the NPS, and as a result of our Community Health Needs Assessment (CHNA) process, Peconic Bay Medical Center and Northwell Health have selected the following priorities and focus areas from New York State DOH's Health Improvement Plan, 2019 - 2024 Prevention Agenda.

The selection of our community health priorities in alignment with the NYSDOH Prevention Agenda has been reviewed and formally approved by the Committee on Community Health of the Northwell Health Board of Trustees.

Prevent Chronic Diseases	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants, and Children
▪ Healthy Eating and Food Security ▪ Physical Activity ▪ Tobacco Prevention ▪ Chronic Disease Preventive Care and Management	▪ Well-Being ▪ Mental and Substance Use	▪ Disorders Prevention ▪ Maternal & Women's Health ▪ Perinatal and Infant Health ▪ Child and Adolescent Health ▪ Cross Cutting Healthy Women, Infants, and Children

Community Service Plan Highlights

Our Community Service Plan brings together our coordinated efforts in disease prevention and promoting health and well-being for our communities. It details our evidence-based programs that are implemented in Peconic Bay Medical Center and Northwell Health overall to address the significant health needs we identified, in alignment with our three selected NYSDOH Prevention Agenda items. As mentioned in other areas of our report, it emphasizes the work we do in collaboration with our strategic partners to ensure equitable access to care and resources to prevent disease. The following section highlights some of our key initiatives that align with our selected Prevention Agenda priority areas. A more comprehensive review of our evidence-based programs, in coordination with other Northwell providers across our service area, is detailed in our Joint Implementation Plan.

Community Service Plan: Programs & Services

Access to Care for the Underserved

Financial Assistance Program (FAP)

In accordance with current policy at Glen Cove Hospital and for all Northwell Health facilities and services, the ability to pay will not be a factor in the process of accepting patients. Every effort will be made to ensure that appropriate payment is made, but in no circumstance will a patient be refused medically necessary treatment due to inability to pay. In addition to our generous Financial Assistance Program (FAP) that is available to patients and their families with household incomes under 500% of the poverty line, Northwell Health has a sliding fee scale program offering services at a reduced fee. All services will be offered to those in need of care who satisfy admission requirements, regardless of age, sex, sexual orientation, race, creed, religion, disability, source of payment or any other personal characteristic.

Northwell Health is dedicated to providing accessible and affordable care to the individuals, families and communities we serve. Through our FAP, we provide discounted services — based on financial need — to those who are uninsured, underinsured, ineligible for government programs or other third-party coverage, or otherwise unable to pay for emergency or other medically necessary care. The program is designed to help patients who have received emergency or other medically necessary services but are uninsured, underinsured, or have exhausted their benefits for a particular service. Eligibility of the program is based on current income and family size (i.e.: less than or equal to $138,750 for a family of four).

The program is promoted through:

- **Multilingual signage throughout Northwell facilities**
- **Multilingual educational brochures at key points of patient contact**
- **Northwell's Financial Assistance Programs & Policies website**
- **Patient bills — all bills include a notice about the FAP, along with the program's toll-free number 800-995-5727**

Additionally, the application process for financial assistance is simplified; patients can apply online for the fastest turnaround time. Applications by mail and telephone are also accepted. Applications are simplified to one page and are available in 22 languages.

Center for Equity of Care

The Center for Equity of Care (CEC) focuses on redesigning Northwell's health care delivery, to provide high-quality equitable care to all our patients and the communities we serve. The CEC is focused on eliminating health disparities through a focus on diversity, equity and inclusion. The CEC's mission is to advance the delivery of culturally and linguistically appropriate health care in partnership with our communities with the goal of achieving health equity. To do this, the CEC establishes policies, procedures, and programs, in addition to training our Northwell team members. In partnership with others, some of our programs include a robust health literacy and language-access program, the establishment of the Hofstra/Northwell medical-legal partnership, and a system-wide social determinants of health screening and navigation program. The CEC has educated and trained our workforce on issues such as diversity and inclusion, unconscious bias, racism, social justice, health literacy, and cultural and linguistic competencies. Through these trainings, we have created a culture change to establish a health care system that aims for belonging and social justice. Alongside our programs and training have been CEC's efforts to empower our patients and communities to be partners in their care. Collectively through these endeavors, the CEC has been Northwell's impetus in mitigating health disparities across race, ethnicity, language, sex, and gender.

Effective Communication in Healthcare

The Center for Equity of Care is a system-wide resource and offers many educational opportunities to ensure the integration of cultural and linguistic competency into the organization's fabric. To ensure meaningful access to health care services for persons with Limited English Proficiency (LEP) or persons whose preferred language is not English, free medical interpretation and document translation services are available 24/7. Sign language interpretation services for the deaf/hard-of-hearing and specific communication tools for visually and speech-impaired patients are also available. For more information, please call the Center for Equity of Care at 516-881-7000.

MedShare

Northwell Health partners with MedShare, an organization that recovers valuable, unused surplus medical supplies and equipment in the United States, which would otherwise be discarded. This past year 1.67 million pounds of quality and unused medical supplies and equipment were successfully diverted from landfills. This partnership successfully bridges the gap between surplus in the U.S. and health care institutions in developing countries, which have a significant need for medical supplies and expertise. Over half of Northwell Health Hospitals and the Integrated Distribution Center provide donations, including beds, biomedical equipment and other assorted medical supplies. In 2020, Northwell Health donated more than 59,000 pounds of unused medical supplies and equipment; and in 2021, Northwell Health donated more than 120,000 pounds of unused medical supplies and equipment.

These donations achieve multiple objectives, especially for women and children in vulnerable communities:

- **Decrease global health disparities**
- **Increase the capacity to effectively care for more women and children in local health care systems**
- **Strengthen global health systems**
- **Improve health outcomes at the institutional and community level**
- **Save lives and increase the capacity to deliver quality health care**

Military Liaison Services

It is Time for "Thank You for Your Service" To Mean More

Each year, approximately 200,000 service members transition from active duty. An average of just 30% of these annual military end-of-service discharges qualify for some form of VA health care coverage; the remaining 70% receive coverage through Tricare for only 90 days post-discharge. As a direct response to the ongoing needs of active-duty personnel, veterans and their families, we established the Northwell Health Military Liaison Services (NHMILS) department in 2021. Northwell Health is helping to ease the burdens for those who have sacrificed tremendously to safeguard our nation; NHMILS encapsulates administrative, social and clinical services and support for our nation's heroes under one roof. NHMILS will support Northwell in strategically standing a new service line dedicated to supporting Northwell Health's clinicians and partners in the community.

The NHMILS is organized into three foundational pillars:

- **Exceptional Care –** Utilizing a proactive holistic approach to care coordination, licensed master social workers connect to service members, veterans, and their families and offer additional support post-discharge. Aspects of care routinely covered include but are not limited to patient transfers, critical care, pre-surgical testing, appointment coordination and scheduling, and conducting needs assessments,
- **Life After Service –** Reimagining how veterans thrive when they return home from active duty, Military Talent is assisting Talent Acquisition with an additional 100 veteran, service members and spouses new hires per year by conducting one on one career planning sessions and advocating with recruiters and hiring managers on their behalf, and
- **Innovation –** Advancing research and discovery to treat our heroes, in close partnership with the Feinstein Institute for Medical Research and the Center for Learning and Innovation, NHMILS works to ensure that every physician across Northwell's system is prepared to understand and care for the needs of veterans and their families.

Caring for service members and their loved ones extends far beyond behavioral health. As the largest health care provider and private employer in New York State, Northwell Health is uniquely positioned to meet these challenges head on. We provide leadership development, support for military families, advocacy for veterans, physical services and employment opportunities. Applying the Community Care Coordination Model to strengthen the private-public partnership between Northwell and the VA, we can address the social determinants of health of veterans and their families and schedule all aspects of clinical and behavioral services.

Furthermore, enveloping existing services, programs, and processes under the umbrella of the Community Care Coordination Model, NHMILS can support ongoing programs and efforts including SkillBridge (DoD "Career Skills" program) and pay differential programs. Moreover, the development of the "Side by Side" series has added value to both the veteran population and the community as a whole; this two-part event provides an opportunity to honor and celebrate our military. An evening ticketed concert, open to the public, supports our Military Liaison Services. We launched this yearly event in 2019 and over the years, we have connected with all the communities we serve in New York City and Long Island, and our efforts have been recognized by national publications and the New York Emmys for Content. The collective efforts across the organization have earned Northwell awards in 2022 including Military Friendly Top 10 Company, Military Friendly Top 10 Employer, Military Friendly Top 10 Spouse Employer, Military Friendly Supplier Diversity Program, and Military Friendly Brand.

Health Solutions

Northwell Health Solutions supports our providers who care for patients with complex medical conditions and social needs, and addresses the challenges navigating access to health care resources.

Northwell Health Solutions also oversees the organization's Health Home program. Northwell's Health Home is a New York State Medicaid program for patients with two or more chronic medical conditions who are vulnerable to poor outcomes. A "Health Home" is not a physical place, but a group of health care and service providers working together to make sure members get the care and services they need to stay healthy. Once enrolled in Health Home, each member will have a care manager who works with them to develop a care plan. A care plan maps out the services needed, to put the members on the road to better health.

Some of the services include:

- **Connecting to primary care providers**
- **Connecting to mental health and substance abuse providers**
- **Connecting to needed medications**
- **Help with housing**
- **Social services (such as food, benefits, and transportation)**
- **Other community programs that can support and assist members**

Human Trafficking Response Program

Human trafficking is a public health issue that requires cooperation and collaboration among health care, law enforcement, community-based organizations and society as a whole. The Northwell Health Human Trafficking Task Force was created in 2018 to ensure a population approach to the crisis of human trafficking. The mission of Northwell's Human Trafficking Task Force is to provide a medical safe haven for survivors and those at risk of human trafficking at the local, national and global level and to educate, promote advocacy, respond, and train in mitigating this public health crisis. The Task Force has already become a recognized leader in rallying the health care industry to combat the social injustice of human trafficking on a local, national and international level. The Task Force has identified team leaders at Northwell hospitals to become experts on the topic, train co-workers, identify potential victims and contribute to best practices. Thanks to the Task Force, Northwell was recently honored as one of six health systems nationwide and selected

to participate in a pilot study by the United Nations through Global Strategic Operatives for the Eradication of Human Trafficking (GSO). The study will aid the World Health Organization (WHO) in creating a standardized set of protocols and guidelines aimed at properly identifying human trafficking victims and helping them find safety. Northwell

The Human Trafficking Task Force has:

- **Hosted over 8,000 attendees and participants at external educational series and symposia,**
- **Trained over 7,000 Northwell Health clinical and non-clinical staff members,**
- **Created community partnerships with the Empowerment Collaborative of LI, Clean State Living, Suffolk County, Anti-Trafficking Initiative, NOMI Networks, and RestoreNYC, and**
- **Prepared and distributed human trafficking education materials for the Emergency Department and Labor & Delivery service lines to display within their respective sites and locations.**

Health's Center for Transgender Care

According to the Trevor Project, transgender youth report higher rates of depression, suicidality and victimization compared to their cisgender peers. Northwell Health's Center for Transgender Care provides comprehensive, culturally competent services to address many of the health needs of trans and gender non-conforming patients in our community. The center offers primary care, immunization, HIV prevention (PrEP) and treatment, screening for sexually transmitted infections and endocrine evaluation (evaluation and treatment with hormone replacement therapy or puberty blockers). The center also provides psychotherapy services specifically around gender transition challenges, health and sexuality education, risk reduction counseling and surgical specialty care for gender affirming surgery (i.e., transitioning). Transgender patients deserve better care and Northwell is committed to training providers to understand their unique needs to deliver gender-affirming and compassionate care.

Prevent Chronic Diseases

The Cancer Services Program

The Cancer Services Program (CSP) at Northwell is in partnership with the New York State Department of HHealth Division of Chronic Disease Prevention, Bureau of Cancer Prevention and Control.

The NYSDOH has 21 funded contractors across the state, of which three contracts are allocated to Northwell:

- **CSP of Staten Island at Staten Island University Hospital (SIUH)**
- **CSP of Nassau County at Long Island Jewish Hospital (LIJH)**
- **CSP of Suffolk County at Peconic Bay Medical Center (PBMC)**

The mission of the CSP program is to reduce the burden of cancer for all New Yorkers through the implementation of population-based and evidenced-based strategies across the cancer care continuum, from prevention and risk reduction to early detection, diagnosis, and treatment through survivorship. The CSP program's priority population are those disproportionately affected by breast, cervical, or colon cancer, or those who are medically underserved and lack health care options. Patients who want to participate in the program need to be New York State residents and must meet minimum age requirements. The program caters to the uninsured and is inclusive of sexual orientation, gender identity, immigration status or physical address. Despite the pandemic's challenges, the CSP programs at Northwell Health met and exceeded all its deliverables for community Outreach and Education.

Since the program's launch we have screened 20,089 uninsured individuals for cancer.

- **Approximately 9,000 members were educated among the 3 Northwell CSP programs**
- **Over 609 education and 1:1 programs were conducted**
- **PBMC facilitated 2,914 screenings for uninsured community members**
- **Through the program, $18,000 in financial support was provided to 55 residents**
- **Several community education events were held across Suffolk County that reached more than 1,000 people.**

Food as Health

Launched in 2018, the Food as Health program is New York State's first-ever hospital-based initiative to comprehensively address food insecurity. The program's aim is to help connect the patients' health with nutrition to improve their overall wellness. Patients who screen positive for food insecurity and have a diagnosis impacted by nutrition receive personalized nutrition counseling sessions, access to nutritious foods from the onsite food pantry, referrals to community resources, and assistance with enrolling in the Supplemental Nutrition Assistance Program (SNAP). Island Harvest distributes. The program is administered in partnership with Long Island Cares, Inc., the Harry Chapin Food Bank, US Foods and Baldor. The goals of the program are to address the full range of factors that can lead to food insecurity, including affordability, a lack of nutritional awareness, transportation/mobility impairments and difficulty in preparing meals.

Patient consultations take place at the Food as Health Center within the hospital, or directly in the patient's room. At discharge, the patient is given a two-day supply of fresh produce and non-perishable food and a "prescription" for two refills. If patients have transportation or mobility issues, Long Island Cares will deliver emergency food supplies to their homes. In addition, dietitians assess and assist patients with resource support programs including ongoing nutrition programs as needed.

Food as Health program highlights for 2021:

- At least **500 bags** were distributed (an insulated bag with products such as milk and cheese, and a bag of fruits and vegetables per recipient).
- **11,018 meals** were delivered to 62 community members through 5,509 deliveries.
- An estimated **75 people** served.
- **103 clicks** onto food drive link in emails sent for virtual food drive.

Center for Tobacco Control

Our Center for Tobacco Control (CTC) provides free cessation services to our community members. The program is facilitated by specialty-trained nurses and nurse practitioners. Its services include individual telephonic or telehealth counseling and coaching, relapse prevention strategies, cessation medications and virtual support groups. Though the pandemic halted in-person services at the CTC, the program effectively adapted to the crisis by expanding its telehealth strategies which have The Center for Tobacco Control (CTC) significantly expanded its outreach and footprint, from the East End of Long Island through the five boroughs of New York City, and up to Westchester County.

Additionally in the first seven months of 2022, the CTC received 1,390 tobacco cessation referrals from physician practices with 527 enrollments, and 5,929 follow-up encounters. Over 1,000 community members were educated about their eligibility and the importance of lung cancer screening. The CTC also provided 550 health care practitioners and students with education and guidance related to the evidence-based practice of treating tobacco use and dependence. The CTC also guides leaders in healthcare organizations to develop policies that mandate tobacco dependence treatment for all tobacco users, in both the inpatient and outpatient settings. For more information about the CTC program 516-466-1980, or email tobaccocenter@northwell.edu.

Center for Tobacco Control successes:

- **2,060** referrals received
- **802** enrollments
- **9,191** follow-up encounters (from prior enrollments)

Promote Well-Being and Prevent Mental and Substance Use Disorders

Dr. Salas-Lopez (center) pictured with faith leader participants at Faith Leaders Forum Part II: An Interfaith Dialogue on Solutions and Next Steps

Inter-Faith Leaders' Mental Health Forum

During the pandemic, behavioral health needs soared throughout the nation. We are determined to enhance access to resources to address the mental health crisis in our communities. Our work in this space has been focused on providing education to increase awareness of mental health issues and reduce associated stigma. We have partnered with our trusted community- and faith-based leaders to develop holistic and equitable community-based solutions to mental health needs, such as the Nassau and Suffolk Mental Health Resource List in English and Spanish. We have established models to bring mental health services into the community and explored innovative solutions to expand access, such as embedding Community Health Ambassadors in houses of worship and community-based organizations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) program helps identify patients in our hospitals whose drinking or substance use may be interfering with their health before it becomes a lifelong addiction. In the SBIRT program, adults who visit a participating health facility are pre-screened during their visit with three to five questions relating to their drinking, smoking, and drug use. If they meet a certain threshold based on that pre-screening, the patient is connected with a health coach for further assessment. Based on that interaction, patients may receive a brief motivational and awareness-raising intervention and, if necessary, a referral for treatment. The program promotes compassionate engagement with patients to identify potential issues. This helps reduce the stigma often associated with drug addiction and alcoholism and helps connect patients to the right treatments at the right time.

In five years, Northwell Health has assessed more than 300,000 patients for substance misuse and addiction through the SBIRT protocol

Promote Healthy Women, Infants, and Children

Northwell's Center for Maternal Health

In Spring 2022, we launched our Center for Maternal Health to address the disproportionate rates of pregnancy-related health risks and maternal deaths among Black women. Black women in New York are three to 12 times more likely to die of childbirth-related causes than white women. The Center is a suite of programs through our sites that support high-risk women in and out of the hospital and train clinicians on best practices. The goal is to establish a truly integrated best practice care model, going further upstream in care delivery, for our high-risk maternal patients in the community.

The initiative of the center's programs is to provide ongoing support to our highest risk mothers and newborns through individualized navigation by a team of health care professionals. The center will address the causes of disparities in maternal health by addressing outcomes for all birthing patients through its Maternal Mortality & Severe Maternal Morbidity (SMM) Review Committee. It will focus on improving maternal health within our communities by establishing a Patient and Family Advisory Council with members who have lived experience with maternal morbidity and mortality. To reach those most in need, the center will also work with community-based organizations to connect women in medically underserved communities to our maternal health services.

Center for Maternal Health's Goals:

- Improve Northwell's workforce knowledge of the impact of **structural racism and implicit bias**
- Further investigate the increased **prevalence of comorbidities in Black women**
- Address **inherent underlying preeclampsia rate in Black women**
- Address increased Cesarean delivery rate in Black women
- Explore **challenges in access to care** (underinsured, lack of trust, limited provider choices, language, and literacy)
- Explore every maternal death to identify factors that can be modified to **prevent future tragedies**

Katz Institute for Women's Health

The Katz Institute for Women's Health (KIWH) is a resource center dedicated to improving all aspects of a woman's health at every stage of her life. KIWH offers women seamless, coordinated access to all of Northwell Health's clinical programs and services across the continuum of care.

Go Red for Women

Go Red for Women is a national movement by the American Heart Association (AHA) to address heart disease and stroke in women. Cardiac conditions such as heart attacks manifest differently for women than men. In a 2012 AHA study, 56% of women identified heart disease as the leading cause of death compared to 30% in 1997. Fewer women than men survive their first heart attack. Hispanic women are also likely to develop heart disease 10 years earlier than white women, and cardiovascular diseases are the leading cause of death for African American women, killing 48,000 annually.

Northwell, through the Department of Cardiology and the KIWH, partners with the AHA to raise awareness and empower women with knowledge on the prevention, recognition and treatment of cardiovascular disease, including stroke. Northwell Health is a proud Live Fierce. Go Red sponsor in New York City, Long Island and Westchester. This year, throughout the month of February, the Go Red for Women campaign held over 25 health promotion events throughout Northwell Health's network of providers to raise awareness, promote heart health, and offer free and accessible preventive services, such as blood pressure screenings, education seminars, wellness sessions lunch and learn sessions, and exercise events.

Baby-Friendly Hospital Initiative

Baby Friendly Hospital Initiative and Designation is an ongoing quality assessment and improvement program focused on adhering to the 10 Steps to Successful Breastfeeding as advised by the World Health Organization, the New York State Department of Health, The Joint Commission, and the accrediting body, Baby-Friendly USA. In 2022, there were 11 events completed in partnership with the Mastic Moriches Shirley Community Library.

Participants from Northwell's Community Scholars Program

Northwell Community Scholars Program

As part of our commitment to our youth, we launched the Northwell Community Scholars (NCS) program, an innovative youth education and scholarship program to create a pathway to college and future employment for adolescents of underserved and underrepresented communities in our service area. This five-year, $5 million effort will focus on mentorship and support for students from school districts in four vulnerable neighborhoods burdened by health and social inequities: Bay Shore and Brentwood in Suffolk County, and Hempstead and Freeport in Nassau County. The program is also in partnership with Nassau and Suffolk Community Colleges.

The program addresses education, health and wellness, and social inequities prevalent in these neighborhoods that were hit hard by the pandemic. The program will support students with continued growth and development, mentorship, college preparation, career advisement, and internship and shadowing opportunities. Northwell staff will also mentor students about employment opportunities within the organization, educating students on careers in clinical services, health administration, information technology, operational support and care coordination.

The goal is to expand the Community Scholars Program to 600 students by 2026

Awards and Accomplishments

- **Accredited Professional Certification Program in Radiologic Technology,** Joint Review Committee on Education in Radiologic Technology (JRCERT), NYSDOH, and American College of Radiology (ACR).

- **Blue Distinction Center for Bariatric Surgery,** Empire Blue Cross Blue Shield.

- **C2X Program, Commitment to Excellence,** Healthcare Association of New York State (HANYS).

- **Diagnostic Imaging Center of Excellence,** ACR.

- **DSC for Advanced Palliative Care,** The Joint Commission (TJC).

- **DSC for Heart Failure,** TJC.

- **DSC for Joint Replacement-Hip, Joint Replacement-Knee,** TJC.

- **Four-Star Rating,** Center for Medicare and Medicaid Services (CMS).

- **National Hospital Organ Donation Campaign-Platinum Recognition,** Health Resources Services Administration (HRSA.

- **Stroke Gold Plus Recognition, Get With The Guidelines-Stroke,** American Heart Association (AHA).

- **Target: Stroke Honor Roll- Elite Plus, Get With The Guidelines-Stroke,** AHA.

- **Target: Type 2 Diabetes Honor Roll,** AHA.

Our Leaders

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This report was prepared by the Office of Community and Population Health at Northwell Health

Implementation Plan

Community Serviced: Suffolk County
NYS DOH Implementation Plan for the following hospitals:
Huntington Hospital, Mather Hospital, Peconic Bay Medical Center, South Oaks Hospital, and South Shore University Hospital
in coordination with other Health System resources, including other partners, has addressed each significant health need identified through the Suffolk County CHNA report.
The CHNA Implementation Strategy was conducted in fulfillment of the requirements of 501(r) or The Affordable Care Act applicable to a 501(c)(3) hospital organization

Hospital	Priority	Focus Area	Goal	Interventions	Family of Measures	Latest update	Partnerships

Huntington Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	**Nutrition Pathways Program:** The purpose of the Nutrition Pathways program is to improve the health and well-being of the poor, underserved, vulnerable, and disadvantaged patients in the communities served by the Dolan Family Health Center, through the identification and addressing of health-related social needs, most notably food insecurity. The program deployed at the Dolan Center, in partnership with Island Harvest, Long Island's largest food bank, provides food insecure individuals and their families, with nutrition counseling and education, healthy food packages and support, and referrals for other community-based programs and resources, as needed. The program also provides weekly community food distribution. The Nutrition Pathways Program has implemented use of the NowPow referral platform, enabling us to link clients with appropriate services, as well as ensure referred services are received, resulting in an improved ability to sustainably address participants' food insecurity and other related social needs. Dolan Family Health Center staff routinely screen patients for food insecurity. Those who screen positive are referred to the Nutrition Pathways Program, where they meet with an Island Harvest registered dietician (RDN) who is embedded on-site. The patients meet with the RDN weekly or bi-weekly for up to 12 visits. At each session, the RDN provides personalized education and advice on diet and health priorities set by the patient. After each session, patients are guided, by the RDN, as they "shop" for food in the program's on-site Pantry/Nutrition Center. Participants also receive practical cooking tips, shopping guides, kitchen tools, and other essential items to encourage and support healthy home meal preparation. While the Nutrition Pathways Program focuses on addressing food insecurity, participants are also screened for needs beyond food assistance and are connected with other community resources to address a full range of social determinants of health. To best serve the needs of the largely LatinX community served at the Dolan Center, the nutritionists who are embedded are competent in communicating to the Spanish-speaking community. In addition to providing nutritionally appropriate food items and recipes, the staff also tries to ensure that food and other materials provided are culturally appropriate and that recipes are palatable, from a cultural lens. Materials are available in both English and Spanish.	• Number of individuals enrolled in the full program and received counseling sessions. • Number of individuals who participated in the weekly Friday community box food distribution. • Number of meals provided • Number of individuals who have been assisted with SNAP benefits enrollment. • Number of individuals with other health-related social needs connect with services/resources.	The Nutrition Pathways Program launched in May 2021 and in April 2022 we conducted our one-year assessment. In this one-year period, Nutrition Pathways achieved the following: • 134 people were enrolled in the full program and received (as of April 30th) a total of 981 counseling sessions. As this program is designed to improve food security for entire households, the program's true impact is significantly higher. With Census data showing an average household size of 3.5 members in the target communities, the true impact is closer to 469 individuals. • Approximately 250 people participated in the weekly Friday community food box distribution at the Dolan Center. Using the Census estimates of household size above, the true reach of the weekly food distribution was approximately 875 individuals. • A total of 29,052 meals were provided (11,772 meals through the one-on-one RDN sessions, and an additional 17,280 meals through the on-site community food box distributions). • 86 individuals have been assisted with Supplemental Nutrition Assistance Program (SNAP) benefits enrollment. • 125 individuals with other health-related social needs were connected with more than 793 services/resources. Common referral needs, other than food insecurity, included immigration assistance, assistance with utilities, assistance with rent/housing, baby care needs, mental health needs, COVID-related assistance (testing and vaccinations), and transportation. Finally, the following outcomes metrics have been tracked since the program inception for 61 patients who have completed at least 12 sessions as of April 30, 2022: • 86 individuals have been assisted with Supplemental Nutrition Assistance Program (SNAP) benefits enrollment. • 125 individuals with other health-related social needs were connected with more than 793 services/resources. Common referral needs, other than food insecurity, included immigration assistance, assistance with utilities, assistance with rent/housing, baby care needs, mental health needs, COVID-related assistance (testing and vaccinations), and transportation. • Significant improvement in healthful behaviors was achieved: o 54% of participants reported increased consumption of healthy foods. o 67% reported a dietary reduction in unhealthy foods. o 26% reported a reduction in meals eaten away from home. o 44% reported increased physical activity. • Significant improvement in health outcomes was achieved: o 50 of participants have achieved reduced BMI (as per medical records). o 36% have achieved reduced blood pressure. o 55% have achieved reduced A1C.	Close collaboration with the Island Harvest team that staffs the registered dietician on-site at Dolan. Financial support of the Mother Cabrini Health Foundation.

Huntington Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Food as Health Program (FAH):** The Food As Health Program was created to help connect the patients health and nutrition to improve their overall wellness. Patients who screen positive for food insecurity, receive personalized nutrition counseling sessions, access to nutritious foods from the on site health food pantry, referrals to community resources, and assistance with SNAP. Island Harvest distributes	# of meals provided, # of days served, # people served	In 2021: - At least 500 bags were distributed (one insulated bag with cold products such as milk and cheese, and one bag of fruits and vegetables per recipient). - 11,018 meals were delivered to 62 community members through 5,509 deliveries. - 75 people estimated to be served. - 103 clicks onto food drive link in emails sent for virtual food drive.	Island Harvest, National Grid grant, Town wide Fund of Huntington, Suffolk County Women's Alliance to End Food Insecurity, Three Village Meals on Wheels
Huntington Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Cancer Service Program:** The Dolan Family Health Center became a NYSDOH Cancer Services Program provider in October 2021. The Cancer Services Program (CSP) provides breast, cervical and colorectal cancer screenings and diagnostic services at NO COST to people who: live in New York State, do not have health insurance, have health insurance with a cost share that may prevent a person from obtaining screening and/or diagnostic services, meet income eligibility requirements and meet age requirements.	Number of patients screened	50 eligible Dolan patients were enrolled in CSP in 2021 for cervical and breast cancer screening.	Suffolk County CSP Program, American Cancer Society, Northwell Rechert Imaging Center

Huntington Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Breast Cancer Screening for Underserved Women:** A Pink Aid Grant for Breast Cancer Screening funding was obtained for the 7th cycle in 2021. The Pink Aid Grant funding period is from March to February. The nursing department coordinated Dolan's self-pay patients to receive no-cost breast screening services by offering free screening mammograms and other breast imaging services utilizing Pink Aid funds. Due to challenges with COVID-19, Pink Aid funding was decreased in 2021-2022 from previous years. In order to reach patients for the entire 12 months of the grant cycle, Dolan Administration was able to use over $8,000 to supplement the program from a Temporary Restricted Account (donor support) for Breast Cancer Services. Keeping the program running without interruption was so critical for patients during the final months of the grant cycle. Removing the financial barrier by offering no-cost screening services continued for these self-pay women.	Number of patients screened	Dolan Family Health Center mammograms completed by self-pay patients increased in 2021 which was hopeful following many women postponing this important health screening during the pandemic. 87% of the self-pay women who had mammograms ordered during the 2021 completed this imaging. This reflected an increase in compliance from 79% in 2020.	Pink Aid LI
Huntington Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Diabetes Tele-Enrichment Program:** Dolan Family health Center's Diabetes Tele-enrichment Program began in May of 2017 by the registered dietician targeting the highest risk diabetic patients. This alternative visit program identifies ten health center patients with HgbA1c levels above 9.0% in need of coaching and support. The RD makes bi-weekly telephone appointments, scheduled phone sessions in which medication adherence, diet, needed services, barriers to self-care are covered. The goal of the program is to simplify access to the RD/Certified Diabetic Educator and expand the patients' nutritional support through the utilization of the organization's existing resources and infrastructure. Once the patient's HgbA1c is below 9.0% they graduate from the program and another patient is added.	Number of patients enrolled	46 patients have graduated successfully from the program and 25 patients have dropped out of the program. At the end of 2021 there were 9 individuals enrolled in the program.	American Diabetes Association

Huntington Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	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	**Health Home:** The Dolan Family Health Center remains the only Northwell Health Home based in a comprehensive primary care setting. This care coordination program is responsible for linking qualified Medicaid patients to supportive services, social services, family supports, specialty appointments, etc. Each member is given careful attention by our care management coordinators and support team to help meet their health care goals. Program goals are to provide coordinated care to reduce avoidable emergency department visits and inpatient stays while connecting members to the community services that are needed for all their medical, behavioral health and social service needs. The social program runs alongside the primary care focus at the health center targeting the most needy and vulnerable of our Medicaid population. Five care management coordinators (including the Health Home Supervisor) enroll and manage qualified Dolan patients in our Pediatric and Adult programs.	Number of patients enrolled	In 2021, the adult program enrollment fluctuated between 212-249 patients and the pediatric program was launched; enrolling a total of 28 patients by years end. Dolan's Health Home is a downstream Care Management Agency of Northwell Health Home. Dolan continues to receive a Tier 1 rating for quality as per Northwell Health Solutions.	Northwell Health Solutions - Health Home
Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	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	**Community Education- Diabetes Management**: Addresses Prevent Chronic Diseases, Preventive Care and Management by educating community members on managing diabetes and prediabetes including information on the Diabetes Prevention Program and how to access.	# participants, # webinar views, program evaluations	4/5/22 webinar was attended by 18 people and has had 248 views as of 9/8/22.	Internal Clinicians

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	**Community Education- Diabetes Management:** A webinar providing community members with education on the prevention of diabetes and pre-diabetes was held. Presented as part of Mather's HealthyU series of free community health education events, the webinar was recorded and is also available for viewing online. Objectives for the webinar included understanding the risk factors for diabetes, understanding the A1C level and what it means in terms of risk for diabetes, ability to list 2 lifestyle changes that will decrease the risk for diabetes, and ability to read a nutritional label and understand the carbohydrate content of different foods. Information about the Diabetes Prevention Program was presented.	# participants, # webinar views, program evaluations	4/5/22 webinar was attended by 18 people and has had 248 views as of 9/8/22.	RN, Diabetes Nurse Educator.

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Community Education- Nutrition:** A series of webinars provided community members with education on healthy eating as well as physical activity. As part of Mather's HealthyU series of free community health education events, three healthy eating webinars were held in 2022. The webinars were recorded and are also available for viewing online. Dietitians presented evidence-based information using three themes: nutrition for achieving fitness goals, nutrition strategies for healthy weight management during menopause, and making peace with food. Nutrition for fitness goals addressed metabolism, body composition and nutrients/micronutrients. The weight management in menopause webinar explained the pathophysiology of menopause, explored the connection between menopause and weight gain, and discussed life-style changes that promote healthy outcomes using the principles of the Mediterranean diet. AHA recommendations for physical activity and other evidence-based information and resources were provided. The making peace with food webinar covered the hunger scale and the ten principles of intuitive eating.	# of webinars, # attendees, # of webinar views	1/18/22 Achieving fitness goals with proper nutrition 2/8/22 Is menopause weighing on you? Nutrition and lifestyle strategies for healthy weight management during this lifecycle phase 4/12/22 Making peace with food Attendees (respectively): 46 + 22 + 32= 100 total in 2022 to date. Webinar views: 155 + 133 + through 9/8/22.	Registered Dietitians.
Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Community Education- Nutrition and Physical Activity:** A Weight Loss Matters Blog educates the community on healthy eating and physical activity. Articles written by dietitians or other clinicians are posted weekly on the blog, with occasional healthy recipes. Topics in 2022 have included exercise and physical activity with breast cancer, healthy lunchbox snacks, benefits of outdoor fitness, loss of control eating, exercise and brain health. https://www.matherhospital.org/our-blogs/weight-loss-matters/	# of posts, click analysis	30 posts in 2022 through 9/8/22 2,589 readers in 2021	Registered Dietitian contributors

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 3: Tobacco prevention	Goal 2.2: Promote tobacco use cessation	**Tobacco Cessation Program:** Mather Hospital hosts a Smoking Cessation course run by the Suffolk County Department of Health. The seven week course covers stress management techniques, behavior modification, relaxation, techniques. Cessation medication is provided for a nominal fee. In addition to providing space, Mather promotes the program to the community. Referrals to the program are also made from the hospital's lung cancer screening program.	# of attendees	Course took place July-September 2022. Estimated # of attendees based on past course: 10	Suffolk County Department of Health
Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Community Education- Preventive Care:** A blog educates community members on screenings for cancer, congestive heart failure management and other chronic disease preventive care and management subjects. Typically posts are made twice/month. A recent post was What you need to know about lung cancer screening. https://www.matherhospital.org/our-blogs/wellness-at-mather-blog/	# of chronic disease prevention/management posts, # clicks	In 2022 to date, posts included Lung Cancer Screening, Congestive Heart Failure, and Radiation Cystitis for Cancer Survivors	Internal

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Community Education- Screening for Cancers:** Community members were provided with education on screening for breast cancer, lung cancer and colorectal cancer. A webinar for each type of cancer screening was presented as part of Mather's HealthyU series of free community health education events. Webinars are recorded and are also available for viewing online. The colorectal cancer screening webinar, presented by a gastroenterologist and associate professor, Zucker School of Medicine, provided an overview of colorectal cancer, early detection/prognosis, risk factors, symptoms, stages, colonoscopy with polypectomy, polyps, screening methods, colonoscopy prep and procedure, U.S. MSTF recommendations. The lung cancer screening webinar, presented by Mather's chief of pulmonary medicine, covered impact on community, survivorship by type and stage, low dose CT scanning, national lung screening trial, screening programs and referral resource. The breast cancer screening webinar focused on COVID's impact and was presented by the medical director of Mather's breast center. It covered the impact of delayed screening, COVID vaccine myths, and risk of COVID exposure/ACR recommended precautions.	# of webinars# of attendees, # of webinar views, program evaluations	1/25/22- What you should know about colorectal cancer screening: 34 attendees, 27 webinar views as of 9/9/22 5/10/22- Should you be screened for lung cancer? 22 attendees, 121 webinar views as of 9/9/22 5/17/22- The impact of COVID-19 on breast cancer screening 13 attendees	Colorectal cancer screening webinar had grant support from the American Cancer Society. Lung cancer screening webinar had grant support from the NYS DOH Community Cancer Prevention initiative. Physicians presented.
Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Skin cancer screenings:** Free skin cancer screenings are provided to community members. Offered onsite and in the community via a mobile unit, a dermatologist provides registrants with skin cancer screenings. This program complements Mather's provision of free sun screen to community members visiting parks, beaches and other outdoor destinations during the summer months, for prevention and early detection of skin cancer.	# of events, # of participants	4/13/22 Port Jefferson Chamber of Commerce Health & Wellness Fest- Skin Cancer Screenings- 20 participants	Northwell mobile unit, clinicians provided the resources for screening and Port Jefferson Chamber of Commerce the venue, helping to reach

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	**Blood Pressure Screenings:** Community members are provided with blood pressure screenings at community events, during Go Red! Heart month, and at a library. The screenings help to identify individuals with high blood pressure for whom follow up is needed.	# of times screening offered, # people screened	2/16/22 Mather Hospital Go Red! Heart Month screening: 20 people screened 4/23/22 Port Jefferson Chamber of Commerce Health & Wellness Fest: 50 people screened 5/22/22 Northwell Health Walk at Port Jefferson: 25 people screened 4 more screenings anticipated at Longwood Public Library (monthly screenings beginning 9/29/22), for an estimated 200 people screened in 2022.	Go Red! Heart month is promoted by the American Heart Association. The health fair was held by the Port Jefferson Chamber of Commerce. Longwood Public Library has requested we provide monthly screenings.

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Breast Cancer Screening Awareness- Paint Port Pink:** Through Paint Port Pink, Mather provides a month of community awareness activities and education events promoting the importance of breast cancer screening. Held in October, Paint Port Pink brings the community together in the fight against breast cancer by spreading awareness, encouraging annual screenings, and providing information/ education.	# events, # participants, # community partners, # website visits	Paint Port Pink takes place in October. In 2021, 168 community partners joined Mather Hospital in promoting breast cancer screening awareness to the community through pink lights, banners, store/restaurant promotions, etc. A webinar provides community members with education on breast cancer (27 people attended webinars promoted through Paint Port Pink in 2021). In 2022, an in-person event will be held that provides community members with education on healthy eating to prevent cancer (American Cancer Society guidelines) and how to perform breast self-exam/other relevant health topics. We estimate 50 community members will receive preventive education. In addition, the Paint Port Pink website provides community members with information on screening including how to access screening if you are uninsured.	Paint Port Pink engages the Village, non-profits and businesses in the Port Jefferson area in promoting awareness of the importance of breast cancer screening. In 2021, Paint Port Pink had 168 community partners. In addition, community members participate in raising awareness through activities such as a Pink your Pumpkin contest utilizing social media.

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Community Education- Heart health:** Community members were educated on heart health through three webinars: Heart care that can save your life, Reduce stress and save your heart, and Are you walking around with a blood clot in your leg? Presented as part of Mather's HealthyU series of free community health education events, the webinars were recorded and are also available for viewing online. Objectives for the reduce stress webinar included Explore current scientific evidence for the relationship between stress and cardiovascular disease, Explore the impact of stress on cardiac health, Discuss actionable strategies to mitigate stress, Discuss actionable strategies to enhance heart health. The COVID pandemic's impact on increased stress and stress cardiomyopathy was discussed. For the blood clot webinar, content included signs and symptoms of DVT, causes and risk factors, DVT anatomy, treatment.	# webinars, # attendees, program evaluations	2/1/22 Heart Care that can Save your Life: 57 attendees 2/15/22 Reduce Stress and Save your Heart: 46 attendees 6/21/22 Are you walking around with a blood clot in your leg?: 16 attendees	Clinician presenters. Some webinars held during Go Red! month
Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Breast Cancer Screening Navigation:** Mather's Breast Cancer Screening Navigation program assists women who are overdue for a mammogram or who never had a mammogram to obtain recommended screening. A patient navigator helps women, including underserved women, to overcome barriers to screening such as language, lack of insurance, or lack of a provider. Through this assistance, breast cancer can be detected earlier when it is more treatable. The program, which collaborates with community partners to addresses disparities, has grant funding from DOH that ends in September 2022; Mather Hospital is working to continue and evolve the program to include navigation for screenings to other cancers such as colorectal and lung.	# women contacted, # women provided navigation, # screenings completed, # positive findings	In 2021, the screening navigator contacted 671 women and provided navigation services for 240 women. 211 screenings were completed and there were 6 positive findings. 2022 data to be completed.	Mather Hospital partners with Elsie Owens Health Center, Nightingale Preventive Care, and the Suffolk County Cancer Services Program to engage underserved women in screening.

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Cancer Service Program:** Mather Hospital helps to increase access to breast and colorectal cancer screening for underserved community members via participation in the Suffolk County Cancer Services Program. In addition, Mather has a Fund for Uninsured/Underinsured for Breast Center patients for services not eligible for CSP.	# CSP breast cancer screenings at Mather # CSP colorectal cancer screenings at Mather # Women assisted by Fund for Uninsured	9 CSP breast cancer screenings in 2021 (data for 2022 not yet available) 5 CSP colorectal cancer screenings in 2021 (data for 2022 not yet available) 17 women assisted by Fund for Uninsured in 2021 (data for 2022 not yet available)	Suffolk County Cancer Services Program, run out of Peconic Bay Medical Center. Mather also coordinates with its physician practice, Harbor View, to provide colorectal cancer screenings.

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Food As Health (FAH) Program:** A food distribution event was held at Comsewogue High School in Port Jefferson Station. Recipients were provided with bags of dairy products, fresh fruits and vegetables, a healthy meal kit, and information on local food pantries and soup kitchens. A collaboration with Northwell's Community and Population Health, Mather Hospital provided staff and supplies for the event, which provided families in an underserved area with nutritious food items that are more difficult for those impacted by food insecurity to obtain. **One off event**	# of bags distributed	At least 500 bags were distributed (one insulated bag with cold products such as milk and cheese, and one bag of fruits and vegetables per recipient).	Suffolk County Women's Alliance to End Food Insecurity partnered in holding the event. Internal Northwell's Community and Population Health and Mather team
Mather Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Food As Health (FAH) Program:** Mather Hospital provides discounted meals to Meals on Wheels, which delivers to homebound, handicapped, chronically ill, or convalescent persons in our community who are unable to prepare their own food. Mather Hospital's dietary department collaborates with Meals on Wheels each year to ensure homebound individuals receive two nutritious meals/day. Ongoing activity that happens throughout the year. **One off event**	# of meals provided, # of days served, # people served	In 2021, 11,018 meals were delivered to 62 community members through 5,509 deliveries. 2022 data not yet available.	This is a partnership with Three Village Meals on Wheels.

Mather Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Food As Health (FAH) Program:** Mather Hospital held a Thanksgiving Food Drive benefitting local food pantries. Food collection and distribution is coordinated by Social Work and assists organizations serving community members affected by food insecurity. In addition, Mather has promoted the Northwell virtual food drive. Event held every year at Thanksgiving. **One off event**	Estimated # of people served (receiving multiple food items), click throughs for emails promoting virtual food drive	75 people estimated to be served in 2021 with food items. 103 clicks onto food drive link in emails sent for virtual food drive.	Social Work runs the drive. Food is donated to local church pantries. The virtual food drive in 2021 that Mather promoted was a collaboration
Peconic Bay Medical Center	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Cancer Service Program:** When it comes to cancer, early detection saves lives. At Peconic Bay Medical Center, our Suffolk County Cancer Services Program is regionally acclaimed for its proactive approach to patient care. We are here for you through every step of the process, from initial screening through creating an individualized, state-of-the-art cancer treatment plan.	Screenings facilitated, Financial support provided, Community education events.	2020-21 statistics: 2,914 Screenings facilitated to uninsured men and women. $18,000 in financial support provided to 55 people. Community education events across Suffolk County to more than 1,000 people.	NYS Department of Health.
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Tai Chi for Arthritis and Balance Program**: is an ancient art form which has many proven therapeutic health benefits. This evidence-based program has been designed to help participants improve muscular strength and endurance, enhance flexibility and balance, and reduce falls.	Number of people who attended the events	16 classes completed at Riverhead Library	Riverhead Free Library and Suffolk County Department of Health.

South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	**Food as Health Program (FAH):** The Food As Health Program was created to help connect the patients health and nutrition to improve their overall wellness. This program offers the qualifying patients access to these onsite food pantry and community resources while they are in the hospital. The program's registered dietitian guides each patient to find the best food for their specific health needs, as well as provides them with healthy recipes and nutrition education based on their comorbid health condition (i.e. diabetes, hypertension, obesity, etc.). These patients are seen by the RD before discharge where an initial nutrition screening, nutrition education, healthy recipes, groceries, as well as assistance with governmental and community resources are provided. After discharge the RD will check-in two additional times over the next couple of months for questions about nutrition, community resources, and coordination of another grocery pick up.	Ethnicity Age Gender Town of Residence Comorbid Health Conditions(i.e. diabetes, hypertension, obesity, etc.) Community Resources Provided	• 708 SDoH screenings for food insecurity • 14% positive screens (14%) • 30% of screened patients newly enrolled this year	Hospital Team: Dietetic Interns Registered Dietitians Head Chef Social Workers/Case Management Interpreters Clinical Team Community Partners: Baldor- Donations of Fresh Produce US Foods- Donations of Non-Perishable Foods Stop & Shop Local Food Pantries Pronto Open Exchange Long Island Cares Mom's Meals NowPow Governmental and Health Agencies: SNAP Offices American Diabetes Association American Heart Association Stonybrook WIC Offices

South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	**The Diabetes Club:** provides current information and support to the community members living with Diabetes. Topics vary according to participants needs.	Number of participants enrolled	2021: Program was put on hold due to COVID. 2022: Number of participants enrolled; 7	SSUH Pharmacy provides educational lectures on antidiabetic medication.
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Stop the Bleed:** an initiative of the American College of Surgeons, was launched in October 2015 by the White House. It's a national awareness campaign and a call to action intended to educate, train and empower civilian bystanders with the necessary skills and tools to help in a bleeding emergency before professional help arrives. When a response is delayed, massive bleeding from any cause can result in death. Similar to how the general public learns and performs CPR, the public must learn proper bleeding control techniques, including how to use their hands, dressings and tourniquets	Number of participants enrolled	2021-90 participants 2022- 100 participants	American College of Surgeons
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Stepping On:** More than one out of four adults aged 65 or older falls each year, leading to both fatal and non-fatal injuries, and threatening safety and independence. Stepping On is an evidence-based community prevention program that empowers independent, older adults to carry out health behaviors that reduce the risks of falls. In a small group setting, older adults learn balance and strength exercises and develop specific knowledge and skills to prevent falls. Workshops are facilitated by trained leaders.	TBD	Postponed due to COVID - goal to restart in late 2022	Internal partners

South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 2: Physical activity	Goal 2.3: Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.	**The Arthritis Foundation Walk with Ease Program:** is an exercise program that is proven to reduce pain and improve overall health. If you can be on your feet for 10 minutes without increased pain, you can have success with Walk with Ease. Benefits: - Motivate yourself to get in great shape - Walk safely and comfortably - Improve your flexibility, strength and stamina - Reduce pain and feel great	Number of participants enrolled	Numbers are low due to COVID 18 Sessions- 10 participants	Arthritis Foundation
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Town of Babylon & Islip Sunscreen Program** – SSUH Sunscreen Program is an innovative way to provide preventive measures in the community for Skin Cancer. A total of more than 50 sunscreen dispensaries have been installed at Islip and Babylon Town parks and beaches thanks to a partnership with the Town of Islip & Babylon. The free SPF 30 broad spectrum sunscreen was stocked for all Long Islanders to use throughout the summer.	Number of people attended	2021 & 2022 May through September	Town of Babylon & Islip Creative Concepts
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	**Teaching Kitchens: Postponed due to COVID- Will resume 2022 Q4** Classes are an opportunity to learn how to shop for, utilize, and prepare healthy and delicious meals. Each class focuses on a different topic that includes a nutrition lesson provided by a dietitian followed by a live cooking demonstration with a SSUH professional chef. Food sampling and recipes are provided.	Number of classes held	Goal to restart the classes in 3/1/23	Partner with Pronto of Long Island and other local food pantries

South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	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	**Community Outreach and Health Education Council :** The Community Outreach and Health Education Council was established in 2015. Its mission is to strengthen partnerships to promote access to the highest quality healthcare, health literacy and wellness to improve the quality of life in all the communities SSUH serves.	Number of events completed	Postponed due to covid 3/2020 Goal to restart: 2022 Q4	Local Faith-Based Organizations and non-profits sit on this committee.
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	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	**Clinics on Fire Island:** Northwell Health immediate care centers are located in Ocean Beach, Cherry Grove and Saltaire on Fire Island. The facilities are open seven days a week from Memorial Day through Labor Day. The immediate care centers are staffed by a physician, physician's assistant or nurse practitioner. People can receive medical care for non-life threatening illnesses and injuries; for those who might need a higher level of medical care, they can call the emergency numbers and will be taken to South Shore University Hospital. After the summer season, the sites are utilized to provide free flu vaccines to Fire Island residents.	Number of patients visited	Events held: 7/22/2021, 7/23/2021, 7/24/2021, 7/15/2021, 7/16/2021, 7/26/2021, 7/23/2021, 7/24/2021 Total of 599 patients seen in 2021	Internal clinicians
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Jammin for the Community:** Northwell employees' partner with our community members to volunteer making Peanut Butter and Jelly sandwiches for those in need. At the close of 2019 the group was able to proudly share that they have made over 160,000 sandwiches.	Number of sandwiches given	2020-2022: Postponed due to Covid Estimated 3/1/23	Local Pantries

South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	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	**Blood Pressure Screenings:** SSUH partners with local Faith Based Organizations to provide Blood Pressure Screenings on the Northwell Bus.	Number of patients seen	2021 & 2022 over 100 participants	Internal clinicians
South Shore University Hospital	**Prevent Chronic Diseases**	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Skin Cancer Screening:** South Shore University Hospital partners with the local Faith Based Organizations to provide Skin Cancer screening on the Northwell Bus.	Number of referrals and visits	Skin Cancer screenings are offered yearly. 3 events. 72 participants, 6 referred	We partner with local Faith-Based organizations

Huntington Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Friendly Hospital Initiative:** The Dolan Family Health Center has been a NYSDOH Breastfeeding Friendly Practice since 2016. This includes: maintaining a breastfeeding-friendly office policy, training all staff to promote, support and protect breastfeeding, discontinuing the distribution of infant formula samples, creating a breastfeeding friendly environment, discussing breastfeeding benefits and management during the prenatal and postpartum periods, encouraging exclusive breastfeeding and providing support, assistance and education to breastfeeding mothers. An RN who provides nursing care in our OB/GYN department is an International Board Certified Lactation Consultant (IBCLC) and a Certified Pediatric NP who provides primary care in our Pediatric department is a Certified Lactation Counselor (CLC). The health center's ability to provide expert breastfeeding guidance and counseling to our patients is a tremendous asset in our continued effort to encourage our patients to exclusively breastfeed, emphasizing the benefits of the first and best nutrition available to babies. Prenatal patients were offered private breastfeeding educational/support sessions with our lactation specialists. Virtual breastfeeding visits via telephone and telehealth have been initiated and offered to our patients in light of COVID-19 practice changes.	# of enrolled patients	2021: All 276 enrolled prenatal patients received breastfeeding education as part of their prenatal care. 71 individualized breastfeeding educational sessions were held and documented in 2021. Providing individualized care is the priority for these women and their babies.	WIC (Suffolk county Dept of Health) program is onsite at Dolan and supports breastfeeding as well.
Huntington Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Reach Out and Read:** The Dolan Family Health Center participates in the Reach-Out-and-Read Program since 2000. This program links literacy with early pediatric visits. Pediatric health care providers provide parents/guardians with information about the importance of reading to their children and age/culturally appropriate books are given to children at well check-ups from six months to five years of age. In 2021, books were given to children of this age group at their 1,847 Complete Physical Exams.	Number of participants enrolled	In 2021, books were given to children of this age group at their 1,847 Complete Physical Exams	Reach-Out-and-Read

Huntington Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**School Supply Drive:** Dolan Family Health Center's Annual School Supply Drive was a Drive-Thru event on a Saturday morning in August, 2021. Dolan pediatric patients who completed their physical exams within the year were invited to participate in this outreach program. The majority of our patients identify as being in need of basic supplies and this event helps students start the school year prepared and confident. **One off event**	Number of backpacks distributed	452 filled backpacks were distributed during the school supply drive-thru at the end of August and during pediatric health center visits prior to school opening.	Donations from BAE, a local business funded the purchase of supplies. Northwell Health Eastern Region – Community Health supplied 50 of these filled backpacks.
Huntington Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Adopt-A-Family:** The Dolan Family Health Center organized the adoption and support for needy families during the December holiday season. Identified families received brand new warm clothing and winter footwear, supermarket gift cards, small kitchen appliances, toys, electronic devices and baby car items. All gifts were wrapped, labeled and presented to these families. **One off event**	Number of gifts distributed	15 Dolan Family Health Center families received holiday gifts by health center, Huntington Hospital and community members.	Huntington Hospital departments and units, Community physician offices

Mather Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 1: Maternal & Women's Health	Goal 1.1: Increase use of primary and preventive health care services among women of all ages, with special focus on women of reproductive age	**Restore, Nurture & Empower for Women (ReNew):** Restore, Nurture & Empower for Women (ReNew) offers alternative pain management to women as part of an integrative oncology clinic. Women are an underserved population when it comes to chronic pain. Alternative pain management strategies can prevent the need to prescribe opioids for pain, and thereby prevent opioid use disorder.	# participants, participant completion rate, participant satisfaction health related quality of life & well being HRQOL/WB-1.1 Increase the proportion of adults who self-report good or better physical health - National benchmark 79.8 (healthy people 2020) Defense and Veterans Pain Rating Scale (DVPRS) Functional outcomes for pain, sleep, mood, activity and stress	For the first two quarters of the project there were 30 intake appointments and 77 treatments. On participant surveys, 99.5% experienced enhanced wellbeing and 100% would recommend to someone with an active cancer diagnosis or a survivor, and 100% said they would continue to participate.	This project has grant support from the Katz Institute for Women's Health

Peconic Bay Medical Center	**Promote Healthy Women, Infants and Children**	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Friendly Hospital Initiative:** Baby Friendly Hospital Initiative and Designation is an ongoing quality assessment and improvement program focused on adhering to the 10 Steps to Successful Breastfeeding as advised by the WHO, NYS DOH, JCAHO and the accrediting body; Baby Friendly USA.	Number of events completed	11 events completed before end of 2022.	Partnership with Mastic Moriches Shirley Community Library.

South Shore University Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Friendly Hospital Initiative:** Baby Friendly Hospital Initiative and Designation is an ongoing quality assessment and improvement program focused on adhering to the 10 Steps to Successful Breastfeeding as advised by the WHO, NYS DOH, JCAHO and the accrediting body; Baby Friendly USA.	Our department tracks exclusive breastfeeding, skin to skin contact and breastfeeding initiation. Our exclusive breastfeeding rate continues to be one of the highest in the system at 46%.	We have been successfully designated a baby friendly hospital in 2021 and continue to track and monitor our measures for compliance. Our goal this year is to return to in-person postpartum breastfeeding support at our community Baby Cafe. We have been virtual since April of 2020 due to COVID.	We have partnered with SSUH leadership, pediatric and obstetrical physicians as well as our nursing staff for our in-patient measures. We have partnered with BFREE and the grant they received through NYS DOH to work with our community, specifically targeting low-income areas. We also have partnered with our physician partners in the out-patient setting to improve prenatal education and support.

South Shore University Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Born to Read:** Each year, SSUH partners with the national Born to Read Program, a family literacy promotion program offered to every newborn delivered at the hospital. Designed to empower parents to be their child's first teacher, handmade cloth bags are presented to the family, containing a book to be read to the child, a list of local libraries, a list of recommended reading to toddlers and preschoolers, and an application for English literacy. The program is available in both Spanish and English.	Number of newborns delivered at hospital	To date: 500 newborns	National Born to Read program
South Shore University Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**My Brother's Keeper (MBK) Program:** Brentwood Union Free School District, (BUFSD), the goal of increasing academic and social outcomes through mentoring, leadership development, college awareness and minimizing the gaps for young men of color. The MBK Community Challenge asks for communities to work with community leaders, educators, business leaders and youth development experts across sectors to design and implement action plans that expand opportunities for All young people; regardless of who they are, where they come from, or the circumstances into which they are born. 2020 & 2021- SSUH donated $4000 to purchase 8 laptops for 8 young men.	Number of participants enrolled	2020 & 2021- SSUH donated $4000 to purchase 8 laptops for 8 young men	My Brother's Keeper Brentwood High School

South Shore University Hospital	**Promote Healthy Women, Infants and Children**	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Distracted Driving:** Is a national injury prevention program focused on decreasing vehicular death and Injury. Reckless and distracted driving is the number 1 killer of teens in America. 4,000 teens die annually; 400K seriously injured; 100%preventable The program is high-energy and interactive, and they share real stories that connect with teens, empowering them with evidence-based strategies to keep themselves and others safe. We seek to change the culture of driving to one that is distraction-free – thereby saving lives not only in this generation, but in all future generations of drivers.	Number of participants enrolled	Events: Participants 04/06/21 : 41 04/07/21 : 50 04/19/21 : 49 04/22/21 : 38 10/01/21 : 53 Total: 5 events with a total of 231 participants	Hauppauge High School West Babylon High School
Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**Community Education- Opioid Use Disorder:** A webinar providing the community with education on opioid use disorder was held. Presented as part of Mather's HealthyU series of free community health education events, the recorded webinar is also available for viewing online. The webinar covered an overview of the opioid epidemic, the source of misused prescription opioids, the role of withdrawal and cravings in escalation, transition to heroin, fentanyl, the three Cs of addiction, signs your loved one is addicted, withdrawal symptoms, components of addiction treatment, finding treatment, overdose prevention, and where to get naloxone.	# of attendees, # of	The 3/1/22 webinar was attended by12 people. The webinar recording had 99 views as of 9/7/22.	Internal Clinicians

Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**NARCAN Training & Kit Distribution/to Prevent Opioid Overdoses:** Addresses Prevent Mental and Substance Use Disorders priority by educating community on opioid disorder and the use of naloxone to reverse opioid overdose. Narcan kits are distributed to participants. Trainings were provided both in-person and via webinar.	# of trainings, # of participants/kits distributed, program evaluations	Trainings provided on 2/3/22, 3/17/22, 4/12/22, 5/26/22, 6/9/22, 6/14/22, 6/21/22, 7/2/22, 7/7/22, 7/23/22, 8/23/22. Through August, 63 community members attended and received kits; this does not include trainings to be held in fall/winter 2022.	The June trainings were part of a Recovery, Resiliency and Hope series that included a collaboration with NAACP Brookhaven, and were held at the request of the EMSL Addiction Services Team in conjunction with their NIH grant.
Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	**Stress First Aid:** Mather Hospital is partnering with the Northwell Institute for Nursing and the Center for Traumatic Stress Resilience & Recovery to implement Stress First Aide, a peer support and self-care framework for managing stress. A Mather team is training all staff on SFA and otherwise supporting implementation. Employees learn to identify where they or their coworkers are on the stress continuum model, skills for intervening, and resources to draw on. Earlier identification and intervention is expected to prevent or reduce the burden of mental illness among health care workers.	# of employees trai	In 2022/2023, all employees will be trained in SFA either through in-person or remote sessions.	Mather's Behavioral Health department is leading the implementation of SFA at Mather with the support of Northwell's CTSRR & Institute for Nursing.

Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**Community Education- Opioid Use Disorder:** A webinar providing the community with education on opioid use disorder was held. Presented as part of Mather's HealthyU series of free community health education events, the recorded webinar is also available for viewing online. The webinar covered an overview of the opioid epidemic, the source of misused prescription opioids, the role of withdrawal and cravings in escalation, transition to heroin, fentanyl, the three Cs of addiction, signs your loved one is addicted, withdrawal symptoms, components of addiction treatment, finding treatment, overdose prevention, and where to get naloxone.	# of attendees, # of webinar recording views, webinar evaluations	The 3/1/22 webinar was attended by 12 people. The webinar recording had 99 views as of 9/7/22.	MD, Psychiatrists and Psychiatry Residents
Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population	**Behavioral Health Screening:** Mather Hospital offers free online mental health and substance abuse screening to the community as well as in-person screening for eating disorders. Screening participants are referred to resources. Online screening for mental health and substance abuse helps to address stigma and other barriers to care, increasing access for those needing services. Free screening for eating disorders is a vital service due to the scarcity of eating disorders programs in the community, connecting individuals to care who might not otherwise receive treatment.	# of online screenings completed, # of in person eating disorder screenings	Online MH/SA screenings: estimated at 150 based on past data Eating disorder screenings: estimated at 19 based on past data	Subscription with MindWise for online screening. Clinician conducts eating disorders screening.

Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages	**Emergency Department MAT/Referral for Opioid Disorder:** For individuals with opioid use disorder presenting in the Emergency Department, Mather Hospital offers Buprenorphine induction and referral to outpatient MAT (in conjunction with the Chemical Dependency Clinic's Intensive Outpatient Program). Access to outpatient MAT is a critical aspect of effective treatment for opioid disorder, and access to MAT is extremely limited in the community. This intervention offers an option to individuals recovering from an opioid overdose to engage in treatment that can help them break the cycle of addiction.	Number of Buprenorphine Inductions in ED Number of Referrals to Chemical Dependency in ED Number of Visits with Both Buprenorphine Inductions and a Referral to Chemical Dependency in ED	2021 data was as follows. 2022 data will be reported once complete. Number of Buprenorphine Inductions in ED: 181 Number of Referrals to Chemical Dependency in ED: 27 Number of Visits with Both Buprenorphine Inductions and a Referral to Chemical Dependency in ED: 6	Internal partners are Mather's Chemical Dependency Clinic and also the Emergency Department service line as this is a system initiative.
Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population	**SBIRT:** Mather Hospital screens patients for substance use disorder, ensuring community members receive treatment for SUD. Screening, Brief Intervention and Referral to Treatment (SBIRT) is conducted in inpatient, outpatient and Emergency Department care settings.	SBIRT # Including: SBIRT # Emergency Department SBIRT # Inpatient SBIRT # Outpatient	2021 numbers below. Will update with 2022 data when complete SBIRT # Total: 610 This includes: SBIRT # Emergency Department: 331 SBIRT # Inpatient: 203 SBIRT # Outpatient: 76	This was implemented in conjunction with DSRIP.
Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**Community Prescription Drug Collection:** Mather Hospital collects unused prescription drugs from community members for safe disposal. This limits access to drugs by community members who may have or develop a substance use disorder. Drugs can be dropped off in the main entrance of the hospital, and drug take back day events are held.	Pounds of drugs collected, # of clicks in email and social media promotions of prescription drug collection	370 pounds of drugs were collected in 2021;	Local law enforcement assists with drug take back days. Pharmacy assists with ongoing collection.

Mather Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages	**Outpatient BH Expansion:** Mather Hospital is engaged in a project to expand access to outpatient behavioral health services in the community and initiate evidence-based, patient centered care models. Partially funded by a NYS DOH Statewide Health Care Facilities Transformation II grant, the project will expand the adolescent psychiatric partial hospitalization program and establish a co-occurring disorders track, create a rapid access intake center to better serve individuals currently seeking behavioral health care in the Emergency Department, and increase Medication Assisted Treatment for individuals with opioid use disorder in conjunction with the Chemical Dependency Clinic's Intensive Outpatient Program.	Adolescent partial hospitalization increased by 10 additional program slots allowing 70% more visits annually. Decreased LOS on the adolescent psychiatric unit and Emergency Department. Rapid access intake center: 1,000 visits/year and a reduction in ED behavioral health visits of 25%. Annual MAT visits increased to 6,400 by year 3 and chemical dependency clinic volume increased by a third. Reduction in opioid admissions as a result of patients accessing MAT/IOP services.	N/A	The NYS Department of Health provided a $6.75 million grant towards the project. Foundation partnership is also making this project possible.

Peconic Bay Medical Center	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	**Caregivers Center**: Brick and mortar location in hospital and virtual workshops/resources provide family caregivers with information and comfort they need to help support them in their time as a caregiver.	Number of caregivers supported Amount of informational workshops Amount of support group sessions	Over 70 caregiver supported by social workers and caregiver coaches. Monthly "Tuesday Talks" detailing resources available to caregivers in the community. In person Caregivers support group meets 1st Wednesday of every month. Virtual Caregivers support group meets 1st Thursday of every month.	Partnerships with multiple local resources including elder law groups, nursing homes etc. (Peconic).
South Shore University Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	**Living Healthy:** Northwell Health's Chronic Disease Self-Management Program (CDSMP), is a 6-session, evidence-based health education program for people with any type of ongoing health problems. This program is designed to help people gain self-confidence in their ability to control their symptoms and manage how their health condition affects their lives.	Number of participants enrolled	Postponed due to COVID - goal to restart in 2023.	Community Engagement Network
South Shore University Hospital	**Promote Well-Being and Prevent Mental and Substance Use Disorders**	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	**Trauma Survivors Network:** Is a community of patients and survivors looking to connect with one another and rebuild their lives after a serious injury. The underlying goal of our resources and programs is to ensure the survivors of trauma a stable recovery and to connect those who share similar stories.	Number of participants enrolled	No activity in 2021	Internal partners


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