Good Samaritan Hospital Medical Center

Community Health Needs Assessment and Improvement Plan

2016-2018

Approved by the Board of Trustees October 4, 2016

Good Samaritan Hospital Medical Center
Catholic Health Services
At the heart of health

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Good Samaritan Hospital Medical Center

Suffolk County

Community Health Needs Assessment and Improvement Plan

2016-2018

Suffolk County Department of Health Services

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Catholic Health Services of Long Island

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

Northwell Health System

Huntington Hospital	270 Park Ave, Huntington, NY 11743
Peconic Bay Medical Center	1300 Roanoke Ave, Riverhead, NY 11901
Southside Hospital	301 E. Main Street, Bay Shore, NY 11706

Eastern Long Island Hospital	201 Manor Pl, Greenport, NY 11944
Brookhaven Memorial Hospital Medical Center	101 Hospital Rd, Patchogue, NY 11772
John T. Mather Memorial Hospital	75 N Country Rd, Port Jefferson, NY 11777
Southampton Hospital	240 Meeting House Ln, Southampton, NY 11968
Stony Brook University Hospital	101 Nicolls Rd, Stony Brook, NY 11794
Veterans Affairs Medical Center	79 Middleville Rd, Northport, NY 11768

The Long Island Health Collaborative is a coalition funded by the New York State Department of Health through the Population Health Improvement Grant. The LIHC provided oversight and management of the Community Health Needs Assessment processes, including data collection and analysis.

Executive Summary

In 2013, Hospitals and both County Departments of Health on Long Island convened to work collaboratively on the community health needs assessment. Over time, this syndicate grew into an expansive membership of academic partners, community-based organizations, physicians and other community leaders who hold a vested interest in improving community health and supporting the NYS Department of Health Prevention Agenda. Designated *The Long Island Health Collaborative*, this multi-disciplinary entity has been meeting monthly to work collectively toward improving health outcomes for Long Islanders. In 2015, the Long Island Health Collaborative was awarded the Population Health Improvement Program (PHIP) grant by the New York State Department of Health. The PHIP is a data-driven entity, pledged to pursue the New York State of Health's Prevention Agenda, making the program a natural driver for the Community Health Needs Assessment cycle.

In 2016, members of the Long Island Health Collaborative reviewed extensive data sets selected from both primary and secondary data sources to identify and confirm Prevention Agenda priorities for the 2016-2018 Community Health Needs Assessment Cycle. Data analysis efforts were coordinated through the Population Health Improvement Program, with the PHIP serving as the centralized data return and analysis hub. As directed by the data results, community partners selected *Chronic Disease* as the priority area with a focus on (1) obesity and (2) preventive care and management *for the* 2016-2018 cycle. The group also agreed that mental health should be highlighted within all intervention strategies. Mental health, is being addressed through attestation and visible commitment to the DSRIP, PPS Domain 4 projects (4.a.i, 4.a.ii, 4.a.iii). Priorities selected in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate mental health throughout intervention strategies. Mental health has been highlighted as a focus area of growing need, which will be addressed by the Nassau Queens Performing Provider System and Suffolk Care Collaborative, DSRIP Performing Provider Systems as they integrate Domain 4 projects

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey, qualitative data from Community-Based Organization Summit events and the LIHC Wellness survey. Secondary, publically-available data sets have been reviewed to determine change in health status and emerging issues within Suffolk County. Sources of secondary data include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor

Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics.

The PHIP staff is comprised of a Senior Director, Program Manager, Data Analyst and Communications Specialist. During assessment and implementation, this team will provide administration, consensus-building, collection, reporting and analysis of data and a neutral location for the Long Island Health Collaborative to convene on a monthly basis. Implementation plans that support the selected priority area for 2016-2018 will be leveraged using resources available with PHIP funding and through partnerships distinguished within the LIHC membership. The Long Island Health Collaborative is committed to utilizing the collective impact model to enhance the quality of work being pursued to meet Community Health Assessment and Implementation Plan requirements. Member organizations are entrenched in the communities in Suffolk County, and are thus able to engage community members in improvement strategies. Community-partners maintain vast networks of counterpart professionals, bringing an increased diversity and enhanced collective impact to the LIHC membership. For a full list of LIHC partners, see Appendix.

The broad community was engaged in assessment efforts through distribution and completion of the Prevention Agenda Community-Member Survey (Appendix). This tool was developed in consensus by community partners from the Long Island Health Collaborative and designed using the Prevention Agenda framework. Available in both online and hard copy format, this survey was translated into certified Latin American-Spanish language. LIHC community partners have displayed an exemplary commitment to distributing and promoting the survey to a diverse-range of community members at a variety of locations.

Distribution and promotion of this survey is occurring throughout a wide-range of social service locations including hospitals, doctor's offices, health departments, libraries, schools, insurance enrollment sites, community-based organizations and beyond. Long Island Health Collaborative member organizations are spearheading community engagement strategies by ensuring that their front-line service departments are handing surveys out to community members. In addition, member organizations have promoted the survey through social media efforts, posted links on their website and distributed surveys at health fairs and other consumer-oriented events.

To engage and prioritize the role of the community-based organizations in the Community Health Assessment, the Long Island Health Collaborative, driven by the Population Health Improvement Program, planned and executed two Summit Events for community-based organizations. Participation during these events was robust, with over 120 organizations represented between both summits. LIHC partners served as trained facilitators, volunteering their time, during "facilitated discussion" roundtables. Discussions were recorded and transcribed by court stenographers and analyzed using Atlas TI software to identify key themes.

With funding secured through the Population Health Improvement Plan, the Long Island Health Collaborative has been supported in leading initiatives focused on decreasing rates of Chronic Disease, specifically those diseases related to obesity and preventive care and management. Initiatives geared to address health disparities and barriers to care are vital to improving health outcomes in Suffolk County. Selected initiatives are supported and implemented by way of the LIHC network and discussed transparently at monthly Long Island Health Collaborative meetings. Long Island Health Collaborative sub-workgroups provide a focused-expertise and strategizing efforts surrounding the development of specific interventions, strategies and activities. LIHC sub-workgroup areas include: Public Education, Outreach and Community Engagement; Academia; Data; Nutrition and Wellness and Cultural Competency and Health Literacy. Sub-workgroup membership is growing continually, which adds to the high level of partnership and diversity of project efforts. Selection of initiatives is data-driven, supported by research and data in alignment with the Population Health Improvement Program's commitment to utilizing evidence-based strategies. PHIP-led initiatives support the NYS Prevention Agenda areas and include:

- "*Are You Ready, Feet?*™" physical activity/walkability campaign and walking portal
- Physician-driven *Recommendation for Walking Program*
- Evidence-Based Stanford Programs
- Mental Health First Aid USA™ Training, Evidence-based Program
- LIHC Wellness Survey to measure program efficiency
- Complete Streets Community and Policy Work
- Leverage PHIP resources to support two synergistic programs: Creating Healthy Schools and Communities, funded by NYS DOH and Eat Smart New York, funded by USDA

The LIPHIP short-term plan for evaluation will begin with extensive qualitative data collection and analysis. We are particularly interested in the degree to which member organizations are collaborating and direct

feedback from community members and member organizations. Process measures include:

- Progress and involvement of various PHIP projects resulting from collaboration and member engagement
- Feedback from partner organizations regarding the benefit of PHIP structure and how PHIP funding has impacted the health landscape
- Primary concerns and community needs voiced by community members via Community Survey
- Areas of need identified by community based organizations during Summit Events
- Emergence of policies supporting collaboration to improve population health and well-being
- Quality of partnership between NYS reform initiatives including DSRIP, SHIP, Prevention Agenda and SHINY

Specific quantitative measures will be analyzed to assess the reach of our various projects within the communities on Long Island.

- Number and organizations from various health sectors that participate and attend LIPHIP meetings and projects
- Reach of organizations and community members through social media, website and additional communications strategies
- How many community members participate in the LIPHIP walking program "*Are you ready, feet?*™" and subsequent data surrounding adaptation of healthy behavior
- Impact of programs that address healthy eating, physical activity, physiological well-being and responsible health practices through evaluation of LIHC wellness survey portal data
- Analysis of results from Prevention Agenda Community Member Survey and second quarter update
- Growth in number of evidence-based Stanford programs being conducted as a result of link between HRH Care, RSVP and LIPHIP
- Improvement in preventable admission and preventable visit data utilizing 3M software
- Hot spotting to identify areas of greater socio-economic need in the Long Island region

What is Population Health?

Population health is an approach to understanding and improving the health of communities. It focuses on health outcomes of groups of individuals. Through population health, care is best delivered when it is well-coordinated between more than just patients and doctors, or patients and hospitals. It needs to reach into the communities where people live, work and play. Coordinated care involved a healthcare team- physicians, nurses, nurse practitioners, physician assistants, pharmacists, physical therapists, home health aides, social service providers and anyone else who tends to patients' needs that extend beyond traditional healthcare. Employment, education, housing, transportation service, along with access to affordable foods and opportunities for physical activity hold as much of an influence on patients' health outcomes as do medical treatments and interventions. Collectively, patient by patient, these factors play a role in getting and keeping the Long Island population healthy.

The Long Island Health Collaborative

The Long Island Health Collaborative (LIHC) is the hub of population health activities on Long Island. The Nassau County Community Health Improvement Plan was created in partnership with community agencies based on priorities determined by the Long Island Health Collaborative. The Long Island Health Collaborative (LIHC) is an extensive workgroup of committed partners who agree to work together to improve the health of Long Islanders. LIHC members include both county health departments, all hospitals on Long Island, community-based health and social service organizations, academic institutions, health plans and local municipalities, among other sectors. The LIHC was formed in 2013 by hospitals and the Health Departments of Suffolk and Nassau Counties with the assistance of the Nassau-Suffolk Hospital Council to develop and implement a Community Health Improvement Plan. In 2015, the LIHC was awarded funding from New York State Department of Health as a regional Population-Health Improvement Program (PHIP). With this funding, we have been able to launch various projects that promote the concept of population health among all sectors, the media and to the public. Our monthly meetings serve as an outlet for member organizations to network, identify opportunities for collaboration, and leverage resources.

Local health departments, hospitals and the Long Island Health Collaborative will work to engage community-based organizations and community members. The PHIP staff members will take a leadership role in compilation, analysis and interpretation of primary data collection and will write County template-documents.

Community Served

This assessment covers Suffolk County, New York. Suffolk County's service area is situated east of the Nassau County Border, extending through the eastern forks of Long Island. It comprises ten towns: Babylon, Huntington, Islip, Smithtown, Brookhaven, Southampton, Riverhead, East Hampton, Shelter Island and Southold. Suffolk County is an area of growing diversity, cultures and population characteristics.

Data presented within this report will demonstrate the existence of vast health disparities stemming from a wide range of socioeconomic factors. Our findings indicate the reality of the linkage of health disparities to a variety of social factors including race, ethnicity, gender, language, age, disabilities, and financial security among others. Elimination of such disparities is a priority throughout the Long Island region as bridging of gaps and services will ultimately improve health outcomes and quality of life for community members.

Founded in 1959, Good Samaritan Hospital Medical Center is a 437-bed not-for-profit, acute care community hospital. Good Samaritan Hospital Medical Center serves a broad geographic area covering western Suffolk County's South Shore and part of southeastern Nassau County, a region that is home to more than 850,000 individuals.

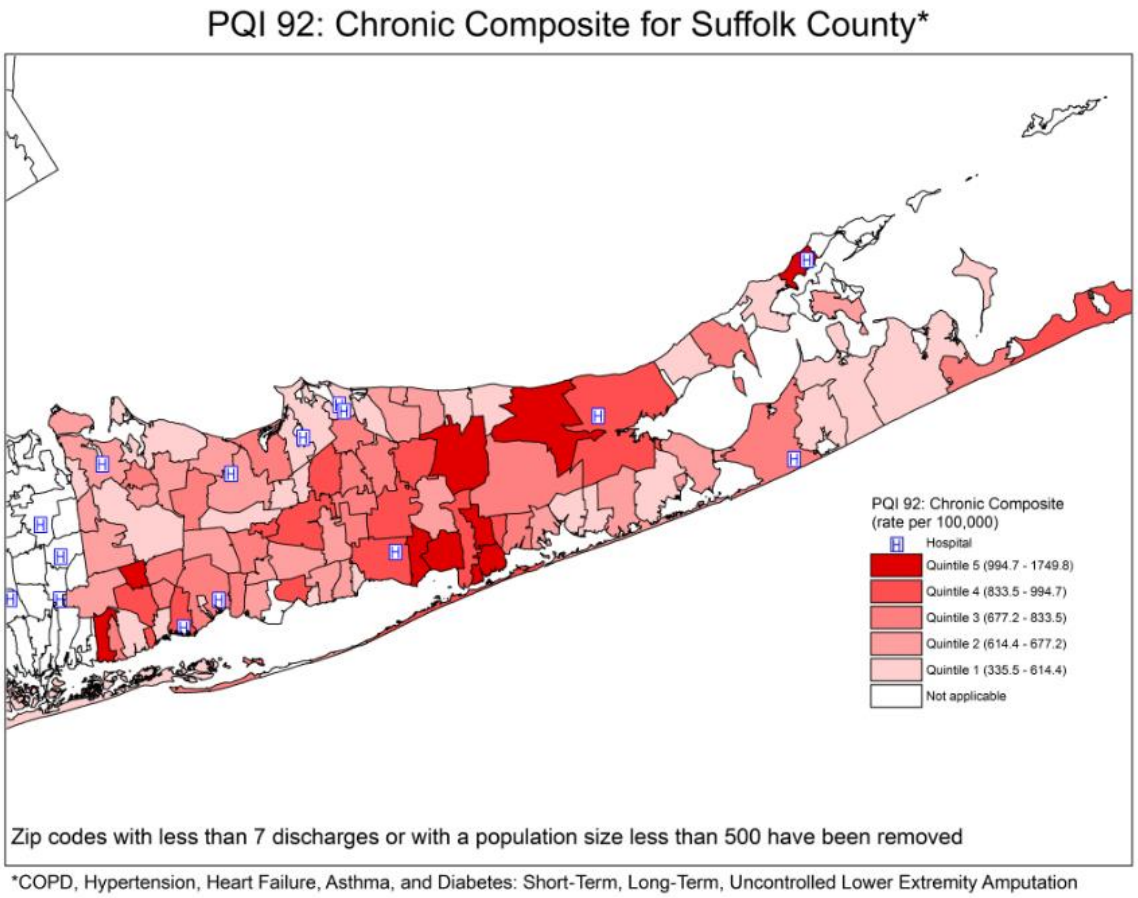
Data Findings

Prevention Quality Indicators

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

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

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



**Source: Agency for Healthcare Research and Quality-Prevention Quality Indicators (http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx)*

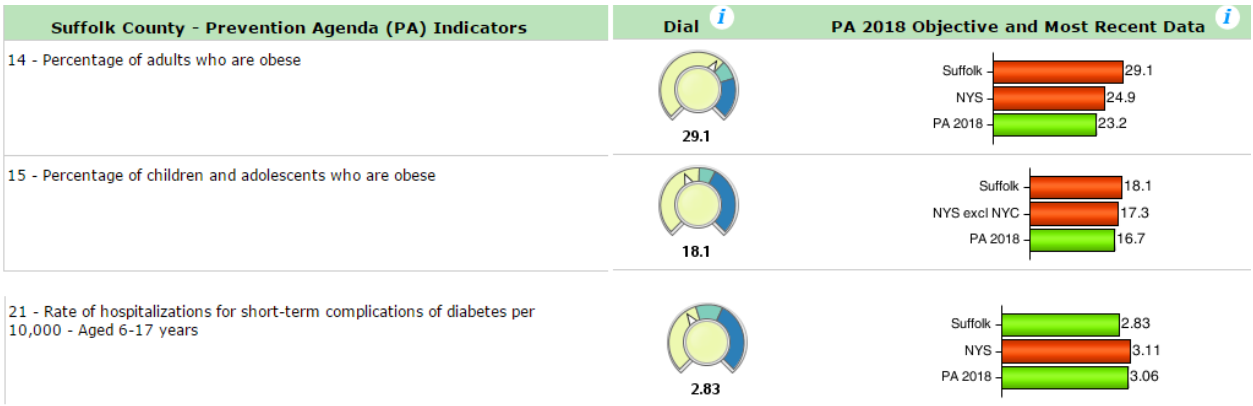
*Prevention Agenda Dashboard**

The Prevention Agenda 2013-2018 is New York State's Health Improvement plan purposed to improve health outcomes and reduce health disparities within five priority areas: Chronic Disease Prevention, Healthy and Safe Environment, Prevention of HIV/STD, Vaccine Preventable Disease and Healthcare-Associated Infections, Promote Healthy Women, Infants and Children and Promote Mental Health and Prevention substance abuse.

Within the dashboard, review of 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System, demonstrates 29.1% of adults in Suffolk County are obese. Obesity rates are higher than figures reported by New York State, 24.9% and the Prevention Agenda Goal of 23.2%. The Long Island Health Collaborative felt interventions should be focused on decreasing chronic disease as a whole, while focusing on obesity, prevention and care management.

The percentage of children and adolescents who are obese in Suffolk County is 18.1% as compared to New York State (and excluding New York City) figure of 17.3%. The Long Island Health Collaborative has declared commitment to reaching the Prevention Agenda 2018 goal of 6.7% or lower.

Rate of hospitalizations for short-term complication of diabetes reflects 2.83 per 10,000 for adults in Suffolk County and 3.11 in New York State. Although this indicator is below the Prevention Agenda Goal of 3.06%, Long Island Health Collaborative emphasized a need for focus on high utilizing pockets within the County with further room for improvement.



** Source: Prevention Agenda 2013-2018: New York State's Health Improvement Plan (https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/)*

Long Island Community Health Assessment Survey

To collect input from community members, and measure the community-perspective as to the biggest health issues in Suffolk County, the LIHC developed a regional survey called the Long Island Community Health Assessment Survey. This survey was distributed via SurveyMonkey® and hard copy formats. The survey was written with

adherence to Culturally and Linguistically Appropriate Standards (CLAS). It was translated into certified Spanish language and large print copies were available to those living with vision impairment. Survey distribution began among LIHC members in January 2016, with over 3,254 surveys collected from Suffolk County residents. Based upon the total population of Suffolk County, survey totals assume a confidence level of 95% and confidence interval of 1.75. Initial analysis took place in March 2016, with a secondary analysis scheduled to occur in June. LIHC members have played an integral role in ensuring surveys are distributed while maintaining validity and reliability among responses. To view a copy of the Long Island Community Health Assessment Survey, see Appendix.

Methodology:

Long Island Community Health Assessment Surveys are being distributed both by paper, and electronically through SurveyMonkey®, to community members. The electronic version is directed by software that places rules on particular questions; for questions 1-5 an individual could select 3 choices and each question was mandatory. Although the rules were written on the paper survey people did not consistently follow them. The paper surveys were sorted into two piles: "rules" and "no rules". The surveys declared "rules" were entered into the SurveyMonkey® collector while those "no rules" were entered into a separate, non-public survey where any number of answers could be selected and others could be skipped.

On March 21, 2016 and June 2, 2016, the PHIP data analyst downloaded results from each of the SurveyMonkey® collectors. The "no-rules" surveys were weighted to ensure survey response validity for those with more than three responses. The weight for each response was 3/x where x is the count of responses. No weight was applied to responses with less than 3 because they had the option to select more and chose not to do so. With the weight determined we applied the formula to the "no rules" data and then added the remaining collectors to the spreadsheet.

Data Findings by Survey Question:

1. When asked ***what the biggest ongoing health concerns in the community where you live are***:
    - Suffolk County respondents agreed that drugs and alcohol abuse, cancer and obesity/weight loss were the top three concerns.
    - These three choices represented roughly 46% of the total responses.

2. When asked ***what the biggest ongoing health concerns for yourself are:***
    - Suffolk County respondents agreed that obesity/weight loss, women's health and wellness and cancer were the top three concerns.
    - These three choices represented roughly 40% of the total responses.

Findings from Questions 1 and 2 of the Long Island Community Health Assessment Survey served as one data-driver for selection of the priority areas for the 2016-2018 Community Health Needs Assessments. An additional focus of this survey tool explored barriers to care, community needs and education or health services.

3. The next question sought to ***identify potential barriers that people face when getting medical treatment***:
    - Suffolk County respondents felt that no insurance, inability to pay co-pays or deductibles and fear were the most significant barriers.
    - These choices received roughly 55% of the total responses.
4. When asked ***what was most needed to improve the health of your community:***
    - Suffolk County respondents felt that drug and alcohol rehabilitation services, healthier food choices, and job opportunities were most needed.
    - These choices accounted for 40% of the total responses.
5. When asked ***what health screenings or education services are needed in your community***:
    - Suffolk County respondents felt that drug and alcohol, mental health/depression, and exercise/physical activity services were most needed.

CBO Summit Event Qualitative Data Analysis and Interpretation

To measure professional expertise from representatives working directly within the community setting, LIHC members planned two summit events for representatives from Community-Based Organizations. An advisory committee was established to provide oversight and strategic planning of these events. Advisory committee members included leaders in health from stakeholder organizations, primarily Long Island Health Collaborative (LIHC) members, who hold a vested interest in the outcome of community improvement strategies and identification

of primary areas of need. Of this committee, two members participated as key leaders, holding extensive backgrounds in qualitative research and facilitation. These key leaders presented an interactive, hands-on curriculum and training for LIHC members who volunteered to take the role of facilitators during the events.

The Suffolk County summit event took place February 10, 2016 at St. Joseph's College in Patchogue, NY. Attendance was robust, with 72 organizations in representation at the Suffolk County Event. Regionally, 119 organizations participated, which contributed to the diversity and breadth of qualitative data collected during events. Seating assignment of participants at facilitated discussion tables was randomized, with seven to twelve participants seated at a table. After permission was granted by participants, they were guided through scripted-facilitated discussion by a trained facilitator. Discussions were recorded and transcribed by certified court reporters.

Data Collection Tool

A script for facilitators was developed and used as our primary data collection tool. Adapted from the Nassau County Department of Health's Key Informant Interview script, this tool was revised to meet a facilitated discussion format. Questions were composed thoughtfully as to evoke an inherent response at first and then expanded upon to encourage digging deeper to obtain a more focused response. Questions pertain to health problems and concerns, health disparities, barriers to care, services available and opportunities for improvement.

Court reporters were positioned at each table during the event to capture conversations accurately. Post-event, transcriptions were transcribed and provided to us in Microsoft Office Word document format. To view a copy of the Facilitator Script, see Appendix.

Data Analysis

ATLAS TI Qualitative Data Analysis software was used to guide and structure analysis process. Members of the Qualitative Analysis team discussed strategy and logistics of project from beginning to completion of report. The analysis team's diversity boasts a wide range of analytic skill. The Principal Research Analyst at Data Gen Inc. served as the lead analyst on this project, during which time she offered expertise on strategy, direction, running qualitative data through Atlas TI software, producing meaningful synthesis of data elements and assisting in the description of the team's methodology. The Atlas TI word-cruncher feature was used within Atlas TI to identify town names (Hempstead, Wyandanch, etc.) spoken in vivo in order to assign the appropriate county flags. If a bi-county

organization specifically spoke about an issue within one of these communities, the quote was coded with the county in which that community lies. If the name of the town was being used as a figure of speech without a specific comment or anecdote about the community, the flags were not applied.

The strategy for selection of codes was multi-layered to ensure all themes were included within the code-list. Key terminology from the New York State Prevention Agenda blueprint (Source: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/) was selected and applied. In addition, in vivo verbiage was taken directly from each transcript. Reading through each transcript and identifying words spoken in vivo (during the event) allowed the analysis team to compile a comprehensive list of selection codes.

Summary of Findings

The *Distinct* and *Cumulative* Prevention Areas by ranking tables, displayed below, outline the New York State Prevention Agenda Priority Areas ranked in order from highest to lowest rate of marked significance of concern among participants.

Summit participants reported chronic disease as the most significant health problem seen within the communities they serve in Suffolk County. In looking at distinct Prevention Agenda Categories, 30.9% of quotations indicated chronic disease being a priority area.

Distinct Prevention Areas by Ranking reflects the number of quotations where the focus area is mentioned at least once and counted once, divided by the total number of Suffolk County quotes.
e.g. "*Chronic Disease is a problem for the community I serve. Many of our members are troubled with obesity and tobacco use*" This quote is coded once for chronic disease.

PA Rank	Suffolk	%*
1	**Chronic Disease**	**30.9%**
2	**Mental Health**	**29.9%**
3	**Healthy and Safe Environment**	**25.4%**
4	**Healthy Women, Infants and Children**	**13.2%**
5	**HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections**	**9.4%**

*** Distinct number of quotations with Suffolk County code and priority area code/total number of quotes applicable to Suffolk County**

Within the priority area of chronic disease, chronic disease management and obesity/nutrition were the most frequently prioritized focal areas. Of the total number of quotes by County, 10.2% of quotations included “Chronic Disease Management” and “Obesity/Nutrition” equally, as topics of importance.

Chronic Disease	
Focus Area	**%***
Chronic Disease Management	10.2%
Obesity/Nutrition	10.2%
Chronic Disease Prevention	7.9%
Diabetes	5.2%
Cancer	4.0%
Other Chronic Conditions	3.9%
Cardiovascular	3.8%
Respiratory	3.6%
Smoking/Tobacco	3.3%

*** Number of quotations with Suffolk county code and focus area code/total number of quotes applicable to Suffolk County**

Analytic Interpretation & Participant Quotations
Chronic Disease is a significant health problem for community members in Suffolk County. Prevention and management of chronic conditions should be a priority for those looking to improve quality of live and improve health outcomes. Furthermore, the prevalence of obesity exacerbates chronic disease and mental health problems. Prevention and effective management of Chronic Disease must occur in order to improve quality of life for community members and to reduce the financial burden being placed on our health care system. I can tell you that we have lots of issues, but if we do not get a hold of our chronic diseases, our chronic problems, our heart problems, our COPD, our obesity. *-Suffolk Event, RN Nurses Evolve PLLC* In Suffolk, I believe that obesity is a huge underlying issue for many chronic medical conditions. The asthma. The high blood pressure. The diabetes. It even can affect mental health with children, with teens. If you have someone who is obese, it affects them socially and emotionally. So addressing obesity is a big issue to affect all the other chronic health conditions that people have. Preventative care, I think if people had more access to preventative care and management, it may reduce the incidents of obesity and reduce some of the other chronic issues. *-Suffolk County Department of Health, Maternal Infant Community Health Collaborative*
The sale and use of electronic cigarettes and hookahs are trending in youthful populations. This trend has added a challenge to strategies focused on smoking reduction. Smoking rates among those living with mental illness have not subsided and targeted resources will be needed to provide assistance. I am very passionate about helping to advocate, changing laws about tobacco use, and helping people to quit smoking, and we do have many dispar populations. Fortunately for us, the rates are going down, however there are new issues coming up, electronic cigarettes, hookah, and kids are starting to pick up those e-cigs, so whenever we feel like we’ve got something done, it’s like we take two steps back. So I enjoy the challenge of working against the tobacco industry to try to keep on top of it, and to help people who are addicted, mentally ill, substance abuse, very high rates of smoking, they are not getting the help that they need, so advocating for them for more resources to be able to quit smoking is very important. *-American Lung Association*
Education focused on healthy eating, chronic disease management or physical activity must be culturally competent and of health literate standards to properly engage the diverse spectrum of community members living in Suffolk County.

Nutrition related diseases, whether it be high blood pressure, diabetes, these are things, even just educating people how to, when they're receiving SNAP, what type of items to buy. Cultural diversity, just having, you know, staff in each facility trained on just the cultural needs of different populations. I see a lot of -- there's a big gap sometimes when someone comes in and speaks another language, and how do you help that person that speaks another language and, like you said, may not be able to even read or write in their own language, so I think a lot of it is just having staff that's educated and more well-rounded to provide those type of service to people that need that direction.
-Long Island Cares

Many cases of COPD and lung cancer are not diagnosed until the condition has progressed into its later stages. Awareness and education surrounding the importance of screenings, for any chronic condition, leads to early diagnosis and thus more effective treatment.

Challenges that we see are people who have been smokers for many years. COPD in particular, probably half the cases that are out there, have not been diagnosed yet. People just feel that oh im a little older, Im a little short of breath, until acute exacerbation and they end up in the hospital with pneumonia and then they are diagnosed. Very similarly, lung cancer, there are no early warning signs for lung cancer. Because women just don't think about it. So we are trying to get them to understand that if you are at risk, get screened. Early screening is very important. We know that lung cancer has huge fatality rates; it's the number one cancer killer in the US for both men and women. Because there is no early warning signs and no screening. So we are really starting to build the push on educating the community about early warning signs, getting screenings for both.
-American Lung Association

The priority area of mental health and substance abuse emerged closely as a second-ranking topic of importance. Qualitative analysis demonstrated, 29.9% of quotations indicating mental health as an area of concern in Suffolk County. Cumulatively, 47.9% of quotations included mental health and substance abuse as an area of concern within communities served in Suffolk County.

Upon further breakdown of the focus areas within the overarching priority area of mental health and substance abuse, "Mental Health Issues", including behavioral, developmental, poor mental health, emerged at the forefront with 18.1% of quotations in Suffolk County. A second focus area, "Substance Abuse", appeared with 11.3% of quotations containing related key words.

Mental Health and Substance Abuse	
Focus Area	**%***
Mental Health Issues	18.1%
Substance Abuse	11.3%
Susceptible Populations	7.4%
Attitudes	4.1%
Anxiety, Mood Disorders, and Associated Emotions	2.9%
Treatment and Recovery	2.7%
Eating Disorders	0.9%
Suicide	0.4%

*** Number of quotations with Suffolk county code and focus area code/total number of quotes applicable to Suffolk County**

Analytic Interpretation & Participant Quotations
Availability of mental health and substance abuse treatment and recovery services is not adequate considering the high demand for service. Prevention and strategies focused on maintaining follow-up care for mental health are equally important. . . . The major issue is the long waiting list and by the time that their appointment comes up they're no longer with us and they fall through the cracks. We don't know where they're going. We don't know if someone is going to follow up so that's part of, you know that lack of prevention as well. It's a long waiting list just to get psych evaluations. *- Community Housing Innovations*
Mental health problems for seniors are often undiagnosed which leads to an inability to provide effective treatments or therapies. When you first mentioned the question about the major health problems, I work in independent housing for seniors, and there are a lot of undiagnosed mental health issues. So they have the mental health, but it's never been diagnosed, and getting the services and the treatment and even medications for that generation becomes very hard. *- Catholic Charities Housing Department*
Substance abuse is a notable problem throughout the Long Island Region. Substance abuse is often recognized within diverse populations including young adults, seniors and Veterans. Talking about specific health concerns, so one of the things we're really looking at the specific health concerns. I think the number on Long Island is over 300 young people are dying a year from heroin overdose. So that's the equivalent of a jumbo jet liner crashing and everybody dying, once a year on Long Island. So if that were to happen, we would be outraged. There would be more of a policy outrage, of why is this happening? So my boss is actually a priest, and he buries a lot of these young people who die every year, so that's really a major push for us. It's criminal. We're not talking about the traditional, you smoke pot, and you move onto a higher drug, a different drug, we're talking prescription medication to heroin overdose to death, within a couple of years. So that's one of the main focuses we're working on. *-Hope House* One of the things, it's a hidden secret is the substance abuse among seniors, you know due to the isolation, but also too there's a lot of seniors that are sitting at home drinking all day and so it is not just a young person or, you know, a middle adult issue, it's a very big issue for seniors. *- At Home Designs*
The relationship between chronic disease and mental health presents care providers with complex challenges related to the interplay between conditions and medication regimen. Mental issues and substance abuse issues, but what comes with that sometimes is obesity, diabetes, high blood pressure. Often times it's the medications that are prescribed Proceedings and that people take actually can cause diabetes and cause people to increase their appetite, and that's the domino effect. Those are many of the health issues. Obviously, for the older population, chronic heart disease, COPD. *-Association for Mental Health and Wellness*

LIHC Wellness Survey

To measure the effectiveness of community wellness programs, the Long Island Health Collaborative, in partnership with leadership from Stony Brook University, developed a survey and HIPAA compliant, web-based Wellness Portal. The evidence-based survey tool, adapted from the Self-Rated Abilities for Health Practices Scale (SRAHP) can be used to collect pre and post program data from participants on healthy eating, physical activity, physiological well

being and responsible health practices. Once data is collected, users enter de-identified information into the portal. The PHIP team provides individualized data for participating organizations.

Good Samaritan Hospital also gathers data using the LIHC Community Health Needs Assessment survey collected from community members at public events, programs and free lectures offered by the hospital. Using the LIHC Community Member Survey Summary of Findings, Good Samaritan Hospital reviewed the data for January 1, 2016 to June 30, 2016 for the hospital's service area by selected zip codes. Below are the findings for Good Samaritan Hospital:

1. What are the biggest ongoing health concerns in the community where you live?
    - Drug & alcohol abuse 41.66%
    - Cancer 35.84%
    - Obesity/weight-loss issues 26.28%
    - Mental health depression/suicide 24.32%
    - Diabetes 22.74%
    - Heart disease & stroke 19.94%
    - Safety 15.09%
    - Asthma/lung disease 11.89%
    - Child health & wellness 11.29%
    - Environmental hazards 10.94%
    - Women's health & wellness 10.02%
    - HIV/AIDS & Sexually Transmitted Diseases (STD) 5.50%
    - Vaccine preventable diseases 3.51%

2. What are the biggest ongoing health concerns for yourself?
    - Obesity/weight-loss issues 28.24%
    - Women's health & wellness 27.32%
    - Cancer 25.91%
    - Heart disease & stroke 25.23%
    - Diabetes 21.18%
    - Mental health depression/suicide 16.36%
    - Safety 14.20%
    - Asthma/lung disease 12.85%
    - Environmental hazards 11.34%
    - Drugs & alcohol abuse 9.02%
    - Child health & wellness 8.83%
    - Vaccine preventable diseases 4.39%
    - HIV/Aids/sexually transmitted disease 3.48%

3. What prevents people in your community from getting medical treatment?
    - No insurance 47.95%
    - Unable to pay co-pays/deductibles 42.82%
    - Fear 31.13%
    - Transportation 21.04%
    - Don't understand need to see a doctor 18.98%
    - Language barriers 14.47%
    - There are no barriers 12.47%

- Don’t know how to find doctors 9.43%
- Lack of availability of doctors 7.97%
- Cultural/religious beliefs 5.57%

4. Which of the following is the MOST needed to improve the health of your community?
    - Drug and alcohol rehabilitation services 31.92%
    - Healthier food choices 29.79%
    - Job opportunities 29.52%
    - Mental health services 24.49%
    - Clean air and water 21.49%
    - Transportation 16.95%
    - Safe places to walk/play 16.52%
    - Weight-loss programs 14.86%
    - Recreation facilities 14.41%
    - Smoking cessation programs 14.07%
    - Safe childcare options 10.94%
    - Safe worksites 5.73%

5. What health screenings or education/information services are needed in your community?
    - Drug and alcohol 26.57%
    - Mental health/depression 23.36%
    - Cancer 21.11%
    - Importance of routine well checkups 20.94%
    - Nutrition 20.64%
    - Exercise/physical activity 20.58%
    - Diabetes 19.49%
    - Blood pressure 19.00%
    - Cholesterol 11.96%
    - Dental screenings 11.64%
    - Heart disease 11.02%
    - Emergency preparedness 10.45%
    - Suicide prevention 7.38%
    - Eating disorders 6.75%
    - HIV/AIDS/STDs 6.20%
    - Vaccination/immunizations 5.32%
    - Disease outbreak information 4.68%
    - Prenatal care 3.51%

6. I identify as:
    - Female 70.58%
    - Male 29.24%
    - Other 0.18%

7. Average age of respondents: 48

8. What race do you consider yourself?
    - White/Caucasian 85.73%
    - Black/African-American 8.92%
    - Multi-racial 3.12%
    - Native American 0.17%
    - Asian/Pacific Islander 0.15%

9. Are you Hispanic or Latino?
    - No 72.37%
    - Yes 20.09%
    - No answer 7.54%

10. What is your annual household income from all sources?
    - $0-$19,999 20.80%
    - $20,000-$34,999 15.19%
    - $35,000-$49,999 8.87%
    - $50,000-$74,999 13.56%
    - $75,000-$125,000 24.58%
    - >$125,000 17.01%

11. What is your highest level of education?
    - College graduate 26.22%
    - High school graduate 21.17%
    - Some college 19.46%
    - Some high school 6.33%
    - Technical school 5.41%
    - Other (Nursing school, GED) 3.73%
    - K-8 grade 2.37%
    - Doctorate 2.13%
    - Graduate school 1.60%

12. What is your current employment status?
    - Employed for wages 56.63%
    - Retired 18.59%
    - Out of work/looking for work 8.04%
    - Out of work, but not currently looking 6.63%
    - Self-employed 6.50%
    - Student 3.50%
    - Military 0.01%

13. Do you currently have health insurance?
    - Yes 90.00%
    - No 7.72%
    - No, but I did in the past 2.29%

For the 2016-2018 cycle, community partners selected *Chronic Disease* as the priority area of focus with (1) obesity and (2) preventive care and management as the focus areas. The group also agreed that mental health should be highlighted within all intervention strategies. Mental health is being addressed through attestation and visible commitment to the Delivery System Reform Incentive Payment (DSRIP), Performing Provider Systems (PPS) Domain 4 projects. Priorities selected in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate mental health throughout the intervention strategies. Domain 4 projects with a focus on mental health include:

- Project 4.a.i Promote mental, emotional and behavioral (MED) well-being in communities
- Project 4.a.ii Prevent substance abuse and other mental emotional disorders

- Project 4.a.iii Strengthen mental health and substance abuse infrastructure across systems
- Project 4.b.i Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health

Hospital partners are fully attested and active participants in DSRIP project and deliverables, thus supporting the emphasis being placed on improving outcomes related to mental health.

Long Island Health Collaborative Driven Interventions, Strategies and Activities

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Engage community members in regional physical activity and wellness campaigns	*1. Increase community and partner engagement through social media tactics* *2. Promote the Are you Ready, Feet?™ Campaign within community networks and increase participation in this region-wide physical activity campaign* *3. Launch a consumer-facing website, adherent to CLAS standards and achieve meaningful web analytics* *4. Launch a volunteer working group of student volunteers who will leverage social media expertise and existing personal networks to further engage community members* *5. Host at least two public, consumer-focused walking events annually* *6. Reach and implement the recommendation for walking program within the primary care setting and engage participating physicians.*	*1. Social media reach* *2. Engage community members in Are you Ready, Feet?™ Campaign* *3. Provide consumer-facing information on LIHC webpage* *4. Establish LIHC Engagement Activation Partnership (LEAP)* *5. Host community walking events* *6. Establish physician Recommendation for Walking Program*	*1. Identify and participate in effective social media strategies and promote the LIHC to consumers* *2. Develop and distribute promotional tools; engage participants via social media strategies* *3. Identify evidence-based resources for health information that adhere to CLAS standards, collect input from LIHC members and clinical experts and build website.* *4.. Promote opportunity among networks, identify role and responsibility, and support LEAP team as they carry out goals and objectives.* *5. Involve key leaders including State and County officials, identify dates, locations and promote events.* *6. Coordinate mailing to Long Island providers, work with Nassau County Medical Society to build program reputation, distribute mock-prescription pads to members for distribution*	*Hospital will build a link to the LIHC on the website.* *Hospital will also promote via Facebook and Twitter.* *Hospital will participate and involve its networking contacts to identify evidence-based health information resources that meet standards.* *Hospital will remain active in LIHC to assist in county and state-wide efforts to promote a healthy Long Island.* *We will include providers in our wellness outreach initiatives.*	*Hospital website* *Hospital social media resources* *Will distribute "Are you ready feet?" cards at Outreach sites and to patients in Cardiac Rehabilitation.* *Hospital hosts a walking event at our annual Moving in May event, and sends a team of employees and patients to the Long Island American Heart Association walk, the Making Strides Against Breast Cancer walk, and the LI Marcum Challenge, Good Sam has a bike team at the Wounded Warrior Soldier Ride.* *CHS will have a team at the second annual Suffolk County Marathon.* *Hospital will send staff member to LIHC meetings and remain active with initiatives.* *Hospital will engage Medical Affairs Department in promoting walking program.*	*The Population Health Improvement Program was initially established as a two-year program. In 2016, funding from New York State Department of Health was secured through January 2018, extending the program to three years.* *Activities will continue on an ongoing basis throughout this time. The Plan-Do-Study-Act (PDSA) framework will be used to evaluate the need for change within intervention strategies*.* *Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.*	*All LIHC activities are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they are CLAS appropriate and meet health literacy skills.* *LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes.* *The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.*

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Provide transparency in population health data analysis activities for stakeholders	*1. Data collection, analysis and reporting strategies will be clearly communicated to LIHC partners during monthly meetings and at data-subgroup meetings. All projects will be publically available on the LIHC website.* *2. PHIP team members will communicate with LIHC members who require data to support and provide expert suggestions on the best way to meet project goals or measure outcomes.* *3. Upon request, the PHIP will engage in data analysis and collection efforts for those projects supporting the Prevention Agenda.* *4. PHIP data workgroup will provide expertise, guidance and build consensus during the development of data collection tools.* *5. PHIP will be utilized as the primary location for return surveys and data analysis strategies.*	*1. Provision of ongoing measurement and public reporting of primary and secondary data sources.* *2. PHIP team will assist member data requirements by leading data reporting projects* *3. PHIP will provide technical support to community-partners during a variety of analysis projects, grant applications and strategic planning* *4. Development of data collection tools* *5. Centralized return hub for data collection efforts*	*1. Monthly reporting summaries to be presented at LIHC meetings, data sets and projects to be posted on data page of website* *2. Open communication-follow up and execution of data focused projects.* *3. Regularly advise the LIHC that data analysis support is available to them. Identify and establish partnerships among community-partners to reduce working in silos and streamline efforts in data analysis.* *4. Research evidence-based measurement tools and adapt them to the specific data collection effort being carried out* *5. List the PHIP location on survey return instructions, collect and sort data responses, develop plans for data analysis while ensuring validity and reliability of data.*	*Hospital will continue to participate in data collection of community needs assessment. We will maintain hospital database and send survey results to LIHC for Island-wide analysis.* *Hospital will participate in Long Island Health Collaborative Wellness Survey to collect data to assist in evaluating wellness program effectiveness.*	*Hospital staff member will be active at both the LIHC group and data subcommittee meetings.* *Hospital has ongoing Cardiac Rehabilitation, bariatric/ weight loss surgery program and support groups, and Pulmonary Rehabilitation that can provide data to assist in evaluation program effectiveness in treating/reducing these chronic disease conditions.* *Diabetes education is offered.*		

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Leverage partnerships and achieve collective impact among LIHC community-partner network	*1. Communicate with partners to understand what activities are occurring within which communities* *2.Identify potential partnerships and introduce compatible partners* *3. Align objectives with organizations currently engagement in Complete Street work to increase sustainable, built environments* *4. Provide central local for grant-partners to collaborate and streamline grant activities that support healthy eating and physical activity*	*1. LIHC will assess resource availability through network of community-partners* *2. LIHC will promote collective impact strategies by leveraging existing resources and identifying partnerships* *3. Support and participate in Complete Streets Policy work* *4. Engagement of two synergistic grants in region: Eat Smart NY (USDA) and Creating Healthy Schools and Communities (NYS DOH)*	*1. Develop efficient surveys and polls which will capture information about parallel projects within Suffolk County Communities.* *2. Manage and ongoing involvement in partnerships with continued effort to identify partnership and streamline activities* *3. Work closely with Local health departments and organizations engaged in Complete Street work, identify opportunities for partnership or support* *4. PHIP to participate in grant-partner meetings, share initiatives which can be used to meet grant deliverables and identify community-partners who may be working in at risk communities on similar projects*	*Will include community partners in ongoing community needs assessment activities.* *Support local health department and Complete Streets work.* *Will identify and support collaborative grant opportunities.*	*Will participate in Long Island Community Health Survey and hospital database of responses.* *Will annually reassess community contacts and partners.* *Will use hospital website and community partners to promote initiatives.* *Will work cooperatively and support LIHC grant efforts.*		
Support and increase Evidence-Based Community-Programming Efforts	*1. Promote and advance evidence-based community programs* *2. Support DSRIP efforts to increase programming throughout the region*	*1. Connect members with providers of Stanford Model programs including: Diabetes-Self Management Program and Chronic Disease Self-Management program* *2. Partner with DSRIP PPS to increase program availability.*	*1. Establish relationship with key providers of this program, PHIP staff member to become trained as a DSMP peer-leader and lead programs within the community setting* *2. Work in partnership with PPS to identify community locations where Stanford Model programs will take place*	*Will support DSRIP efforts to provide location for programs.*	*Will engage existing community partners in program.*		

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Increase community awareness of Mental Health/Substance Abuse	*1. Establish workgroup, identify strategies, meet regularly to address the need for increased awareness and focus on Mental Health and Substance abuse* *2. Promote program to community partners and identify where/which organizations are certified to lead training* *3. Commit to addressing mental health as a priority area by attesting and contributing to PPS strategies*	*1. Development of a mental health focused LIHC sub-workgroup* *2. Increase availability of Evidence-Based Mental Health First Aid USA ™ training program for community members and front line healthcare workforce* *3. Position strategies to support DSRIP Domain 4 projects related to addressing mental health*	*1. Identify leaders and advocates for those living with mental health and substance abuse issues, host first meeting, review data in support of strategies* *2. Host evidence based program for LIHC members or employees of organizations who work with this population* *3. Ensure PPSs are represented on Mental Health/Substance Abuse workgroup, communicate and present Domain 4 milestones related to MH/SA and identify strategies that the LIHC can support*	*Will support LIHC mental health initiatives.* *Will support DSRIP mental health projects.*	*Will review data and work on program planning to support mental health issues on Long Island.*		
Alignment with state reform initiatives including DSRIP and SHIP	*1. Identify strategies supporting DSRIP-PPS efforts* *2. Work in direct partnership with PPS workgroups and provide support to leverage LIHC network within various strategies* *3. Provide data analysis strategies to PPS data-focused teams to address health disparities and*	*1. PHIP attendance regional PPS PAC meetings* *2. PHIP participation in workgroup projects: data hot-spotting, cultural competency/ health literacy, community engagement* *3. PHIP participation in data hot-spotting strategies*	*1. Attendance at meetings; synthesis of information obtained from meetings; alignment of goals with DSRIP milestones* *2. PHIP to become actively involved in DSRIP workgroup strategies and suggest collaborative efforts to support milestone achievement, open communication, meaningful projecting efforts* *3. Contribute to data hot spotting efforts through data mining and analysis efforts, presenting activities during monthly LIHC meetings*	*Will attend LIHC meetings to be aware of PHIP initiatives related to DSRIP-PPS efforts.* *Participate in data collection efforts.*	*Will support initiatives, engage community via community outreach efforts.* *Will strive to address health disparities by providing services in identified communities of need.* *Engage community partners in efforts.*		

*Institute for Healthcare Improvement, Cambridge, Massachusetts: Plan-Do-Study-Act (PDSA) (http://www.ihi.org/resources/pages/tools/plandostudyactworksheet.aspx

Good Samaritan Hospital Driven Interventions, Strategies and Activities

Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Priority One—Obesity *Nutrition and Weight Management*	*To improve community health by reducing the incidence of obesity and related co-morbidities such as heart disease and diabetes by providing individuals with the tools and knowledge to positively impact food choices and activity levels.*	*Offer the Healthier Families Program which is a free, 10—week educational series that promotes a healthy lifestyle. This is offered in collaboration with the identified, underserved area in the Bay Shore School District and the Bay Shore Wellness Alliance. This program was recognized by HANYS with an honorable mention for its 2016 Community Improvement Award.*	*Participants are measured-Height/Weight/BMI.* *BMI is measured at end of session for improvement.* *Survey students and parents to demonstrate a greater knowledge and awareness of healthy lifestyle after the 10-week session.* *Participants have goals of 500 minutes of exercise.* *Measure change in behavior.*	*Identify children in grades 3-5 in the targeted area who are at risk for future obesity-related health issues.*	*Hospital community outreach and other staff. Collaborate with Bay Shore School District, Bay Shore Wellness Alliance and Youth Enrichment Services.*	*Annually*	*To target medically underserved communities, and families.* *Target at risk populations.*
		Offer Food for Thought Workshops which focuses on the importance of nutrition.	*Increase change in knowledge by 75%, will be measured at the conclusion of each lecture via a survey instrument.*	*Hospital provides keynote speakers for workshops.*	*Hospital clinical and non-clinical staff and community partners (West Islip Fire Dept., St. Anthony's High School).*	*One workshop each Spring/Fall season; two in a year.*	
		Offer bariatric educational seminars and support groups.	*Increase awareness and change in knowledge of obesity throughout the surrounding areas by 25% measured via exit surveys.*	*Seminars are hosted by Good Samaritan bariatric surgeons.*	*Disseminating details of the event to the community via social media, flyers, etc.*	*Monthly*	
		Participate as a team in the American Cancer Society's "Making Strides Against Breast Cancer" walk held at Jones Beach.	*Increase the number of participants over the previous year.*	*Hospital staff participates in walk.*	*GSH outreach staff.*	*Annually*	

Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Priority Two— *Preventive Care and Management:* ***heart health, diabetes and cancer.*** *Increase community knowledge and access to preventive care and management for heart health diseases such as cardiovascular disease, diabetes, etc.*	*Provide the proper tools and knowledge for individuals to understand the importance of screenings and preventative health.*	*Annual Theresa Patnode Santmann Heart and Soul Symposium, a free seminar exploring aspects of wellness and chronic illnesses.*	*Measure number of screenings provided.*	*Hospital is host for the event.*	*Hospital partners with Captain Bill's Restaurant.* *GSH outreach and clinical staff.*	*Annually*	*To target medically underserved communities* *Target at risk populations*
		"Open Your Heart to Health" event at Westfield South Shore Mall in Bay Shore. Community members have the opportunity to talk to cardiologists, registered dietitians, cardiology technologists and nurses offering information on cardiac health and prevention in addition to providing blood pressure and cholesterol screenings. Participants experience hands-on learning/ activities.	*Measure number of screenings provided.*	*Hospital staff provide screenings.* *GSH outreach and clinical staff to take blood pressure and provide health counseling.*	*Blood pressure equipment. GSH clinical and outreach staff. Education literature in English, and other languages as needed. Partner with venue host Westfield Mall.*	*Annually*	
		Participate in free, community-based screenings for cholesterol and high blood pressure held at local libraries, street fairs and festivals, and community and hospital-based health fairs.	*Measure number of screenings provided at each event.*	*GSH outreach and clinical staff.*	*Staff to provide screening, screening equipment, event materials Partner with North Babylon, Islip, Bay Shore and Sayville Chambers of Commerce.*	*Held once a month at the West Islip Public Library.* *Street fairs occur weekly during the months of May & June.*	
		Provide free community lectures highlighting nutrition and cardiology and provide speakers and information on the importance of nutrition, heart health, etc. Provide free BMI and blood pressure screenings.	*Count number of attendees at workshops and increase change in knowledge by 75% measured at the conclusion of each lecture via exit surveys.*	*Hospital provides staff and partners for community lectures.*	*Hospital serves as host venue for lectures.*	*Two workshops each spring and fall; four in a year.*	

Goal	*Outcome Objectives*	*Interventions/Strategies/ Activities*	*Process Measures*	*Hospital Role*	*Hospital Resources*	*By When*	*Will action address disparity*
Priority Two— *Preventive Care and Management:* ***heart health, diabetes and cancer.***	*Offer diabetes education to community to help community recognize pre-diabetes and prevent the onset of Type 2 diabetes.*	*Good Samaritan offers the New York State 16-week Diabetes Prevention Program.*	*Provide initial risk assessment for diabetes. Participants weighed at every meeting; physical activity, weight and diets are recorded in a journal.* *Increase the number of participants who lost the desired 7% percent or more of their body weight and participated in reaching the 150 minutes of physical activity by 5%. Increase the average weight loss by two pounds.*	*Certified educators facilitate the program.*	*Hospital partner NYS Department of Health, GSH outreach staff, and certified Instructors.*	*Annually*	*Target at risk populations*
	Provide health screenings and education materials on preventive health to underserved community members at local churches.	*Participate in Healthy Sundays events.*	*Track number of attendees at each event and measure number of screenings conducted (blood pressure, cholesterol BMI).*	*Volunteer staff conducts screenings, counseling, and referral if needed. Information.*	*Hospital staff*	*Nine held annually.*	
	Offer free smoking cessation programs. *(According to CDC, smoking—as well as second-hand smoke—is a major cause of cardiovascular disease.*	*Hospital will offer Learn to be Tobacco- Free Program.*	*Follow-up phone call for three months after the program, and a survey at 6 and 12 months.* *Increase quit rate by 5%.*	*Partner with Suffolk County Department of Health to offer program.*	*The Long Island Cancer Help and Wellness Center provides facility for program.*	*Six week program with weekly meetings. Six sessions per year & one reunion meeting.*	

Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Priority Two— *Preventive Care and Management:* ***heart health, diabetes and cancer.***	*Reduce cancer mortality and morbidity with education, screenings and support. Provide the latest treatment options for those with malignant disease, with special attention to health disparities such as higher incidence of cancer in specific populations.*	*GSH hosts "Positively Pink!" event at the Westfield South Shore Mall in Bay Shore. Community members are able to talk to breast health experts, registered dietitians and nurses offering information on breast health and prevention. Provide on-site mammography appointment scheduling and blood pressure and BMI screenings.*	*Increase the number of screenings by 5%.*	*Hospital arranges and provides clinical and non-clinical staff for the event.*	*Hospital partner Westfield Mall serves as venue for the event.* *GSH outreach and clinical staff provide education and screenings.*	*Annually*	*To target medically underserved communities* *Target at risk populations*
		Provide free community lectures highlighting cancer. *"Good Sam University" Lectures offer speakers/ information on the importance of preventing cancer, and living a healthier lifestyle. BMI and blood pressure screenings offered.*	*Increase attendance rate by 5%.* *Increase the change in knowledge by 75% measured by exit surveys.*	*Hospital is host venue for event.*	*GSH outreach and clinical staff.*	*One workshop each Spring/ Fall season; Two in a year.*	
		Educational videos posted on Youtube.com/gshmc. Educational videos on various topics such as genetic counseling, colon cancer prevention and diagnosis, etc.	*Increase the number of views by 50%, benchmarked at 1,000 views.*	*Public and External Affairs staff.*	*Social media platform: Youtube*	*Throughout the year.*	

Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Mental Health	*To provide target populations with information about the signs and symptoms of mental health and substance abuse issues. Offer link to community-based clinical programs and services.*	*Refer appropriate patients to services within CHS, if available.*	*Measure the total number of referrals and decrease by 5%.*	*Provide referrals to appropriate services.*	*Hospital clinical staff.*	*During the 2016-2018 cycle.*	*To target medically underserved communities.* *Target at risk populations.*
	Support LIHC projects related to mental health.	*Participate in the mental health focused LIHC sub-workgroups.*	*Have hospital representation at the LIHC sub-workgroup.*	*Support LIHC mental health initiatives*	*Hospital staff.*	*Attend meetings conducted during the 2016-2018 cycle.*	

Long Island Health Collaborative Partnerships and Sustainability

The Long Island Health Collaborative first convened in 2013, with membership and partner-engagement gaining exponentially over time. With funding awarded through the New York State Department of Health, the Long Island Health Collaborative has made enhanced strides in only a few short months. LIHC partners have demonstrated their commitment to maintaining engagement with community-partners by advocating on behalf of the LIHC, promoting LIHC initiatives and bringing counterpart organizations to the table during monthly meetings. As strategies are implemented, progress will be measured on an ongoing basis. Baseline data from the Long Island Community Member Survey will allow for strategic decision making based upon the effectiveness of strategies and improvements in outcomes. Strategic direction and project oversight is guided by the PHIP Steering Committee members, who are presented with outcome data on a quarterly basis. Mid-course modifications will be identified and implemented in response to data evaluation strategies.

Dissemination and Transparency

Health Communication Strategies and Transparency are two key roles of the Population Health Improvement program. The Long Island Health Collaborative website is designed to engage consumers and provide transparency in population health initiatives and data analysis efforts. Working documents developed by the LIHC are available to the public as they are posted on the LIHC website. The Suffolk County Executive Summary will be publically available through the consumer facing portion of the Long Island Health Collaborative website at: http://www.lihealthcollab.org. Copies of the executive summary will also be printed and distributed at any community forum events.

APPENDIX

LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY

Your opinion is important to us!

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

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

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

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

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

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

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

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

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

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

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

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

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

For statistical purposes only, please complete the following:

I identify as: ☐ Male ☐ Female ☐ Other

What is your age? _____

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

What race do you consider yourself?

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

Are you Hispanic or Latino? ☐ Yes ☐ No

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

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

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

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

What is your highest level of education?

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

What is your current employment status?

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

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

Do you have a smart phone? ☐ Yes ☐ No

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

Script for Community-Based Organization Summit Event Facilitators

Introductions

1. Introduce yourself to the group

2. As you notice, we have a court reporter with us today. This is (Name of Transcriber)

Information collected during this discussion will be used to develop the Community Need Assessment Reports for Nassau and Suffolk counties. We would like to use direct quotes from our conversation, referencing your organization, and without using your name to supplement the report. Please let us know if you do not want your organization to be quoted. If there are questions you do not want to respond to, you can pass. Your participation in this program is voluntary. With your permission, this interview will be transcribed and documented. Do I have permission from everyone?

This discussion will last about one hour and twenty minutes. If after this interview you have questions or concerns, you may contact the Long Island Health Collaborative at 631-257-6957. Thank you.

I would like to begin with Introductions. Going around the table, please introduce yourself and tell me what organization you represent.

Everyone should have a card (or two for bi-county organizations). This will help us identify who would like to speak (or on behalf of which county they are speaking).
Demonstrate Example by holding up cards "In Nassau we feel that youth risk is a concern, while in Suffolk, we feel senior housing is a concern. In Nassau and Suffolk, we feel that transportation is a concern".

To ensure (Name of Transcriber) is able to accurately capture responses and match them to the representative speaking, it will be important to adhere to the event guidelines, which I will read to you:

1. *If you would like to share your opinion or respond to another speaker's feedback, please raise your number card. I (the facilitator) will prompt you to speak.*
2. *Everyone will be given a chance to respond.*
3. *Do your best to talk slowly, taking pauses, so the transcriber can capture your response accurately.*
4. *Although it may be tempting, please do not interrupt the person speaking.*
5. *During this discussion, we hope to hear a wide range of views and differences in opinion.*
6. *Details from this discussion and participant identities will remain confidential among the group.*

Are there any other guidelines that you would like to add to this list?
Does anyone have questions about the event guidelines?

Let's get started:

What makes you excited to work for the organization you are representing?

1. Please identify some of the biggest health problems for the people/communities you serve.

{Leave this as open ended, probing for specificity, then follow-up with list of priorities}.

2. *Now we are going to move a little deeper into this discussion.*

Hand each group member a list of NYS DOH priorities with focus areas. Read through the priority areas. Ask participants to review and consider.

a. *Of the focus areas listed, which are important to the people/communities you serve?*
First participant to speak identifies one priority area (eg. Mental Health/Substance Abuse). The facilitator should remain on this priority area until everyone has provided feedback (if applicable). Ask if anyone else can identify areas of need within this priority area. Then move on to the next priority area.

Facilitator will be responsible for ensuring all priority areas have been mentioned by end of discussion.

b. What specific health concerns, within these focus areas, are important to the various groups your organization serves?

If participant conversation moves toward the topic of "barriers", facilitator should re-direct the focus of the conversation by reminding the group to look at the list of health concerns under each focus area. Ask "How are the health concerns listed on the handout important to the people/communities you serve?"

3. According to the Office of Minority Health (2011), Health Disparities are defined as "Differences in health outcomes that are closely linked with social, economic and environmental disadvantage". Let's discuss some of the factors related to health disparities that affect the health care community members receive.

   Ask questions a-f. Probe participants for specificity as they provide responses.

   a. In what way do race and/or ethnicity affect the health care they receive?
   b. How do issues of identity related to gender affect the health care they receive?
   c. Describe how language affects the health care they receive?
   d. How does age affect the health care received by the community you serve?
   e. How do disabilities affect the health care they receive?
   f. How does financial security affect the quality of health care they receive?
   g. Are there any other factors that we have not discussed? Please describe.

4. What barriers keep people in the community you serve from obtaining or using the resources needed to address these issues?

   If participants are having trouble, please give an example. {Ideas could include: transportation, issues of insurance, religion/cultural difference, fear, doctor availability, etc.}

5. How can these barriers you described be addressed?
   a. In what ways can services be improved?
   b. What additional services are needed in the community you serve?
   c. What strategies do you recommend for overcoming these barriers?

6. What resources are used by your community members in relation to the health needs you have identified?

   If participants are having trouble, please give an example. {Ideas could include: (i.e. health services, community education programs, screenings, etc.)}

   a. How often do they access these services?
   b. Where do they access these services?
   c. What resources are not available that you feel should be?

7. What additional services or programs are needed to improve the community's health?

LIHC Member List

Hospitals, Hospital Association and Hospital Systems	Website
Brookhaven Memorial Hospital Medical Center	www.brookhavenhospital.org
Catholic Health Services of Long Island	www.chsli.org
Eastern Long Island Hospital	www.elih.org
Glen Cove Hospital	www.northwell.edu
Good Samaritan Hospital Medical Center	www.goodsamaritan.chsli.org
Huntington Hospital	www.northwell.edu
Long Island Jewish Valley Stream	www.northwell.edu
John T. Mather Memorial Hospital	www.matherhospital.org
Mercy Medical Center	www.mercymedicalcenter.org
Nassau-Suffolk Hospital Council	www.nshc.org
Nassau University Medical Center	www.numc.edu
North Shore University Hospital	www.northwell.edu
Northwell Health System	www.northwell.edu
Peconic Bay Medical Center	www.pbmchealth.org
Plainview Hospital	www.northwell.edu
St. Catherine of Siena Medical Center	www.stcatherines.chsli.org
St. Charles Hospital	www.stcharles.chsli.org
St. Francis Hospital	www.stfrancis.chsli.org
St. Joseph Hospital	www.stjoseph.chsli.org
Southampton Hospital	www.southamptonhospital.org
South Nassau Communities Hospital	www.southnassau.org
South Oaks Hospital	www.south-oaks.org
Southside Hospital	www.northwell.edu
Stony Brook University Hospital	www.stonybrookmedicine.edu
Syosset Hospital	www.northwell.edu
Veterans Affairs Medical Center	www.northport.va.gov
Winthrop University Hospital	www.winthrop.org
Local County Health Departments	**Website**
Nassau County Department of Health	www.nassaucountyny.gov

Suffolk County Department of Health Services	www.suffolkcountyny.gov
Medical Societies and Associations	**Website**
Long Island Dietetic Association	www.eatrightli.org
Nassau County Medical Society	www.nassaucountymedicalsociety.org
New York State Nurses Association	www.nysna.org
New York State Podiatric Medical Association	www.nyspma.org
Suffolk County Medical Society	www.scms-sam.org
Community-Based Organizations	**Website**
Adelphi New York Statewide Breast Cancer Hotline and Support Program	www.breast-cancer.adelphi.edu
Alzheimer's Association, Long Island Chapter	www.alz.org
American Cancer Society	www.cancer.org
American Foundation for Suicide Prevention	www.afsp.org
American Heart Association	www.heart.org
American Lung Association of the Northeast	www.lung.org
Association for Mental Health and Wellness	www.mentalhealthandwellness.org
Asthma Coalition of Long Island	www.asthmacommunitynetwork.org
Attentive Care Services	www.attentivecareservices.com
Caring People	www.caringpeopleinc.com
Community Growth Center	www.communitygrowthcenter.org
Cornell Cooperative Extension - Suffolk County	www.ccesuffolk.org
Epilepsy Foundation of Long Island	www.efli.org
Evolve Wellness	www.evolvewellness.net
Family & Children's Association	www.familyandchildrens.org
Family First Home Companions	www.familyfirsthomecompanions.com
Federation of Organizations	www.fedoforg.org
Girls Inc. LI	www.girlsincli.org
Health and Welfare Council of Long Island	www.hwcli.com
Health Education Project / 1199 SEIU	www.healthcareeducationproject.org
Hispanic Counseling Center	www.hispaniccounseling.org
Hudson River Healthcare	www.hrhcare.org
Life Trusts	www.lifetrusts.org

Long Island Association	www.longislandassociation.org
Long Island Association of AIDS Care	www.liaac.org
Long Island Council of Churches	www.liccny.org
Make the Road NY	www.maketheroad.org
Maurer Foundation	www.maurerfoundation.org
Mental Health Association of Nassau County	www.mhanc.org
Music and Memory	www.musicandmemory.org
New York City Poison Control	www.nyc.gov
Options for Community Living	www.optionscl.org
Pederson-Krag Center	www.pederson-krag.org
People Care Inc.	www.peoplecare.com
Pulse of NY	www.pulseofny.org
Retired Senior Volunteer Program	www.rsvpsuffolk.org
RotaCare	www.rotacareny.org
SDC Nutrition PC	www.call4nutrition.com
Smithtown Youth Bureau	www.smithtownny.gov
Society of St. Vincent de Paul Long Island	www.svdpli.org
State Parks LI Regional Office	www.nysparks.com
Sustainable Long Island	www.sustainableli.org
The Crisis Center	www.thecrisisplanner.com
Thursday's Child	www.thursdayschildofli.org
TriCare Systems	www.tricaresystems.org
United Way of Long Island	www.unitedwayli.org
YMCA of LI	www.ymcali.org
School and Colleges	**Website**
Adelphi University	www.adelphi.edu
Farmingdale State College	www.farmingdale.edu
Hofstra University	www.hofstra.edu
Molloy College	www.molloy.edu
St. Joseph's College	www.sjcny.edu/long-island
Stony Brook University	www.stonybrook.edu
Western Suffolk BOCES Creating Healthy Schools and Communities, NYS DOH	www.wsboces.org

Performing Provider Systems (DSRIP PPS)	Website
Nassau Queens PPS	www.nassauqueenspps.org
Suffolk Care Collaborative	www.suffolkcare.org
Insurers	**Website**
1199SEIU/Health Education Project	www.1199seiu.org
Fidelis Care	www.fideliscare.org
North Shore-LIJ CareConnect Insurance Company	www.careconnect.com
United Healthcare	www.unitedhealthcare.com
Regional Health Information Organizations	**Website**
Healthix Inc.	www.healthix.org
New York Care Information Gateway	www.nycig.org
Businesses and Chambers	**Website**
Air Quality Solutions	www.iaqguy.com
Greater Westhampton Chamber of Commerce	www.westhamptonchamber.org
Honeywell Smart GRID Solutions	www.honeywellsmartgrid.com
PSEG of Long Island	www.psegliny.com
TeK Systems	www.teksystems.com
Temp Positions	www.tempositions.com
Time to Play Foundation	www.timetoplay.com
Municipal Partners	**Website**
New York State Association of County Health Officials	www.nysacho.org
New York State Department of Parks and Recreation	www.nyparks.com
Suffolk County Legislature	www.legis.suffolkcountyny.gov