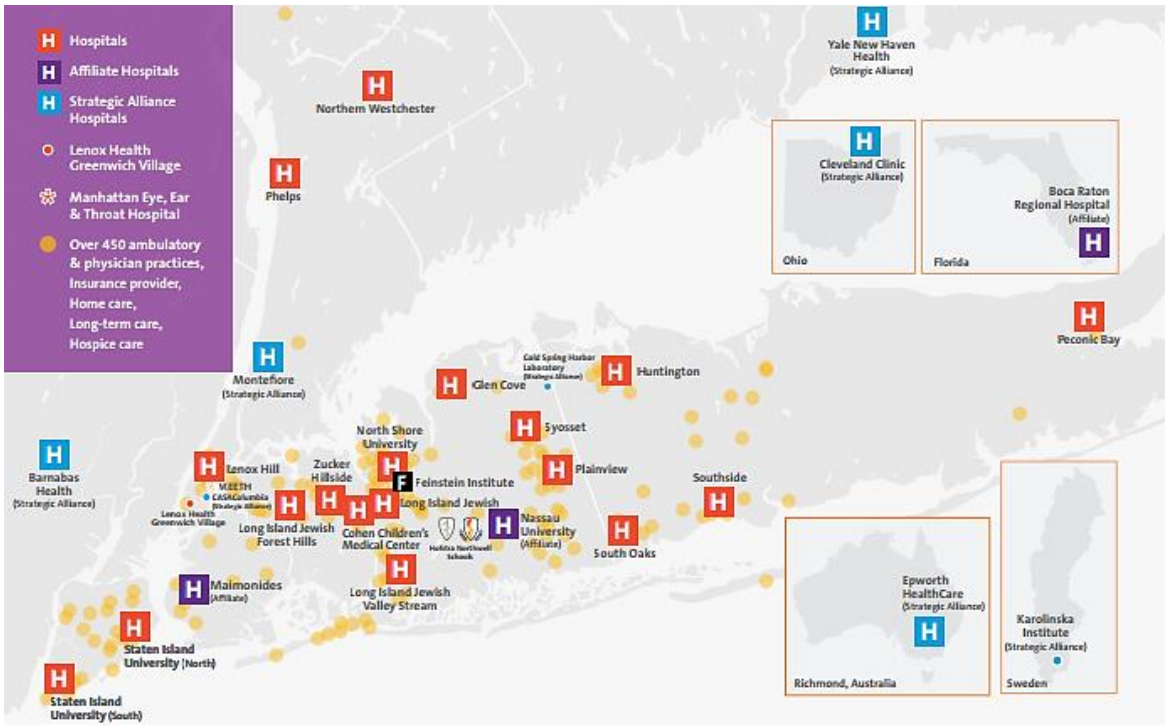
Northwell Health
Community Service Plan 2016-2019

Suffolk County Service Area
CHNA



Suffolk County Community Health Needs Assessment

Suffolk County Health Indicator Status Since 2013 CHNA

The 2013-2016 Implementation Plan activities have had an impact in improving and meeting New York State Prevention Agenda Objectives that were related to health disparities, chronic disease, obesity and behavioral health as shown below. Since 2013, Northwell Health has delivered over 4000 community health programs and over 65,000 health screenings. Examples of interventions that helped achieved these goals include robust chronic disease and cancer screening programs; implementation of culturally relevant evidence-based chronic disease self-management education; prevention of childhood obesity through school-based projects as well as promotion of policies and practices in support of breastfeeding; creation of community environments that promote and support healthy food and beverage choices and physical activity; elimination of exposure to secondhand smoke and prevention of the initiation of tobacco use by youth, especially among low socioeconomic status (SES) populations and the promotion of tobacco cessation, especially among low SES populations and those with poor mental health; and strengthened infrastructure to promote mental, emotional and behavioral wellbeing. However, the burden of health disparities, chronic disease, obesity and behavioral health issues is still present as demonstrated below by the indicators that have not met the New York State Department of Health (NYSDOH) Prevention Agenda Objectives and/or have worsened indicating the need to continue to address the 2013-2016 priority agenda item and focus areas.

Since the last community health needs assessment the following NYSDOH Prevention Objectives[1] have:

Improved

Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics
Premature deaths: Ratio of Hispanics to White non-Hispanics
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years*
Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics
Percentage of adults (aged 18-64) with health insurance*
Assault-related hospitalization rate per 10,000
Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics
Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years*
Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home*
Asthma emergency department visit rate per 10,000 - Aged 0-4 years*
Age-adjusted heart attack hospitalization rate per 10,000 *
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years
Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months*
Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years *

[1] New York State Department of Health Prevention agenda Dashboard https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=60 Assessed November 2016.

Premature births: Ratio of Black non-Hispanics to White non-Hispanics
Percentage of infants exclusively breastfed in the hospital*
Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics
Exclusively breastfed: Ratio of Hispanics to White non-Hispanics
Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births
Maternal mortality rate per 100,000 births
Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs*
Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs*
Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs*
Percentage of women (aged 18-64) with health insurance*
Age-adjusted suicide death rate per 100,000
**Significant change*

No Significant Change
Percentage of premature deaths (before age 65 years)#
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years#
Rate of hospitalizations due to falls per 10,000 - Aged 65+ years#
Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years #
Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge
Percentage of residents served by community water systems with optimally fluoridated water#
Percentage of adults who are obese#
Percentage of cigarette smoking among adults#
Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years#
Asthma emergency department visit rate per 10,000 population
Percentage of adults with flu immunization - Aged 65+ years
Newly diagnosed HIV case rate per 100,000
Difference in rates (Black and White) of newly diagnosed HIV cases
Difference in rates (Hispanic and White) of newly diagnosed HIV cases
Gonorrhea case rate per 100,000 women - Aged 15-44 years
Gonorrhea case rate per 100,000 men - Aged 15-44 years
Chlamydia case rate per 100,000 women - Aged 15-44 years
Primary and secondary syphilis case rate per 100,000 men
Primary and secondary syphilis case rate per 100,000 women
Percentage of preterm births#
Percentage of children aged 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs#
Percentage of children (aged under 19 years) with health insurance#
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years
Percentage of unintended pregnancy among live births
Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic #
Unintended pregnancy: Ratio of Hispanics to White non-Hispanics #

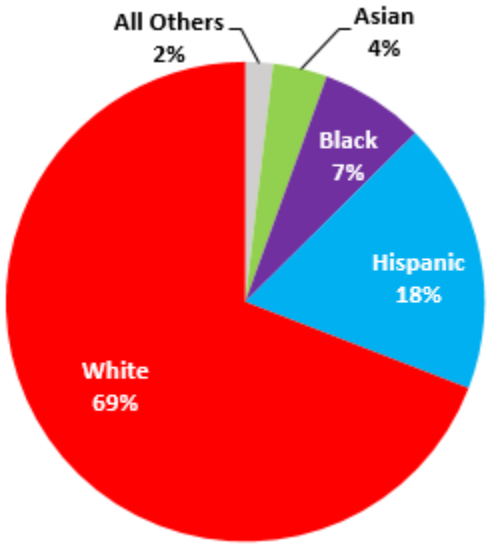
Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births #
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month#
Age-adjusted percentage of adult binge drinking during the past month
 # did not meet NYSDOH Prevention agenda Objectives

Worsened
Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics
Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics
Percentage of children and adolescents who are obese
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years
Premature births: Ratio of Hispanics to White non-Hispanics
Premature births: Ratio of Medicaid births to non-Medicaid births
Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics
Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics
Percentage of live births that occur within 24 months of a previous pregnancy*
**Significant change*

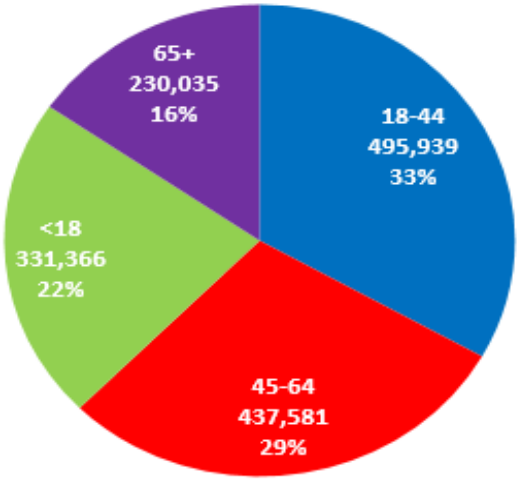
Demographic Profile

Our primary service areas in Suffolk County encompass four hospitals; Huntington Hospital; Southside Hospital; Peconic Bay Medical Center; and South Oaks Hospital, a facility dedicated to providing treatment and recovery from acute psychiatric illness and addiction. Suffolk County has a population of 1,494,921 that is 52% female and has an age distribution of 22% aged less than 18 years, 33% aged between 18 and 44 years old, 29% aged 45 to 64, and 16% over 65 years of age. On the map of Percent Population 0-17 yrs, there is a large concentration of children aged 0-17 located in Miller Place, Mastic, Sagaponack, Centerport and Sound Beach. Also, there is large concentration of older adults (aged 65+) in Orient, New Suffolk, East Marion, Shelter Island Heights and Peconic shown on the Percent Population Older Adults 65+ map. The racial distribution of Suffolk County is 69% white, 18% Hispanic, 7% black, and 4% Asian. Approximately 15% of Suffolk County residents are foreign-born and 21% of residents speak a language other than English at home. As you can see in the map below, foreign-born residents of Suffolk are concentrated in Brentwood, Copiague, Central Islip, Islandia and Wyandanch.

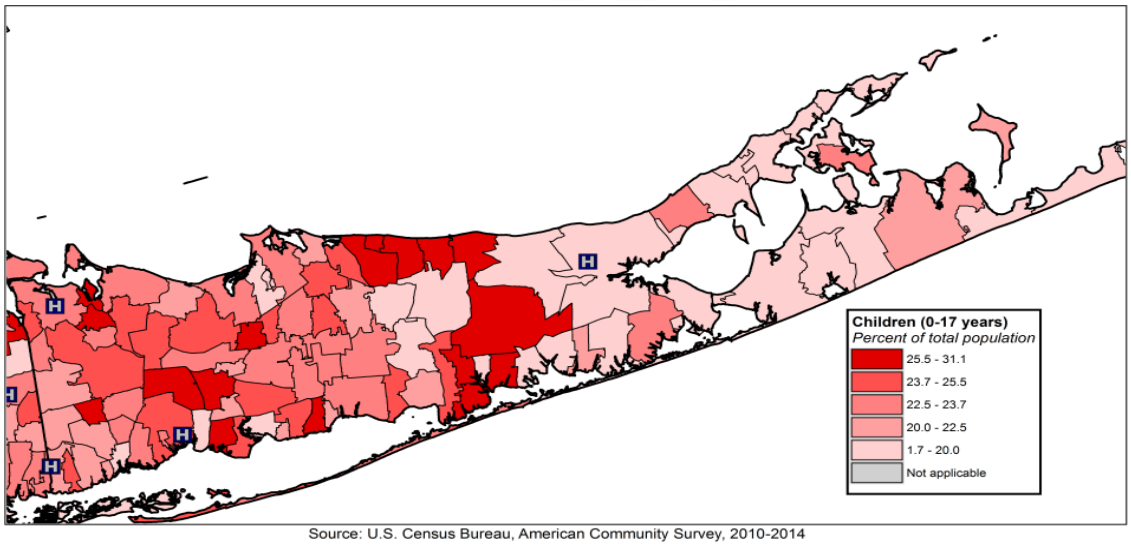
SUFFOLK COUNTY RACIAL DIVERSITY



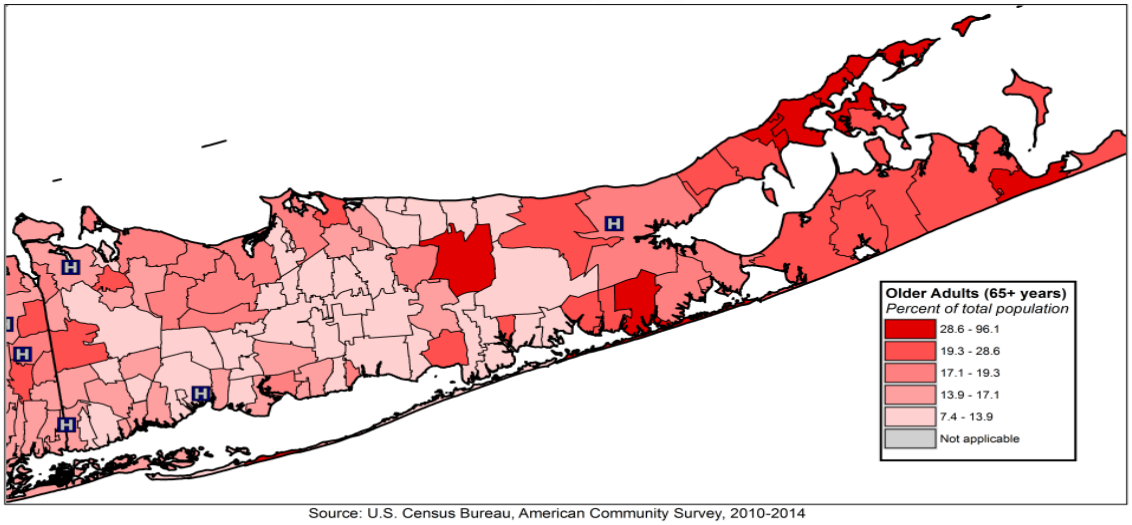
SUFFOLK COUNTY POPULATION AGE DISTRIBUTION



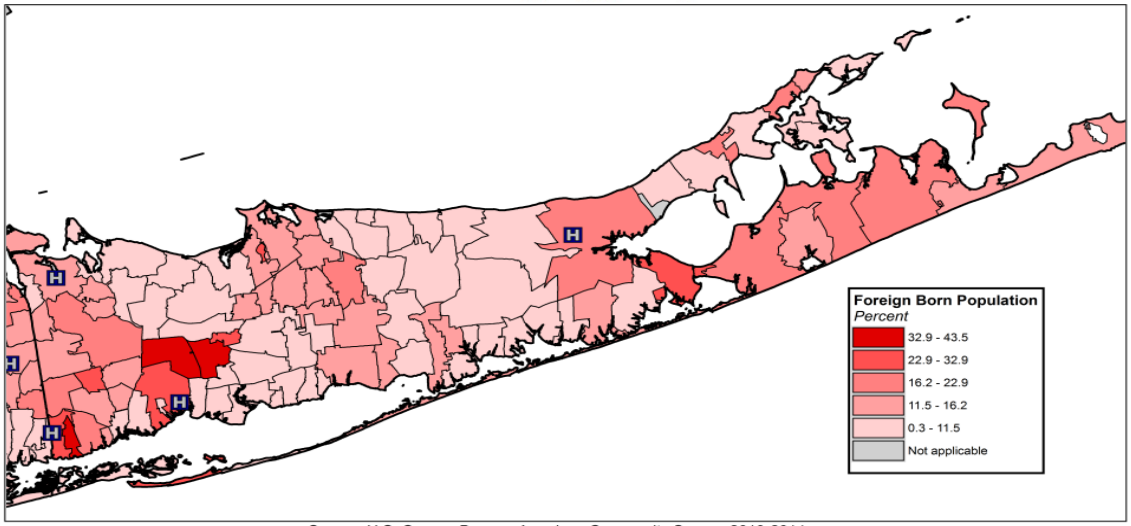
Source: Truven Market Discovery.v2015.03.26.tpn



Source: U.S. Census Bureau, American Community Survey, 2010-2014



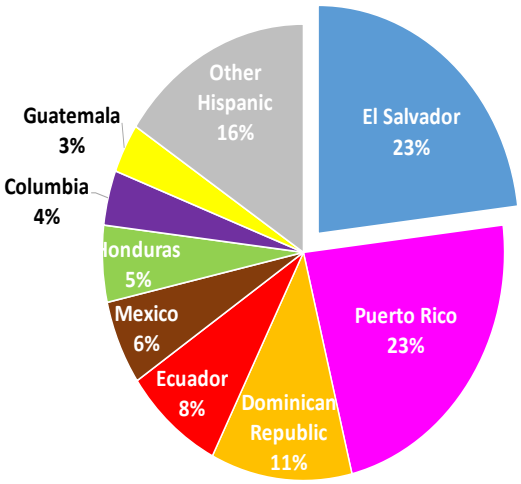
Source: U.S. Census Bureau, American Community Survey, 2010-2014



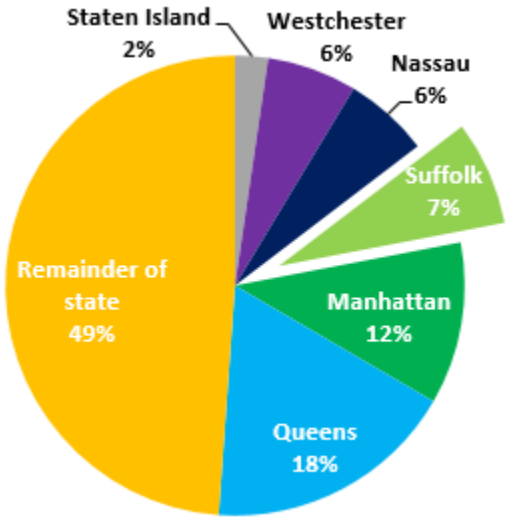
Source: U.S. Census Bureau, American Community Survey, 2010-2014

The Hispanic population is the most largely represented minority in Suffolk County. Within the Hispanic population, there are several countries of origin represented. Approximately 68% of the Hispanic population is composed of Central American, South American, and Spanish subgroups. Twenty-three percent of the Hispanic population is Puerto Rican, while 6% is Mexican. Suffolk County alone makes up 7% of the State's Hispanic population. The next most largely represented minority population in Suffolk County is the black population. Suffolk County makes up 4% of the State's black population.

HISPANIC/LATINO SUB-POPULATIONS

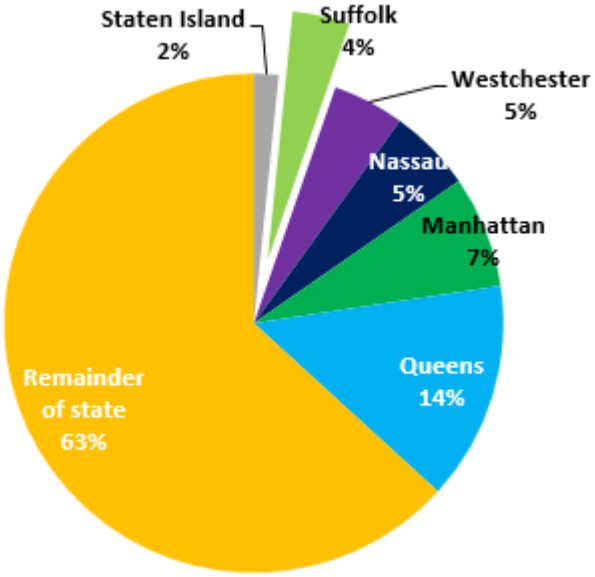


PERCENT OF STATE HISPANIC POPULATION



*Other is comprised of Central American, South American, and Spanish sub-groups; tpn

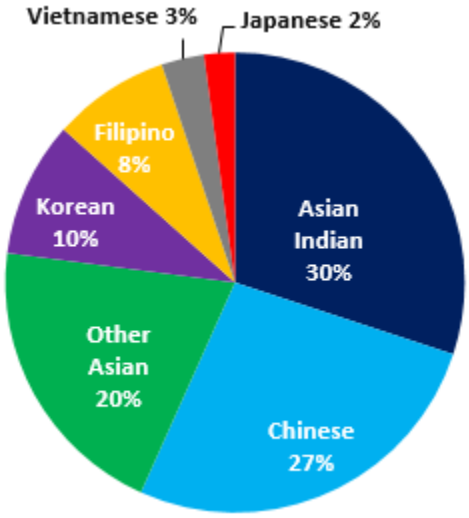
PERCENT OF STATE BLACK POPULATION



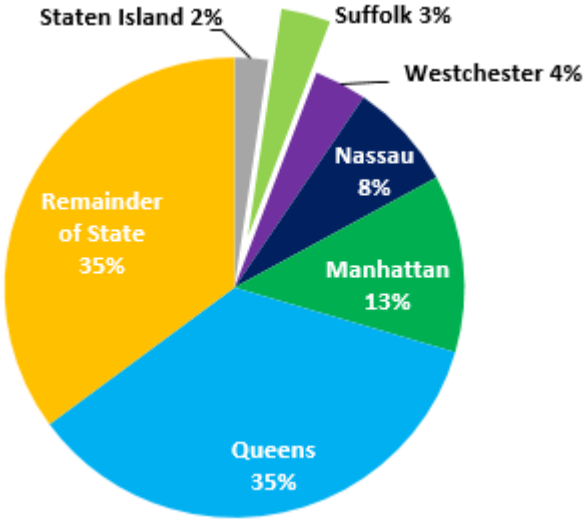
Source: Truven Market Discovery.v2015.03.26, ACS Census 2014; tpn

In addition, there are several countries of origin represented in the Asian population of Suffolk County. The breakdown of Asian subpopulations is as follows: 30% Asian Indian, 27% Chinese, 20% other Asian, 10% Korean, 8% Filipino, 3% Vietnamese, and 2% Japanese. Suffolk County makes up 3% of the State's Asian population.

SUFFOLK ASIAN SUB-POPULATIONS



PERCENT OF NY STATE ASIAN POPULATION

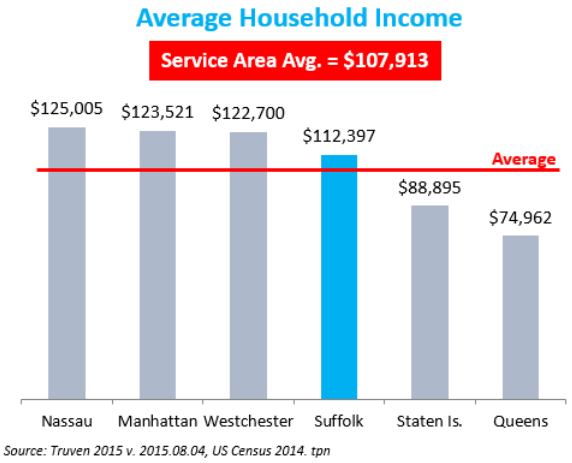


Source: Truven Market Discovery.v2015.03.26, ACS Census 2014; tpn

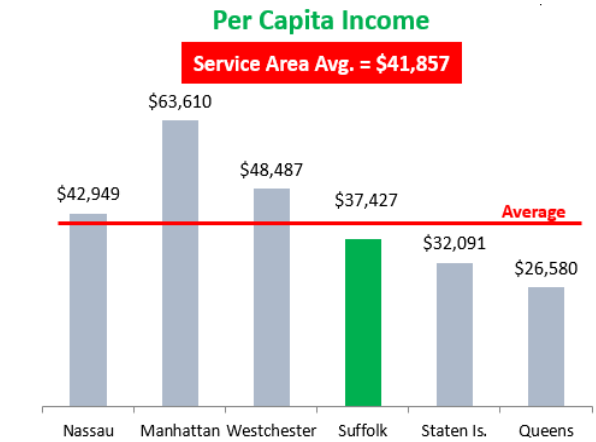
Social Determinant Analysis

Secondary data on various social determinants of health in Suffolk County was analyzed to identify factors that may contribute to the health status of the population of Suffolk County. The results of this analysis are as follows.

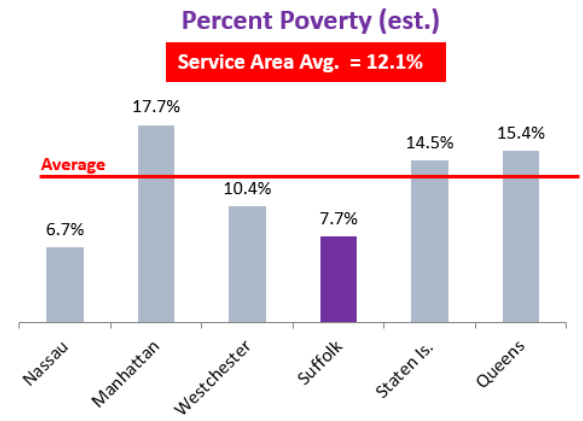
The average household income is $112,397, just above our service area average, while the per capita income is $37,427, below the service area average. It's important to understand that there exists socioeconomic disparity in Suffolk County in which there are pockets of extreme wealth and pockets of poverty. As a whole, however, the county's poverty rate is 7.7% and the unemployment rate is 6.8%. The greatest rates of poverty are concentrated in Mastic Beach, Bellport, Greenport, Riverhead and Central Islip. Furthermore, the greatest rates of unemployment are concentrated in East Marion, West Sayville, Mastic Beach, Calverton and Stony Brook.



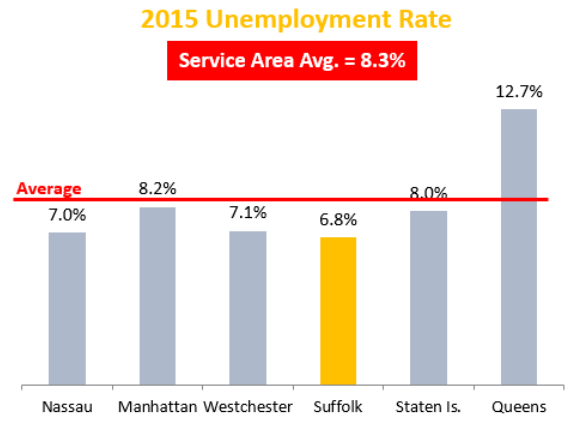
Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn



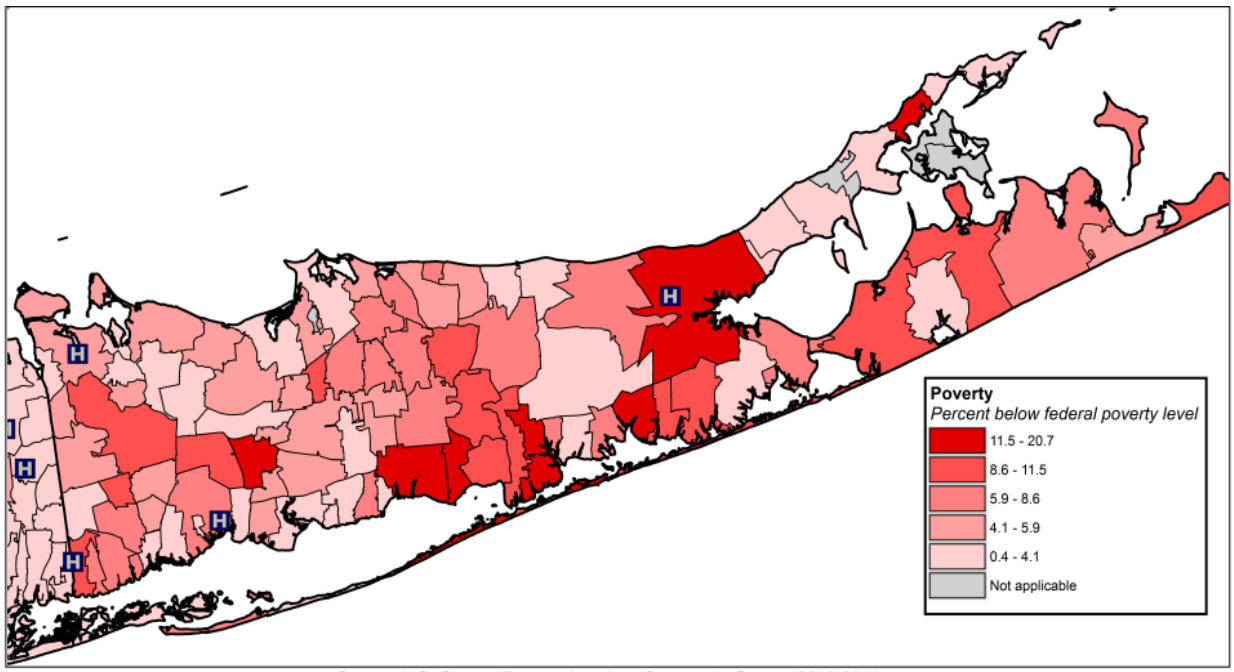
Source: Truven 2015 v. 2015.08.04, US Census 2014. Tpn



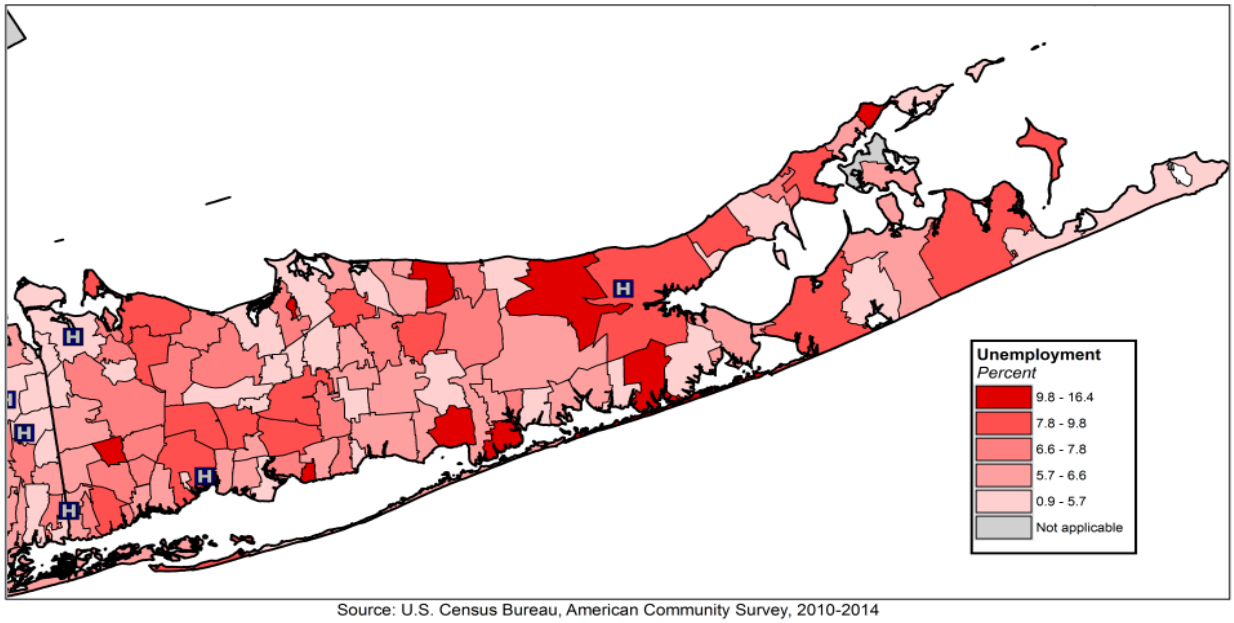
Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn



Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn

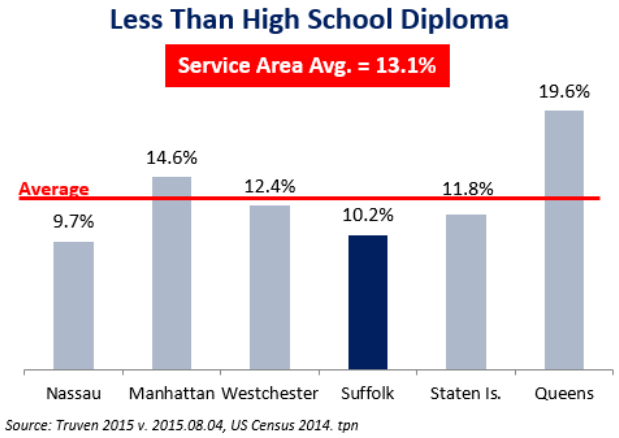


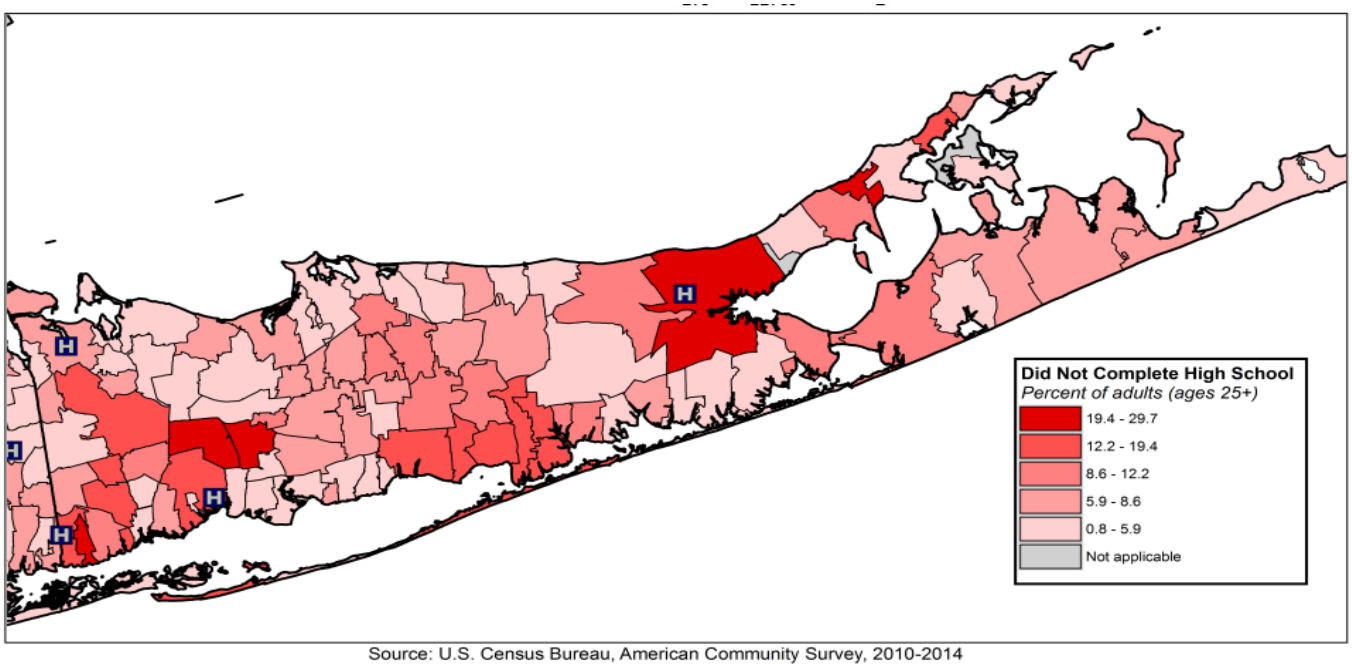
Source: U.S. Census Bureau, American Community Survey, 2010-2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014

Poverty and unemployment are not the only socioeconomic determinants of health. Educational attainment is perhaps the most important factor contributing to one's health status. In Suffolk County, 88% of students graduate from high school, and 64.8% of residents have attended at least some college[2]. As the map below indicates that the highest concentration of adults in Suffolk who did not complete high school are located in Brentwood, Central Islip, Copiague, Riverhead and Peconic.

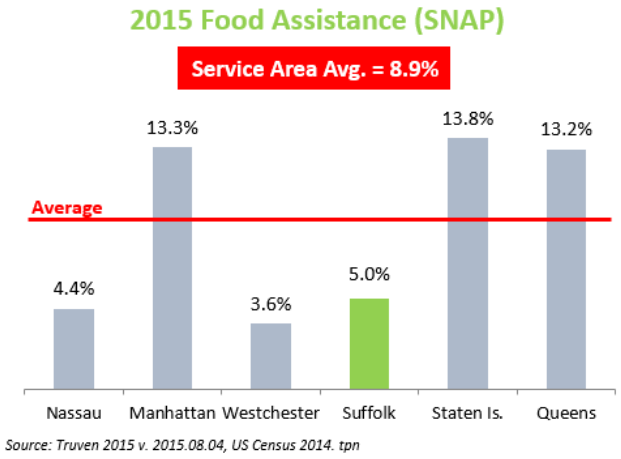




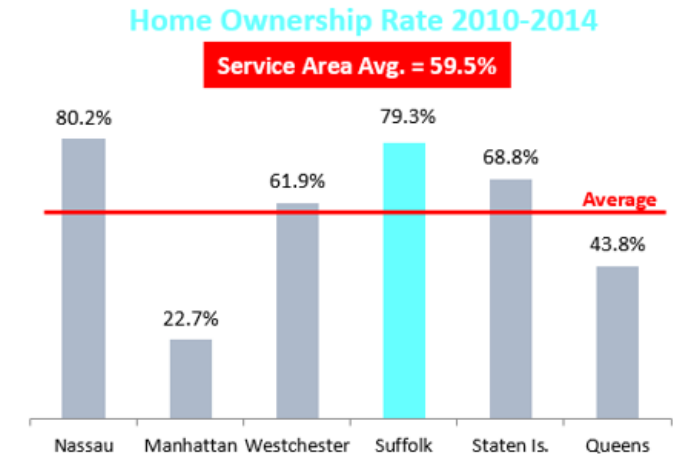
Source: U.S. Census Bureau, American Community Survey, 2010-2014

[2] U.S. Dept of Education, EDFacts 2012-2013

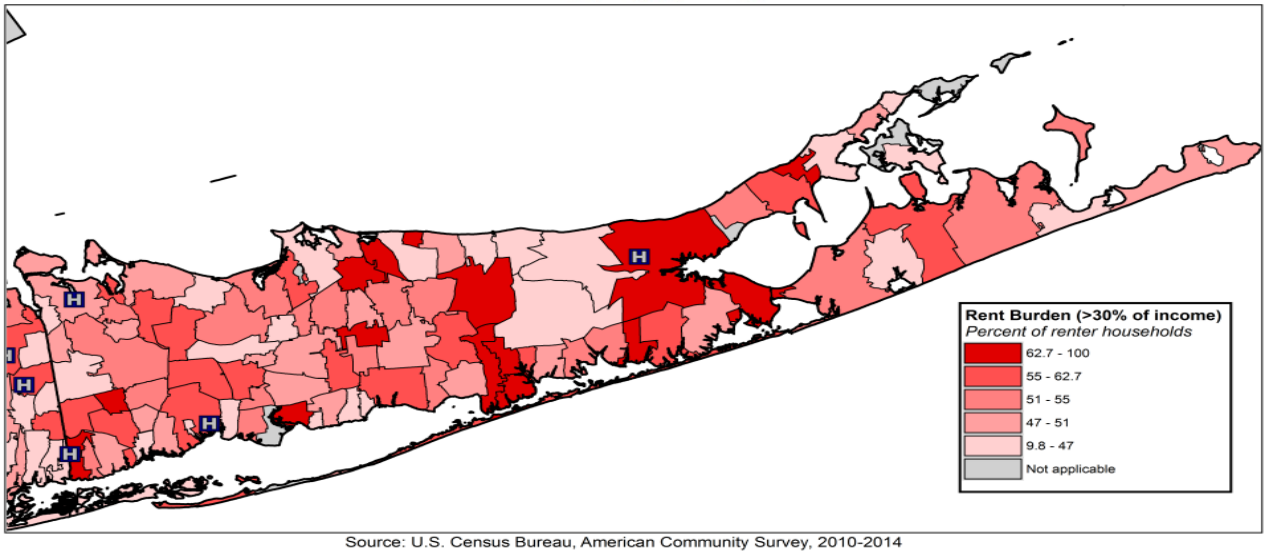
Income, employment, and educational attainment greatly impact health in a number of ways, but perhaps the most discernible is one's ability to buy food, especially healthful foods. An estimated 7% of the population of Suffolk experiences food insecurity, with approximately 95,540 food insecure individuals living in Suffolk[3]. Approximately 5% of Suffolk residents receive food assistance (SNAP). This is nearly half of our service area average and, the graph below illustrates that there is a significant divide in food assistance amongst our counties served.



Other contributors to health status include neighborhood safety and housing security. In 2014, the county experienced a violent crime rate of 148 per 100,000 inhabitants, compared to 365 per 100,000 nationally[4], suggesting Suffolk County is relatively safe. The percentage of Suffolk residents experiencing housing insecurity in the last 12 months was 40.8% in 2014[5] and, according to the American Housing Survey, 2.4% of housing units were overcrowded. The home ownership rate in Suffolk from 2010-2014 was 79.3%. However, it is also important to examine rent burden in Suffolk. The U.S. Census Bureau American Community Survey defines rent burden as the percentage of renter households whose gross rent (rent plus utilities) is greater than 30 percent of their monthly pre-tax income. In Suffolk, we see the greatest concentration of rent burden in Peconic, Quogue, Westhampton, Mastic and Mastic Beach.



[3] Map the Meal Gap, 2013
[4] FBI Uniform Crime Reporting, 2014
[5] eBRFSS, 2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014

Access to exercise and walking suitability are environmental factors that also contribute to health status. Ninety-four percent of residents report having access to exercise opportunities and 91.2% believe their neighborhoods are suitable for walking[6]. One's environment is also shaped by the accessibility of health services in the area. When it comes to healthcare in Suffolk County, services are not very accessible, when compared to state averages. The population to primary care provider ratio is 1317:1[7], while the NYS average is 1200:1 and the population to mental health provider ratio is 420:1[8], on par with the state average. Eleven percent of the population is uninsured.[9] For that eleven percent of the population that is uninsured, this can be a significant financial burden.

Health status is also shaped by an individual's social support network and their individual behaviors. The social association rate is increasingly used as an indicator of social connectedness in the community. The social association rate for Suffolk County, determined by the number of membership associations per 10,000 residents, was 6.5 in 2013[10], slightly less than the state average of 7.9. When it comes to diet and nutrition, only about 26% of Suffolk residents consume the recommended daily intake of fresh fruits and vegetables[11], despite Suffolk being an epicenter of farming in Lower New York. Twenty-two percent of adults report having no leisure time physical activity[12]. Fourteen percent of adults in Suffolk County smoke and 19% report drinking excessively[13]. A staggering 23% percent of driving deaths in Suffolk were attributed to alcohol from 2012-2014[14]. In addition, the drug overdose mortality rate in Suffolk is 18 per 100,000 deaths and, from 2012-2014, Suffolk County experienced 823 drug overdose deaths[15].

---

[6] eBRFSS, 2014
[7] Area Health Resource File, American Medical Association, 2013
[8] CMS, National Provider Identification File
[9] Dartmouth Atlas of Healthcare, 2013
[10] County Business Patterns, 2013
[11] eBRFSS, 2014
[12] CDC Diabetes Interactive Atlas, 2012
[13] eBRFSS, 2014
[14] Fatality Analysis Reporting System, 2010-2014
[15] CDC WONDER Mortality Data, 2012-2014

Primary Data Analysis

The CHA/CHIP committee determined that in addition to census, hospitalization and vital statistics data, the assessment should include the "voice of the community" (e.g. the community's perception of need). The group agreed that quantitative and qualitative data should be collected from community organizations and the population-at-large. Two subcommittees– Community-Based Organizations and Community-Wide Survey– were formed with representation from the four not-for-profit hospitals, academic partners and the Suffolk County Department of Health. The full report and methodology can be found in Appendix.

Community-Based Organization Summit

The Nassau County and Suffolk County Departments of Health and all Long Island hospitals, worked together with the Long Island Health Collaborative staff in order to collect data that would propel the Community Health Needs Assessment Cycle 2016-2019. To gather qualitative data for these assessments, the Long Island Health Collaborative held two Community-Based Organization Summits in February 2016. Hosting one in each county with more than 100 total organizations represented, facilitated discussions were used to gather information about the communities served. The findings are summarized below.

Chronic Disease

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 summit quotations indicated Chronic Disease as a priority area. Cumulatively, 52.1% of quotations in Suffolk included one or more Chronic Disease keyword. Chronic Disease Management and Obesity/Nutrition were the most frequently prioritized focal areas. Summit participations stated that improving communities' access to healthy foods, coupled with youth education focused on healthy living and nutrition, is needed to curb the increasing rates of diabetes, heart disease, and obesity in young populations. In addition, provision of nutrition and physical activity education to parents is a valuable preventive strategy that, once passed down to future generations, will help to dissipate the prevalence of obesity.

Mental Health and Substance Abuse

Mental Health and Substance Abuse emerged closely as a second-ranking topic of importance. Qualitative analysis demonstrated, 29.9% of quotations indicated 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 and developmental, 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.

Healthy and Safe Environment

Healthy and Safe Environments were discussed as an area of concern within 25.4% of Suffolk County quotations. Cumulatively, 33.8% of quotations from Suffolk County included aspects of Healthy and Safe Environment. Within this area, "Homes" was reflected in 11.2% of quotations with "Access to care" following in close second with 8.2% of quotations. The focus area of "Homes" covered issues related to safe and affordable housing and tobacco-free housing. The "Access" focus area included key words and themes such as access to care; food; service; school and stores. The lack of affordable housing in Suffolk County contributes to unsafe

living environments, which is considerably problematic for seniors and veterans. Availability of stable housing has a direct correlation with access to health services and individuals' ability to prioritize their healthcare. In addition, a sustainable-built environment provides increased opportunity for community members to engage in physical activity, promotes easy access to health services and healthy food options.

Healthy Women, Infants, and Children

The priority area of Healthy Women, Infants and Children was highlighted as a focus area of concern within 13.2% of Suffolk County quotations. Cumulatively, 19.5% of quotations from Suffolk County included aspects of Healthy Women, Infants and Children. Within this area, "Children's Health" was reflected in 9.3% of quotations with "Maternity/Mother" following with 5.8% of quotations. Children's health issues were inclusive of keywords related to well child visits; child neglect; safe childcare options; developmental delays and dental problems for children. The focus area "Maternity/Mother" covers issues related to breastfeeding; health insurance for mothers; reproductive care; young mothers and utilization of preventive health services for mothers. Incidence of infant mortality, prematurity and low-birth rate babies is higher among the African American population. It is vital that expectant mothers, especially those in high-risk populations, are accessing comprehensive health services. Post-delivery is the perfect time to engage mothers in follow-up care by linking them to services.

HIV, STD, Vaccine Preventable Diseases

HIV, STD, Vaccine Preventable Diseases and Health Care-Associated Infections comprised 9.4 % of distinct and 12.7% of cumulative Suffolk County quotes. Although this area comprised the least majority of total quotations, interpretative analysis provides strong evidence that there is a desperate need for additional services reaching those living with HIV/AIDS. This population requires a unique set of integrated care services, which seems to be lacking in accessibility. Furthermore, there are new emerging disease trends that will be important for professionals to address moving forward.

Disparities and Barriers

Disparities among the senior population were of high importance to summit participants with 18.4% of quotations in Suffolk County being coded under this topic. The focus area of "Senior Issues" included key words related to aging, Alzheimer's, finances, abuse, cognitive loss, crisis, falls, housing and safety. One theme of particular relevance was a resource need for caregivers who are often times unprepared for the decision-making and financial responsibility associated with caring for a family member.

Barriers to care were discussed frequently during the summit event, with a majority of conversation surrounding this topic. The top-three emerging focus areas included: "access barriers," "financial," and "care barriers." Quotations related to access barriers accounted for 19.9% of barrier quotations in Suffolk County. Financial barriers were another frequently discussed barrier to care. Keywords associated with financial barriers include: affordability, barriers to funding, financial burdens, pay scales and poverty. Of the Suffolk County quotations flagged with barriers to care, financial barriers comprised 16.1% while care barriers comprised 13.4%. Care barriers include keywords related to: continuity of care, preventative care, service, staffing, medication, office hours and technology.

Individual Community Member Survey Results

In Suffolk County we conducted individual community member surveys in partnership with the Long Island Health Collaborative (partners in Nassau County as well). Surveys were distributed by paper and electronically through Survey Monkey to community members. On June 2nd we downloaded each of the collectors from Survey Monkey and began to analyze the results. The findings are summarized below:

When asked ***what the biggest ongoing health concerns in the community where you live are***: Suffolk County respondents felt that Drug and Alcohol Abuse, Cancer, and Obesity/Weight Loss were the top three concerns. In Suffolk, these three choices represented roughly 46% of the total responses.

When asked ***what the biggest ongoing health concerns for yourself are:*** Suffolk County respondents felt that Obesity/Weight Loss, Women's Health and Wellness, and Cancer were the top three concerns. In Suffolk, these three choices represented roughly 40% of the total responses.

The next question sought to ***identify potential barriers that people face when getting medical treatment***. Suffolk respondents felt that No Insurance, being Unable to Pay Co-pays or Deductibles, and Fear were the most significant barriers. These choices received roughly 55% of the total responses.

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.

For the final question people were asked ***what health screenings or education services are needed in your community*** and Suffolk County respondents felt that the Drug and Alcohol, Mental Health/Depression, and Exercise/Physical Activity services were most needed.

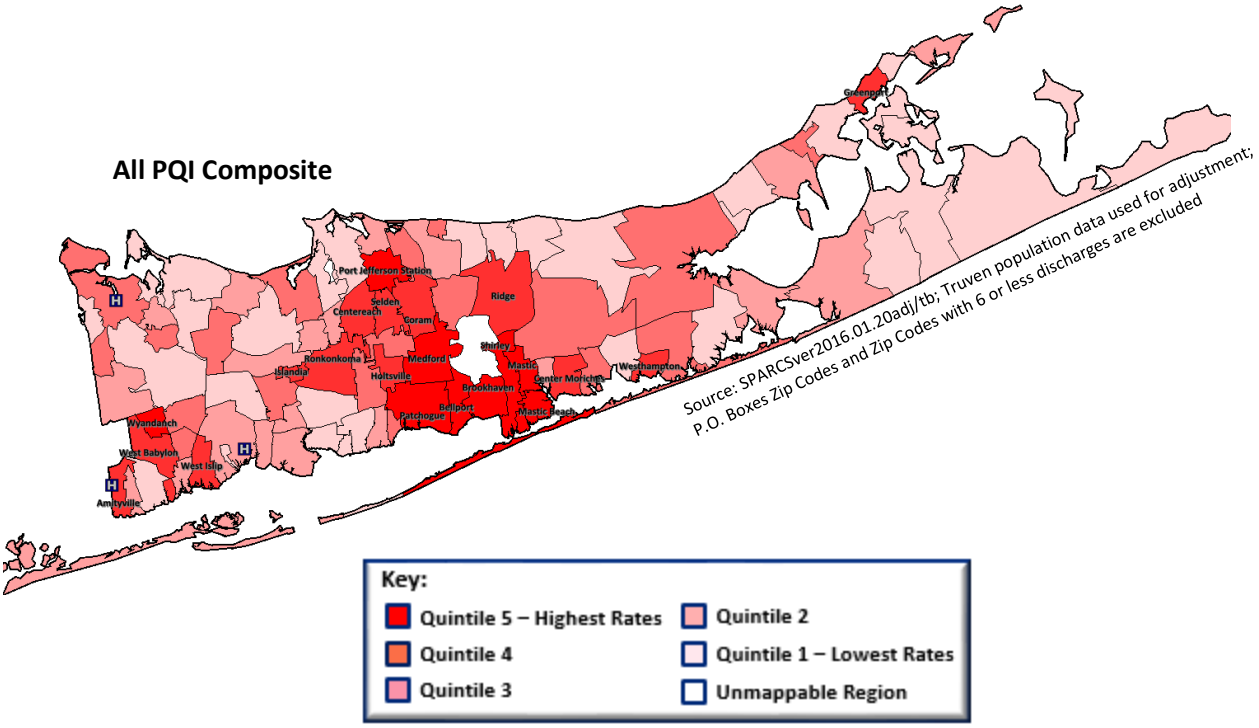
In total, 5397 surveys have been collected between December and June 2nd, 2016. For Suffolk County there were 3559 respondents in total, which means our responses have a confidence level of 95% and a confidence interval of 1.75. These values are based on the 2010 census for Nassau and Suffolk counties.

Secondary Data Analysis

As aforementioned, sources of information included SPARCS data (version 2016), NYSDOH Vital Statistics, NYS Cancer Registry and the NYSDOH Surveillance System. Data were age-adjusted (direct standardization of rates) based on 2010 U.S. standard population. A mapping of Prevention Quality Indicators (PQIs) quintiles was also used as part of the data analysis to identify pockets of diminished health in the counties we serve. For PQIs, quintiles are assigned to the data based on their comparative rates of disease per 100,000 population, and we use these quintiles to assess the relative health of different zip codes. The quintiles are arranged 5 to 1 with the 5th quintile containing the highest rates of the targeted PQIs and their associated conditions, while quintile 1 contains the lowest rates.

Prevention Quality Indicator (PQI) Composite

Of Suffolk County's 117 zip codes, some consistently emerged in PQI quintiles 4 or 5, indicating high rates of disease and poorer health outcomes in those areas. These areas include: Amityville, Wyandanch, West Babylon, West Islip, Islandia, Ronkonkoma, Holtsville, Centereach, Selden, Port Jefferson Station, Coram, Medford, Patchogue, Bellport, Ridge, Brookhaven, Mastic, Shirley, Mastic Beach, Center Moriches, Westhampton, and Greenport.

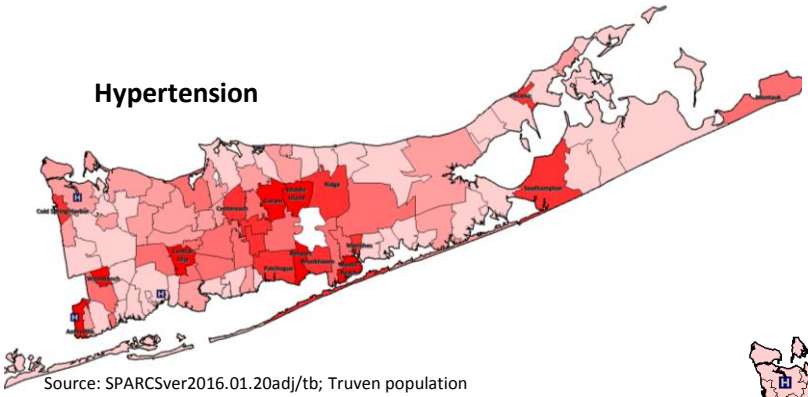


Chronic Disease

To assess chronic disease prevalence in Suffolk County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). In addition, communities within the county that have higher prevalence rates than the county average have been identified.

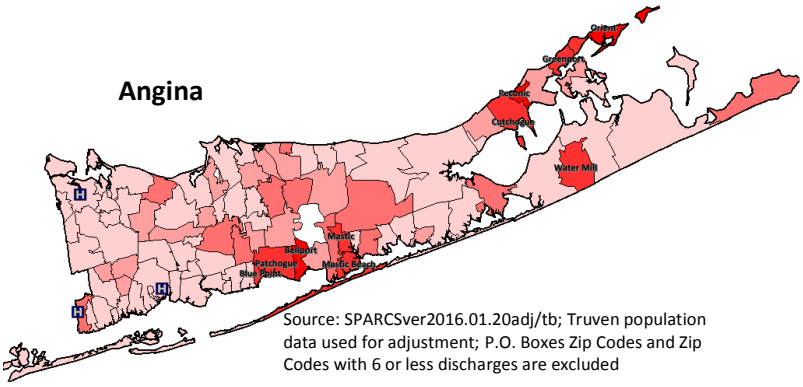
Coronary heart disease and congestive heart failure hospitalization rates in Suffolk were worse than the NYS average and greater than the NYSPAO. Cerebrovascular (Stroke) disease mortality was slightly better than the state average but did not achieve the NYSPAO. Circulatory PQIs had the highest rates in Amityville, Ronkonkoma, Centereach, Selden, Patchogue, Bellport, Ridge, Mastic, Shirley, Mastic Beach, Peconic, and Commack.

Hypertension



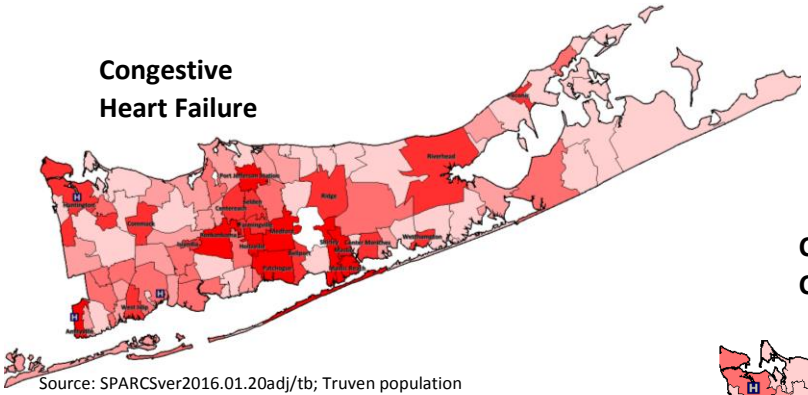
Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Angina



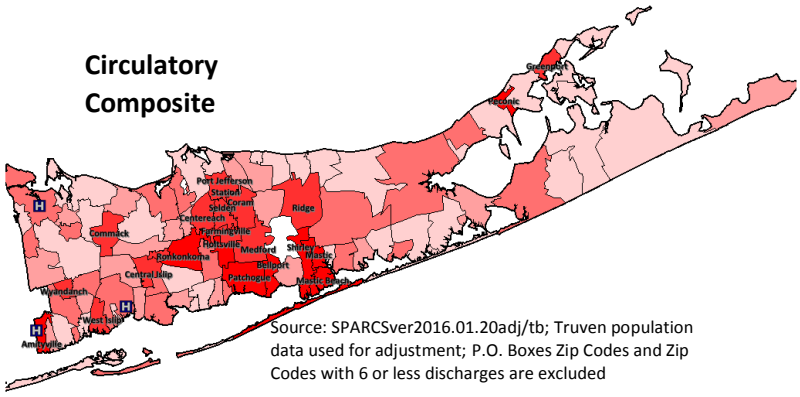
Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Congestive Heart Failure



Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Circulatory Composite



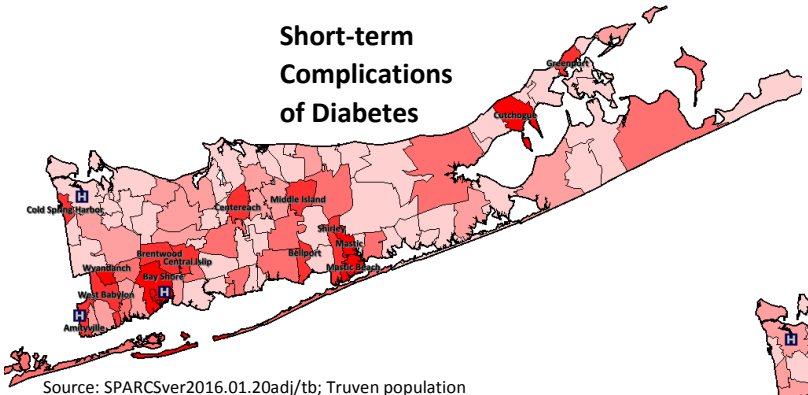
Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Key:

- Quintile 5 – Highest Rates
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 – Lowest Rates
- Unmappable Region

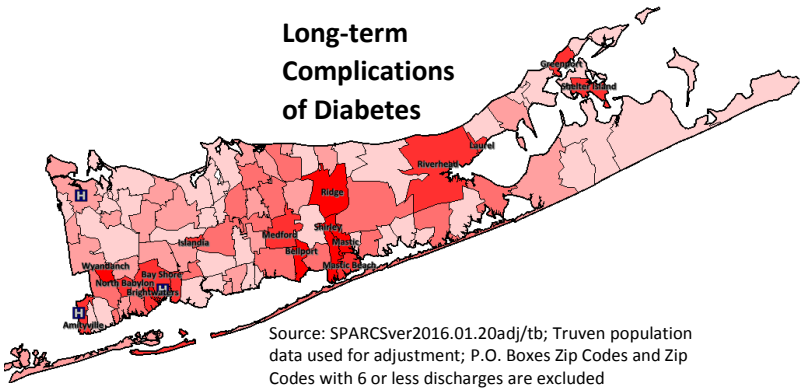
Diabetes prevalence rates in Suffolk County were 9%, lower than the NYS average of 10.4% but still well above the NYSPAO of 5.7%. The diabetes short term complication hospitalization rate was better than the NYS average but did not achieve the NYSPAO for both people ages 6-17 and ages 18+ years. Obesity rates for adults (BMI>30) were 20.9%, below the NYS average of 24% but still above the NYSPAO of 15%. Diabetes PQIs had the highest rates in Ridge, Mastic, Shirley, Mastic Beach, Riverhead, Cutchogue, Greenport, and Wyandanch.

Short-term Complications of Diabetes



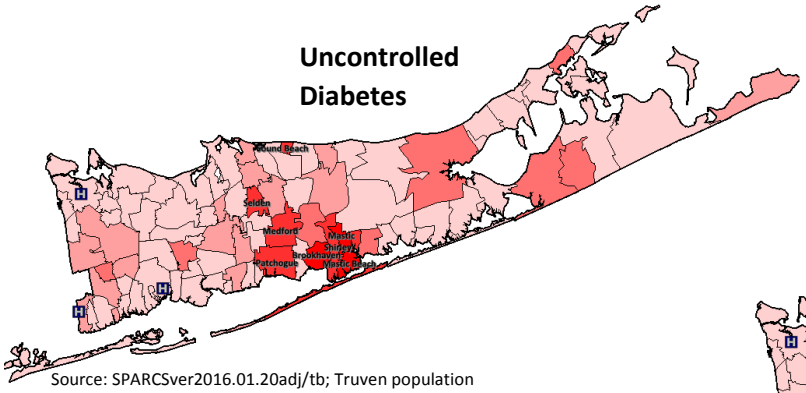
Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Long-term Complications of Diabetes



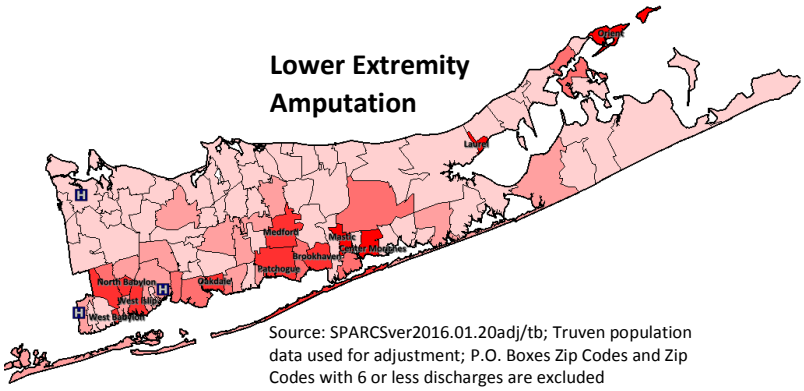
Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Uncontrolled Diabetes



Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

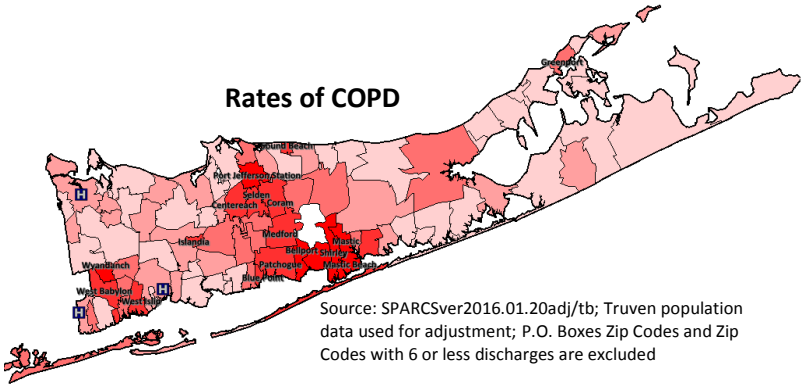
Lower Extremity Amputation



Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

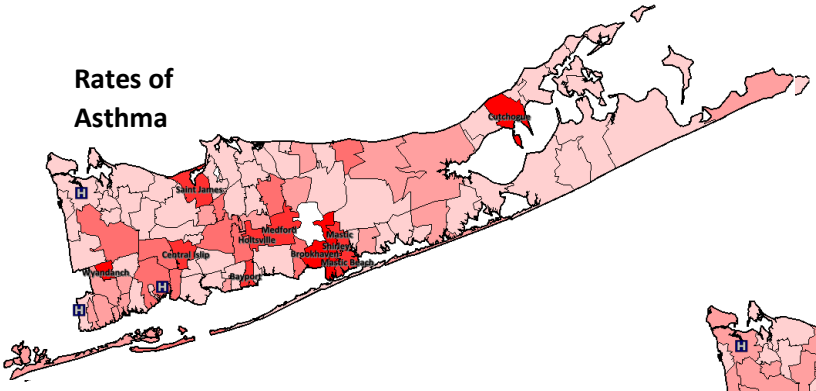
Cigarette smoking rates for adults in Suffolk County were 17.7%, below the NYS and US averages, but above the NYSPAO of 12%. ED Chronic Obstructive Pulmonary Disease adult hospitalizations per 10,000 in Suffolk County were 40.6, below the NYS average of 41.3, but above NYSPAO of 31. Wyandanch, Mastic, Shirley, Mastic Beach and Port Jefferson Station had the highest rates of COPD. Suffolk County asthma-related hospitalization rates were below the NYS and US averages, as well as the NYSPAO. However, there are areas with increased rates as shown on the map below.

Rates of COPD



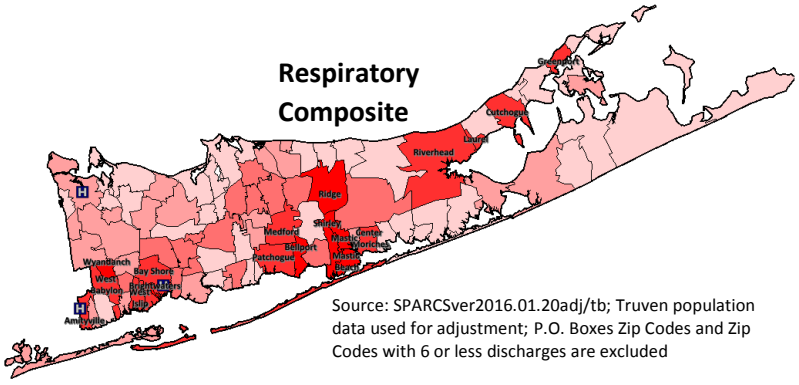
Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Rates of Asthma



Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

Respiratory Composite



Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

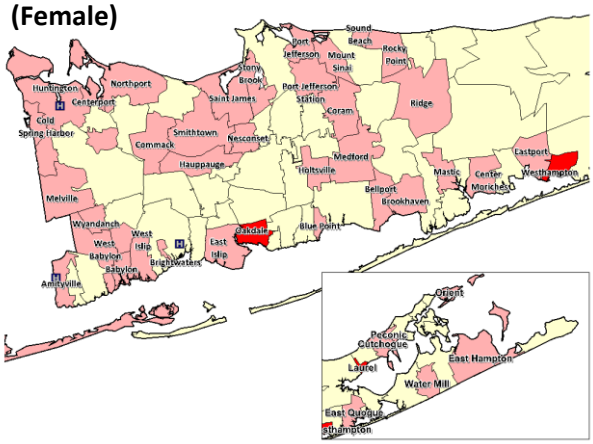
Key:

- Quintile 5 – Highest Rates
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 – Lowest Rates
- Unmappable Region

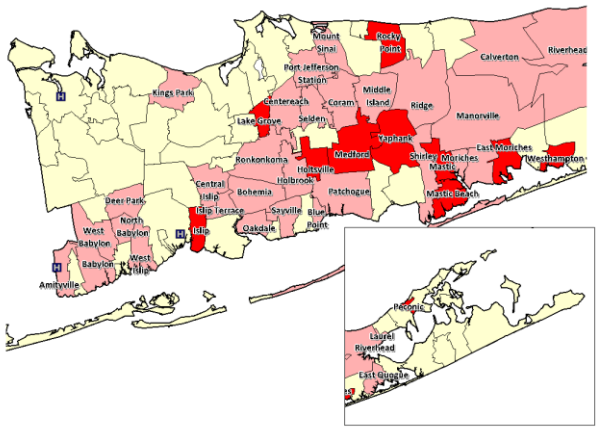
Lifestyle data including nutrition and physical activity are major factors in the prevention and management of chronic disease. Approximately 78.8% of Suffolk County adults report that they are engaged in some type of leisure time physical activity which is above the NYS rate (73%) but below the NYSPAO target of 80%. Twenty-six percent of Suffolk residents report that they eat 5 or more fruits and vegetables per day. This is slightly below the NYS average (27%) and below the NYSPAO target (33%).

Breast cancer early stage diagnosis rates (62.1%) were lower than the NYS average but cervical cancer early stage diagnosis rates (47.3%) were greater than the US and NYS averages. Both rates, however, are still below the NYSPAO. The highest female breast cancer rates were located in the communities of Oakdale and Westhampton. Prostate cancer rates were highest in Mount Sinai, East Moriches, and Westhampton. Lung Cancer incidence for men and women per 100,000 respectively were 79.9 and 69.3. For both males and females, incidence is above the NYS and US averages, and well above the NYSPAO.

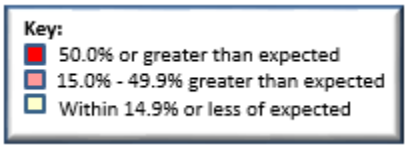
Breast Cancer (Female)



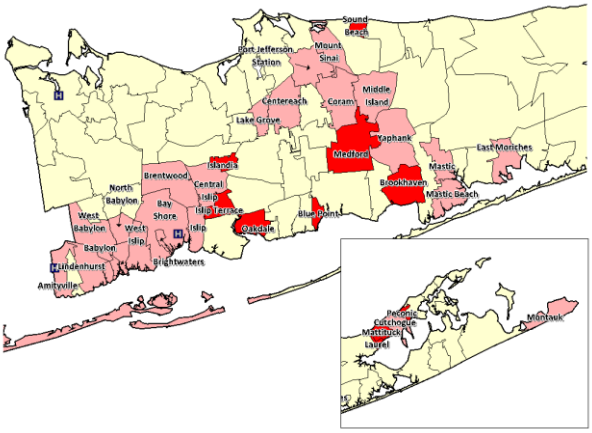
Lung Cancer



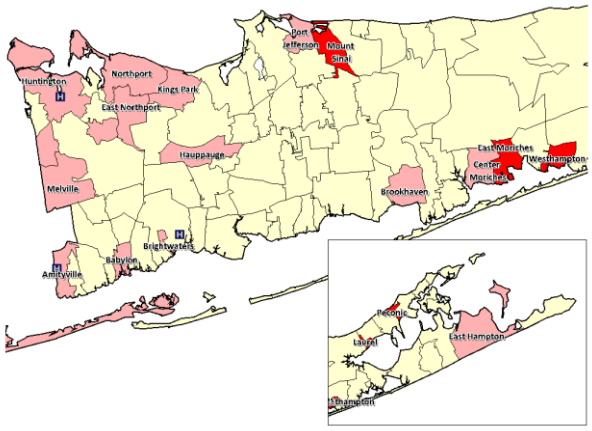
Source: New York State Department of Health, New York State Cancer Registry - http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm; *New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new data is currently available



Colorectal Cancer



Prostate Cancer



Source: New York State Department of Health, New York State Cancer Registry - http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm; *New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new data is currently available

Healthy Safe Environment

To assess preventable injury prevalence in Suffolk County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). Fall-related hospitalizations for Suffolk residents aged 65+ years (per 10,000) were 224, higher than the NYS rate of 198 and well above the NYSPAO target of 155. The highest rates were present in East Northport, Smithtown, Bohemia, East Setauket, Port Jefferson station, Centereach, Brookhaven and Center Moriches.

Below is a table outlining injury statistics for Suffolk County, compared to NYS averages, and color-coded by whether Suffolk is significantly better than, significantly worse than, or comparable to the state average. Suffolk County is significantly worse than NYS on most injury indicators, with the exception of poisoning hospitalization rates and falls under the age of 10.

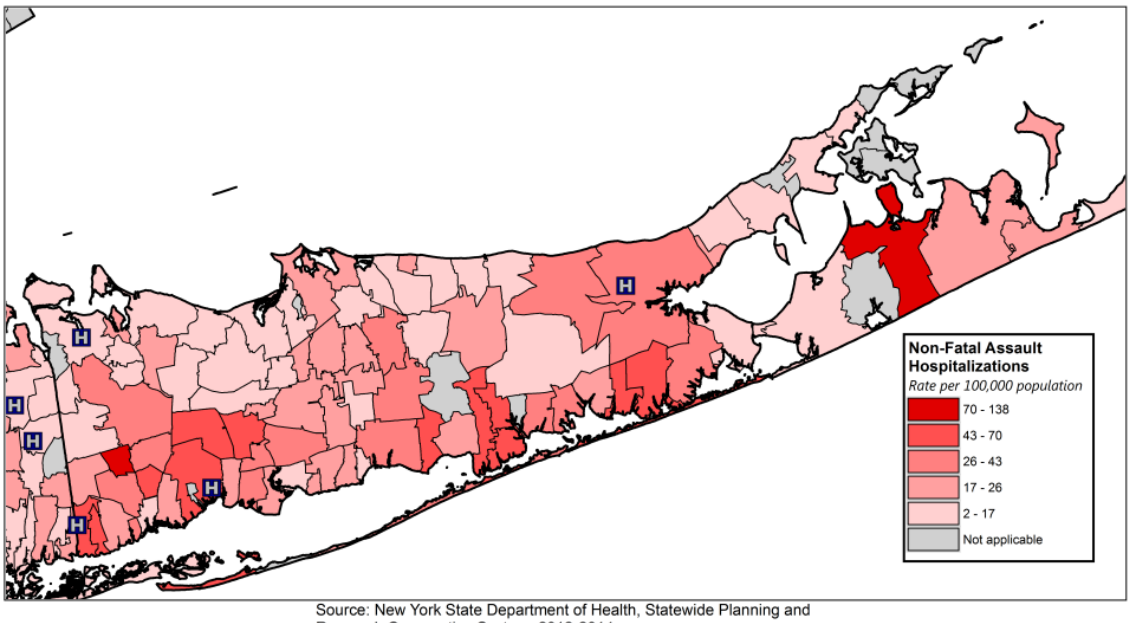
Injury Statistics for Suffolk County

Indicator	3 year total	County Rate	NYS Rate	Sig Dif	County Ranking Group
Falls Hospitalization Rate per 10,000					
Crude	21323	47.4	39.4	Yes	
Age-adjusted	21323	41.7	34.7	Yes	
<10 years	516	9.7	8.9	No	
10-14 years	236	7.6	6.1	Yes	
15-24 years	464	7.9	5.7	Yes	
25-64 years	5212	21.7	18.4	Yes	
65-74 years	3171	89	75.2	Yes	
75-84 years	5392	263.2	220.3	Yes	
85+ years	6332	697.5	560.2	Yes	
Poisoning Hospitalization rate per 10,000					
Crude	5125	11.4	11.1	No	
Age-adjusted	5125	11.2	10.7	No	
Motor Vehicle Mortality Rate per 100,000					
Crude	443	9.8	6.3	Yes	
Age-adjusted	443	9.7	6	Yes	
Non-Motor Vehicle Mortality Rate per 100,000					
Crude	1548	34.4	21.4	Yes	
Age-adjusted	1548	32	19.5	Yes	
Traumatic Brain Injury Hospitalization Rate per 10,000					
Crude	5458	12.1	10	Yes	
Age-adjusted	5458	11.5	9.4	No	
Alcohol Related Motor Vehicle Injuries and Deaths per 100,000					
Crude	2103	46.8	33.3	No	

Key*:
- Significantly Better than NYS Average
- No Significant Difference from NYS Average
- Significantly Worse than NYS Average

*Where significance was not available, better, the same or worse than the New York State Average;
Source: New York State Department of Health
https://www.health.ny.gov/statistics/chac/indicators/inj.htm

Finally, neighborhood safety also plays an important role in one's ability to achieve and maintain good health. The rate of non-fatal assault hospitalizations in a neighborhood speaks to its relative safety and whether or not residents may feel comfortable walking, biking, or otherwise exercising outside. Wyandanch, Sagaponack, Bellport and Central Islip have relatively high rates of non-fatal assault hospitalizations, with over 70 hospitalizations per 100,000.



Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2012-2014

Healthy Women, Infants, and Children

To assess the prevalence conditions related to the health of women, infants and children in Suffolk County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). The percent of women receiving first trimester prenatal care is on par with the NYS average (73%) but below the NYSPAO (90%). However, the percentage of low birth weight births in Suffolk County (7.6%) is below both the NYS and US averages and is approaching the NYSPAO (5%). Women receiving late or no prenatal care were 4% for the county but the following communities had increased rates: Copiague, Amityville, Wyandanch, Deer Park, Bay Shore, Brentwood, Islandia, Mastic, Riverhead and Water Mill. Low birth weight rates were also elevated in many of the above communities. Pregnant women enrolled in WIC had gestational diabetes at a rate of 6.2% versus a NYS rate of 5.5%. The percent of obese children (ages 2-4 years) enrolled in WIC was 21% versus a NYS rate of 13%. Anemia and underweight in the pediatric WIC population was also above the NYS rate. Breastfeeding rates of mothers in the WIC program were on par with the state average.

Below is a table outlining birth-related statistics for Suffolk County, compared to NYS averages, and color-coded by whether Suffolk is significantly better than, significantly worse than, or comparable to the state average. As shown in the table below, Suffolk County is significantly worse than NYS on most WIC indicators, but significantly better than or comparable to NYS on most other indicators.

Birth-Related Statistics for Suffolk County

Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	County Ranking Group
Percentage of births					
% of births to women aged 25 years and older without a high school education	5,205	13.6	14.1	Yes	4th
% of births to out-of-wedlock mothers	17,736	37.5	40.9	Yes	2nd
% of births that were multiple births	2,134	4.5	3.9	Yes	4th
% of births with early (1st trimester) prenatal care	35,572	77.2	73.1	Yes	2nd
% of births with late (3rd trimester) or no prenatal care	1,912	4.2	5.6	Yes	2nd
% of births with adequate prenatal care (Kotelchuck)	32,152	70.4	69.1	Yes	3rd
WIC Indicators					
% of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011)	15,174	84.8	86.5	Yes	4th
% of pregnant women in WIC with gestational weight gain greater than ideal (2009-2011)	8,257	44.8	41.7	Yes	1st
% of pregnant women in WIC with gestational diabetes (2009-2011)	1,166	6.2	5.5	Yes	3rd
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	1,375	7.3	7.1	No	1st
% of WIC mothers breastfeeding at least 6 months (2010-2012)	1,882	32.3	38.2	Yes	1st
% of infants fed any breast milk in delivery hospital	34,377	83.1	83.1	No	1st
% of infants fed exclusively breast milk in delivery hospital	14,049	33.9	40.7	Yes	4th
% of births delivered by cesarean section	20,975	44.4	34.1	Yes	4th
Mortality rate per 1,000 live births					
Infant (less than 1 year)	210	4.4	5	No	1st
Neonatal (less than 28 days)	140	3	3.4	No	1st
Post-neonatal (1 month to 1 year)	70	1.5	1.5	No	2nd
Fetal death (20 weeks gestation or more)	160	3.4	6.6	Yes	1st
Perinatal (20 weeks gestation to less than 28 days of life)	300	6.3	10	Yes	1st
Perinatal (28 weeks gestation to less than 7 days of life)	182	3.8	5.4	Yes	1st
Maternal mortality rate per 100,000 live births +	10	21.1	20	No	3rd
Low birthweight indicators					
% very low birthweight (less than 1.5 kg) births	608	1.3	1.4	Yes	2nd
% very low birthweight (less than 1.5kg) singleton births	412	0.9	1.1	Yes	2nd
Newborn drug-related diagnosis rate per 10,000 newborn discharges					
Newborn drug-related diagnosis rate per 10,000 newborn discharges	468	100.7	95	No	2nd

Key*:

Significantly Better than NYS Average

No Significant Difference from NYS Average

Significantly Worse than NYS Average

*Where significance was not available, better, the same or worse than the New York State Average;

Source: http://www.health.ny.gov/statistics/chac/chai/docs/mih_28.htm; The county ranking groups: 1 - most favorable to 4 - least favorable. These county ranking groups are categorized based on the quartile distribution of all county rates

Pediatric Obesity

Many chronic conditions have their roots in pediatric obesity. Diabetes, cardiovascular disease, cancer, orthopedic conditions, pulmonary disease and gastrointestinal disease are co-morbidities of obesity. Currently, Type 2 Diabetes is the most common form of diabetes diagnosed in adolescents. The NYSDOH has required school districts to measure and report body mass index, a measure of obesity using a person's height and weight, in order to identify overweight and obesity in the school aged children and adolescents. The following tables and maps identify the prevalence of overweight and obesity in geographic areas based on school districts.

The school districts with over 40% of children and adolescents classified as overweight or obese are:

Suffolk County School Districts with 40% of Students Classified as Overweight or Obese

Brentwood	Central Islip	Greenpoint
Mastic Beach	Patchogue	Riverhead
Yaphank		

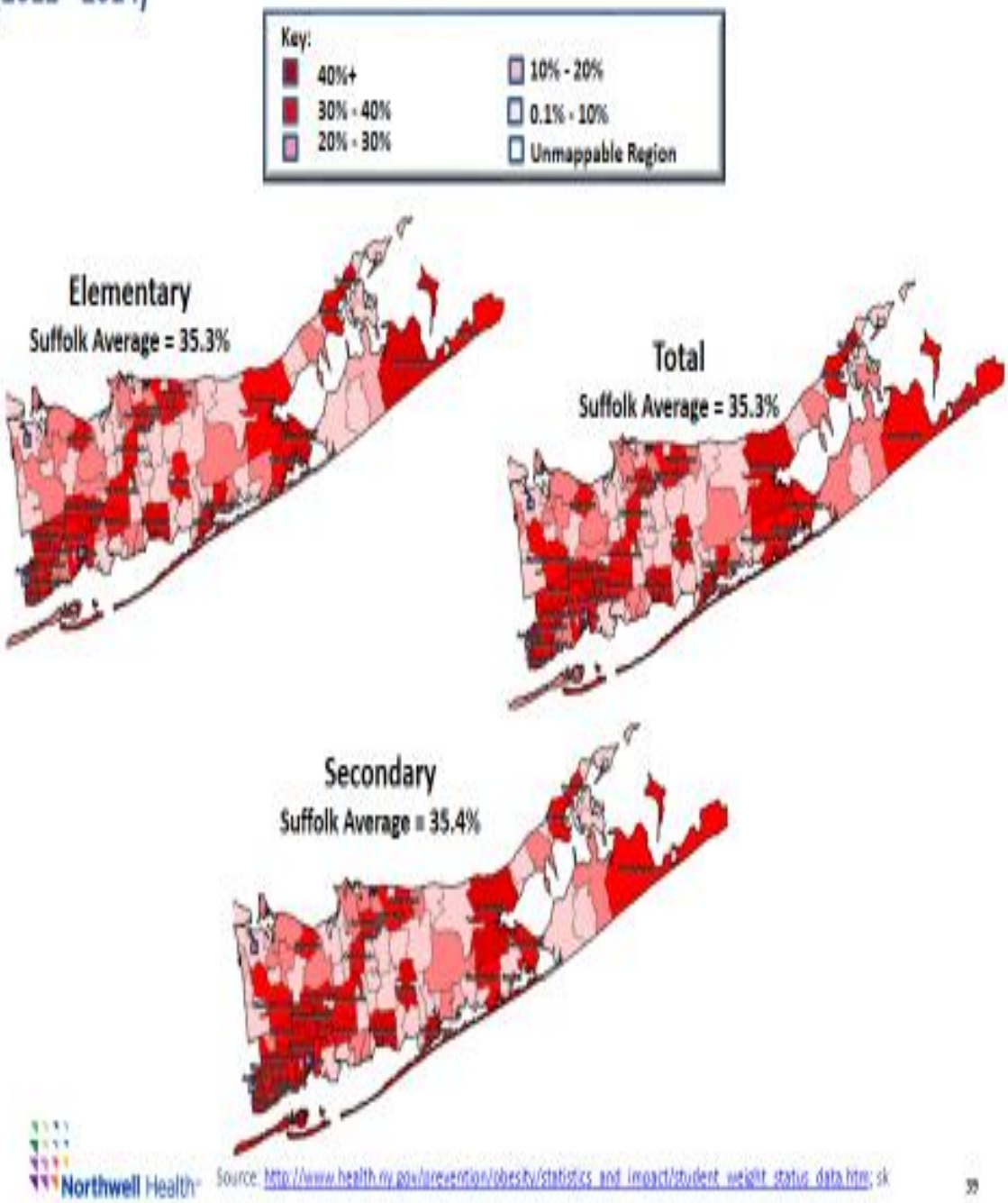
The school districts with over 30% of children and adolescents classified as overweight or obese are:

Suffolk County School Districts with 30% of Students Classified as Overweight or Obese

Amityville	Bayshore	Bohemia
Center Moriches	Centereach	E. Hampton
Deer Park	E. Hampton	E. Quogue
Hampton Bays	Huntington Station	Islip
King Park	Islip Terrace	Lindenhurst
Miller Place	Montauk	Riverhead
Rocky Point	West Bablylon	West Hampton

School District Overweight/Obese Percentages

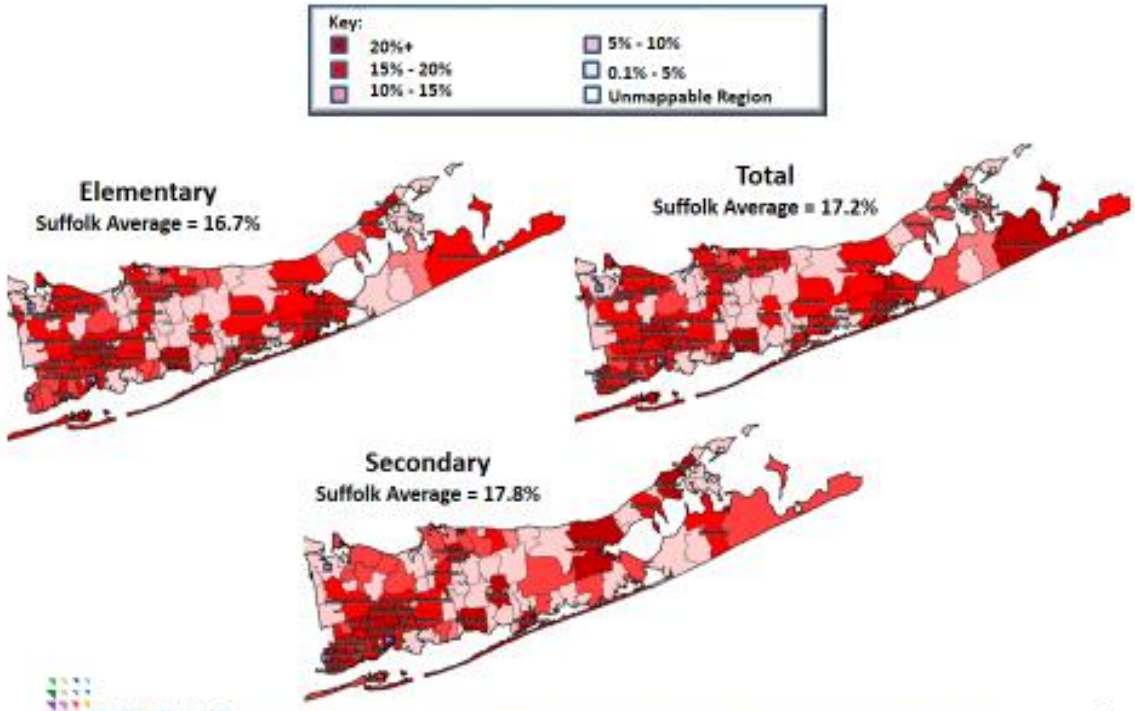
(2012 - 2014)



Northwell Health

Source: http://www.health.ny.gov/prevention/obesity/statistics_and_impact/student_weight_status_data.htm; sk

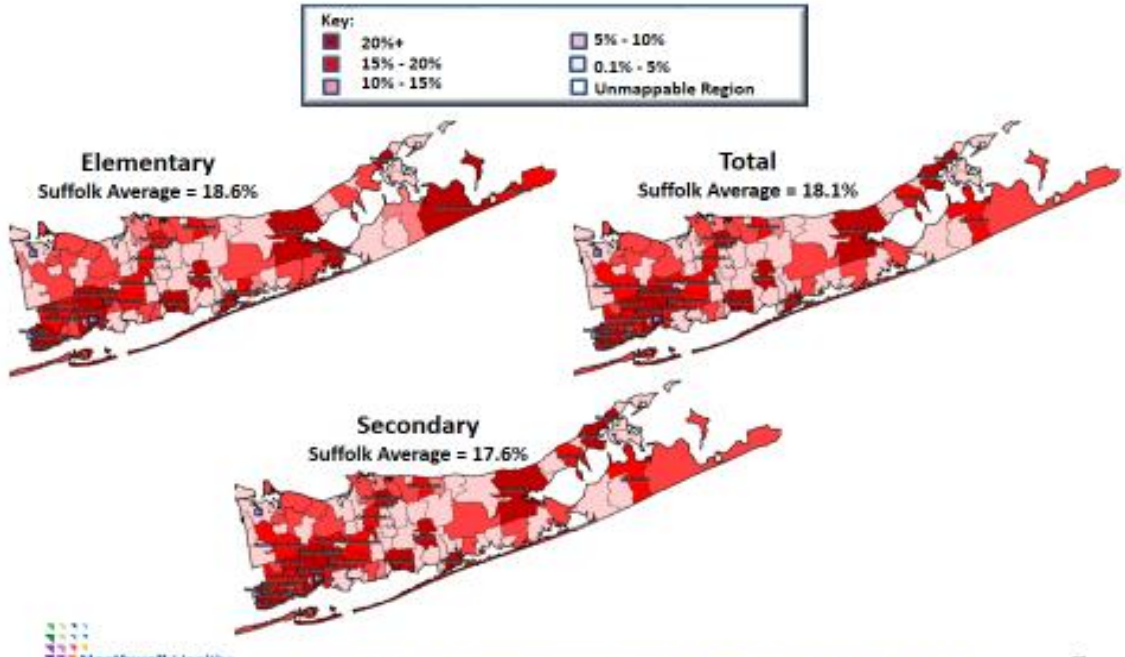
School District Overweight Percentages
(2012 - 2014)



Northwell Health

Source: http://www.health.ny.gov/prevention/obesity/statistics_and_impact/student_weight_status_data.htm sk

School District Obese Percentages
(2012 - 2014)

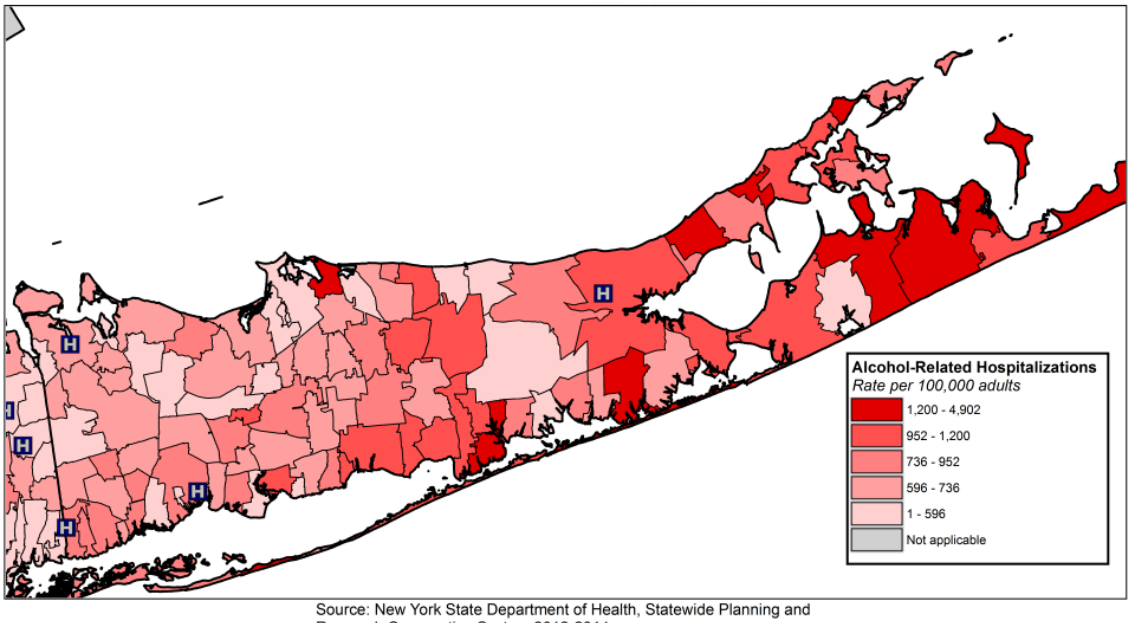


Northwell Health

Source: http://www.health.ny.gov/prevention/obesity/statistics_and_impact/student_weight_status_data.htm sk

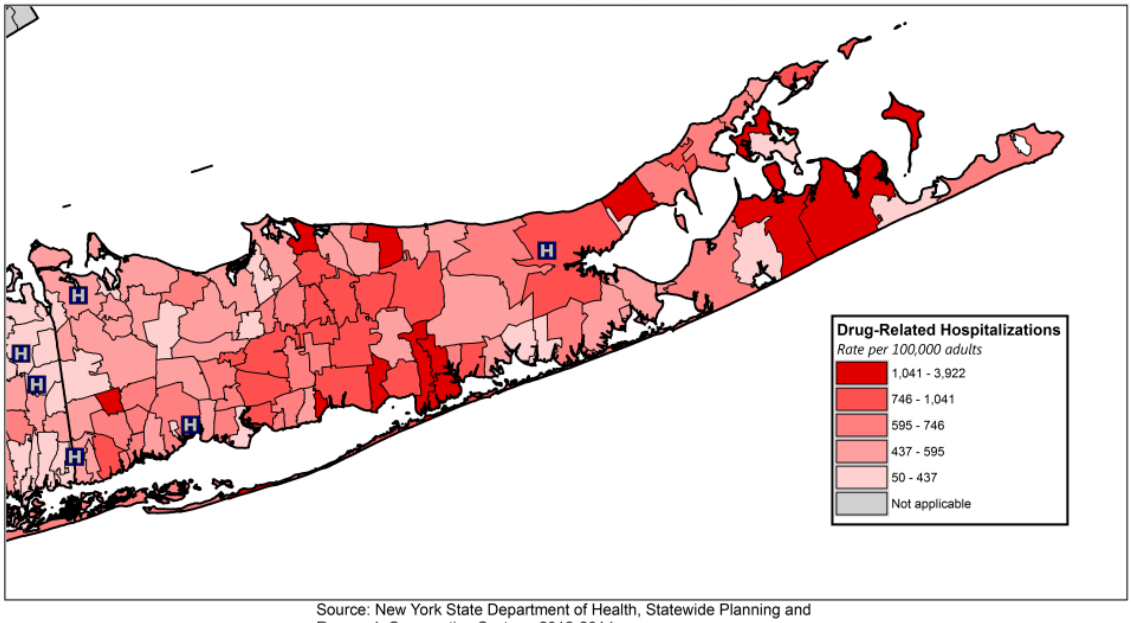
Mental Health and Substance Abuse

To assess the prevalence of mental health disorders and substance abuse in Suffolk County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). Although the suicide rate (per 100,000) for Suffolk County was 6.8, lower than the NYS rate (7.5), it was still above the NYSPAO of 4.8. The percent of Suffolk County adults reporting 14 or more days with poor mental health in the last month was 13% compared to NYS (11%) and above the NYSPAO of 7.8%. PQI data for mental health emergency department visits showed increased rates in the following communities: Patchogue, Medford, Coram, Middle Island, Brookhaven, Manorville, Mastic Shirley, Mastic Beach, Moriches, Middle Island, Wading River, Riverhead, Southold, Water Mill, and Orient. Suffolk County's rate of binge drinking is 21%, above NYS (19%) and the NYSPAO of 13.4%. The map below illustrates the areas within Suffolk that have a higher concentration of alcohol-related hospitalizations which include Ocean Beach, Peconic, East Marion, Mattituck and Wainscott. Drug-related Suffolk County hospitalization rates (per 10,000) were 25, on par with the NYS average and slightly below the NYSPAO (26). Those areas with higher concentrations of drug-related hospitalizations are Ocean Beach, Mattituck, Mastic Beach, Port Jefferson and Mastic. PQI data for substance abuse emergency department visits showed increased rates in the following communities: Bohemia, Ronkonkoma, Patchogue, Medford, Coram, Port Jefferson, Miller Place, Rocky Point, Brookhaven, Manorville, Mastic Beach, Riverhead, Mattituck, Peconic, Greenport, and East Marion. New York opioid and heroin death rates were higher than any other state and rose by 2000% from heroin and 200% from opioids. Suffolk County heroin and opioid death rates were 8.1 and 6.7 percent respectively.[16] Suffolk County had the highest number of heroin deaths in the state.



Source: New York State Department of Health, Statewide Planning and Research Cooperative System 2012-2014

[16] Prescription Opioid Abuse and Heroin Addiction in New York State. Report from Office of NYS Comptroller. (June 2016) https://www.osc.state.ny.us/press/releases/june16/heroin_and_opioids.pdf

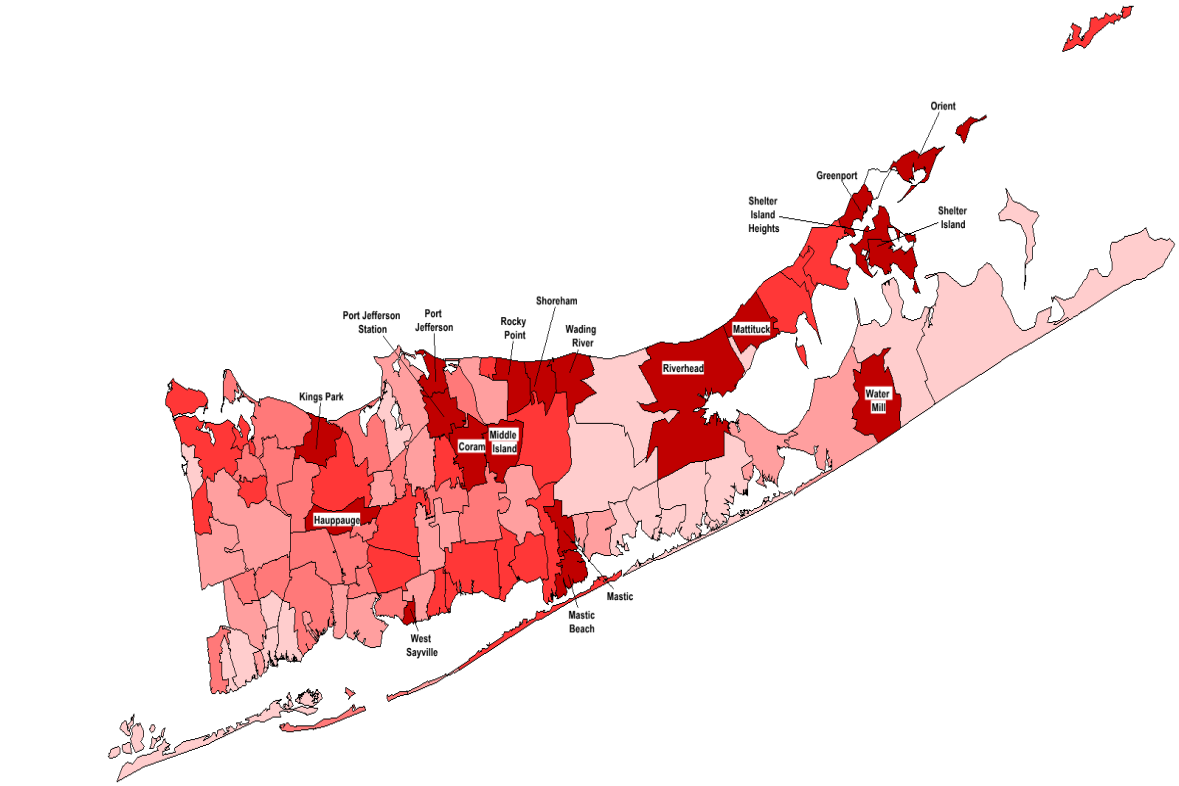


Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2012-2014

This data was also supported by the analysis of serious mental illness in Suffolk. The calculation of serious mental illness rates first required establishing a definition of all behavioral health diagnoses that qualify as a Serious Mental Illness (SMI). After review of scholarly and regulatory research, it was determined that the definition most relevant and applicable was New York State's Office of Mental Health's (OMH) DSM4-R/ICD-9 diagnoses codes for Serious Mental Illness, a criteria used to determine eligibility for Health Home services for Medicaid recipients. CMS General Equivalency Mappings (GEMs) were applied to crosswalk all ICD-9 diagnoses codes to find their ICD-10 equivalents. The updated definition was then applied to NYS DOH Statewide Planning and Research Cooperative Systems, (SPARCS) claims based data source. The definition was used to analyze all inpatient admissions within Northwell Health's service area counties, with a principle diagnoses code defined as an SMI for the full years of 2014-2015. The data was stratified by patient origin (county and zip code), gender and age-group. Adjusted rates were calculated after stratifying both inpatient volumes and US census based population estimates (sourced from Truven Health Analytics) by patient origin (county and zip), gender, and age-group. An average county-level rate was calculated and used as a benchmark comparison when analyzing at the zip-code level. The adjusted rates per zip-code, per county, were then ranked into quintiles, and visualized using MapInfo, a geo-spatial software program. While the analysis is indicative of a density of patients and cases, and can add value in future planning and community health initiatives, it is not without its limitations. The primary limitation of the analysis is that it is far from comprehensive, restricted to just claims-based data looking at inpatient admissions based on a principle diagnoses of SMI. However, its value is in its ability to provide a relational understanding in terms of neighborhoods and communities with the highest rates of SMI.

The county rate of Serious Mental Illness (SMI) in Suffolk was 336.7 per 100,000 population. The highest rates of SMI were found in the Eastern Long Island & Central Suffolk communities. Zip code 11777, Port Jefferson, had the one of the highest rates in all of Suffolk, with a total of 651.1 per 100,000 population. Areas exhibiting high rates include: Coram, Greenpoint, Hauppauge, King Park, Mastic, Mastic Beach, Mattituck, Middle Island, Orient, Riverhead, Rocky Point, Shelter Island, Shoreham, Wading River and Watermill.

Suffolk County Serious Mental Illness (SMI) Rates



Quintile	Key
Highest 1	
2	
3	
4	
Lowest 5	

HIV, STDs, Vaccine-Preventable Diseases & Health Care-Associated Infections

To assess the prevalence of HIV, STDs. Vaccine-Preventable Diseases & Health Care-Associated Infections in Suffolk County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). Suffolk County's newly diagnosed HIV case rate (per 100,000) was 7, significantly below the NYS rate (19) and NYSPAO (23). The Suffolk County Gonorrhea case rate (per 100,000) was 29, lower than NYS (94) but above NYSPAO (19). The tuberculosis case rate (per 100,000) for Suffolk County was 3.4, below NYS (4.9) but above NYSPAO (1). Suffolk County case rates for chlamydia and pelvic inflammatory disease hospitalizations were also below the NYS rate.

Below is a table outlining HIV/AIDS and STD Rates for Suffolk County in comparison to NYS averages, color-coded by whether Suffolk is significantly better than, significantly worse than, or comparable to NYS. Suffolk County is significantly better than NYS across all HIV/AIDS and STD rates.

Suffolk County HIV/AIDS and STD Rates

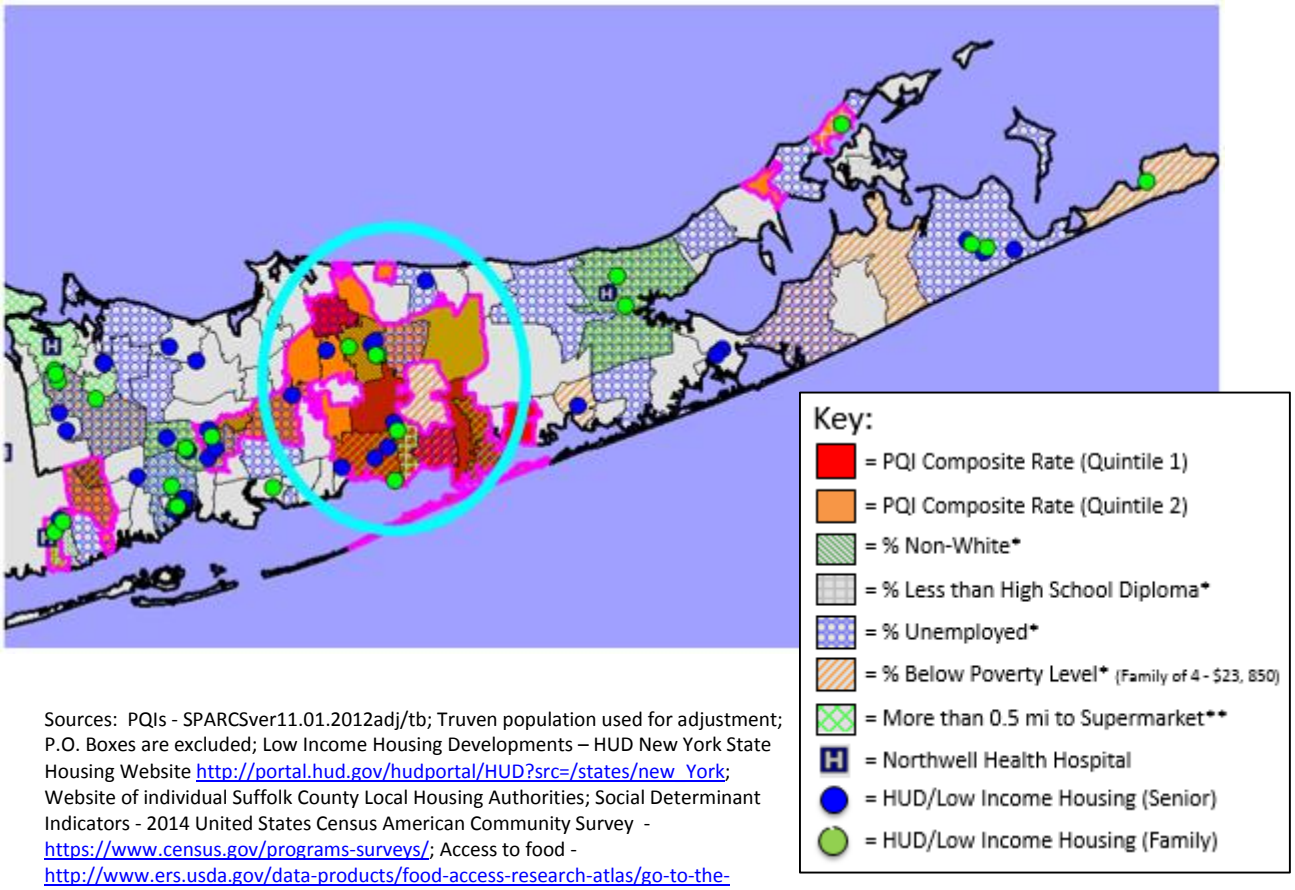
Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	County Ranking Group
HIV case rate per 100,000					
Crude	317	7	19.1	Yes	3rd
Age-adjusted	317	7.4	19.1	Yes	3rd
AIDS case rate per 100,000					
Crude	197	4.4	12.2	Yes	3rd
Age-adjusted	197	4.4	12.2	Yes	3rd
AIDS mortality rate per 100,000					
Crude	58	1.3	4	Yes	3rd
Age-adjusted	58	1.1	3.7	Yes	3rd
Early Syphilis rate per 100,000					
Early syphilis case rate per 100,000	195	4.3	14.4	Yes	4th
Gonorrhea case rate per 100,000					
All ages	1,577	35.1	107.7	Yes	3rd
Aged 15-19 years	331	104.3	368.1	Yes	3rd
Chlamydia case rate per 100,000 males					
All ages	2,877	130	336	Yes	2nd
Aged 15-19 years	523	317.5	1,029.10	Yes	2nd
Aged 20-24 years	1,172	785.1	1,492.70	Yes	2nd
Chlamydia case rate per 100,000 females					
All ages	7,482	327.6	672.3	Yes	2nd
Aged 15-19 years	2,448	1,604.90	3,595.50	Yes	2nd
Aged 20-24 years	3,093	2,242.70	3,432.20	Yes	2nd
% of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013)	3,896	63.2	72.2	Yes	2nd
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	188	2.2	3	Yes	2nd

Key*:
Significantly Better than NYS Average
No Significant Difference from NYS Average
Significantly Worse than NYS Average

*Where significance was not available, better, the same or worse than the New York State Average;
Source: New York State Department of Health https://www.health.ny.gov/statistics/chac/chai/docs/sti_28.htm; The county ranking groups: 1 - most favorable to 4 - least favorable. These county ranking groups are categorized based on the quartile distribution of all county rates

Suffolk County Summary of Findings

Finally, PQI and social determinant data were overlaid to identify areas of greatest need in Suffolk County. Areas of Suffolk County that fall into Quintiles 4 & 5 of the PQI Composite Rate were mapped. Then we began to overlay characteristics that provide some indication of health outcomes such as percent Non-White, percent Less than High School Diploma, percent Unemployed, and percent Below Poverty Level. In addition, areas where less than 70% were located within 0.5 mi to a supermarket, which classifies an urban area as food insecure were highlighted. Ultimately, there was a substantial overlap between social determinants of health, a lack of easy access to food, and poor health outcomes. This overlap was most apparent in Centereach, Selden, Coram, Medford, Patchogue, Bellport, Ridge, Brookhaven, Mastic, Shirley, and Mastic Beach (this area is circled on the map below).



Sources: PQIs - SPARCSver11.01.2012adj/tb; Truven population used for adjustment; P.O. Boxes are excluded; Low Income Housing Developments – HUD New York State Housing Website http://portal.hud.gov/hudportal/HUD?src=/states/new_York; Website of individual Suffolk County Local Housing Authorities; Social Determinant Indicators - 2014 United States Census American Community Survey - https://www.census.gov/programs-surveys/; Access to food - http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx

In both our primary and secondary data analyses, major trends emerged regarding chronic disease, particularly obesity and the health behaviors associated with obesity, as well as mental health and substance abuse and access to healthcare. In our primary data analysis, both individual community members and community-based organizations expressed concerns about obesity and weight loss, and advocated for improving access to healthy foods and recreation. In addition, survey respondents and summit participants expressed concern about the growing need for increased mental health and substance abuse services. We saw the impacts of substance abuse, including drugs, alcohol, and tobacco, in our secondary data analysis as well. Finally, much of the conversation in our primary data analyses was centered on access and disparities in access.

Therefore, as a result of the 2016 primary and secondary data analysis the following health priorities, which are also impacted by identified social determinants of health such as poverty, unemployment, lack of housing, education and healthy food access which are present in specific in Suffolk County, emerged as pressing community health issues in the Northwell Health Suffolk County Service area:

- Chronic disease, especially in at risk and diverse communities
- Obesity
- Decreased consumption of and access to healthy foods
- Decreased physical activity and access to safe recreational areas
- Mental health and substance abuse
- Access to healthcare
- Lack of affordable housing
- Health and social issues related to the senior population

APPENDIX

Long Island Health Collaborative 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.iagguy.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

Suffolk County Community Member 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 survey monkey 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 3,910 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 1.57. Initial analysis took place in March 2016, a secondary analysis took place in June 2016, and a third analysis took place in November 2016. 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 Survey Monkey, 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 Survey Monkey 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 21st 2016, June 2nd 2016, and November 1st 2016, the PHIP data analyst downloaded results from each of the Survey Monkey 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 felt 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 felt 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.

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

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
☐ Black/African American
☐ Native American
☐ Asian/Pacific Islander
☐ Multi-racial
☐ 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
☐ Some high school
☐ High school graduate
☐ Technical school
☐ Some college
☐ College graduate
☐ Graduate school
☐ Doctorate
☐ 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.

Suffolk County Qualitative Needs Assessment:

Findings from Community-Based Organization Summit Events

A Collaborative Approach to Assessing Community Needs

May 2016

Table of Contents

Introduction

Long Island Health Collaborative Partners

The Long Island Population Health Improvement Program (LIPHIP) is a New York State Department of Health grant-funded initiative designed to promote population health activities. The LIPHIP is organized by the Nassau-Suffolk Hospital Council (NHSC), the membership association for all hospitals on Long Island. The core of the LIPHIP is an extensive workgroup of committed partners who agree to work together to improve the health of all Long Islanders.

Advisory Committee Members and Program Facilitators

The Long Island Health Collaborative would like to thank members of the CBO Summit Advisory Committee who volunteered their time and expertise during the planning and execution of this event. Advisory Committee members attended countless meetings, provided oversight during development of data collection tools and some participated as lead-facilitators during the summit events.

- Harriet Gourdine-Adams, Chief Officer for Care Coordination, Tri Care Systems DBA LIAAC
- Celina Cabello, Epidemiologist, Nassau County Department of Health
- Laurel Janssen-Breen*, Associate Professor, Assistant Chair, Department of Nursing, St. Joseph's College
- Tavora Buchman, Director, Quality Improvement, Epidemiology and Research, Director, Tuberculosis Control, Nassau County Department of Health
- Elizabeth Cohn, Director, Center for Health Innovation, Adelphi University
- Nancy Copperman, Assistant Vice President, Public Health and Community Partnerships, Strategic Planning, Northwell Health, Nassau-Queens PPS
- Linda Efferen, Medical Director, Suffolk Care Collaborative
- Amy Hammock*, Assistant Professor, Department of Family, Population and Preventative Medicine, Stony Brook Medicine
- Chris Hendriks, Vice President, Public & External Affairs, Catholic Health Services of Long Island
- Grace Kelly Mc-Govern, Public Relations Director, Suffolk County Department of Health
- John J. Perkins Jr. EPIC Physician Co-Champion, St. Charles Hospital Rehabilitation Liaison
- Matt Tannenbaum, Nutrition Intern, Northwell Health
- Karen Tripmacher, Director, Community Education and Health Benefit, Winthrop University Hospital
- Althea Williams, Senior Manager, Provider and Community Engagement, Suffolk Care Collaborative

LIHC member organizations Adelphi University and St. Joseph's College provided meeting space and served as the host for both events.

* Amy Hammock and Laurel Janssen-Breen hold expertise in facilitation skills and qualitative analysis, serving as valuable key-leaders during the facilitator training for LIHC members.

Overview of Service Area

Suffolk County, comprising the eastern region of Long Island, is an area of growing diversity, cultures and population characteristics. Data presented within this report will demonstrate the relationship between health disparities and a wide range of socioeconomic factors. Our findings confirm the presence of the

correlation between health status to a variety of social determinants including race, ethnicity, gender, language, age, disabilities, and financial security. Elimination of 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 throughout Suffolk County.

The Long Island Population Health Improvement Program (LIPHIP) is a New York State Department of Health, grant-funded initiative, designed to promote population health activities. The LIPHIP is organized by the Nassau-Suffolk Hospital Council (NSHC), the membership association for all hospitals on Long Island. The core of the LIPHIP is an extensive workgroup of committed partners who agree to work together to improve the health of all Long Islanders. This workgroup, called the Long Island Health Collaborative, consists of the two county health departments, all hospitals on Long Island, physician leaders, representatives from nursing and mid-level provider associations, dozens of community-based health and social service organizations, academic institutions, health plans, local municipalities, and many other sectors.

The Suffolk County Department of Health and Nassau County Department of Health along with all hospitals located on Long Island appointed the LIPHIP as the workgroup lead for collecting data to propel the Community Health Needs Assessment Cycle 2016-2018. To address our desire to capture the valuable perspectives of representatives from community-based organizations and social service agencies on Long Island, the LIPHIP planned two Summit Events during which qualitative data was collected. Representatives from a comprehensive network of organizations who possess unparalleled experience working with community members throughout Long Island were invited to participate during the events. Participating organizations emphasized the importance of an opportunity to network and share expertise amongst counterpart agencies as a value-added benefit during events. Collaborative spirit was bountiful and indicative of the passion and commitment community agencies have for improving health outcomes on Long Island.

Qualitative data collected during facilitated discussion summit events has been analyzed, interpreted and presented within the *Summary of Findings* section. This report will serve as a county-level framework for informing Community Health Improvement Plans as well as plans for intervention. This tool will be publically available through the Long Island Population Health Improvement Program Website, and will be useful to a multidisciplinary spectrum of professional organizations who serve the community. Aspects covered include identifying priority areas according to the New York State Department of Health Prevention Agenda 2013-2017, reoccurring themes outside of the Prevention Agenda parameters, health disparities and barriers to care and novel recommendations for improving services and programs.

Methodology

Event Planning and Structure

An advisory committee was established to provide oversight of strategic planning Community Based Summit 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, selected due to their extensive background in qualitative research and facilitation skills. These key leaders, Dr. Laurel Janssen-Breen, Associate Professor, St. Joseph's College and Amy Hammock, Assistant Professor, Stony Brook University presented an interactive, hands-on curriculum and training for LIHC members who volunteered to take the role of facilitators during the 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.

Three summit events were hosted on different dates in varying locations to increase appeal and engagement toward a broad range of participating organizations.

- Adelphi University, Garden City NY, February 2, 2016
- St. Joseph's College, Patchogue, NY, February 10, 2016
- Online Based Summit, WebEx, February 12, 2016

Attendance was robust, with 45 organizations in representation at the Nassau County Event; 72 organizations at the Suffolk County Event and 2 organizations during the CBO Summit Event. In total, 119 organizations participated, which contributed to the diversity and breadth of qualitative data collected during events.

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. Script components include: Introductions, Request for Permissions, Instructions, Event Guidelines and Questions. 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.

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.

Analysis team:

- Dr. Laurel Janssen-Breen, Associate Professor Assistant Chair, St. Joseph's College
- Michael Corcoran, Data Analyst, Population Health Improvement Program
- Alyssa Dahl, Principal Research Analyst, Data Gen Healthcare Analytics
- Janine Logan, Senior Director, Nassau-Suffolk Hospital Council, Population Health Improvement Program
- Kate McCale, Director of Quality and Education, Rochester Regional Healthcare Association, Nassau-Suffolk Hospital Council
- Sarah Ravenhall, Program Manager, Population Health Improvement Program
- Kim Whitehead, Communications Specialist, Population Health Improvement Program

Alyssa Dahl, Principal Research Analyst 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.

County Differentiation: Within the Long Island region, bordering counties Nassau and Suffolk are distinct in character and complexity, driving our decision to separate the data by county. In order to maintain a unique identity for each County-level report, each quotation was coded as applicable to ***one*** county.

Quotations from bi-county organizations, who participated at the Suffolk event, were coded as Suffolk. Likewise, quotations from bi-county organizations participating during the Nassau event were coded as Nassau. Any quotation where the participant verbally or physically (by holding up the appropriate county card) indicated they were speaking on behalf of a county, were flagged accordingly.

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.

Strategy for selection of codes

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 (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.

Categories and sub-categories

Categories and sub-categories were selected using a combination of NYS Department of Health Priority Areas and Focus Area framework within Prevention Agenda blueprint, and key themes emerging from transcripts.

- Keywords were linked to each sub-category, for example: (*A. Chronic Disease 1. Diabetes <u>Keywords</u>: Diabetes, A1C, amputations, blood glucose, blood sugar etc.)*

A. Chronic Disease
    1. Diabetes
    2. Respiratory
    3. Cardiovascular
    4. Cancer
    5. Other Chronic Conditions
    6. Smoking
    7. Obesity/Nutrition
    8. Chronic Disease Prevention
    9. Chronic Disease Management
B. Healthy and Safe Environment
    1. Injuries

2. Environment-Violence
3. Environment-Air Quality
4. Environment-Built
5. Environment-Water
6. Healthy and Safe Environment-Homes
7. Healthy and Safe Environment-Access

C. Healthy Women, Infants and Children
1. Children's Health
2. Infants Health
3. Pregnancy
4. Childbirth
5. Maternity/Mother

D. Mental Health and Substance Abuse
1. Mental Health-Attitudes
2. Mental Health-Treatment and Recovery
3. Substance Abuse
4. Eating Disorders
5. Anxiety, Mood Disorders and associated emotions
6. Suicide
7. Mental Health- General
8. Mental Health- Susceptible Populations

E. HIV, STD, Vaccine Preventable Diseases and Health Care- Associated Infections
1. HIV and STDs
2. Vaccines
3. Hepatitis
4. Healthcare-Associated Infections
5. General

F. Disparities
1. Race/Ethnicity
2. Language
3. Special Populations
4. Gender
5. Gender/Identity/Orientation
6. Religion
7. Age
8. Senior Issues
9. General

G. Barriers
1. Access
2. Financial
3. Culture
4. Communication
5. Transportation
6. Insurance
7. Care
8. Employment
9. Disabilities
10. Research

H. Barrier/Disparity

1. Education

I. Additional Services
    1. Community and Bridging Services
    2. Financial Assistance
    3. Policy
    4. Service Expansion and Improvement

Methodology for Deeper Dive (Second Analysis)

A focused set of secondary analyses was completed after the initial identification of key themes and priorities in order to better understand the population needs within broad categories of health and/ or access issues. Three broad categories from the initial analysis were further subdivided:

- Access Barriers —> 15 new categories
  For example: For/ due to "fear," "integrated systems," or "service availability."
- Educational Barriers and Disparities —> 21 new categories
  For example: For/ due to "health literacy," "addressing misconceptions," "caregivers."
- Promoting Mental Health and Preventing Substance Abuse —> 32 new categories
  For example: For/ due to "proper treatment," "incarcerated populations," "linked to abuse."

The following steps were taken to complete the Deeper Dive:

- Exportation of all quotations coded for a broad category in the initial analysis.
- Re-read quotations with attention to identify more specific health needs, barriers, disparities, or special populations at risk.
- Compiled a new list of sub-groups to code quotations for and the keywords that can be used to identify these new codes in the future.
- Applied the new sub-grouped codes to select quotations on an individual basis.

Any quotation from the original broad category that did not fit into a new sub-group was excluded from this analysis. These quotations were acceptable for the initial analysis when the intent was to identify key themes and priorities. In contrast, these quotations were not considered suitable for the secondary analyses because they lacked information to describe the problem, identification of populations at risk, or suggestions of possible remedial interventions. This was a very infrequent occurrence. The below example illustrates when this action was taken:

For example, a participant states, "I see mental health as the most important issue for the community I serve." This quotation fits well into the initial analysis when the intent was to identify and rank key themes by importance. In contrast, this quotation would not fit well into the secondary analyses because it does not provide any additional information about who is affected, why it is a problem, or what can be done to intervene. A quotation that would very easily be acceptable for the secondary analyses would be, for example, "I see mental health as the most important issue for the community I serve because we have problems with homelessness, people fear discrimination, and it is difficult for them to receive and maintain proper treatment."

In addition to sub-dividing broad categories from the initial analysis, a new category for quotations was created in order to address "food insecurity."

The following steps were taken to identify and code quotations for food insecurity:

- Exported all quotations for a set of codes which may have captured food insecurity. This set of quotations consisted of any quotation given a code for 1) access to health foods (a new access barriers sub-group), 2) obesity, or 3) access to safe and healthy environments.
- Re-read quotations with attention to identify any that indicated food insecurity.
- Applied a new code to select quotations identified for food insecurity on an individual basis.

For all new codes created in the secondary analyses, the following data was delivered:

1. Quotation exports
2. Code co-occurrence frequencies
3. Tabular frequencies of quotations according to the county being represented by the speaker

NYS Department of Health Prevention Agenda Areas

The New York State Department of Health Prevention Agenda Areas of Focus shaped the framework for project development and analysis.

1. Chronic Diseases
    a. Obesity
    b. Tobacco Use and Secondhand Smoke Exposure
    c. Preventive Care and Management

2. Healthy and Safe Environment
    a. Injuries and Violence
    b. Outdoor Air Quality
    c. Built Environment
    d. Water Quality

3. Healthy Women, Infants and Children
    a. Maternal and Infant Health
    b. Child Health
    c. Reproductive Health and Wellness
4. Mental Health and Substance Abuse
    a. Mental, Emotional and Behavioral Health
    b. Substance Abuse and Mental, Emotional, and Behavioral Health Disorders
    c. Integration of Promotion, Prevention, Treatment and Recovery Services

5. HIV, STD, Vaccine Preventable Diseases and Health Care-Associated Infections
    a. HIV and STDs
    b. Vaccination Against Vaccine-Preventable Diseases
    c. Hepatitis C Virus (HCV)
    d. Healthcare-Associated Infections

For additional information on the NYS Department of Health Prevention Agenda areas, please visit: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Summary of Findings

Total number of quotations coded applicable to Suffolk County=850

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. Cumulatively 52.1% of quotations in Suffolk were identified as being inclusive of one or more Chronic Disease keyword.

Distinct Prevention Areas by Ranking

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**

Cumulative Prevention Areas by Ranking

Cumulative Prevention Areas reflects the number of focus areas mentioned within one of the priority area per quote, 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 twice for Chronic Disease because obesity and tobacco use are two separate focus areas.

PA Rank	Suffolk	%*
1	**Chronic Disease**	**52.1%**
2	**Mental Health**	**47.9%**
3	**Healthy and Safe Environment**	**33.8%**
4	**Healthy Women, Infants and Children**	**19.5%**
5	**HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections**	**12.7%**

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

Prevention Agenda Areas by Focus Area

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.

Due to the complexity of Mental Health and Substance Abuse as a focus area, the analysis team saw potential benefit within a second round of analysis, covering all aspects of mental health and substance abuse at a granular level. This second analysis is described within the *Deeper Dive* section V of this report.

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*
Additional interpretation located within "Deeper Dive" Section of this report.

Healthy and Safe Environments were discussed as an area of concern within 25.4% of Suffolk County quotations. Cumulatively, 33.8% of quotations from Suffolk County included aspects of Healthy and Safe Environment.

Within this area, "Homes" were reflected in 11.2% of quotations with "Access to care" following in second with 8.2% of quotations. The focus area of "homes" covered issues related to safe and affordable housing and tobacco-free housing.

The “Access” focus area included key words and themes such as access to care; food; service; school and stores. After further exploration of the code “Access”, the analysis team sought further investigation of this area within a second round of analysis, which is described within the Deeper Dive section V of this report.

Healthy and Safe Environment	
Focus Area	**%***
Homes	11.2%
Access	8.2%
Violence	6.1%
Injuries	3.4%
Built	2.6%
Air Quality	1.4%
Water	0.8%

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

Analytic Interpretation & Participant Quotations
The lack of affordable housing in Suffolk County creates unsafe living environments, which can be considerably problematic for seniors and veterans. Availability of stable housing has a direct correlation with barriers to accessing health services. Just to speak about the chronic homeless population, which is a lot of people out there, there are veterans out there, there are a lot of people freezing to death on Long Island, which is insane that that’s still happening. To that piece, and it’s connected to health, is definitely affordable housing. or you have landlords who are buying houses who are literally renting to 20 people in a ranch house, that’s made for three, four, maybe five people. *-Hope House*
A sustainable, built environment provides increased opportunity for community members to engage in physical activity and promotes easy access to health services and healthy food options. I'd say leading a healthy lifestyle, so whether that's access to healthier food options and beverage options. A lot of the communities that we work in may not have a grocery store nearby or they'll have corner stores and if you then look at the percentage of the population that doesn't own a vehicle, you have to think about these families that now have to walk, like, how far do they have to walk to get healthy food for their families and if the closest thing that they can access is some type corner store, you know, that tends to have high caloric foods that are nutrient deficient, then also you have communities that maybe aren't necessarily walk friendly, you know, you went to increase these opportunities for physical activity in getting families and kids outside. *-Sustainable Long Island* One thing I wanted to address for all of these things too is the nutrition part of it, but also on the other end of that is the movement and the exercise and the recreational opportunities that need to be stressed. There is not one chronic disease that isn't helped by some sort of exercise, and unfortunately, especially out in Suffolk County, a lot of our communities are not walkable, there are no sidewalks, but even there are no bike paths, there is no -- not no, there is few bike path, and the different places where people can do inexpensive activities. Not everybody can afford to join a gym, not everybody can or has the access to that kind of program, but I think the schools need to really concentrate on lifetime activities, what the children are learning that can carry through for a lifetime in their gym classes, in their programs that they're offered, and the towns themselves with coming up with recreation and activities for the community.

-At Home Designs

A safe home environment is incredibly important for seniors who may be susceptible to falls and injuries due to their medication regimen.

I just want to put for the record one thing about the falls and the senior citizens, because there are a lot of seniors who, because some of the medications, they are not taking it properly or they are overmedicated or they don't realize they have hazards in their home. So we see a lot of folks, seniors, who don't want to admit they are not as steady as they used to be, so they are falling.
-Stony Brook Medicine

Domestic violence persists in select Suffolk County neighborhoods which is an overall environmental safety concern contributing to an increase in at-home injuries.

Forms of Elder Abuse including physical, emotional and financial yield to unsafe and dangerous home-environments for seniors.

Looking at injuries and violence I think really especially when you're looking at it from a public health perspective, domestic violence and sexual assault are definitely public health concerns because it may be affecting one person we see that, you know, people are missing work. We're seeing a tremendous increase in traumatic brain injuries or violence issues. And also looking at things, we see a lot of elder cases so it may not be physical abuse, but financial exploitation, emotional abuse. People you know mismatching medications, refusing to give medications particularly when their caregivers are overmedicating people that they're taking care of.

-VIBS

Community members of lower socio-economic status often experience barriers to accessing high quality health care and poorer health outcomes. Significant health disparities and poor outcomes related to asthma are seen in Hispanic and African American populations.

We know that in populations of poverty, we see many more hospitalizations and emergency room visits for asthma. But African Americans are five times more likely to die from asthma than Caucasian. Hispanic are three to five times more likely to end up in the hospital than white children. So from -- it is sometimes related to genetics, but mostly to lower socioeconomic status and lack of -- barrier -- lack of access to good healthcare in their communities. It is also very closely related to the housing situation.
- Asthma Coalition of Long Island/American Lung Association of the Northeast

Lack of affordable housing and transportation in low socio-economic neighborhoods contribute to a barrier accessing community services or supermarkets which carry nutritious food choices.

I just wanted to add that housing and transportation are two of the biggest issues for our members. The lack of Section 8 housing, safe and affordable housing. Our members don't have extra cash to pay for realtor fees for an apartment, security deposit, moving expenses, transportation. Not everybody has a car. If you travel by bus in Suffolk County, it can take you three hours to go a couple of miles. So transportation is a very, very big issue. We have supermarkets that are closing left and right predominantly in lower income communities. So you go to your local, little store, they're not carrying healthy foods.

-Association for Mental Health and Wellness

Additional interpretation of "Access to services" located within "Deeper Dive", section V.

The priority area of Healthy Women, Infants and Children was highlighted as a focus area of concern within 13.2% of Suffolk County quotations. Cumulatively, 19.5% of quotations from Suffolk County included aspects of Healthy Women, Infants and Children.

Within this area, “Children’s Health” was reflected in 9.3% of quotations with “Maternity/Mother” following with 5.8% of quotations. Children’s health issues were inclusive of keywords related to well child visits; child neglect; safe childcare options; developmental delays and dental problems for children.

The focus area “Maternity/Mother” covers issues related to breastfeeding; health insurance for mothers; reproductive care; young mothers and utilization of preventive health services for mothers.

Healthy Women, Infants and Children	
Focus Area	**%***
Children’s Health	9.3%
Maternity/Mother	5.8%
Pregnancy	2.4%
Infant’s Health	1.5%
Childbirth	0.6%

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

Analytic Interpretation & Participant Quotations
The availability of childcare services is not adequate in Suffolk County. Due to this gap, mothers face challenges with accessing social, health or education services. And the other is that the mothers don't have adequate child care. We expect in this society that women should be working, and they have to work to make a living, but there is not adequate child care. All the services and all the programs are very good, we provide them, but it doesn’t link to the people who really need it. So that’s why we see so few of them attending those services. *-Cornell Cooperative Extension*
Incidence of infant mortality, prematurity and low-birth rate babies is higher among the African American population. It is vital that expectant mothers, especially those in high-risk populations, are accessing comprehensive health services. Post-delivery is the perfect time to engage mothers in follow-up care by linking them to services. When it comes to birth outcomes, there is still a very high incidence of infant mortality, pre-term weight, mostly for the African American population. Even before that woman becomes pregnant, What is being done in the preconception period; What is the health of that mother like; Does she have chronic disease; Is that chronic disease being managed; Is she going every year for routine OB-GYN care; Is she being screened for HIV? Because the health of that woman before the pregnancy even occurs can impact on that outcome, preconception, prenatal and what we call the intra-conception phase. After she has that baby, before that next pregnancy we want to make sure she gets linked to services. *-Planned Parenthood, Nassau County Event, Region Specific*
Nutrition education should begin in the school setting and extend into the home environment. Parents and caregivers are the key to sustaining healthy eating practices outside of the school setting. Nutrition, starting at school-age level. Fundraising. They do fundraising with chocolates, McDonald's fundraising. We need nutrition workshops, not just for the children at the school-age level. We somehow need to get the parents involved. It's much easier to go to McDonald's and have dinner in a snap. We all like our junk foods once in a while, but it tends to be an everyday affair. *-Brentwood/Bay Shore Breast Cancer Coalition*

HIV, STD, Vaccine Preventable Diseases and Health Care-Associated Infections comprised 9.4% of distinct and 12.7% of cumulative Suffolk County quotes. Although this area comprised the least significant majority of quotations, interpretative analysis provides strong evidence that there is a desperate need for

additional services reaching those living with HIV/AIDS. This population requires a unique set of integrated care services, which seems to be lacking in accessibility. Furthermore, there are new emerging disease trends that will be important for professionals to address moving forward.

HIV, STD, Vaccine Preventable Diseases and Health Care-Associated Infections	
Focus Area	**%***
HIV-AIDS	7.5%
Sexually Transmitted Disease	3.1%
Vaccines	0.8%
Hepatitis	0.7%
General Infections	0.4%
Associated-Infections	0.2%

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

Analytic Interpretation & Participant Quotations
Stigma and cultural views create barriers to providing testing, education or care to those living with HIV/AIDS. **New York State law now requires primary care providers to offer HIV testing services to patients; however there are gaps in proper utilization or awareness of this guideline.** What I'm most excited about is we have the tools and resources to end the HIV/AIDS epidemic. It's a matter of getting everyone aware of their status and maintaining their care for the end of the viral spread. It's meant to keep the disease virally suppressed so they maintain their health and don't transmit the disease. The stigma though still exists and it prevents people from getting tested and people from getting treatment. I work with a lot of clients who are diagnosed late, and at that point HIV has progressed to AIDS. There are complications that aren't necessary if there is primary care in the first place. It is New York State law that doctors have to offer the test for AIDS, but people do not know that, and some doctors do not offer the test. But I'm excited that we have the tools to end the epidemic. -*Thursday's Child*
Care for people living with HIV has progressed to the point where we now need to focus on the provision of well-rounded, comprehensive care, which may include a focus on cases of HIV coupled with chronic diseases. Mental health and substance abuse are issues commonly associated with those living with HIV or AIDS. So we know that HIV is now a manageable disease. A person can take medication and pretty much live a healthy life, as somebody who doesn't have it. One of the things that have really affected the linkage and adherence to treatment has been mental health and substance abuse. So that's why this program came, to really address to work with the person, and provide them that individual education and figure out why they aren't accessing. Do they know what addiction means? What stigma is associated with mental health and substance abuse? So these are all main topics that I would meet with them individually to really figure out, is it culturally, if somebody in their family thinks, if you go to mental health you're crazy. They're not going to access those services. So it's really the education piece is very crucial to help them understand that importance and eventually linking with them, so that it could in turn help them in other parts of their life like their HIV, and be able to manage it and live an overall healthy live. -*Stony Brook Medicine EPIC*

Theories supporting anti-vaccination are popularizing, which has led to children being unvaccinated. Programs providing evidence-based information and education on the effectiveness and benefit of vaccinations may be helpful to address this.

I know some with regarding to the HIV STD and vaccine preventable diseases are the anti-vaccers. Social media has exacerbated these days you know, there's a huge one side or the other side, totally opposite. And people tend to believe those little things that they see, and they don't even see where they came from or what the source is. And it does not matter, and it's really hard to change people's mind, but it is a huge issue because kids are not getting vaccinated, and we are going to start to see more and more of these flare ups of childhood diseases that have been eradicated, or close to that should have been. So it is an issue.
-PSEG Long Island REAP Program

Disparities, Barriers, Education & Additional Services

Disparities among the senior population were of high importance to summit participants with 18.4% of quotations in Suffolk County being coded under this topic. The focus area of "Senior Issues" included key words related to aging, alzheimer's, finances, abuse, cognitive loss, crisis, falls, housing and safety. One theme of particular relevance was a resource need for caregivers who are often times unprepared for the decision-making and financial responsibility associated with caring for a family member.

Disparities related to "age" were indicated within 8.1% of the total Suffolk County quotations.

Disparities	
Focus Area	**%***
Senior Issues	18.4%
Age Disparities	8.1%
Race/Ethnicity Disparities	7.8%
Language Disparities	7.4%
Special Population Disparities	6.8%
Gender-Identity-Orientation Disparities	3.1%
Gender Disparities	2.7%
General Disparities	1.1%
Religion Disparities	1.1%

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

Analytic Interpretation & Participant Quotations

Many caregivers are unprepared for and faced with financial challenges that come hand in hand with the responsibilities of providing for and managing daily life for a family member.

Many of the services or support programs for people caring for someone with Alzheimer's or dementia take place at home, home care, which we try to educate the general public about and that calls for financial planning. The medical part of it may be covered, going to the neurologist or ongoing medical treatment, but to get someone to come into the home to help out often is private pay. So, that's a very big financial aspect. So, people that kind of fall in the middle -- you know, there's Medicaid, of course, there is a community Medicaid, but people who are in the middle, not very, very wealthy, it's a big financial burden on the family. So, if the person who has been diagnosed is the main breadwinner and the family cannot get assistance, that's a big issue.
-Alzheimer's Association

To everybody's point regarding the ageing population there's nearly one million caregivers on Long Island

and in order to be preventive in many situations we have to get information to those caregivers. And many of those caregivers don't identify themselves as one. So it's that population as well that we have to educate and give resources to not only for those that they maybe caring for, but as preventative information for themselves.
-*Utopia Homecare*

The LGBT community in Suffolk County is one that is medically underserved with many who have unmet health needs. To access services, many LGBT community members travel to New York City.

The LGBT community, in my opinion as a professional, I think they are underserved. That impacts their access to care and the level of care that they're getting and the services that they are providing. I know a lot of trans people on Long Island who commute to New York City for health care. So as a region, we're not serving their population. It's a population that needs more help. I can tell you there are thousands of trans people on Long Island who need services. The health issue I deal with specifically impacts this community more so than others.
-*Thursday's Child*

There are compounding barriers to accessing care that can be seen within the large population of undocumented individuals in Suffolk County. Such barriers include: lack of insurance coverage; financial barriers to paying for care; cultural and language barriers; not understanding of how to navigate the health system; transportation barriers and beyond.

Along with all the cultural and financial barriers and expectations, you also have a large undocumented population. So they don't have access to the same kind of medical care or other services that might enable them to go for medical care like transportation, like some government subsidies, and things like that. So the undocumented population is huge on Long Island and they don't have coverage and they don't have the resources.
-Adelphi University

As the age of the baby boomer population advances, expanded health services and financial resources will be needed to support this population. An added challenge may be seen for families who are experiencing poverty or financial debt into retirement age.

I wanted to add to her comment which another challenge again is Suffolk and Nassau County. If you look at the population demographics of Suffolk and Nassau for people who are under the age of five it's slightly increased. People, who are K to 12, flat because those families are leaving. It's the baby boomers that are shooting up in the last 12 years. The senior population has increased close to 33 percent and we're not really prepared for that at all. We're not prepared with our programs; we're not prepared with accessibility. Prepare for that increase in population so that's another challenge.
-Suffolk County Department of Health, Division of Prevention Medicine

There are extreme challenges associated with linking vulnerable populations, particularly the undocumented community to the services they need.

I actually wanted to comment about the LGBT community, but certainly we're seeing racial minorities and there is higher prevalence in those communities and historically less access to care. Particularly with the undocumented community we faced a lot of challenges to link diagnosis of HIV positive individuals to care. A lot of it leads to housing. A lot of folks aren't getting emergency housing opportunities or even SafeLink, the cell phones, those government cell phones, that's really difficult when you don't have the means to call up and make an appointment. So definitely among the undocumented population and I feel among Hispanic gay men and black gay men, because there is an additional stigma.
-*Thursday's Child*

Because community members seek treatment they are comfortable with, to increase service utilization among ethnically diverse populations, it is imperative that the availability of health literate and culturally competent services is increased.

People tend to seek out doctors or health care providers that speak their language or even of their own

ethnicity. There is a certain comfort to them there, you know, even if that might not be where they should be going or where they need to go, but they kind of stick to what they're comfortable with.
-Adelante of Suffolk County

Barriers to care were discussed frequently during the summit event, with a majority of conversation surrounding this topic. The top-three emerging focus areas included: “access barriers” and “financial and “care barriers”.

19.9% of barrier quotations in Suffolk County were related to “access” barriers. “Access barriers” included themes related to access to care; housing and transportation. Because “Access barriers” emerged as a leading focus area, the Analysis team had specific questions and considerations related to what “Access” really referred to. Within the “Deeper Dive” section V, this theme will be further broken down into sub-groupings.

“Financial barriers” were another frequently discussed barrier to care. Keywords associated with financial barriers include: affordability, barriers to funding, financial burdens, pay scales and poverty. Of the Suffolk County quotations flagged with barriers to care, “Financial Barriers” comprised 16.1%.

“Care barriers” comprised 13.4% of the total Suffolk County Barriers quotations. “Care barriers” include keywords related to: continuity of care, preventative care, service, staffing, medication, office hours and technology.

Barriers to Care	
Focus Area	**%***
Access Barriers	19.9%
Financial Barriers	16.1%
Care Barriers	13.4%
Insurance Barriers	12.1%
Transportation Barriers	9.3%
Cultural Barriers	6.1%
Communication Barriers	5.5%
Disability Barriers	4.9%
Employment Barriers	3.2%
Research Barriers	0.6%

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

Analytic Interpretation & Participant Quotations

Lack of financial security and stability are directly connected with a person’s ability to take accountability for their health needs, making decisions related to health statuses even more challenging.

Lack of financial security is a significant barrier for the senior population, often contributing to an inability to access health services.

If you lack financial means, you have a very difficult time finding a provider paying for your medications. Even if you are insured, you may have a difficult time paying co-pays, deductibles. The new plans that are out there, oftentimes, have very high deductibles and co-pays, and there are some help with the premiums, but they can still be out of reach for many people to access. Medicaid recipients have very good coverage in some ways, but it can be also difficult to find good providers under Medicaid. So

finances are a big issue.

- *Suffolk County Department of Health, Maternal Infant Community Health Collaborative*

There's just lack of financial security with our seniors. Really the numbers are staggering and dumbfounding. I can't even begin to tell you. You know, we go into some of these homes and like I said their income is $900 per month. You know, and so then they don't even know about Medicaid. So then it's a whole process of getting the Medicaid because they need services, and they are in debt now, because they didn't even realize they were entitled to Medicaid, and even people how have some money, who own the home, do not realize that they have access to these, to Medicaid, and to other avenues for financial relief. It definitely, the financial end of it, is a problem amongst our seniors.

-*Federation of Organizations*

Prioritization of needs for a family or caregiver is often based upon perceived urgency or necessity which often leaves preventative care and routine well visits to the wayside.

You look at people who are impoverished; they take care of their most drastic needs first. They need air, food, shelter. If there is no money left over after those three things, the other things get thrown to the wayside. You know, you get by without adequate clothing. You get by without preventative home care. Get by without going to a doctor, not just for preventive care, but when you are sick. If the kids are hungry, or if you are being threatened with eviction, the thing that drops off is taking care of your health, because that is not an urgent thing.
-*Catholic Home Care, Good Shepherd Hospice, Nassau event, Region specific*

The undocumented population is often left underserved due to misconceptions, mistrust or fear regarding their citizenship status. Community outreach focused on establishing trust, and culturally appropriate education focused on how to access services is an effective way to combat this fear.

You can let people know, you don't have to be afraid to go to the doctor if you are undocumented. You don't have to be afraid to call for help if you are undocumented. Here are ways that you can improve your health. This is what's going on mental health wise, and here is what you can do about it. I think that's important. I think I might have missed my chance before, but I just have to get this in there. We really need to fund care for people who are uninsured and ineligible for insurance. We need mental health sources for people. We need substance abuse treatment for all people. Medical care for all people. So it doesn't matter what your immigration status is or economics are. It is out there for everybody that needs it. We are one village. We are one community. What affects the undocumented people that live over here affects everybody. So that's I think we need to, you know, address getting - some funding and some services in place that's really important.

- *Suffolk County Department of Health, Maternal Infant Community Health Collaborative*

Stigma associated with individuals living with HIV, AIDS or those who identify as LGBTQ, has impacted the quality of care accessible to such vulnerable populations. Arming providers and front-line workers with the education needed to appropriately communicate with this population will improve gaps in service care.

I think the biggest barriers are stigma, both real and believed. We need competent providers across Long Island, and we might have points here and there, but it's a long island. I'm talking about all the different aspects of our culture that make us multi-dimensional; language, identity, LGBT, sexual identity, our HIV status. And I think it has to start with how we, as providers, do our intakes, ask our initial questions, because that person at the front desk who welcomes you, how they address you, how they speak to you, makes all the difference if that person will come back to you. Who's at the front desk? It has to be culturally relevant; otherwise we're never going to get past the perceived lack of competency.

-*LGBT Network*

Increased availability of health literate and culturally competent services, especially for minority populations, is an important component of improving health status. Establishing trust and demonstrating respect sets the groundwork for continuity of care.

I wanted to add two things that are barriers - trust, especially for the minority populations, where you provide the service and if they're coming is that they trust that organization. They may not trust you, but if they trust that organization they will come and seek that service, so the barrier is the trust you develop. And the cultural sensitivity who is the educator, who is the in-between person, who is providing that information or that service, is sensitive, is respectful, has the empathy, all those qualities that we probably seek out and we get burnt out, or we have people on front line and it's very hard to continue to do, so that becomes a barrier eventually, to provide the good sense, the services that we intend to do.

-Cornell Cooperative Extension

A disconnect between availability of health insurance and ensuring coverage is problematic among undocumented community members in Suffolk County. Vulnerable populations are often unaware of the health coverage plans available to them.

And that brings up the issue of health insurance which definitely affects the Brentwood/Bay Shore community because we have many undocumented individuals. We have to fight for them to get health insurance.

-Brentwood/Bay Shore Breast Cancer Coalition

Educational Disparities and Barriers, is another topic that the Data Analysis group felt should be further explored, with 19.6.0% of Suffolk County quotations. Themes related to educational disparities and barriers are broken down by sub-group within section V, A Deeper Dive.

Educational Disparities and Barriers	
Focus Area	**%***
Educational Disparities and Barriers	19.6%

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

After participants were asked to identify the most significant problems, barriers and disparities for the community they serve, participants were led to share their innovative ideas as to what additional services and programs are needed to improve the health of Suffolk County residents. Response to this question yielded very interesting results and many suggestions were closely related in concept.

Suggestions were broken down into four themes: service expansion and improvement; community and bridging services; policy and financial assistance.

"Service expansion and improvement" was the most frequently mentioned concept, with 16.7% of Suffolk County quotations addressing this topic. Suggestions for service expansion and improvement included ideas related to: extended provider service hours; additional screenings; screening for social determinants of health; culturally competent and linguistically appropriate services; workforce training for professionals and additional community health workers.

"Community and bridging of services" was a second commonly suggested theme including ideas related to: hiring health leads, empowering community members, health fairs, developing resource centers, bridging gaps in care, networking, establishing partnerships, family-centered advocacy and working with

faith-based organizations. “Community and bridging of services” was mentioned within 12.9% of the total Additional Service flagged Suffolk County Quotations.

Additional Services	
Focus Area	**%***
Service Expansion and Improvement	16.7%
Community and Bridging Services	12.9%
Policy	5.5%
Financial Assistance	3.8%

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

Analytic Interpretation & Participant Quotations
To deliver effective services, it is absolutely critical that providers and community-based organizations are providing education and services that are adherent to Culturally and Linguistically Appropriate Standards of care. All service providers, including physicians and front-line staff members should be participating in trainings which address cultural competency, health literacy and unconscious bias. I just -- a couple of people mentioned this. I do think it is important to reach people in their communities through people from their communities. So there are people that are like them. People that have the same experiences. That speaks their language. That will disseminate real accurate information. Can dispel some fears. Can educate. You can let people know, you don't have to be afraid to go to the doctor if you are undocumented. You don't have to be afraid to call for help if you are undocumented. Here are ways that you can improve your health. This is what's going on mental health wise, and here is what you can do about it. I think that's important. I think I might have missed my chance before, but I just have to get this in there. We really need to fund care for people who are uninsured and ineligible for insurance. We need mental health sources for people. We need substance abuse treatment for all people. Medical care for all people. So it doesn't matter what your immigration status is or economics are. It is out there for everybody that needs it. We are one village. We are one community. What affects the undocumented people that live over here affects everybody. So that's I think we need to, you know, address getting some funding and some services in place that's really important. *- Suffolk County Department of Health, Maternal Infant Community Health Collaborative*
Collaborative partnerships and community-wide communication efforts are essential in being able to assist community members in reaching the services they truly need. So I think that the awareness is for every level about all kinds of things because it's going to affect everybody differently. But the awareness and people say "Oh, it's on the database, I don't think it works." Because then nobody knows about the database and then everybody forgets to talk to each other and tell them what’s out there. And I think awareness is the primary thing. Are we all always going to be on top of everything? No, but I think it's these kinds of things, these kinds of get-togethers, these kinds of networking on a regular basis, actually give people an opportunity to talk. Not just network, not just wander around the room, and perhaps walk into someone, but to actually collaborate and find out information about other places is what people really need on a health care level to find out what's happening. *-Suffolk Cooperative Library System* I think one of the things that we have heard a lot today is that there are opportunities and services out there, but how can we collaborate, how can we connect people and connect different programs that are doing the same thing and how can we work together. I think that is a big problem in health care across the board for services.

-*Sustainable Long Island*
Provision of system navigation efforts may be an effective way to both empower patients, and to achieve desirable patient outcomes. Many patients do not know where to start, or how to access health or social services. An in person guide may supplementary for those who are looking to take the first step, to avoid being lost within the complexity of system navigation. And then, I would say even like a single point of entry to human services, to me, would be the ideal, regardless of whether I have a physical disability, or maybe I need help because I am an aging senior, or I need help because I have a child who has a substance abuse problem. Almost as if there was one central door to go through that somebody could then be an advocate for me, and help steer me to the right resources. -*Developmental Disabilities Institute*
Community champions may be useful in identifying areas of synergy and introducing partnerships among organization to address some of the barriers linked with connecting people to services. One of the things that would really help improve the services is the idea of having like community committees, having community leaders, community champions, a place for all of these people to convene together so you can figure out where services are overlapping and how you can connect your constituents with other services that they might need because you can do these programs, revamping corner stores or improving the built environment, but there are still all these other issues lie transportation and lack of education, so I think it's really essential, I know the Wyandanch Leadership Committee, they have that, that's been around for a little while. I think it's really essential that those things start popping up on Long Island and it's important for these leaders to be active in all these different agencies to be involved so we can connect people to what they need. -*Sustainable Long Island*

Taking a Deeper Dive

Barriers to Accessing Care

A secondary analysis of “Access Barriers” was taken to better understand the key themes of significance. Identification of sub-groupings was completed by carefully reading each quotation flagged under this code and identifying the sub-groups as emerged throughout the transcription. Based upon this identification, Access barriers were divided into 15 new sub-groups as identified within the table below.

Of the total “Access Barrier” quotations in Suffolk County, “Transportation” emerged at the forefront with 26.8% of the total Suffolk County barrier-flagged quotations. “Transportation” included discussion of: inadequate public transportation services or community members who do not have access to private transportation/cars.

“Understanding and Awareness” comprised 26.2% of the Suffolk County Access Barrier quotations. This sub-group refers to: community members being unaware of services or how to obtain services; people not seeing the purpose in obtaining care and stigma surrounding requesting particular services.

“Systems” was the third barrier with highest significant to accessing care, fulfilling 26.2% of the total Suffolk County Access barrier quotations. “System” barriers include: integrated care models, system complexities, paperwork, applications, and provision of patient centered care.

Barriers to Accessing Care	
Sub-Group	**%**
Transportation	26.8%
Understanding and Awareness	26.2%
Systems	26.2%
Lack of Support	25.0%
Service Availability	24.4%
Financial	19.5%
Insurance	16.5%
Housing	16.5%
Literacy	10.4%
Disabilities	7.3%
Culture/Religion	5.5%
Access to Healthy Foods	4.3%
Policy	3.0%
Fear	1.8%
Integrated Systems	0.0%

***Number of Quotations with County Code and *subgroup divided by number of quotations in parent group Barriers to Care.**

Analytic Interpretation & Participant Quotations
Convenience and lack of adequate transportation services are deterrents for community members in accessing care, particularly for those who require preventive screenings or follow-up health services. **Transportation is a monumental challenge throughout Suffolk County, extending to communities on the eastern most region of Long island.** With us, I know transportation is a big thing. We deal with a lot of the east end. For Montauk there is no transportation for them. We partner with providers all over Suffolk County and partner with Hudson River Healthcare, so they can go to their local health center and be able to be screened, and we try to make it as easy as possible, and we offer transportation to mammography or doctor's appointments. That's one of the biggest things that we see. *-Suffolk Cancer Department of Health, Cancer Services Program* Transportation, I think it would be helpful. They are putting in more barriers to limited access to transportation rather than open it up. All the research shows if you are accessing your care after the year appointments or going to the doctor that you are going to utilize fewer resources. It is better for your patients, but they are putting barriers in place where you can't access them. If you can't get an ambulette, have the person use the ambulance. We want the people to follow up. We want them to be healthy, but by limiting what they can use, we are limiting their ability to follow up. *-John T. Mather Memorial Hospital*
To promote available resources, Development of a centralized hub or library resource center for accessing information about health services, resources, accessing assistance for social determinants such as housing, heat/electric; etc. in order to support patient navigation and empowerment. Maybe if there was an Island wide push towards something central where this is where you can go to get information to help you, it's free, non -- whatever it is, you know, to access that information for services or

a place where you can meet people in person in your community where it is easily accessible, you know. That's one of the issues in terms of transportation. But maybe a central place in each community, or through the phone, again where it's easier to pick up the phone -- of course, if you have a phone, but you know, I think making it as accessible to -- there are such great resources that a lot of us don't know about on the Island. Having that ability to access them.
-Girls Inc.

There are compounding barriers to accessing care for those who do not know how to navigate the system in Suffolk County. Such barriers include: lack of affordable housing, transportation, additional bilingual care services and an increase in mental health services.

I'm going to say, from what I have heard, people don't know about those. So how are they accessing those services; or are they not accessing the services; and what other resources do you feel are needed? We have already said more housing; better transportation; more bilingual providers; more psychosocial programs; more access to mental health providers; more transportation out in Suffolk County. That's a big barrier.
-Pilgrim Psychiatric Center

Food Insecurity

In exploring “access barriers”, specifically with healthy food choices in mind, the analysis team chose to investigate linkages between financial barriers and accessing healthy food options. Many families living in poverty or of low socio-economic status are forced to prioritize personal need based upon the amount of money they have in their pocket. There are many resources available for families including: group classes, food pantries or government subsidies, which would support healthy eating and healthy meal decision making. Bridging families who are vulnerable to these resources should be a top priority in decreasing food insecurity.

Analytic Interpretation & Participant Quotations
Food insecurity among families of low socio-economic status is a growing concern in Suffolk County. Although healthy food options may be accessible, financial strain forces decision makers to prioritize needs.
As part of Feeding America, we take part in a national survey called the Hunger Study. We go out and we talk to the community itself. We ask them very detailed questions. The result of the Hunger Study always show that people choose not to eat properly so that they can pay the rent or have transportation or get medicine or see a doctor. So if they have to make a choice, they will chose to go without a meal or not eat properly or go to McDonald's and split a hamburger up and give it to the kids so that they have something in their stomachs. We always say that it's a choice, but if the other issues were taken care of properly, then hunger would not be an issue either. *-Adelphi University, School of Health Studies, Nassau County Event-specific to region*
I want to talk about food insecurity. On Long Island people don't think that Long Island has an issue, but they do. Because families on a fixed income very often can't afford food at the end of the month and they are making decisions about whether they want to pay for transportation to a doctor or copays for their medical prescription or get food to eat. A lot of seniors are on SNAP benefits, food stamps. Also they use the local community food pantry to supplement their food. *-Family and Children’s Association, Nassau County Event- specific to region*

Educational Barriers and Disparities

A secondary analysis of Educational Barriers and Disparities was taken to better understand the key themes of significance layered within this topic. Identification of sub-groupings was completed by carefully reading each quotation and identifying the sub-groups as discussed within the transcription. Educational barriers and disparities were divided into 21 new sub-groups as identified within the table below.

Of the total "Education Barrier" quotations in Suffolk County, "Patient Engagement" emerged at the forefront with 35.7% of the total quotations. "Patient Engagement" included discussion of: decision making, healthy lifestyles, patient activation measures, empowerment and self-management skills.

"System navigation" comprised 20.1% of the Suffolk County Education Barrier quotations. This sub-group refers to: building trust, respect, helping with paperwork, accessing services, and connecting dots.

"Health literacy" was the third most significant education barrier, fulfilling 16.9% of the total Suffolk County Access barrier quotations. Health literacy barriers include cultural competency, language and effective communication.

Education	
Sub-group	**%**
Patient Engagement	35.7%
System Navigation	20.1%
Health Literacy	16.9%
Caregivers	13.6%
Workforce	13.0%
Central Information Hub	11.7%
Nutrition	11.7%
Addressing Misconceptions	10.4%
Drugs and Alcohol	9.1%
Mental Health / Depression	9.1%
HIV/AIDS and STDs	7.8%
Prenatal Care	7.1%
Screenings	5.2%
Schools	5.2%
Exercise and Physical Activity	3.9%
Gender	2.6%
Vaccines and Immunizations	1.9%
Violence	0.6%
Eating Disorders	0.6%
Routine Well Checkups	0.6%
Emergency Preparedness	0.0%

***Number of Quotations with County Code and subgroup divided by number of quotations in parent group Educational Disparities and Barriers.**

Analytic Interpretation & Participant Quotations
Strategies focused on empowering patients will improve a person's ability to make autonomous, informed decisions bringing about improved health and patient satisfaction outcomes. I can certainly say that one of the biggest challenges for them is to truly understand how their actions and choices impact their health. We try to educate them on the proper practices that they should keep in mind, however when you are dealing with the adult population, they do want to exercise the choice of enjoying things that may not be the most healthy thing for them. We do put together groups and supports to, again, educate and provide services for them to make healthy choices like teaching them how to cook healthy. We also provide services that smoking cessation class, so that they can understand the effects of smoking, not only to themselves but to those around them, and we have seen in recent times that we are seeing -- longevity is starting to exist, whereas prior it was pretty typical that our population would be deceased 25 years earlier than someone without a disability, and we are seeing more longevity in the population, which is a good thing. *-Maryhaven Center of Hope* We utilize that model of care in our CMS innovation funding and we saw very positive results so you know to really engage people on the preventive level how to identify and understand their health, their triggers, and how to communicate effectively to the people that can help them and being able to communicate critically important to give them the tools the skills, but also the confidence to be able to do that. And there are evidence based strategies for that in terms of the mental emotional and behavioral health. I wanted to say that there are also other programs and interventions out there that can be provided on a general perspective for all healthcare providers that will make this more confident in dealing with issues of mental health and substance abuse. *-Dominican Sisters Family Health Services, Inc.*
Providing education to the community about what services and programs are available, and how to access them will increase participation in self-management and accountability of personal health. Community Health Advocates who are able to explain and guide community members through various processes would serve as a resource person for underserved populations. Caseworkers that will follow up. If that case management type of model in the community is available, they will have a point person. I see a lot of times when patients are out of our care, and they don't have that point of contact where they can facilitate whatever they are looking for, who to go, who to drive them to their care. They don't have active resources or they can't get them or don't utilize them. Maybe since the funding is there for these type of initiatives, maybe that can be part of at least what their goal is. *-John T. Mather Memorial Hospital*
Health literacy should be engrained in health services to maximize comprehension of health information, allowing them to make clear and informed decisions in regard to their health. I would say maybe push for health literacy. I think that's a main component of how to follow up, how to maintain yourself, how to access services and finding the way how to get that out to the community. *-John T. Mather Memorial Hospital*

Mental Health and Substance Abuse

Due to the overwhelming intricacy of Mental Health and Substance Abuse, its associated conditions, contributing factors, linkages between other conditions and populations at risk, a high-level analysis was conducted to break down and further explore this Priority Area.

The NYS Department of Health Priority Area of promoting mental health and preventing substance abuse was broken down into 32 categories within 4 sub-groups. These groupings are broken down within the table below. Categories are sorted by highest percent of significance within each sub-group.

Promote Mental Health and Prevent Substance Abuse		
CATEGORIES	**Substance Abuse**	29%
	Cognitive	14%
	Eating Disorders	3%
	Developmental	2%
	Suicide	1%
	Hoarding	0%
CONTRIBUTING FACTORS	**Lack of Service Availability**	21%
	Coordination of Care for Mental Health	17%
	Patient Empowerment	16%
	Proper Treatment	13%
	Stigma	10%
	Housing	8%
	Transportation	7%
	Insurance Coverage	6%
	Mental Health Medications	6%
	Integration of Mental Health into Primary Care	3%
	Employment	1%
	Education in Schools	0%
LINKAGES	**Abuse**	9%
	Financial	7%
	Chronic Disease with Mental Health	6%
	Mental Health with Substance Abuse	2%
	Drug Use with Violence	2%
	ED Visits	0%
VULNERABLE POPULATIONS	**Homeless**	11%
	Veterans	10%
	Seniors	8%
	Young People	5%
	Young Women	3%
	Caregivers	2%
	Undocumented	2%
	Incarcerated	2%

***Number of Quotations with County Code and sub-group/category divided by number of quotations in parent group Mental Health and Substance Abuse.**

Analytic Interpretation & Participant Quotations
Substance abuse, particularly heroin, is a growing concern on Long Island. An increase in the number of mental health treatment and recovery services would alleviate the length in appointment wait times.

With the heroin piece, there's a lack of response. For suboxone, you have to go to a special doctor, so we have limited doctors out there for that. Detoxes and rehabs are not so bad, but lack of accessible and quick response care for someone in crisis, but again, you are left to the hospitals. For the mental health piece, you could get someone an appointment if they were in crisis; now, that doesn't happen. I've been doing this twenty-two years. I see private clients, and when their kid needs a psychiatrist, they wait a month or two. Again, if the person is in crisis enough, they have to go to the emergency room. I sat at meetings with Suffolk Officials, and they know it's a problem, but as far as I see it, I don't think anything has been done about it.
-Hope House

A general lack of mental health service availability, including comprehensive-treatment and recovery approaches is creating a gap in need for service.

Counselors, therapists, and mental health providers are limited. There aren't people specializing in eating difficulties. Facilities are calling me and asking, Where do I send them? Where do I go? I have to send them out of state. Here we are, one point five million in each county, and we don't have the servicers to meet the needs of this population. I think that's something we need to look into. We need to find more coordination with mental health services, and just an awareness that there is an issue out there.

-Suffolk County Department of Health, Office of Health Education

Cases involving abuse and trauma are often linked with the occurrence of mental health issues, chronic disease and substance abuse.

I just want to add that a word that hasn't been brought up yet is "trauma." When I look at all five of these, I can see where trauma can play a role in all five of these. You know, we're talking about chronic diseases. When somebody here has suffered from a trauma might have an eating disorder, might have obesity issues, might be smoking tobacco or using drugs because of a trauma they've had. Healthy and safe environment. Trauma is such a big part. When we look at individuals who suffer from mental illness, we look at our veterans. We look at the children that we work with. The trauma can range from domestic violence in the home, physical abuse, sexual abuse, bullying. This is a total package.
-Association for Mental Health and Wellness

Veterans are often faced with mental health and substance abuse issues which put them at-risk for becoming homeless.

I deal mainly with low income veterans. The ones that are either homeless or at high risk of becoming homeless. Of course they have a lot of mental issues, PTSD, and also, substance abuse. There is a lot of that.
-Suffolk County United Veterans

.

Participating Organizations

Below is a list of organizations and representatives titles who participated as servicing Suffolk County or Bi-County populations.

Organization	Title of Participating Representative
Adelante of Suffolk County, Inc. Central Islip, NY	1. Director
Adelphi, Breast Cancer Hotline and Support Program Garden City, NY	1. Bilingual Outreach Coordinator
Aetna Better Health and Gurwin MLTCP Suffolk County	1. Senior Account Manager
AHRC Nassau Plainview, NY	1. Director of Health Services
Alzheimer's Association Melville, NY	1. Program Specialist
American Heart Association Plainview, NY	1. Director of Community Health
American Lung Association of the Northeast Hauppauge, NY	1. Senior Director, Health Education
Association for Mental Health and Wellness Ronkonkoma, NY	1. Deputy Director for Strategic Initiatives
Asthma Coalition of Long Island/American Lung Association of the Northeast Hauppauge, NY	1. Director
At Home Designs Wading River, NY	1. Certified Aging in Place Design and Resource Consultant
Babylon Breast Coalition Copiague, NY	1. President
Brentwood/Bay Shore Breast Cancer Coalition Brentwood, NY	1. Founder 2. Alexandra Velez
Brookhaven Memorial Hospital Diabetes Wellness Center Patchogue, NY	1. Diabetes Wellness Coordinator
Caring People Central Islip, NY	1. Home Care Consultant
Catholic Charities Hicksville, NY	1. Assessment and Advocacy Specialist 2. Housing Specialist
Good Shepherd Hospice, Catholic Home Care Farmingdale, NY	1. Account Manager
PSEG Long Island REAP program Hauppauge, NY	1. Account Manager
Community Housing Innovations Patchogue, NY	1. Assistant Executive Director

Cornell Cooperative Extension Riverhead, NY	1. Regional Program Director, Long Island
Dominican Sisters Family Health Services, Inc. Hampton Bays, NY	1. Director, New Programs
EOC of Suffolk Patchogue, NY	1. Outreach Coordinator
Family Service League of Long Island Bay Shore, NY	1. Coordinator Family Service League Positive STEP Program
Girls Incorporated of Long Island Deer Park, NY	1. Executive Director
Gordon Heights Civic Association Middle Island, NY	1. President
Honeywell, EmPower NY Nassau and Suffolk Counties	1. Program Coordinator
Hope House Port Jefferson, NY	1. Director, Project Hope II, Residential Social Worker 2. Director, Pax Christi Hospitality Center
HRH Care Coram, NY	1. Community Health Educator
Pilgrim Psychiatric Center Brentwood, NY	1. Director of Case Management
LGBT Network Woodbury, Bay Shore, Sag Harbor	1. Director of Community Engagement and Partnerships
Long Island Cares, Inc. The Harry Chapin Food Bank Hauppauge, NY	1. Chief Government Affairs Officer 2. Chief Network Officer 3. Nutrition Resource Manager and Chief Network Officer
John T. Mather Memorial Hospital Port Jefferson, NY	1. Director of Social Work
Maurer Foundation for Breast Health Education Hauppauge, NY	1. Program Manager
New York City Poison Control Center New York City	1. Health Educator
Outreach Bellport, NY	1. Bellport Site Director
Peconic Bay Medical Center, Cancer Services Program Riverhead, NY	1. Program Director 2. PETO Coordinator
RN Nurses Evolve Smithtown, NY	1. CEO
Safe Harbor Housing for Seniors Wading River, NY	1. Director
SCO Family of Services Dix Hills, NY	1. Program Director
SILO Suffolk County Living Organization Holtsville, NY	1. Housing Coordinator
St. Joseph's Village Senior Housing Selden, NY	1. Service Coordinator

St. Mary's Healthcare System for Children New Hyde Park, NY	1. Project Manager, Strategic Initiatives
Starflower Experiences Wyandanch, NY	1. Executive Director
Suffolk Cooperative Library System Bellport, NY	1. Administrator of Outreach Services
Suffolk County Bureau of Public Health Nursing Hauppauge, NY	1. Director of Suffolk County Bureau of Public Health Nursing
Suffolk County Department of Health Services, Office of Health Education Hauppauge, NY	1. Director of School Education
Suffolk County Department of Health, Maternal Infant Community Health Collaborative (MICHC) West Islip, NY	1. Program Coordinator
Suffolk County Office of Minority Health Great River, NY	1. Health Program Analyst I
Suffolk County United Veterans, AMHW Yaphank, NY	1. Outreach Coordinator
Suffolk County, Division of Prevention Medicine, Falls Prevention Programs Great River, NY	1. Management Coordinator
Sustainable Long Island Farmingdale, NY	1. Senior Community Planner
TempPositions Melville, NY	1. Account Executive
The American Cancer Society Hauppauge, NY	1. Senior Market Manager, Community Engagement
The Research Foundation for SUNY, Stony Brook, Adolescent Medicine Division Stony Brook, NY	1. CAPP Coordinator/Education Specialist 2. Education Specialist
Thursday's Child Patchogue, NY	1. EIS Manager
Town of Smithtown Horizons Counseling and Education Center Smithtown, NY	1. Assistant Program Coordinator, Assistant Director
United Lifeline & United Home Services Bethpage, NY	1. Director, Community Relations
Utopia Homecare Kings Park, NY	1. Certified Senior Advisor
VIBS: Domestic Violence and Rape Crisis Center Islandia, NY	1. SANE Coordinator 2. SANE Liaison
Visiting Nurse Service and Hospice of Suffolk Northport, NY	1. Director of Intake and Business Development
YMCA of Long Island Huntington, NY	1. Associate Director

*Services Provided**

Organization	Services
Adelante of Suffolk County, Inc. Central Islip, NY	Adelante of Suffolk County, Inc.'s mission statement is: To inspire forward movement in the lives of the diverse people of the community, by promoting a deeper understanding and respect for cultural differences and similarities; by empowering young people to realize their unlimited potential; and by protecting our seniors, and those with special needs, while improving their quality of life. Services provided includes: Youth Education; Adult Education; Mental Health; Behavioral Health; Food Pantry; Outreach and Advocacy; One Stop Center for Dept. of Labor and Dept. of Social Services in Central Islip.
Adelphi, Breast Cancer Hotline and Support Program Garden City, NY	The Mission of the Adelphi New York Statewide Breast Cancer Hotline and Support Program is to educate, support, empower, and advocate for breast cancer patients, professionals and the community. Services include a statewide breast cancer hotline, support groups, counseling, education, community outreach and advocacy.
Aetna Better Health and Gurwin MLTCP Suffolk County	Aetna Better Health and Gurwin offers a Medicaid Managed Long Term Care plan available to those who qualify and offers a Medicare-Medicaid plan to those who qualify via Aetna Better Health FIDA Plan. Keeping you healthy; keeping you home.
AHRC Nassau Plainview, NY	Nassau County AHRC Foundation is a registered 501(c)(3) charitable organization whose mission is to publicly solicit and receive funds for the benefit of individuals with intellectual and other developmental disabilities. Thousands of children and adults benefit from the Foundation's support to organizations such as AHRC Nassau, Brookville Center for Children's Services, Citizens, Advantage Care, Diagnostic Treatment Center and other community-based organizations serving those with special needs. Through our partner organizations, we're able to support services that span across a lifetime, ensuring that the people and families we support have the resources to live meaningful lives. 56 bed 24-hour nursing facility for people with I/DD and complex medical needs. Day Habilitation services for approximately 1500 adults with I/DD in Nassau, Medicaid Service Coordination, Special Needs Summer camp and respite program; Children's residential program for children with autism.
Alzheimer's Association Melville, NY	Alzheimer's Association is a non-profit organization providing information, resources, programs and support for individuals with Alzheimer's disease or a related dementia.
American Heart Association Plainview, NY	The American Heart Association is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke. Founded by six cardiologists in 1924, our organization now includes more than 22.5 million volunteers and supporters. We fund innovative research, fight for stronger public health policies, and provide critical tools and information to save and improve lives. Our nationwide organization includes 156 local offices and more than 3,000 employees. We moved our national headquarters from New York to Dallas in 1975 to be more

	centrally located. The American Stroke Association was created as a division in 1997 to bring together the organization's stroke-related activities. To improve the lives of all Americans, we provide public health education in a variety of ways. We're the nation's leader in CPR education training. We help people understand the importance of healthy lifestyle choices. We provide science-based treatment guidelines to healthcare professionals to help them provide quality care to their patients. We educate lawmakers, policymakers and the public as we advocate for changes to protect and improve the health of our communities.
American Lung Association of the Northeast Hauppauge, NY	The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, through research, education and advocacy. Our work is focused on five strategic imperatives: to defeat lung cancer; to improve the air we breathe; to reduce the burden of lung disease on individuals and their families; to eliminate tobacco use and tobacco-related diseases; and to monitor and enhance organizational effectiveness.
Association for Mental Health and Wellness Ronkonkoma, NY	Services provided by the Association for Mental Health and Wellness include: Adult Psychiatric Rehabilitation, Clinic Services, Permanent & Supportive Housing, Veterans Shelter and Permanent Housing, Veterans Peer Support Services, Care Management for Adults, Mental Health Education, Trainings and Advocacy, Care Management for Children, Recovery Center, and Peer Support Groups.
Asthma Coalition of Long Island/American Lung Association of the Northeast Hauppauge, NY	The Asthma Coalition does not provide services, but is a resource for patient and provider education programs and materials. We train facilitators to teach asthma self-management and we also provide trainings for clinicians on the National Heart Lung & Blood Institute National Asthma Education and Prevention Program Expert Panel 3 Guidelines for Treatment and Diagnosis of Asthma.
At Home Designs Wading River, NY	At Home Designs is dedicated to adapting homes to people's needs as they grow older. We are an aging in place design resource company and work to empower older citizens and those with disabilities choice, control, dignity and independence. We work in partnership with architects, contractors and health care professionals to create a team approach to provide services to make a home more livable. We offer home safety assessments, design solutions and provide community resources to support aging in the environment one chooses. Those resources include adult day programs, home care agencies, agencies who provide respite, eldercare attorneys and geriatric care managers and doctors that make house calls. We also provide long term resources when remaining at home is no longer the best solution.
Babylon Breast Coalition Copiague, NY	Babylon Breast Coalition provides services for the community including: transportation, cleaning services, prepared foods, etc. Services are provided for women undergoing treatment in breast and gynecological cancers. We also provide women with a gift of hope and inspiration, bag with many items in it for women diagnosed with breast or gynecological cancers.

Brentwood/Bay Shore Breast Cancer Coalition Brentwood, NY	The Brentwood/Bay Shore Breast Cancer Coalition provides support for food, transportation, medications, and other basic needs.
Brookhaven Memorial Hospital Diabetes Wellness Center Patchogue, NY	The Brookhaven Memorial Hospital, Diabetes Wellness Center provides Diabetes Self-Management Education Program for Type 1 and Type 2 diabetes; “Wellness Wednesday - "Living Well Series” Wellness and Prevention program; You do not have to have diabetes to join the FREE classes FREE classes offered,: Support groups Type 1 and Type 2 DM, Lectures, Chair Yoga, Walk for Wellness Walking Club, Cooking Demonstrations, Garden Club, Smoking Cessation classes, Diabetes Prevention Program, Fall Prevention Program, Celebration of Life Event, 5 Alive Club.
Caring People Central Islip, NY	Caring People provides care coordination, home health aide services, RN & LPN services.
Catholic Charities Hicksville, NY	Catholic Charities provides services including: Chemical Dependency Services, Commodity Supplemental Food Program, Disaster Response, HIV/AIDS Services, Housing (affordable apartments for Seniors and People with Disabilities), Immigrant Services, Mental Health Outpatient Services (clinics/suicide prevention training), Mental Health Residential Services (Teaching Family/ Project Independence / Project Veterans Independence), Nutrition Outreach Education Project (SNAP), Parish Social Ministry(Support for local Programs/Central Information and Referral), Regina Maternity Services, Residential Services for People with Developmental Disabilities (Case Management/ Community Integration/Skills Development/Community Residences), Senior Services (Case Management/Meals-On-Wheels/Senior Community Service Centers), Women, Infants and Children Program (Food/Nutrition Education/Referral to Health and Social Services).
Good Shepherd Hospice, Catholic Home Care Farmingdale, NY	Catholic Home Care is a Certified Home Care Agency providing Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Social Work and Aides to Home Bound patients with Acute care needs. Good Shepherd Hospice provides home-based End Of Life services for terminally ill Home bound patients and their families.
PSEG Long Island REAP program Hauppauge, NY	The PSEG LI REAP is a program for income-eligible customers designed to help them save energy and lower their electric bills. Participation in REAP can make your home healthier and safer. In addition participants are guided to other services outside our company that can help them with any special needs.
Community Housing Innovations Patchogue, NY	Community Housing Innovations provides emergency shelter for singles and families, transitional to permanent housing for single men and women, supportive housing for a variety of at risk populations (mentally ill, substance abuse, disabled), foreclosure prevention, first time homeownership assistance and education, permanent affordable housing throughout Long Island and the Lower Hudson Valley.
Cornell Cooperative Extension	Cornell Cooperative Extension of Suffolk County assists and

Riverhead, NY	educates residents, businesses and professionals in a broad spectrum of topics by providing research-based information on parenting, diabetes management, nutrition and wellness, horticulture, environmental protection, marine restoration and sustainable agriculture. Experts from our four main program areas—Family Health and Wellness, Marine, Agriculture and 4-H Youth Development—reach tens of thousands of adults, children, professionals and businesses each year. We bring this free and low-cost knowledge directly to people at workshops, children's camps, libraries and schools. We also work one-on-one with fisherman, farmers and growers to strengthen these industries, bringing tourism and advancing economic development. CCE programs have had a significant impact on communities and industry in Suffolk for nearly a century.
Dominican Sisters Family Health Services, Inc. Hampton Bays, NY	Dominican Sisters Family Health Service, an affiliate agency of Catholic Charities of the Archdiocese of New York, offers a comprehensive suite of preventative, treatment and care management services in eleven counties throughout New York State.
EOC of Suffolk Patchogue, NY	The Economic Opportunity Council of Suffolk, Inc. (EOC of Suffolk, Inc.) is a not-for-profit 501 (c) (3) minority community based organization (CBO) incorporated in the State of New York on May 5, 1967. The EOC of Suffolk, Inc. is Suffolk County's designated community action agency, recipient of the Federal Community Service Block Grant, which supports activities designed to assist low-income families and individuals receiving assistance under part A of Title IV of the Social Security Act. Our mission is to promote a goal of self-sufficiency by broadening the minds of children, revitalizing communities, and assisting families and children in need through the provision of services and to coordinate available federal, state, local and private resources. Services provided include: Family development; housing programs; SNUG Violence Prevention; Suffolk County Family Court Children's Nursery; Veteran's Services; HIV/AIDS/HIV(-) targeted prevention and support services; Wyandanch Weed and Seed; Chronic Health Care Coordination; Montauk Child Care; Services for People with Developmental Disabilities; Way to Grow Child Care Learning Center; Youth and Adolescent Services.
Family Service League of Long Island Bay Shore, NY	Since the onset of Family Service League, our mission has been to maintain and strengthen the family structure throughout the communities we serve. Our mission is challenged ever day— by social pressures, economic hardship and the erosion of moral responsibility. But our determination is strong and our commitment unwavering since 1926. Our spectrum of social service programs comprehensively addresses the multitude of pressing social and economic issues facing Long Islanders today, and is meeting the challenges that our communities must face in the years to come. FSL is one of the largest non-profit social service organizations in the region. Our valued programs help and serve over 50,000 people annually. FSL delivers tangible help and crisis intervention across a wide range of service areas including mental illness, drug and alcohol addiction, homelessness, job training, computer literacy, trauma counseling, at-risk youth, and family and senior citizen support services. Additionally, FSL operates pre-school learning centers, Universal Pre-K programs, recreational camping,

	and Suffolk County's only Community School. All told… FSL operates more than 60 programs at over 21 locations throughout Suffolk County.
Girls Incorporated of Long Island Deer Park, NY	Girls Incorporated of Long Island provides research-based girls empowerment programming to girls 5-18 year olds. We provide afterschool programming, workshops at CBO's and libraries, a girls' conference and some parent-child programs.
Gordon Heights Civic Association Middle Island, NY	The mission of the Gordon Heights Civic Association is to develop and maintain among the resident of Gordon Heights, Long Island, New York an interest in the civic, social, economic, and political welfare of said residents and through organization to promote and conduct activities to this end. To promote good will, mutual understanding, and a closer relationship among the members and to give practical expression to these purposes by extending voluntary assistance in times of illness, distress, or crisis. Focus areas and services include: legislation; law enforcement; housing; fire district; highway department; parks department
Honeywell, EmPower NY Nassau and Suffolk Counties	EmPower New York provides no-cost energy efficiency solutions to income-eligible New Yorkers. Nearly 100,000 of your neighbors are saving energy and saving money with EmPower New York, without spending a dime. Whether you own your home or rent, a participating contractor will be assigned to you to assess if your home would benefit from free energy upgrades such as: Air sealing to plug leaks and reduce drafts; Insulation to make your home more comfortable all year round; Replacement of inefficient refrigerators and freezers; New energy-efficient lighting; Plus, free health and safety checks of your smoke detectors, appliances and more.
Hope House Port Jefferson, NY	Since its founding in 1980, the Community House with 10 beds has grown to a 30-bed house that provides a compassionate approach to crisis intervention and a residential community for homeless young people in need. The program serves primarily youth between the ages of 16 and 21 years. It offers a creative living space where a young person can grow and develop. Services offered include: Hope Academy; Pax Christi Hospitality Center; The Human Services Center; The Sr. Jean Beagan, O.P. Family and Children Counseling Center; Montfort Therapeutic Residence/Our Lady of Peace Academy; St. Louis de Montfort Academy; Wisdom House; Siena House; St. Maximilian Kolbe Outpatient Addictions Treatment Center
HRH Care Coram, NY	Since Hudson River HealthCare opened its doors in 1975, we have remained committed to providing high quality health care to all who seek it. Hudson River HealthCare, now known as HRHCare, has multiple locations throughout New York's Hudson Valley and Long Island. We are a not-for-profit, New York State licensed, federally qualified health center. HRHCare delivers culturally sensitive, linguistically appropriate, full life cycle primary, preventative, behavioral and oral health care and enabling & care coordination services, regardless of one's ability to pay. Our goal and commitment is to help our communities get & stay healthy. We believe high quality health care starts with compassion and dignity, and is available when and where you need it.

Pilgrim Psychiatric Center Brentwood, NY	Pilgrim Psychiatric Center provides a continuum of inpatient and outpatient psychiatric, residential, and related services with approximately 380 inpatient beds and 4 outpatient treatment centers plus one ACT Team throughout Suffolk County. The campus includes several residential agencies on the grounds such as Central Nassau Guidance Center and Transitional Services, Charles K. Post, a residential treatment center operated by the New York State Office of Alcohol and Substance Abuse, and Phoenix House, a residential treatment center for those with substance abuse diagnosis. Development of the surrounding acreage has been planned for the near future. The campus is within easy access to parkways, public transportation, and local shopping.
LGBT Network Woodbury, Bay Shore, Sag Harbor	The organizations of the LGBT Network provide a variety of programs and services at its four community centers, including one in Sag Harbor on the East End, one in Bay Shore in Western Suffolk, one in Woodbury in Nassau County, and one in Little Neck in Queens, with a fifth location slated to open in Patchogue in Suffolk County in late 2016/early 2017. Service provided include: Youth Leadership and Development; Social and Recreational; Community-Building; Health and Wellness; Advocacy services; Community Education as well as Special Events and Initiatives.
Long Island Cares, Inc. The Harry Chapin Food Bank Hauppauge, NY	Long Island Cares brings together all available resources for the benefit of the hungry on Long Island, and provides to the best of our ability for the humanitarian needs of our community. We provide food when and where it's needed, while promoting self-sufficiency and public education.
John T. Mather Memorial Hospital Port Jefferson, NY	John T. Mather Memorial Hospital is an accredited 248-bed, non-profit community teaching hospital dedicated to providing a wide spectrum of health care services of the highest quality to the residents of Suffolk County in a cost effective manner. As members of the Mather Hospital Family - trustees, medical staff, hospital staff, volunteers and benefactors - we are committed to providing care to the best of our ability showing compassion and respect and treating each patient in the manner we would wish for our loved ones. We will meet or exceed each patient's expectations through the continued collaborative efforts of each and every member of the Mather Hospital Family.
Maurer Foundation for Breast Health Education Hauppauge, NY	The Maurer Foundation for Breast Health Education provides: Breast Health Educational Programming for high schools, colleges, community groups and businesses. We offer bilingual programming as well.
New York City Poison Control Center New York City	The New York City Poison Control Center is a national, free hotline staffed by pharmacists and nurses who respond to intentional and unintentional poisonings by providing recommendations
Outreach Bellport, NY	Building healthy lives is what Outreach is all about. For over three decades, we've been a premier provider and champion of quality, life-changing drug and alcohol abuse treatment and training services - the kind that help individuals and their families throughout

	the Greater New York area cope with their problems, heal themselves and move forward in a more positive direction. We know. We understand. And we're totally committed to making a difference now and in the future. Our mission is to inspire individuals and families to achieve a life of unlimited potential by developing and delivering the highest quality evidence-based behavioral health services and training.
Peconic Bay Medical Center, Cancer Services Program Riverhead, NY	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 an initial screening through creating an individualized, state-of-the-art cancer treatment plan. There's a reason why Peconic Bay Medical Center is considered a top Long Island medical center, and that's because we put patients first. We believe that every person in Suffolk County deserves access to high-quality health care, especially cancer screenings. As part of our cancer services program, we offer free cancer screening to uninsured residents of Suffolk County who meet eligibility requirements.
RN Nurses Evolve Smithtown, NY	RN Nurses Evolve provides a professional approach to the sourcing of the most experienced and vetted Nurse Practitioner for doctor offices, hospitals and clinics.
Safe Harbor Housing for Seniors Wading River, NY	Safe Harbor Housing for Seniors provides Transitional Housing For Abused Elderly.
SCO Family of Services Dix Hills, NY	SCO Family of Services provides a multitude of human service programs ranging from residential services (OMH/ OPWDD), day school/ educational services, community residence programs, shelters, mother-baby programs, residential substance abuse services, Bridges to Health, Out-patient Community Mental Health Clinic.
SILO Suffolk County Living Organization Holtsville, NY	SILO Suffolk County Living Organization provides: Benefits and financial Advisement; Housing; Advocacy; Educational and Transition advisement; Barrier removal; Employment and incentives for people with disabilities; Lending Closet and TRAID; Travel and transportation services.
St. Joseph's Village Senior Housing Selden, NY	St. Joseph's Village Senior Housing provides housing, social services, counseling, program planning, and beyond.
St. Mary's Healthcare System for Children New Hyde Park, NY	St. Mary's Hospital for Children is a 97-bed post-acute Skilled Nursing Facility. Services provided include: St. Mary's Home Care Certified Home Health Agency (Special Needs CHHA ages 0-44) provides Skilled Nursing, PT, OT, ST, Nutrition, Social Work St. Mary's Community Care Professionals Licensed Home Care Services Agency (LHCSA) – provides Private Duty Nursing St. Mary's Case Management through Care at Home and Medicaid Service Coordination; Center for Pediatric Feeding Disorders Early Education Center (Medical Special Education preschool).
Starflower Experiences	Starflower Experiences provides educational programs and events

Wyandanch, NY	focused on the environment and our relationship to our living planet.
Suffolk Cooperative Library System Bellport, NY	The Outreach Services department of the Suffolk Cooperative Library System provides outreach guidance and consultation to the 56 public libraries in Suffolk County. Outreach Services works to ensure access to people with disabilities.
Suffolk County Bureau of Public Health Nursing Hauppauge, NY	The Suffolk County Bureau of Public Health Nursing is a home care agency that provides skilled nursing care and specialize in maternal child health in addition to wound care and asthma.
Suffolk County Department of Health Services, Office of Health Education Hauppauge, NY	The Suffolk County Department of Health Services, Office of Health Education provides public health education addressing those high risk behaviors that CDC has identified as causing mortality and morbidity among our population. Tobacco: Adult cessation programs, Vendor Education classes for Tobacco Vendors, Enforcement of ATUPA and Clean Indoor Air Laws, Tobacco and emerging tobacco prevention programs for secondary school students and community agencies., Dietary and Physical Activity Patterns: Diabetes Prevention Program for adults, Eating Disorders and Body Image Awareness programs for secondary school students, college age students and school based and mental health professionals, puberty lessons Safety and Injury Prevention: Peer Education Trainings-Bullying Prevention (Up-stander Programs), Suicide Prevention, Sports Injury Prevention for community members, SunWise, Summer Safety, Defensive Driving for County Employees STI/HIV Prevention: STI/HIV prevention programs for secondary school students Drugs and Alcohol: Narcan trainings for professionals, community agencies and parents Public Health Education Communications: Quarterly newsletters (The Health Issue, SADD Newsletter) to schools concerning emerging health concerns
Suffolk County Department of Health, Maternal Infant Community Health Collaborative (MICHC) West Islip, NY	The Suffolk County MICHC Program provides services to women of childbearing age, including outreach, education, advocacy, referrals to services, service coordination and home visiting. These services are delivered by community health workers who are indigenous to the communities we serve, including Bay Shore, Brentwood, Central Islip, Amityville, Wyandanch and Copiague. We also provide educational workshops for professionals and consumers.
Suffolk County Office of Minority Health Great River, NY	The Suffolk County Office of Minority Health provides community Outreach and Education on ways to reduce risk of Chronic Disease such as Diabetes, Obesity/Overweight, Heart Disease/ Stroke, Cancer, HIV/AIDS and STIs, Infant Mortality.
Suffolk County United Veterans, AMHW Yaphank, NY	Suffolk County United Veterans runs an emergency shelter for homeless veterans, as well as transitional and permanent housing for veterans; maintains two food pantries; performs outreach for the VA's supportive services for veteran families program, which assists homeless veterans and those at high risk of becoming homeless to obtain permanent housing; provides case management, education and job training and PTSD support.

Suffolk County, Division of Prevention Medicine, Falls Prevention Programs Great River, NY	The Suffolk County Department of Health Services through the Division of Preventive Medicine has partnered with the New York State Department of Health to implement evidence-based community fall prevention programs that serve older adults. Programs reach all regions of the county utilizing different resources and partnerships that provide falls prevention programming in Suffolk County communities. These programs are Staying Independent for Life, a two hour falls and injury prevention seminar for senior citizens, Stepping On: Building Confidence and Reducing Falls, and Tai Chi, Moving for Better Balance provided in partnership with the Suffolk County YMCA. Between 2010 and 2015 these programs collectively reached over 2,800 senior citizen residents to teach them about how to prevent falls in the home and live independently.
Sustainable Long Island Farmingdale, NY	The mission of Sustainable Long Island (SLI) is to promote economic development, environmental health, and social equity for all Long Islanders, now and for generations to come. SLI is a catalyst and facilitator for sustainable development. We cultivate the conditions, identify resources, and provide tools to advance sustainability on Long Island. Our programs range from working to improve healthy food access (Youth-staffed Farmers' Market Project; Community Garden Initiative; Healthy Corner Stores Project; NYSDOH Creating Healthy Schools & Communities); environmental health (Town of Islip Local Waterfront Revitalization Program; Long Beach Master Comprehensive Plan Update/Local Waterfront Revitalization Program; Riverhead Brownfield Opportunity Area Project); and improve economic development (Long Beach Business Support Program; Culture and Arts-based Tourism Corridors; Bellport Area Beautification and Job Readiness Project).
TempPositions Melville, NY	Founded in 1962, The TemPositions Group of Companies is one of the country's largest regional full-service staffing agencies offering temporary, contract, temp-to-hire, direct hire and recruitment process outsourcing services. We serve the New York, Connecticut, New Jersey and Northern California markets. While there are very few companies that can offer clients a truly broad range of skill sets, we can. We're comprised of multiple specialized divisions, each staffed with individuals possessing years of hands-on industry experience. By having similar backgrounds to both our clients and the professionals they place, our internal staff understands the nuances and can select precisely the right individuals for the job. They can also proactively identify innovative ways of assisting our clients, and develop the appropriate systems or programs to translate these ideas into reality.
The American Cancer Society Hauppauge, NY	For over 100 years, the American Cancer Society (ACS) has worked relentlessly to save lives and create a world with less cancer. Together with millions of our supporters worldwide, The American Cancer Society helps people stay well and get well, find cures, and fight back against cancer. Programs provided includes: Road to Recovery, Reach to Recovery, Wig Program, Look Good Feel Better, Clinical Trials Matching Program, Hope Lodge,

	cancer.org, National Cancer Information Center (1-800-227-2345), I Can Cope, ACS Cancer Survivors Network.
The Research Foundation for SUNY, Stony Brook, Adolescent Medicine Division Stony Brook, NY	The Research Foundation for SUNY, Stony Brook Adolescent Medicine Division is the controlling agent for the Comprehensive Adolescent Pregnancy Prevention (CAPP) grant and as such, most of the services provided are through the grant initiative. Services provided include: • Evidence-based interventions and adult preparation workshops for adolescent groups or individuals. The interventions address reproductive and sexual health of teens and young adults up to the age of 21 and include information on abstinence and healthy relationships. The workshops can cover financial literacy, career development, emotional and social well-being, self-esteem, to name a few. • Linkage to medical care at any one of three Adolescent Medicine Clinics for youth ages 12 through 25. • Assistance with enrollment into the Family Planning Benefit Program. • Workshops for community members and professionals on how to speak with your teens about their reproductive health, Minors' rights to confidentiality, what's happening in Suffolk, mental health, and beyond. • Provide resources to community and social services.
Thursday's Child Patchogue, NY	The mission on Thursday's Child is "to develop, to coordinate, and to provide services for People Living with HIV/AIDS on Long Island." The mission of the Early Intervention Service program is to offer assistance to individuals who are newly diagnosed with HIV, assistance to those who need to re-gain access to care, and to promote health through community outreach and education.
Town of Smithtown Horizons Counseling and Education Center Smithtown, NY	The Town of Smithtown Horizons Counseling and Education Center provides individual and group counseling for both adolescents and adults with substance use disorders (including a satellite site at Hauppauge High School); psychoeducation about substance use; prevention/education services to individuals in a variety of community-based settings; parenting classes; gender-specific clinical programming; psychiatric evaluation; medication management services; we also host an Ancillary Withdrawal (Suboxone induction) program operated by Central Nassau Guidance and Counseling Services at our main site.
United Lifeline & United Home Services Bethpage, NY	United Lifeline and United Home Services provides personal emergency response systems, medication dispensers, cellular units and other technology for safety and independence as well as membership based, discounted home maintenance program.
Utopia Homecare Kings Park, NY	Utopia Home Care pledges to treat every client with compassion and dignity, and to help them achieve as much independence as possible. Our staff is experienced in every level of care, including accident rehabilitation, post-hospital convalescence, illness, and short- and long-term disability. We offer a variety of care services, tailored to address the unique needs of each individual and available 24 hours a day, 7 days a week. Services provided include: home care services; assisted living; companions and staffing

	services.
VIBS: Domestic Violence and Rape Crisis Center Islandia, NY	VIBS provides free and confidential services to survivors of domestic violence and rape/sexual assault. Services include: counseling for children, teens, adults, and elders; legal advocacy; outreach and court accompaniment; crisis/hotline intervention; and community education. We also have 3 SANE (Sexual Assault Nurse Examiner) Centers located in Suffolk County. The goal of these centers is to provide confidential and sensitive treatment to rape and sexual assault victims. Services provided include: medical care/forensic examination, medications to prevent STIs/HIV/pregnancy (if applicable), evidence collection and storage, emotional support and advocacy, and referrals for follow-up counseling and/or medical care.
Visiting Nurse Service and Hospice of Suffolk Northport, NY	Visiting Nurse Service and Hospice of Suffolk is a not-for-profit home care and hospice agency providing registered nurses, enterostomal therapy & wound care, home health aide care, physical, speech and occupational therapies, hospice care, in patient and at-home, medical social workers, registered dieticians, palliative care, infusion therapy and acupuncture.
YMCA of Long Island Huntington, NY	The YMCA is a cause-driven-driven organization that is for youth development, healthy living and social responsibility. The Y's major programs include after school programs, daycare programs, preschool education, physical fitness, chronic disease prevention, aquatic safety and more. Our service locations have gyms, weight rooms, swimming pools, classrooms, camp grounds, multi-space centers and other facilities. It is important to the Y that all persons- "regardless of age, income or background" – can participate in Y programs. The goal of the YMCA is to strengthen communities. Each location supports a neighborhood, so in the YMCA's terms the YMCA serves, or is anchored in more 10,000 communities world-wide.

*List of services provided collected from Summit Event participant pre-survey or from participating organization's website. This list may not be inclusive of the entirety of services provided by the organization.

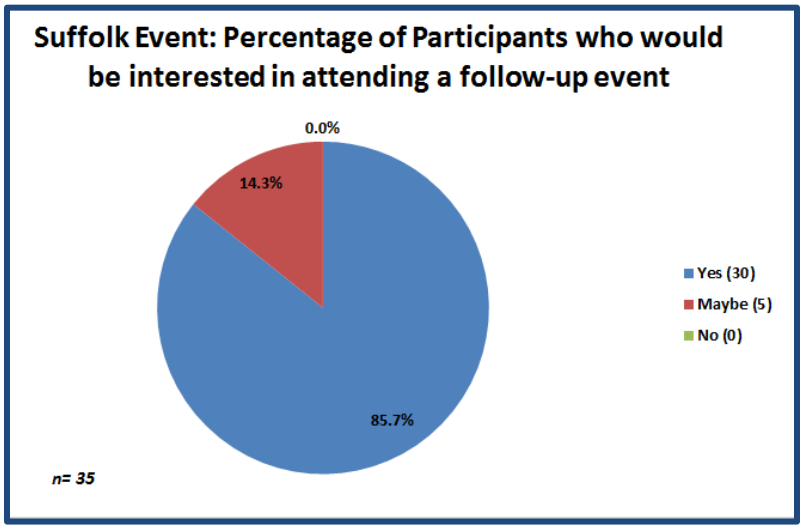
Conclusion

Qualitative data collected during the Community-Based Organization Summit Events has provided a rich assessment of what issues community-level service providers feel are the most pressing for community members on Long Island. The data analysis process was strategically planned out to focus not only on the NYS Prevention Agenda areas, but to also bring other high-priority concerns related to health equity, disparities and barriers to care for people in Suffolk County. The selected analysis strategy was only one way, of many possible, to draw parallels, examine correlations and determine the need for additional support within Suffolk County.

Qualitative data from community key-holders is incredibly valuable to the Long Island Health Collaborative' s mission to assist the full spectrum of health and social service providers to provide better healthcare, more efficiently and cost-effectively for all Long Islanders through population health activities. Information collected will be investigated continually and synthesized appropriately to support future partnerships and program funding.

In addition to data collection, both summit events provided vast networking opportunities for participants, with time built in to meet and converse with community partners built directly into the program. During the networking opportunity, participants learned about other programs and organizations serving their target community and establish connections with fellow service providers. The response from participants was overwhelmingly positive, with many encouraging the allowance of more networking time during future events. In response to this feedback, the Long Island Health Collaborative sent an evaluation survey to all participants to gauge the interest in attending a follow-up event.

Of 35 participants who completed the evaluation survey, 35(100%) responded yes or maybe when asked if they would be interested in attending a follow-up event.



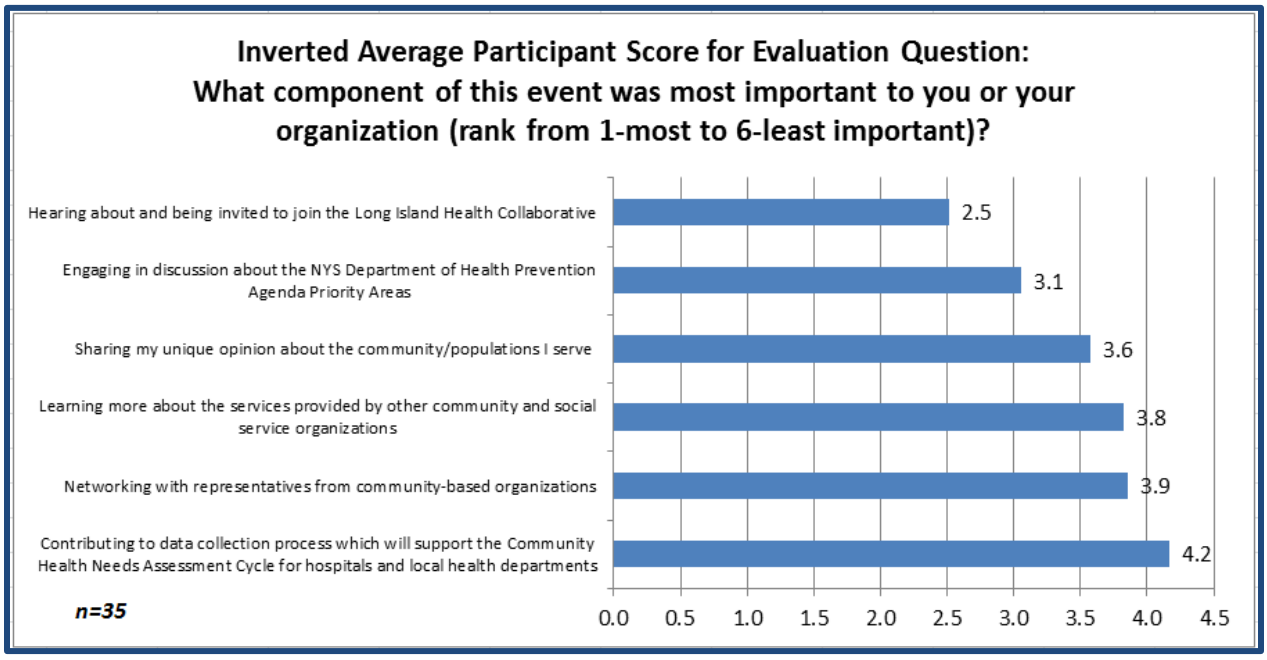
Participant feedback was overwhelmingly positive with select quotes listed below:

- I had wished our discussions could have progressed and unfolded, without such a time constraint... maybe another half hour would have been beneficial.
- It is important to have the opportunity to connect in common cause, especially because services here are so "silo-ed." Understanding the needs and clearly defining the problems is a huge step,

but we need to really do something to address the problem. I think this initiative shows a really promising start, but I really hope it leads us to action.

- I appreciated the stenographer; knowing that what was being said has the chance of really being heard by people who maybe could make a difference in these matters.
- I liked the table discussion - it was a comprehensive way to get a lot of opinions on the same subject quickly.
- Wonderful opportunity to share information and concerns with other CBO representatives.

In response to the question: "*What component of this event was most important to you or your organization?*", the majority of participants felt that Contributing to the data collection process which will support the Community Health Needs Assessment Cycles for hospitals and local health departments and networking with representatives from community-based organizations were the most valuable aspects of participation.



The most valuable takeaway following Summit Events was the inherent passion and vested interest within community partners to improve health outcomes through advancement of equity and reduction of disparities and barriers within communities on Long Island. The Long Island Health Collaborative is planning future events to address the results of this data analysis, and to provide community partners with an extended opportunity to enhance and support collaboration among colleagues.

The Long Island Health Collaborative would like to send express unwavering gratitude to the community based organizations who participated during the CBO Summit Events. The voice of our front-line community service professionals will have a profound effect on our plans for working collaboratively to address health barriers, disparities and social determinants of health into the coming months. We sincerely appreciate your devotion and advocacy to the betterment of health for all Long Islanders.

For more information about the Long Island Health Collaborative, please visit: www.lihealthcollab.org

Appendix

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: ***(5 MINUTES)***

1. *What makes you excited to work for the organization you are representing?* ***(5 MINUTES)***
2. 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}.
3. *Now we are going to move a little deeper into this discussion.* ***(5 MINUTES)***
   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.

(10 MINUTES)

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?"

(5 MINUTES)

4. 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.

   (10 MINUTES)

5. 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 MINUTES)

6. 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?

   What strategies do you recommend for overcoming these barriers? ***(5 MINUTES)***

7. 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?

   (5 MINUTES)

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

   (5 MINUTES)

Rev. 2/5/16