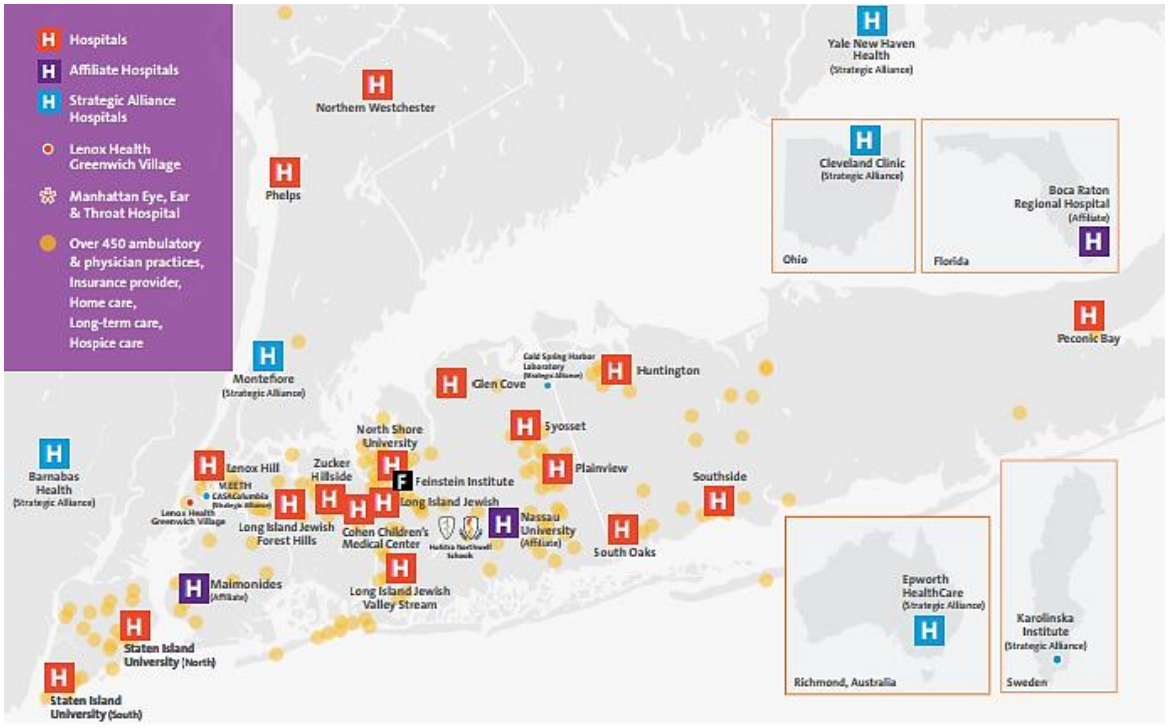
Northwell Health NYSDOH Community Service Plan 2016-2018 Summary Report



County Service Area:

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

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Executive Summary

1. *2016-2018 Northwell Health Prevention Agenda Priorities:*

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

PRIORITY AREA: Prevent Chronic Disease

- FOCUS AREA: Reduce obesity in children & adults
    - Create community environments that promote & support healthy food and beverage choices & physical activity
    - Prevent childhood obesity through early child care & schools
    - Expand the role of health care, health service providers, & insurers in obesity prevention
    - Expand the role of public & private employers in obesity prevention
- FOCUS AREA: Increase access to high-quality chronic disease preventive care & management in both clinical & community settings
    - Increase screening rates for cardiovascular disease, diabetes, & breast/cervical/colorectal cancers, especially among disparate populations
    - Promote use of evidence-based care to manage chronic diseases
    - Promote culturally relevant chronic disease self-management education

Integration of mental health awareness & screening

To address the mental health needs identified by the CHNA process, the South Oaks Hospital and Zucker Hillside Hospital will focus on the following Priority Agenda Item and focus areas:

PRIORITY AREA: Promote Mental Health & Prevent Substance Abuse

- FOCUS AREA: Promote Mental, Emotional, & Behavioral Health
    - Promote mental, emotional, & behavioral well-being in communities
- FOCUS AREA: Strengthen Infrastructure Across Systems
    - Support collaboration among professionals working in fields of mental, emotional, and behavioral health promotion & chronic disease prevention, treatment, and recovery
    - Strengthen infrastructure for mental, emotional, and behavioral health promotion & mental, emotional, and behavioral disorder prevention

2. *Changes to the 2013-2016 selected priorities you selected since 2013 and emerging issues identified*

The 2016-2018 Northwell Health NYDSOH Prevention Agenda Priorities are remained similar to the 2013-2016 NYDSOH Prevention Agenda Priorities. As a result of the increasing evidence of the impact of social determinants of health on health outcomes and disparities, Northwell Health expanded the community needs assessment to include both primary and secondary data analysis and mapping of determinants of health for each county in the Northwell Health service area. The determinants of health encompass the range of personal, social, economic, and environmental factors that influence health status. The determinants of health reach beyond the boundaries of traditional health care to include Centers for Disease Control and Prevention[1] (CDC) categories of: policymaking; social factors; health services; individual behavior and biology and genetics.

The 2013-2016 Implementation Plan activities have had an impact in improving and meeting some of New York State Prevention Agenda Objectives that were related to health disparities, chronic

[1] Centers for Disease Control and Prevention (CDC). "Social Determinants of Health: Know What Affects Health." Oct. 2015. Web. June 2016.

disease, obesity and behavioral health as shown on the New York State Prevention Agenda Dashboard[2]. 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 by the other 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[3].

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 areas in every county, emerged as pressing community health issues in the Northwell Health Service area:

[2] NYSDOH Prevention Agenda Dashboard https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard accessed November 2016.
[3] Ibid.

Nassau County

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

New York County

- Chronic disease, especially in at risk and diverse communities
- Obesity
- Mental health and substance abuse
- Decreased physical activity and access to safe recreational areas
- Decreased consumption and access to healthy foods
- Mental health and substance abuse
- Access to healthcare
- Healthy indoor and outdoor air

Queens County

- Chronic disease, especially in at risk and diverse communities
- Obesity
- Mental health and substance abuse
- Healthy indoor and outdoor air

- Decreased physical activity and access to safe recreational areas
- Access to healthcare
- Decreased consumption of and access to healthy foods
- Language and cultural sensitivity

Richmond County

- 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
- Healthy indoor and outdoor air/ tobacco free living
- Access to healthcare

Suffolk County

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

Westchester County

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

Nassau, Queens and Suffolk Mental Health

- Increased alcohol and drug Abuse
- Increased prevalence of mental health disorders especially depression and suicide
- Chronic disease, especially in at risk and diverse communities
- Tobacco use
- Access to healthcare
- Lack of affordable housing

3. *What data was included in the Community Health Needs Assessment Primary and Secondary Data collection and Analysis?*

Primary Analysis

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

impact wellness were included in the assessment. To collect and analyze primary data, Northwell Health partnered with local health departments, area hospitals/health systems and community–based organizations in each of the six counties in our service area, as well as the Long Island Health Collaborative (LIHC), recipient of the NYSDOH Population Health Improvement Program, which focuses on health in Nassau and Suffolk Counties.

Secondary Analysis

Since the Northwell Health service area includes, Nassau, New York, Queens, Richmond, Suffolk, and Westchester counties, secondary community health data collection, assessment and NYSDOH Priority Agenda Item selection was performed by county. Sources of information included SPARCS data (version 2016), NYSDOH Vital Statistics, NYS Cancer Registry, the NYSDOH Surveillance System, New York State DOH Prevention Agenda Dashboard, Behavioral Health Risk Factor Surveillance System, Northwell Health TSI Reporting and Analytics and U.S Census data. Data were age-adjusted (direct standardization of rates) based on 2010 U.S. standard population.

A mapping of Prevention Quality Indicators (PQIs) quintiles was also used as part of the health data analysis. PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which quality community health and outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. With high-quality, population health and community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in

hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community.

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

4. Community and Local Health Department Community Health Needs Assessment and Implementation Plan Partners

Northwell Health began the Community Health Needs Assessment (CHNA) process in January 2016. As an integrated health care system, the Office of Strategic Planning was the lead corporate office that planned, coordinated and reported the CHNA in collaboration with internal and external stakeholders for Northwell Health. System stakeholders included senior leadership, the Committee on Community Health of the Northwell Board of Trustees, executive directors and staff of Northwell hospitals, Office of Strategic Planning, Office of Government and Community Affairs and corporate service lines. External stakeholders included representatives from county health departments, area hospitals, academia, business, government agencies and community based organizations with an emphasis on those who serve communities with health disparities. A series of internal and external stakeholder meetings were

[4] Centers for Disease Control and Prevention (CDC). "Social Determinants of Health: Know What Affects Health." Oct. 2015. Web. June 2016.

held to discuss the process including: the CHNA methodology; recruitment of community, academic and government partners; secondary data analysis; primary data collection from external stakeholders; evaluation of primary data; identification of health system and community resources; identification of NYSDOH Priority Agenda items and development of the implementation plan. The Committee on Community Health of the Northwell Board of Trustees was updated on the CHNA process during its quarterly meetings, provided feedback on the process including the selection of the NYSDOH Priority Agenda items and approved the recommended NYSDOH Priority Agenda items and the implementation plan for Northwell Health as the governing body of community health of the Northwell Board of Trustees.

5. *How is Northwell Health engaging the broad community in the community health needs assessment and implementation plan?*

Northwell Health and its service area stakeholders agreed that quantitative and qualitative data should be collected from community organizations and the population-at-large in the forms of community member and community-based organization/provider surveys, facilitated focus groups and town halls in each of the service area counties. External stakeholders were presented the data analysis and provided feedback in the selection of the Northwell NYSDOH Prevention Agenda Priorities and Focus Areas. Area health coalitions from all 5 service area counties including the lead health departments and other community-based organizations, schools, national/regional health organizations and academia are included as partners in the Northwell Health Implementation Plan. Their roles include partnering in community outreach, education, engagement, delivery of evidence-based interventions, providing social services related to identified social determinant of health needs, advocacy and policy formation.

6. *Northwell Health Implementation Plan Evidence –based Interventions/Strategies/Activities*

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

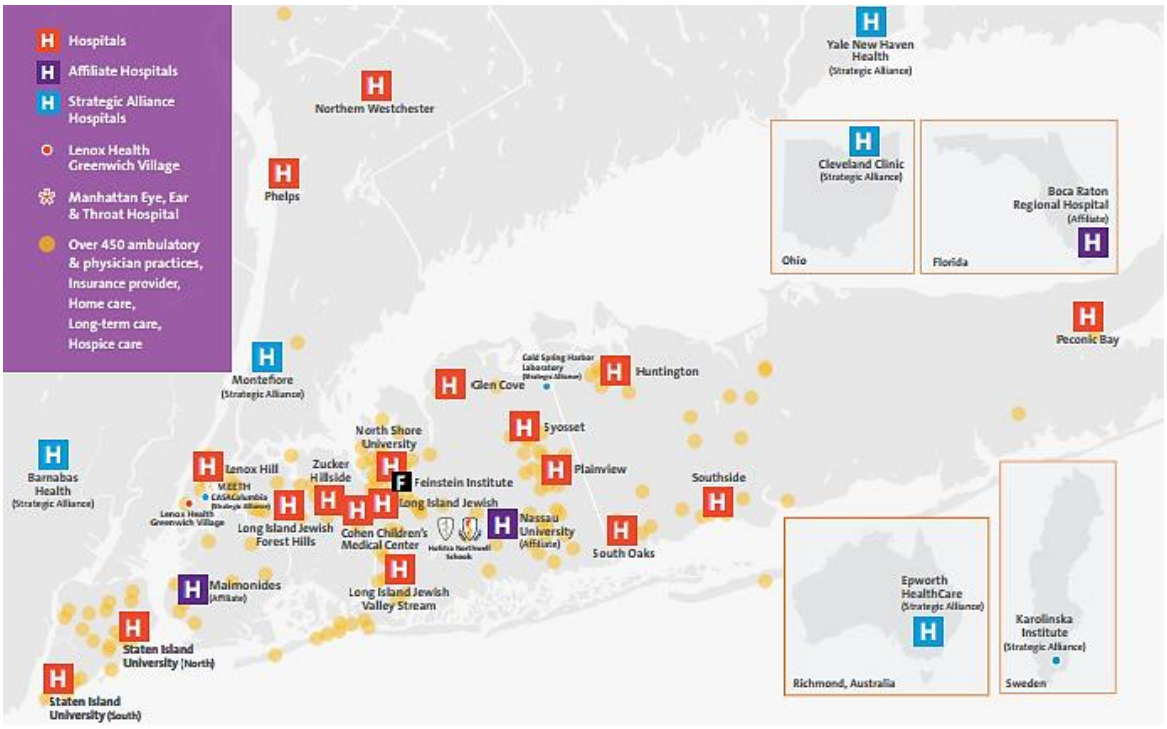
1. Stanford Chronic Disease Self-Management Program (CDSMP)
2. **"¡Vida SI, Diabetes NO!"** (Life YES! Diabetes NO!) - an outcomes-focused approach that will take a comprehensive and systematic look at diabetes among Latinos with the goal of uncovering the root causes, leading to more effective and efficient delivery of prevention, education, testing and treatment.
3. Breast Feeding Friendly Primary Care Practices
4. Breast Feeding Friendly Hospitals
5. Complete Streets Initiatives
6. Smoke-free Environments
7. 5 "A's" Tobacco Cessation Counseling
8. AHRQ Health Literacy Toolkit for Primary Care Practices
9. Healthy Corner Store Initiative
10. Stepping On
11. Project Fit America
12. Healthy Vending Guidelines
13. Bully Reduction/Anti-Violence Education (BRAVE) School-based Program
14. PH2, PH9 and SBIRT Behavioral Health Screens

7. Implementation Plan Evaluation and Process Outcomes

Northwell Health's Implementation Plan's evaluation measures include performance measures related to the 2016-2018 NYSDOH Prevention Agenda Objectives and health system SMART

objectives related to the NYSDOH Prevention Agenda Objectives. In addition, short term metrics have been identified to track activities related to the long term indicators.

Northwell Health
Community Service Plan 2016-2019



About Northwell Health

Northwell Health strives to improve the health of the communities it serves and is committed to providing the highest quality clinical care; educating the current and future generations of health care professionals; searching for new advances in medicine through the conduct of bio-medical research; promoting health education; and caring for the entire community regardless of the ability to pay. Every role, every person, every moment matters. We put our patients and customers at the center of everything we do, while acting on our core values: Caring, Excellence, Innovation and Integrity.

Formerly known as North Shore-LIJ Health System, Northwell Health has undergone significant growth in the last several years. Today, Northwell is New York's largest integrated health care system and one of the largest in the country as well. With five tertiary hospitals, three specialty care hospitals, ten community hospitals, and three affiliates, this 21 hospital system is 61,000 people looking at healthcare differently.

The purpose of this report is to assess and to respond to community health needs as a system. This findings in this report are organized into the priority and focus areas put forth by the New York State Department of Health (NYSDOH) Prevention Agenda, which is aimed at reducing health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them. The New York State Department of Health Prevention Agenda is based on the U.S. Surgeon General's National Prevention Strategy, released June 16, 2011, which aims to guide our nation in the most effective and achievable means for improving health and well-being.

New York State Department of Health Prevention Agenda

The Prevention Agenda involves a unique mix of organizations to collaborate and work together across communities to improve the health and quality of life for all New Yorkers. The Prevention Agenda envisions New York as the Healthiest State in the Nation, and features five priority areas:

- Prevent chronic diseases
  - Focus area 1: Reduce Obesity in Children and Adults
  - Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
  - Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
- Promote healthy and safe environments
  - Focus Area 1: Outdoor Air Quality
  - Focus Area 2: Water Quality
  - Focus Area 3: Built Environment
  - Focus Area 4: Injuries, Violence and Occupational Health
- Promote healthy women, infants and children
  - Focus Area 1: Maternal and Infant Health
  - Focus Area 2: Child Health
  - Focus Area 3: Reproductive, Preconception and Inter-Conception Health
- Promote mental health and prevent substance abuse
  - Focus Area 1: Promote mental, emotional and behavioral (MEB) well-being in communities
  - Focus Area 2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
  - Focus Area 3: Strengthen Infrastructure across Systems
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated infections
  - Focus Area 1: Prevent HIV and STDs
  - Focus Area 2: Prevent Vaccine-Preventable Diseases
  - Focus Area 3: Prevent Healthcare-Associated Infections

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups.

Northwell Health Service Area 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 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. (See appendix for Individual County Community Health Needs Assessments).

Collaborative Process and Criteria for Prioritizing NYSDOH Priority Agenda Items

Northwell Health began the Community Health Needs Assessment (CHNA) process in January 2016. As an integrated health care system, the Office of Strategic Planning was the lead corporate office that planned, coordinated and reported the CHNA in collaboration with internal and external stakeholders for Northwell Health. System stakeholders included senior leadership, the Committee on Community Health of the Northwell Board of Trustees, executive directors and staff of Northwell hospitals, Office of Strategic Planning, Office of Government and Community Affairs and corporate service lines. External stakeholders included representatives from county health departments, area hospitals, academia, business, government agencies and community based organizations with an emphasis on those who serve communities with health disparities. A series of internal and external stakeholder meetings were held to discuss the process including: the CHNA methodology; recruitment of community, academic and government partners; secondary data analysis; primary data collection from external stakeholders; evaluation of primary data; identification of health system and community resources; identification of NYSDOH Priority Agenda items and development of the implementation plan (See Individual County Community Health Needs Assessments for stakeholder participation). The Committee on Community Health of the Northwell Board of Trustees was updated on the CHNA process during its quarterly meetings, provided feedback on the process including the selection of the NYSDOH Priority Agenda items and approved the recommended NYSDOH Priority Agenda items and the Implementation Plan for Northwell Health as the governing body of community health of the Northwell Board of Trustees.

Primary Analysis

The CHNA stakeholders determined that in addition to census, hospitalization and vital statistics data, the assessment should include the “voice of the community” (e.g. the community’s perception of need). This assessment included individual and community health priorities, barriers to accessing health care and strategies to improve the individual’s and community’s health. Social determinants of health which impact wellness were included in the assessment. The group agreed that quantitative and qualitative data should be collected from community organizations and the population-at-large in the forms of community member and community-based organization/provider surveys, facilitated focus groups and town halls. To collect and analyze primary data, Northwell Health partnered with local health departments, area hospitals/health systems and community–based organizations in each of the six counties in our service area, as well as the Long Island Health Collaborative (LIHC) which focuses on health in Nassau and Suffolk County. LIHC is a partnership of Long Island's hospitals, county health departments, health providers, community-based social and human service organizations, academic

institutions, health plans, local government, and the business sector, all engaged in improving the health of Long Islanders. Full reports for the primary data methodology and analysis for individual counties can be found in the Individual County Community Health Needs Assessments.

Secondary Analysis

Since the Northwell Health service area includes, Nassau, New York, Queens, Richmond, Suffolk, and Westchester counties, secondary community health data collection, assessment and NYSDOH Priority Agenda Item selection was performed by county. Sources of information included SPARCS data (version 2016), NYSDOH Vital Statistics, NYS Cancer Registry, the NYSDOH Surveillance System, New York State DOH Prevention Agenda Dashboard, Behavioral Health Risk Factor Surveillance System, Northwell Health TSI Reporting and Analytics and U.S Census data. Data were age-adjusted (direct standardization of rates) based on 2010 U.S. standard population.

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Determinants of Health

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

1) Policymaking

Public policies at the local, state, and federal level influence community health and can impact all other factors that influence overall individual health. Public policy affects housing, education, income, access to food, the availability and quality of health care, and the environment in which we live. Tobacco policies and built environment regulations are just two of the many avenues to promote better community health.

Across New York City and in Nassau, Suffolk, and Westchester counties, the Complete Streets Act is seeking to improve roadways to be safer and better suited for walking and biking. A “complete

[1] Centers for Disease Control and Prevention (CDC). "Social Determinants of Health: Know What Affects Health." Oct. 2015. Web. June 2016.

street" is a roadway planned and designed to consider the safe, convenient access and mobility of all roadway users of all ages and abilities. This includes sidewalks, lane striping, bicycle lanes, paved shoulders, signage, crosswalks, and pedestrian signals. The Complete Streets initiative will allow more citizens to achieve the health benefits associated with active forms of transportation. Complete Streets is active in Nassau, Suffolk, and Westchester counties, as well as all of New York City (NYC DOT Sustainable Streets).

Tobacco legislation is pivotal in reducing smoking rates and improving the health status of individuals. Across New York City, the Smoke Free Air Act of 1995 has been amended several times in recent years to respond to changing smoking trends. In 2002 it was amended to prohibit smoking in virtually all workplaces and recreational venues, and in 2009 it was amended to prohibit smoking on and around hospital grounds. In 2013, the Smoke Free Air Act was amended to include e-cigarettes in all of its existing components. New York City has also adopted Tobacco 21, making 21 the minimum age to purchase tobacco products anywhere in the city. Suffolk County has also adopted Tobacco 21 legislation and Nassau County's minimum age to purchase tobacco products is 19. Suffolk County has also adopted legislation to prohibit smoking in county parks and beaches. Northwell Health, as a lead agency in collaboration with the New York City Department of Health and Mental Hygiene and Smoke Free NYC has helped 13 Queens Community Boards to pass Smoke Free Housing Resolutions and 3000 apartments become smoke free. Recently, the US Housing and Urban Development announced that public housing developments will be required to provide a smoke-free environment affecting approximately 940,000 public housing units.

2) Social Factors

Social determinants of health reflect the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age. Also known as *social and physical determinants* of health, they impact a wide range of health, functioning, and quality-of-life outcomes.

a) Socioeconomic Factors

i) Income

A large body of research documents the links between income and a wide array of health indicators across the life span, beginning even before birth. Children in poor families are about seven times as likely to be in poor or fair health as children in families with incomes at or above 400% of the federal poverty level (FPL). In addition, lower-income children experience higher rates of asthma, heart conditions, hearing problems, digestive disorders and elevated blood lead levels[2]. Higher income is also linked with better health and longer life among adults. Poor adults are nearly five times as likely to report being in poor or fair health as adults with family incomes at or above 400% of FPL. Among adults at age 25, those in the highest-income group can expect to live more than six years longer than their poor counterparts[2].

ii) Poverty

The CDC defines poverty as a condition in which "a person or group of people lack human needs because they cannot afford them."[3] In the United States, the federal poverty level is expressed as an annual pre-tax income level indexed by size of

[2] Robert Wood Johnson Foundation. (2011, April). Income, Wealth and Health. *Exploring the Social Determinants of Health*. Retrieved June, 2016.

[3] Centers for Disease Control and Prevention (CDC). "Social Determinants of Health: Know What Affects Health." Oct. 2015. Web. June 2016.

household and age. For example, in 2016, the federal poverty level was $11,880 for an individual younger than 65 years of age and $24,300 for a family of four.[4] Poverty and poor health worldwide are inextricably linked, as poverty is both a cause and a consequence of poor health. Prosperity provides individuals with resources that can be used to avoid or buffer exposure to health risks. By contrast, poverty affects health by limiting access to such resources.

iii) Employment

Unemployed Americans—7.8 million as of November 2016—face numerous health challenges beyond loss of income.[5] Laid-off workers are 54% more likely than those continuously employed to have fair or poor health, and 83% more likely to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis.[2]

b) Educational Attainment

People who graduate from high school have better health than those who do not complete high school. In fact, research shows education is the strongest predictor of long-term health.[6] Educational attainment and high school graduation rates can be strong predictors of health outcomes. For example, nearly 33% of adults that did not graduate from high school are obese, while 21% of those who graduated from college are obese.[7] In addition, children of parents that did not graduate from high school have an obesity rate 3.1x higher than those children whose parents earned a college degree (30.4% compared to 9.5%).[8] High school graduates have better health and lower medical costs than high school dropouts do, and college graduates have even better health and lower medical costs than high school graduates do. Graduation from high school is associated with an increase in average lifespan of 6 to 9 years.[9]

c) Food Security

Food insecurity refers to United States Department of Agriculture's measure of lack of access to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecure households are not

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[4] United States Department of Health and Human Services. https://aspe.hhs.gov/poverty-guidelines Accessed November 2016.

[5] U.S. Bureau of Labor Statistics. http://www.bls.gov/

[6] American Public Health Association. Public Health and Education: Working Collaboratively Across Sectors to Improve High School Graduation as a Means to Eliminate Health Disparities. *Policy Statement*. Retrieved June, 2016.

[7] Trust for America's Health and Robert Wood Johnson Foundation. F as in Fat: How Obesity Threatens America's Future - 2011. Washington, D.C.: Trust for America's Health, 2011. (Accessed June 2016). Based on data using the previous BRFSS methodology in use from 2008-2010.

[8] Singh GK, Kogan MD. *Childhood obesity in the United States, 1976-2008: Trends and Current Racial/Ethnic, Socioeconomic, and Geographic Disparities*. A 75th Anniversary Publication. Health Resources and Services Administration, Maternal and Child Health Bureau. Rockville, Maryland: U.S. Department of Health and Human Services, 2010.

[9] American Public Health Association. Public Health and Education: Working Collaboratively Across Sectors to Improve High School Graduation as a Means to Eliminate Health Disparities. *Policy Statement*. Retrieved June, 2016.

necessarily food insecure all the time. Food insecurity may reflect a household's need to make trade-offs between basic needs, such as housing or medical bills, and purchasing nutritionally adequate, healthful foods. There exists a paradox of sorts in which food insecurity and lack of access to healthy foods are consistently linked to obesity.[10] Some studies demonstrate a linear relationship between food insecurity and obesity, while others demonstrate a U-shaped relationships. In both instances, there exists a point in which individuals may have enough money to buy typically cheaper, energy-dense and processed foods, but not enough money to buy fresh, healthy alternatives. In addition, many low income neighborhoods are classified as 'food deserts' meaning nutritious foods are hard to obtain. In these neighborhoods, supermarkets are often too far to be accessible by foot or public transportation, leading residents to opt for the unhealthy or energy-dense foods sold at local convenience stores.

The Island Harvest identified 181,480 individuals in Nassau and Suffolk as food insecure (85,540 and 95,540, respectively), and Map the Meal Gap identified 243,570 food insecure individuals in New York County, 298,250 in Queens County, 48,380 in Richmond County, and 84,970 in Westchester County.[11] In total, Northwell's service area encompasses 856,650 food insecure individuals.

d) Crime and Violence

The circumstances that give rise to violence are also made worse by violence, feeding a cycle of poor community health. A lack of safety worsens the risk factors for violence, thus perpetuating it. Fear of violence erodes trust and social ties, so residents are isolated and not able to participate in group processes that promote community health and well-being. In addition, areas of high crime make it difficult for residents to feel safe and comfortable exercising outdoors. Lack of perceived safety and fear of neighborhood violence are strongly correlated with poorer health outcomes, especially in regards to chronic diseases like asthma[12] and obesity.[13]

e) Social Support

Social connectedness improves physical health and mental and emotional well-being. A landmark study from the University of Michigan found that lack of social connection is actually a greater detriment to health than obesity, smoking and high blood pressure. Strong social connection leads to a 50% increased chance of longevity, strengthens the immune system, and helps faster recovery from disease.[14] In addition, people who feel more connected to others have lower levels of anxiety and depression, and also have higher self-

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[10] Franklin, B., Jones, A., Love, D., Puckett, S., Macklin, J., & White-Means, S. (2011). Exploring Mediators of Food Insecurity and Obesity: A Review of Recent Literature. *Journal of Community Health J Community Health*, 37(1), 253-264. doi: 10.1007/s10900-011-9420-4

[11] Map the Meal Gap. Retrieved June 2016, from http://map.feedingamerica.org/

[12] Apter, A. J., Bogen, D. K., Boyd, R. C., Garcia, L. A., Have, T. T., & Xingmei, W. (2010, September). Exposure to community violence is associated with asthma hospitalizations and emergency department visits. The Journal of Allergy and Clinical Immunology, 126(3), 552-557

[13] Appugliese, D., Bradley, R. H., Cabral, H. J., Lumeng, J., & Zuckerman, B. (2006). Neighborhood safety and overweight status in children. Archives of Pediatrics & Adolescent Medicine, 160, 25-31.

[14] House, J., Landis, K., & Umberson, D. (1988, July 29). Social relationships and health. *Science, 241*(4865), 540-545. doi:10.1126/science.3399889

esteem, greater empathy for others and are generally more trusting and cooperative. Ultimately, social connectedness generates a positive feedback loop of social, emotional, and physical well-being.

f) Built Environment

i) Housing

The connection between housing and health has been well known for more than a century—Florence Nightingale once wrote, "The connection between health and the dwelling of the population is one of the most important that exists." Today there is renewed interest in understanding the complex pathways connecting housing factors, neighborhood factors, social factors, adverse health outcomes, and disproportionate disease burden—particularly with respect to skyrocketing rates of chronic diseases such as asthma, obesity, and diabetes[15] Dilapidated housing is associated with exposures to lead, asthma triggers (such as mold, moisture, dust mites, and rodents), and mental health stressors such as violence and social isolation[15]. In addition, secondhand and third hand smoke exposure is a danger, especially to children, in crowded housing units. There is a wealth of research pointing to the dangers of secondhand smoke as well as the tendency for residual smoke particles to persist in walls, carpet, and furnishings known as third hand smoke.

ii) Access to Exercise Opportunities

Increasing evidence suggests that land-use and transportation decisions can facilitate or obstruct the creation and maintenance of healthy communities[16]. A healthy community protects and improves the quality of life for its citizens, promotes healthy behaviors and minimizes hazards for its residents. By assessing community characteristics such as sidewalks, transportation options, availability of public recreational space, and mixed-use design, we can measure corresponding health outcomes, including rates of physical activity, obesity, asthma, injury, and crime, as well as indicators of mental health and social capital.

3) Health Services

Across the lifespan, our health care system is designed to help people stay healthy, recover from illness, live with chronic disease or disability, and cope with death and dying. Quality health care delivers these services in ways that are safe, timely, patient centered, efficient, and equitable. Unfortunately, Americans too often do not receive care they need or receive worse care than others resulting in health disparities. Both access to services and the quality of health services can greatly impact health. Lack of access, limited insurance coverage, and limited cultural competency among providers create barriers to receiving services. These barriers ultimately lead to unmet health needs, delays in appropriate care, and hospitalizations that could be prevented.

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[15] Hood, E. (2005). Dwelling Disparities: How Poor Housing Leads to Poor Health. *Environmental Health Perspectives*, *113*(5), A310–A317.

[16] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*, *83*(3), 457–502. http://doi.org/10.1111/j.1468-0009.2005.00409.x

a) Availability of Primary Care Providers
Multiple analyses conducted on the supply of primary care providers and preventive services show that primary care helps prevent illness and death and is associated with a more equitable distribution of health in populations[17]. Ultimately, availability of primary care and preventive services plays a large part in patients' ability to access these services and to maintain well-being and prevent disease.

b) Insurance Coverage
Access to care is often dictated by an individual's insurance status and their ability to pay. For the uninsured in the United States, however, out-of-pocket healthcare costs are simply too high to afford and much of the uninsured population chooses to avoid healthcare altogether. Population groups that do not have health insurance are less likely to have a source of primary care and thus have less access to the entire health system[18].

c) Language and Cultural Competency
In 2002 the Institute of Medicine released *Unequal Treatment*[17], a seminal report documenting extensive evidence of disparities in the burden of disease, quality and appropriateness of care, and health outcomes among specific US populations, in particular ethnic minorities. Language and communication problems may lead to patient dissatisfaction, poor comprehension and adherence, and lower quality of care[19]. In addition to language and interpretation issues, if providers, organizations, and systems do not work together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor quality care, or being dissatisfied with their care. For instance, African Americans and other ethnic minorities report less partnership with physicians, less participation in medical decisions, and lower levels of satisfaction with care[20]. Subsequently, lower quality patient-physician interactions are associated with lower overall satisfaction with health care.

4) Individual Behavior

Individual behavior also plays a role in health outcomes. Many public health and health care interventions focus on changing individual behaviors such as substance abuse, diet, and physical activity. Positive changes in individual behavior can reduce the rates of chronic disease.

a) Diet and Nutrition
A healthy diet is a pillar of well-being throughout the lifespan. It promotes the achievement of healthy pregnancy outcomes; supports normal growth, development and aging; helps maintain a healthful body weight; reduces chronic disease risks; and promotes overall health and well-being. Americans consume many different habitual dietary patterns, which

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[17] Institute of Medicine. (2002, March). Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare. Shaping the Future for Health. Retrieved June, 2016.
[18] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*, *83*(3), 457–502. http://doi.org/10.1111/j.1468-0009.2005.00409.x
[19] Carrasquillo, O., Orav, E. J., Brennan, T. A., Burstin, H. R. 1999. Impact of language barriers on patient satisfaction in an emergency department. Journal of General Internal Medicine, 14, 82-87.
[20] Saha, S., Arbelaez, J. J., Cooper, L. A. 2003. Patient-physician relationships and racial disparities in the quality of health care. American Journal of Public Health, 93, 1713-1719.

reflect their life experiences and wide-ranging personal, socio-cultural and other environmental influences.

b) Physical Activity

Physical activity is shown to reduce all-cause mortality, reduce the risk for cardiovascular disease, lower blood pressure and rates of hypertension, as well as decrease blood lipid levels. It is estimated that being physically inactive is responsible for 1 in 10 deaths among U.S. adults[21] and that sedentary adults pay, on average, $1500 more per year in healthcare costs than physically active adults[22]. In addition, physical inactivity and/or sedentary lifestyle is perhaps the greatest contributor to the obesity epidemic in the United States. In 2015 New York ranked as the 40th most inactive state in the country[23].

c) Alcohol and Substance Abuse

Alcohol and drug dependence often go hand in hand. Research shows that people who are dependent on alcohol are much more likely than the general population to use illicit drugs, and people with drug dependence are much more likely than the general population to drink alcohol. While alcohol and substance abuse problems are public health crises in their own respects, alcohol and substance abuse also contribute to a number of other health problems. Patients with alcohol and drug use disorders are more likely to have psychiatric disorders, are more likely to attempt suicide and are more likely to suffer from chronic diseases[24].

i) Tobacco

Cigarette smoking is the leading preventable cause of death in the United States. Tobacco causes more than 480,000 deaths each year in the United States.[25] This is nearly one in five deaths. Not only are cigarette and tobacco use often associated with increased mortality, but they are leading contributors to increased morbidity and chronic disease as well. According to the United States Department of Health and Human Services[26] smoking is estimated to increase the risk—For coronary heart disease by 2 to 4 times, For stroke by 2 to 4 times, Of developing lung cancer by 25 times.

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[21] Danaei G, Ding EL, Mozaffarian D, et al. The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors. PLoS Med 6(4): e1000058. doi:10.1371/journal.pmed.1000058, 2009.

[22] Anderson LH, Martinson BC, Crain AL, et al. Healthcare Charges Associated with Physical Inactivity, Overweight, and Obesity. *Preventing Chronic Disease*, 2(4):A09, 2005.

[23] United Health Foundation: America's Health Rankings. Retrieved November 2016, from http://www.americashealthrankings.org/explore/2015-annual-report/measure/Overall/state/NY

[24] Stinson FS et al., Drug and Alcohol Dependence 80 (2005) 105–116

[25] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014

[26] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014

ii) Opioid and Heroin

Deaths from Opioid and Heroin rose over the past decade. New York experienced death rates that were higher than any other state for which CDC data was available. New York death rates rose by 2000% from heroin and 200% from opioids[27]. The consequences of this abuse have been devastating and are continuing to rise, as the number of unintentional overdose deaths has nearly quadrupled since 1999. Heroin acts as a cheaper alternative to prescription opioids so we see a rise in heroin addiction and heroin overdose as well. Governor Andrew Cuomo and legislative leaders announced an agreement on June 14, 2016 to combat heroin and opioid abuse in New York State. The comprehensive legislation package will limit opioid prescriptions from 30 to 7 days, require mandatory prescriber education on pain management methods, and eliminate burdensome insurance barriers to treatment. In addition, this legislative package will expand support for New Yorkers in recovery, increasing treatment beds by 270 and substance use program slots by 2,335[28].

5) Health Disparities

Our innate biology and genetic makeup contribute to health outcomes in different ways. For instance, with some exception, breast cancer is mostly prevalent in women rather than men. In addition, carrying the BRCA1 or BRCA2 gene increases one's risk for developing breast or ovarian cancer. These are just two examples of how one's risk for developing disease may be linked to their biology and genetic makeup. So while health is increasingly linked to social and physical determinants, it is important to understand and investigate the differences in health outcomes among different population subgroups. The U.S. DHHS Office of Minority Health provides detailed Minority Population Profiles describing the health disparities faced by ethnic subgroups. Their findings are as follows:

In general, the death rate for African Americans is higher than for Whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide. Although African American adults are 40 percent more likely to have high blood pressure, they are less as likely than their non-Hispanic White counterparts to have their blood pressure under control. In 2010, African Americans were 30 percent more likely to die from heart disease than non-Hispanic whites. Furthermore, African Americans are almost twice as likely to be diagnosed with diabetes as non-Hispanic whites and they are more likely to suffer complications from diabetes, such as end-stage renal disease and lower extremity amputations.

Some health conditions and risk factors that significantly affect Hispanics are: asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease. In addition, Hispanics have higher rates of obesity than non-Hispanic Whites and there are also disparities among Hispanic subgroups. For instance, while the rate of low birth weight infants is lower for the total Hispanic population in comparison to non-Hispanic Whites, Puerto Ricans have a low

[27] 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

[28] NYS Governor's Office. (2016, June 14). Governor Cuomo and Legislative Leaders Announce Agreement to Combat Heroin and Opioid Abuse in New York State. Retrieved June, 2016, from https://www.governor.ny.gov/news/governor-cuomo-and-legislative-leaders-announce-agreement-combat-heroin-and-opioid-abuse-new

birth weight rate that twice that of non-Hispanic Whites. Also, Puerto Ricans suffer disproportionately from asthma, HIVAIDS and infant mortality while Mexican-Americans suffer disproportionately from diabetes.

It is important to note that Asian American women have the highest life expectancy (85.8 years) of any other ethnic group in the U.S. However, life expectancy varies among Asian subgroups: Filipino (81.5 years), Japanese (84.5 years), and Chinese women (86.1 years)[29]. Asian Americans are most at risk for the following health conditions: cancer, heart disease, stroke, unintentional injuries (accidents), and diabetes. Asian Americans also have a high prevalence of chronic obstructive pulmonary disease, hepatitis B, HIV/AIDS, smoking, tuberculosis, and liver disease. In 2012, tuberculosis was 24 times more common among Asians, with a case rate of 18.9 as compared to 0.8 for the non-Hispanic White population.

County Specific Community Health Needs Analysis

The county sections included in this report contain the county specific outcomes since the 2013 CHNA, primary and secondary data analysis of the 2016 CHNA and the collaborative stakeholder process as described previously that was used to determine the New York State Department of Health Prevention Agenda Priority Areas that will be the focus of the Northwell Health Implementation Plan. The geographic regions in the Northwell Health service area include:

1) Nassau County
2) New York County
3) Queens County
4) Richmond County
5) Suffolk County
6) Westchester County

Northwell Health Service Area County Identified Health Priorities

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 areas in every county, emerged as pressing community health issues in the Northwell Health Service area:

Nassau County

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

[29] NIH, Office of Women's Health 2006. Women of Color Health Data Book: Adolescents to Seniors, page 65. http://orwh.od.nih.gov/pubs/WomenofColor2006.pdf

New York County

- Chronic disease, especially in at risk and diverse communities
- Obesity
- Mental health and substance abuse
- Decreased physical activity and access to safe recreational areas
- Decreased consumption and access to healthy foods
- Mental health and substance abuse
- Access to healthcare
- Healthy indoor and outdoor air

Queens County

- Chronic disease, especially in at risk and diverse communities
- Obesity
- Mental health and substance abuse
- Healthy indoor and outdoor air
- Decreased physical activity and access to safe recreational areas
- Access to healthcare
- Decreased consumption of and access to healthy foods
- Language and cultural sensitivity

Richmond County

- 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
- Healthy indoor and outdoor air/ tobacco free living
- Access to healthcare

Suffolk County

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

Westchester County

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

Nassau, Queens and Suffolk Mental Health

- Increased alcohol and drug Abuse
- Increased prevalence of mental health disorders especially depression and suicide
- Chronic disease, especially in at risk and diverse communities
- Tobacco use
- Access to healthcare
- Lack of affordable housing

Northwell Health NYSDOH Priority Agenda Prioritization

The NYSDOH Priority Agenda Items were selected based on the following criteria adapted from the Catholic Health Association Assessing and Addressing Community Health Needs Manual:

1. Magnitude- The magnitude of the problem as it relates to the number of community members impacted by the issue.
2. Severity- The severity of the problem which is determined by the risk of morbidity and mortality associated with the problem.
3. Historical trends- The prevalence of the issue over time.
4. Alignment of the problem with the organization's strengths and priorities.
5. Impact of the problem on vulnerable populations.
6. Importance of the problem to the community.
7. Existing resources addressing the problem.
8. Relationship of the problem to other community issues.
9. Feasibility of change and the availability of evidence-based approaches.
10. Value of immediate intervention versus any delay, especially for long-term or complex threats.

A discussion and debate approach was utilized to identify Priority Agenda Items. Health system, county and regional priority-setting groups comprised of representatives from internal and external CHNA stakeholders met to discuss the needs identified in the primary and secondary data analysis, and applied the criteria listed above to these needs to identify priorities. Priority-setting group consensus on Priority Agenda Items and focus areas was reached. The priority-setting groups then proceeded to validate the priorities chosen to confirm that the needs identified are the needs that should be addressed by presenting the process used for setting priorities and conclusions to internal and external

stakeholders. These stakeholders included community-based organizations, academic public health experts, health system and facility community health staff, and other key stakeholders.

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

PRIORITY AREA: Prevent Chronic Disease

- FOCUS AREA: Reduce obesity in children & adults
    - Create community environments that promote & support healthy food and beverage choices & physical activity
    - Prevent childhood obesity through early child care & schools
    - Expand the role of health care, health service providers, & insurers in obesity prevention
    - Expand the role of public & private employers in obesity prevention
- FOCUS AREA: Increase access to high-quality chronic disease preventive care & management in both clinical & community settings
    - Increase screening rates for cardiovascular disease, diabetes, & breast/cervical/colorectal cancers, especially among disparate populations
    - Promote use of evidence-based care to manage chronic diseases
    - Promote culturally relevant chronic disease self-management education

Integration of mental health awareness & screening

To address the mental health needs identified by the CHNA process, the South Oaks Hospital and Zucker Hillside Hospital will focus on the following Priority Agenda Item and focus areas:

PRIORITY AREA: Promote Mental Health & Prevent Substance Abuse

- FOCUS AREA: Promote Mental, Emotional, & Behavioral Health
    - Promote mental, emotional, & behavioral well-being in communities
- FOCUS AREA: Strengthen Infrastructure Across Systems
    - Support collaboration among professionals working in fields of mental, emotional, and behavioral health promotion & chronic disease prevention, treatment, and recovery
    - Strengthen infrastructure for mental, emotional, and behavioral health promotion & mental, emotional, and behavioral disorder prevention

Implementation Plan

The Northwell Health Implementation Plan for 2016-2019 includes the goals, objectives, activities, and performance measures planned to address the chosen New York State Prevention Agenda Priority Areas (see the appendix for the Northwell Health Implementation Plan for 2016-2019).

Community Resource Directories

The Northwell Service area community resources are vast. Northwell Health provides annually updated community service plans which list the community health improvement programs available to residents in our service area which are available in print or on the Northwell health website on the following link https://www.northwell.edu/about/our-organization/office-community-and-public-health/reports . The most comprehensive, current and easily searchable inventory of community resources in our service area are found on the sites described below. These sites include linkages to community resources such as **c**ommunity outreach agencies; religious services organizations; local government social service organizations; not for profit health and welfare agencies; community based health education; local public health programs; education; youth development programs; housing; food access organizations; clothing and furniture banks; transportation services; employment support services; specialty education; community-based clinical services and advocacy organizations; specialty community-based/clinical services for individuals with developmental disabilities; specialty education for special needs children; Ryan White Programs; HIV prevention/outreach and social services; peer/family mental health advocacy organizations; self-advocacy and family support; foster care agencies; family support/training; community-based behavioral health and substance abuse treatment support services; National Alliance on Mental Illness (NAMI);and alternatives to incarceration.

The United Way 211 Long Island database http://www.unitedwayli.org/findhelp , is a searchable directory of over 3000 local health and human service agencies and programs. A similar database is available for the metropolitan area. Developed by the Greater New York Hospital Foundation, HITE – the Health Information Tool for Empowerment – is an online resource (http://www.hitesite.org/Default.aspx) for community members, social workers, discharge planners, and other information and referral providers with over 5000 services. The Long Island Health Collaborative also contains a community health resource list on their website https://www.lihealthcollab.org/healthy-resources.aspx . HITE's and 211's comprehensive customizable directories helps community members and the social services workforce provide fast, accurate linkages for community health programs and social services. All information in the HITE and 211 resource database is verified and updated annually.

Northwell Health

Implementation Plan 2016-2019

PRIORITY AREA: Prevent Chronic Diseases: Increase access to high quality chronic disease preventive care and management in both clinical and community settings
GOALS: *Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.* *Promote culturally relevant chronic disease self-management education.* *Promote tobacco use cessation, especially among low SES populations and those with poor mental health.* *Reduce exposure to secondhand smoke.* *Reduce health disparities*

PERFORMANCE MEASURES		
Northwell Indicators	**Source**	**Frequency**
By December 31, 2019 increase public awareness of chronic disease prevention through utilization of media channels by 15% from 2016 Northwell Health public relations data.	*Public Relations media stats*	*Annually*
By December 31, 2019, increase the percentage of adults participating in screenings from disparate communities by 10% from 2016 community benefit data.	*Community Benefit reporting* *Northwell Health Solutions Population Health Analytics*	*Annually*

By December 31, 2019, increase the percentage of patients by 25% in medical home or team-based care models, especially in practices that serve disparate communities.	*Northwell Health Solutions Population Health Analytics*	*Annually*
By December 31, 2019, increase the percentage of primary care practices by 50% that receive technical assistance and quality improvement training to health care organizations and providers, especially those serving disparate communities to attain NCQA Patient Centered Medical Home Level 3 designation.	*Northwell Health Solutions Population Health Analytics*	*Annually*
By December 31, 2019 increase the percentage of adults participating in chronic self disease management programs by 30% from 2016 Northwell Center for Equity of Care data.	*Center for Equity of Care data* *Northwell Health Solutions Population Health Analytics*	*Annually*
By December 31, 2019, increase provider compliance with 5A's (chart review) tobacco cessation counseling by 25%. *By December 31, 2019, increase in volume of electronic medical record for tobacco counseling by 25%.* *By December 31, 2019, increase in number of smoke free housing unit by 2000 units.* *By December 31, 2019, increase in number of organizations with voluntary smoke free outdoor air policies by 3.*	*Center for Tobacco Control(CTC) Data;* *EMR data* *Northwell Health Solutions Population Health Analytics* *OCPH;* *NYSDOH,NYCDOMH tobacco control data*	*Annually*
NYSDOH Prevention Agenda Objectives/Indicators	**Source**	**Frequency**
By December 31, 2018, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%.	NYS Behavioral Risk Factor Surveillance System [BRFSS]	*Annually*
By December 31, 2018, increase the percentage of adult health plan members with diabetes whose blood glucose is in good control (hemoglobin A1C less than 8%): • By 7% from 58% (2011) to 62% for residents enrolled in Medicaid Managed Care.	NYS QARR) (PA Tracking Indicator; Health Disparities Indicator)	*Annually*

• By 10% from 55% (2011) to 60.5% for residents enrolled in commercial managed care insurance. • By 10% from 56% (2011) to 62% for black adults enrolled in Medicaid Managed Care.		
By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90): • By 10% from 63% (2011) to 70% for residents enrolled in commercial managed care health insurance. • By 7% from 67% (2011) to 70% for residents enrolled in Medicaid Managed Care. • By 15% among black adults enrolled in Medicaid Managed Care from 58% (2011) to 70%.	NYS QARR) (PA Tracking Indicator; Health Disparities Indicator)	*Annually*
By December 31, 2018 decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students by 30% from 21.2% (2010) to 15.0%. *By December 31, 2018, decrease the prevalence of cigarette smoking by adults ages 18-24 years by 17% from 21.6% (2011) to 18%.* *By December 31, 2018, decrease the prevalence of cigarette smoking by adults ages 18 years and older:* • *By 17% from 18.1% to 15.0% among all adults.* • *By 28% from 27.8% (2011) to 20.0% among adults with income less than $25,000.* • *By 17% from 29% (2011) to 24% among adults who report poor mental health.* *By December 31, 2018, decrease the percentage of adults who report being exposed to secondhand smoke during the past 7 days by 10%.*	NYS Behavioral Risk Factor Surveillance System [BRFSS]; NY Adult Tobacco Survey; NYS Youth Tobacco Survey; Community Activity Tracking,	*Annually*

Activity: Raise public awareness of the impact of healthy lifestyle behaviors on prevention of Chronic Disease	**Short-term metrics monitoring**	**Northwell HealthFacility**	**Community Partner**
Incorporate wellness messaging into hospital publications, website and patient education media channels with community partners.	Track scope /reach of hospital based media channels Track scope /reach of community based media channels.	System wide	National, regional and local community partners including health, faith-based, social service, ethnic, industry and ethnic organizations and coalitions
Identify additional community based media channels with community partners for ongoing promotion of campaign (i.e. LTE, OpEd, etc).	Track number of community based earned media credited.	System wide Community written, television and social media outs	National, regional and local community partners including health, faith-based, social service, ethnic, industry and ethnic organizations and coalitions
Partner with Long Island Health Collaborative, a partnership between the Nassau and Suffolk County hospitals, departments of health, Nassau Suffolk Hospital Council and community based organizations (CBO), media campaign and website.	Track # of hits to Long Island Health Collaborative Wellness Site, social media connections and specifically the Ready Move Feet initiative https://www.lihealthcollab.org/	Nassau &Suffolk County Facilities Long Island Health Collaborative (see website for members https://www.lihealthcollab.org/	Long Island Health Collaborative (see website for members https://www.lihealthcollab.org/
Continue to be lead organizer of the Community Outreach and Health Education Coalition (COHEC), a multi-sector partnership including Southside Hospital and	Track events and program outreach of COHEC	Southside Hospital	Community Outreach and Health Education Coalition Members include: Adelante of Suffolk County First Baptist Church of Bayshore Bethel AME Church of Bayshore Majsid Dural Quran

community based-organizations			Mercy Haven Youth Enrichment Services Family Service League Islip Town Branch NAACP Pronto Long Island
Partner with the New York City Department of Health Community Coalitions in Queens, New York and Richmond Counties outreach campaigns	Track # of hits to coalition's' website, social media connections and Northwell Health media channel outreach.	Queens, New York and Richmond County Facilities	*New York*- Washington Hts/Inwood- Lead Organization- Washington Heights CORNER Project *Queens* – Jamaica – Lead Organization-Public Health Solutions Rockaways – Lead Organization Rockaway Waterfront Alliance-Richmond- Stapleton- Lead Organization –Staten Island Partnership for Community Wellness
¡Vida SI, Diabetes NO! (Life YES, Diabetes NO!) -Lenox Hill Hospital in coalition with an unprecedented group of leading healthcare providers, public and private sector companies, community-based organizations and the media are pooling their individual strengths and coming together to build a sustainable path to health and wellness for the Latino community affected by diabetes.	Impressions, reach, frequency, clicks, -Social Media engagement including likes, shares	Lenox Hill Hospital The Katz Institute for Women's Northwell Health	American Diabetes Association, American Heart Association, Azteca America, Comunilife, CS 55, Fantástico, Goya Foods, Hispanic Federation, Humana, Latinarrific, Maimonides Medical Center, Mario Bosquez - Author The Chalupa Rules, Office of the Bronx Borough President, Office of the Brooklyn Borough President, Office of the Manhattan Borough President, Regional Aid for Interim Needs, Inc. (R.A.I.N.), Telemundo47, Univision, Union Community

			Health Center and Wyckoff Heights Medical Center.
Partner with the Westchester Department of Health Coalition, a partnership between the Westchester County hospitals, department of health, l and community based organizations in media campaign and outreach.	Track # of hits to Coalition's Site and social media connections including partner outreach and Northwell Health media channel outreach.	Westchester Facilities	Westchester Department of Health Westchester Hospitals Community partners to include: A Home, Bedford Seniors Bethel Baptist Church, Community Center of NW Fountain of Eternal Life Church Lexington Center for Recovery Mt. Kisco Fox Center Mt. Kisco Interfaith Food Pantry Neighbors Link Pinecrest Manor Pleasantville Seniors Pound Ridge Seniors Stint Francis AME Zion Church Community Center Interfaith Food Pantry Lexington Center for Recovery
Continue to be lead organizer of the Staten Island Community Partnership Program, a multi-sector partnership including Staten Island University Hospital and community based-organizations	Track events and program reach of Task Force	Staten Island University Hospital	Staten Island Community Partnership Program Members Beacon Christian Community Health Center Bikers Against Child Abuse, Inc.; Day Care Council of New York; Early Childhood Direction Center; Eden II Programs; Families On The Move of New York City, Inc.; Tiered Engagement Network (TEN);

			Healthy Families Staten Island; Literacy Inc.; Los Niños Services; Nate's Pharmacy; New York Center for Interpersonal Development; NYCDOHMH Healthy Homes Program; New York Public Library; Person Centered Care Services; Projectivity; Project Hospitality; Seamen's Society for Children and Families; Staten Island Legal Services; Children's Aid Society; Staten Island General Preventive Program; Richmond Early Learning Center; Urban Community Empowerment Project Inc.
Partner with NYSDOH Delivery System Reform Incentive Payment Performing Provider Systems	Track community and provide outreach	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS
Activity: Target community health screenings to communities with high prevalence of Preventable Quality Indicators and needs based on the Community Health Needs Assessment (CHNA)	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Use CHNA data to identify communities with high disease prevalence rates	Track # screenings in health disparate communities or community participants from health disparate communities using	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative

especially communities with other socio-economic risk factors.	resident zip codes reported as a percentage of all health screenings.		Westchester Medical Center PPS Staten Island PPS
Collaborate CBOs in high need communities who serve high risk population and provide access to health screening and navigation to primary care and social service programs	Track # screenings in health disparate communities or community participants from health disparate communities with community partners reported as a percentage of all health screenings including NYSDOH Cancer Services Programs. Track # of community members screened; and/or navigated to social service programs such as health access, food assistance and housing programs; and/or navigated to primary care providers through care navigators, the Northwell Financial Assistance Unit and community based organization partners	System wide	Community partners such as : LIHC COHEC American Cancer Society Hudson Health Services NYSDOHMH Community Coalitions "¡Vida SI, Diabetes NO!" (Life YES! Diabetes NO!) Partners Staten Island Community Partnership Program Regional PPSs Westchester Community Partners Northwell community partners
Create a data base for community health screenings referrals and follow-up care navigation.	Analysis of demographic, health screening results and navigation follow-up data.	System wide	
Create/Expand chronic disease management support groups at hospital and community sites.	Track number and origin of referrals to and participants in chronic disease support groups.	System wide	Community partners as described previously.
Activity: Provide access to community-based chronic disease self management programs with a focus on health disparate populations.	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Implement the evidence-based Stanford Chronic	Analyze Pre and Post validated knowledge, behavior assessments,	System wide	Local Health Departments Regional PPS such as:

Disease Self-Management Program (CDSMP).	participant demographic data and disease outcomes in selected Northwell Health Programs		Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS Community partners such as: Sisters United, Adelphi University YMCA of LI Korean Community Services Backstretch Employee Service Team, Belmont Racetrack Adelante Town of North Hempstead
Train and support CBOs in delivering CDSMP to community members	Track number of CBO leaders trained, programs delivered and participants attending programs.	System wide	As listed above
Train and support Northwell Health staff in delivering CDSMP to community members	Track number of leaders trained, programs delivered and participants attending programs.	System wide	As listed above
Establish clinical-community linkages that connect patients/community members to self-management education and community resources.	Track number of referrals to/ from community based organizations/providers who attend CDSMP programs. Track patients and community members referred to CDSMP programs.	System wide	As listed above
Partner with regional Delivery System Reform Incentive Payment Programs	Track number of organizations delivering and participants in CDSMP programs	System wide	As listed above
Train and support patients with hypertension to	Track number of patients with hypertension practicing home monitoring of blood pressure	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative

promote home blood pressure monitoring			Westchester Medical Center PPS Staten Island PPS
Launch **"¡Vida SI, Diabetes NO!"** (Life YES! Diabetes NO!) is an outcomes-focused approach that will take a comprehensive and systematic look at diabetes among Latinos with the goal of uncovering the root causes, leading to more effective and efficient delivery of prevention, education, testing and treatment. Activities: 1. Draw attention to the diabetes crisis in the Latino community. Highlight healthy lifestyle choices needed to prevent diabetes. 2.Increase Latino diabetes testing. 3.Identify care and treatment options available for Latinos with type 1 & type 2 diabetes. 4.Encourage policy makers, health professionals and residents to respond to diabetes more forcefully	# of people receiving genetic testing # of people reached who may be at risk # of people referred to care/early detection/prediabetes # screened for BMI, Glucose, A1C Health outcome analysis # of engaged coalition partners # of Proclamations/recognitions/legislation regarding Latino Diabetes Prevention/Management Advancement of a mandate to test all Latinos (At risk populations) on first visit by PCPs (A1C)	Lenox Hill Hospital The Katz Institute for Women's Health Northwell Health	American Diabetes Association, American Heart Association, Azteca America, Comunilife, CS 55, Fantástico, Goya Foods, Hispanic Federation, Humana, Latinarrific, Maimonides Medical Center, Mario Bosquez - Author The Chalupa Rules, Office of the Bronx Borough President, Office of the Brooklyn Borough President, Office of the Manhattan Borough President, Regional Aid for Interim Needs, Inc. (R.A.I.N.), Telemundo47, Univision, Union Community Health Center and Wyckoff Heights Medical Center.

and effectively for our communities.			
Deliver evidence-based Diabetes Management programs	Track # of patients with diabetes who enroll in Outpatient Nutrition Program; record their progress. Track # of participants with one or more chronic diseases who have attended a self-management program; track number of referrals from health care professionals; number and percent of adults among populations who have attended.	Peconic Bay Medical Center	Suffolk County Department of Health
Deliver in collaboration with DSRIP community –based organizations community member cultural competency health literacy workshops aimed at empowering community members to understand access to language interpreter services and increase communication with providers	Track community member cultural competency health literacy workshops	Systemwide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS
Develop and provide cultural competency and health literacy (CCHL) training to providers and community-based organizations through in-person train the trainer and web-based modalities	Track CCHL training development activities Track trainings and participant attendance and post training evaluation Track usage of select sample of primary care provider usage of teach back and AHRQ CCHL recommended practices measured by PCMH Level 3 certification.	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS

Activity: Implement a multi-media Tobacco Control Campaign across the service area.	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Incorporate Tobacco Control messaging into hospital publications, website and patient education media channels.	Track scope /reach of hospital based media channels.	System wide	
Identify additional community based media channels with community partners for ongoing promotion of campaign.	Track scope /reach of community based media channels.	System wide	
Identify additional community based media channels with community partners for ongoing promotion of campaign (i.e. LTE, OpEd, etc).	Track number of community based earned media.	System wide	NYC Smoke Free Tobacco Action Coalition Regional Asthma Coalitions Local Health Departments Local Community Coalitions (as described previously)
Incorporate use of NYS Quit Line and CTC community programming into media messaging.	Track number of calls to Quit line.	System wide	
Expand community cessation programs in collaboration with Northwell Center for Tobacco Control , DSRIP Performing Provider Systems and DOH as needed.	Track number community members in smoking cessation classes.	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS Local Health Departments

Activity: Increase the number of providers utilizing best practice guidelines to support patient education re: smoking cessation.	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Participate in New York City Tobacco Free Hospital Campaign.	Track level of achievement (Bronze through Gold) with associated program metrics.	New York City Facilities	NYCDOHMH
Educate healthcare providers on evidence based best practices – the "5A's" (ask, advise, assess, assist and arrange) and work with organizational leaders to develop systems change policies to ensure that all practitioners treat their tobacco dependent patients: 1) Provide in-depth training on smoking cessation protocols to hospital and community based providers. 2) Educate providers during hospital grand rounds or regularly scheduled series. 3) Coordinate with NYS DOH Bureau of Tobacco Control Workgroup to assure that electronic medical record screens include best practice protocols and	Track # of trainings, sites, participants and policy changes. Track Grand Rounds - increase in knowledge & intent to change behavior. Track # Protocols integrated into provider practice Survey of participants' satisfaction with program, knowledge, and intent to change practice behavior. Track # of trainings Track # planning meetings scheduled to discuss curriculum.	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS

prompts for treating tobacco dependence. 4) Educate providers on the availability of the new Medicaid tobacco cessation counseling codes and benefits. 5) Work with the Hofstra-Northwell School of Medicine curriculum committee to integrate best practice protocols into medical school curriculum and practicums.			
Promote the integration of the 5A's into electronic medical records and provider education curriculums.	Track annual provider practice specific EMR tobacco use screening, counseling and referral data. Track activity with academic partners in curriculum development and tobacco cessation education	System wide	As described above
Partner with regional Delivery System Reform Incentive Programs	Track number of providers using "5A's" (ask, advise, assess, assist and arrange) in practice	System wide	As described above
Partner with NYCDOHMH, Smoke Free NYC, Suffolk Care Collaborative and Nassau Queens PPS to promote smoke free environments in multiunit dwellings and outdoor spaces	Track number of stakeholder (i.e. co-op/condominium/HUD Housing/community board/CBO, etc.) meetings Track number of Smoke Free policy changes Track number of Smoke Free multi-dwelling units	NYC, Suffolk and Nassau County Facilities	NYCDOHMH, Smoke Free NYC, Suffolk Care Collaborative and Nassau Queens PPS

PRIORITY AREA ***Preventing Chronic Diseases: Reduce Obesity in Children and Adults***
GOALS: *Create community environments and initiatives that promote and support healthy food and beverage choices and physical activity.* *Promote school-based healthy eating and physical activity programs* *Promote breast feeding.* *Expand the role of health care and health service providers in obesity prevention.* *Expand the role of Northwell Health in promoting employee obesity prevention.*

PERFORMANCE MEASURES		
Northwell Indicators	**Source**	**Frequency**
By December 31, 2019, increase public awareness of obesity prevention through utilization of media channels by 15% from 2016 Public Relations data.	*Public Relations media stats*	*Annually*
By December 31, 2019, increase the percentage of adults participating in walking activities disparate communities by 15% from 2016 LIHC data.	*LIHC website*	*Annually*
By December 31, 2019, increase the percentage of seniors participating in Stepping On Program by 10% from 2016 data.	*Northwell Center for Equity of Care Stepping on Data*	*Annually*
By December 31, 2019, increase the percentage of newborns being discharged on breastfeeding by 10% from 2016 data.	*Facility Latch On and Baby Friendly Hospital metrics*	*Annually*
By December 31, 2019, increase the number of breast feeding friendly pediatric practices, worksites, community and daycare sites by 15%	Cohen Children's Medical Center General Pediatrics data	*Annually*
By December 31, 2019, increase the number of employees pledging to complete health risk assessments and viewing wellness videos by 10%.	HR Employee Wellness Pledge data	*Annually*

By December 31, 2019, increase the number of healthy food and beverage vending items by 10%.	HR employee wellness vending audits	Annually
By December 31, 2019, increase the number of fresh produce access sites for patients, visitors and employees by 15%.	HR employee wellness fresh produce access audits	Annually
NYSDOH Prevention Agenda Objectives/ Indicators	**Source**	**Frequency**
By December 31, 2018, reduce the percentage of children who are obese: • *By 5% from 13.1% (2010) to 12.4% among WIC children (ages 2-4 years).* • *By 5% from 17.6% (2010-12) to 16.7% among public school children Statewide reported to the Student Weight Status Category Reporting system.* • *By 5% from 20.7% (2010-11) to 19.7% among public school children in New York City represented in the NYC Fitnessgram.*	*NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS]; NYS Student Weight Status Category Reporting; NYC Fitnessgram; BRFSS*	*Annually*
By December 31, 2018, reduce the percentage of adults ages 18 years and older who are obese: • *By 5% from 24.5% (2011) to 23.2% among all adults.* • *By 5% from 26.7% (2011) to 25.4% among adults with an annual household income of < $25,000.* • *By 10% from 32.5% (2011) to 29.3% among adults with disabilities.*	*BRFSS*	*Annually*
By December 31, 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%.	*Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital*	*Annually*

By December 31, 2018, reduce disparities in breastfeeding rates among Black and Hispanic women by 10% measured by the changes in the ratio of Black Non-Hispanic and Hispanic to White non-Hispanic percentage of infants exclusively breastfed in the hospital	*Records, NYC DOHMH*	
By December 31, 2018, increase the percentage of adults ages 18 years and older who participate in leisure-time physical activity: • *By 5% from 73.7% (2011) to 77.4% among all adults.* • *By 10% from 59.0% (2011) to 65.0% among adults with less than a high school education.* • *By 10% from 49.9% (2011) to 54.9% among adults with disabilities.*	*BRFSS*	*Annually*

Activity: Raise public awareness of the impact of healthy lifestyle behaviors on prevention of Obesity.	**Short-term metrics monitoring**	**Northwell Health Facility**	**Community Partner**
Incorporate wellness messaging into hospital publications, website and patient education media channels.	Track scope /reach of hospital based media channels. Track scope /reach of community based media channels.	System wide	
Identify additional community based media channels with community partners for ongoing promotion of campaign (i.e. LTE, OpEd, etc).	Track # of community based earned media.	System wide	Local Community coalitions as described previously
Partner in the Long Island Health Collaborative Website and "Ready, Move Feet" online walking initiative	Track # of hits to Long Island Health Collaborative Wellness Site and online walking initiative program enrollment and outcome data.	Nassau &Suffolk County Facilities	LIHC
Partner with the New York City Department of Health Community Coalitions in Queens, Manhattan and Richmond Counties for outreach	Track # of hits to coalition's' website and/or social media connections and outreach.	Queens, Manhattan and Richmond	New York City Department of Health Community Coalitions

		County Facilities	
Activity: Increase community member increased physical activity and healthy eating including school-based healthy eating and physical activity programs.	**Short-term metrics monitoring**	**Northwell Health Facility**	**Community Partner**
Promote and support community walking groups and fundraising walks with the Long Island Health Collaborative through "Ready, Move Feet", School-based Wellness, Complete Streets and Health Corner Store initiatives	Track hits and usage of LIHC website, number of walking groups, community participation in online walking initiative, complete street and healthy corner store policies/activities	Nassau and Suffolk Facilities	LIHC
Provide senior evidence-based Stepping On falls prevention program focusing on daily strength and balance exercises through Northwell Center for Equity of Care and Northwell Trauma Centers	Northwell Center for Equity of Care Stepping On pre and post evaluation data.	Manhattan, Queens. Nassau and Suffolk Facilities	Local Libraries Local Senior Centers Local Health Departments
Provide evidence-based "Healthier Tomorrows" obesity management program in partnership with the YMCA at their facilities.	Healthier Tomorrow's Program outcome data.	Huntington Southside	YMCA
Expand school-based obesity prevention programs focusing on increasing physical activity and healthy eating.	Cohen Children's Medical Center Kohl's Cares for Kids Program data Northern Westchester Hospital's school-based education data Peconic Bay Medical Center's Project Fit America Staten Island Community Partnership Program Pediatric Obesity Initaitive	Cohen Children's Medical Center, Northern Westchester Hospital, Peconic Bay Medical Center, Staten Island University Hospital	Local school districts Faith-based organizations

Partner with the New York City Department of Health Community Coalitions in Queens, Manhattan and Richmond Counties	Track coalition activities and outcomes related to chronic disease and social determinants of health	Queens, Manhattan and Richmond County Facilities	New York City Department of Health Community Coalitions
Partner with the Westchester Department of Health Coalition, a partnership between the Westchester County hospitals, Westchester Department of Health, and community based organizations in media campaign and outreach.	Track coalition activities and outcomes related to physical activity and healthy eating	Westchester Facilities	Westchester Department of Health Coalition
Partner with regional Delivery System Reform Incentive Payment Programs	Track number activities and outcomes related to physical activity and healthy eating	System wide	Regional PPS such as: Nassau Queens PPS Suffolk Care Collaborative Westchester Medical Center PPS Staten Island PPS
Activity: Expand the role of health care and health service providers in obesity prevention.	**Short-term metrics monitoring**	**Northwell Health Facility**	**Community Partner**
Initiate a "Health Walking Prescription" program beginning in adult primary care settings	Track usage in Primary Care Setting	Nassau and Suffolk County facilities	LIHC
Expand the NYSDOH Pediatric Obesity Prevention: Creating Breastfeeding Friendly Communities that increases pediatric primary care provider, worksite, daycare and community promotion and support of breastfeeding to prevent pediatric obesity.	NYSDOH Pediatric Obesity Prevention: Creating Breastfeeding Friendly Communities tracking data	Cohen Children's Medical Center	NYSDOH, NCDOH, SCDOH Nassau and Suffolk Day Care Councils, Sustainable LI, WIC, YMCA LI, Lactation Consultants, Pediatric Primary Care Practices including LIFQHC

Activity: Promote breast feeding in birthing hospitals.	**Short-term metrics monitoring**	**Northwell Health Facility**	**Community Partner**
Participate in NYSDOH Latch On Program and Baby Friendly Hospital Programs.	Track # of bottles of formula distributed to healthy newborns in the hospital each month (Latch On NYC indicator) Track Baby-Friendly USA Evaluation Criteria Track # of families provided prenatal breastfeeding education Track # babies discharged that are being solely and primarily breast fed.	Staten Island University Hospital, Long Island Jewish Medical Center, North Shore University Hospital, LIJ @ Forest Hills Huntington Hospital, Northern Westchester Hospital, Phelps Memorial Hospital	NYSDOH Pediatric Obesity Prevention: Creating Breastfeeding Friendly Communities
Activity: Expand the role of Northwell Health in promoting employee obesity prevention.	**Short-term metrics monitoring**	**Northwell Health Facility**	**Community Partner**
Increase the number of employees pledging to complete health risk assessments and viewing wellness videos.	Track HR Benefits data	System wide	
Expand employee wellness healthy eating initiatives specifically vending machine options.	Perform annual vending audits	System wide	
Increase the number of employees participating in Northwell employee healthy eating, physical activity and relaxation initiatives	Track employee wellness data	System wide	

PRIORITY AREA Promote Mental Health and Prevent Substance Abuse
GOALS: *Promote mental, emotional and behavioral (MEB) well-being in communities* *Prevent underage drinking, non-medical use of prescription pain relievers drugs by youth, and excessive alcohol consumption by adults* *Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.* *Prevent suicides among youth and adults.* *Reduce tobacco use among adults who report poor mental health.* *Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.* *Strengthen infrastructure for MEB health promotion and MEB disorder prevention.*

PERFORMANCE MEASURES		
Northwell Health Indicators	**Source**	**Frequency**
By December 31, 2019, increase behavioral health service utilization by 25% in primary care practices with mental health providers	*Northwell Health Solutions Population Health Data*	*Annually*
By December 31, 2019, increase primary care service utilization by 25% in behavioral health practices with primary care providers	*Northwell Health Solutions Population Health Data*	*Annually*
By December 31, 2019, increase the crisis stabilization services by 25% through collaborations with behavioral health community based organizations	*Northwell Health Solutions Population Health Data*	*Annually*

By December 31, 2019, increase the number of mental health providers trained in tobacco cessation by 15% from 2013 CTC data.	*CTC Data*	*Annually*
*By December 31, 2019, increase p*rovider compliance with 5A's (chart review) by 15% using CTC data.	*CTC Data*	*Annually*
*By December 31, 2019, i*ncrease in volume of electronic medical record for tobacco counseling by 15%.	*EMR data*	*Annually*
By December 31, 2019, expand the reach of BRAVE program by 5%.	*BRAVE Program Data*	*Annually*
By December 31, 2019, expand the reach of Prevention Resource Center program by 2 additional coalitions (1%).	*Prevention Resource Center Data*	*Annually*
By December 31, 2019, increase the number of Outpatient home visits by 3%.	SOH data	Annually
NYSDOH Prevention Agenda Objectives/Indicators	**Source**	**Frequency**
By December 31, 2018, reduce the percentage of adult New Yorkers reporting 14 or more days with poor mental health in the last month by 10% to no more than 10.1%. (Baseline: 11.1%, 2011)	BRFSS	*Annually*
By December 31, 2018, reduce the number of youth grades 9-12 who felt sad or hopeless by 10% to no more than 22.4%. (Baseline: 24.9 %, 2011)	YRBS	*Annually*
By December 31, 2018, reduce the percentage of youth ages 12-17 years reporting the use of non-medical use of painkillers. (Baseline: 5.26% 2009-2010, NSDUH, Target: 4.73%)	NSDUH	*Annually*
By December 31, 2018, reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past year by 10% to no more than 6.4%. (Baseline: 7.1 suicide attempts per 100, 2011 YRBS)	YRBS	*Annually*
By December 31, 2018, reduce the age-adjusted suicide mortality rate by 10% to 5.9 per 100,000. (Baseline: 6.6 per 100,000, Bureau of Biometrics 2007-2009)	Bureau of Biometrics	*Annually*

By December 31, 2018, reduce the prevalence of cigarette smoking among adults who report poor mental health by 15% from 31.2% in 2011 to 26.5%. (Baseline: 31.2%, 2011)	NY Adult Tobacco Survey	*Annually*
By December 31, 2018, increase in number of smoke free housing unit by 1500 units. *By December 31, 2018, increase in number of organizations with voluntary smoke free outdoor air policies by 3.*	Northwell Health Data	*Annually*
By December 31, 2018, identify indicator data and establish baseline targets for data required to plan and monitor county-level, strengths-based efforts that promote MEB health and prevent substance abuse and other MEB disorders. • *Identify specific roles different sectors (e.g., governmental and nongovernmental) and key initiatives (e.g., Health Reform) have in contributing toward MEB health promotion and MEB disorder prevention in New York State.* • *Collaborate with researchers and practitioners to develop and disseminate a compendium of evidence-based interventions and policies that promote MEB health and prevent MEB disorders.* • *Strengthen training and technical assistance of primary care physicians, MEB health workforce and community leaders in evidence-based, including cultural sensitivity training, approaches to MEB disorder prevention and mental health promotion.*	County Data	*Annually*

Activity: Prevent suicides among youth and adults.	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Expand Bully Reduction/Anti-Violence Education (BRAVE) School-based Program.	Track schools participating. Track system changes in bully reduction policies in schools.	Zucker Hillside Hospital South Oaks Hospital	Local School districts, Local health departments, NAMI
Expand utilization of the Rosen Family Wellness Center	Track center utilization data.	Zucker Hillside Hospital	Local Veteran's Associations,

evidence-based treatment and resources by Iraq and Afghanistan war veterans impacted by post-traumatic stress disorder, traumatic brain injury and associated behavioral health issues as well as 911 first responders.		South Oaks Hospital	community-based social service and behavioral organizations. Local health department
Activity: Promote mental, emotional and behavioral (MEB) well-being in communities	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Expand utilization of the Unified: Behavioral Health Center for Military Veterans and Their Families evidence-based treatment and resources by military personnel, veterans, and their families, including children.	Track center utilization data.	Zucker Hillside Hospital South Oaks Hospital	Local Veteran's Associations, community-based social service and behavioral organizations
Expand the reach of the Prevention Resource Center facilitating partnerships among schools, communities, and prevention providers to promote evidence-based strategies to decrease the prevalence of alcohol, drug use, and problem gambling in Suffolk County communities.	Track # partnerships, programs and participants	South Oaks Hospital	School districts, community-based social service and behavioral organizations, Local health department, Shinnecock Indian Health Service, NAMI, Suffolk Care Collaborative, Nassau Queens PPS

Identify specific roles different sectors (e.g. governmental and nongovernmental) and key initiatives (e.g. Health Reform) have in contributing toward MEB health promotion and MEB disorder prevention in Nassau, queens and Suffolk Counties.	Inventory of organizations with MEB in scope of services. Identify partners for coalition for MEB health promotion. Form coalition for MEB health promotion.	Zucker Hillside Hospital South Oaks Hospital	School districts, community-based social service and behavioral organizations, Local health department, Shinnecock Indian Health Service, NAMI, Suffolk Care Collaborative, Nassau Queens PPS
Collaborate with researchers and practitioners to develop and disseminate a compendium of evidence-based interventions and policies that promote MEB health and prevent MEB disorders.	Inventory evidence-based programs that promote MEB health and prevent MEB disorders.	Zucker Hillside Hospital South Oaks Hospital	Primary care providers, Community – based behavioral health organizations Suffolk Care Collaborative, Nassau Queens PPS
Embed behavioral health providers in selected primary care practices Embed primary care providers in behavior	Track behavioral health and primary care service utilization in integrated practices	System-wide Zucker Hillside Hospital South Oaks Hospital	Primary care providers, Community – based behavioral health organizations Suffolk Care Collaborative,

			Nassau Queens PPS
Strengthen training and technical assistance of primary care physicians, MEB health workforce and community leaders in evidence-based, including cultural sensitivity training, approaches to MEB disorder prevention and mental health promotion.	Identify primary care practices. Track # of trainings, sites, participants Track Grand Rounds - increase in knowledge & intent to change behavior. Track protocols integrated. Track PH2 and PH9 primary care provider screening rates Track # Perinatal Mood and Anxiety Disorder Screenings (PMAD) Track # NARCAN trainings and participants - South Oaks	Zucker Hillside Hospital South Oaks Hospital System-wide	Primary care providers, Community – based behavioral health organizations, Suffolk Care Collaborative, Nassau Queens PPS
Activity: Reduce tobacco use among adults who report poor mental health through community tobacco control awareness campaign	**Short-term metrics monitoring**	**Northwell Health Facility**	**Community Partner**
Identify additional community based media channels with community partners for ongoing promotion of campaign.	Track scope /reach of community based media channels.	System wide Zucker Hillside Hospital South Oaks Hospital	Center for Tobacco Control, Tobacco action Coalition, Smoke Free NYC, Local Health Departments
Identify additional community based media channels with community partners for ongoing promotion of campaign (i.e. LTE, OpEd, etc).	Track # of community based earned media.	System wide Zucker Hillside Hospital South Oaks Hospital	Center for Tobacco Control, Tobacco action Coalition, Smoke Free NYC, Local Health Departments
Incorporate use of NYS Quit Line and CTC community	Track # of calls to Quit line.	System wide	Center for Tobacco Control,

programming into media messaging.		Zucker Hillside Hospital South Oaks Hospital	Tobacco action Coalition, Smoke Free NYC, Local Health Departments
Expand community cessation programs in collaboration with CTC and DOH as needed.	Track # community members in smoking cessation classes.	System wide Zucker Hillside Hospital South Oaks Hospital	Center for Tobacco Control, Tobacco action Coalition, Smoke Free NYC, Local Health Departments, Korean Community Services, Chinese Planning Council, LI YMCA
Activity : Increase the number of providers utilizing best practice guidelines to support patient education re: smoking cessation.	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Educate healthcare providers on evidence based best practices – the "5A's" (ask, advise, assess, assist and arrange) and work with organizational leaders to develop systems change policies to ensure that all practitioners treat their tobacco dependent patients: 1) Provide in-depth training on smoking cessation protocols to hospital and community based providers.	Track # of trainings, sites, participants and policy changes. Track Grand Rounds - increase in knowledge & intent to change behavior. Track # Protocols integrated Survey of participants' satisfaction with program, knowledge, and intent to change practice behavior. Track # of trainings Track # planning meetings scheduled to discuss curriculum.	System wide Zucker Hillside Hospital South Oaks Hospital	Primary care providers, Community-based behavioral health organizations, Suffolk Care Collaborative, Nassau Queens PPS

2) Educate providers during hospital grand rounds or regularly scheduled series. 3) Coordinate with NYS DOH Bureau of Tobacco Control Workgroup to assure that electronic medical record screens include best practice protocols and prompts for treating tobacco dependence. 4) Educate providers on the availability of the new Medicaid tobacco cessation counseling codes and benefits. 5) Work with the Hofstra-Northwell School of Medicine curriculum committee to integrate best practice protocols into medical school curriculum and practicums.			
Track annual Facility specific EMR tobacco use screening, counseling and referral data. Track activity with academic partners in curriculum development and tobacco cessation education.	Track annual Facility specific EMR tobacco use screening, counseling and referral data. Track activity with academic partners in curriculum development and tobacco cessation education	System wide Zucker Hillside Hospital South Oaks Hospital	Local area higher education institutions
Partner with regional Delivery System Reform Incentive Programs	Track number of providers using "5A's" (ask, advise, assess, assist and arrange) in practice	System wide	Regional Delivery System Reform Incentive Programs

Partner with NYCDOHMH, Smoke Free NYC, Suffolk Care Collaborative and Nassau Queens PPS to promote smoke free environments in multiunit dwellings and outdoor spaces	Track number of stakeholder (i.e. co-op/condominium/HUD Housing/community board/CBO, etc.) meetings Track number of Smoke Free policy changes Track number of Smoke Free multi-dwelling units	NYC, Suffolk and Nassau County Facilities	NYCDOHMH, Smoke Free NYC, Suffolk Care Collaborative and Nassau Queens PPS
Activity: Prevent underage drinking, non-medical use of prescription pain relievers drugs by youth, and excessive alcohol consumption by adults.	**Short- term metrics**	**Northwell Health Facility**	**Community Partner**
Participate in the 100 Schools Project, a DSRIP MEB education program for school staff to recognize signs of distress, how to approach students and, where appropriate, their families, how to access local behavioral and mental health providers and how to handle behavioral crises.	# schools reached and staff trained	Zucker Hillside Hospital South Oaks Hospital	School Districts, Regional Delivery System Reform Incentive Programs Local health departments
Prescription Opioid Management Strategy activities: 1.Community education to reduce opiate misuse 2.Practice guidelines and opiate tapering provider workgroup 3. SBIRT/Naloxone/Inpatient screening, practice guidelines and patient education	# Practice Guidelines- inpatient (including pro-active, interdisciplinary and standardized peri-operative) and outpatient Opiate Tapering: Medication-Assisted Treatment, Provider Survey analysis Track alternative pain management treatments (Strategies, resource and access assessments) Track identification of at-risk patients (for substance use disorder [SBIRT] and for complications of opiate use) Track non-prescription Naloxone for those at-risk for overdose	Zucker Hillside Hospital South Oaks Hospital	Suffolk Care Collaborative Nassau Queens PPS Suffolk County Department of Health, Nassau County department of Health, NYCDOHMH,

	Track education – patients, providers and communities (APP, website, in-office streaming, community events) Track workforce issues: avoiding dependence, defining critical functions and opiate thresholds for returning to work Track Safe Opiate Disposal efforts		Community partners