WINTHROP-UNIVERSITY HOSPITAL

COMMUNITY SERVICE PLAN

2016 - 2018

Your Health Means Everything.™

Winthrop-University Hospital
259 First Street
Mineola, NY 11501
www.winthrop.org
1-866-WINTHROP

Approved by the Board of Directors November 7, 2016

WINTHROP-UNIVERSITY HOSPITAL
COMMUNITY SERVICE PLAN
2016-2018

Nassau County Collaborative Assessment
Nassau County Department of Health
Lawrence E. Eisenstein, MD, FACP, Commissioner of Health
200 County Seat Drive, North Entrance
Mineola, NY 11501
(516) 742-6154

Participating Hospitals in Collaborative Assessment

Catholic Health Services of Long Island

Mercy Medical Center	1000 N Village Ave., Rockville Centre, NY 11571
St. Francis Hospital	100 Port Washington Blvd., Roslyn, NY 11576
St. Joseph Hospital	4295 Hempstead Turnpike, Bethpage, NY 1 1714

Northwell Health System

Glen Cove Hospital	101 St. Andrews Lane, Glen Cove, NY 11542
Long Island Jewish Valley Stream	900 Franklin Ave., Valley Stream, NY 11580
North Shore University Hospital	300 Community Drive, Manhasset, NY 11030
Plainview Hospital	888 Old Country Road, Plainview, NY 11803
South Oaks Hospital	400 Sunrise Highway, Amityville, NY 11701
Syosset Hospital	221 Jericho Turnpike, Syosset, NY 11791

Nassau University Medical Center	2201 Hempstead Turnpike, East Meadow, NY 11554
South Nassau Communities Hospital	1 Healthy Way, Oceanside, NY 11572
Winthrop-University Hospital	259 First Street, Mineola, NY 11501

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

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EXECUTIVE SUMMARY

SELECTION OF PRIORITIES

In 2016, Winthrop-University Hospital joined with members of the Long Island Health Collaborative to review extensive data sets selected from primary and secondary sources to identify and confirm Prevention Agenda priorities for the 2016-2018 Community Service Plan cycle. Data analysis efforts were coordinated through the Long Island Population Health Improvement Program (LIPHIP), who served as the centralized data return and analysis hub. As directed by the data results, community partners selected **Chronic Disease** as the priority area with a focus on **(1) Obesity and (2) Preventive Care and Management for the 2016-2018 Cycle**. Mental health emerged as a growing concern. Therefore, the group also agreed that Mental Health should be highlighted.

Priorities in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate Mental Health throughout Intervention Strategies.

DATA

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey, qualitative data from the Nassau County Community-Based Organization Summit Event and the LIHC Wellness survey. Secondary, publically-available data sets include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda Dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), NYS Cancer Registry, and New York State Vital Statistics.

PARTNERSHIPS

The LIPHIP is organized by the Nassau-Suffolk Hospital Council (NSHC), the membership association for all hospitals on Long Island. The core of the LIPHIP is an extensive workgroup of committed partners who work together to improve the health of all Long Islanders. This workgroup, called the Long Island Health Collaborative, consists of the two county health departments, all hospitals

on Long Island, physician leaders, representatives from nursing and mid-level provider associations, dozens of community-based health and social service organizations, and many other sectors. Winthrop has been extensively involved in this initiative since the LIHC's inception in 2013.

The Long Island Health Collaborative is committed to utilizing the collective impact model to enhance the quality of work being pursued to meet Community Health Implementation Plan requirements. Member organizations are entrenched in Nassau County communities, and are able to engage community members in improvement strategies.

In addition, the Hospital's local partners from the Winthrop Community Cultural Advisory Committee meet quarterly to discuss health needs and seek solutions. Several of our partners, the Hispanic Counseling Center, the *Yes We Can* community center in Westbury, the Hempstead Hispanic Civic Association, and St. Brigid's Church in Westbury, have offered to partner with us to encourage community participation and provide space for educational programs so that they may be conveniently located for their clients.

COMMUNITY ENGAGEMENT

The broad community was engaged in assessment efforts through distribution and completion of the Prevention Agenda Community-Member survey. This tool was developed in consensus by community partners from the Long Island Health Collaborative and designed using the Prevention Agenda framework. Available in both online and hard copy format, this survey was translated into certified Latin American-Spanish language. LIHC partners distributed and promoted the survey to a diverse range of community members at a variety of locations, including hospitals, doctor's offices, health departments, libraries, school, insurance enrollment sites, community-based organizations and more. In addition, member organizations promoted the survey through social media efforts, posting links on their website and distributing surveys at health fairs and other events.

To engage and prioritize the role of the community-based organizations (CBOs) in the assessment, the Long Island Health Collaborative, driven by the LIPHIP, planned and executed a Nassau County Summit Event. Participation during this events was robust, with 45 organizations attending the summit. Discussions were recorded and transcribed by court stenographers and analyzed using Atlas TI software to identify key themes.

Community engagement will continue through monthly meetings with the Long Island Health Collaborative to discuss evidenced-based programming, public outreach initiatives and changes in health trends. Local community partners are kept up-to-date through quarterly meetings of Winthrop's Community Cultural Advisory Committee. Winthrop maintains a survey on its website that requests input from the community on current health concerns. Evaluation forms at community programs are utilized as a method of feedback from community members. Social media platforms, Facebook and Twitter, keep the Hospital and the community connected.

INTERVENTIONS/STRATEGIES/ACTIVITIES

Selection of initiatives is data-driven, supported by research and discussions with community partners, including Winthrop's Community Cultural Advisory Committee, and senior leadership within the Hospital. Disparities will be addressed by partnering with community-based organizations in select communities to hold culturally relevant chronic disease management educational programs. A bilingual nurse is now on the Winthrop team, who will be able to communicate effectively with participants. Our initiatives support the NYS Prevention Agenda areas and include:

- Evidenced-based programming:
    - Stanford Program for Chronic Disease Management
    - CDC Diabetes Prevention Program
    - Tai-Chi for Arthritis
    - Breastfeeding Initiative – Baby-Friendly® Hospital
    - 5-2-1-0 Healthy Lifestyle Program
- Increased efforts to raise participation in breast cancer and colorectal cancer screenings

- Promote Tobacco Cessation – Supporting DSRIP project 4.b.i.
- Mental Health and Substance Abuse – will be addressed through public education and stress management techniques
- Continued support of Long Island heath *Collaborative "Are You Ready, Feet?™* Physical activity/walkability campaign and walking portal

PROGRESS

Progress will be tracked through quantitative data collection and analysis. The Plan is a dynamic document that will be continually reviewed according to the quality improvement measurement standards of the Hospital, PDSA (Plan, Do, Study, Act), and revised as needed according to changes in community need or resources. Process measures include:

- Number of children being presented with 5-2-1-0 take-home packets of information at Head Start programs; percent of children who have an unhealthy weight
- Number of parents at parents meetings (Head Start) and/or support groups
- Documentation counseling rate of parents of children with unhealthy weight at Winthrop's Pediatric Clinic in Hempstead
- Documentation in Winthrop's Pediatric Clinic in Hempstead of "No Juice" counseling rate for parents of toddlers
- % of new mothers exclusively breastfeeding upon hospital
- Number of participants in evidenced-based chronic disease prevention programs, including the Stanford Chronic Disease Self-Management Program and CDC Diabetes Prevention Program
- Post-evaluation forms for chronic disease intervention classes
- Number of individuals who develop an action plan for self-management
- Number of seniors participating in Tai Chi; post evaluation forms
- Number of individuals referred for smoking cessation programs; # attending
- Number of supportive educational programs for stress management
- Number of individuals contacted and referred for breast cancer and colorectal cancer screenings; # of individuals screened
- # of individuals participating in *Are You Ready Feet™* LIHC campaign

COMMUNITY SERVICE PLAN REPORT

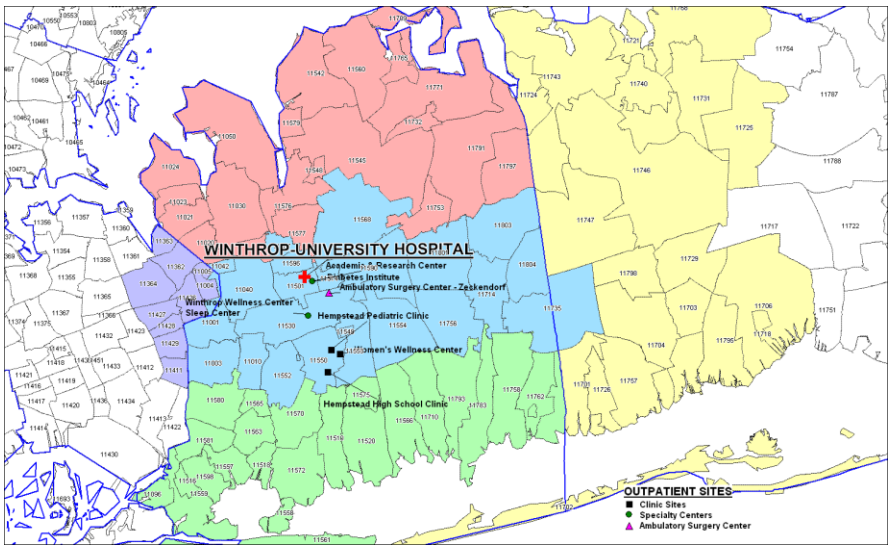
MISSION STATEMENT

It is the mission of Winthrop-University Hospital to provide high-quality, safe, culturally competent, and comprehensive healthcare services in a teaching and research environment, which improve the health and well-being of the residents of Nassau County and contiguous county areas…based on a profound commitment to an enduring guiding principle – "Your Health Means Everything."

1. WINTHROP'S SERVICE AREA

Nassau County is unique in that it presents complex polarity, representing a wide range of both healthy and sick community members from opposite ends of the health continuum. Data presented within this report will demonstrate the existence of vast health disparities stemming from a wide range of socioeconomic factors. Our findings indicate the reality of the linkage of health disparities to a variety of social factors including race, ethnicity, gender, language, age, disabilities, and financial security, among others. Elimination of such disparities is a priority throughout the Long Island region, as the bridging of gaps and services will ultimately improve health outcomes and quality of life for community members.

Winthrop's service area is defined geographically and by patient population. The Hospital's primary/core service area **has historically been Nassau County, specifically, Core Areas A, B, and C (See map below).** The secondary service area, represented by Areas D and E, is also considered in the Hospital's strategic planning process for purposes of establishing new programs and services. Based on an analysis of our patient population (See Table 1 below), Core Areas A, B & C account for 80.9% of discharges.



***Blue**: Core A; **Green**: Core B; **Pink**: Core C; **Purple**: Core D; **Yellow**: Core E*

Discharge Data 2015 (excluding normal newborns)		
Core Areas	**Total**	**% of Total**
A	16,984	53.68%
B	7,144	22.58%
C	1,215	3.84%
Nassau Total	**25,343**	**80.09%**
D	1,671	5.28%
E	455	1.44%
Other	4,084	12.9%
TOTAL	**31,724**	**100%**

Core Areas A, B and C include "select communities," i.e., communities that are experiencing health disparities. They include Elmont (11003), Inwood (11096), Freeport (11520), Glen Cove (11542), Uniondale (11553), Long Beach (11561), Roosevelt (11575), Hempstead (11550) and Westbury (11590). This inpatient population totals 35% of our population from Core Areas A, B & C. Significant attention was paid to communities with health disparities.

Discharge Data 2015 – Select Communities (excluding normal newborns)				
Core Areas	**Total Select Communities**	**% of Total Select Communities**	**WUH Total**	**% of WUH Total Select Communities**
A	7,000	78.6%	16,984	27.6%
B	1,657	18.6%	7,144	6.5%
C	249	2.8%	1,215	. 9%
TOTAL	**8,906**	**100%**	**25,343**	**35%**

2. DATA

In 2016, Winthrop-University Hospital joined with Nassau County Hospitals, the Nassau County Department of Health and others to review extensive data sets to identify and confirm Prevention Agenda priorities for the 2016-2018 Community Service Plan cycles. Data analysis efforts were coordinated through the Long Island Population Health Improvement Program (LIPHIP), which served as the centralized data return and analysis hub.

The core of the LIPHIP is an extensive workgroup of committed partners who work together to improve the health of all Long Islanders. This workgroup, the Long Island Health Collaborative, consists of Nassau

and Suffolk county health departments, all hospitals on Long Island, physician leaders, representatives from nursing and mid-level provider associations, dozens of community-based health and social service organizations, academic institutions, health plans, local municipalities, and many other sectors. Winthrop has been extensively involved in this initiative since its inception in 2013. For a list of members, please visit www.lihealthcollab.org/membership-directory.aspx

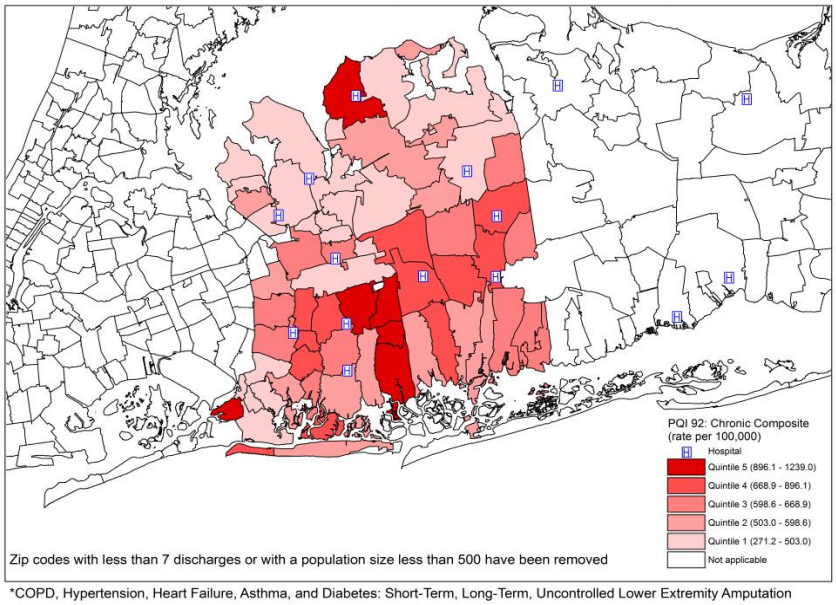
Data presented within this report will demonstrate the existence of vast health disparities stemming from a wide range of socioeconomic factors. Findings indicate the reality of a linkage of health disparities to a variety of social factors including race, ethnicity, gender, language, age, disabilities and financial security among others.

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey, qualitative data from the Nassau County Community-Based Organization Summit Event, and the LIHC Wellness survey. Secondary, publically-available data sets include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), NYS Cancer Registry, and New York State Vital Statistics.

Prevention Quality Indicators

Prevention Quality Indicators (PQI), are defined by the Agency for Health Research and Quality* (AHRQ) and can be useful when examining preventable admissions. Using SPARCS data, the LIPHIP created a visual representation of preventable admissions related to Chronic Disease at the zip code level. PQI 92 is defined as a composite of chronic conditions per 100,000 Adult Population.

PQI 92: Chronic Composite for Nassau County*



*COPD, Hypertension, Heart Failure, Asthma, and Diabetes: Short-Term, Long-Term, Uncontrolled Lower Extremity Amputation

Conditions identified by ICD-9 code included in PQI 92 are: short and long-term complications, Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, Heart Failure, Angina, Uncontrolled Diabetes, and Lower-Extremity Amputations among patients with Diabetes.

The above map demonstrates the zip codes in Nassau County representing the most significant number of preventable cases per 100,000 adult population.* Quintile 5 represents 896.1-1239.0 per 100,000 adult cases, and can be identified by dark red coloring. This quintile demonstrates within which zip does the largest pockets of potentially preventable hospital visits related to chronic disease fall. As displayed within the PQI Chronic Composite for Nassau County, there is a notable occurrence of Chronic Disease among a majority of communities, particularly those connected to low socioeconomic status. The zip codes for Quintile 5 are 11550 (Hempstead) and 11590 (Westbury), two communities within Winthrop's Core Service Area A that experience health disparities.
*Source: Agency for Healthcare Research and Quality-Prevention Indicators/www.qualityindicators.ahrq.gov/modeules/pqu_resources.aspx)

Prevention Agenda Dashboard

Within the Dashboard, review of 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System, demonstrates that 19.8% of adults in Nassau County are obese. Although obesity rates in Nassau are lower than New York State, obesity remains an issue that is closely related to chronic conditions including heart disease, stroke, type 2 diabetes and other leading causes of preventable conditions highlighted above in PQI 92, the Chronic Disease Composite for Nassau County.

In addition to the above data, we reviewed the social determinants of health – conditions in which we live, work and play.[1] Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality and extent of our education; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. These concerns were addressed in our recent community needs assessment.

3. IDENTIFICATION OF PRIORITIES

As directed by the data results, community partners selected ***Chronic Disease*** as the priority area with a focus on ***(1) Obesity and (2) Preventive Care and Management*** for the 2016-2018 Cycle. The group also agreed that Mental Health should be highlighted as an area of overlay with intervention strategies.

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

Priorities in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate Mental Health throughout Intervention Strategies.

COMMUNITY ENGAGEMENT

The broad community was engaged in assessment efforts through distribution and completion of the Prevention Agenda Community-Member survey. This tool was developed in consensus by community partners from the Long Island Health Collaborative and designed using the Prevention Agenda framework. Available in both online and hard copy format, this survey was translated into certified Latin American-Spanish language. LIHC partners distributed and promoted the survey to a diverse range of community members at a variety of locations, including hospitals, doctor's offices, health departments, libraries, school, insurance enrollment sites, community-based organizations and more. In addition, member organizations promoted the survey through social media efforts, posting links on their website. For a copy of the survey, please see the Appendix, Attachment 2.

Survey Results are calculated according to Nassau County in its entirety; select communities' responses were analyzed separately to determine their specific needs.

1. When asked ***what the biggest ongoing health concerns in the community where you live***:
    - Nassau County Respondents felt that Cancer, Drug and Alcohol Abuse, and Obesity/Weight Loss were the top three concerns. These three choices represented 43% of the total responses.
        - Select communities cited cancer, diabetes, and Drug and Alcohol Abuse. This represented 40% of the total responses.

2. When asked ***what the biggest ongoing health concerns for yourself:***
    - Nassau County respondents felt that Heart Disease and Stroke, Cancer, and Obesity/Weight Loss were the top three concerns. In Nassau, these three choices represented roughly 43% of the total responses.
        - Select communities cited obesity/weight loss, diabetes and cancer as top concerns, accounting for 39% of the total responses.

3. The next question sought to ***identify potential barriers that people face when getting medical treatment***:

    - Respondents felt that No Insurance, being Unable to Pay Co-pays or Deductibles, and Fear were the most significant barriers. These choices received roughly 55% of the total responses.
        - Select communities identified No Insurance, being Unable to Pay Co-pays or Deductibles, and being unable to understand the need to see a doctor as significant. This accounted for 54.8% of total responses.

4. When asked ***what was most needed to improve the health of your community:***
    - Healthier Food Choices, Clean Air & Water, and Weight Loss Programs accounted for 42% of the total responses.
        - Healthier food choices, Job Opportunities, and Clean Air & Water were top concerns for select communities, accounting for 38.37% of the total responses.

5. For the final question, people were asked ***what health screenings or education services are needed in your community***:
    - Nassau County respondents felt that the Blood Pressure, Cancer, and Diabetes services were most needed. This represented 27% of the total respondents.
        - Select communities cited Diabetes, Blood Pressure and Nutrition, representing 27% of the responses.

To engage and prioritize the role of the community-based organizations (CBOs) in the assessment, the Long Island Health Collaborative, driven by the LIPHIP, planned and executed a **Nassau County Summit Event**. Participation was robust, with 45 organizations attending the summit. LIHC partners served as trained facilitators during "facilitated discussion" roundtables. Discussions were recorded and transcribed by court stenographers and analyzed using Atlas TI software to identify key themes. Please see Appendix, Attachment 3, for event Script.

Summit Results - Summit participants reported Chronic Disease as the most significant health problem seen within the communities they serve in Nassau County**.** In looking at distinct Prevention Agenda Categories, 26.1% of quotations indicated Chronic Disease being a priority area. Cumulatively 42.5% of quotations in Nassau were identified as being inclusive of one or more Chronic Disease keywords.

Within the Chronic Disease Priority Area, ***Chronic Disease Management*** and ***Obesity/Nutrition*** were the most frequently mentioned focal areas. Of the total number of quotes by County, 10.2% of quotations included "Chronic Disease Management" as a topic of importance. Obesity/Nutrition was a focal area of 9.8% in Nassau.

Mental Health and Substance Abuse emerged closely as a second-ranking Priority Area. Analysis shows 2.1% quotations in Nassau indicate Mental Health as a priority. Cumulatively, 36.9% of the total number of quotes included Mental Health and Substance Abuse as a priority area.

Distinct Prevention Areas by Ranking
Distinct Prevention Areas by Ranking reflects the number of quotations where the focus area is mentioned at least once and counted once, divided by the total number of Nassau County quotes.

Example of Quotation: "Chronic Disease is a problem for the community I serve. Many of our members are troubled with obesity and tobacco use." This quote is coded once for chronic disease.

Rank	**Nassau**	**%***
1	Chronic Disease	**26.1%**
2	Mental Health	**23.0%**

3	Healthy and Safe Environment	**20.1%**
4	Healthy Women, Infants and Children	**19.1%**
5	HIV, STD and Vaccine Preventable Disease and Health-Care Associated Infections	**6.2%**

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

Cumulative Prevention Areas by Ranking
Cumulative Prevention Areas reflects the number of focus areas mentioned within one of the priority areas per quote, divided by the total number of Nassau County quotes.

Example of Quotation "Chronic Disease is a problem for the community I serve. Many of our members are trouble with obesity and tobacco use." This quote is coded twice for Chronic Disease because obesity and tobacco use are two separate focus areas.

Rank	**Nassau**	**%***
1	Chronic Disease	42.5%
2	Mental Health	36.9%
3	Healthy and Safe Environment	26.6%
4	Healthy Women, Infants and Children	24.9%
5	HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections	8.1%

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

For a complete analytic interpretation and participant quotations, please refer to the Appendix, Attachment 4.

Results of both the Key-Informant Interviews and the Individual Surveys were shared with the workshop on March 22, 2016.

- Community-wide survey results:
  - Representative of demographics in the county
  - Obesity, Chronic Disease (Cancer, Cardiovascular Disease) and Mental Health emerged as priorities
- Summit Results
  - Chronic disease reported
  - Obesity ranked as a risk factor
  - Mental Health reported as important

Attendees Included:

Organization	**Title**
Catholic Health Services	Vice President, Public and External Affairs.

LIPHIP	1. Data Analyst
Nassau County Department of Health	1. Epidemiologist
Nassau-Suffolk Hospital Council	1. Senior Director, Communications & Population Health 2. Program Manager – PHIP 3. Communication Specialist
Northwell Health	Assistant Vice President, Public Health and Community Partnerships
South Nassau Communities Hospital	Director of Education
St. Francis Hospital	Director, Rehabilitation & Community Services
Winthrop-University Hospital	Director, Community Education & Health Benefit

In addition to meeting with the workgroup for the assessment results, Winthrop engaged local community partners in discussions during three separate committee meetings on August 5, September 30 and December 1, 2016, to share the results of the assessment and confirm priorities. These results were also shared via e-mail with those who could not attend. This group of partners, Winthrop's Community Cultural Advisory Committee, represents local communities who are low-income, have minority populations, and who experience health disparities. Concerns and possible ways to address needs were also discussed at all meetings.

- Discussions determined that obesity and knowledge about chronic disease prevention/management are the most crucial conditions to be addressed – in particular, asthma and diabetes
- Concerns were also raised about mental health issues, drugs and alcohol abuse
- During all discussions, it was agreed that Winthrop needs to go into the community, during weekends or other appropriate times when the underserved are available. Our partners believed that educational classes would be attended by members of the community, if held at appropriate times
- Participating agencies offered to partner with Winthrop to provide space to offer classes on chronic disease self-management

Members of Winthrop's Community Cultural Advisory Committee:

Agency	**Representative**
CASA Nassau County Coordinating Agency for Spanish Americans	1. Director 2. Administrative Aide
Community Physician	Hempstead Location
Cornell University Cooperative Extension Nassau County	Nutrition Program Director
EOC of Nassau County, Inc.	Program Director, Head Start Director, Family Development Center
Girl Scouts of Nassau County, Inc.	Fund Development Officer
Hempstead Hispanic Civic Association, Inc.	Executive Director
Hempstead NAACP AHEAD Foundation	Community Advocate
Hispanic Brotherhood of Rockville Centre	1. Executive Director 2. Co-Director

Hispanic Counseling Center	1. CEO 2. Program Coordinator
LI Asthma Coalition	Director
LI Minority Aids Coalition	CEO
Nassau BOCES	Teen & Parenting Program
Nassau County Department of Health	Commissioner
Nassau County Perinatal Services	Educator
North Shore Child & Family Guidance	Executive Director of the Leeds Program
Noticia (Hispanic newspaper)	Publisher
Project Independence	Deputy Commissioner, Department of Services for the Aging – Town of North Hempstead
SHIP/AHEC	Community Advocate
St. Brigid's Casa Mary Johanna	Immigration Ministry Representative

4. IDENTIFICATION OF INTERVENTIONS/STRATEGIES

Selection of initiatives is data-driven, supported by research and discussions with community partners, including Winthrop's Community Cultural Advisory Committee, and senior leadership within the Hospital. Disparities will be addressed by partnering with community-based organizations in select communities to hold culturally relevant chronic disease management educational programs. A bilingual nurse is now on the team, who will be able to communicate effectively with participants. Winthrop will focus on Hempstead and Westbury, two communities that account for approximately 25% of our inpatients from select communities. Because of the collaborative efforts in Nassau County, other hospitals will focus on the select communities closest to them.

Our initiatives support the NYS Prevention Agenda areas and include:

- Evidenced-based programming:
    - Stanford Program for Chronic Disease Management
    - CDC Diabetes Prevention Program
    - Tai-Chi for Arthritis
    - Breastfeeding Initiative – Baby-Friendly® Hospital
    - 5-2-1-0 Healthy Lifestyle Program
- Tobacco Cessation – Supporting DSRIP project 4.b.i.
- Mental Health and Substance Abuse – will be addressed through public education and stress management techniques
    - Stress Management information will also be available at all hospital community education lectures and outreach events
- Continued support of Long Island heath *Collaborative "Are You Ready, Feet?™* Physical activity/walkability campaign and walking portal

These initiatives will build on the past priorities of ***Chronic Disease*** as a priority area, with the focus on obesity and preventive care and management. Mental health strategies will be included.

DSRIP ALIGNMENT

Our initiatives in chronic disease management through The Stanford Program are aligned with DSRIP interventions and 4.b.i., chosen by the Nassau/Queens PPS.

BECAUSE OF LANDSCAPE LAYOUT, COMPLETE CHART IS IN APPENDIX 1.

5. MAINTAINING ENGAGEMENT

- Winthrop meets monthly with the Long Island Health Collaborative to discuss evidenced-based programming, public outreach initiatives and changes in health trends. Local community partners are kept up-to-date through quarterly meetings of Winthrop's Community Cultural Advisory Committee.
- Winthrop maintains a survey on the website that requests input from the community on currently health concerns.
- Evaluation forms at community programs are utilized as a method of feedback from community members. These forms also request ideas for new programs.
- Social media platforms – Facebook and Twitter – keep the Hospital and the community connected

Progress will be tracked through quantitative and qualitative data collection and analysis. The Plan is a dynamic document that will be continually reviewed according to the quality improvement measurement standards of the Hospital, PDSA (Plan, Do, Study, Act), and revised as needed according to changes in community need or resources.

Progress will also be tracked through CBISA™ (Community Benefit Inventory for Social Accountability) software, a comprehensive way for Winthrop to measure its impact on the community.

6. DISSEMINATION TO THE PUBLIC

The Executive Summary will be posted on Winthrop's website, at https://www.winthrop.org/community-service-plan. A written copy is available at Winthrop's Welcome Center, located at 1300 Franklin Avenue, Suite ML-5 in Garden City. Individuals may also request a written copy by mail by contacting the Office of Public Affairs at (516) 663-2234.

2016 Updated Summary of Prevention Agenda Programs

Focus Area 1 – Obesity, Nutrition & Healthy Weight

A. Obesity Screenings in Primary Care Provider Officers

The identification and counseling of children who are obese (BMI =/>95%) was implemented in 2013 in the WUH Hempstead Pediatric Clinic, an area suffering health disparities. The Clinic utilizes the 5-2-1-0 program as a way of teaching parents and children a healthy lifestyle. The plan incorporates five servings of fruits and vegetables, no more than two hours of screen time (including TV and IPADS), one hour of exercise and zero sugary drinks. The objective is to teach children the basics of a healthy lifestyle; the intended goal is to achieve a long-term positive impact on their health.

Through this program, primary care providers are encouraged to consistently document Body Mass Index (BMI), provide lifestyle counseling, and develop individual care plans and follow-up measures.

During 2015, the tracking measure was revised to "documentation of counseling rate" as we lacked resources to continue the follow-up mailings. During 2016, counseling documentation rate was 90%.

Evaluation of Impact – Obesity is a challenging issue. Parental follow-through can be difficult.

B. Childhood Obesity Screenings in the Community

During 2014, Winthrop collaborated with the Head Start communities located in Hempstead and Westbury to bring the 5-2-1-0 program to their families. The plan included giving each child a packet of information about the program to share with their parents, documenting BMI's and providing nutritional counseling for families of children identified as having an unhealthy weight. The healthy lifestyle program was introduced at Head Start parent meetings.

During 2015, agreements were in place with Head Start and Winthrop, detailing the program and objectives. Plans were revised to invite **all** parents to participate in a workshop that would offer nutritional counseling and support to parents of children who are identified as having BMIs that are considered "high" or "very high."

The program was implemented in 2016. Each child received a packet of information about the program, including sheets where they track their food and activity level by coloring in the appropriate boxes. To date, 238 children were measured in Hempstead and 16.5% were in the high range; 18.9% in the very high range. In Westbury, 212 children were measured; 15.5% of children were in the high range and 19.3% were in the very high range.

Evaluation of Impact – This is a new intervention. Administrators at both Hempstead and Westbury locations have praised the partnership and would like us to expand to other Head Start locations. More parental "buy-in" is needed. Although we offered nutritional counseling in the form of support group, parents did not respond. Going forward, we hope to attend parent meetings in the spring and fall to explain the program more fully and encourage participation.

C. Baby-Friendly Hospital

Strategy identified in 2013 was to achieve Baby Friendly Designation and improve percentage of newborns who only receive breast milk when discharged from the Hospital.

In 2014, Winthrop was awarded Baby-Friendly Designation by Baby-Friendly, USA; during 2016, 50% of babies were only receiving breast milk when discharged from Winthrop.
In addition to the above, Winthrop offers a breastfeeding support group. Over 110 different women attended the support group during 2016.

Evaluation of Impact - NYS Prevention Agenda Goal is 48.3% of women exclusively breastfeed upon hospital discharge – Winthrop reach 50% during 2016

Focus Area 2 – Preventing Chronic Disease

A. National Diabetes Prevention Program

Winthrop offered the National Diabetes Prevention Program at no cost at the Diabetes Education Center. It is important to note that approximately 28% of participants were from communities with health disparities.

Participation involves a commitment for one year and includes classes held weekly during the first six months. It then transitions to every other week and then monthly during the second six months of the year.

Six new diabetes prevention classes were started in 2016 – a total of **242 individuals** participated in the Diabetes Prevention Program in 2016.

Impact is evaluated through the following:

Percentage of sessions with weight documented during months 1 to 12 100%
Percentage of sessions with physical activity documented during months 1 to 12. 70%

In 2016, we transitioned to completed QTAC participant satisfaction surveys. Please see the following results:

Months 1 to 6 – 25 surveys
Months 7 to 12 – 21 surveys

I know more about lifestyle changes like diet and exercise that are recommended for my health condition.		
Months 1-6 Participant Satisfaction Survey	84% strongly agree	16% agree
Months 7-12 Participant Satisfaction Survey	95% strongly agree	5% agree

***I have been able to maintain the lifestyle changes for my health that I have made*.**			
Months 1-6 Participant Satisfaction Survey	52% strongly agree	48% agree	
Months 7-12 Participant Satisfaction Survey	62% strongly agree	29% agree	9% disagree

I now have a better understanding of how to manage my health and/or physical activity.		
Months 1-6 Participant Satisfaction Survey	80% strongly agree	20% agree
Months 7-12 Participant Satisfaction Survey	86% strongly agree	14% agree

In addition to the above statistics, during 2015 one group found the support so helpful that they decided to continue their group on their own after the class ended. They named themselves the "DiaBEATers," and get together regularly to exchange healthy recipes, enjoy a healthy meal out or even take a tour of a local grocery store to learn about nutritious food options. They feel it helps them stay "focused and motivated."

Note: The Diabetes Case Findings in Hempstead initiative was not implemented due to limited resources, as well as a cancellation of American Diabetes classes at the Hispanic Counseling Center.

B. New Program – Tai Chi for Arthritis

Targeting Chronic Disease, Stress Management & Fall Prevention

Based on health trends and opportunities for training through a grant, Winthrop reviewed the above evidenced-based program at the end of 2015 and decided to pilot it in the community. It has been extremely successful.

Winthrop implemented the eight-week, twice a week program in January of 2106. Since then, six programs have been offered – four at the Welcome Center and two at the *Yes We Can* Community Center in Westbury, a community with health disparities. Approximately 200 people have participated.

Evaluation of Impact – The response to the program has been tremendous, with community members calling and requesting classes. Anonymous post-evaluation forms are collected as part of the program and submitted to QTAC-NY (Quality & Technical Assistance Center of NY) for evaluation. Here is a summary of the report:

- 93% of participants experienced a reduced fear of falling
- 90% would recommend the program to a friend or relative
- 89% continued to do exercises they learned in the program
- 53% reported that they are "very sure" they can become steadier on their feet. Another 50% feel sure they

Follow-Up Workshop Participant Evaluation – In addition to the above, Winthrop distributes a post-satisfaction form to individuals who return for the "refresher" portion of the workshop. This form collects information regarding the impact the program has on participants over a longer period. The following is a short summary:

- 75% indicated that they felt more self-confident performing daily activities
- 72.3% indicated that they were stronger and more flexible
- 68.4% indicated that they balance improved
- 67.1% indicated that their posture has improved.

NUTRITION AND HEALTHY WEIGHT (OBESITY) -CHRONIC CONDITIONS
PROMOTE CHRONIC DISEASE SELF-MANAGEMENT AND PREVENT OBESITY

In the 2013 CHNA, Winthrop created and implemented "Active Living," A four-part free-of-charge series that addresses chronic condition management and the benefits of a healthy lifestyle through nutrition, exercise and stress management. In 2014 and 2015,, a total of 127 individuals attended session at Winthrop and out in the community. Due to limited resources of staff and space, we were only able to offer one program during 2016.

Evaluation of Impact – Participants are given a Wellness Survey, both pre- and post-program. Based on results, the Active Living program is influencing the health practices of its participants in a positive way. To start, more than 75% of the participants completed at least 3 of the 4 parts. After attending the program, no matter how many parts of the series were completed, the participants scored 10% more positive on the Nutrition section and nearly 7% on the Exercise section.

APPENDIX

1. Work Plan Chart

2. Individual Survey – English & Spanish

3. Summit Script

4. Analytic Interpretation of CBO Participants – Summit

Priority/Focus Area: Chronic Disease Preventive Care & Management
Reduce Obesity in Children & Adults

Goal	Outcome Objectives	Winthrop Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
Priority One – Chronic Disease Preventive Care and Management *Increase the percentage of individuals taking the NDPP in communities with health disparities to 32% of enrollees*	*Short Term – Educate at-risk individuals about prevention* *Intermediate – Change behavior* *Long Term – Reduce the number of individuals with Diabetes*	*National Diabetes Prevention Program* *Director of Diabetes Education Center will meet with community physicians in Westbury & Hempstead to promote the free program and increase referrals*	*# of participants in the program* *Post-evaluation forms*	*Community physicians refer patients based on blood test results*	*Winthrop will help physicians identify & diagnose pre-diabetes and provide a brochure for patients to facilitate onboarding*	*2016 to 2018 cycle*	*Yes*
Increase percentage of adults with arthritis, asthma, cardiovascular disease or diabetes who have taken a course or class to learn how to self-manage their condition. (New program – will develop baseline)	*Short Term – Arrange training for staff and peer leaders in Stanford program* *Intermediate – Offer classes at hospital and in community* *Long Term – # of Participants who develop an action plan*	*Stanford Program for Chronic Conditions*	*# of individuals in program* *# of individuals who develop an action plan* *# of programs offered*	*Recruit participants in communities with health disparities*	*Meeting space - "Yes We Can" Community Center in Westbury* *Hispanic Counseling Center* *St. Brigid's Church* *Hempstead Hispanic Civic Association*	*2016 – 2018 cycle*	Yes*– programs will also be offered in communities with health disparities*
Increase the # of individuals screened for colorectal cancer	*Short Term – Identify barriers to colorectal screening*	*80% by 2018 Colorectal Cancer Screening Initiative*	*# of community organizations contacted*	*Community Partners will provide outreach to foster the program.*	*Volunteering time to raise awareness*	*2016 – 2018 cycle*	*Yes – outreach will be made to communities with health disparities*

	Intermediate – Overcome challenges of barriers to screenings & Increase cancer screening awareness *Long Term 80% of targeted population will be screened for colon cancer*	*Reach out to community partners to discuss barriers to screening* *Promote screening awareness through public education* *Develop a direct access process for colorectal cancer screening*	*# of public educational programs/events attended* *# of community members counseled and referred for screening* *# of individuals screened*	*Community physicians will support the program by encouraging participation and sharing knowledge with patients about the importance of screening.* *Physicians will refer patients for screening*	*Physicians will share their expertise*		
To increase the # of women screened for breast cancer according to clinical guidelines. *To improve the quality of breast cancer screening and diagnostic follow-up among age-appropriate patient populations.*	*Short Term - Expand current outreach into the community to target women in underserved populations who have not been screened.* *Intermediate – Patient navigators will work with referred patients, discuss barriers to accessing care, assist with resolving barriers* *Long term – Increase the number of women who will be up-to-date with breast cancer screening guidelines*	*NAPBC (Nationally Accreditation Program for Breast Centers) Patient Navigation Initiative* *Contact community partners to formalize referral relationships* *Develop workflows for patients to navigate the system* *Develop workflows for patients who are uninsured or underinsured; get financial assistance when qualified*	*# of women contacted* *% of women who need screening* *% of women who go for the screening*	*Community partners will refer women to patient navigator for initial screening to see they are appropriate for a mammogram*	*New program – TBD* *NYS Department of Health Grant - NAPBC Patient Navigation Project*	*800 by 2017* *800 by 2018*	*Yes – initiative focuses on communities with health disparities*

Promote Tobacco Use Cessation *DSRIP Project – Nassau/Queens PPS*	*Short term – Re-evaluate current smoking cessation program* *Intermediate – Plan best way to provide outreach* *Long Term – Reduce # of smokers*	*Examine current Winthrop smoking cessation program* *Evaluate issues with smoking cessation – discuss best practices to help addiction* *Refer patients to NYS Smokers' Quitline*	*# of individuals referred to NY Smokers Hotline* *# of inpatients referred to hospital smoking cessation program* *# of participants in a hospital smoking cessation program*	*DRSIP project - 4.b.i.* *Will also be addressed by Nassau/Queens PPS*	*Staffing, space, educational materials*	*2016-2018 cycle*	*Yes*
Priority Two – Reduce Obesity in Children *Prevent childhood obesity through early childhood care and schools*	*Short Term - Increase family knowledge of healthy lifestyle* *Intermediate - Change health behaviors* *Long Term - Improve health*	*5-2-1-0 Program* *Provide 5-2-1-0 take-home packets* *Offer support group/educational meetings to parents of overweight children*	*Number of children weighed & provided with information packet* *# of parents at parent meetings and/or support groups* *% of children who are obese*	*Community outreach – school obtains parental consent* *Head Start reinforces healthy lifestyle with children*	*Staff - Children are weighed at Head Start Schools in Hempstead & Westbury* *Meeting space for parental support groups* -	*2016-2018 cycle*	*Yes*
Expand the role of health service providers in obesity prevention	*Short Term - Promote obesity awareness* *Intermediate - Change health behaviors* *Long Term - Improve health*	*Identify children who are obese* *Provide counseling to improve lifestyle behaviors* *Implement no-juice campaign*	*Track counseling rate of 5-2-1-0* *Track no juice educational documentation rate for toddlers*	*Hospital Program – clinic in community with health disparities* *Parents are encouraged to partner with providers*	*Hospital Resources – staff to track rates*	*2016-2018 Cycle*	*Yes*

Increase the percentage of infants who are exclusively breastfed	*Short term - Exclusive breastfeeding* *Intermediate – Longer duration of breastfeeding* *Long Term - Better health for women and children*	*Baby Friendly® Hospital* *Raise awareness about the benefits of breastfeeding* *Refer moms to supportive services for breastfeeding*	*Percentage of women who exclusively breastfeed upon leaving the hospital*	*Internationally Board Certified Lactation Consultant Community physicians support women to be successful in breastfeeding goals* *WIC –Women, Infants & Children support moms in breastfeeding*	*Educational materials for women*	*Increase percentage to 53% by 2018*	*Yes – all women who give birth at Winthrop are included*
Additional Initiatives *Promote mental health & Wellness, Prevent Falls*	*Short term - improve moment* *Intermediate – better balance and stress reduction* *Long Term – promote empowerment and general well-being*	*Tai Chi for Arthritis*	*# of participants* *Post-program evaluation forms*	*Community partners will promote program*	*Space at CBO's to offer program*	*2016-2018 cycle*	*Yes – programs will be offered in communities with health disparities*
Active Participation in Long Island Health Collaborative Wellness Goals *Engage community members in regional physical activity and wellness campaigns*	*Short Term- Engage community at Hospital programs & Events* *Intermediate – Raise awareness about the importance of maintaining a healthy lifestyle* *Long Term – Reduce Obesity*	*Hospital will provide social media outreach* *Participate in Are you Ready, Feet?™ Campaign*	*# of individuals signed onto the wellness portal for the Ready, Feet?™ Campaign*	*Promotion through social media, hospital events and hospital publications*	*Staffing*	*2016-2018 cycle*	*Yes – Programs are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they*

							are CLAS appropriate and meet health literacy skills. *LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes.*
Increase community awareness of Mental Health/Substance Abuse	*Short term - Identify strategies, meet regularly to address the need for increased awareness and focus on Mental Health and Substance abuse* *Intermediate - Promote initiatives to community partners*	*Participate in Evidence-Based Mental Health First Aid USA ™ training program for community members and front line healthcare workforce* *Provide stress management information at all hospital programs/events*	*# of individuals/session for Mental Health First Aid USA training program* *# of participants at community programs related to stress management*	*Interventions, supportive linkages will be passed on by Winthrop community-based partners*	*Staffing, expertise*	*2016-2018 Cycle*	*Yes*

	Long Term – provide support in raising awareness about mental health	*Provide community programs on stress management*					
Leverage partnerships and achieve collective impact among LIHC community-partner network	*Short term - Communicate with partners to understand what activities are occurring within which communities* *Intermediate - Identify potential partnerships and introduce compatible partners* *Long Term - Align objectives with organizations currently engaged in built environments*	*LIHC will assess resource availability through network of community-partners* *LIHC will promote collective impact strategies by leveraging existing resources and identifying partnerships* *Support Complete Streets Policy work*	*LIHC will develop efficient surveys and polls which will capture information about parallel projects within Nassau County Communities.* *LIHC will manage and ongoing involvement in partnerships with continued effort to identify partnership and streamline activities* *LIHC will work closely with Local Health Departments and organizations engaged in Complete Street work, identify opportunities for partnership or support*	*Winthrop will attend meetings and participate in projects dedicated to improving the health of the community*	*Staffing*	*2016-2018 Cycle*	*Yes*

Support and increase Evidence-Based Community-Programming Efforts	*Short Term- Promote and advance evidence-based community programs* *Intermediate - Support DSRIP efforts to increase programming throughout the region* *Long Term- An increase in number of evidenced-based programs*	*LIHC will connect members with providers of Stanford Model programs* *LIHC will partner with DSRIP PPS to increase program availability.* *LIHC will work in partnership with PPS to identify community locations where Stanford Model programs will take place*		*Winthrop will participate in training workshops*	*Winthrop will commit staff for training* *Space for programs*	*2016-2018 cycle*	*Yes* *Programs will be offered in communities with health disparities*

WINTHROP
University Hospital
Your Health Means Everything®

LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY

Your opinion is important to us!

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

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

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

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

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

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

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

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

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

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

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

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

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

For statistical purposes only, please complete the following:

I identify as: ☐ Male ☐ Female ☐ Other

What is your age? _____

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

What race do you consider yourself?

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

Are you Hispanic or Latino? ☐ Yes ☐ No

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

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

What is your annual household income from all sources?

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

What is your highest level of education?

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

What is your current employment status?

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

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

Do you have a smart phone? ☐ Yes ☐ No

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

WINTHROP

ENCUESTA DE EVALUACIÓN DE SALUD DE LA COMUNIDAD DE LONG ISLAND

¡Su opinión es importante para nosotros!

El objetivo de esta encuesta es obtener su opinión sobre problemas de salud que son importantes en su comunidad. Los Departamentos de Salud de los Condados y los hospitales de Long Island, en conjunto, emplearán los resultados de esta encuesta y otra información para ayudar a diseñar programas de salud en su comunidad. Por favor complete solo una encuesta por adulto mayor de 18 años. Las respuestas de la encuesta son anónimas. Gracias por participar.

1. ¿Cuáles son las mayores inquietudes de salud en SU COMUNIDAD? (Por favor marque 3 como máximo)

- ☐ Asma/enfermedad pulmonar
- ☐ Cáncer
- ☐ Salud y bienestar infantil
- ☐ Diabetes
- ☐ Abuso de drogas y alcohol
- ☐ Riesgos ambientales
- ☐ Enfermedad cardíaca y derrame cerebral
- ☐ VIH/SIDA y enfermedades de transmisión sexual (ETS)
- ☐ Salud mental depresión/suicidio
- ☐ Obesidad/pérdida de peso
- ☐ Seguridad
- ☐ Enfermedades prevenibles mediante vacunación
- ☐ Salud y bienestar de la mujer
- ☐ Otras (por favor especifique) _____

2. Actualmente, ¿cuáles son las mayores inquietudes de salud para USTED? (Por favor marque 3 como máximo)

- ☐ Asma/enfermedad pulmonar
- ☐ Cáncer
- ☐ Salud y bienestar infantil
- ☐ Diabetes
- ☐ Abuso de drogas y alcohol
- ☐ Riesgos ambientales
- ☐ Enfermedad cardíaca y derrame cerebral
- ☐ VIH/SIDA y enfermedades de transmisión sexual (ETS)
- ☐ Salud mental depresión/suicidio
- ☐ Obesidad/pérdida de peso
- ☐ Seguridad
- ☐ Enfermedades prevenibles mediante vacunación
- ☐ Salud y bienestar de la mujer
- ☐ Otras (por favor especifique) _____

3. ¿Qué factores impiden que la gente de su comunidad reciba tratamiento médico? (Por favor marque 3 como máximo)

- ☐ Creencias culturales / religiosas
- ☐ No saber cómo encontrar un médico
- ☐ No entender la necesidad de consultar a un médico
- ☐ Temor (por ejemplo, no estar listo para enfrentar/hablar sobre un problema de salud)
- ☐ Falta de médicos disponibles
- ☐ Barreras del idioma
- ☐ Falta de seguro médico
- ☐ Transporte
- ☐ Imposibilidad de pagar copagos/deducibles
- ☐ No hay impedimentos
- ☐ Otros (por favor especifique) _____

4. ¿Qué es lo que MÁS se necesita para mejorar la salud de su comunidad? (Por favor 3 como máximo)

- ☐ Aire y agua limpios
- ☐ Servicios de rehabilitación del abuso de drogas y alcohol
- ☐ Opciones de alimentación más saludables
- ☐ Oportunidades de empleo
- ☐ Lugares seguros de trabajo
- ☐ Servicios de salud mental
- ☐ Instalaciones recreativas
- ☐ Opciones seguras de cuidado infantil
- ☐ Lugares seguros para caminar/jugar
- ☐ Programas para dejar de fumar
- ☐ Transporte
- ☐ Programas para bajar de peso
- ☐ Otro (por favor especifique) _____

5. ¿Qué exámenes de salud o servicios de educación/información se necesitan en su comunidad? (Por favor marque 3 como máximo)

- ☐ Presión arterial
- ☐ Cáncer
- ☐ Colesterol
- ☐ Revisiones odontológicas
- ☐ Diabetes
- ☐ Información sobre brotes de enfermedades
- ☐ Drogas y alcohol
- ☐ Trastornos de la alimentación
- ☐ Preparación para emergencias
- ☐ Ejercicio/actividad física
- ☐ Enfermedad cardíaca
- ☐ VIH/SIDA y Enfermedades de transmisión sexual (ETS)
- ☐ Importancia de exámenes de rutina en personas sanas
- ☐ Salud mental/depresión
- ☐ Nutrición
- ☐ Atención prenatal
- ☐ Prevención del suicidio
- ☐ Vacunas
- ☐ Otros (por favor especifique) _____

6. ¿Dónde obtienen, usted y su familia, la mayor parte de su información sobre salud? (Marque todas las opciones que correspondan)

- ☐ Médico/profesional de la salud
- ☐ Familiares o amigos
- ☐ Departamento de Salud
- ☐ Hospital
- ☐ Internet
- ☐ Biblioteca
- ☐ Periódicos/revistas
- ☐ Radio
- ☐ Organización religiosa
- ☐ Escuela primaria/secundaria
- ☐ Redes sociales (Facebook, Twitter, etc.)
- ☐ Televisión
- ☐ Lugar de trabajo
- ☐ Otro (por favor especifique) _____

Por favor complete la siguiente información solo para fines estadísticos:

Me identifico como: ☐ Hombre ☐ Mujer ☐ Otro

¿Qué edad tiene? _____

Código postal de residencia: _____ **Ciudad de residencia**: _____

¿De qué raza se considera?

- ☐ Blanca/caucásica
- ☐ Negra/afroamericana
- ☐ Nativa americana
- ☐ Asiática/isleña del Pacífico
- ☐ Multiracial
- ☐ Otra (por favor especifique) _____

¿Es usted hispano(a) o latino(a)? ☐ Sí ☐ No

¿Qué idioma habla usted en su casa? (Marque todos los que corresponda.)

- ☐ Inglés
- ☐ Portugués
- ☐ Español
- ☐ Italiano
- ☐ Farsi
- ☐ Polaco
- ☐ Chino
- ☐ Coreano
- ☐ Hindú
- ☐ Criollo haitiano
- ☐ Criollo francés
- ☐ Otro

Teniendo en cuenta todas las fuentes de ingreso, ¿cuál es el ingreso anual de su hogar?

- ☐ $0-$19,999
- ☐ $20,000 a $34,999
- ☐ $35,000 a $49,999
- ☐ $50,000 a $74,999
- ☐ $75,000 a $125,000
- ☐ Más de $125,000

¿Cuál es su nivel más alto de educación alcanzado?

- ☐ Kinder-8° grado
- ☐ Algunos años de educación secundaria
- ☐ Bachiller
- ☐ Escuela técnica
- ☐ Algunos años de educación terciaria
- ☐ Graduado universitario
- ☐ Escuela de postgrado
- ☐ Doctorado
- ☐ Otro (por favor especifique) _____

¿Cuál es su situación laboral actual?

- ☐ Jornalero
- ☐ Estudiante
- ☐ Militar
- ☐ Trabajador independiente
- ☐ Retirado
- ☐ Desempleado y buscando trabajo
- ☐ Desempleado pero no busco trabajo

¿Actualmente posee seguro médico? ☐ Sí ☐ No ☐ No, pero tuve con anterioridad

¿Tiene un teléfono inteligente? ☐ Sí ☐ No

Si tiene problemas de salud o dificultades para recibir asistencia, por favor llame a la Red LIHC para obtener información sobre los recursos disponibles al 631-257-6957.	**Por favor entregue esta encuesta completada a:** **LIHC** **Nassau-Suffolk Hospital Council** **1383 Veterans Memorial Highway, Suite 26** **Hauppauge, NY 11788** **También puede enviar la encuesta completada por fax al 631-435-2343**	**En Long Island, todos los hospitales sin fines de lucro ofrecen ayuda financiera a las personas que no pueden pagar la totalidad o parte de su atención de emergencia u otra atención médica necesaria.** **Para obtener información sobre la ayuda financiera que ofrecen los hospitales de Long Island, por favor visite el sitio web de cada hospital.**

Script for Community-Based Organization Summit Event Facilitators

Introductions

1. Introduce yourself to the group

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

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

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

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

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

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

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

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

Let's get started: ***(5 MINUTES)***

1. *What makes you excited to work for the organization you are representing?* ***(5 MINUTES)***
2. Please identify some of the biggest health problems for the people/communities you serve. {Leave this as open ended, probing for specificity, then follow-up with list of priorities}.
3. *Now we are going to move a little deeper into this discussion.* ***(5 MINUTES)***
   Hand each group member a list of NYS DOH priorities with focus areas. Read through the priority areas. Ask participants to review and consider.

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

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

(10 MINUTES)

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

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

(5 MINUTES)

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

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

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

   (10 MINUTES)

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

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

   (5 MINUTES)

6. How can these barriers you described be addressed?
   a. In what ways can services be improved?
   b. What additional services are needed in the community you serve?

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

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

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

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

   (5 MINUTES)

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

   (5 MINUTES)

Analytic Interpretation & Participant Quotations
Improving communities' access to healthy foods, coupled with youth education focused on healthy living and nutrition, is needed to curb the increasing rates of diabetes, heart disease, and obesity in young populations. I would say that there is a real concern with diabetes and heart disease among impoverished children and the communities that Long Island Cares serves. Absolutely, diabetes and heart disease, and we are seeing it at a young age. One of the barriers and problems is not having access to health and food, and nutrition education. By providing that, coupling that with access, being able to buy food from the food bank, where they can have it is really important. *–LI Cares*
Provision of nutrition and physical activity education to parents is a valuable preventive strategy that once passed down to future generations, will help to dissipate the prevalence of obesity. So obesity, we are having a lot of people that we are seeing every day and they are not getting healthy, but they don't know, they don't know what is healthy, and they think what they are eating is healthy. That's why we are trying to educate them and tell them about the food groups and tell them about the sugar and about the physical activity education and so adults can tell their children. I think obesity is a big problem. *–Cornell Cooperative Extension*
Chronic co-morbidities create complexities in health which impact the management and prevention of chronic disease for patients and providers alike. We see a lot of people who are worried about breast cancer and other types of cancer, but also have co-morbidities like diabetes being one of the most prevalent conditions, and people do have a lot of questions in regard to nutrition, but there is a general lack of knowledge in terms of the right dietary guidelines or how the prevent disease through nutrition. *-Adelphi NY Statewide Breast Cancer Hotline*
The sale and use of electronic cigarettes and hookahs are trending in youthful populations. This trend has added a challenge to strategies focused on smoking reduction. Smoking rates among those living with mental illness have not subsided and targeted resources will be needed to provide assistance. I am very passionate about helping to advocate, changing laws about tobacco use, and helping people to quit smoking, and we do have many despair populations. Fortunately for us, the rates are going down, however there are new issues coming up, electronic cigarettes, hookah, and kids are starting to pick up those e-cigs, so whenever we feel like we've got something done, it's like we take two steps back. So I enjoy the challenge of working against the tobacco industry to try to keep on top of it, and to help people who are addicted, mentally ill, substance abuse, very high rates of smoking, they are not getting the help that they need, so advocating for them for more resources to be able to quit smoking is very important. *-American Lung Association*

Mental Health and Substance Abuse	
Focus Area	**%***
Mental Health Issues	**16.4%**
Substance Abuse	**6.9%**
Anxiety, Mood Disorders and Associated Emotions	**4.4%**
Susceptible Populations	**4.2%**
Treatment and Recovery	**2.5%**
Suicide	**1.2%**
Attitudes about Mental health	**1.0%**
Eating Disorders	**0.2%**

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

Analytic Interpretation & Participant Quotations
The need for mental health and substance abuse services is growing at a substantial rate, creating a shift in demand for services. Mental health issues as obstacles for young mothers are a steadily increasing issue, typically linked to substance abuse. After 30 years, there's been almost a complete change that I've seen in the population that we serve, and we have a much more serious mental health problem. Mental health is the number one obstacle for these young women to transition into motherhood and to survive in this world, and a lot of it traces back to drug and alcohol abuse, physical abuse in their own families. - *MOMMAS House*
Social determinants of health play an integral role in addressing issues concerning mental health and substance abuse. It all falls together. When you have people who are in poverty they are not eating well; when you have people in poverty they tend to be depressed and have mental disorders, which very often leads to alcohol or substance abuse, heroin, which is a huge problem in this area. It's all interwoven I am trying to say. - *Catholic Home Care*
Access to adequate mental health and substance abuse treatment/recovery services is limited, which has created a gap in care for those in need and negatively impacted hospital readmission rates. We used to have a Mental Health Department within our hospital, Glen Cove, but they closed it down two years ago, I believe, because of funding. Now it is difficult to try to figure out where to send our patients, especially from family medicine, the Care Center. We would send them upstairs within the Mental Health Department in our hospital, but now we have to send them outside for services, so access becomes a problem. - *Northwell Health Ambulatory Care Center*
Additional interpretation located within "Deeper Dive" Section of this report.

Healthy and Safe Environment	
Focus Area	**%***
Access	6.9%
Homes	6.8%
Violence	5.0%
Injuries	2.7%
Built Environment	2.7%
Air Quality	1.4%
Water	1.2%

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

Analytic Interpretation & Participant Quotations
Components of one's surrounding environment, such as quality of air and water, may at times be overlooked. These considerations should be widely recognized as key elements that play a vital role in the health of Long Island communities. Air quality and water quality impact every issue that we have here, and I think that that's something that we have to get a hold on for all the health of our communities. I think it's really important that we realize that the water quality and the air quality, even though it might be better here on Long Island, is still

something that absolutely, positively impacts health.
-RN Nurses Evolve, PLLC

The lack of affordable housing in Nassau County contributes to unsafe living environments, which is considerably problematic within the senior population. Availability of stable housing has a direct correlation with access to health services and individuals' ability to prioritize their healthcare.

We work with homeless youth, we work with preventive care. We have substance abuse programs. All of these seem very relevant. I think when I think of seniors the health and safe environment is also really important because there's not any affordable housing on Long Island. So, they're living in homes that might not be safe for them. So, it really opens them up or leaves them vulnerable to falls and makes it difficult for them to live in safety a lot of the time.
-Family and Children's Association

Similar to what everybody has said, but I do think one of the parameters that are really impending upon us with our medical care is the housing resources in Nassau County. You know, unless you're stable in your housing, you have a place to go every night, you can't think about tomorrow without the anxieties of where you're going to be living, how you're going to be eating, how you're going to be getting back to a shelter placement. So the combination of housing and the lack of available transportation in Nassau County. I think it's a huge hindrance of getting our mental health services and getting our physical, you know, care from our local clinics or hospitals.
-Family and Children's Association

A sustainable-built environment provides increased opportunity for community members to engage in physical activity, promotes easy access to health services and healthy food options.

I'd say leading a healthy lifestyle, so whether that's access to healthier food options and beverage options. A lot of the communities that we work in may not have a grocery store nearby or they'll have corner stores and if you then look at the percentage of the population that doesn't own a vehicle, you have to think about these families that now have to walk, like, how far do they have to walk to get healthy food for their families and if the closest thing that they can access is some type corner store, you know, that tends to have high caloric foods that are nutrient deficient, then also you have communities that maybe aren't necessarily walk friendly, you know, you want to increase these opportunities for physical activity in getting families and kids outside.
-Sustainable Long Island

Gang violence exists in select Nassau County neighborhoods, creating unsafe environments and ultimately impacting access to health services, stores, schools and other valuable community resources.

Undocumented workers who sustain workplace injuries often lack the knowledge and resources needed to access health care services via the worker's compensation law.

Reducing gang violence is a big issue. Also injuries, at work injuries. A lot of the undocumented, they don't know that they are eligible for Worker's Compensation, so sometimes they come to us that they don't have insurance, and they were told that they are not eligible because you are undocumented, so we educate them. We tell them who they need to go see, they need to take things to. We fill out Worker's Compensation forms for them and tell them that yes, they are eligible.
-Coordinating Agency for Spanish Americans

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

Healthy Women, Infants and Children	
Focus Area	**%***
Children's Health	11.2%
Maternity/Mother	8.5%
Pregnancy	2.9%

Infant's Health	1.5%
Childbirth	0.8%

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

Analytic Interpretation & Participant Quotations
Young mothers may not have the resources, information, or support needed to properly care for their children. Young moms don't have a clue as to how to meet the health needs of their babies and children. Meeting their immunization schedules, feeding them appropriately. This is a very serious problem. *-MOMMAS House*
Mothers are often overburdened with the challenges associated with providing for their loved ones, which makes it difficult for them to find the time or resources necessary in which to take care of themselves or seek out preventive services. What we find is women are so used to taking care of everyone else. You really have to educate them, empower them, to take care of their own health before they help their family member and children. And that's engrained in culture and it's hard to deal with. *-Adelphi University, Breast Cancer Hotline and Support Program*
Increased availability of health literate and culturally competent services, especially for women, mothers and caregivers, is an important component of improving health status. The work we're doing with American College of Obstetrics and Gynecology is trying to educate women on caring for themselves and understanding problems that arise during pregnancy and following, immediately following birth. Not only the language, but the literacy barrier of what the health care professional says and what the patient hears. *-PULSE of NY*
Incidence of infant mortality, prematurity and low-birth rate babies is higher among the African American population. It is vital that expectant mothers, especially those in high-risk populations, are accessing comprehensive health services. Post-delivery is the perfect time to engage mothers in follow-up care by linking them to services. When it comes to birth outcomes, there is still a very high incidence of infant mortality, pre-term weight, mostly for the African American population. Even before that woman becomes pregnant, What is being done in the preconception period; What is the health of that mother like; Does she have chronic disease; Is that chronic disease being managed; Is she going every year for routine OB-GYN care; Is she being screened for HIV? Because the health of that woman before the pregnancy even occurs can impact on that outcome, preconception, prenatal and what we call the intra-conception phase. After she has that baby, before that next pregnancy we want to make sure she gets linked to services. *-Planned Parenthood of Nassau County*

HIV, STD, Vaccine Preventable Diseases and Health Care-Associated Infections	
Focus Area	**%***
HIV-AIDS	2.7%
Sexually Transmitted Disease	2.3%
Vaccines	1.7%
General Infections	1.0%
Associated-Infections	0.4%
Hepatitis	0.0%

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

Analytic Interpretation & Participant Quotations

Care for people living with HIV has progressed to the point where we now need to focus on the provision of well-rounded, comprehensive care, which may include a focus on cases of HIV coupled with chronic diseases.

Pre-exposure prophylaxis (PrEP) is a therapeutical approach to preventing HIV transmission with an impressive rate of effectiveness. Community organizations are working with providers to encourage the support of this treatment for those who may be at risk for transmission.

So we do have people with HIV living longer which on one hand is great, on the other hand, now the medical issues are becoming more and more complex, so in addition to managing their HIV, they have all the other stuff that all the rest of us get.

We're also trying to work with physicians in the community, not us in particular, but some of our outside colleagues to let them know, PrEP is now available for people who are in a relationship with someone who is HIV positive, they themselves can be prescribed PrEP, which is great because it's something like a 92 percent chance of non-transmittal. But we're running into providers that for their own moral issues or for their own thinking that that means people are just going to run around and have whatever kind of lifestyle, don't want to prescribe. So we're trying to get out there and, kind of, educate and advocate.
-Options for Community Living

Professionals are beginning to see an increase in rates of sexually transmitted disease within senior populations. Increasing awareness and providing education, specific to the target population, will assist in combatting these rates.

An area that I think needs to be addressed that has not is in the aging community where you have a lot of dementia and Alzheimer's. That has one of the highest incidents of STD especially in our communities where they're collected together whether assisted living, nursing homes or senior communities. So it's an education process that I think we need to get into that senior community, especially as their mental capacity is diminishing with dementia and Alzheimer's.

-National Aging in Place Council

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

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

The population of Nassau County represents a diverse mosaic of ethnicities, cultures, religions, languages and identities, making access to Culturally Competent, individualized services a priority within this area.

I guess in terms of concrete, tangible or, you know, quantifiable health problems, Nassau County has extremely high rates of HIV, other STIs and teen pregnancy. . .the Hempstead community has a wide range of individuals, of cultures of people, and that doesn't work well with the catchall model of services. So I think that that is affecting the rates that we are seeing as well.
-Planned Parenthood of Nassau County

Disparities	
Focus Area	**%***
Senior Issues	17.0%
Special Population Disparities	16.4%
Age Disparities	11.4%
Language Disparities	10.8%
Race/Ethnicity Disparities	10.0%
Gender-Identity-Orientation Disparities	2.3%
General Disparities	2.1%
Gender Disparities	1.0%
Religion Disparities	1.0%

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

Analytic Interpretation & Participant Quotations
Many caregivers are unprepared for and faced with financial challenges that come hand in hand with the responsibilities of providing for and managing daily life for a family member. Dementia and cognitive loss seems to be a huge issue in our community. We're not prepared as a country to take care of people with dementia, but more so the caregivers are not. One-third of the caregivers become bankrupt because they have to leave their jobs to take care of a loved one. And I don't think as a culture we're prepared to handle that. . . It's a huge issue. -Music and Memory
There are compounding barriers to accessing preventative care seen within the large population of undocumented individuals in Nassau County. Such barriers include: no insurance coverage; financial barriers to paying for care; cultural and language barriers; no understanding of how to navigate the health system; transportation barriers and beyond. Along with all the cultural and financial barriers and expectations, you also have a large undocumented population. So they don't have access to the same kind of medical care or other services that might enable them to go for medical care like transportation, like some government subsidies, and things like that. So the undocumented population is huge on Long Island and they don't have coverage and they don't have the resources. *-Adelphi University, Breast Cancer Hotline and Support Program*
As the age of the baby boomer population advances, expanded health services and financial resources will be needed to support this population. An added challenge may be seen for families who are experiencing poverty or financial debt into retirement age. The baby boomers have been saddled with debt that they were not expecting. Hearing about all these parents carrying their kids' education debt and that becomes their debt, not just the kids' debt. As much as I think the baby boomers are going to be putting the crunch on the health care system, I think they are going to be putting stress on other areas, they thought they had this retirement funding, but when they actually get there they don't, because of all the unforeseen expenses and, let's face it, Long Island is one of the most expensive places on the planet to live. So people who really decide to stay here and retire probably are facing expenses that they didn't imagine 20 years ago, like property taxes. To stay in a house that is paid off, and pay the taxes and utilities, it's almost as much as the mortgage was 30 years ago. -Society of St. Vincent de Paul

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

Barriers to Care	
Focus Area	**%***
Access Barriers	25.1%
Financial Barriers	18.3%
Insurance Barriers	16.2%
Care Barriers	12.4%
Cultural Barriers	11.2%
Transportation Barriers	8.1%
Communication Barriers	6.8%
Disability Barriers	6.2%
Employment Barriers	4.6%
Research Barriers	0.4%

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

Analytic Interpretation & Participant Quotations
Lack of financial security and stability are directly connected with a person’s ability to take accountability for their health needs, making decisions related to health statuses even more challenging. The lack of financial security immobilizes all of your functioning as a person. It affects your mental health. It makes you start with bad decision, drugs, violence, you know. If you have some financial security, your road to stability it is a little bit stronger no matter what community you're living in. *-Family and Children’s Association*
Prioritization of needs for a family or caregiver is often based upon perceived urgency or necessity, which can result in preventative care and routine well visits falling to the wayside. You look at people who are impoverished; they take care of their most drastic needs first. They need air, food, shelter. If there is no money left over after those three things, the other things get thrown to the wayside. You know, you get by without adequate clothing. You get by without preventative home care. Get by without going to a doctor, not just for preventive care, but when you are sick. If the kids are hungry, or if you are being threatened with eviction, the thing that drops off is taking care of your health, because that is not an urgent thing. *-Catholic Home Care, Good Shepherd Hospice*
The undocumented population is often left underserved due to misconceptions, mistrust or fear regarding their citizenship status. Community outreach focused on establishing trust, and culturally appropriate education focused on how to access services is an effective way to combat this fear. For our health centers, I would say, because we are federally qualified, when we reach out to the undocumented populations or organizations, they have a fear that by coming into our sites, we're going to report them or disclose their information to immigration services. That's a barrier for us sometimes. *-NuHealth, Long Island Federally Qualified Health Centers*
Stigma associated with individuals living with HIV, AIDS or those who identify as LGBTQ, has impacted the quality of care accessible to such vulnerable populations. Arming providers and front-line workers with the education needed to appropriately communicate with this population is a method used to improve gaps in service care.

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

-LGBT Network

Educational Disparities and Barriers, is another topic that the Data Analysis group felt should be further explored, with 23.0% of Nassau County quotations. Themes related to educational disparities and barriers are broken down by sub-group within section V, A Deeper Dive.

Educational Disparities and Barriers	
PA-Topic	**%***
Educational Disparities and Barriers	23.0%

Additional Services	
Focus Area	**%***
Service Expansion and Improvement	21.4%
Community and Bridging Services	13.1%
Policy	4.4%
Financial Assistance	3.7%

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

Analytic Interpretation & Participant Quotations

The need for service providers with an understanding of Culturally and Linguistically Appropriate Standards of care enhances the ability to provide care to diverse populations. All service providers, including physicians and front-line staff members should be participating in trainings which address cultural competency, health literacy and unconscious bias.

We've worked over the years in trying to identify what the cultural and ethnic barriers are. Mainly preventative screening in breast cancer and treatment and every group has different cultural barriers that you have to address. We've recently gone into the Muslim community who have completely different barriers than women of color, Hispanic women, African American, women. So if you don't gear your education to that particular group, you're not going to be successful. And you have to have people who are part of the culture, you who can speak the language, and can identify with clients to educate them, so that they get the care that they need.
-Adelphi University Breast Cancer Hotline and Support Program

Provision of system navigation efforts may be an effective way to both empower patients, and to achieve desirable patient outcomes. Many patients do not know where to start, or how to access health or social services. An in person guide may supplementary for those who are looking to take the first step, to avoid being lost within the complexity of system navigation.

Education is very important, and then secondly, I think that social work services, case management

services, that are vital to getting our clients, anyway, the services and resource that they desperately need. Because they don't even know where to start, it falls upon us to really hold their hand, put their appointments on the calendar, call the transportations with them, and make sure that they're there on time, the whole process just like they were little kids until they get to the point where they realize they now have to take over. So the only way to empower the client and do the work with them at the beginning and then eventually give them the power to do it themselves.
-MOMMA'S House

Interconnected, integrated IT networks support partnerships and transparency between service organizations in a synergistic way that has the potential to help bridge gaps in care and allow continuity of care for patients, particularly those representing vulnerable populations.

But from my point of view, one of the things that can help with the question you asked is better IT or better connectivity between the different providers. We spend a lot of time chasing down clients, so if they don't show up to their appointments, they don't have a solid address, they're homeless. So to kind of be able to collaborate you have to be able to share the information, and I know there are steps being taken towards that, but in a perfect world, you know, a lot of my clients will show up at DSS, that they'll show up for, but I don't know that they're there. If I could tap into it, you know, so it's the sharing of information on a broad level.
-EAC Network

For service providers to effectively meet the needs of community members, they must remain adaptable to the constantly changing community landscape. Innovative ideas will can position providers ahead of such change.

I would say constantly looking at the needs of the community and changes as we see those needs changing. Being able to look for opportunities that are innovative and have an impact on the community that we serve.
-Family and Children's Association