Suffolk County

Community Health Assessment and Improvement Plan

2016-2018

Steven Bellone
Suffolk County Executive

James L. Tomarken, MD, MPH, MBA, MSW
Commissioner of Health

Suffolk County Department of Health Services
3500 Sunrise Highway, Suite 124
P.O. Box 9006
Great River, NY 11739-9006
Main (631) 854-0100
scdhsweb@suffolkcountyny.gov

CHIP created based on priorities set by the Long Island Health Collaborative (LIHC)

1383 Veterans Memorial Highway • Suite 26 • Hauppauge • NY 11788 • **Phone:** (631) 435-3000 • **Fax:** (631) 435-2343 or (631) 435-3540

Participating Hospitals Listed in Appendix

Suffolk County

2016-2018 Community Health Assessment and Improvement Plan

Suffolk County Department of Health Services

James L. Tomarken, MD, MPH, MBA, MSW, Commissioner of Health
3500 Sunrise Highway, Suite 124
P.O. Box 9006
Great River, New York 11739-9006
(631) 854-0100

The Long Island Health Collaborative (LIHC) is a coalition funded by the New York State Department of Health through the Population Health Improvement Grant. The LIHC provided oversight and management of the Community Health Needs Assessment processes, including data collection and analysis. Participating hospitals and hospital systems included the following:

Catholic Health Services of Long Island

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

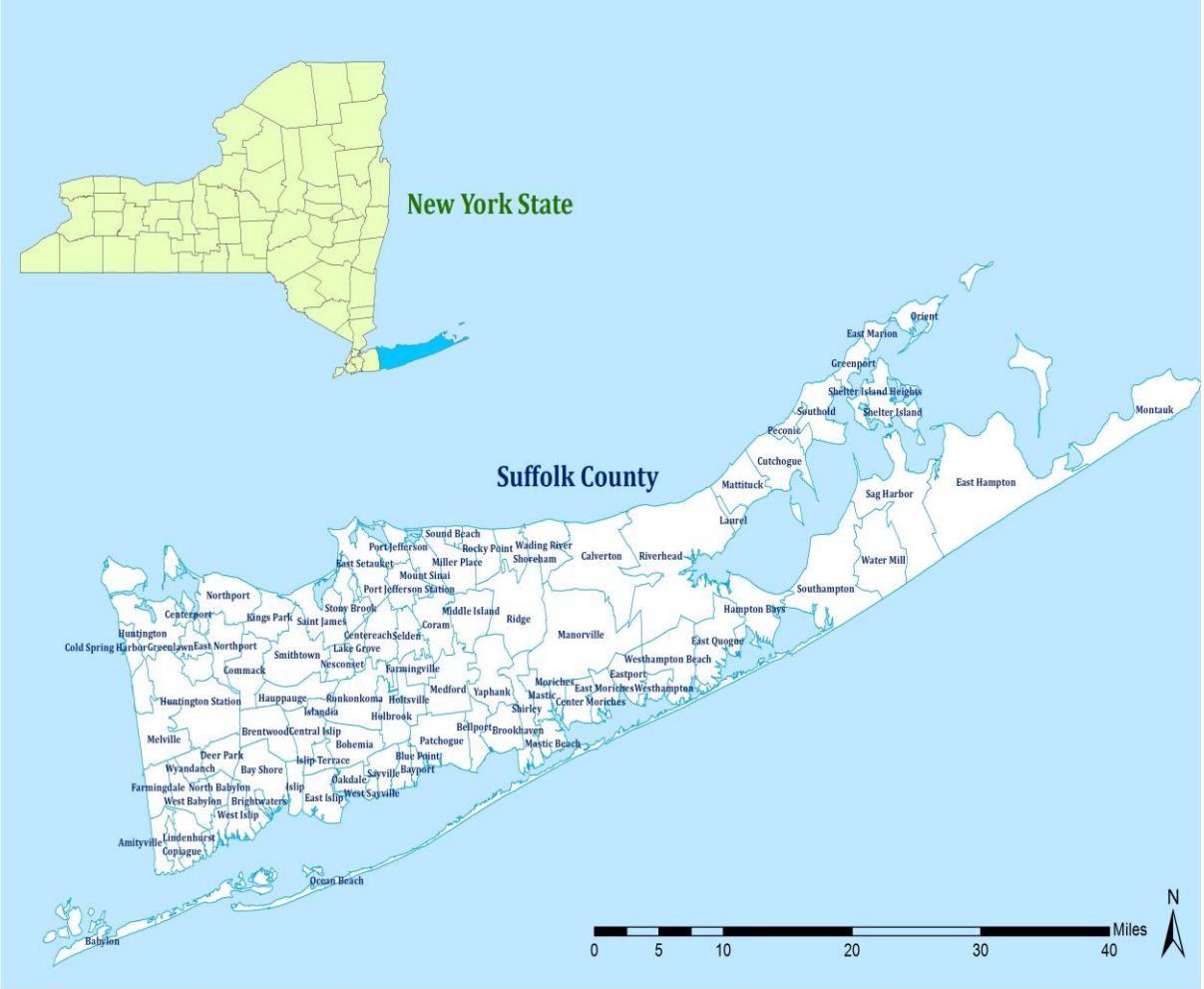
Northwell Health System

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

Other Suffolk County Institutions

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

The Suffolk County Community Health Assessment and Improvement Plan was created in collaboration with community agencies based on priorities determined by the "Long Island Health Collaborative," established in January 2013. The Long Island Health Collaborative (LIHC), funded by the New York State Department of Health's Population Health Improvement Program, was developed by hospitals and the Health Departments of Suffolk and Nassau Counties with the assistance of The Nassau-Suffolk Hospital Council to develop and implement a Community Health Improvement Plan (CHIP). Representatives throughout the health department contributed to the development of the goals and objectives. The objective of the CHIP was to partner with community agencies and develop and monitor programs to improve the quality of health of the community.



SUFFOLK COUNTY

COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN 2016

Table of Contents

Executive Summary

The 2016 Community Health Assessment and Improvement Plan reflects the ongoing priorities and commitment of the Suffolk County Department of Health Services (SCDHS) to healthcare improvement for Suffolk County residents. In response to a multitude of newly available data and health initiatives spearheaded by the Long Island Health Collaborative (LIHC), the Population Health Improvement Program (PHIP), and the Delivery System Reform Incentive Program (DSRIP) along with several partnerships among stakeholders in the community the prevention agenda priority areas of increasing access to high quality chronic disease preventive care and obesity reduction were chosen again. Furthermore, an emphasis on the importance of mental health needs in the community was re-iterated. This Community Health Assessment and Implementation Plan was created to improve the population health of Suffolk County and to address the *New York State Prevention Agenda* goals.

The LIHC is a multidisciplinary syndicate of local (Suffolk and Nassau County) health departments, academic partners, community based organizations, hospitals, community leaders, and physicians with a vested interest in supporting the New York State Department of Health (NYSDOH) Prevention Agenda. After receiving funding from the NYSDOH Population Health Improvement Program (PHIP) grant, members of the LIHC have reviewed extensive data sets selected from both primary and secondary data sources to identify and confirm Prevention Agenda priorities. The LIHC conducted several key research initiatives including organizing the Community-Based Organization Summit Events and the Long Island Community Health Assessment Survey to engage the broad

community in the region's community health assessment efforts. Furthermore, LIHC has provided analysis of secondary publically-available data sets including resources from the Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics.

The Delivery System Reform Incentive Program (DSRIP) headed in Suffolk County by the Suffolk Care Collaborative, is part of a statewide Medicaid reform agenda, to reduce avoidable hospitalizations and ED utilization by 25% over five years and to improve health quality through health system reform. The Suffolk Care Collaborative published an in depth Community Needs Assessment in 2014 with special emphasis on Medicaid recipients and uninsured residents. The report is also an in depth primary data analysis of county wide surveys, as well as secondary data reports from the NYSDOH, SPARCS and DSRIP databases identifying the special needs and disparities of Suffolk County residents.

The wealth of health information has led to the selection of data-driven initiatives in alignment with evidence based strategies to focus on the priorities of chronic disease with a special emphasis on obesity and preventive care and management, as well as an overlay of mental health with a special emphasis on substance abuse and behavioral health disorders. Suffolk also chose to focus on Chronic Disease Prevention through tobacco cessation. The initiatives include the:

- Are You Ready, Feet?™ physical activity/walkability campaign and walking portal
- Physician-driven Recommendation for Walking Program

- Complete Streets Community and Policy Work
- Leverage PHIP resources to support two synergistic programs: Creating Healthy Schools and Communities, funded by NYS DOH and Eat Smart New York, funded by USDA
- SCDHS Bureau of Public Health Nursing to provide education and referrals for at risk patients for obesity, mental health conditions and substance abuse
- SCDHS Diabetes Prevention Program
- Support DSRIP efforts to increase programming throughout the region, including access to evidence based Stanford Model Programs
- Mental Health First Aid USA™ Training, Evidence-based Program
- SCDHS Food Desert Program
- SCDHS Community Mental Hygiene Programs for suicide prevention and reduction of substance abuse
- SCDHS Office of Health Education Bullying Prevention Program for school age children
- SCDHS Naloxone Training
- 24/7 Hotline to increase access to treatment and support services for Substance Abuse
- SCDHS Tobacco Cessation Program

The SCDHS works in partnership with several entities including the LIHC and many contracted agencies and community based organizations enlisted in this report. Each division of the SCDHS maintains relationships with key stakeholders in the community and enlists their participation through the various programs. For each project of the SCDHS, monitoring and evaluation for quality and effectiveness will be performed. Process

measures are identified specifically for each individual aspect of the programs. In addition, the LIHC's activities will be evaluated with assistance of the PHIP's extensive qualitative data collection and analysis. The degree to which member organizations are collaborating will be looked at and direct feedback from community members and member organizations will be assessed.

Specific quantitative measures will be analyzed to assess the reach of our various projects within the communities on Long Island, including but not limited to:

- Number and organizations from various health sectors that participate and attend Long Island PHIP meetings and projects;
- Reach of organizations and community members through social media, website and additional communications strategies;
- How many community members participate in the Long Island PHIP walking program "*Are you ready, feet?™*" and subsequent data surrounding adaptation of healthy behavior;
- Impact of programs that address healthy eating, physical activity, physiological well-being and responsible health practices through evaluation of LIHC wellness survey portal data and/or data collected by individual initiatives;
- Analysis of results from ongoing Prevention Agenda Community Member Surveys;
- Growth in number of evidence-based Stanford programs being conducted as a result of link between Hudson River Health Care, Retired Senior Volunteer Program, Suffolk Care Collaborative and Long Island PHIP.

Community Health Assessment and Improvement Plan

COMMUNITY SERVED

Suffolk County, occupying the eastern end of Long Island, has a land area of 912.2 square miles. Suffolk County's service area is situated east of the Nassau County border, extending through the eastern forks of Long Island. It comprises ten towns: Babylon, Huntington, Islip, Smithtown, Brookhaven, Southampton, Riverhead, East Hampton, Shelter Island and Southold. Suffolk County is an area of growing diversity, cultures and population characteristics. Using 2014 Population Estimates from 2010 U.S. Census Demographic Profile data, the total population of Suffolk County is estimated to be 1,502,968. The median age of the population is 41 years, with 22.2% of the population below the age of 18. Of the 1,168,726 residents aged 18 and older, 48.7% are male and 51.3% are female. Seniors aged 65 and older make up 15.2% of the population, with 43.2% males and 56.8% females. Children under the age of five make up 5.4% of the population.

According to 2014 Population Estimates from 2010 U.S. Census Demographic Profile data, 18.2% of the population is Hispanic/Latino, 69.3% of the population is non-Hispanic White, 7.14% is non-Hispanic African American/Black, 3.9% is Asian, 0.2% is American Indian and Alaskan Native and 1.2% are two or more races. Suffolk County is also home to two Indian reservations, the Shinnecock Reservation in Southampton as well as the Poospatuck Reservation, Unkechaug Nation in Shirley.

According to the 2014 American Community Survey, the unemployment rate in Suffolk for those aged 16 and older was 7.1% countywide: 6.8% for whites, 10.5% for African Americans, and 7.1% for Hispanics. Median household income in 2014 was

$88,323 (± $1,030, margin of error). By race, the median household incomes were $91,684 (± $1,083) for whites, $68,322 for African Americans/blacks (± $3,133), $72,423 (± $2,950) for Hispanics/Latinos, $96,123 (± $5,730) for Asians, $47,111 (± $8,946) for American Indians/Alaskan Natives, and $61,455 (± $3,491) for those listed as other. About 6.8% of Suffolk County residents are below the poverty level (5.4% of whites, 13.3% of African Americans/blacks, and 11.6% of Hispanics/Latinos).

Looking at eight different demographic indicators (Percent High School Graduate, Percent Bachelor's Degree, Speak Only English, Unemployment Rate, Percent Below Poverty Level, Percent with Cash Public Assistance of Food Stamps/SNAP, Median Income, and Percent Foreign Born), twenty of the zip codes with the least optimal results from each indicator were identified. Of these, eighteen zip codes that were common to at least four of the indicators were selected to represent "Identified Zip Codes" for analysis. These communities included:

Town	**ZIP**
Amityville	11701
Bay Shore	11706
Bellport	11713
Brentwood	11717
Central Islip	11722
Copiague	11726
Huntington Station	11746
Islandia	11749
Lindenhurst	11757
Patchogue	11772
Wyandanch	11798
Riverhead	11901
Greenport	11944

Mastic	11950
Mastic Beach	11951
Middle Island	11953
Robins Island/New Suffolk	11956
Shirley	11967

COLLABORATIVE PROCESS TO DETERMINE PREVENTION AGENDA PRIORITIES

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

One of the roles of the LIHC is to choose the priorities for the New York State's Prevention Agenda for the Long Island Region. For the 2013-2017 New York State

Prevention Agenda, LIHC's work focused on chronic disease prevention and treatment, with an emphasis on reducing obesity in adults and children. It also addressed the need for better coordinated mental health/substance abuse treatment and prevention services.

In 2016, members of the Long Island Health Collaborative (membership is listed in the pages that follow) reviewed extensive data sets selected from both primary and secondary data sources to identify and confirm Prevention Agenda priorities for the 2016-2018 Community Health Needs Assessment Cycle. Data analysis efforts were coordinated through the Population Health Improvement Program, with the PHIP serving as the centralized data return and analysis hub.

COMMUNITY HEALTH ASSESSMENT

Primary data sources collected and analyzed include the Long Island Community Health Assessment Survey and the Qualitative Data from Community-Based Organization Summit events. Secondary, publically-available data sets have been reviewed to determine changes in health status and emerging issues within Suffolk County. Sources of secondary data include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics. The data findings are as follows.

Prevention Quality Indicators and Chronic Disease Conditions

Prevention Quality Indicators (PQI), are defined by the Agency for Health Research and Quality* (AHRQ) and can be useful when examining preventable admissions. Using 2014 SPARCS data, the PHIP created a visual representation of preventable admissions related to Chronic Disease at the zip code level (Figure 1).

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

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

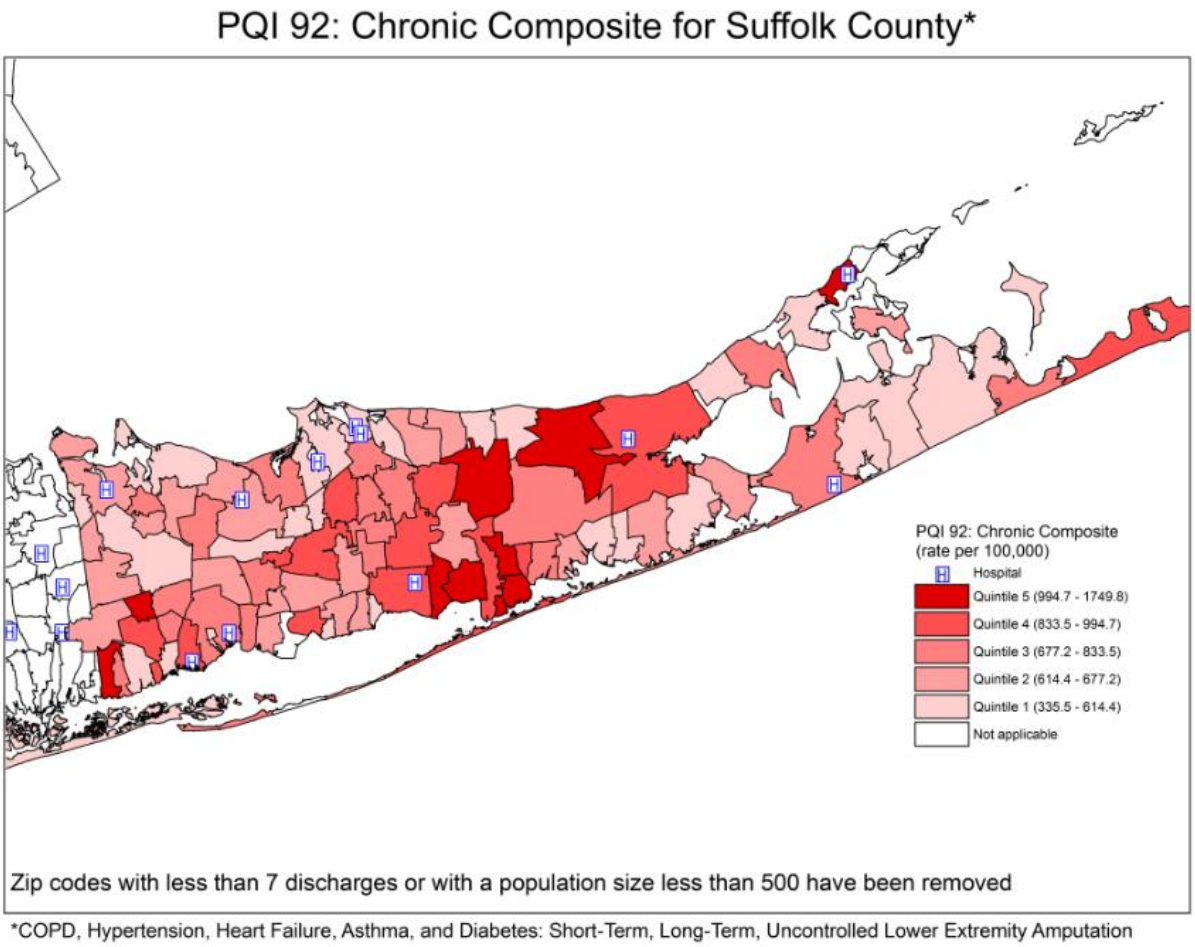


Figure 1. Map of preventable admissions related to Chronic Disease at the zip code level in Suffolk County. **Source: Agency for Healthcare Research and Quality-Prevention Quality Indicators (http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx)/ (Based on 2014 SPARCS Data)*

Prevention Agenda Dashboard and Chronic Disease Prevention Indicators

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

Obesity

Within the dashboard in the section titled, "Prevent Chronic Diseases," as illustrated in figure 2, review of 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System (eBRFSS), demonstrates 29.1% of adults in Suffolk County are obese. Obesity rates are higher than figures reported by New York State, 24.9% and the Prevention Agenda Goal of 23.2%. In addition, eBRFSS data for 2013 to 2014 indicate that the percentage of adults that are overweight or obese is 63.8% for Suffolk and 60.5% for New York State.

The percentage of children and adolescents who are obese in Suffolk County is 18.1% as compared to New York State (and excluding New York City) figure of 17.3%. The Long Island Health Collaborative has declared a commitment to reaching the Prevention Agenda 2018 goal of 6.7% or lower. A review of the data for children and adolescents by zip code reveals pockets where these rates are higher (21.6% +) than the overall Suffolk County rate.

Diabetes Mellitus

Rate of hospitalizations for short-term complication of diabetes reflects 4.83 per 10,000 for adults in Suffolk County and 6.47 in New York State. Although this indicator is below the Prevention Agenda Goal of 4.86, the Long Island Health Collaborative emphasized a need for focus on high utilizing pockets within the County with further room for improvement. In addition, the rate has been on a slightly upward trend (see Figure 3 below). As is evident in Figure 4, below, the SPARCS rate of hospitalizations for Type 2 diabetes is higher (158.8 per 100,000) for the identified zip codes versus the rest of Suffolk County (89.5 per 100,000).

Suffolk County - Prevention Agenda (PA) Indicators	Dial	PA 2018 Objective and Most Recent Data
14 - Percentage of adults who are obese	29.1	Suffolk 29.1; NYS 24.9; PA 2018 23.2
15 - Percentage of children and adolescents who are obese	18.1	Suffolk 18.1; NYS excl NYC 17.3; PA 2018 16.7
21 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	2.83	Suffolk 2.83; NYS 3.11; PA 2018 3.06

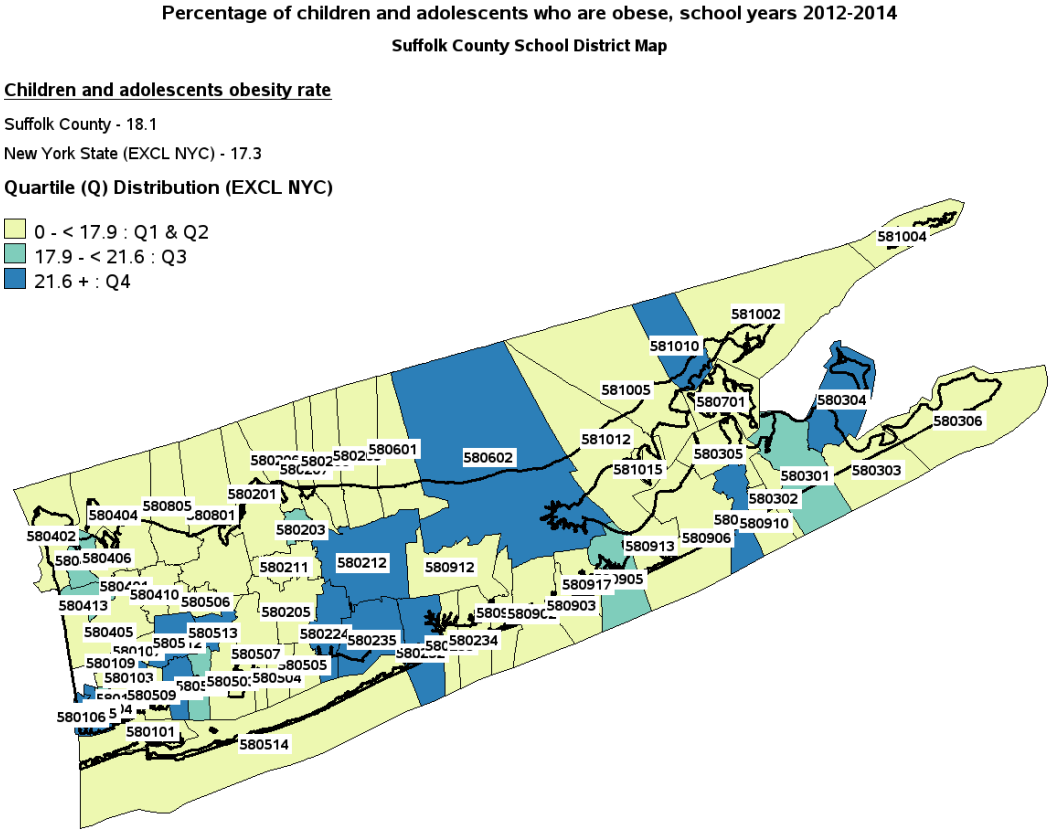


Figure 2. New York state prevention agenda indicators on obesity for Suffolk County.
** Source: Prevention Agenda 2013-2018: New York State's Health Improvement Plan (https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/)*

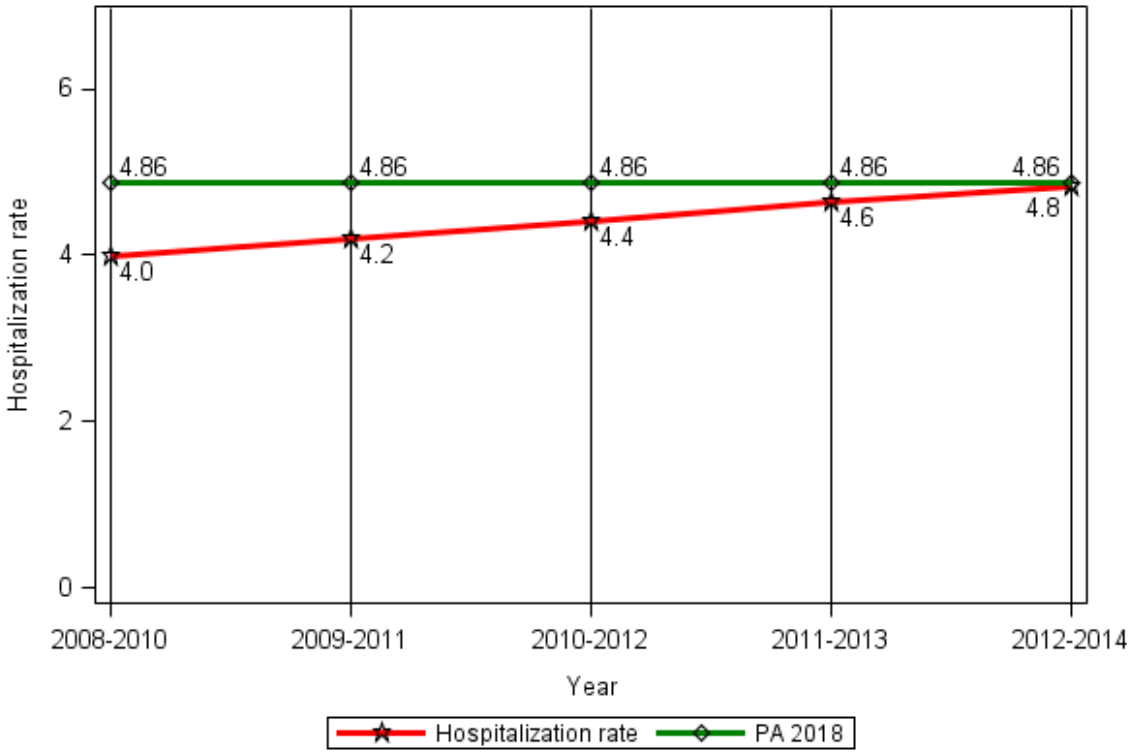


Figure 3. Trend in the short-term hospitalization rates secondary to diabetes in Suffolk County.

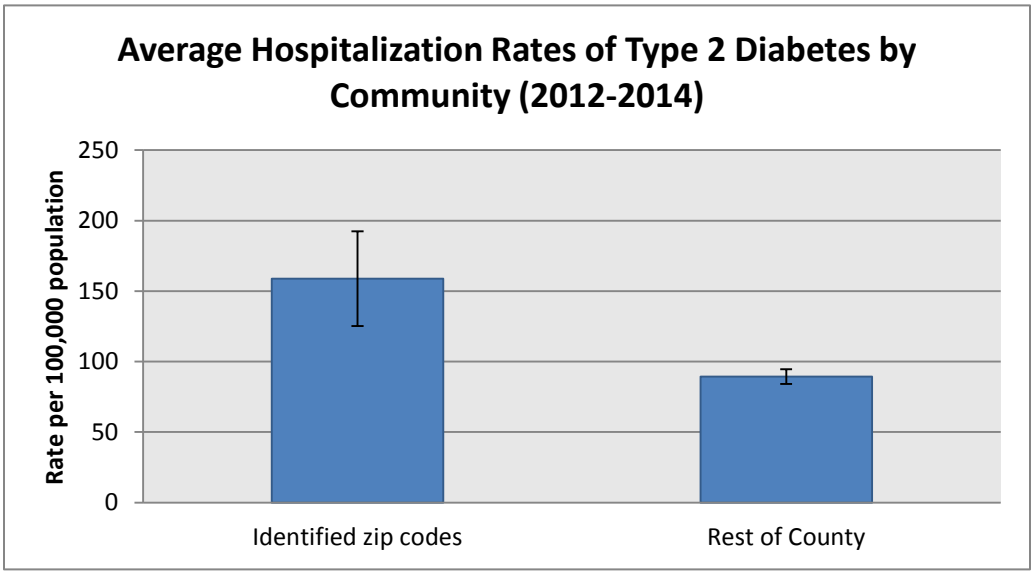


Figure 4. Comparison of hospitalization rates in Identified Zip Codes vs. the rest of Suffolk County.

Ischemic Heart Disease

According to SPARCS data, hospitalization rates for ischemic heart disease between 2012 and 2014 were higher for Suffolk County (426.6 per 100,000) as compared to both New York State with and without New York City Included (363.2 and 348.4 per 100,000, respectively). This is demonstrated in Figure 5 below. There was no significant difference in these rates between the Identified Zip Codes and the rest of Suffolk County.

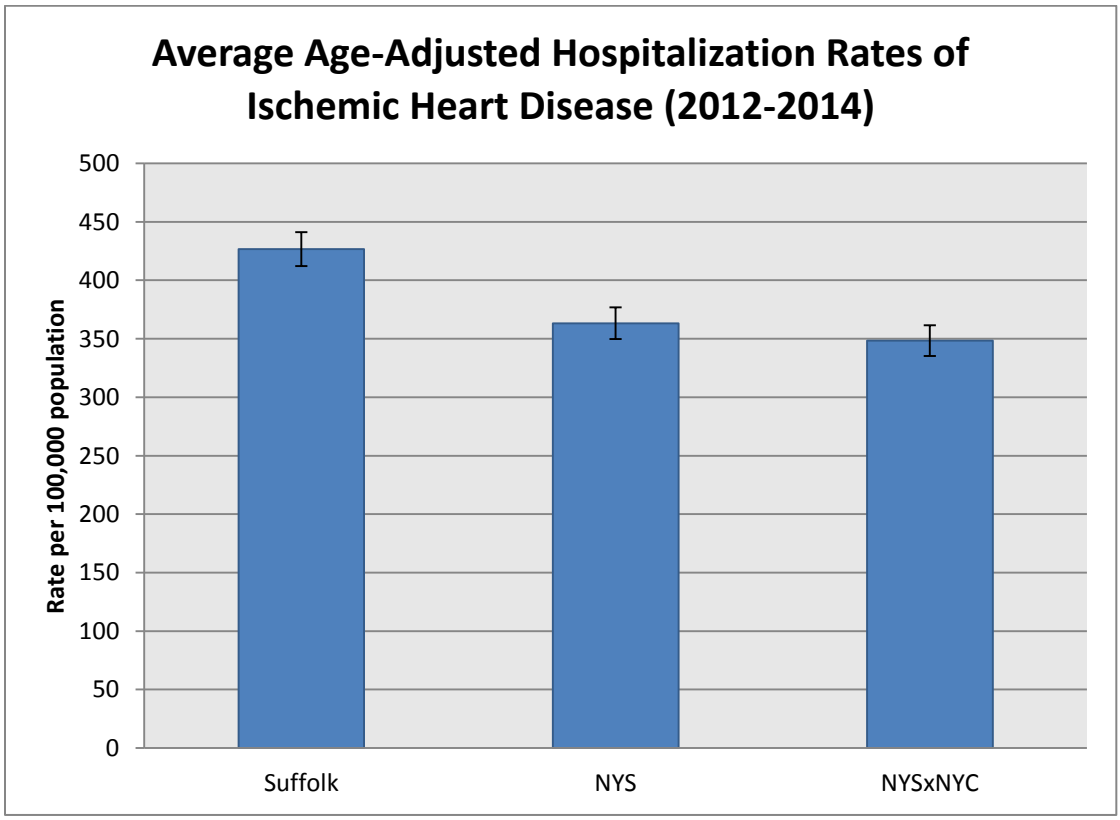


Figure 5. Comparison of age-adjusted hospitalization rates due to ischemic heart disease in Suffolk County vs New York State with and without New York City.

Stroke

Figure 6 below shows the rate of hospitalizations for stroke in the Identified Zip Codes, which were also higher than the rates for the rest of Suffolk County (150.1 per 100,000 compared to 125.0 per 100,000).

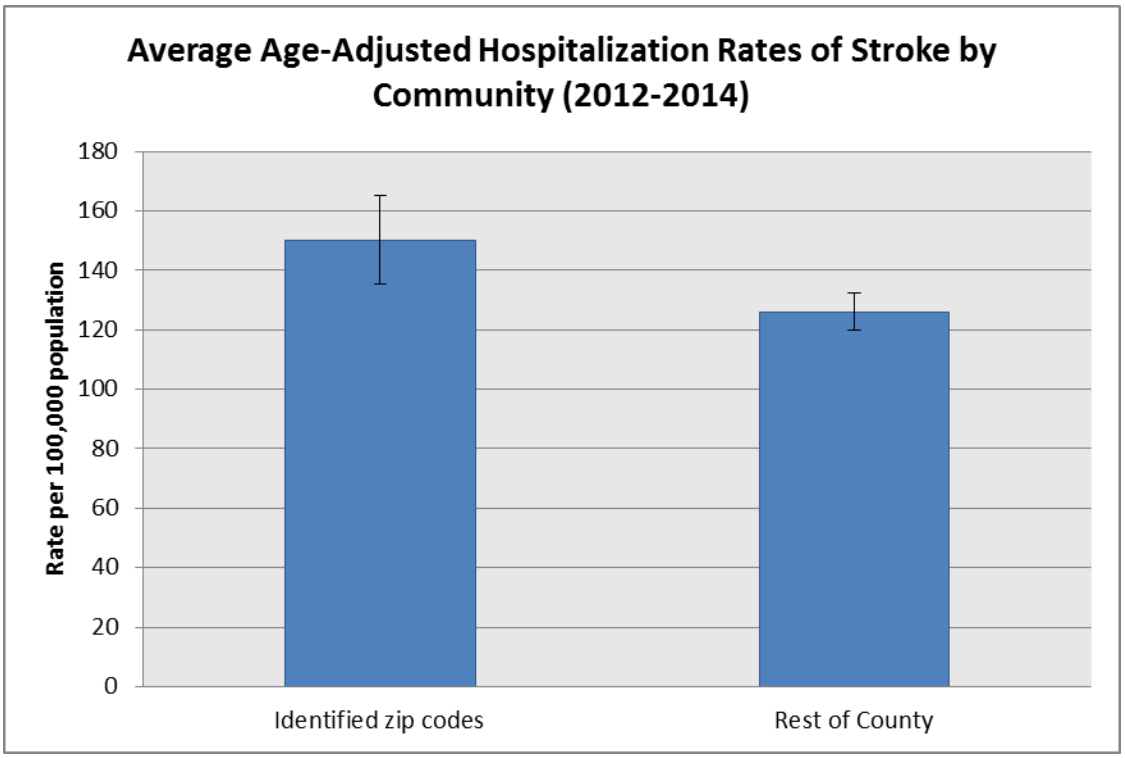


Figure 6. Comparison of age-adjusted hospitalization rates due to stroke in Identified Zip Codes vs. the rest of Suffolk County.

Mental Health

In the area of mental health, two important indicators were examined, as both are higher in Suffolk County compared to NY State. First, according to the 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System data, the age-adjusted percentage of adults with poor mental health for 14 or more days in the last month was 13.8% in Suffolk

County compared with 11.2% for NY State as a whole. This is above the Prevention Agenda goal of 10.1%. Second, according to the 2012-2014 vital records data cited on the Prevention Agenda Dashboard, the age-adjusted suicide death rate per 100,000 was also higher in Suffolk County (8.9%) than NY State (7.9%), and the Prevention Agenda goal for this indicator is 5.9%.

Substance Abuse

Using SPARCS data from 2012-2014, when Suffolk County is compared to the State of New York, a disparity is seen between the state and the county in hospitalization rates for opioid drug dependence, as is demonstrated in Figure 7 below. More specifically, Suffolk County has a higher rate of age-adjusted hospitalization secondary to opioid abuse than the State of New York, excluding New York City.

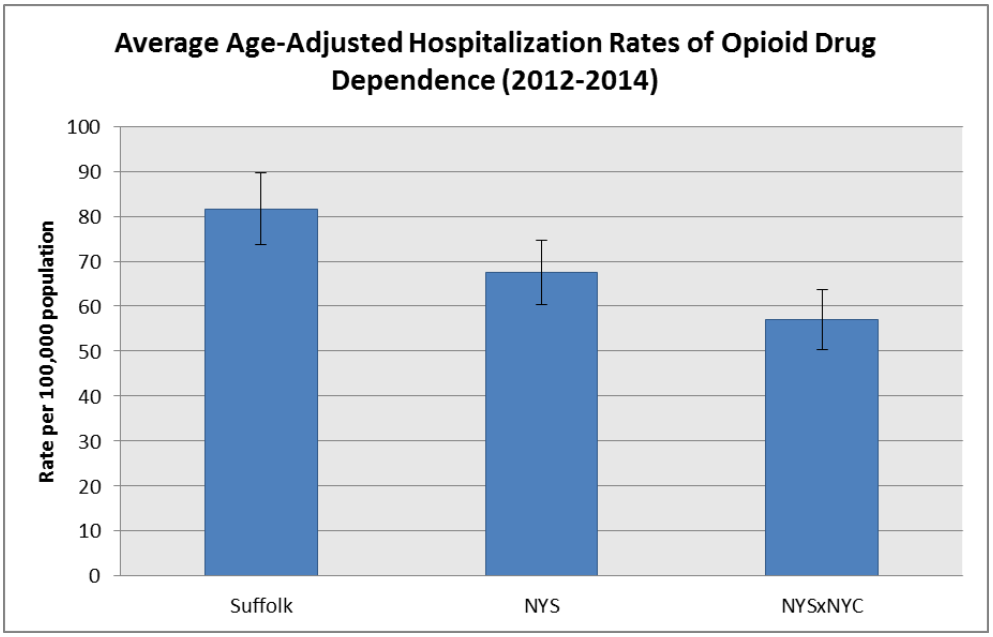


Figure 7. Rate of hospitalization in Suffolk County due to opioid abuse, compared to the State of New York with and without New York City.

A review of the SPARCS and Vital Statistics 2012 – 2014 data for substance abuse indicators (based on both primary and secondary diagnoses), as shown in Table 1, reveals several trends when the county averages are compared to the Identified Zip Codes and the rest of Suffolk County. The most important trend to note is the difference between hospitalization and emergency department visits among those who abuse opioids specifically as compared to all drugs of abuse (including opioids). The average rate of hospitalization and the average rate of ED visits per 100,000, secondary to opioid use are relatively close for the Identified Zip Codes and the rest of Suffolk County. By contrast, the average rate of hospitalization and the average rate of ED visits per 100,000, secondary to substance abuse in general, are substantially higher in the Identified Zip Codes as compared to the rest of Suffolk County. These differences are clearly illustrated in Figures 8 through 11. This suggests that opioid abuse is a county-wide problem, while substance abuse in general is more pronounced in the Identified Zip Codes.

Substance Abuse Indicators:	**Suffolk**	**Identified Zip Codes**	**Rest**
Average Age Adjusted Substance Abuse Hospitalizations/100,000**	1873.92	2297.17	1695.15
Average Age Adjusted Substance Abuse ED Visits/100,000**	4092.18	5302.34	3544.74
Average Age Adjusted Opioid - Substance Abuse Hospitalizations/100,000**	320.38	326.95	321.78
Average Age Adjusted Opioid - Substance Abuse ED Visits/100,000**	306.76	312.25	308.28
Average Age Adjusted Drug Overdose Mortality/100,000***	14.54	15.51	14.65

**SPARCS Database 2012-2014 ***Vital Statistics Database 2012-2014

Table 1. Substance abuse indicators in Suffolk County for 2012-2014.

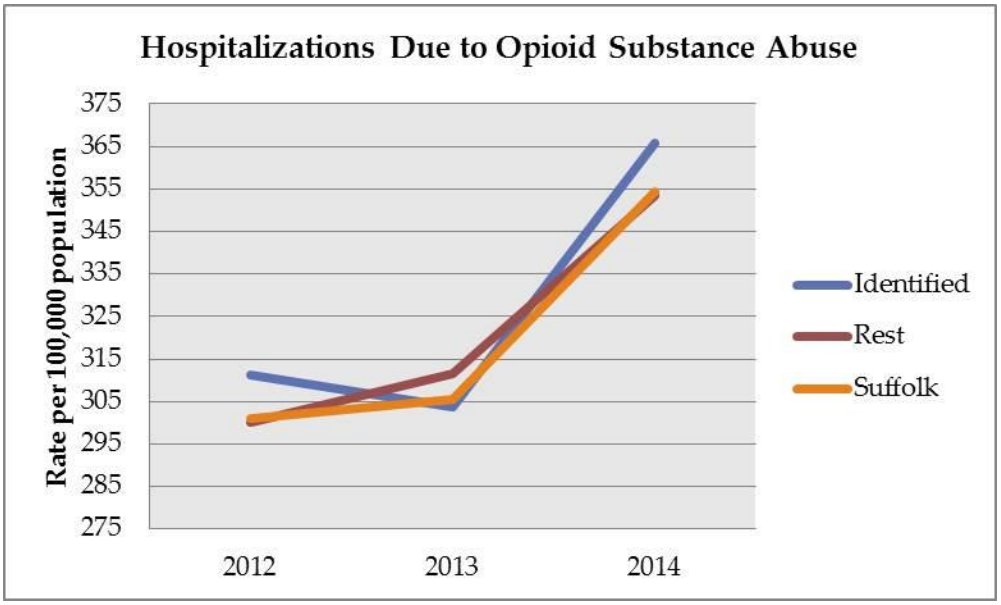


Figure 8. Rate of hospitalization in Suffolk County due to opioid abuse.

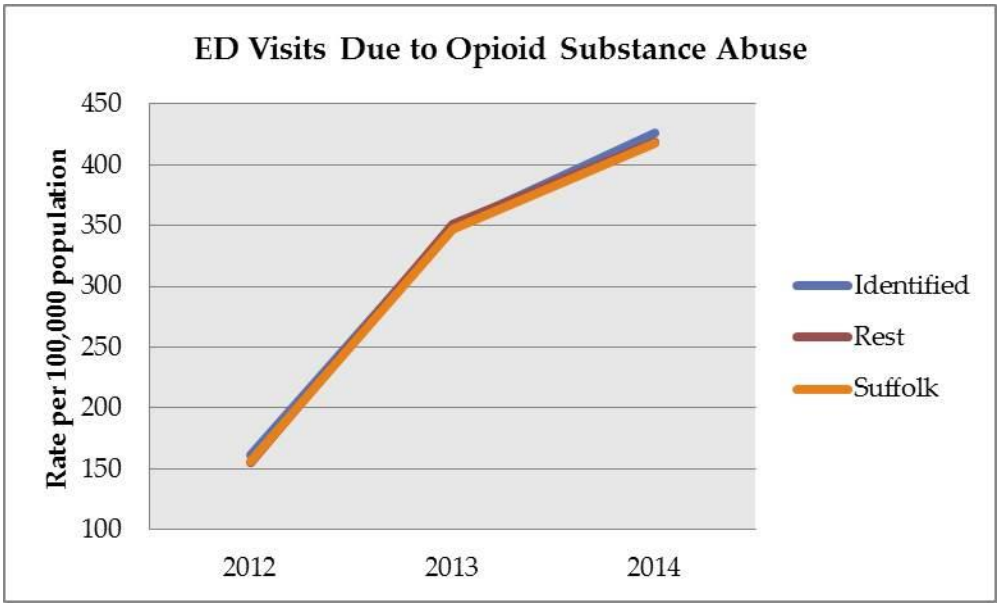


Figure 9. Rate of emergency department visits in Suffolk County due to opioid abuse.

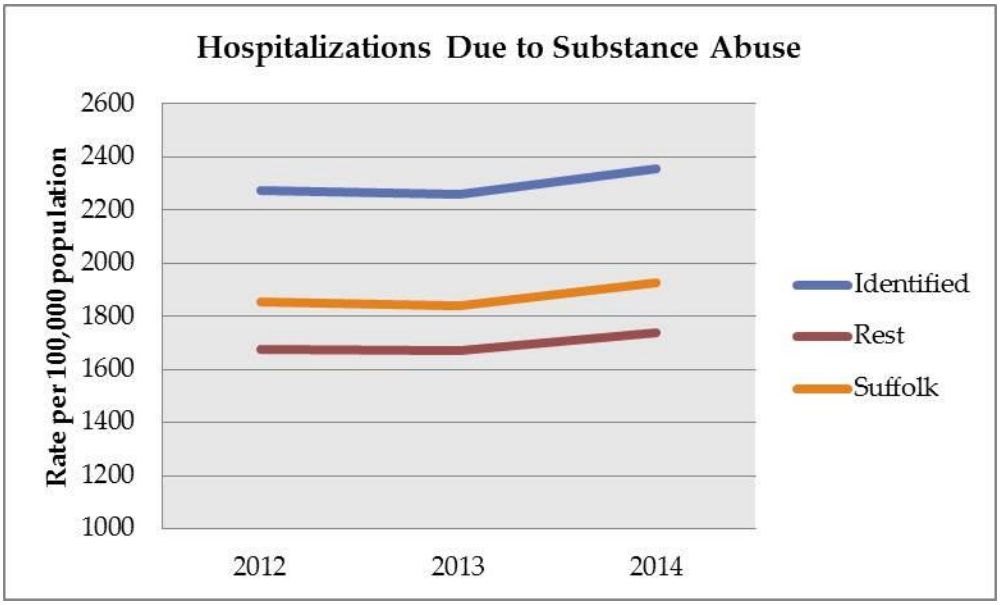


Figure 10. Rate of hospitalization in Suffolk County due to substance abuse, including opioid abuse.

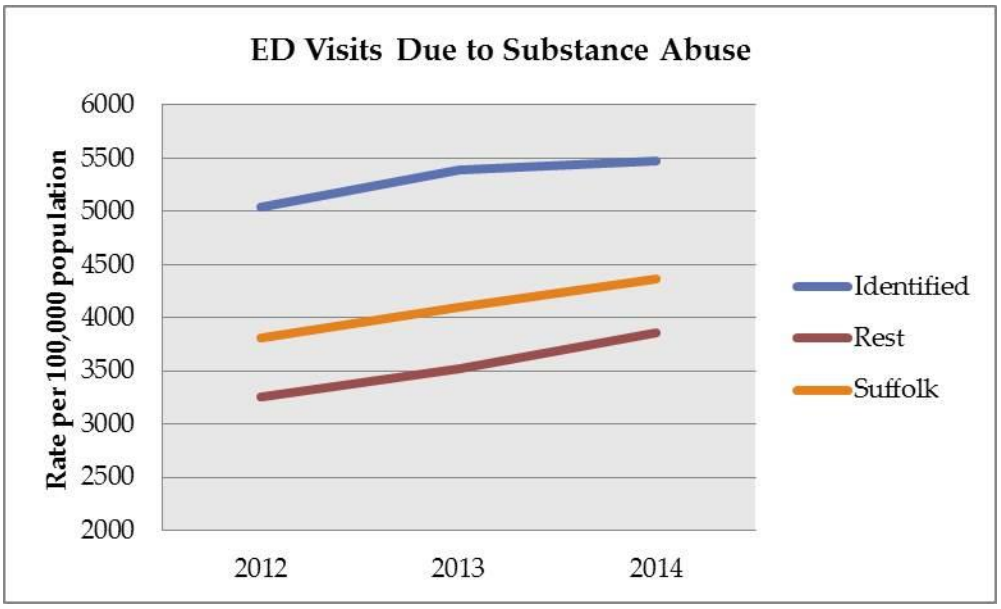


Figure 11. Rate of emergency department visits in Suffolk County due to substance abuse, including opioid abuse.

According to the Prevention Agenda Dashboard, Suffolk's percentage of cigarette smoking adults (14.4%) is higher than the Prevention Agenda goal of 12.3%, even if it is lower than the State-wide percent of 15.6% (from the 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System {BRFSS}). Additionally, review of SPARCS hospitalization data shows that hospitalizations for COPD among people aged 18 to 64 are higher for the identified zip codes compared to the rest of Suffolk County (see Figure 12 below).

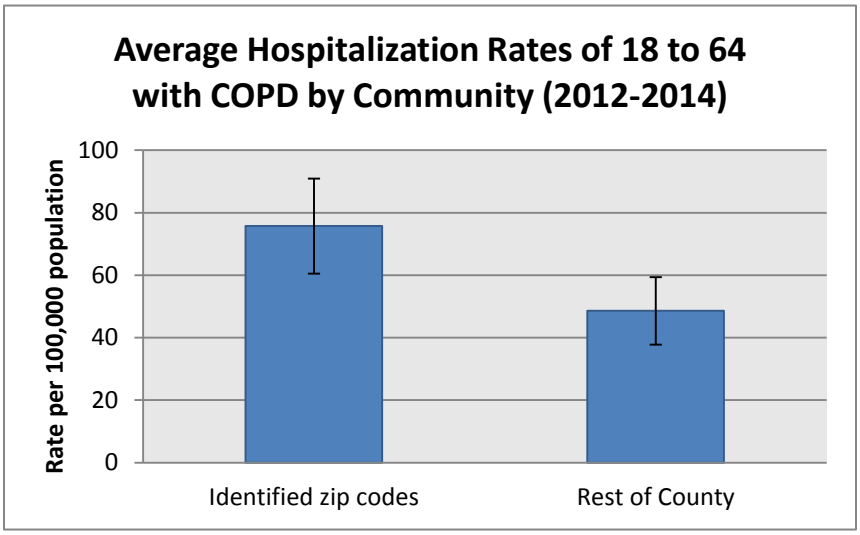


Figure 12. Average COPD Hospitalization Rates 18-64 by Community (2012-2014)

Based on these findings, the Long Island Health Collaborative felt interventions should be focused on decreasing chronic disease as a whole, while focusing on obesity, prevention and care management. Additionally, the decision was made to add an overlay of Mental Health/Substance Abuse to address the related findings. Suffolk County also chose to include the continuation of its tobacco cessation program to the Community Health

Improvement Plan, since tobacco use continues and has the potential to increase with the popularity of vaping and e-cigarettes.

Long Island Community Health Assessment Survey

To collect input from community members, and measure the community-perspective as to the biggest health issues in Suffolk County, the LIHC developed a regional survey called the Long Island Community Health Assessment Survey. This survey was distributed via survey monkey and hard copy formats. The survey was written with adherence to Culturally and Linguistically Appropriate Standards (CLAS). It was translated into certified Spanish language and large print copies were available to those living with vision impairment. Survey distribution began among LIHC members in January 2016, with over 3,910 surveys collected from Suffolk County residents. Based upon the total population of Suffolk County, survey totals assume a confidence level of 95% and confidence interval of 1.57. Initial analysis took place in March 2016, a secondary analysis took place in June 2016, and a third analysis took place in November 2016. LIHC members have played an integral role in ensuring surveys are distributed while maintaining validity and reliability among responses. To view a copy of the Long Island Community Health Assessment Survey, see Appendix.

Methodology:

Long Island Community Health Assessment Surveys were distributed both by paper, and electronically through Survey Monkey, to community members. The electronic version

is directed by software that places rules on particular questions; for questions 1-5 an individual could select 3 choices and each question was mandatory. Although the rules were written on the paper survey people did not consistently follow them. The paper surveys were sorted into two piles: "rules" and "no rules." The surveys declared "rules" were entered into the Survey Monkey collector while those "no rules" were entered into a separate, non-public survey where any number of answers could be selected and others could be skipped.

On March 21st 2016, June 2nd 2016, and November 1st 2016, the PHIP data analyst downloaded results from each of the Survey Monkey collectors. The "no-rules" surveys were weighted to ensure survey response validity for those with more than three responses. The weight for each response was 3/x where x is the count of responses. No weight was applied to responses with less than 3 because they had the option to select more and chose not to do so. With the weight determined, the formula was applied to the "no rules" data and then added the remaining collectors to the spreadsheet.

Data Findings by Survey Question:

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

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

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

3. The next question sought to ***identify potential barriers that people face when getting medical treatment***:
    - Suffolk County respondents felt that No Insurance, Inability to pay co-pays or deductibles, and Fear were the most significant barriers.
    - These choices received roughly 55% of the total responses.
4. When asked ***what was most needed to improve the health of your community:***
    - Suffolk County respondents felt that Drug and Alcohol Rehabilitation Services, Healthier Food Choices, and Job Opportunities were most needed.
    - These choices accounted for 40% of the total responses.
5. When asked ***what health screenings or education services are needed in your community***:
    - Suffolk County respondents felt that Drug and Alcohol, Mental Health/Depression, and Exercise/Physical Activity services were most needed.

CBO Summit Event Qualitative Data Analysis and Interpretation

To capture input from professional representatives working directly within the community setting, LIHC members planned two summit events for representatives from Community-Based Organizations. An advisory committee was established to provide oversight and strategic planning of these events. Advisory committee members included leaders in health from stakeholder organizations, primarily Long Island Health Collaborative (LIHC) members, who hold a vested interest in the outcome of community improvement strategies and identification of primary areas of need. Of this committee, two members participated as key leaders, holding extensive backgrounds in qualitative research and facilitation. These key leaders presented an interactive, hands-on curriculum and training for LIHC members who volunteered to take the role of facilitators during the events.

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

Data Collection Tool

A script for facilitators to facilitate discussion was developed and used as the primary data collection tool. Questions were composed thoughtfully as to evoke an inherent response at first and then expanded upon to encourage digging deeper to obtain a more focused response. Questions pertain to health problems and concerns, health disparities, barriers to care, services available and opportunities for improvement.

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

Data Analysis

ATLAS TI Qualitative Data Analysis software was used to guide and structure analysis process. Members of the Qualitative Analysis team discussed strategy and logistics of project from beginning to completion of report. The analysis team's diversity boasts a wide range of analytic skills. The Principal Research Analyst at Data Gen Incorporated served as the lead analyst on this project, during which time she offered expertise on strategy, direction, running qualitative data through Atlas TI software, producing meaningful synthesis of data elements and assisting in the description of the team's methodology. The Atlas TI word-cruncher feature was used within Atlas TI to identify town names (for example, "Wyandanch") spoken in vivo in order to assign the appropriate county flags. If a bi-county organization (Nassau and Suffolk counties) specifically spoke about an issue within one of these communities, the quote was coded with the county in

which that community lies. If the name of the town was being used as a figure of speech without a specific comment or anecdote about the community, the flags were not applied.

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

Summary of Findings

The *Distinct* and *Cumulative* Prevention Areas by ranking tables, displayed below, outline the New York State Prevention Agenda Priority Areas ranked in order from highest to lowest rate of marked significance of concern among participants. As shown in table 2, summit participants reported Chronic Disease as the most significant health problem seen within the communities they serve in Suffolk County. In looking at distinct Prevention Agenda Categories, 30.9% of quotations indicated Chronic Disease being a priority area. Distinct Prevention Areas by Ranking reflects the number of quotations where the focus area is mentioned at least once and counted once, divided by the total number of Suffolk County quotes. For example, "*Chronic Disease is a problem for the community I serve. Many of our members are troubled with obesity and tobacco use.*" This quote is coded once for Chronic Disease.

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

Table 2 * Distinct number of quotations with Suffolk County code and priority area code/total number of quotes applicable to Suffolk County

Within the Priority Area of Chronic Disease, Chronic Disease Management and Obesity/Nutrition were the most frequently prioritized focal areas, as shown in Table 3. Of the total number of quotes by County, 10.2% of quotations applicable to Suffolk County included "Chronic Disease Management" and "Obesity/Nutrition" equally, as topics of importance.

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

Table 3 * Number of quotations with Suffolk county code and focus area code/total number of quotes applicable to Suffolk County

Table 4 below presents the analytic interpretation of the comments made related to chronic disease. The "analytic interpretation" is a synthesis statement of various comments made by participants on a particular concept. Following the analytic interpretations are some examples of quotations made by participants.

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

another language, and how do you help that person that speaks another language and, like you said, may not be able to even read or write in their own language, so I think a lot of it is just having staff that's educated and more well-rounded to provide those type of service to people that need that direction. *-Long Island Cares*
Many cases of COPD and lung cancer are not diagnosed until the condition has progressed into its later stages. Awareness and education surrounding the importance of screenings, for any chronic condition, leads to early diagnosis and thus more effective treatment. Challenges that we see are people who have been smokers for many years. COPD in particular, probably half the cases that are out there, have not been diagnosed yet. People just feel that oh im a little older, Im a little short of breath, until acute exacerbation and they end up in the hospital with pneumonia and then they are diagnosed. Very similarly, lung cancer, there are no early warning signs for lung cancer. Because women just don't think about it. So we are trying to get them to understand that if you are at risk, get screened. Early screening is very important. We know that lung cancer has huge fatality rates; it's the number one cancer killer in the US for both men and women. Because there is no early warning signs and no screening. So we are really starting to build the push on educating the community about early warning signs, getting screenings for both. *-American Lung Association*

Table 4. Analytic interpretation and participant quotations related to chronic disease.

The Priority Area of Mental Health and Substance Abuse emerged closely as a second-ranking topic of importance. Qualitative analysis demonstrated, 29.9% of quotations indicating Mental Health as an area of concern in Suffolk County.

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

Mental Health and Substance Abuse	
Focus Area	**%***
Mental Health Issues	18.1%
Substance Abuse	11.3%
Susceptible Populations	7.4%
Attitudes	4.1%

Anxiety, Mood Disorders, and Associated Emotions	2.9%
Treatment and Recovery	2.7%
Eating Disorders	0.9%
Suicide	0.4%

Table 5 * Number of quotations with Suffolk county code and focus area code/total number of quotes applicable to Suffolk County

Below is a table of the analytic interpretation of the comments made related to mental health and substance abuse. The "analytic interpretation" is a synthesis statement of various comments made by participants on a particular concept. Following the analytic interpretations are examples of quotations made by participants.

Analytic Interpretation & Participant Quotations
Availability of mental health and substance abuse treatment and recovery services is not adequate considering the high demand for service. Prevention and strategies focused on maintaining follow-up care for mental health are equally important. . . . The major issue is the long waiting list and by the time that their appointment comes up they're no longer with us and they fall through the cracks. We don't know where they're going. We don't know if someone is going to follow up so that's part of, you know that lack of prevention as well. It's a long waiting list just to get psych evaluations. *- Community Housing Innovations*
Mental health problems for seniors are often undiagnosed which leads to an inability to provide effective treatments or therapies. When you first mentioned the question about the major health problems, I work in independent housing for seniors, and there are a lot of undiagnosed mental health issues. So they have the mental health, but it's never been diagnosed, and getting the services and the treatment and even medications for that generation becomes very hard. *- Catholic Charities Housing Department*
Substance abuse is a notable problem throughout the Long Island Region. Substance abuse is often recognized within diverse populations including young adults, seniors and Veterans. Talking about specific health concerns, so one of the things we're really looking at the specific health concerns. I think the number on Long Island is over 300 young people are dying a year from heroin overdose. So that's the equivalent of a jumbo jet liner crashing and everybody dying, once a year on Long Island. So if that were to happen, we would be outraged. There would be more of a policy outrage, of why is this happening? So my boss is actually a priest, and he buries a lot of these

young people who die every year, so that's really a major push for us. It's criminal. We're not talking about the traditional, you smoke pot, and you move onto a higher drug, a different drug, we're talking prescription medication to heroin overdose to death, within a couple of years. So that's one of the main focuses we're working on. *-Hope House* One of the things, it's a hidden secret is the substance abuse among seniors, you know due to the isolation, but also too there's a lot of seniors that are sitting at home drinking all day and so it is not just a young person or, you know, a middle adult issue, it's a very big issue for seniors. *- At Home Designs*
The relationship between chronic disease and mental health presents care providers with complex challenges related to the interplay between conditions and medication regimen. Mental issues and substance abuse issues, but what comes with that sometimes is obesity, diabetes, high blood pressure. Often times it's the medications that are prescribed Proceedings and that people take actually can cause diabetes and cause people to increase their appetite, and that's the domino effect. Those are many of the health issues. Obviously, for the older population, chronic heart disease, COPD. *-Association for Mental Health and Wellness*

Table 6. Analytic interpretation and participant quotations related to mental health and substance abuse.

For the 2016-2018 cycle, community partners selected ***Chronic Disease*** as the Priority Area with a focus on (1) Reduce Obesity in Children and Adults and (2) Increase Access to High-quality Chronic Disease Preventive Care and Management in Clinical and Community Settings. The group also agreed that ***Mental Health*** (Promoting Mental, Emotional and Behavioral Well-Being in Communities and Preventing Substance Abuse) should be highlighted areas of overlay within all intervention strategies. This area, mental health, is being addressed through attestation and visible commitment to the Delivery System Reform Incentive Program (DSRIP), Performing Provider System (PPS) Domain 4 projects (4.a.i, 4.a.ii, 4.a.iii). Priorities selected in 2013 remain unchanged from the 2016 selection; however, a stronger emphasis has been placed on the need to integrate Mental Health throughout Intervention Strategies. Mental health has been highlighted as a focus

area of growing need, which will be addressed by the Suffolk Care Collaborative (PPS) as they work on Domain 4 projects. Domain 4 projects with a focus on mental health include:

- Project 4.a.i Promote mental, emotional and behavioral (MED) well-being in communities
- Project 4.a.ii Prevent substance abuse and other mental emotional disorders
- Project 4.a.iii Strengthen mental health and substance abuse infrastructure across systems
- Project 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health

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

Additional mental health activities will be undertaken by the Suffolk County Department of Health Services to further address this identified area of need. Finally, the Department will continue to incorporate tobacco use cessation into its activities to reduce chronic disease.

COMMUNITY HEALTH IMPROVEMENT PLAN

Goal	**Action #1. Prevent Chronic Diseases. Reduce Obesity in Children and Adults: Long Island Health Collaborative to engage community members in regional physical activity and wellness campaigns.**
Outcome Objectives	1 Increase community and partner engagement through social media tactics. 2. Promote the Are you Ready, Feet?™ Campaign within community networks and increase participation in this region-wide physical activity campaign. 3. Launch a consumer-facing website, adherent to CLAS standards and achieve meaningful web analytics. 4. Launch a volunteer working group of student volunteers who will leverage social media expertise and existing personal networks to further engage community members. 5. Host at least two public, consumer-focused walking events annually. 6. Reach and implement the recommendation for walking program within the primary care setting and engage participating physicians. 7. Align objectives with organizations currently engaged in Complete Street work to increase sustainable built environments. 8. Provide central location for grant partners to collaborate and streamline grant activities that support healthy eating and physical activity.
Interventions/ Strategies/ Activities	1. Identify and participate in effective social media strategies and promote the LIHC to consumers. 2. Develop and distribute promotional tools; engage participants via social media strategies. 3. Identify evidence-based resources for health information that adhere to CLAS standards, collect input from LIHC members and clinical experts and build website. 4. Establish LIHC Engagement Activation Partnership (LEAP). Promote this opportunity among networks, identify role and responsibility, and support LEAP team as they carry out goals and objectives. 5. Involve key leaders including State and County officials, identify dates, locations and promote events. 6. Coordinate mailing to Long Island providers, work with Suffolk County Medical Society to build program reputation, distribute mock-prescription pads to members for distribution to establish physician recommendations for a walking program for patients. 7. Support and participate in Complete Streets Policy work. 8. Engagement of two synergistic grants in region: Eat Smart NY (USDA) and Creating Health Schools and Communities (NYSDOH).
Process	1. The Plan-Do-Study-Act (PDSA) framework will be used to evaluate the need for change within intervention

measures	strategies. 2. Measures will include monitoring of social media and website metrics; monitoring of "Are You Ready Feet" Portal usage; attendance at community partner meetings, including LEAP team meetings and LIHC and LIHC subcommittee meetings; number of walking events and participation numbers for these events; quantity of prescription pads distributed.
Partner Role	1. Promote social media, website, and "Are You Ready Feet" campaign; work to promote membership in LEAP program; support, plan, promote, and participate in the walking events; encourage providers to utilize prescriptions for exercise in patient care practice. 2. LIHC to work with SCDHS and organizations engaged in Complete Streets work to identify opportunities for partnership or support. 3. PHIP to participate in grant-partner meetings to share initiatives which can be used to meet grant deliverables and identify community partners who may be working in at risk communities on similar projects.
Partner Resources	Long Island Health Collaborative Membership.
By When	Activities will continue on an ongoing basis in 2016 through 2018. Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.
Will Action Address Disparity?	Yes. Prevention strategies are reviewed by a National Standards for Culturally and Linguistically Appropriate Services (CLAS) workgroup to ensure they are CLAS appropriate and meet health literacy skills. LIHC partners work within communities that have been identified as being at high risk for health disparities. The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.

Goal	**Action #2. Prevent Chronic Diseases. Reduce Obesity in Children and Adults: To provide education to new mothers through the Suffolk County Department of Health Services Certified Home Health Agency.**
Outcome Objectives	Within the Suffolk County Department of Health Services (SCDHS) Bureau of Public Health Nursing (Certified Home Health Agency) staff will work with new mothers to improve their understanding of breastfeeding and to increase awareness of obesity as a chronic disease.

Interventions/ Strategies/ Activities	While providing home care visits, public health nurses shall educate new mothers on breastfeeding and obesity and its risks for chronic disease. Education provided will be in accordance with established guidelines. Educational resources shall be provided, including but not limited to community resources.
Process measures	Number of nurses who utilize the training (that was provided in September 2016) with their patients, and patient acceptance of referrals to outside programs. Breastfeeding length of time, number exclusively breastfed vs. mixed vs. totally bottle fed.
Partner Role	Referrals to be made to and educational materials obtained from: Local Hospitals, WIC, la leche league, Breast Feeding Coalition, NYS Breastfeeding Quality Improvement in Hospitals, Cornell Cooperative Extension Nutrition & Diabetes Program. Staff training on obesity management in primary care provided by SCDHS in collaboration with DVAMC Northport.
Partner Resources	Referrals to SCHDS CHHA; in-services; referral to lactation specialist in local community health centers; on-line information; referral to nutrition/diabetes classes located in local health centers & community venues.
By When	Services to be on going and process measures to start 2017.
Will Action Address Disparity?	Yes. Population served includes uninsured and is provided in communities identified as being at high risk for health disparities.

Goal	**Action #3. Prevent Chronic Diseases. Reduce Obesity in Children and Adults: To prevent or delay diabetes in those identified with pre-diabetes.**
Outcome Objectives	Suffolk County Office of Health Education will offer at least three (3) Diabetes Prevention Programs each year to those at risk.
Interventions/ Strategies/ Activities	Diabetes Prevention Program will be scheduled at convenient locations throughout the county including hospitals. One health educator who is trained as a Master Trainer will train additional Lifestyle Coaches and be able to expand the program.
Process measures	Number of year-long classes held. Number of participants who reach weight loss and physical activity goals.
Partner Role	Local hospitals will host the year-long programs, including providing space for classes and advertising the program to their catchment areas to increase attendance.
Partner Resources	Space in the hospitals. News-letters and direct mailing to physicians and patients. SCDHS Staff.
By When	Classes will be ongoing.

Will Action Address Disparity?	Yes. Many of those at risk for diabetes or currently have prediabetes are at risk for health disparities.

Goal	**Action #4. Prevent Chronic Diseases. Reduce Obesity in Children and Adults: By increasing access to healthy food in communities at risk for health disparities.**
Outcome Objectives	Continue implementation of a Food Desert Program.
Interventions/ Strategies/ Activities	Identify Bodegas in socioeconomically distressed area with no local supermarket with greatest chance to success in increasing produce sales and consumption. Work with bodega owner to improve visibility of produce.
Process measures	Number of bodegas where intervention completed. Photographic evidence of improved visibility of produce in the bodega.
Partner Role	Bodega operators to make changes to improve availability and visibility of produce. To perform planning and assessment of project and its success.
Partner Resources	SCDHS Office of Minority Health, Island Harvest, Sustain-able LI, Suffolk County Department of Social Services, and Suffolk County Food Policy Council.
By When	Ongoing.
Will Action Address Disparity?	Yes, project is being performed in socio-economically distressed areas within the county where there is a high risk for disparities.

Goal	**Action #5. Prevent Chronic Disease: Promote Tobacco Use Cessation.**
Outcome Objectives	To decrease the prevalence of tobacco use in Suffolk County residents.

Interventions/ Strategies/ Activities	To continue to provide smoking cessation classes "Learn to Be Tobacco Free" to residents of Suffolk County.
Process measures	Maintain statistics on the number of people participating in classes and their quit rates.
Partner Role	To provide space for classes as well as private space for the NP to meet with patients. Partners also advertise the program within their catchment areas.
Partner Resources	Suffolk County Department of Health Services Tobacco Cessation staff and Hospitals, Libraries, Town facilities, and HRHCare Federally Qualified Health Centers (FQHC).
By When	Program already implemented, to continue, ongoing.
Will Action Address Disparity?	Yes. The incidence of tobacco related cancers and death rates are higher in African Americans.

Goal	**Action #6. Chronic Disease – Increase Access to High Quality Chronic Disease Preventive Care and Management: Support and Increase Evidence-Based Community-Programming Efforts.**
Outcome Objectives	1. Promote and advance evidence-based community programs 2. Support Delivery System Reform Incentive Payment Program (DSRIP) efforts to increase programming throughout the region.
Interventions/ Strategies/ Activities	1. Connect members with providers of Stanford Model programs including: Diabetes-Self Management Program and Chronic Disease Self-Management program. 2. Partner with DSRIP PPS to increase program availability. To identify community locations where Stanford Model programs will take place.
Process measures	Feedback from DSRIP and providers of Stanford Model Programs on increases in utilization based on initiatives undertaken by Long Island Health Collaborative.
Partner Role	To work to increase access to chronic disease preventive care management among Suffolk County residents.
Partner Resources	Long Island Health Collaborative Membership, DSRIP PPS, providers of Stanford Model Programs.
By When	Activities will continue on an ongoing basis in 2016 through 2018. Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.

Will Action Address Disparity?	Prevention strategies are reviewed by a National Standards for Culturally and Linguistically Appropriate Services (CLAS) workgroup to ensure they are CLAS appropriate and meet health literacy skills. LIHC partners work within communities that have been identified as being at high risk for health disparities. The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.

Goal	**Action #7. Chronic Disease – Increase Access to High Quality Chronic Disease Preventive Care and Management.**
Outcome Objectives	To ensure access to a Patient Centered Medical Home for the medically underserved within Suffolk County.
Interventions/ Strategies/ Activities	1. Provide Community Benefit Grant to support HRHCare Federally Qualified Health Centers (FQHC). 2. Partner with HRHCare for the provision of Sexually Transmitted Disease (STD) and Tuberculosis (TB) services.
Process measures	1. Continued provision of FQHC services within Suffolk County. 2. Monitoring of STD and TB service statistics.
Partner Role	To provide a Patient Centered Medical Home in multiple community based facilities throughout Suffolk County and to provide contracted STD and TB services on behalf of Suffolk County Department of Health Services.
Partner Resources	Suffolk County, HRHCare.
By When	Ongoing 2016 and beyond.
Will Action Address Disparity?	Yes. HRHCare has a longstanding history of being a provider of high quality, affordable, culturally sensitive, and linguistically appropriate care to predominantly low-income and underinsured or uninsured populations. HRHCare's health centers are located in many of Suffolk's "Identified Zip Codes" that have under and uninsured individuals.

Goal	**Action #8. Promote Mental Health and Prevention of Substance Abuse: To identify new mothers at risk for substance abuse and mental health problems & refer them for treatment.**
Outcome Objectives	Within the Suffolk County Department of Health Services (SCDHS) Bureau of Public Health Nursing (Certified Home Health Agency) staff will identify and refer at risk new mothers with substance abuse and/or mental health issues, as well as to educate and counsel them on recognizing and reporting signs and symptoms to promote well-being.

Interventions/ Strategies/ Activities	Provision of training of Bureau of Public Health Nurses on evidence based screenings for substance abuse and depression. These nurses will work with a population of high risk mothers from hospital referrals or at risk mothers identified through the child find program. Staff will use skilled nursing visits to administer evidence based tools such as the Patient Health Questionnaire 2 (PHQ2) and Extended Patient Health Questionnaire 9 (PHQ9), Post Natal Depression Scale (Edinburgh) & the Screening Brief Intervention & Referral to Treatment (SBIRT) and based on the results, referrals for treatment will be made.
Process measures	Identify and measure how many mothers who have mental and/or substance abuse issues. How many of these were referred for indicated services.
Partner Role	Direct Referrals to and from The Suffolk County Department of Health Services (SCDHS) Bureau of Public Health Nursing (Certified Home Health Agency) program.
Partner Resources	Hospitals Engaged in Child Find Program; Bureau of Public Health Nursing Coordinators at South Side Hospital and Stony Brook University Hospital; Early Intervention (SCDHS Division of Services for Children with Special Needs); Association for Mental Health and Wellness Directory of Mental Health Services in Suffolk County (www.mhaw.org); Suffolk Care Collaborative (DSRIP).
By When	Services to be ongoing, and process measures to start in 2017. SBIRT Training began in 2015 and is ongoing.
Will Action Address Disparity?	Yes. Previously identified high risk mothers due to increased social needs.

Goal	**Action #9. Promote Mental Health and Prevention of Substance Abuse: Strengthen Infrastructure Across Systems: Reduce Substance Abuse.**
Outcome Objectives	Foster collaboration among agencies, both OASAS Funded and non- OASAS-funded, that offer substance abuse prevention services. To optimize existing resources by reducing redundancy of same services, improving proficiencies in sharing resources and training capabilities. To share resources, creating “expert” providers.
Interventions/ Strategies/ Activities	To host one networking event that allows for information sharing and cooperation among agencies that provide a variety of prevention services.

Process measures	Data on attendance and resultant efforts to optimize resources (e.g. illustrations of benefits of shared talent pool and resources).
Partner Role	All prevention agencies to participate in event and share/distribute relevant information about services.
Partner Resources	Funded and non- OASAS-funded substance abuse prevention programs.
By When	Planning in 2017 with goal of workshop in late 2017 or early 2018.
Will Action Address Disparity?	No.

Goal	**Action #10. Promote Mental Health and Prevention of Substance Abuse: Strengthen Infrastructure Across Systems: Prevent Suicide.**
Outcome Objectives	To promote awareness and interventions related to suicide among youth for individuals, schools, and communities.
Interventions/ Strategies/ Activities	Collaborate with other professional organizations to offer a suicide prevention workshop/ conference.
Process measures	Data on attendance in workshop/conference.
Partner Role	Certified trainers to provide relevant training, presentations and awareness events for the workshop.
Partner Resources	Local and/or State funded and non-funded prevention programs, school systems, coalitions, law enforcement, legislative body.
By When	Planning in 2017 with goal of workshop in late 2018.
Will Action Address Disparity?	No.

Goal	**Action #11. Promote Mental Health and Prevention of Substance Abuse: Prevent Unhealthy High Risk Behaviors.**
Outcome Objectives	To promote participation in the Evidence-Based Mental Health First Aid USA ™ training program.

Interventions/ Strategies/ Activities	Participate in Long Island Health Collaborative that established a workgroup to identify strategies to address mental health issues and increase availability of the Mental Health First Aid Training and circulate information related to providers of this program and available training opportunities.
Process measures	Collect data on attendance and participation/offerings.
Partner Role	Promote program to community partners and identify where/which organizations are certified to lead training.
Partner Resources	OASAS Funded and Non-OASAS-funded prevention programs, school systems, coalitions, law enforcement, and legislative body.
By When	Project to be ongoing starting in 2017.
Will Action Address Disparity?	No.

Goal	**Action #12. Promote Mental Health and Prevention of Substance Abuse: To prevent bullying, reduce aggression and improve healthy communication in school age children.**
Outcome Objectives	To train students at two high schools each year to become peer educators. The peer educators will then present information and conduct activities to help younger students become upstanders (people who recognize when something is wrong and act to make it right).
Interventions/ Strategies/ Activities	School district representatives with an interest in the program will coordinate with health education staff to select students to be trained and staff to co- facilitate 6-12 training sessions.
Process measures	Number of students trained in the school district. Number of students who participate in the classroom peer-to-peer lessons.
Partner Role	Recruiting students, recruiting faculty/staff to work with trainer, securing space for trainings, coordinating classroom presentations by peer leaders.
Partner Resources	Space, scheduling, co-facilitators, transportation for peer leaders to other schools.
By When	Project to be on-going. Each school year, at least two (2) new schools will participate.

Will Action Address Disparity?	Yes. Many schools districts on Long Island are diverse. Peer leaders are chosen to represent groups within the school including, ethnic minorities and the LGBT population.

Goal	**Action #13. Promote Mental Health and Prevention of Substance Abuse: Strengthen Infrastructure Across Systems: Increase access to treatment and support services for those struggling with substance abuse through a 24/7 hotline.**
Outcome Objectives	To improve access to care for those struggling with substance abuse. Support services are also available for family and friends of those with struggling with addiction.
Interventions/ Strategies/ Activities	Support and oversight of a 24/7 substance abuse hotline to link callers to appropriate treatment. All callers are screened by a certified medical professional. Thirty (30), 60 and 90 day follow-up calls are conducted to encourage engagement in treatment.
Process measures	Monthly Reports that include number of daily calls; number of follow-up calls (30/60/90 day from initial call); number confirmed in treatment; number confirmed in support services.
Partner Role	Long Island Council on Alcohol and Drug Dependence (LICADD) will operate the hotline and Communities of Solution (COS), a network of local, community based treatment providers, are assisting with streamlining referrals and access to treatment and support services.
Partner Resources	LICADD staff operates the hotline and provides some support services. COS works closely with LICADD to streamline and improve access to treatment and support services.
By When	Planning in 2016 with implementation in April 2016 and continue through 2018.
Will Action Address Disparity?	No.

Goal	**Action #14. Promote Mental Health and Prevention of Substance Abuse: Continue to regularly offer free Naloxone training to increase education and availability of Naloxone.**
Outcome Objectives	To increase the number of people in the community able to administer Naloxone in a timely manner in order to reduce the number of opioid related overdose deaths.

Interventions/ Strategies/ Activities	Continue to provide free trainings on overdose recognition, naloxone administration and dispensing overdose response kits.
Process measures	Maintain statistics on the number of trainings provided and the number of individuals trained.
Partner Role	To provide venues for provision of training, to encourage people to become trained, and to increase SCDHS' ability to reach at risk population through force multiplication.
Partner Resources	Suffolk County Hospitals' Screening, Brief Intervention and Referral to Treatment (SBIRT) Teams, New York State Department of Health Substance Abuse Resources, 24/7 Long Island Council on Alcohol and Drug Dependence (LICADD) Community Substance Abuse Hotline.
By When	Ongoing, continuing since program was implemented in 2013.
Will Action Address Disparity?	No.

Plans for Sustaining Partnerships and Tracking Progress

Long Island Health Collaborative Partnerships and Sustainability

The Long Island Health Collaborative (LIHC) first convened in 2013, with membership and partner-engagement gaining exponentially over time. With funding awarded through the New York State Department of Health, the Long Island Health Collaborative has made enhanced strides in only a few short months. LIHC partners have demonstrated their commitment to maintaining engagement with community-partners by advocating on behalf of the LIHC, promoting LIHC initiatives and bringing counterpart organizations to the table during monthly meetings.

As strategies are implemented, progress will be measured on an ongoing basis. Baseline data from the Long Island Community Member Survey will allow for strategic decision making based upon the effectiveness of strategies and improvements in outcomes. Strategic direction and project oversight is guided by the PHIP Steering Committee members, who are presented with outcome data on a quarterly basis. Mid-course modifications will be identified and implemented in response to data evaluation strategies.

Dissemination and Transparency

Health Communication Strategies and Transparency are two key roles of the Population Health Improvement program. The Long Island Health Collaborative website is designed to engage consumers and provide transparency in population health initiatives and data analysis efforts. Working documents developed by the LIHC are

available to the public as they are posted on the LIHC website. The Suffolk County Executive Summary will be publically available through the consumer facing portion of the Long Island Health Collaborative website at: http://www.lihealthcollab.org. Copies of the executive summary will also be printed and distributed at any community forum events.

Suffolk County Department of Health Services Partnerships and Sustainability

The Divisions of the SCDHS maintain additional ongoing collaborations with community based organizations beyond those of the LIHC. Program areas will work with these agencies to accomplish the goals in each action area. Continued participation in the LIHC will provide easy access to increase collaboration as needed. In addition, Divisions such as the Community Mental Hygiene Division have State agency contacts that assist in the support and maintenance of programming within the Department.

The process measures outlined in each action description will be used to determine effectiveness of the effort and modifications in the plans will be made, depending on the results. SCDHS staff has been provided with Performance Improvement training in 2016, through an initiative of the Suffolk County Executive and these principals will be used as part of the action assessments.

Dissemination and Transparency

SCDHS provides information on programming to the community through its Divisions, its Public Information Officer, the LIHC, and other public venues. The Department maintains social media communications via Website, Twitter, and Facebook.

Additionally, press releases, email notifications, and other communications methods will be used, appropriate to the actions in the Community Health Improvement Plan. The SCDHS Community Health Assessment & Improvement Plan for 2016-2018 will be posted on the Department's website.

Internal reporting on progress of the action plan within SCDHS through various staff meetings will provide an opportunity to share ideas for improvement, request additional internal support, and assist with "getting the word out" on availability of programming to the public.

APPENDICES

LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY

Your opinion is important to us!

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

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

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

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

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

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

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

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

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

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

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

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

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

For statistical purposes only, please complete the following:

I identify as: ☐ Male ☐ Female ☐ Other

What is your age? _____

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

What race do you consider yourself?

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

Are you Hispanic or Latino? ☐ Yes ☐ No

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

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

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

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

What is your highest level of education?

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

What is your current employment status?

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

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

Do you have a smart phone? ☐ Yes ☐ No

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

Script for Community-Based Organization Summit Event Facilitators

Introductions

1. Introduce yourself to the group
2. As you notice, we have a court reporter with us today. This is (Name of Transcriber)

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

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

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

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

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

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

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

Let's get started:

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

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

a. Of the focus areas listed, which are important to the people/communities you serve?

First participant to speak identifies one priority area (eg. Mental Health/Substance Abuse). The facilitator should remain on this priority area until everyone has provided feedback (if applicable). Ask if anyone else can identify areas of need within this priority area. Then move on to the next priority area.

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

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

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

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

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

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

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

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

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

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

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

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

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

LONG ISLAND Health COLLABORATIVE

connecting you to better health

The Long Island Health Collaborative (LIHC) . . . your local hospitals, county health departments, health and welfare organizations, and colleges working together to improve the health of all Long Islanders.

LIHC Member List

Hospitals, Hospital Association and Hospital Systems	***Website***
Brookhaven Memorial Hospital Medical Center	**www.brookhavenhospital.org**
Catholic Health Services of Long Island	**www.chsli.org**
Eastern Long Island Hospital	**www.elih.org**
Glen Cove Hospital	**www.northwell.edu**
Good Samaritan Hospital Medical Center	**www.goodsamaritan.chsli.org**
Huntington Hospital	**www.northwell.edu**
Long Island Jewish Valley Stream	**www.northwell.edu**
John T. Mather Memorial Hospital	**www.matherhospital.org**
Mercy Medical Center	**www.mercymedicalcenter.org**
Nassau-Suffolk Hospital Council	**www.nshc.org**
Nassau University Medical Center	**www.numc.edu**
North Shore University Hospital	**www.northwell.edu**
Northwell Health System	**www.northwell.edu**
Peconic Bay Medical Center	**www.pbmchealth.org**
Plainview Hospital	**www.northwell.edu**
St. Catherine of Siena Medical Center	**www.stcatherines.chsli.org**
St. Charles Hospital	**www.stcharles.chsli.org**
St. Francis Hospital	**www.stfrancis.chsli.org**

St. Joseph Hospital	www.stjoseph.chsli.org
Southampton Hospital	http://www.southamptonhospital.org/
South Nassau Communities Hospital	www.southnassau.org
South Oaks Hospital	www.south-oaks.org
Southside Hospital	www.northwell.edu
Stony Brook University Hospital	www.stonybrookmedicine.edu
Syosset Hospital	www.northwell.edu
Veterans Affairs Medical Center	www.northport.va.gov
Winthrop University Hospital	www.winthrop.org

Local County Health Departments	***Website***
Nassau County Department of Health	www.nassaucountyny.gov
Suffolk County Department of Health Services	www.suffolkcountyny.gov

Medical Societies and Associations	***Website***
Long Island Dietetic Association	www.eatrightli.org
Nassau County Medical Society	www.nassaucountymedicalsociety.org
New York State Nurses Association	www.nysna.org
New York State Podiatric Medical Association	www.nyspma.org
Suffolk County Medical Society	www.scms-sam.org

Community-Based Organizations	***Website***
Adelphi New York Statewide Breast Cancer Hotline and Support Program	www.breast-cancer.adelphi.edu
Alzheimer's Association, Long Island Chapter	www.alz.org
American Cancer Society	www.cancer.org
American Foundation for Suicide Prevention	www.afsp.org
American Heart Association	www.heart.org
American Lung Association of the Northeast	www.lung.org
Association for Mental Health and Wellness	www.mentalhealthandwellness.org
Asthma Coalition of Long Island	www.asthmacommunitynetwork.org
Attentive Care Services	www.attentivecareservices.com
Caring People	www.caringpeopleinc.com

Community Growth Center	www.communitygrowthcenter.org
Cornell Cooperative Extension - Suffolk County	www.ccesuffolk.org
Epilepsy Foundation of Long Island	www.efli.org
Evolve Wellness	www.evolvewellness.net
Family & Children's Association	www.familyandchildrens.org
Family First Home Companions	www.familyfirsthomecompanions.com
Federation of Organizations	www.fedoforg.org
Girls Inc. LI	www.girlsincli.org
Health and Welfare Council of Long Island	www.hwcli.com
Health Education Project / 1199 SEIU	www.healthcareeducationproject.org
Hispanic Counseling Center	www.hispaniccounseling.org
Hudson River Healthcare	www.hrhcare.org
Life Trusts	www.lifetrusts.org
Long Island Association	www.longislandassociation.org
Long Island Association of AIDS Care	www.liaac.org
Long Island Council of Churches	www.liccny.org
Make the Road NY	www.maketheroad.org
Maurer Foundation	www.maurerfoundation.org
Mental Health Association of Nassau County	www.mhanc.org
Music and Memory	www.musicandmemory.org
New York City Poison Control	www.nyc.gov
Options for Community Living	www.optionscl.org
Pederson-Krag Center	www.pederson-krag.org
People Care Inc.	www.peoplecare.com
Pulse of NY	www.pulseofny.org
Retired Senior Volunteer Program	www.rsvpsuffolk.org
RotaCare	www.rotacareny.org
SDC Nutrition PC	www.call4nutrition.com
Smithtown Youth Bureau	www.smithtownny.gov
Society of St. Vincent de Paul Long Island	www.svdpli.org
State Parks LI Regional Office	www.nysparks.com
Sustainable Long Island	www.sustainableli.org

The Crisis Center	www.thecrisisplanner.com
Thursday's Child	www.thursdayschildofli.org
TriCare Systems	www.tricaresystems.org
United Way of Long Island	www.unitedwayli.org
YMCA of LI	www.ymcali.org
School and Colleges	***Website***
Adelphi University	www.adelphi.edu
Farmingdale State College	www.farmingdale.edu
Hofstra University	www.hofstra.edu
Molloy College	www.molloy.edu
St. Joseph's College	www.sjcny.edu/long-island
Stony Brook University	www.stonybrook.edu
Western Suffolk BOCES Creating Healthy Schools and Communities, NYS DOH	www.wsboces.org
Performing Provider Systems (DSRIP PPS)	***Website***
Nassau Queens PPS	www.nassauqueenspps.org
Suffolk Care Collaborative	www.suffolkcare.org
Insurers	***Website***
1199SEIU/Health Education Project	www.1199seiu.org
Fidelis Care	www.fideliscare.org
North Shore-LIJ CareConnect Insurance Company	www.careconnect.com
United Healthcare	www.unitedhealthcare.com
Regional Health Information Organizations	***Website***
Healthix Inc.	www.healthix.org
New York Care Information Gateway	www.nycig.org

Businesses and Chambers	Website
Air Quality Solutions	www.iaqguy.com
Greater Westhampton Chamber of Commerce	www.westhamptonchamber.org
Honeywell Smart GRID Solutions	www.honeywellsmartgrid.com
PSEG of Long Island	www.psegliny.com
TeK Systems	www.teksystems.com
Temp Positions	www.tempositions.com
Time to Play Foundation	www.timetoplay.com

Municipal Partners	Website
New York State Association of County Health Officials	www.nysacho.org
New York State Department of Parks and Recreation	www.nyparks.com
Suffolk County Legislature	www.legis.suffolkcountyny.gov

Acknowledgements:

Special thanks are due to the contributing staff of the Suffolk County Department of Health Services, the Nassau-Suffolk Hospital Council (NSHC), including Janine Logan, Director of Communications at NSHC, Sarah Ravenhall, Michael Corcoran, and Kimberly Whitehead of the Population Health Improvement Program (PHIP) the Nassau County Department of Health and all of the collaborative member organizations and other partners. In addition, thanks are due to the contributions of the Preventive Medicine Residents of the State University of New York at Stony Brook, Dr. Donald McLaren, Dr. Kimberly Noel, Dr. Edward Kalpas, and Dr. Yuri Jadotte.