Suffolk County

Community Health Needs Assessment and Improvement Plan 2016-2018

Suffolk County Department of Health Services

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Catholic Health Services of Long Island

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

Northwell Health System

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

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

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

Executive Summary

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

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

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

York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics.

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

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

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

posted links on their website and distributed surveys at health fairs and other consumer-oriented events.

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

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

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

The LIPHIP short-term plan for evaluation will begin with extensive qualitative data collection and analysis. We are particularly interested in the degree to which member organizations are collaborating and direct feedback from community members and member organizations. Process measures include:

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

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

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