Long Island Population Health Improvement Program (LIPHIP)
Attendance & Meeting Summary: November 9, 2:30-4:30pm

Member Attendance: See list attached

Welcome & Introductions	Janine Logan, Nassau-Suffolk Hospital Council/Long Island Health Collaborative welcomes committee members to the September Long Island Health Collaborative Meeting.
LIHC PHIP Establishment and Role	Janine Logan, Nassau Suffolk Hospital Council provides a background on the institution of the Long Island Health Collaborative and Population Health Improvement Program. The Long Island Health Collaborative programs and initiatives belong to members. The role of the PHIP team includes convening key players, building consensus, organizing projects and supporting the needs of members as related to population health strategies.
DSRIP Performing Provider System Partnerships • **Building Bridges** • **Cultural Competency/Health Literacy TTT**	The delivery system reform incentive payment program's (DSRIP) purpose is to restructure the healthcare delivery system by reinvesting in Medicaid program. Program components are based upon achieving specific results in system transformation, clinical management and population health. The goal is to reduce avoidable hospital visits by 25% over a 5 year period. When the PHIP was established, the State asked that PHIPs serve as a resource for the Performing Provider Systems. The PPSs are the entities responsible for creating and implementing the DSRIP project. All PHIP initiatives are developed in alignment with regional DSRIP milestones with input from key stakeholders from both performing provider systems: Suffolk Care Collaborative and Nassau Queens PPS.

	In partnership with DSRIP community engagement milestones, the PHIP planned and executed two Communications, Data and Networking events named *Building Bridges with the Long Island Health Collaborative*. The target audience includes: community leaders, faith-based organizations, community-based organizations, care managers, discharge planners, ambulatory sites and provider sites who serve higher numbers of Medicaid/Self-pay patients. Building Bridges was established as a follow up event to the PHIP CBO summits which were held by the LIHC in February. During the events, participants will have the opportunity to: • network with counterpart organizations • discuss and contribute to prioritization of social determinants of health • leave with strong resources, budding partnerships and a comprehensive communication tool featuring HITE and 211 The Nassau County event took place Wednesday October 5 at Hofstra University. 55 organizations were represented. Participants self-categorized their services based on the social determinant of health. Suffolk's event took place Thursday October 20th with 61 organizations in attendance. In response to qualitative outcomes obtained from the February Summit events, a communication tool was developed for front-line staff members. This tool featured the 211 and HITE resource directory platforms. This tool will act as a reminder for those case managers, discharge planners and professionals who are confronted with questions about accessing community services. **Evaluation and Feedback** ***Nassau County (n=24)*** *What component of this event was most important to you or your organization? Please rank in*

	order from 1-most to 5-least important. 1. Networking with service providers, case managers and discharge planners 2. Learning about the resource directories United Way 211 and HITE 3. Hearing about and being invited to join the Long Island Health Collaborative 4. Sharing my unique opinion about the community/populations I serve 5. Finding out how the qualitative data collected in February (at CBO Summit Events) is being used *How do you plan to use the communications tool?* • Share with social workers • Use to identify training services for organization • Provide with staff to use with families • Will add my organization to HITE • Share with community partners • Send to Care Management Leadership • Community service department team of Medicaid service coordinators and community rehabilitation staff 12 organizations felt they would like to network more than 1x annually 7 organizations felt that they would benefit from networking 1x annually ***Suffolk County (n=34)*** *What component of this event was most important to you or your organization? Please rank in order from 1-most to 5-least important.* 1. Networking with service providers, case managers and discharge planners 2. Learning about the resource directories United Way 211 and HITE 3. Finding out how the qualitative data collected in February (at CBO Summit Events) is being used

	4. (tie) Hearing about and being invited to join the Long Island Health Collaborative 4. (tie) Sharing my unique opinion about the community/populations I serve How do you plan to use the communications tool? • Use it as a regular resource for our volunteers and clients. • To provide referrals to behavioral health treatment. • Share with social workers, discharge planners, and other community health workers • Outreach coordination. • Distribute to patients and other community organizations. • Using it as an education tool for our employees. 23 organizations felt they would like to network more than 1x annually 12 organizations felt that they would benefit from networking 1x annually Nancy Copperman, Northwell Health suggests as a next step the collaborative develops a plan for sharing this information with providers who service patients. **Cultural Competency/Health Literacy** Members of the two performing provider systems and Long Island PHIP have met throughout the year to develop a region-specific Train the Trainer curriculum and program for those professionals who work in communities in Queens and Long Island. This strategy is one arm of the full plan for enhancing CCHL skills across the workforce on Long Island. History of program: The cultural competency/health literacy vendor subgroup, comprised of LIHC members and CCHL umbrella workgroup members of Suffolk Care Collaborative have been meeting to explore locally based vendors with the expertise and capability to develop a tailored CCHL curriculum and host a training for Train the Trainer (TTT) Organizational Leads

	who will then be able to train the workforce at a limitless number of sessions throughout Long Island. This curriculum will be geared toward community based organizations, social service organizations, local health departments and beyond. After sending an RFP to five vendors, we received two competitive and high quality proposals from 1199 Training and Employment Fund and Hofstra's National Center for suburban studies/Health Equity institute. After weighing each program, the subgroup decided to move forward and offer the lead to Hofstra University. Martine Hackett will be leading the project. Martine Hackett is Assistant Professor of Health Professions at Hofstra University. She has a wealth of experience in related trainings, notably taking the lead on a component of the University of Albany's Advancing Cultural Competence program "Addressing Suburban Structures: Health and Latino Communities on Long Island". Martine will be leading a Train the Trainer Organizational Lead session on Monday November 7th. This session will be a full-day, 7.5 hour session. Post-session, TTTs will come back to their organization to train internal employees. They will leave the program with all the tools they need to facilitate either a 7.5 hour TTT session, or a 2 hour staff session. In addition, they will be asked to facilitate outside trainings within partner organizations. The specifics of this commitment will depend largely on the capacity of the organization. Having a TTT on-site becomes an asset to the organization as they are able to provide this program, free-of-cost (aside from overhead), for their community partners. The PHIP team will be responsible for program logistics and providing support to the TTT trainers and connecting TTTs to organizations who request trainings. The PHIP and two performing provider systems are sharing 30 spots. There will be opportunity for future trainings in 2017. Program registration is closed, with 41 final applicants. The workgroup will review applications to determine who will be accepted to the program based on reach and access to vulnerable populations. Once we have a core-group trained, we will set up

	and host additional trainings. Martine's training style is interactive and multi-modal. Training components include: • Health disparities specific to Long Island • Hot spotting • Overview of select zip codes • Story maps • Self-reflective piece • Unconscious bias • Health Literacy (spoken and written) • Teach back method The program was held Monday November 7, 2016. 33 Participants were trained ***Post-Program 25 Participants Responded:*** • 100% felt the training was appropriate for their level of experience • 76% felt the usefulness of information received in training was excellent • 64% felt the structure of the training session was excellent • 68% felt the pace of the training session was excellent • 76% felt the convenience of the training schedule was excellent • 80% felt the usefulness of the training materials was excellent ***What did you like most about the training?*** • Teach back method • Interactive structure • Trainer received excellent evaluation • Role playing activity • Tools and curriculum supported confidence in facilitating the program

	Curriculum is accessible to all partners via the Long Island Health Collaborative website at: https://www.lihealthcollab.org/cchl.aspx
Engaging Community Partners within Nutrition and Physical Activity Programs on Long Island	The Complete Streets/Nutrition and Wellness workgroup is working to identify synergistic programming within two grants: Creating Healthy Schools and Communities, NYS DOH and Eat Smart, New York through the USDA. The workgroup would like to leverage existing partnerships through the LIHC/PHIP membership, especially among those who are working within the target communities focused upon within each grant. **Creating Healthy Schools and Communities**: *Grant Partners: Western Suffolk BOCES, Sustainable Long Island, Stony Brook Medicine* Five-year (2015-2020) public health initiative to reduce major risk factors of obesity, diabetes, and other chronic diseases in high-need school districts and associated communities statewide. Goal: to implement mutli-component evidence-based policies, place-based strategies, and promising practices to increase demand for and access to healthy, affordable foods and opportunities for daily physical activity. Targeted communities: Brentwood, Central Islip, Southampton/Shinnecock Indian Nation, Wyandanch and Roosevelt **SNAP-Ed Eat Smart New York (ESNY) USDA**: *Grant Partners: Cornell Cooperative Extension (Nassau and Suffolk), Family Residences and Essential Enterprises (FREE)* Five-year (2014-2019) community-based nutrition education and obesity prevention program to reduce major risk factors of obesity, diabetes, and other chronic diseases in high-need school districts and associated communities statewide. SNAP-Ed ESNY utilizes a variety of hands-on education strategies in the community and partnering agencies. Goal; to implement comprehensive multi layered evidence based strategies: improve the likelihood that persons eligible for SNAP will make healthy food choices within a limited budget and choose physically

	active lifestyles consistent with the current Dietary Guidelines for Americans and the associated USDA Food Guidance System, MyPlate. This workgroup is co-chaired by Nancy Copperman, Northwell Health and Zahrine Bajwa, Cornell Cooperative Extension. The focus has been on bridging community partnerships, particularly in various grant projects that are being led on Long Island: Creating Healthy Schools and Communities, NYS DOH and Eat Smart NY, ESNY, USDA. The workgroup is comprised of a diverse group of professionals with expertise in nutrition, environmental sustainability, obesity, walkability and beyond. The group is looking for diverse and growing partnerships within the Long Island Health Collaborative network of partners. Benefits of partnering include: • Collective impact among hospitals, local health departments, academia, community-based, social service organizations and industry partners • Support statewide reform programs such as DSRIP and SHIP • Supports population health requirements and initiatives For hospital partners: • ***Increase Community Benefit*** • Direct link to community members • Address Community Health Needs Assessments and social determinants of health • Supplement hospital programs with FREE initiatives offered through grant-funded programs • Build and leverage partnerships • Tap existing resources • Reach wider patient populations • Reinforce messaging through grant-funded incentives

	Grant partners speak about activities which fall under the two regional grants. Activities within grants include: **Creating Healthy Schools and Communities** *School Setting and Building Settings*: District wellness committees and wellness policies, school building wellness teams and champions, physical activity and nourishing foods, engagement of students, staff, families and community partners *Community Outreach*: Implementation of nutrition standards for food/beverage sold, educational activities on nutrition and physical activity, worksite wellness programs, Complete Streets, roadway projects, media, way-finding signage, auditing, evaluation and measurement, healthy *Corner Retail and Farmers Markets* **Eat Smart New York** School, after school and camp programs Child care programs and policies Community gardens Enhance farmers markets Committees and coalitions Community wellness and worksite wellness safe streets Helping families with education and prevention strategies Corner stores, retail stores and bodegas Laundromats Digital connect (Text2BHealthy) Social media and marketing If you are looking to support the programs occurring within the CHSC and Eat Smart grants, please contact the appropriate partner: Zahrine Bajwa, Regional Director, Nutrition, Health and Obesity Prevention, Cornell Cooperative

	Extension **ZB12@cornell.edu** Erika Hill, Senior Program Coordinator, Sustainable Long Island **EHill@sustainableli.org** Karyn Kirschbaum, School Health Policy Specialist, Western Suffolk BOCES **KKirschb@wsboces.org** Sarah Ravenhall, Program Manager, Population Health Improvement Program, Nassau-Suffolk Hospital Council **SRavenhall@nshc.org** Cara J Montesano, Public Health Nutrition Programs Coordinator, Stony Brook Medicine **Cara.Montesano@stonybrookmedicine.edu** Ilene Corina, PULSE of LI suggests the group develop a plan for promoting these services to the public.
Website Update	Kim Whitehead, Communications Coordinator, PHIP gives an inside look to how we measure the LIHC/PHIP website and determine successes. In studying traffic numbers and patters, we can learn about our audience and the most effective ways to drive our message with help of the website, by learning what engages them the most, what brings them in, when they leave, and what they do while they're on the site. <u>An overview of website traffic since its launch on April 13, 2016:</u> **Pageviews 37,903** - the total number of pages viewed. Repeated views of a single page are counted **Unique Pageviews 28,403** - the number of sessions during which the specified page was viewed at least once. A unique pageview is counted for each page URL + page Title combination **Sessions 15,802** - the period time a user is actively engaged with your website, app, etc **Avg. Session Duration 00:01:41** - the average length of a session **% New Sessions 71.28%** - an estimate of the percentage of session that were from new visitors

	Most viewed pages, in order: 1. **Homepage**, 5,000 visits, 13% of our traffic 2. **Blog Post, "7 Long Island Adventures You Need to Take This Summer",** 3,600 visits, 9.5% of our traffic 3. **Portal Log In + Dashboard,** 5,100 visits total, 14% of our traffic 4. **Blog Post, "Kid-Approved Outdoor Fun on Long Island",** 2,000 visits, 5% of our traffic The "Goals" we've set in order to measure successes and see what people are doing on the site: 1. Landing on the portal log in page 2. Landing on the events calendar page 3. Landing on the portal sign-up page 4. Landing on the Join The LIHC page 5. Landing on the Newsletter sign up page 6. Landing on the "Thank you Contact page" which is where a person lands after submitting a request to "Contact the LIHC" 7. Landing on the "thank you event page" where a person lands after they submit an event to the site.
Academic Partners Workgroup	Members of the Academic Partners workgroup met Tuesday November 8, 2016. The PHIP is looking to reinvigorate LEAP (LIHC Engagement Activation Partnership-flyer attached) by tapping into clubs, honors societies or student associations which are pre-established on campus. Applicable student groups can include any discipline or study and undergraduate or graduate level students. The LEAP is a volunteer opportunity for those passionate about health to engage their networks e.g. faith-based, employers, families, friends and beyond by sharing information about Long Island Health Collaborative population health initiatives taking place on Long Island.

	If you know of a student group who may be willing to get involved, please let us know by clicking the following link**:** https://www.surveymonkey.com/r/LEAPStudentGroup The PHIP team will contact the chair of the group, introduce the Long Island Health Collaborative and discuss how this group may be able to participate. We understand that each group will have individual views, ideas and capacity for involvement. Our hope is that by reaching out, we will make it more manageable for students to participate. In addition, the Academic Partners workgroup is exploring opportunities to align PHIP goals, DSRIP transformation efforts and academic accreditation/internal requirements for Long Island Academic Partner Organizations through workforce development strategies.
Behavioral Health Workgroup	Janine Logan, Senior Director and Dr. Linda Efferen, VP, Medical Director, Suffolk Care Collaborative give an overview on the development of Regional Planning Consortium (RPCs). The RPC's are the behavioral health expertise in the region. They are a place where everyone with a connection to the behavioral health community can come together to trouble shoot issues related to the Behavioral Health Transformation Agenda –first item is Medicaid Managed Care. We have an opportunity to plan together as a region, and we have CMS backing us (under the 1115 Waiver). This is where and how our community will be heard. Through the RPC's, Community Based Providers will be part of the discussion around problem solving the service roadblocks that exist in their regions. Initially, the discussion will focus on issues related to the transition to Medicaid Managed Care, but later the group will have the authority to make recommendations to the plans (and to the State of NY) around funding new projects and improving network capacity to ensure people are getting the services they need. Providers will have an opportunity to form relationships with the Managed Care Companies operating in their region. The RPC will use data from these plans to inform the ongoing

	discussions – some of this data will be shared at the 2nd stakeholder meeting The next stakeholder meeting is scheduled for Friday December 16th 10-12pm. You must register via event brite at: https://www.eventbrite.com/e/long-island-partnership-regional-planning-consortium-rpc-2nd-meeting-registration-28933624249 if you plan to attend.
LIHC Workgroup: Data	The next project that the PHIP is working on is an analysis on some of the major causes of death in Nassau and Suffolk Counties. When we received the data from the New York State Department of Health they sent the cause of death, zip code of death, various demographic information, and the census tract that the individual lived in. The PHIP wanted to look at the two most common causes of deaths by census tract and provide this data to the LIHC. This report will focus on Cancer and Ischemic Heart Disease. Maps have already been created to show the areas with the largest rate of these deaths and we are in the process of presenting this information in a meaningful matter. We are taking the census tract maps from the United States Census Bureau, highlighting the regions with the highest rates, providing demographic information about the census tract, and providing a narrative describing the geography of the region. We hope that this document will be completed in early December and that it could be used by the county health departments, hospitals, and community based organizations when they plan the locations of various services. The Community Member Survey analysis was performed on November 1st and saw a significant increase in the number of participants. There are currently 6,568 surveys collected; 2,335 are from Nassau County and 3,910 are from Suffolk County. When comparing the cumulative results from November 1st to the cumulative results from June 2nd, there are minimal differences. When asked what the biggest ongoing health concern for yourself are, Nassau County respondents now felt that Heart Disease and Stroke, Cancer, and Obesity/Weight Loss were the top concerns instead of Obesity/Weight Loss, Women's Health and Wellness, and Heart

	Disease and Stroke. When asked what health screenings or education services are needed in your community, Nassau County respondents now felt that Blood Pressure, Cancer, and Diabetes related services were most needed instead of Cancer, Diabetes, and Blood Pressure related services were most needed. There was no change in the top concerns for Suffolk County. The next Data Workgroup is looking to meet the week following Thanksgiving. Topics for the meeting include a discussion about the Community Member Survey, a review of the finalized Vital Statistics report, and a discussion about a Population Health Portal.
Grant Updates and Announcements	2017 meeting dates will be sent post meeting. All meetings will take place 9:30-11:30am in response to feedback from partners. The Professional Resources page has been launched: https://www.lihealthcollab.org/professional-resources.aspx Within this page, there is a list of resources on collective impact, population health strategies and system transformation efforts. The Long Island Health Collaborative often refers to these resources to find best practices, motivation, and proven research to support and inspire our work. The 4th annual Population Health Summit entitled "Working Across Sectors to Address Social Determinants of Health" is co-hosted by the New York State Health Foundation, the New York Academy of Medicine and NYU School of Medicine's Department of Population Health. The Summit will seek to deepen and extend the understanding of ongoing efforts in New York State and nationally that demonstrate the effective collaboration between healthcare and other sectors to advance population health. This program is being held Monday December 12th, 2016. To gain visibility within the population health arena, the PHIP composed an abstract for poster

	presentation which if accepted, will be presented during the summit. Titled “Cross-Collaborative Identification of Unmet Health Needs and Disparate Areas on Long Island: Presentation of Primary Data Collection at the Community Level”. Learning Objectives include: • Identify the advantages of a collaborative approach when assessing community health needs in a geographically challenging region • Gain familiarity with and substantiate the value of evidence-based data collection tools for acquisition of meaningful primary data elements • Explain the value in collection of novel, actionable data for justification of enhanced or extended community services • Recognize the distinction between qualitative and quantitative data collection and analysis methods, while reinforcing the role of both approaches in the application of health interventions. • Brainstorm innovative ideas for using data analysis and reporting to drive community improvement and strategic planning. We will be notified by November 14 if our abstract is approved. All partners of the LIHC, PHIP program are listed as authors on this abstract. Discussion and feedback is always welcomed during monthly LIHC meetings. Partners are also encouraged to sign up for one of the Long Island Health Collaborative workgroups as this setting is where partners have in depth discussions regarding various LIHC initiatives. The more diverse our workgroup membership is, the more we are able to accomplish and move the needle through collective impact.
Adjournment	The next LIPHIP Meeting is scheduled for: December 15, 9:30-11:30am this meeting will take place via webex. 2017 meetings will take place in 1393 conference room-same business park in Hauppauge, different building to accommodate membership growth. We are incredibly thankful for all that our members do to drive LIHC initiatives.

Lawrence Eisenstein, MD, MPH, Nassau County Health Department, Health Commissioner; Cara Montesano, Stony Brook Medicine, Dietitian; Susan Jayson, Suffolk Care Collaborative, Director of Behavioral Health; Ilene Corina, PULSE Center for Patient Safety; Michael Corcoran, Nassau-Suffolk Hospital Council, Data Analyst; Patricia Gilroy, Catholic Health Services, Manager, Community Benefits; Chris Hendriks, Catholic Health Services, Vice President, Public & External Affairs; Doreen Guma, Time to Play Foundation, Founder; Erika Hill, Sustainable Long Island, Senior Program Coordinator; Kenneth Kataria, Options for Community Living, Care Coordinator; Karyn Kirschbaum, WSBOCES, School Health Policy Specialist; Janine Logan, Nassau-Suffolk Hospital Council, Senior Director; Sarah Ravenhall, Nassau-Suffolk Hospital Council, Program Manager; Kim Whitehead, Nassau-Suffolk Hospital Council, Communications Specialist; Vincent Strynkowski, Society of St. Vincent; Esperanza Viera, Good Samaritan Hospital, Community Health Educator; Sofia Gondal, Suffolk Care Collaborative, Community Engagement Liaison; Josephine Connelly Schoonen, Stony Brook Medicine, Director; Lisa Benz Scott, Stony Brook University, Programming and Public Health; Maura Homes, Family First Home Companions, Director of Marketing; Zahrine Bajwa, Cornell Cooperative Extension, Regional Director, Nutrition and Wellness/Family Health and Wellness; Besai Barrera, Fidelis Care, Outreach Specialist; Peggy Bushman, Temp Positions, Account Executive; Nancy Copperman, Assistant Vice President, Public Health and Community Partnerships, Nothwell Health; Kelly DeVito, Horizon Counseling, Youth Service Specialist; Linda Efferen, Stony Brook Administrative Services, Medical Director Office of Population Health; Marilyn Fabbricante, St. Charles Hospital, Executive Director, Public and External Affairs; Grace Kelly-McGovern, Suffolk County Department of Health, Public Information Officer; Irene Koundourakis, NuHealth NUMC, Community Outreach Coordinator; Sue Palo, St. Francis Hospital, Director, Rehabilitation and Community Services; Janet Romeo, EPIC LI, Community Education Coordinator; Yvonne Spreckels, Stony Brook University Hospital, Director of Community Relations; Stuart Vincent, John T. Mather Memorial Hospital; Kate Zummo, South Nassau Communities Hospital, Director of Education; Joseph Sarno, NADAP, Senior Vocational Case Manager; Gary Carpenter, Marcum, Director of Healthcare Services; Michael DeAmicis, National Aging in Place, Planner; Gilbert Burgos, NQP, Executive Director; Victoria Miranda, SBU CHSC, Dietetic Intern; Caitlin Cassidy, SBU CHSC, Dietetic Intern; Nancy Colombo, Maria Regina, Admissions/Marketing Manager; Adam Pickman, New Horizon Counseling Center, Account Manager; Larry Ware, NHCC, Manager of Community Relations; Lauren Roge, Custom Computers, Healthcare Solutions; Stephanie Yanes, American Diabetes Association, Development Manager; Melissa Schuhmacher,

Arbors Assisted Living, Director Business Development; James Sheridan, American Diabetes Association, Regional Director; Brian Pritchard, South Oaks Hospital, Admissions Director.