

Mercy Medical Center

Community Health Needs Assessment and Improvement Plan

2016-2018



Approved by the Board of Trustees on October 4, 2016



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Nassau County

Community Health Needs Assessment and Improvement Plan

2016-2018

Nassau County Department of Health

Lawrence E. Eisenstein, MD, FACP, Commissioner of Health

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Mineola, NY 11501

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Catholic Health Services of Long Island

Mercy Medical Center	1000 N Village Ave, Rockville Centre, NY 11571
St. Francis Hospital	100 Port Washington Blvd, Roslyn, NY 11576
St. Joseph Hospital	4295 Hempstead Turnpike, Bethpage, NY 11714

Northwell Health System

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

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

The Long Island Health Collaborative is a coalition funded by the New York State Department of Health through the Population Health Improvement Grant. The LIHC provided oversight and management of the Community Health Needs Assessment 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 within all intervention strategies. 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 Nassau 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 Nassau 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 Nassau 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 Programming
- 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 DSRIIP, 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

What is Population Health?

Population health is an approach to understanding and improving the health of communities. It focuses on health outcomes of groups of individuals. Through population health, care is best delivered when it is well-coordinated between more than just patients and doctors, or patients and hospitals. It needs to reach into the communities where people live, work and play. Coordinated care involves a healthcare team of physicians, nurses, nurse practitioners, physician assistants, pharmacists, physical therapists, home health aides, social service providers and anyone else who tends to patients' needs that extend beyond traditional healthcare. Employment, education, housing, transportation service, along with access to affordable foods and opportunities for physical activity hold as much of an influence on patients' health outcomes as do medical treatments and interventions. Collectively, patient by patient, these factors play a role in getting and keeping the Long Island population healthy.

The Long Island Health Collaborative

The Long Island Health Collaborative (LIHC) is the hub of population health activities on Long Island. The Nassau County Community Health Improvement Plan was created in partnership with community agencies based on priorities determined by the Long Island Health Collaborative. The Long Island Health Collaborative (LIHC) is an extensive workgroup of committed partners who agree to work together to improve the health of Long Islanders. LIHC members include both county health departments, all hospitals on Long Island, community-based health and social service organizations, academic institutions, health plans and local municipalities, among other sectors. The LIHC was formed in 2013 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. In 2015, the LIHC was awarded funding from New York State Department of Health as a regional Population-Health Improvement Program (PHIP). With this funding, we have been able to launch various projects that promote the concept of population health among all sectors, the media and to the public. Our monthly meetings serve as an outlet for member organizations to network, identify opportunities for collaboration, and leverage resources.

Local health departments, hospitals and the Long Island Health Collaborative will work to engage community-based organizations and community members. The PHIP staff members will take a leadership role in compilation, analysis and interpretation of primary data collection and will write County template-documents.

Community Served

This assessment covers Nassau County, New York. Nassau County's service area sits east of the Queens's borough and west of Suffolk County. It comprises two cities: Long Beach, Glen Cove and three towns Hempstead, North Hempstead and Oyster Bay. Nassau County is unique in that it presents complex polarity, representing a wide range of both healthy and sick community members from opposite ends of the health continuum.

Data presented within this report will demonstrate the existence of vast health disparities stemming from a wide range of socioeconomic factors. Our findings indicate the reality of the linkage of health disparities to a variety of social factors including race, ethnicity, gender, language, age, disabilities, and financial security among others. Elimination of such disparities is a priority throughout the Long Island region as bridging gaps and services will ultimately improve health outcomes and quality of life for community members.

Located in south central Nassau County, Mercy's primary service area has a population of about 435,000. The population is ethnically quite diverse, more than half of it African-American, Hispanic or Asian. Nearly a third of residents speak a language other than English in the home, and more than a quarter are foreign born. Mercy's primary service area also comprises some of the poorest populations in Nassau County, including four of the eight highest poverty zip codes in the county. A majority of all individuals in the county below the poverty level live in Mercy's primary service area. While a third of the residents in this service area have a bachelor's degree, nearly a quarter from these high-poverty zip codes do not have a high school diploma.

Data Findings

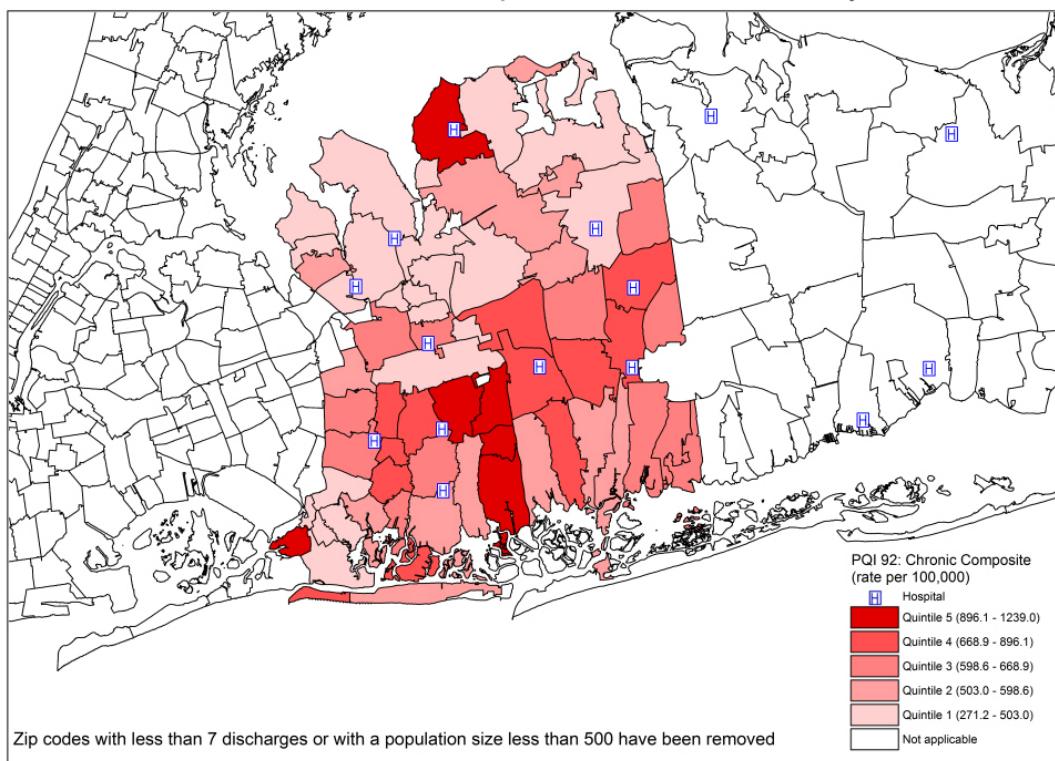
Prevention Quality Indicators

Prevention Quality Indicators (PQI), are defined by the Agency for Health Research and Quality* (AHRQ) and can be useful when examining preventable admissions. Using SPARCS data, the 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 Nassau County representing the most significant number of preventable cases per 100,000 adult population. Quintile 5 represents 896.1-1239.0 per 100,000 adult cases, and can be identified by dark red coloring. This quintile demonstrates within which zip codes the largest pockets of potentially preventable hospitals visits related to chronic disease fall. As displayed within the PQI Chronic Composite for Nassau County, there is a notable occurrence of Chronic Disease among a majority of communities, particularly those connected to low socioeconomic status.

PQI 92: Chronic Composite for Nassau County*



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

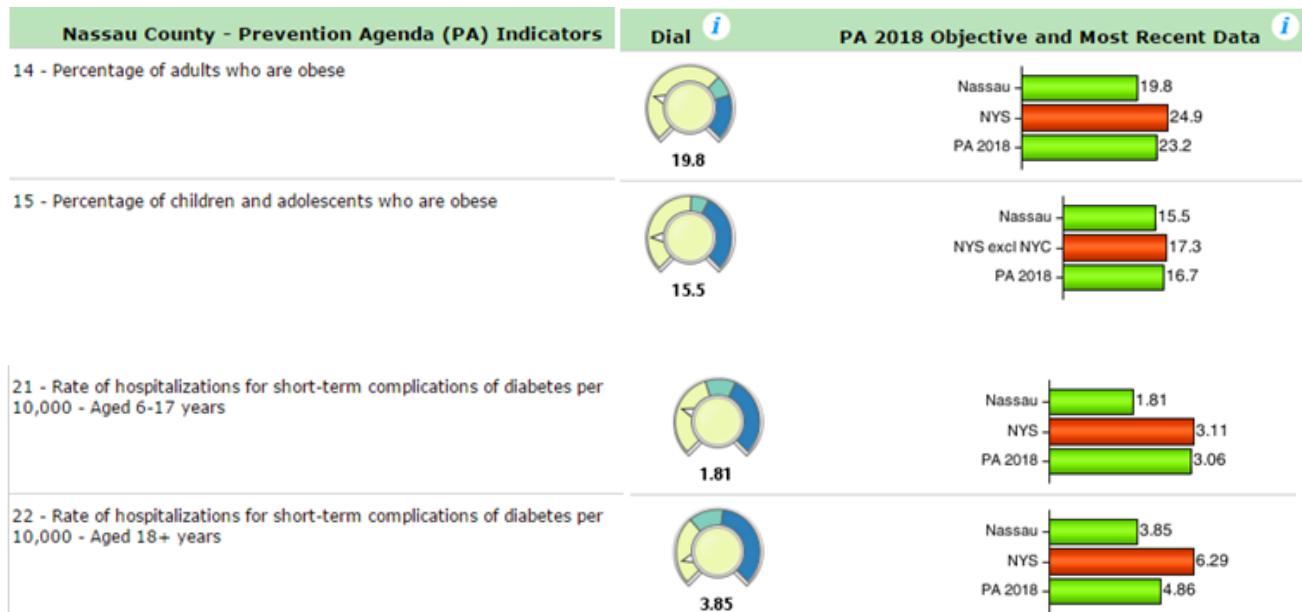
*Source: Agency for Healthcare Research and Quality-Prevention Quality Indicators (http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx)

*Prevention Agenda Dashboard**

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 substance abuse.

Within the dashboard, review of 2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System, demonstrates 19.8% of adults in Nassau County are obese. Although obesity rates in Nassau are lower than New York State, 24.9% and the Prevention Agenda Goal of 23.2%, the Long Island Health Collaborative felt interventions should be focused on decreasing chronic disease as a whole, with a focus on obesity, prevention and care management.

Rate of hospitalizations for short-term complication of diabetes reflects 3.85 per 10,000 for adults in Nassau County and 6.29 in New York State. Again, Nassau falls under the Prevention Agenda goal of 4.86 per 10,000; information into the portal. The PHIP team provides individualized data for participating organizations; however, the Long Island health Collaborative emphasized a need for focus on high utilizing pockets within the County with further room for improvement.



* Source: Prevention Agenda 2013-2018: New York State's Health Improvement Plan (https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/)

Long Island Community Health Assessment Survey

To collect input from community members, and measure the community-perspective as to the biggest health issues in Nassau County, the LIHC developed a regional survey called the Long Island Community Health Assessment Survey. This survey was distributed via SurveyMonkey® 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 1,007 surveys collected in Nassau County. Based upon the total population of Nassau County, survey totals assume a confidence level of 95% and confidence interval of 3. Initial analysis took place in March 2016, with a secondary analysis scheduled to occur in June. 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 are being distributed both by paper, and electronically through SurveyMonkey®, 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 SurveyMonkey® 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 21, 2016 and June 2, 2016, the PHIP data analyst downloaded results from each of the SurveyMonkey® 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 we applied the formula 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:***
 - Nassau County respondents agreed that cancer, drugs and alcohol abuse and obesity/weight loss were the top three concerns.
 - These three choices represented roughly 43% of the total responses.
 2. When asked ***what the biggest ongoing health concerns for yourself are:***
 - Nassau County respondents agreed that obesity/weight loss, women's health and wellness, and heart disease and stroke were the top three concerns.
 - These three choices represented roughly 43% 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.***
 - Nassau County respondents felt that Fear, no insurance, and inability to pay co-pays or deductibles 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:***
 - Nassau County respondents felt that healthier food choices, clean air and water and weight loss programs 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:***
 - Nassau County respondents felt that cancer, diabetes, and blood pressure services were most needed.

CBO Summit Event Qualitative Data Analysis and Interpretation

To measure professional expertise from 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 Nassau County summit event took place February 2, 2016 at Adelphi University in Garden City, NY. Attendance was robust, with 45 organizations in representation at the Nassau 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 was developed and used as our primary data collection tool. Adapted from the Nassau County Department of Health's Key Informant Interview script, this tool was revised to meet a facilitated discussion format. 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 transcribed and provided to us 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 skill. The Principal Research Analyst at Data Gen Inc. 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 (Hempstead, Wyandanch, etc.) spoken *in vivo* in order to assign the appropriate county flags. If a bi-county organization 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.

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

Distinct Prevention Areas by Ranking

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

e.g. “*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	Nassau	%*
1	Chronic Disease	26.1%
2	Mental Health	23.0%
3	Healthy and Safe Environment	20.1%
4	Healthy Women, Infants and Children	19.1%
5	HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections	6.2%

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

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

those e-cigs, so whenever we feel like we've got something done, it's like we take two steps back. So I enjoy the challenge of working against the tobacco industry to try to keep on top of it, and to help people who are addicted, mentally ill, substance abuse, very high rates of smoking, they are not getting the help that they need, so advocating for them for more resources to be able to quit smoking is very important.
-American Lung Association

The priority area of mental health and substance abuse emerged closely as a second-ranking topic of importance. Qualitative analysis demonstrated, 26.1% of quotations indicating mental health as an area of concern in Nassau County. Cumulatively, 36.9% of quotations included mental health and substance abuse as an area of concern within communities served in Nassau 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 16.4% of quotations in Nassau County. A second focus area, "substance abuse", appeared with 6.9% of quotations containing related key words.

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

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

Analytic Interpretation & Participant Quotations
The need for mental health and substance abuse services is growing at a substantial rate, creating a shift in demand for services. Mental health issues as obstacles for young mothers are a steadily increasing issue, typically linked to substance abuse.
After 30 years, there's been almost a complete change that I've seen in the population that we serve, and we have a much more serious mental health problem. Mental health is the number one obstacle for these young women to transition into motherhood and to survive in this world, and a lot of it traces back to drug and alcohol abuse, physical abuse in their own families. <i>- MOMMAS House</i>
Social determinants of health play an integral role in addressing issues concerning mental health and substance abuse.
It all falls together. When you have people who are in poverty they are not eating well; when you have people in poverty they tend to be depressed and have mental disorders, which very often leads to alcohol or substance abuse, heroin, which is a huge problem in this area. It's all interwoven I am trying to say. <i>- Catholic Home Care</i>
Access to adequate mental health and substance abuse treatment/recovery services is limited,

which has created a gap in care for those in need and negatively impacted hospital readmission rates.

We used to have a Mental Health Department within our hospital, Glen Cove, but they closed it down two years ago, I believe, because of funding. Now it is difficult to try to figure out where to send our patients, especially from family medicine, the Care Center. We would send them upstairs within the Mental Health Department in our hospital, but now we have to send them outside for services, so access becomes a problem.

- Northwell Health Ambulatory Care Center

LIHC Wellness Survey

To measure the effectiveness of community wellness programs, the Long Island Health Collaborative, in partnership with leadership from Stony Brook University, developed a survey and HIPAA compliant, web-based Wellness Portal. The evidence-based survey tool, adapted from the Self-Rated Abilities for Health Practices Scale (SRAHP) can be used to collect pre and post program data from participants on healthy eating, physical activity, physiological well being and responsible health practices. Once data is collected, users enter de-identified information into the portal. The PHIP team provides individualized data for participating organizations.

Mercy Medical Center also gathers data using the LIHC Community Health Needs Assessment survey collected from community members at public events, programs and free lectures offered by the hospital. Using the LIHC Community Member Survey Summary of Findings, Mercy Medical Center reviewed the data for January 1, 2016 to June 30, 2016 for the hospital's service area by selected zip codes. Below are the findings Mercy Medical Center:

1. What are the biggest ongoing health concerns in the community where you live?

- | | |
|--|--------|
| • Cancer | 41.33% |
| • Drug & alcohol abuse | 34.66% |
| • Obesity/weight-loss issues | 31.13% |
| • Diabetes | 28.58% |
| • Heart disease & stroke | 23.23% |
| • Mental health depression/suicide | 17.76% |
| • Safety | 14.93% |
| • Environmental hazards | 13.39% |
| • Child health & wellness | 12.62% |
| • Women's health & wellness | 12.57% |
| • Asthma/lung disease | 11.27% |
| • HIV/AIDS & Sexually Transmitted Diseases (STD) | 8.21% |
| • Vaccine preventable diseases | 2.99% |

2. What are the biggest ongoing health concerns for yourself?

- | | |
|------------------------------|--------|
| • Obesity/weight-loss issues | 33.97% |
| • Women's health & wellness | 31.37% |

• Cancer	28.33%
• Heart disease & stroke	26.71%
• Diabetes	24.06%
• Safety	15.84%
• Environmental hazards	14.77%
• Mental health depression/suicide	11.18%
• Asthma/lung disease	10.22%
• Child health & wellness	9.84%
• Drugs & alcohol abuse	5.54%
• HIV/Aids/sexually transmitted disease	4.19%
• Vaccine preventable diseases	3.59%

3. What prevents people in your community from getting medical treatment?

• No insurance	43.36%
• Unable to pay co-pays/deductibles	42.27%
• Fear	33.28%
• Don't understand need to see a doctor	27.18%
• Language barriers	15.73%
• Transportation	11.33%
• There are no barriers	10.89%
• Don't know how to find doctors	9.34%
• Cultural/religious beliefs	8.04%
• Lack of availability of doctors	6.40%

4. Which of the following is the MOST needed to improve the health of your community?

• Healthier food choices	39.18%
• Weight-loss programs	29.26%
• Job opportunities	28.85%
• Clean air and water	27.57%
• Drug and alcohol rehabilitation services	21.84%
• Mental health services	20.56%
• Safe places to walk/play	15.70%
• Recreation facilities	14.76%
• Safe childcare options	12.98%
• Smoking cessation programs	12.61%
• Transportation	8.60%
• Safe worksites	6.12%

5. What health screenings or education/information services are needed in your community?

• Importance of routine well checkups	22.44%
• Cancer	22.32%
• Blood pressure	21.95%
• Diabetes	21.92%
• Nutrition	21.89%
• Drug and alcohol	21.36%
• Exercise/physical activity	20.25%
• Mental health/depression	16.61%
• Cholesterol	13.64%
• Emergency preparedness	12.41%
• Heart disease	11.31%
• Dental screenings	11.24%
• Eating disorders	10.00%
• Disease outbreak information	7.33%
• Vaccination/immunizations	5.92%
• Suicide prevention	5.88%

• HIV/AIDS/STDs	6.51%
• Prenatal care	3.46%
6. I identify as:	
• Female	74.80%
• Male	25.02%
• Other	0.18%
7. Average age of respondents:	47
8. What race do you consider yourself?	
• White/Caucasian	73.60%
• Black or African-American	16.92%
• Asian/Pacific Islander	4.64%
• Multi-racial	4.45%
• Native American	0.39%
9. Are you Hispanic or Latino?	
• No	69.97%
• Yes	24.22%
• No answer	5.81%
10. What is your annual household income from all sources??	
• \$0-\$19,999	12.55%
• \$20,000-\$34,999	12.97%
• \$35,000-\$49,999	8.20%
• \$50,000-\$74,999	14.11%
• \$75,000-\$125,000	29.15%
• >\$125,000	22.18%
11. What is your highest level of education?	
• College graduate	33.12%
• Graduate school	22.98%
• Some college	17.25%
• High school graduate	15.04%
• Doctorate	4.24%
• Some high school	3.97%
• Technical school	3.32%
• K-8 grade	2.77%
• Other (GED, Nursing school)	0.37%
12. What is your current employment status?	
• Employed for wages	59.85%
• Retired	15.48%
• Self-employed	11.54%
• Out of work/looking for work	4.69%
• Out of work, but not currently looking	4.41%
• Student	4.03%
• Military	0%

13. Do you currently have health insurance?	
• Yes	91.84%
• No	7.06%
• No, but I did in the past	1.10%

For the 2016-2018 cycle, community partners selected *Chronic Disease* as the priority area of focus with (1) obesity and (2) preventive care and management as the focus areas. The group also agreed that mental health should be highlighted within all intervention strategies. Mental health is being addressed through attestation and visible commitment to the Delivery System Reform Incentive Payment (DSRIP), Performing Provider Systems (PPS) Domain 4 projects. 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 the intervention strategies. 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 socioeconomic status populations and those with poor mental health

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

Long Island Health Collaborative Driven Interventions, Strategies and Activities

Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Engage community members in regional physical activity and wellness campaigns	<p>1. Increase community and partner engagement through social media tactics</p> <p>2. Promote the Are you Ready, Feet?™ Campaign within community networks and increase participation in this region-wide physical activity campaign</p> <p>3. Launch a consumer-facing website, adherent to CLAS standards and achieve meaningful web analytics</p> <p>4. Launch a volunteer working group of student volunteers who will leverage social media expertise and existing personal networks to further engage community members</p> <p>5. Host at least two public, consumer-focused walking events annually</p> <p>6. Reach and implement the recommendation for walking program within the primary care setting and engage participating physicians.</p>	<p>1. Social media reach</p> <p>2. Engage community members in Are you Ready, Feet?™ Campaign</p> <p>3. Provide consumer-facing information on LIHC webpage</p> <p>4. Establish LIHC Engagement Activation Partnership (LEAP)</p> <p>5. Host community walking events</p> <p>6. Establish physician Recommendation for Walking Program</p>	<p>1. Identify and participate in effective social media strategies and promote the LIHC to consumers</p> <p>2. Develop and distribute promotional tools; engage participants via social media strategies</p> <p>3. Identify evidence-based resources for health information that adhere to CLAS standards, collect input from LIHC members and clinical experts and build website.</p> <p>4. Promote opportunity among networks, identify role and responsibility, and support LEAP team as they carry out goals and objectives.</p> <p>5. Involve key leaders including State and County officials, identify dates, locations and promote events.</p> <p>6. Coordinate mailing to Long Island providers, work with Nassau County Medical Society to build program reputation, distribute mock-prescription pads to members for distribution</p>	<p>Hospital will build a link to the LIHC on the website.</p> <p>Hospital will also promote via Facebook and Twitter.</p> <p>“Are you ready feet?” cards are currently being distributed at community events.</p> <p>Hospital will participate and involve its networking contacts to identify evidence-based health information resources that meet standards.</p> <p>Hospital will remain active in LIHC to assist in county and state-wide efforts to promote a healthy Long Island.</p> <p>Hospital will include providers in our wellness outreach initiatives.</p>	<p>Hospital social media resources.</p> <p>Hospital will include identified health information resources on hospital website.</p> <p>Hospital will distribute “Are you ready feet?” cards at outreach sites.</p> <p>Hospital sends a team of employees and patients to the Long Island American Heart Association walk, the Making Strides Against Breast Cancer walk, and the LI Marcum Challenge.</p> <p>Hospital will send staff member to LIHC meetings and remain active with initiatives.</p> <p>Hospital will engage Medical Affairs Department in promoting walking program.</p>	<p>The Population Health Improvement Program was initially established as a two-year program. In 2016, funding from New York State Department of Health was secured through January 2018, extending the program to three years.</p> <p>Activities will continue on an ongoing basis throughout this time. The Plan-Do-Study-Act (PDSA) framework will be used to evaluate the need for change within intervention strategies*.</p> <p>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.</p>	<p>All LIHC activities are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they are CLAS appropriate and meet health literacy skills.</p> <p>LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes.</p> <p>The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.</p>

Goal	Outcome Objectives	Interventions/ Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Provide transparency in population health data analysis activities for stakeholders	<p>1. Data collection, analysis and reporting strategies will be clearly communicated to LIHC partners during monthly meetings and at data-subgroup meetings. All projects will be publicly available on the LIHC website.</p> <p>2. PHIP team members will communicate with LIHC members who require data to support and provide expert suggestions on the best way to meet project goals or measure outcomes.</p> <p>3. Upon request, the PHIP will engage in data analysis and collection efforts for those projects supporting the Prevention Agenda.</p> <p>4. PHIP data workgroup will provide expertise, guidance and build consensus during the development of data collection tools.</p> <p>5. PHIP will be utilized as the primary location for return surveys and data analysis</p>	<p>1. Provision of ongoing measurement and public reporting of primary and secondary data sources.</p> <p>2. PHIP team will assist member data requirements by leading data reporting projects</p> <p>3. PHIP will provide technical support to community-partners during a variety of analysis projects, grant applications and strategic planning</p> <p>4. Development of data collection tools</p> <p>5. Centralized return hub for data collection efforts</p>	<p>1. Monthly reporting summaries to be presented at LIHC meetings, data sets and projects to be posted on data page of website</p> <p>2. Open communication-follow up and execution of data focused projects.</p> <p>3. Regularly advise the LIHC that data analysis support is available to them. Identify and establish partnerships among community-partners to reduce working in silos and streamline efforts in data analysis.</p> <p>4. Research evidence-based measurement tools and adapt them to the specific data collection effort being carried out</p> <p>5. List the PHIP location on survey return instructions, collect and sort data responses, develop plans for data analysis while ensuring validity and reliability of data.</p>	<p>Hospital will continue to participate in data collection of community needs assessment. We will maintain hospital database and send survey results to LIHC for island-wide analysis.</p> <p>Hospital will participate in Long Island Health Collaborative Wellness Survey to collect data to assist in evaluating wellness program effectiveness.</p> <p>Hospital plans to incorporate Wellness tool and outcome results in future outpatient Performance Improvement reporting.</p>	<p>Hospital staff member will be active at both the LIHC group and data subcommittee meetings.</p>		

Goal	Outcome Objectives	Interventions/ Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Leverage partnerships and achieve collective impact among LIHC community-partner network	<p>1. Communicate with partners to understand what activities are occurring within which communities</p> <p>2. Identify potential partnerships and introduce compatible partners</p> <p>3. Align objectives with organizations currently engagement in Complete Street work to increase sustainable, built environments</p> <p>4. Provide central local for grant-partners to collaborate and streamline grant activities that support healthy eating and physical activity</p>	<p>1. LIHC will assess resource availability through network of community-partners</p> <p>2. LIHC will promote collective impact strategies by leveraging existing resources and identifying partnerships</p> <p>3. Support and participate in Complete Streets Policy work</p> <p>4. Engagement of two synergistic grants in region: Eat Smart NY (USDA) and Creating Healthy Schools and Communities (NYS DOH)</p>	<p>1. Develop efficient surveys and polls which will capture information about parallel projects within Nassau County Communities.</p> <p>2. Manage and ongoing involvement in partnerships with continued effort to identify partnership and streamline activities</p> <p>3. Work closely with Local Health Departments and organizations engaged in Complete Street work, identify opportunities for partnership or support</p> <p>4. PHIP to participate in grant-partner meetings, 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</p>	<p>Include community partners in ongoing community needs assessment activities.</p> <p>Include community partners in Hospital Community Advisory Council.</p> <p>Support local Health Department and Complete Streets work.</p> <p>Identify and support collaborative grant opportunities.</p>	<p>Long Island Community Health Survey and hospital database of responses.</p> <p>Annually reassess community contacts and partners. Add to Community Advisory Council guest list as appropriate.</p> <p>Hospital website, and community partners</p> <p>Work cooperatively and support LIHC grant efforts.</p>		
Support and increase Evidence-Based Community-Programming Efforts	<p>1. Promote and advance evidence-based community programs</p> <p>2. Support DSRIP efforts to increase programming throughout the region</p>	<p>1. Connect members with providers of Stanford Model programs including: Diabetes-Self Management Program and Chronic Disease Self-Management program</p> <p>2. Partner with DSRIP PPS to increase program availability.</p>	<p>1. Establish relationship with key providers of this program, PHIP staff member to become trained as a DSMP peer-leader and lead programs within the community setting</p> <p>2. Work in partnership with PPS to identify community locations where Stanford Model programs will take place</p>	Support DSRIP efforts to provide location for programs.	Engage existing community partners to support events.		

Goal	Outcome Objectives	Interventions/ Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
<i>Increase community awareness of Mental Health/Substance Abuse</i>	<p>1. Establish workgroup, identify strategies, meet regularly to address the need for increased awareness and focus on Mental Health and Substance abuse</p> <p>2. Promote program to community partners and identify where/which organizations are certified to lead training</p> <p>3. Commit to addressing mental health as a priority area by attesting and contributing to PPS strategies</p>	<p>1. Development of a mental health focused LIHC sub-workgroup</p> <p>2. Increase availability of Evidence-Based Mental Health First Aid USA ™ training program for community members and front line healthcare workforce</p> <p>3. Position strategies to support DSRIP Domain 4 projects related to addressing mental health</p>	<p>1. Identify leaders and advocates for those living with mental health and substance abuse issues, host first meeting, review data in support of strategies</p> <p>2. Host evidence based program for LIHC members or employees of organizations who work with this population</p> <p>3. Ensure PPSs are represented on Mental Health/Substance Abuse workgroup, communicate and present Domain 4 milestones related to MH/SA and identify strategies that the LIHC can support</p>	<p>Support LIHC Mental Health initiatives.</p> <p>Support DSRIP mental health projects.</p>	<p>Review data and work on program planning to support Mental Health issues on Long Island.</p>		

Goal	Outcome Objectives	Interventions/ Strategies/ Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
<i>Alignment with state reform initiatives including DSRIP and SHIP</i>	<p>1. Identify strategies supporting DSRIP-PPS efforts</p> <p>2. Work in direct partnership with PPS workgroups and provide support to leverage LIHC network within various strategies</p> <p>3. Provide data analysis strategies to PPS data-focused teams to address health disparities and</p>	<p>1. PHIP attendance regional PPS PAC meetings</p> <p>2. PHIP participation in workgroup projects: data hot-spotting, cultural competency/ health literacy, community engagement</p> <p>3. PHIP participation in data hot-spotting strategies</p>	<p>1. Attendance at meetings; synthesis of information obtained from meetings; alignment of goals with DSRIP milestones</p> <p>2. PHIP to become actively involved in DSRIP workgroup strategies and suggest collaborative efforts to support milestone achievement, open communication, meaningful projecting efforts</p> <p>3. Contribute to data hot spotting efforts through data mining and analysis efforts, presenting activities during monthly LIHC meetings</p>	<p>Attend LIHC meetings to be aware of PHIP initiatives related to DSRIP-PPS efforts.</p> <p>Will participate in data collection efforts.</p>	<p>Support initiatives, engage community via community outreach efforts.</p> <p>Will strive to address health disparities by providing services in identified communities of need.</p> <p>Engage community partners in efforts.</p>		

*Institute for Healthcare Improvement, Cambridge, Massachusetts: Plan-Do-Study-Act (PDSA) (<http://www.ihi.org/resources/pages/tools/plandostudyactworksheet.aspx>)

Mercy Medical Center-Driven Interventions, Strategies and Activities

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Priority One— Obesity <i>Reduce obesity in adults through community-based awareness initiatives such as free community lectures and BMI screenings.</i>	Enhance consumer access for weight loss surgery.	<i>Deliver at least 36 weight loss sessions to the community.</i>	<i>Survey attendees before and after session to see if there is an increase in knowledge.</i>	<i>Partner with the New York Bariatric Group to facilitate the training.</i>	<i>Hospital staff and partner with New York Bariatric Group.</i> <i>Public Affairs staff promote sessions through social media.</i>	<i>36 weight loss sessions each year.</i>	<i>To target medically underserved communities and populations</i>
		<i>Mercy Medical Center offers a bariatric clinic for underserved individuals who are obese and at risk for developing related health issues.</i>	<i>Track number of patients seen at Mercy's clinic and at the New York Bariatric Group who are eligible for reduced-fee care.</i>	<i>Provide bariatric clinic for eligible individuals.</i>	<i>Clinic is located at Mercy Medical Center.</i>	<i>Clinic available for eligible individuals.</i>	
	<i>Increase awareness of achieving and maintaining a healthy weight.</i>	<i>Provide free screenings for cholesterol and blood pressure, and BMI screenings at community site locations.</i>	<i>Keep track of the number of attendees at each event and number of referrals.</i>	<i>Provide clinical staff to community site locations to provide screenings and provide health counseling and referral as needed.</i>	<i>Clinical and non-clinical staff</i>	<i>At least 8 events per year</i>	

Mercy Medical Center-Driven Interventions, Strategies and Activities

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Priority Two— Preventive Care and Management.	Increase access to high-quality disease preventive care for heart disease and diabetes in both clinical and community settings.	Mercy Medical Center annual Wellness Fair provides free blood pressure screenings with health education and information.	Count number of attendees at events. Provide additional wellness event by year end 2017.	Set up and invite community to annual event.	Clinical and non-clinical staff, educators and community outreach staff.	Annually	To target medically underserved communities and populations.
	Increase knowledge of disease preventive care in both clinical and community settings.	Mercy to use the Speakers Bureau to provide information on a variety of medical topics	Conduct surveys before and after speaker event to determine if there was an increase in knowledge on the covered topic. Increase lectures by 5% over previous year.	Hospital provides speakers for each event delivered by medical staff and support staff, depending on topic.	Clinical and non-clinical staff, educators and community outreach staff.	One session per month.	
	Increase knowledge of diabetes care and prevention.	Diabetes Education & Lectures	Conduct surveys before and after speaker event to determine if there was an increase in knowledge on the topic.	Delivered by the certified diabetic educator.	Clinical and non-clinical staff, educators and community outreach staff.	Three per month.	
		Free wound care screenings are offered at the annual Wellness Fair.	Track number of wound care screenings performed and the number of individuals recommended for follow-up care.	Plan and host annual event.	Clinical and non-clinical staff, educators and community outreach staff.		
	Participate in community programs designed to reach people outside of traditional health care settings.	Participate in Healthy Sundays event.	Provide free blood pressure and BMI screenings at churches. Provide influenza vaccinations (in season). Measure number of screenings, referrals and flu shots.	Volunteer clinical staff attend events at parish and community locations to provide screenings, health information and referral as needed.	Clinical and non-clinical volunteer staff.	Four to five events annually.	

Mercy Medical Center-Driven Interventions, Strategies and Activities

Goal	Outcome Objectives	Interventions/ Strategies/Activities	Process Measures	Hospital Role	Hospital Resources	By When	Will action address disparity
Mental Health	<i>Increase community awareness of mental health/substance abuse.</i>	<i>Mercy Medical Center to support LIHC projects related to addressing mental health.</i>	<i>Ensure Mercy staff are represented on Mental Health/Substance Abuse workgroup.</i>	<i>Hospital staff will participate in LIHC workgroup meetings.</i>	<i>Mercy staff to attend workgroup meeting.</i>	<i>Annually as scheduled</i>	<i>To target underserved communities.</i> <i>Target at risk populations.</i>
	<i>To provide target populations with information about the signs and symptoms of mental health and substance abuse issues. Offer link to community-based clinical programs and services.</i>	<i>Refer appropriate patients to services within CHS, if available.</i>	<i>Count the total number of referrals to CHS facilities.</i>	<i>Hospital staff refers to appropriate services.</i>	<i>Hospital staff make referrals as appropriate.</i>	<i>Annually</i>	

Long Island Health Collaborative Partnerships and Sustainability

The Long Island Health Collaborative 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 Nassau 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, and are available upon request. MMC's Community Health Needs Assessment is also available on the Mercy Medical Center website at <http://mercymedicalcenter.chsli.org/> and the Catholic Health Services website at: <http://www.chsli.org/content/community-benefit>

APPENDIX

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)

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma/lung disease | <input type="checkbox"/> Heart disease & stroke | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS & Sexually | <input type="checkbox"/> Vaccine preventable diseases |
| <input type="checkbox"/> Child health & wellness | Transmitted Diseases (STDs) | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental health | <input type="checkbox"/> Women's health & wellness |
| <input type="checkbox"/> Drugs & alcohol abuse | depression/suicide | |
| <input type="checkbox"/> Environmental hazards | <input type="checkbox"/> Obesity/weight loss issues | _____ |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma/lung disease | <input type="checkbox"/> Heart disease & stroke | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS & Sexually | <input type="checkbox"/> Vaccine preventable diseases |
| <input type="checkbox"/> Child health & wellness | Transmitted Diseases (STDs) | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental health | <input type="checkbox"/> Women's health & wellness |
| <input type="checkbox"/> Drugs & alcohol abuse | depression/suicide | |
| <input type="checkbox"/> Environmental hazards | <input type="checkbox"/> Obesity/weight loss issues | _____ |

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

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

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

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

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

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

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?

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	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.hrrcare.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.sjcn.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.iaqquy.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