Nassau County
Community Health Needs Assessment and Improvement Plan
2016-2018

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

Catholic Health Services of Long Island

<table>
<thead>
<tr>
<th>Mercy Medical Center</th>
<th>1000 N Village Ave, Rockville Centre, NY 11571</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Francis Hospital</td>
<td>100 Port Washington Blvd, Roslyn, NY 11576</td>
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<tr>
<td>St. Joseph Hospital</td>
<td>4295 Hempstead Turnpike, Bethpage, NY 11714</td>
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Northwell Health System

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<tr>
<th>Glen Cove Hospital</th>
<th>101 St. Andrews Lane, Glen Cove, NY 11542</th>
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<tr>
<td>Long Island Jewish Valley Stream</td>
<td>900 Franklin Ave, Valley Stream, NY 11580</td>
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<tr>
<td>North Shore University Hospital</td>
<td>300 Community Drive, Manhasset, NY 11030</td>
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<tr>
<td>Plainview Hospital</td>
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<td>South Oaks Hospital</td>
<td>400 Sunrise Highway, Amityville, NY 11701</td>
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<td>Syosset Hospital</td>
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<td>2201 Hempstead Turnpike, East Meadow, NY 11554</td>
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<td>South Nassau Communities Hospital</td>
<td>1 Healthy Way, Oceanside, NY 11572</td>
</tr>
<tr>
<td>Winthrop University Hospital</td>
<td>259 First Street, Mineola, NY 11501</td>
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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 DSRIP, SHIP, Prevention Agenda and SHINY

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

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 of 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.

*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.

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.

<table>
<thead>
<tr>
<th>PA Rank</th>
<th>Nassau</th>
<th>%*</th>
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<tbody>
<tr>
<td>1</td>
<td>Chronic Disease</td>
<td>26.1%</td>
</tr>
<tr>
<td>2</td>
<td>Mental Health</td>
<td>23.0%</td>
</tr>
<tr>
<td>3</td>
<td>Healthy and Safe Environment</td>
<td>20.1%</td>
</tr>
<tr>
<td>4</td>
<td>Healthy Women, Infants and Children</td>
<td>19.1%</td>
</tr>
<tr>
<td>5</td>
<td>HIV, STD and Vaccine Preventable Disease and Health Care-Associated Infections</td>
<td>6.2%</td>
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* 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 the prevent disease through nutrition.

– Adelphi NY Statewide Breast Cancer Hotline

The sale and use of electronic cigarettes and hookahs are trending in youthful populations. This trend has added a challenge to strategies focused on smoking reduction. Smoking rates among those living with mental illness have not subsided and targeted resources will be needed to provide assistance.

I am very passionate about helping to advocate, changing laws about tobacco use, and helping people to quit smoking, and we do have many despair populations. Fortunately for us, the rates are going down, however there are new issues coming up, electronic cigarettes, hookah, and kids are starting to pick up
those e-cigs, so whenever we feel like we’ve got something done, it’s like we take two steps back. So I enjoy the challenge of working against the tobacco industry to try to keep on top of it, and to help people who are addicted, mentally ill, substance abuse, very high rates of smoking, they are not getting the help that they need, so advocating for them for more resources to be able to quit smoking is very important.

-American Lung Association

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.

<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse</th>
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<tbody>
<tr>
<td>Mental Health Issues</td>
<td>16.4%</td>
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<tr>
<td>Substance Abuse</td>
<td>6.9%</td>
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<tr>
<td>Anxiety, Mood Disorders and Associated Emotions</td>
<td>4.4%</td>
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<tr>
<td>Susceptible Populations</td>
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<td>Treatment and Recovery</td>
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<tr>
<td>Suicide</td>
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<tr>
<td>Attitudes about Mental health</td>
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<tr>
<td>Eating Disorders</td>
<td>0.2%</td>
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</table>

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

Analytic Interpretation & Participant Quotations

The need for mental health and substance abuse services is growing at a substantial rate, creating a shift in demand for services. Mental health issues as obstacles for young mothers are a steadily increasing issue, typically linked to substance abuse.

After 30 years, there's been almost a complete change that I've seen in the population that we serve, and we have a much more serious mental health problem. Mental health is the number one obstacle for these young women to transition into motherhood and to survive in this world, and a lot of it traces back to drug and alcohol abuse, physical abuse in their own families.

-MOMMAS House

Social determinants of health play an integral role in addressing issues concerning mental health and substance abuse.

It all falls together. When you have people who are in poverty they are not eating well; when you have people in poverty they tend to be depressed and have mental disorders, which very often leads to alcohol or substance abuse, heroin, which is a huge problem in this area. It's all interwoven I am trying to say.

-Catholic Home Care

Access to adequate mental health and substance abuse treatment/recovery services is limited,
which has created a gap in care for those in need and negatively impacted hospital readmission rates.

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

- Northwell Health Ambulatory Care Center

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 21.36%
   • Drug and alcohol 21.09%
   • 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.
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| Engage community members in regional physical activity and wellness campaigns | 1. Increase community and partner engagement through social media tactics  
2. Promote the Are you Ready, Feet™ Campaign within community networks and increase participation in this region-wide physical activity campaign  
3. Launch a consumer-facing website, adherent to CLAS standards and achieve meaningful web analytics  
4. Launch a volunteer working group of student volunteers who will leverage social media expertise and existing personal networks to further engage community members  
5. Host at least two public, consumer-focused walking events annually  
6. Reach and implement the recommendation for walking program within the primary care setting and engage participating physicians. | 1. Social media reach  
2. Engage community members in Are you Ready, Feet™ Campaign  
3. Provide consumer-facing information on LIHC webpage  
4. Establish LIHC Engagement Activation Partnership (LEAP)  
5. Host community walking events  
6. Establish physician Recommendation for Walking Program | 1. Identify and participate in effective social media strategies and promote the LIHC to consumers  
2. Develop and distribute promotional tools; engage participants via social media strategies  
3. Identify evidence-based resources for health information that adhere to CLAS standards, collect input from LIHC members and clinical experts and build website.  
4. Promote opportunity among networks, identify role and responsibility, and support LEAP team as they carry out goals and objectives.  
5. Involve key leaders including State and County officials, identify dates, locations and promote events.  
6. Coordinate mailing to Long Island providers, work with Nassau County Medical Society to build program reputation, distribute mock-prescription pads to members for distribution | Hospital will build a link to the LIHC on the website.  
Hospital will also promote via Facebook and Twitter.  
*Are you ready feet?” cards are currently being distributed at community events.  
Hospital will participate and involve its networking contacts to identify evidence-based health information resources that meet standards.  
Hospital will remain active in LIHC to assist in county and state-wide efforts to promote a healthy Long Island.  
Hospital will include providers in our wellness outreach initiatives. | Hospital social media resources.  
Hospital will include identified health information resources on hospital website.  
Hospital will distribute “Are you ready feet?” cards at outreach sites.  
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.  
Hospital will send staff member to LIHC meetings and remain active with initiatives.  
Hospital will engage Medical Affairs Department in promoting walking program. | 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.  
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*.  
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. | 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.  
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.  
The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities. |
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<td>Provide transparency in population health data analysis activities for stakeholders</td>
<td>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 publically available on the LIHC website. 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. 3. Upon request, the PHIP will engage in data analysis and collection efforts for those projects supporting the Prevention Agenda. 4. PHIP data workgroup will provide expertise, guidance and build consensus during the development of data collection tools. 5. PHIP will be utilized as the primary location for return surveys and data analysis</td>
<td>1. Provision of ongoing measurement and public reporting of primary and secondary data sources. 2. PHIP team will assist member data requirements by leading data reporting projects. 3. PHIP will provide technical support to community-partners during a variety of analysis projects, grant applications and strategic planning. 4. Development of data collection tools. 5. Centralized return hub for data collection efforts</td>
<td>1. Monthly reporting summaries to be presented at LIHC meetings, data sets and projects to be posted on data page of website. 2. Open communication-follow up and execution of data focused projects. 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 streamlining efforts in data analysis. 4. Research evidence-based measurement tools and adapt them to the specific data collection effort being carried out. 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.</td>
<td>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.</td>
<td>Hospital will participate in Long Island Health Collaborative Wellness Survey to collect data to assist in evaluating wellness program effectiveness.</td>
<td>Hospital staff member will be active at both the LIHC group and data subcommittee meetings.</td>
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<td><strong>Leverage partnerships and achieve collective impact among LIHC community-partner network</strong></td>
<td>1. Communicate with partners to understand what activities are occurring within which communities 2. Identify potential partnerships and introduce compatible partners 3. Align objectives with organizations currently engaged in Complete Street work to increase sustainable, built environments 4. Provide central local for grant-partners to collaborate and streamline grant activities that support healthy eating and physical activity</td>
<td>1. LIHC will assess resource availability through network of community-partners 2. LIHC will promote collective impact strategies by leveraging existing resources and identifying partnerships 3. Support and participate in Complete Streets Policy work 4. Engagement of two synergistic grants in region: Eat Smart NY (USDA) and Creating Healthy Schools and Communities (NYS DOH)</td>
<td>1. Develop efficient surveys and polls which will capture information about parallel projects within Nassau County Communities. 2. Manage and ongoing involvement in partnerships with continued effort to identify partnership and streamline activities 3. Work closely with Local Health Departments and organizations engaged in Complete Street work, identify opportunities for partnership or support 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</td>
<td>Include community partners in ongoing community needs assessment activities. Include community partners in Hospital Community Advisory Council. Support local Health Department and Complete Streets work. Identify and support collaborative grant opportunities.</td>
<td>Long Island Community Health Survey and hospital database of responses.</td>
<td>Annually reassess community contacts and partners. Add to Community Advisory Council guest list as appropriate.</td>
<td>Work cooperatively and support LIHC grant efforts.</td>
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<td><strong>Support and increase Evidence-Based Community-Programming Efforts</strong></td>
<td>1. Promote and advance evidence-based community programs 2. Support DSRIP efforts to increase programming throughout the region</td>
<td>1. Connect members with providers of Stanford Model programs including: Diabetes-Self Management Program and Chronic Disease Self-Management program 2. Partner with DSRIP PPS to increase program availability.</td>
<td>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 2. Work in partnership with PPS to identify community locations where Stanford Model programs will take place</td>
<td>Support DSRIP efforts to provide location for programs.</td>
<td>Hospital website, and community partners</td>
<td>Engage existing community partners to support events.</td>
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| Increase community awareness of Mental Health/Substance Abuse        | 1. Establish workgroup, identify strategies, meet regularly to address the need for increased awareness and focus on Mental Health and Substance abuse  
2. Promote program to community partners and identify where/which organizations are certified to lead training  
3. Commit to addressing mental health as a priority area by attesting and contributing to PPS strategies | 1. Development of a mental health focused LIHC sub-workgroup  
2. Increase availability of Evidence-Based Mental Health First Aid USA™ training program for community members and front line healthcare workforce  
3. Position strategies to support DSRIP Domain 4 projects related to addressing mental health | 1. Identify leaders and advocates for those living with mental health and substance abuse issues, host first meeting, review data in support of strategies  
2. Host evidence based program for LIHC members or employees of organizations who work with this population  
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 | Support LIHC Mental Health initiatives.  
Support DSRIP mental health projects. | Review data and work on program planning to support Mental Health issues on Long Island. |                                                                                                     |                                                                                                                                       |
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| Alignment with state reform initiatives including DSRIP and SHIP | 1. Identify strategies supporting DSRIP-PPS efforts  
2. Work in direct partnership with PPS workgroups and provide support to leverage LIHC network within various strategies  
3. Provide data analysis strategies to PPS data-focused teams to address health disparities and | 1. PHIP attendance regional PPS PAC meetings  
2. PHIP participation in workgroup projects: data hot-spotting, cultural competency/health literacy, community engagement  
3. PHIP participation in data hot-spotting strategies | 1. Attendance at meetings; synthesis of information obtained from meetings; alignment of goals with DSRIP milestones  
2. PHIP to become actively involved in DSRIP workgroup strategies and suggest collaborative efforts to support milestone achievement, open communication, meaningful projecting efforts  
3. Contribute to data hot spotting efforts through data mining and analysis efforts, presenting activities during monthly LIHC meetings | Attend LIHC meetings to be aware of PHIP initiatives related to DSRIP-PPS efforts.  
Will participate in data collection efforts. | Support initiatives, engage community via outreach efforts.  
Will strive to address health disparities by providing services in identified communities of need.  
Engage community partners in efforts. |  |  |
### Priority One—Obesity

**Reduce obesity in adults through community-based awareness initiatives such as free community lectures and BMI screenings.**

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<td>Enhance consumer access for weight loss surgery.</td>
<td>Deliver at least 36 weight loss sessions to the community.</td>
<td>Survey attendees before and after session to see if there is an increase in knowledge.</td>
<td>Partner with the New York Bariatric Group to facilitate the training.</td>
<td>Hospital staff and partner with New York Bariatric Group. Public Affairs staff promote sessions through social media.</td>
<td>36 weight loss sessions each year.</td>
<td>To target medically underserved communities and populations</td>
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<td>Mercy Medical Center offers a bariatric clinic for underserved individuals who are obese and at risk for developing related health issues.</td>
<td>Track number of patients seen at Mercy’s clinic and at the New York Bariatric Group who are eligible for reduced-fee care.</td>
<td>Provide bariatric clinic for eligible individuals.</td>
<td>Clinic is located at Mercy Medical Center.</td>
<td>Clinic available for eligible individuals.</td>
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<td>Increase awareness of achieving and maintaining a healthy weight.</td>
<td>Provide free screenings for cholesterol and blood pressure, and BMI screenings at community site locations.</td>
<td>Keep track of the number of attendees at each event and number of referrals.</td>
<td>Provide clinical staff to community site locations to provide screenings and provide health counseling and referrals as needed.</td>
<td>Clinical and non-clinical staff</td>
<td>At least 8 events per year</td>
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<td><strong>Priority Two—Preventive Care and Management.</strong></td>
<td>Increase access to high-quality disease preventive care for heart disease and diabetes in both clinical and community settings.</td>
<td>Mercy Medical Center annual Wellness Fair provides free blood pressure screenings with health education and information.</td>
<td>Count number of attendees at events. Provide additional wellness event by year end 2017.</td>
<td>Set up and invite community to annual event.</td>
<td>Clinical and non-clinical staff, educators and community outreach staff.</td>
<td>Annually</td>
<td>To target medically underserved communities and populations.</td>
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<td>Increase knowledge of disease preventive care in both clinical and community settings.</td>
<td>Mercy to use the Speakers Bureau to provide information on a variety of medical topics</td>
<td>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.</td>
<td>Hospital provides speakers for each event delivered by medical staff and support staff, depending on topic.</td>
<td>Clinical and non-clinical staff, educators and community outreach staff.</td>
<td>One session per month.</td>
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<td>Increase knowledge of diabetes care and prevention.</td>
<td>Diabetes Education &amp; Lectures</td>
<td>Conduct surveys before and after speaker event to determine if there was an increase in knowledge on the topic.</td>
<td>Delivered by the certified diabetic educator.</td>
<td>Clinical and non-clinical staff, educators and community outreach staff.</td>
<td>Three per month.</td>
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<td>Free wound care screenings are offered at the annual Wellness Fair.</td>
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<td>Track number of wound care screenings performed and the number of individuals recommended for follow-up care.</td>
<td>Plan and host annual event.</td>
<td>Clinical and non-clinical staff, educators and community outreach staff.</td>
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<td>Participate in community programs designed to reach people outside of traditional health care settings.</td>
<td>Participate in Healthy Sundays event.</td>
<td>Provide free blood pressure and BMI screenings at churches. Provide influenza vaccinations (in season). Measure number of screenings, referrals and flu shots.</td>
<td>Volunteer clinical staff attend events at parish and community locations to provide screenings, health information and referral as needed.</td>
<td>Clinical and non-clinical volunteer staff.</td>
<td>Four to five events annually.</td>
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<td>Mental Health</td>
<td>Increase community awareness of mental health/substance abuse.</td>
<td>Mercy Medical Center to support LIHC projects related to addressing mental health.</td>
<td>Ensure Mercy staff are represented on Mental Health/Substance Abuse workgroup.</td>
<td>Hospital staff will participate in LIHC workgroup meetings.</td>
<td>Mercy staff to attend workgroup meeting.</td>
<td>Annually as scheduled</td>
<td>To target underserved communities. Target at risk populations.</td>
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<td>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.</td>
<td>Refer appropriate patients to services within CHS, if available.</td>
<td>Count the total number of referrals to CHS facilities.</td>
<td>Hospital staff refers to appropriate services.</td>
<td>Hospital staff make referrals as appropriate.</td>
<td>Annually</td>
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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
LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY

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

1. What are the biggest ongoing health concerns in THE COMMUNITY WHERE YOU LIVE? (Please check up to 3)
   - □ Asthma/lung disease
   - □ Heart disease & stroke
   - □ Safety
   - □ Cancer
   - □ HIV/AIDS & Sexually
   - □ Vaccine preventable diseases
   - □ Child health & wellness
   - □ Transmitted Diseases (STDs)
   - □ Women’s health & wellness
   - □ Diabetes
   - □ Mental health
   - □ Other (please specify)
   - □ Drugs & alcohol abuse
   - □ depression/suicide
   - □ Environmental hazards
   - □ Obesity/weight loss issues

2. What are the biggest ongoing health concerns for YOURSELF? (Please check up to 3)
   - □ Asthma/lung disease
   - □ Heart disease & stroke
   - □ Safety
   - □ Cancer
   - □ HIV/AIDS & Sexually
   - □ Vaccine preventable diseases
   - □ Child health & wellness
   - □ Transmitted Diseases (STDs)
   - □ Women’s health & wellness
   - □ Diabetes
   - □ Mental health
   - □ Other (please specify)
   - □ Drugs & alcohol abuse
   - □ depression/suicide
   - □ Environmental hazards
   - □ Obesity/weight loss issues

3. What prevents people in your community from getting medical treatment? (Please check up to 3)
   - □ Cultural/religious beliefs
   - □ Lack of availability of doctors
   - □ Unable to pay co-pays/deductibles
   - □ Don’t know how to find doctors
   - □ Language barriers
   - □ There are no barriers
   - □ Don’t understand need to see a doctor
   - □ No insurance
   - □ Other (please specify)
   - □ Transportation
   - □ 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)
   - □ Clean air & water
   - □ Mental health services
   - □ Smoking cessation programs
   - □ Drug & alcohol rehabilitation services
   - □ Recreation facilities
   - □ Transportation
   - □ Healthier food choices
   - □ Safe childcare options
   - □ Weight loss programs
   - □ Job opportunities
   - □ Safe places to walk/play
   - □ Other (please specify)
   - □ Safe worksites

5. What health screenings or education/information services are needed in your community? (Please check up to 3)
   - □ Blood pressure
   - □ Eating disorders
   - □ Mental health/depression
   - □ Cancer
   - □ Emergency preparedness
   - □ Nutrition
   - □ Cholesterol
   - □ Exercise/physical activity
   - □ Prenatal care
   - □ Dental screenings
   - □ Heart disease
   - □ Suicide prevention
   - □ Diabetes
   - □ HIV/AIDS & Sexually
   - □ Vaccination/immunizations
   - □ Disease outbreak information
   - □ Transmitted Diseases (STDs)
   - □ Other (please specify)
   - □ Drug and alcohol
   - □ Importance of routine well checkups
6. Where do you and your family get most of your health information? (Check all that apply)

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

*For statistical purposes only, please complete the following:*

I identify as:  
- Male
- Female
- Other

What is your age? _______________________

ZIP code where you live: _______________________

Town where you live: _______________________

What race do you consider yourself?

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

Are you Hispanic or Latino?

- Yes
- No

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

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

What is your annual household income from all sources?

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

What is your highest level of education?

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

What is your current employment status?

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

Do you currently have health insurance?

- Yes
- No
- No, but I did in the past

Do you have a smart phone?

- Yes
- No

If you have health concerns or difficulty accessing care, please call the Long Island Health Collaborative for available resources at: 631-257-6957.

Please return this completed survey to:
LIHC
Nassau-Suffolk Hospital Council
1383 Veterans Memorial Highway, Suite 26
Hauppauge, NY 11788
Or you may fax completed survey to 631-435-2343

All non-profit hospitals on Long Island offer financial assistance for emergency and medically necessary care to individuals who are unable to pay for all or a portion of their care. To obtain information on financial assistance offered at each Long Island hospital, please visit the individual hospital’s website.
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

<table>
<thead>
<tr>
<th>Hospitals, Hospital Association and Hospital Systems</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brookhaven Memorial Hospital Medical Center</td>
<td><a href="http://www.brookhavenhospital.org">www.brookhavenhospital.org</a></td>
</tr>
<tr>
<td>Catholic Health Services of Long Island</td>
<td><a href="http://www.chsli.org">www.chsli.org</a></td>
</tr>
<tr>
<td>Eastern Long Island Hospital</td>
<td><a href="http://www.elih.org">www.elih.org</a></td>
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<tr>
<td>Glen Cove Hospital</td>
<td><a href="http://www.northwell.edu">www.northwell.edu</a></td>
</tr>
<tr>
<td>Good Samaritan Hospital Medical Center</td>
<td><a href="http://www.goodsamaritan.chsli.org">www.goodsamaritan.chsli.org</a></td>
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<tr>
<td>Huntington Hospital</td>
<td><a href="http://www.northwell.edu">www.northwell.edu</a></td>
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<td>Long Island Jewish Valley Stream</td>
<td><a href="http://www.matherhospital.org">www.matherhospital.org</a></td>
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<tr>
<td>John T. Mather Memorial Hospital</td>
<td><a href="http://www.mercymedicalcenter.org">www.mercymedicalcenter.org</a></td>
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<td>Mercy Medical Center</td>
<td><a href="http://www.nshc.org">www.nshc.org</a></td>
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<tr>
<td>Nassau-Suffolk Hospital Council</td>
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<td>Nassau University Medical Center</td>
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<tr>
<td>North Shore University Hospital</td>
<td><a href="http://www.northwell.edu">www.northwell.edu</a></td>
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<tr>
<td>Northwell Health System</td>
<td><a href="http://www.northwell.edu">www.northwell.edu</a></td>
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<tr>
<td>Peconic Bay Medical Center</td>
<td><a href="http://www.pbmchealth.org">www.pbmchealth.org</a></td>
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<tr>
<td>Plainview Hospital</td>
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<td>St. Catherine of Siena Medical Center</td>
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<td>St. Charles Hospital</td>
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<td>Southampton Hospital</td>
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<td>South Nassau Communities Hospital</td>
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<td>Syosset Hospital</td>
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<td>Veterans Affairs Medical Center</td>
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<tr>
<td>Winthrop University Hospital</td>
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### Local County Health Departments

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<th>Website</th>
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<tr>
<td>Nassau County Department of Health</td>
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### Medical Societies and Associations

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<th>Organization</th>
<th>Website</th>
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<tr>
<td>Long Island Dietetic Association</td>
<td><a href="http://www.eatrightli.org">www.eatrightli.org</a></td>
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<tr>
<td>Nassau County Medical Society</td>
<td><a href="http://www.nassaucountymedicalsociety.org">www.nassaucountymedicalsociety.org</a></td>
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<td>New York State Nurses Association</td>
<td><a href="http://www.nysna.org">www.nysna.org</a></td>
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<td>New York State Podiatric Medical Association</td>
<td><a href="http://www.nyspma.org">www.nyspma.org</a></td>
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<tr>
<td>Suffolk County Medical Society</td>
<td><a href="http://www.scms-sam.org">www.scms-sam.org</a></td>
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### Community-Based Organizations

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<tr>
<td>Adelphi New York Statewide Breast Cancer Hotline and Support Program</td>
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<td>Alzheimer's Association, Long Island Chapter</td>
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<tr>
<td>American Cancer Society</td>
<td><a href="http://www.cancer.org">www.cancer.org</a></td>
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<tr>
<td>American Foundation for Suicide Prevention</td>
<td><a href="http://www.afsp.org">www.afsp.org</a></td>
</tr>
<tr>
<td>American Heart Association</td>
<td><a href="http://www.heart.org">www.heart.org</a></td>
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<tr>
<td>American Lung Association of the Northeast</td>
<td><a href="http://www.lung.org">www.lung.org</a></td>
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<tr>
<td>Association for Mental Health and Wellness</td>
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<td>Asthma Coalition of Long Island</td>
<td><a href="http://www.asthmacommunitynetwork.org">www.asthmacommunitynetwork.org</a></td>
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<td>Attentive Care Services</td>
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<td>Caring People</td>
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<td>Community Growth Center</td>
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<td>Cornell Cooperative Extension - Suffolk County</td>
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<td>Epilepsy Foundation of Long Island</td>
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<td>Evolve Wellness</td>
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<td>Family &amp; Children's Association</td>
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<td>Family First Home Companions</td>
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<td>Federation of Organizations</td>
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<td>Health and Welfare Council of Long Island</td>
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<td>Health Education Project / 1199 SEIU</td>
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<td>Hispanic Counseling Center</td>
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<td>Hudson River Healthcare</td>
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<td>Life Trusts</td>
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<td>Long Island Association of AIDS Care</td>
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<td>Long Island Council of Churches</td>
<td><a href="http://www.liccny.org">www.liccny.org</a></td>
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<td>Make the Road NY</td>
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<td>Maurer Foundation</td>
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<td>Mental Health Association of Nassau County</td>
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<td>Music and Memory</td>
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<td>New York City Poison Control</td>
<td><a href="http://www.nyc.gov">www.nyc.gov</a></td>
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<td>Options for Community Living</td>
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<td>Pulse of NY</td>
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<td>Retired Senior Volunteer Program</td>
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<td>RotaCare</td>
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<td>SDC Nutrition PC</td>
<td><a href="http://www.call4nutrition.com">www.call4nutrition.com</a></td>
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<td>Smithtown Youth Bureau</td>
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<td>Society of St. Vincent de Paul Long Island</td>
<td><a href="http://www.svdpli.org">www.svdpli.org</a></td>
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<td>State Parks LI Regional Office</td>
<td><a href="http://www.nysparks.com">www.nysparks.com</a></td>
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<td>Sustainable Long Island</td>
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<td>The Crisis Center</td>
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<td>Thursday's Child</td>
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<td>TriCare Systems</td>
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<td>YMCA of LI</td>
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**School and Colleges**

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<thead>
<tr>
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<td>Adelphi University</td>
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<td>Farmingdale State College</td>
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<td>Hofstra University</td>
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<td>St. Joseph’s College</td>
<td><a href="http://www.sjcny.edu/long-island">www.sjcny.edu/long-island</a></td>
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<td>Stony Brook University</td>
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<td><strong>Western Suffolk BOCES</strong></td>
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<td><strong>Performing Provider Systems (DSRIP PPS)</strong></td>
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<td>New York Care Information Gateway</td>
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<td>New York State Department of Parks and Recreation</td>
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