

St. Charles Hospital

Community Health Needs Assessment and Improvement Plan

2016-2018



Approved by the Board of Trustees on October 4, 2016



St. Charles Hospital
Catholic Health Services
At the heart of health

200 Belle Terre Road
Port Jefferson, NY • (631) 474-6797
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Suffolk County

Community Health Needs Assessment and Improvement Plan

2016-2018

Suffolk County Department of Health Services

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Catholic Health Services of Long Island

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

Northwell Health System

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

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

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

Executive Summary

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

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

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

Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics.

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

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

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

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

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

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

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

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

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

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

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 involved a healthcare team- 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 Suffolk County, New York. Suffolk County's service area is situated east of the Nassau County Border, extending through the eastern forks of Long Island. It comprises ten towns: Babylon, Huntington, Islip, Smithtown, Brookhaven, Southampton, Riverhead, East Hampton, Shelter Island and Southold. Suffolk County is an area of growing diversity, cultures and population characteristics.

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.

St. Charles Hospital is located on the north shore of Suffolk County in the Town of Brookhaven. A not-for-profit hospital with 243 beds, St. Charles is a member of Catholic Health Services. The community served includes both the primary and secondary catchment area. The primary catchment area represents more than 440,000 residents, which accounts for 81% of the hospital's admissions. The service area has not changed since 2008. For the purposes of this CHNA, the primary service area consists of Port Jefferson, Port Jefferson Station, Rocky Point, Mount Sinai, Miller Place, East Setauket, Stony Brook, Ridge, Coram, Middle Island, Centereach, Sound Beach, Ronkonkoma, Shoreham, Wading River, Shirley, Saint James, Lake Grove, Riverhead, Yaphank, Patchogue and Medford.

Data Findings

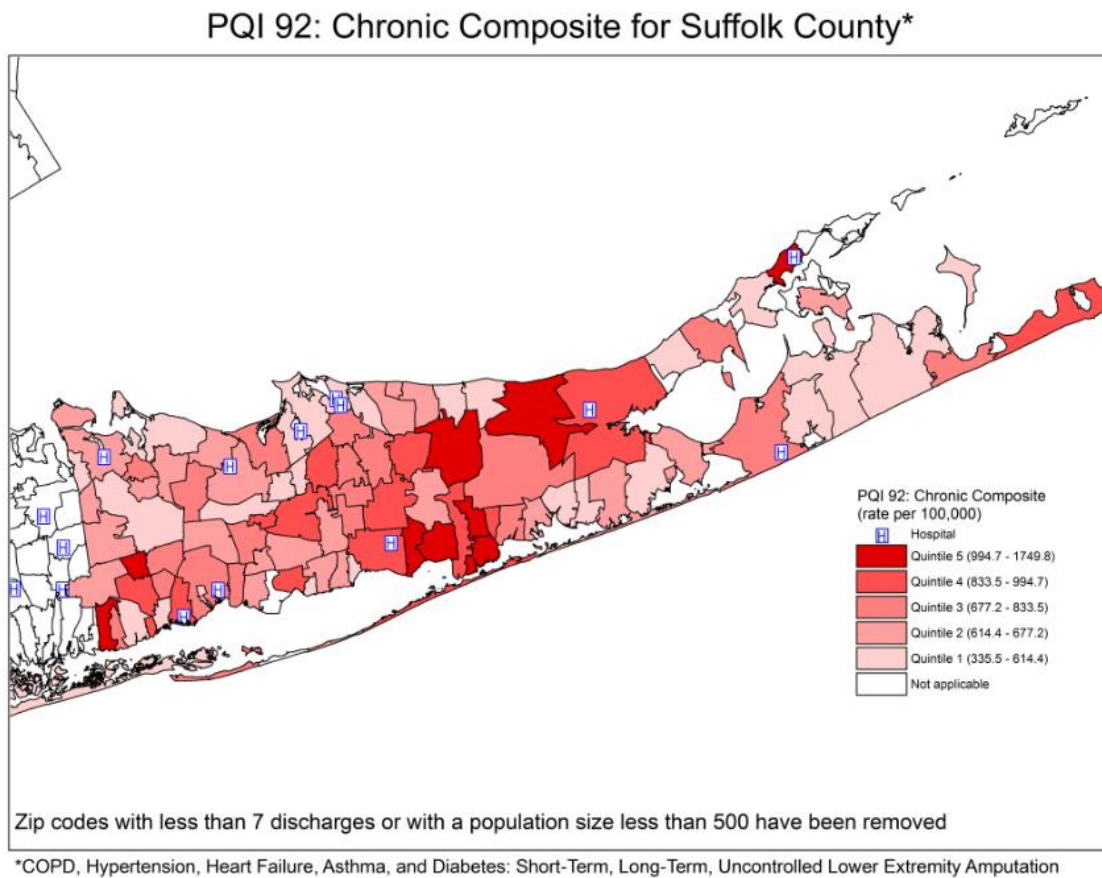
Prevention Quality Indicators

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



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

Prevention Agenda Dashboard*

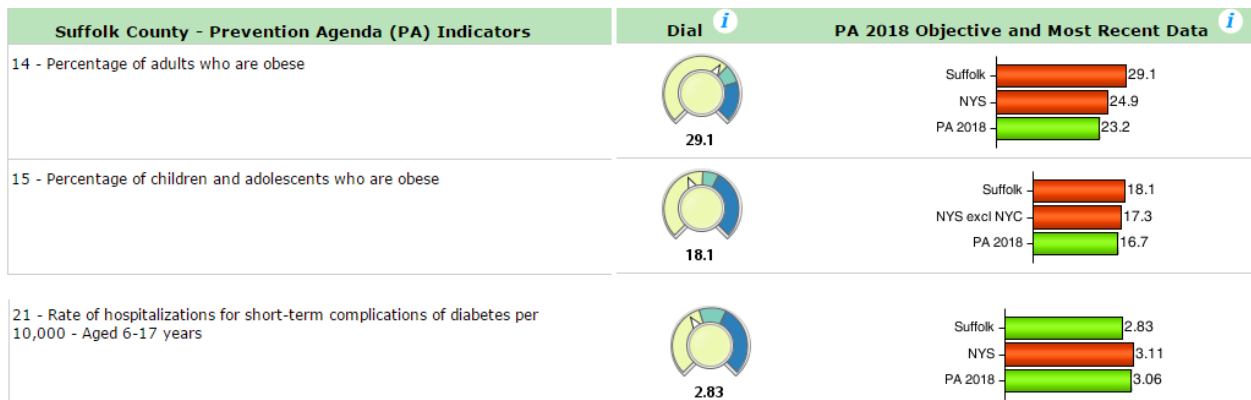
The Prevention Agenda 2013-2018 is New York State's Health Improvement plan purposed to improve health outcomes and reduce health disparities within five priority areas: Chronic Disease Prevention, Healthy and Safe

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 29.1% of adults in Suffolk County are obese. Obesity rates are higher than figures reported by New York State, 24.9% and the Prevention Agenda Goal of 23.2%. The Long Island Health Collaborative felt interventions should be focused on decreasing chronic disease as a whole, while focusing on obesity, prevention and care management.

The percentage of children and adolescents who are obese in Suffolk County is 18.1% as compared to New York State (and excluding New York City) figure of 17.3%. The Long Island Health Collaborative has declared commitment to reaching the Prevention Agenda 2018 goal of 6.7% or lower.

Rate of hospitalizations for short-term complication of diabetes reflects 2.83 per 10,000 for adults in Suffolk County and 3.11 in New York State. Although this indicator is below the Prevention Agenda Goal of 3.06%, 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 Suffolk 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 3,559 surveys collected from Suffolk County residents. Based upon the total population of Suffolk County, survey totals assume a confidence level of 95% and confidence interval of 1.75. Initial analysis took place in March 2016 and a secondary analysis took place in June 2016. LIHC members have played an integral role in ensuring surveys are distributed while maintaining validity and reliability among responses. To view a copy of the Long Island Community Health Assessment Survey, see Appendix.

Methodology:

Long Island Community Health Assessment Surveys 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:*

- Suffolk County respondents felt that Cancer, Drugs and Alcohol Abuse and Obesity/Weight Loss were the top three concerns.
 - These three choices represented roughly 46% of the total responses.
2. When asked ***what the biggest ongoing health concerns for yourself are:***
- Suffolk County respondents felt that Obesity/Weight Loss, Women's Health and Wellness, and Cancer were the top three concerns.
 - These three choices represented roughly 40% of the total responses.

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

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

CBO Summit Event Qualitative Data Analysis and Interpretation

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

Data Collection Tool

A script for facilitators 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 Suffolk County. In looking at distinct Prevention Agenda Categories, 30.9% of quotations indicated chronic disease being a priority area.

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

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

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

Within the priority area of chronic disease, chronic disease management and obesity/nutrition were the most frequently prioritized focal areas. Of the total number of quotes by County, 10.2% of quotations included “Chronic Disease Management” and “Obesity/Nutrition” equally, as topics of importance.

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

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

| Analytic Interpretation & Participant Quotations |
|--|
| <p>Chronic Disease is a significant health problem for community members in Suffolk County. Prevention and management of chronic conditions should be a priority for those looking to improve quality of live and improve health outcomes. Furthermore, the prevalence of obesity exacerbates chronic disease and mental health problems.</p> <p>Prevention and effective management of Chronic Disease must occur in order to improve quality of life for community members and to reduce the financial burden being placed on our health care system. I can tell you that we have lots of issues, but if we do not get a hold of our chronic diseases, our chronic problems, our heart problems, our COPD, our obesity. -Suffolk Event, RN Nurses Evolve PLLC</p> <p>In Suffolk, I believe that obesity is a huge underlying issue for many chronic medical conditions. The asthma. The high blood pressure. The diabetes. It even can affect mental health with children, with teens. If you have someone who is obese, it affects them socially and emotionally. So addressing obesity is a big issue to affect all the other chronic health conditions that people have. Preventative care, I think if people had more access to preventative care and management, it may reduce the incidents of obesity and reduce some of the other chronic issues. -Suffolk County Department of Health, Maternal Infant Community Health Collaborative</p> <p>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.</p> |

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

-American Lung Association

Education focused on healthy eating, chronic disease management or physical activity must be culturally competent and of health literate standards to properly engage the diverse spectrum of community members living in Suffolk County.

Nutrition related diseases, whether it be high blood pressure, diabetes, these are things, even just educating people how to, when they're receiving SNAP, what type of items to buy. Cultural diversity, just having, you know, staff in each facility trained on just the cultural needs of different populations. I see a lot of -- there's a big gap sometimes when someone comes in and speaks another language, and how do you help that person that speaks another language and, like you said, may not be able to even read or write in their own language, so I think a lot of it is just having staff that's educated and more well-rounded to provide those type of service to people that need that direction.

-Long Island Cares

Many cases of COPD and lung cancer are not diagnosed until the condition has progressed into its later stages. Awareness and education surrounding the importance of screenings, for any chronic condition, leads to early diagnosis and thus more effective treatment.

Challenges that we see are people who have been smokers for many years. COPD in particular, probably half the cases that are out there, have not been diagnosed yet. People just feel that oh im a little older, Im a little short of breath, until acute exacerbation and they end up in the hospital with pneumonia and then they are diagnosed. Very similarly, lung cancer, there are no early warning signs for lung cancer. Because women just don't think about it. So we are trying to get them to understand that if you are at risk, get screened. Early screening is very important. We know that lung cancer has huge fatality rates; it's the number one cancer killer in the US for both men and women. Because there is no early warning signs and no screening. So we are really starting to build the push on educating the community about early warning signs, getting screenings for both.

-American Lung Association

The priority area of mental health and substance abuse emerged closely as a second-ranking topic of importance. Qualitative analysis demonstrated, 29.9% of quotations indicating mental health as an area of concern in Suffolk County. Cumulatively, 47.9% of quotations included mental health and substance abuse as an area of concern within communities served in Suffolk County.

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

| Mental Health and Substance Abuse | |
|---|-----------|
| Focus Area | %* |
| Mental Health Issues | 18.1% |
| Substance Abuse | 11.3% |
| Susceptible Populations | 7.4% |
| Attitudes | 4.1% |
| Anxiety, Mood Disorders, and Associated Emotions | 2.9% |
| Treatment and Recovery | 2.7% |
| Eating Disorders | 0.9% |
| Suicide | 0.4% |

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

| Analytic Interpretation & Participant Quotations |
|--|
| <p>Availability of mental health and substance abuse treatment and recovery services is not adequate considering the high demand for service. Prevention and strategies focused on maintaining follow-up care for mental health are equally important.</p> <p>. . . The major issue is the long waiting list and by the time that their appointment comes up they're no longer with us and they fall through the cracks. We don't know where they're going. We don't know if someone is going to follow up so that's part of, you know that lack of prevention as well. It's a long waiting list just to get psych evaluations. <i>- Community Housing Innovations</i></p> |
| <p>Mental health problems for seniors are often undiagnosed which leads to an inability to provide effective treatments or therapies.</p> <p>When you first mentioned the question about the major health problems, I work in independent housing for seniors, and there are a lot of undiagnosed mental health issues. So they have the mental health, but it's never been diagnosed, and getting the services and the treatment and even medications for that generation becomes very hard. <i>- Catholic Charities Housing Department</i></p> |
| <p>Substance abuse is a notable problem throughout the Long Island Region. Substance abuse is often recognized within diverse populations including young adults, seniors and Veterans.</p> <p>Talking about specific health concerns, so one of the things we're really looking at the specific health concerns. I think the number on Long Island is over 300 young people are dying a year from heroin overdose. So that's the equivalent of a jumbo jet liner crashing and everybody dying, once a year on Long Island. So if that were to happen, we would be outraged. There would be more of a policy outrage, of why is this happening? So my boss is actually a priest, and he buries a lot of these young people who die every year, so that's really a major push for us. It's criminal. We're not talking about the traditional, you smoke pot, and you move onto a higher drug, a different drug, we're talking prescription medication to heroin overdose to death, within a couple of years. So that's one of the main focuses we're working on. <i>-Hope House</i></p> <p>One of the things, it's a hidden secret is the substance abuse among seniors, you know due to the isolation, but also too there's a lot of seniors that are sitting at home drinking all day and so it is not just a young person or, you know, a middle adult issue, it's a very big issue for seniors. <i>- At Home Designs</i></p> |
| <p>The relationship between chronic disease and mental health presents care providers with complex challenges related to the interplay between conditions and medication regimen.</p> <p>Mental issues and substance abuse issues, but what comes with that sometimes is obesity, diabetes, high blood pressure. Often times it's the medications that are prescribed Proceedings and that people take actually can cause diabetes and cause people to increase their appetite, and that's the domino effect. Those are many of the health issues. Obviously, for the older population, chronic heart disease, COPD. <i>-Association for Mental Health and Wellness</i></p> |

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.

St. Charles Hospital 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, St. Charles Hospital 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 St. Charles Hospital:

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

- Drug & alcohol abuse 51.93%
- Cancer 42.13%
- Obesity/weight loss issues 31.33%
- Mental health depression/suicide 30.22%
- Heart disease & stroke 22.41%
- Diabetes 18.25%
- Safety 11.02%
- Child health & wellness 10.89%
- Women's health & wellness 10.80%
- Asthma/lung disease 8.97%
- Environmental hazards 7.74%
- Vaccine preventable diseases 3.62%
- HIV/AIDS & Sexually Transmitted Diseases (STD) 2.77%

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

- Obesity/Weight Loss Issues 35.58%
- Heart disease & stroke 30.06%
- Cancer 28.68%
- Women's Health & Wellness 27.75%
- Diabetes 18.57%
- Mental health depression/suicide 16.39%
- Asthma/lung disease 11.37%
- Safety 11.09%
- Environmental hazards 9.83%
- Child health & wellness 9.43%
- Drugs & alcohol abuse 8.71%
- Vaccine preventable diseases 3.12%
- HIV/Aids/sexually transmitted disease 1.73%

3. What prevents people in your community from getting medical treatment?
 - Unable to pay co-pays/deductibles 49.76%
 - No insurance 49.00%
 - Fear 31.70%
 - Transportation 18.87%
 - Don't understand need to see a doctor 18.53%
 - There are no barriers 10.43%
 - Lack of availability of doctors 10.42%
 - Language barriers 7.85%
 - Don't know how to find doctors 7.82%
 - Cultural/religious beliefs 3.51%

4. Which of the following is the MOST needed to improve the health of your community?
 - Drug and alcohol rehabilitation services 39.04%
 - Mental health services 30.37%
 - Healthier food choices 30.03%
 - Job opportunities 26.71%
 - Weight loss programs 21.86%
 - Safe places to walk/play 20.71%
 - Clean air and water 19.04%
 - Recreation facilities 16.07%
 - Transportation 15.15%
 - Smoking cessation programs 12.47%
 - Safe childcare options 12.05%
 - Safe worksites 2.65%

5. What health screenings or education/information services are needed in your community?
 - Drug and alcohol 34.16%
 - Mental health/depression 30.57%
 - Exercise/physical activity 24.65%
 - Cancer 21.51%
 - Importance of routine well checkups 20.30%
 - Nutrition 19.24%
 - Diabetes 17.11%
 - Blood pressure 14.38%
 - Heart disease 11.12%
 - Dental screenings 10.40%
 - Emergency preparedness 9.49%
 - Suicide prevention 8.83%
 - Eating disorders 8.17%
 - Cholesterol 7.91%
 - Vaccination/immunizations 4.79%
 - Disease outbreak information 4.28%
 - HIV/AIDS/STDs 3.96%
 - Prenatal care 2.33%

6. I identify as:
 - Female 72.44%
 - Male 27.31%
 - Other 0.25%

7. Average age of respondents: 49

8. What race do you consider yourself?
 - White/Caucasian 91.40%
 - Black/African-American 3.65%

| | |
|---|--------|
| • Asian/Pacific Islander | 2.35% |
| • Multi-racial | 2.22% |
| • Native American | 0.39% |
| 9. Are you Hispanic or Latino? | |
| • No | 80.02% |
| • Yes | 10.77% |
| • No answer | 9.21% |
| 10. What is your annual household income from all sources?? | |
| • \$0-\$19,999 | 13.86% |
| • \$20,000-\$34,999 | 10.05% |
| • \$35,000-\$49,999 | 9.92% |
| • \$50,000-\$74,999 | 15.76% |
| • \$75,000-\$125,000 | 28.80% |
| • >\$125,000 | 21.60% |
| 11. What is your highest level of education? | |
| • College graduate | 32.39% |
| • Graduate school | 18.77% |
| • High school graduate | 15.30% |
| • Some college | 14.65% |
| • Technical school | 5.78% |
| • Doctorate | 4.76% |
| • Some high school | 3.21% |
| • K-8 grade | 0.64% |
| • Other (GED, nursing school) | 0.64% |
| 12. What is your current employment status? | |
| • Employed for wages | 65.72% |
| • Retired | 15.72% |
| • Out of work but not currently looking | 5.80% |
| • Out of work/looking for work | 5.15% |
| • Self-employed | 0.52% |
| • Student | 0.18% |
| • Military | 0.13% |
| 13. Do you currently have health insurance? | |
| • Yes | 86.15% |
| • No | 11.64% |
| • No but I did in the past | 2.21% |

Analysis of surveys again indicates continued community concern over obesity and co-morbidities of diabetes, stroke and heart disease. It is important to note however that the issue of drug and alcohol abuse was cited as the number one ongoing health concern in the community.

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 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?TM 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?TM 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 Suffolk 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 at hospital 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>We will include providers in our wellness outreach initiatives.</p> | <p>Hospital website</p> <p>Hospital social media resources</p> <p>Will include identified health information resources on hospital website.</p> <p>Will distribute “Are you ready feet?” cards at hospital and community outreach events.</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>Will engage hospital 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 Suffolk 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 |
|---|---|---|--|---|--|----------------|--------------------------------------|
| <p><i>Provide transparency in population health data analysis activities for stakeholders</i></p> | <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 publically 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</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 |
|--|---|--|--|--|---|----------------|--------------------------------------|
| <i>Leverage partnerships and achieve collective impact among LHC community-partner network</i> | <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. LHC will assess resource availability through network of community-partners</p> <p>2. LHC 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 occurring within Suffolk 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>Will include community partners in ongoing community needs assessment activities.</p> <p>Will include community partners in Hospital Community Advisory Council.</p> <p>Will support local health department and Complete Streets work.</p> <p>Will identify and support collaborative grant opportunities.</p> | <p>Will participate in Long Island Community Health Survey.</p> <p>Will annually reassess community contacts and partners</p> <p>Will use hospital website, and community partners to promote initiatives</p> <p>Will work cooperatively and support LHC grant efforts.</p> | | |
| <i>Support and increase Evidence-Based Community-Programming Efforts</i> | <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> | <p>Will support DSRIP efforts to provide location for programs.</p> | <p>Will engage community partners to support programs.</p> | | |

| 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>Will support LIHC Mental Health initiatives.</p> <p>Will support DSRIP mental health projects.</p> | <p>Review data and work on program planning to support mental health issues on Long Island.</p> <p>Add or expand existing behavioral health programs to support patients with chronic conditions.</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>Will attend LIHC meetings to be aware of PHIP initiatives related to DSRIP-PPS efforts.</p> <p>Will participate in data collection efforts.</p> | <p>Will 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>Will engage community partners in efforts.</p> | | |

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

St. Charles Hospital's 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 Prevent obesity in children with a focus on nutrition and exercise. | Strengthen partnerships with Sachem and Comsewogue schools districts in St. Charles Hospital's ThinkHEALTHY program. | Host at least four healthy nutrition/exercise programs for children at Comsewogue and Sachem elementary schools from 2016-2018. | Hospital will track number of programs held at each school and count of attendees. Plan a quiz or game with attendees to assess comprehension. | Engage student population and parents and increase participants' knowledge of importance of healthy lifestyle. | St. Charles Hospital registered dietitians and physical therapists. | The hospital's ThinkHEALTHY program, activities will continue on an ongoing basis through 2018. | All activities are developed with the elimination of health disparities as an overarching goal. Data acquired through the PHIP will help direct actions aimed at reducing health disparities. |
| | Launch a healthy eating/exercise program at local schools. | Host at least two educational programs at Comsewogue elementary schools, and continue programs at Wenonah Elementary school for parents on healthy nutrition/exercise for children. | Hospital will track number of programs held at Comsewogue elementary schools and count of attendees. Give a short survey or quiz to attendees to demonstrate knowledge of healthy food choices. | Engage student population and parents and increase participants' knowledge of importance of healthy lifestyle. | St. Charles Hospital registered dietitians and staff. | Programs to be scheduled throughout 2016-2018. (Due to a Sachem administrative change in 2017, the program will be re-evaluated at that time by the school district for future participation). | |
| | Create programs that promote and support healthy food/beverage choices and physical activity. | Host at least four healthy nutrition/exercise programs for children at the hospital. | Hospital will track programs held and attendance at each. Survey participants on knowledge of topics before and after program. | Engage attendees and increase participants' knowledge of importance of healthy lifestyle. | St. Charles Hospital registered dietitians and staff. | Initiative to continue through 2016-2018. | |
| | Communicate SCH programs and services to partners. | Identify effective social media strategies to engage community. | Identify at least two new community partners. | Survey new partners to determine how they learned of programs and services. | St. Charles Community Outreach staff. | Initiative to continue through 2016-2018. | |

| Goal | Outcome Objectives | Interventions/ Strategies/Activities | Process Measures | Hospital Role | Hospital Resources | By When | Will action address disparity |
|--|---|---|---|---|---|---|--|
| Priority Two: Preventive Care—Chronic Disease Increase access to high-quality disease preventive care and management for cardiovascular disease and diabetes through the Speakers to Go program. The program provides free education to the community on various health and wellness programs and promotes healthier lifestyles. | Engage the community in its own health care by increasing the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life. | Conduct free community lectures by providing free-of-charge clinical experts that offer educational seminars and information on the prevention of disease and injury, improve health and enhancing quality of life. Develop marketing strategies to target specific groups with information and education. | Hospital presently provides 30 community lectures annually and will seek to increase that number to 32 and maintain for 2016-2018. | Hospital will identify target populations and set up lectures for these populations. Market seminars, screenings, outreach programs and support groups. Social media reach. | Volunteers from hospital clinical and non-clinical staff. Hospital will engage partners such as local senior centers, civic organizations, libraries, schools, and LHC members. | Initiative to continue through 2016-2018. | All activities are developed with elimination of health disparities for underserved populations. Data acquired through the PHIP will help direct actions aimed at reducing health disparities. |
| | | Identify and participate in effective social media strategies to promote Speakers to Go program | Survey Speakers to Go partners to determine how they learned of the program. | Develop two strategies to promote the program. | Public Relations staff. | To continue through the 2016-2018 cycle. | |
| | Implement educational and community-based programs and strategies that are designed to reach people outside of traditional health care settings. | Offer free support groups for overeaters anonymous, weight loss surgery support, and pre-diabetes. | Offer at least three support groups per year. Identify number of participants in each group and survey attendees for the value of the support group to the community. | Arrange support groups, meeting space, and facilitators. | Hospital to provide meeting facilitators and meeting space. | Offer three support groups per year in the 2016-2018 cycle. | |
| | | Partner with organizations outside the health care arena: schools, worksites and community centers. | Establish at least three new partnerships over the 2016-2018 cycle. | Seek partnerships through local community and through LHC. | Public Relations staff. | To continue through the 2016-2018 cycle. | |
| | | Participate in Healthy Sundays events. | Participate in at least four Healthy Sunday events. | Provide screenings for blood pressure, BMI, and flu vaccines. | Volunteers from hospital RN staff and non-clinical staff. | Four events to be held each year. | |

| Goal | Outcome Objectives | Interventions/ Strategies/Activities | Process Measures | Hospital Role | Hospital Resources | By When | Will action address disparity |
|----------------------|---|--|--|--|--|--|--|
| Mental Health | <i>Improve access to mental health programs and resources in our Medically-Supervised Detoxification unit, for the rehabilitation population and patients admitted with a cancer diagnosis.</i> | <i>Increase availability of medically supervised detoxification beds.</i> | <i>St. Charles Hospital will open an additional 10 beds for medically supervised detoxification by the end of 2016.</i> | <i>Open additional beds.</i> | <i>St. Charles Hospital's administrative staff Staff.</i> | <i>During the 2016-2019 cycle.</i> | <i>All activities are developed with elimination of health disparities as an overarching goal. Data acquired through the PHIP will help direct actions aimed at reducing health disparities. To target underserved communities, families and at risk populations.</i> |
| | <i>Improve community access to mental health programs and resources.</i> | <i>Increase availability of Intranasal Narcan for individuals at risk of overdose.</i> | <i>Become a designated distributor of intranasal Narcan to patients and families of those living with drug addiction issues.</i> | <i>Present information at the Emergency Department.</i> | <i>Hospital clinical and non-clinical staff.</i> | <i>Hospital to become designated distributor by end of year 2016.</i> | |
| | | <i>Provide multi-disciplinary program on substance abuse for purpose of preventing drug addiction, early intervention, educate on warning signs. Invite community partners and local health department to take part in planning the multi-disciplinary, day-long program on substance abuse.</i> | <i>A post program survey will be performed to measure effectiveness.</i> | <i>SCH will serve as host for substance abuse program.</i> | <i>Hospital resources include: addictionologist, physician, psychiatrist, psychologist, nurses, care managers, social workers and chaplains. Engage partners such as Suffolk County Department of Health, local legislators, and Fr. Frank Pizzarelli, Executive Director, Founder, CEO of Hope House Ministries (a bi-county, not-for-profit, community-based ministry dedicated to providing comprehensive and competent residential and counseling assistance to adolescents with addiction and mental health issues.</i> | <i>St. Charles Hospital will host one educational event for substance abuse prevention in October, which is Substance Abuse Awareness Month.</i> | |

| Goal | Outcome Objectives | Interventions/ Strategies/Activities | Process Measures | Hospital Role | Hospital Resources | By When | Will action address disparity |
|----------------------|---|--|--|--|----------------------------------|---|--|
| Mental Health | Improve community access to mental health programs and resources. | Provide patients admitted to St. Charles with community resources for cancer services. | Create a cancer resource guide that will be distributed to all patients admitted to St. Charles with an active cancer diagnosis. | Develop and publish guide. | Hospital Public Affairs staff. | During the 2016-2018 cycle. | To target underserved communities, families and at risk populations. |
| | Support LIHC projects related to mental health | Participate in the mental health focused LIHC sub-workgroup. | Have hospital representation at LIHC sub-workgroup. | Support LIHC Mental Health initiatives. | Hospital staff and LIHC members. | Attend meetings conducted during the 2016-2018 cycle. | |
| | Provide target populations with information about the signs and symptoms of mental health and substance abuse issues. Offer link to CHS and community-based clinical programs and services. | Refer appropriate patients to services within CHS, if available. | Count total number of referrals.. | Provide referrals to appropriate services. | Hospital clinical staff. | During the 2016-2018 cycle. | |

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 Suffolk County Executive Summary will be publically available through the consumer facing portion of the Long Island Health Collaborative website at: <http://www.lihealthcollab.org>. Copies of the executive summary will also be printed and distributed at any community forum events. The summary is also available on the hospital website at <http://stcharleshospital.chsli.org/> as well as the Catholic Health Services website at <http://www.chsli.org/>

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 Transmitted Diseases (STDs) | <input type="checkbox"/> Vaccine preventable diseases |
| <input type="checkbox"/> Child health & wellness | <input type="checkbox"/> Mental health | <input type="checkbox"/> Women's health & wellness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> depression/suicide | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Drugs & alcohol abuse | <input type="checkbox"/> Obesity/weight loss issues | |
| <input type="checkbox"/> Environmental hazards | | |

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 Transmitted Diseases (STDs) | <input type="checkbox"/> Vaccine preventable diseases |
| <input type="checkbox"/> Child health & wellness | <input type="checkbox"/> Mental health | <input type="checkbox"/> Women's health & wellness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> depression/suicide | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Drugs & alcohol abuse | <input type="checkbox"/> Obesity/weight loss issues | |
| <input type="checkbox"/> Environmental hazards | | |

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"/> Fear (e.g. not ready to face/discuss health problem) | <input type="checkbox"/> Transportation | |

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 Transmitted Diseases (STDs) | <input type="checkbox"/> Vaccination/immunizations |
| <input type="checkbox"/> Disease outbreak information | <input type="checkbox"/> Importance of routine well checkups | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Drug and alcohol | | |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Doctor/health professional | <input type="checkbox"/> Library | <input type="checkbox"/> Social Media (Facebook, Twitter, etc.) |
| <input type="checkbox"/> Family or friends | <input type="checkbox"/> Newspaper/magazines | <input type="checkbox"/> Television |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Radio | <input type="checkbox"/> Worksite |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Religious organization | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Internet | <input type="checkbox"/> School/college | _____ |

For statistical purposes only, please complete the following:

I identify as: Male Female Other

What is your age? _____

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

What race do you consider yourself?

- | | | |
|---|---|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Native American | <input type="checkbox"/> Multi-racial |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other (please specify) |
| _____ | | |

Are you Hispanic or Latino? Yes No

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

- | | | | | | |
|----------------------------------|-------------------------------------|----------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Spanish | <input type="checkbox"/> Italian | <input type="checkbox"/> Farsi | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Hindi | <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> French Creole | <input type="checkbox"/> Other |

What is your annual household income from all sources?

- | | | |
|---|--|---|
| <input type="checkbox"/> \$0-\$19,999 | <input type="checkbox"/> \$20,000 to \$34,999 | <input type="checkbox"/> \$35,000 to \$49,999 |
| <input type="checkbox"/> \$50,000 to \$74,999 | <input type="checkbox"/> \$75,000 to \$125,000 | <input type="checkbox"/> Over \$125,000 |

What is your highest level of education?

- | | | |
|---|---|---|
| <input type="checkbox"/> K-8 grade | <input type="checkbox"/> Technical school | <input type="checkbox"/> Graduate school |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Some college | <input type="checkbox"/> Doctorate |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> College graduate | <input type="checkbox"/> Other (please specify) |
| _____ | | |

What is your current employment status?

- | | | |
|---|--|---|
| <input type="checkbox"/> Employed for wages | <input type="checkbox"/> Self-employed | <input type="checkbox"/> Out of work and looking for work |
| <input type="checkbox"/> Student | <input type="checkbox"/> Retired | <input type="checkbox"/> Out of work, but not currently looking |
| <input type="checkbox"/> Military | | |

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

Do you have a smart phone? Yes No

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

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 |

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|--|--|
| 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 |

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|--|--|
| New York State Podiatric Medical Association | www.nyspma.org |
| Suffolk County Medical Society | www.scms-sam.org |
| Community-Based Organizations | Website |
| Adelphi New York Statewide Breast Cancer Hotline and Support Program | www.breast-cancer.adelphi.edu |
| Alzheimer's Association, Long Island Chapter | www.alz.org |
| American Cancer Society | www.cancer.org |
| American Foundation for Suicide Prevention | www.afsp.org |
| American Heart Association | www.heart.org |
| American Lung Association of the Northeast | www.lung.org |
| Association for Mental Health and Wellness | www.mentalhealthandwellness.org |
| Asthma Coalition of Long Island | www.asthmacommunitynetwork.org |
| Attentive Care Services | www.attentivecareservices.com |
| Caring People | www.caringpeopleinc.com |
| Community Growth Center | www.communitygrowthcenter.org |
| Cornell Cooperative Extension - Suffolk County | www.ccesuffolk.org |
| Epilepsy Foundation of Long Island | www.efli.org |
| Evolve Wellness | www.evolvewellness.net |
| Family & Children's Association | www.familyandchildrens.org |
| Family First Home Companions | www.familyfirsthomecompanions.com |
| Federation of Organizations | www.fedoforg.org |
| Girls Inc. LI | www.girlsincli.org |
| Health and Welfare Council of Long Island | www.hwcli.com |
| Health Education Project / 1199 SEIU | www.healthcareeducationproject.org |
| Hispanic Counseling Center | www.hispaniccounseling.org |
| Hudson River Healthcare | www.hrhcare.org |
| Life Trusts | www.lifetrusts.org |
| Long Island Association | www.longislandassociation.org |
| Long Island Association of AIDS Care | www.liaac.org |
| Long Island Council of Churches | www.liccny.org |
| Make the Road NY | www.maketheroad.org |
| Maurer Foundation | www.maurerfoundation.org |
| Mental Health Association of Nassau County | www.mhanc.org |

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| 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.sjcnny.edu/long-island |
| Stony Brook University | www.stonybrook.edu |
| Western Suffolk BOCES Creating Healthy Schools and Communities, NYS DOH | www.wsboces.org |
| Performing Provider Systems (DSRIP PPS) | Website |
| Nassau Queens PPS | www.nassauqueenspps.org |
| Suffolk Care Collaborative | www.suffolkcare.org |

| Insurers | Website |
|---|--|
| 1199SEIU/Health Education Project | www.1199seiu.org |
| Fidelis Care | www.fideliscare.org |
| North Shore-LIJ CareConnect Insurance Company | www.careconnect.com |
| United Healthcare | www.unitedhealthcare.com |
| Regional Health Information Organizations | Website |
| Healthix Inc. | www.healthix.org |
| New York Care Information Gateway | www.nycig.org |
| Businesses and Chambers | Website |
| Air Quality Solutions | www.iaqguy.com |
| Greater Westhampton Chamber of Commerce | www.westhamptonchamber.org |
| Honeywell Smart GRID Solutions | www.honeywellsmartgrid.com |
| PSEG of Long Island | www.psegliny.com |
| TeK Systems | www.teksystems.com |
| Temp Positions | www.tempositions.com |
| Time to Play Foundation | www.timetoplay.com |
| Municipal Partners | Website |
| New York State Association of County Health Officials | www.nysacho.org |
| New York State Department of Parks and Recreation | www.nyparks.com |
| Suffolk County Legislature | www.legis.suffolkcountyny.gov |