

Community Health Needs Assessment and Improvement Plan 2019-2021

Suffolk County

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Long Island Community Hospital

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Stony Brook University Hospital www.stonybrookmedicine.edu

Winthrop University Hospital www.winthrop.org

Coalition: The Long Island Health Collaborative (LIHC) LIHC is a coalition funded by the New York State Department of Health through the Population Health Improvement Program (PHIP) grant. The LIHC is overseen by the Nassau-Suffolk Hospital Council. The LIHC provided oversight and management of the Community Health Needs Assessment processes, including data collection and analysis.

Engagement of Local Partners

The LIHC meets bi-monthly, and its Steering Committee meets quarterly. The LIHC staff regularly reaches out to organizations and other entities, continually adding to the diversity of the LIHC and scope of its impact on communities throughout Nassau and Suffolk. The Community Health Needs Assessment is the main vehicle through which progress will be observed and measured. This primary data collection tool is analyzed twice a year, allowing the collaborative and its partners to spot trends and thereby make mid-course corrections. These data reports are further informed by the feedback from collaborative participants solicited at each bi-monthly collaborative meeting and Steering Committee members at each quarterly meeting. This feedback also contributes to mid-course corrections in collective strategies.

Long Island Community Hospital – Community Health Needs Assessment and Improvement Plan 2019-2021

Executive Summary

Long Island Community Hospital is a voluntary, not-for-profit community hospital in Patchogue, Suffolk County, New York. Long Island Community Hospital has maintained a commitment to providing access to quality health care since its founding in 1956. Long Island Community Hospital has grown from a 100-bed hospital founded to meet the needs of the Village of Patchogue, to a Hospital with an operating license for 306 beds that serves the lives of more than 400,000 people living in 28 different communities.

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 Collaborative grew into an expansive membership of academic partners, community-based organizations, physicians, health plans, schools and libraries, local municipalities and other community partners who held a vested interest in improving community health and supporting the New York State Department of Health (NYSDOH) Prevention Agenda. Designated the *Long Island Health Collaborative*, this multi-disciplinary entity now meets bi-monthly to work collectively toward improving health outcomes for Long Islanders. Since 2015, the LIHC has received its funding from the NYSDOH Population Health Improvement Program (PHIP) grant. A primary responsibility of the LIHC is data collection and analysis, which is manifested in the supervision of the Community Health Needs Assessment process for the Long Island region.

In 2019, 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 2019-2021 Community Health Needs Assessment cycle. Data analysis efforts were coordinated through the Long Island Health Collaborative, which served as the centralized data return and analysis hub. As directed by the data results, community partners selected:

- 1. Prevent Chronic Disease**
Focus Area 4: Chronic Disease Preventive Care and Management
- 2. Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area 2: Mental and Substance Use Disorders Prevention

The **health disparity** in which partners are focusing their efforts rests on the inequities experienced by those in low-income neighborhoods. As such, low-income – one social determinant of health – precludes members from low-income

communities from accessing preventive and/or medical care due to their difficulty to afford co-payments/deductibles (if insured) or care at all if they are uninsured. Additionally, financially-stressed individuals have difficulty affording nutritious foods, leaving them more vulnerable to poorer chronic disease management outcomes, since nutrition and diet play a pivotal role in almost every chronic disease.

Priorities selected in 2019 remain unchanged from the 2016 selection; however, for 2019, a specific priority regarding mental health and substance use was selected, as opposed to placing an overarching emphasis on these two issues as was done in the previous cycle. This is in response to the raging opioid crisis in both counties. New York State Department of Health statistics report that for 2016 in Suffolk County there were 344 deaths from any opioid, 129 heroin overdose deaths, and 192 deaths from synthetic opioids (other than methadone).¹ There is also a surge in mental health issues and suicides, particularly among the youth population.^{2 3 4 5}

Primary data sources. Long Island and Eastern Queens Community Health Assessment Survey (CHAS) (*Appendix A*) and the results from focus groups and key community-based organization leader interviews. The latter results were compiled in the report – *Focus Groups and In-Depth Interviews*. (*See Appendix B*)

Secondary data source. Publically-available data sets were reviewed to determine change in health status and emerging issues within Suffolk County. Sources of secondary data: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, Prevention Quality Indicators (PQI), Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS), New York State Community Health Indicator Reports (CHIRS), and New York State Vital Statistics.

Long Island Community Hospital participates in the Long Island Health Collaborative activities. This includes review of all data collected and analyzed by the LIHC, with Suffolk County Department of Health input and consultation offered when appropriate. Long Island Community Hospital also relies upon the LIHC to disseminate information about the importance of proper nutrition and physical activity among the general public in an effort to assist Suffolk residents in better managing their chronic diseases and/or preventing the onset of chronic diseases. These efforts, along with process and outcome measures, are defined in the work plan (see Appendix E). Finally, Long Island Community

Hospital participates in the LIHC's bi-monthly stakeholder meetings and avails itself of LIHC's extensive network. *See Appendix C for a list of partners.*

Long Island Community Hospital has established a leadership position in health promotion, prevention and education throughout the community. Long Island Community hospital was founded by a community focused Board of Directors and continues with more than 25 members from the community who serve on the governing Board. In addition the Hospital established an Advisory Council to receive further input to the needs of the community's residents. There are more than 30 members on the Advisory Council. Members are typically active in other areas of the community and include: civic leaders, members of the clergy, school representatives, public health advocates, business leaders and service and fraternal club members.

Community Outreach has long been a mainstay for Long Island Community Hospital. Long Island Community Hospital's outreach program participates in community health fairs, with senior and community centers, as well as civic associations throughout the region. Long Island Community Hospital is also an active member of eight Chambers of Commerce in the community. Membership with these chambers affords LI Community Hospital the opportunity to learn of the needs of the workforce and business leaders in the community. Long Island Community Hospital has a strong presence in the civic and service clubs,(e.g. Kiwanis, Rotary Club, Lions,) houses of worship, the YMCA and Boys and Girls Club, local government health and social service programs, the social service agencies, senior living communities and public libraries. The engagement of the broader community, for assessment processes, is achieved through the LIHC's and its partners' ongoing distribution of the Long Island and Eastern Queens Community Health Needs Assessment. This survey is offered online via a Survey Monkey link and is available to residents at public events, workshops, educational programs, interventions, etc., which are offered by LIHC partners. It is also distributed among physician offices, hospital waiting areas, libraries, schools, federally-qualified health clinics, insurance enrollment sites, among other public venues. The LIHC aggressively promotes the survey through social media and asks LIHC participants to post the survey link on each of their websites. Results from the Community Health Assessment Survey are analyzed twice a year. Findings are shared with all LIHC participants, with the media, and posted on the LIHC website. Surveys were distributed by paper and electronically, through Survey Monkey, to community members from January 1, 2018 through December 31, 2018

with 810 surveys collected in Suffolk County. A certified translation of the survey is available in the following languages: Spanish, Polish, and Haitian Creole. Large print copies are also available to those living with vision impairment.

For this assessment cycle, the LIHC also engaged the community through focus groups and key informant interviews with leaders of community-based organizations (CBO). The research firm Eureka Facts Inc. conducted the focus groups and CBO interviews, interpreted the results, and produced the report. Focus groups were held in low-income communities (Riverhead and Wyandanch). *(See Appendix B for the full report and research methodology).*

For implementation processes, the LIHC capitalizes on its role as neutral convener of diverse partners and follows the collective impact model and framework.⁶ As such, the LIHC serves as a backbone organization, providing its diverse partners with data analytics and administrative support in the areas of community outreach and education. It encourages the broad community to participate in chronic disease self-management programs offered by our partners, our walking program, and in our bi-monthly meetings, which are open to the public. Additionally, our Cultural Competency Health Literacy program engages workforce members in the health and social services sector.

The Long Island Community Hospital specifically addresses the selected priorities through education and interventions. For the condition of diabetes, we offer the New York State National Diabetes Prevention Program (NYS NDPP) to help individuals screened as borderline to prevent full-blown diabetes, and for those already diagnosed we offer the American Diabetes Association Program at Long Island Community Hospital. Diabetes is one of the leading causes of death in New York State, (excluding New York City), according to the New York State Department of Health's Vital Statistics. Diabetes is a very prevalent chronic disease among residents in Suffolk County. The hospital continues its offering of the diabetes education program, which was developed in 2006, with the support of the Suffolk County Lions Diabetes Education Foundation www.sclionsdiabetes.org and Lions International. The hospital also offers a Diabetes Self-Management Education Program (DSME). This service helps individuals who have diabetes learn to manage it. These are the statistics:

- Diabetes mortality rates are 14% of all deaths in Suffolk County and are the highest in the region
- Diabetes hospitalization rates in Suffolk County are also highest in the region at 15.9%
- Suffolk County has 29.1% of its population classified as obese. This exceeds both the State at 24.9% and the country at 23.2%
- The rate of hospitalization for short term complications due to diabetes per 10,000 increased to 4.83.
- 6.3% of Suffolk County residents are at risk for pre-mature death due to diabetes.

Additionally, diabetes prevention, education, and treatment are offered at the Long Island Community Hospital – Bellport Primary Care Center. This is a convenient location for area residents to obtain primary care not only for diabetes, but for hypertension, tobacco cessation, obesity, mental health and substance abuse, women’s health and cardiovascular.

Substance Use Disorders

- The prevalence of heroin use is increasing, due to its low cost and ease of accessibility
- In 2016 Our Emergency Room has noted a significant increase in drug related visits.
- In Suffolk County, drug related admissions increased by 9% from 2013 to 2014. As such, Long Island Community Hospital has identified a strong need for community education, prevention and treatment services to quell this rising epidemic.
- According to the Substance Abuse and Mental Health Services Administration, SAMSHA the number of people aged 12 and older who have used heroin increased from 373,000 in 2007 to 669,000 in 2012.

As per information obtained from SAMSHA, Heroin is a highly addictive narcotic, with users representing a variety of ages, races and other backgrounds. Fatal overdose, the contraction of Hepatitis C and/or HIV and addiction and dependence are among a plethora of negative side effects that can result from heroin use. In addition to physical danger, heroin use threatens a user’s social ties – often straining family bonds, friendships and professional relationships.

Long Island Community Hospital offers Mental Health Family Education; for family and friends of people struggling with mental illness and or substance abuse meets twice a month.

Long Island Community Hospital has six primary care centers recognized as NCQA (National Committee for Quality Assurance) as a Patient Centered Medical Home, which is a patient centered approach to care which are able to provide assessments to patients with behavioral health issues and or substance abuse. LI Community Hospital also provides

“MAT” services (medical assisted treatment for substance abuse) for those willing to accept treatment. In addition our Out Patient Chemical Dependency program is licensed under the NYS Office of Alcoholism and Substance Abuse Services (NYS OASAS). They provide assessment, treatment, education, and linkage to other community services for patient 18 years and older.

Other Programs

Annually, Long Island Community Hospital offers two free wellness events for the community. This year Long Island Community Hospital collaborated with the Patchogue YMCA to provide the community an interactive health education experience. Utilizing educational games and creative stations including CPR and AED demonstrations where we were able to educate and inform the community about healthy lifestyle choices. Also included were physical activities for adults and children including bounce houses and obstacle courses along with Zumba instruction, all promoting movement to improve health. In addition LI Community Hospital collaborated with the Boys & Girls Club of Bellport Area and provided a Day of Dance event focused on moving to improve heart health through dance. Collaborating with community dance studios they provided dance instruction along our hospital chef who led cooking demonstrations; enabling the attendees to taste and learn how to prepare new heart healthy recipes.

Additional Community Health Programs

In addition to the many programs and services offered by Long Island Community Hospital, there are many other community programs to help achieve better health. Some organizations that we currently work with are:

- Boys & Girls Club of Bellport
- The Diabetes Resource Coalition of Long Island
- YMCA of Patchogue
- Cornell University Cooperative Extension of Suffolk County
- St. Joseph College
- Bellport and Patchogue Head Start
- Hudson River Health Center Patchogue and Shirley
- Bellport Hagerman East Patchogue Alliance
- School Districts
- Service Clubs
- House of Worship
- Local Libraries
- NPF Organizations

- Mental Health Agencies
- Substance Abuse Agencies
- Nursing Homes and Assisted Living

The LIHC, on behalf of its participants and the community members each participant serves, supports the following evidence-based activities and programs:

- Chronic disease self-management education workshop series (Stanford model)
- Are You Ready Feet?[™] walking campaign and portal
- Cultural Competency Health Literacy training
- Awareness Campaign (Live Better) via social media and traditional media platforms

These activities were selected in consultation with LIHC participants. The Are You Ready, Feet?[™] initiative stems from a 2013 consensus decision among Collaborative partners to embrace walking as a simple, low-cost, easy activity that most anyone of any age could perform. Walking is an evidence-based intervention that offers proven benefits to one's physical and mental health. The Are You Ready, Feet?[™] initiative is the venue through which the Collaborative and its partners promote walking. *See Research and Supporting Evidence in Appendix D.* The Chronic Disease Self-Management education/workshop series is the research-based Stanford model proven, through 20 years of research, to increase healthful behaviors, improve health status, and decrease healthcare utilization.⁷ The LIHC promotes CDSME workshops offered by its participants. In late 2019, the LIHC is funding a series of CDSME workshops in Suffolk County. The Cultural Competency Health Literacy training follows a train-the-trainer model. The training/program for healthcare/social service workforce members was developed by the LIHC and the region's two Performing Provider Systems in 2016 using information collected from a local assessment tool. The original curriculum was developed by Dr. Martine Hackett, PhD, Associate Professor of Health Professions at Hofstra University. Dr. Hackett is an expert in community-based participatory research, program planning and evaluation, and research methods. The program helps address health disparities that manifest themselves in cultural and linguistic barriers. The full-day workshop covers issues surrounding health equity, cultural competency and humility, and health literacy. The program's efficacy is evaluated via the rigorous, evidence-based Kirkpatrick Four-Level Training Evaluation Model.⁸ Collaborative participants rely upon LIHC's

use of social media and traditional media to cross-promote collaborative partners' programs, interventions, events, workshops, etc., as well as general messaging about healthy lifestyle behaviors (physical activity and proper nutrition). The Live Better Awareness Campaign utilizes best practices for message conveyance. There is evidence as to the user engagement and sustainability effects of social media and mass media regarding health messaging. Investigation in this area is ongoing. (See *Research and Supporting Evidence in Appendix D*) The Community Guide, a website that houses the official collection of all Community Preventive Services Task Force findings and the systemic reviews on which they are based, was also referenced.⁹

The LHC will use these process measures to track the impact of the above mentioned interventions/strategies/activities.

- Number of attendees (graduates) at CDSME workshops
- Pre and post knowledge about chronic disease self-management (CDSME participants)
- Number of clicks on Live Better chronic disease landing page and chronic disease video
- Number of new Are You Ready, Feet? portal users
- Number of Are You Ready, Feet? school-based challenges/total students engaged
- Number of Cultural Competency Health Literacy training workshops/total attendees
- Social media analytics: posts, engagements, mentions
- Number of earned media mentions

Community Health Assessment

Demographics. 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. Total population: 1,497,595 (49.2% male; 50.8% female) those aged 65+ comprise 15.6% of the population and those aged 35 to 64 comprise 41.8% of the population. In terms of income, 40.7% of the population earns less than \$74, 999 with nearly half of that group earning less than \$34,999 annually. The region is predominately white at 80.5% with 7.8% black/African American, and 3.9% Asian. Hispanic or Latino represents 18.6% of the population. The percentage of the population (5 years and over) that speaks a language other than English is 22.7%. Of those who speak a language other than English, 40.3% report they speak English "less than very well." In terms of education, for those age 25 and over, 28.4% are high school graduates, 19.1% hold a bachelor degree, and 15.8% hold a

graduate professional diploma. The percentage of people with health insurance is 93%.¹⁰

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/health literacy, 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. There are 17 select communities in which a variety of socioeconomic factors lead to vast health disparities. These communities are: Wyandanch, Central Islip, Brentwood, Riverhead, Bay Shore, Copiague, Mastic, Mastic Beach, Bellport, Amityville, Calverton, Patchogue, Shirley, Greenport, Lindenhurst, West Babylon, and Ridge.

Long Island Community Hospital serves the needs of 28 towns and villages in Suffolk County. The Hospital's primary and secondary service area census is 400,000 persons. It includes Brookhaven (one of the fastest growing towns in New York), and expands from west to east from Sayville to Moriches and north to Coram and Selden. Currently the highest number of hospital visits originates from the town of Patchogue, which is ethnically diverse and includes a high number of minorities. The individual median income that on average is 25 percent less than other Suffolk County residents. Census data notes an unemployment rate for the 28 communities of 6.73% with several areas over 10% including Brookhaven, West Sayville, and Mastic Beach. The poverty rate for our community is at 7.69% which is well above State and County averages with several communities with rates in excess of 10 percent including Bellport at 16.9%, Mastic Beach at 17.5%, and Mastic at 13.2%, and Patchogue at 12.4% and Yaphank at 11.1%. While the County has areas of wealth, the population served by the Hospital contains 7 out of 10 communities with the lowest median income in Suffolk County. Approximately 102,000 individuals in Suffolk County live below the federal poverty level. With 28,800 living in our catchment area that approximates 28% of the total.

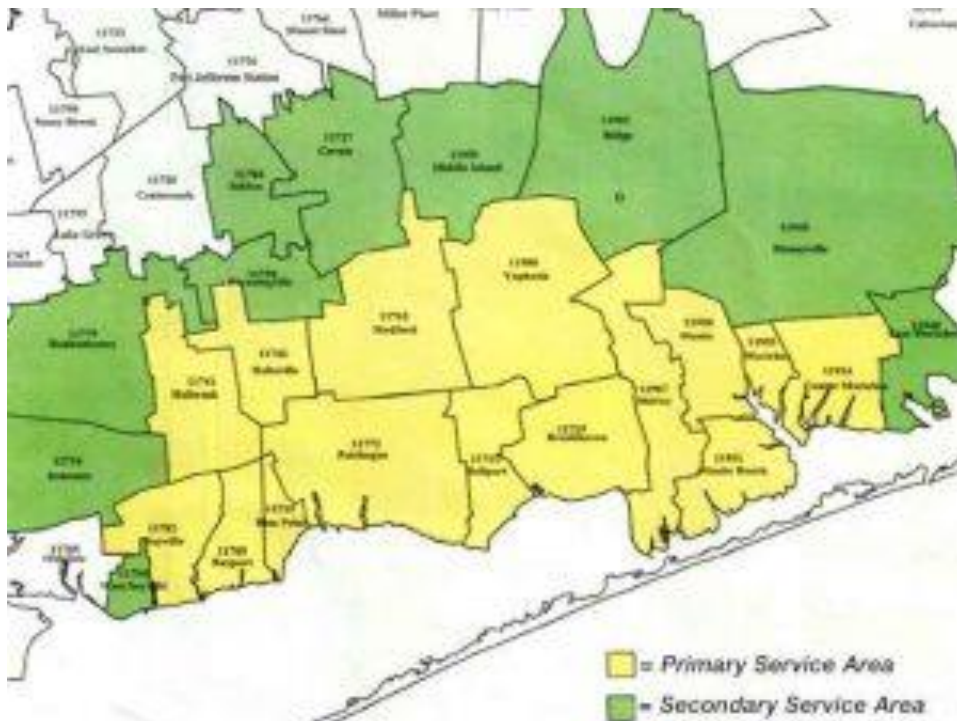
Population	Suffolk County	New York State
2015	1,501,587	19,795,791

Population	Suffolk County	New York State
2010	1,493,346	19,378,110
% Change	0.5%	2.2%
Persons Under 5 Years	5.8%	6.0%
Persons Under 18 Years	24.0%	21.0%
Persons 65 Years and Over	15.6%	15.0%
Female Persons	50.8%	51.4%
White Alone	84.9%	70.1%
Black or African American Alone	8.4%	17.6%
American Indian/Alaska Native Alone	0.6%	1.0%
Asian Alone	4.2%	8.8%
Native Hawaiian/Other Pacific Islander Alone	0.1%	0.1%
Two or More Races	1.8%	2.4%
Hispanic or Latino	16.5%	18.8%
White Alone (Not Hispanic or Latino)	68.6%	56.0%
Living in Same House 1 Year and Over	93.2%	89.0%
Foreign Born Persons	15.1%	22.5%
Language Other Than English Spoken At Home	22.0%	30.4%
High School Graduate (% of persons 25 years +)	89.9%	85.6%
Bachelor's Degree or Higher (% of persons 25 years +)	34.0%	34.2%
Veterans	74,323	828,526
Mean Travel Time To Work (minutes, workers age 16+)	31.4%	32.3%
Housing Units (2008-2012*)	570,670	8,206,739

Population	Suffolk County	New York State
Homeownership Rate (2008-2012*)	80.1%	54.5%
Housing Units in Multi Unit Structures	14.2%	50.5%
Median Value of Owner Occupied Units	375,100	283,400
Households	493,849	7,262,279
Persons Per Household	2.98	2.63
Per Capita Money Income	37,634	33,236
Median Household Income	88,663	59,269
Persons Below Poverty Level	7.8%	15.4%

Source U.S. Census Bureau: State and County Quick Facts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits

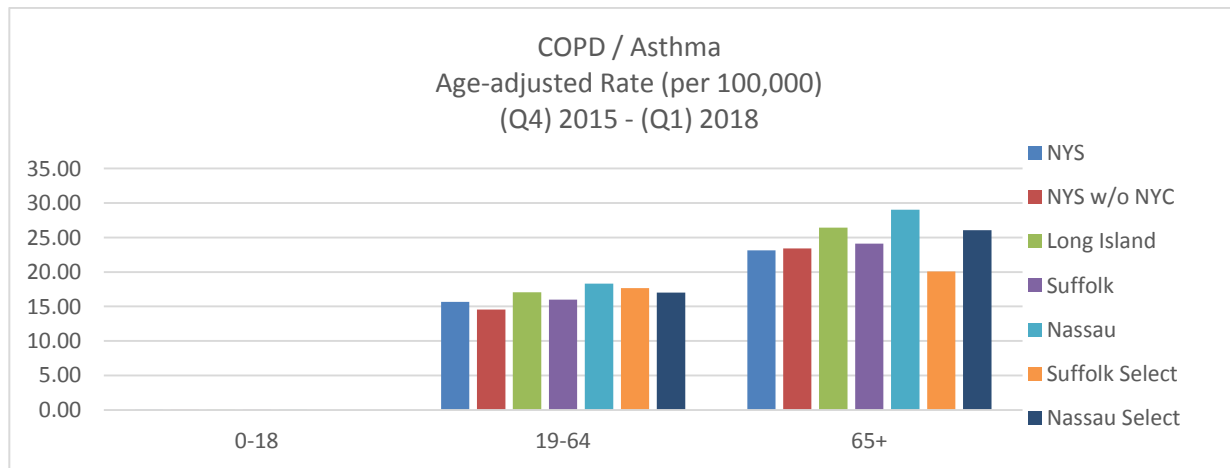
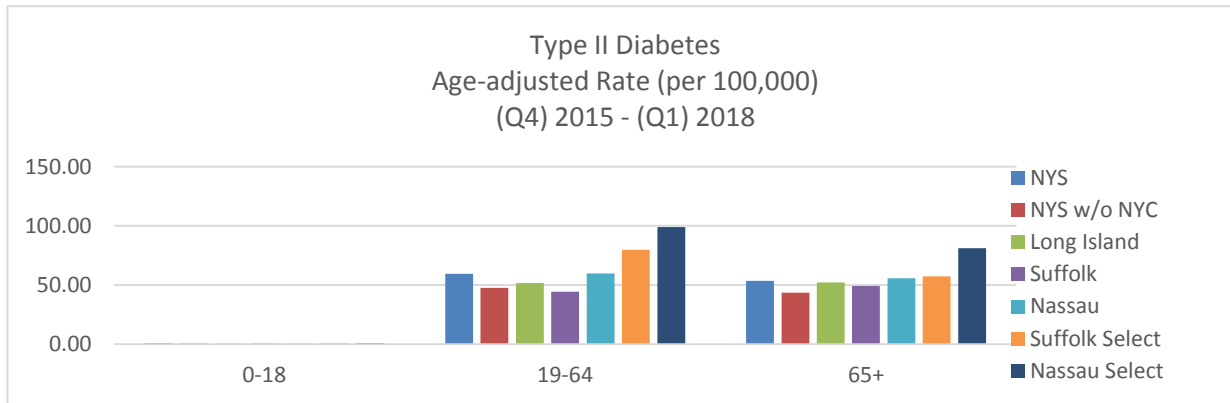
Long Island Community Hospital Primary and Secondary market areas



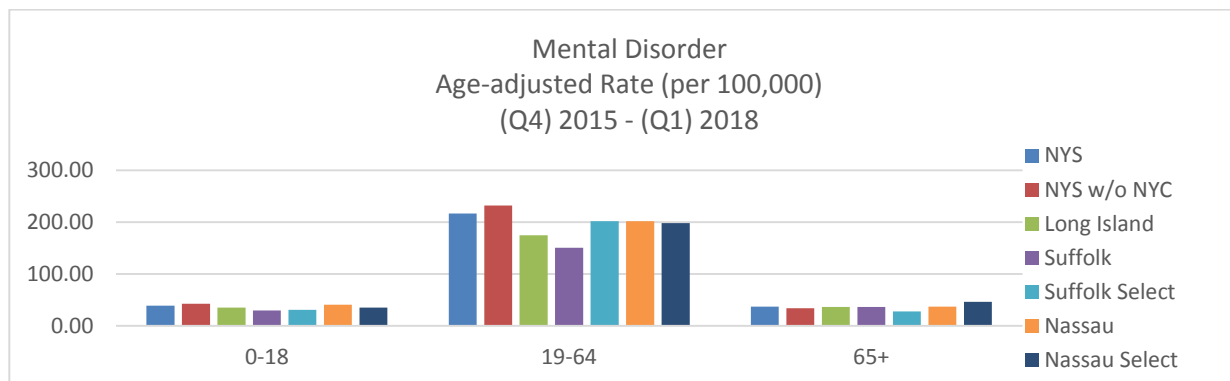
Data Depiction of Health Status of Community. The following bar charts illustrate the prevalence of chronic diseases, especially among those 65 and over. We present SPARCS data on all cancers, type 2 diabetes, and chronic obstructive

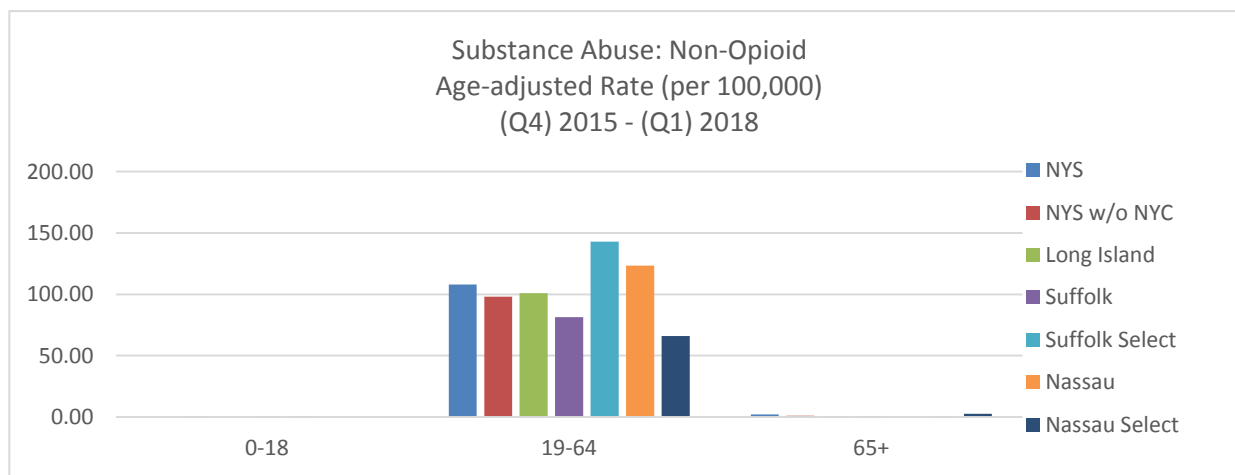
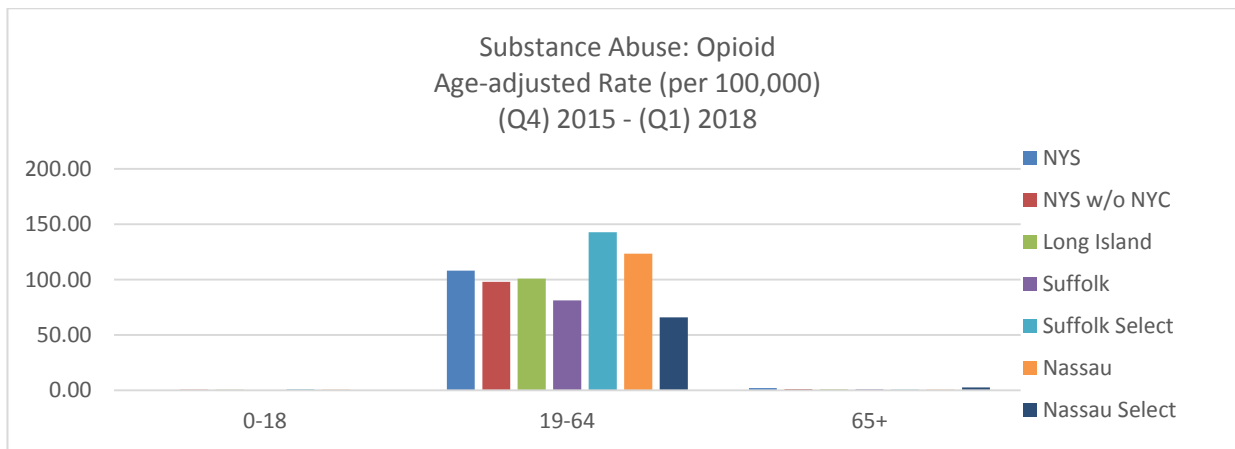
pulmonary disease/asthma.

SPARCS Analyses



The following bar charts illustrate the issue with mental health and substance misuse. It is especially troublesome among those 19 – 64 years of age. Abuse of opioids and non-opioids is occurring at about twice the rate among the Suffolk Select population compared to the overall Suffolk population.

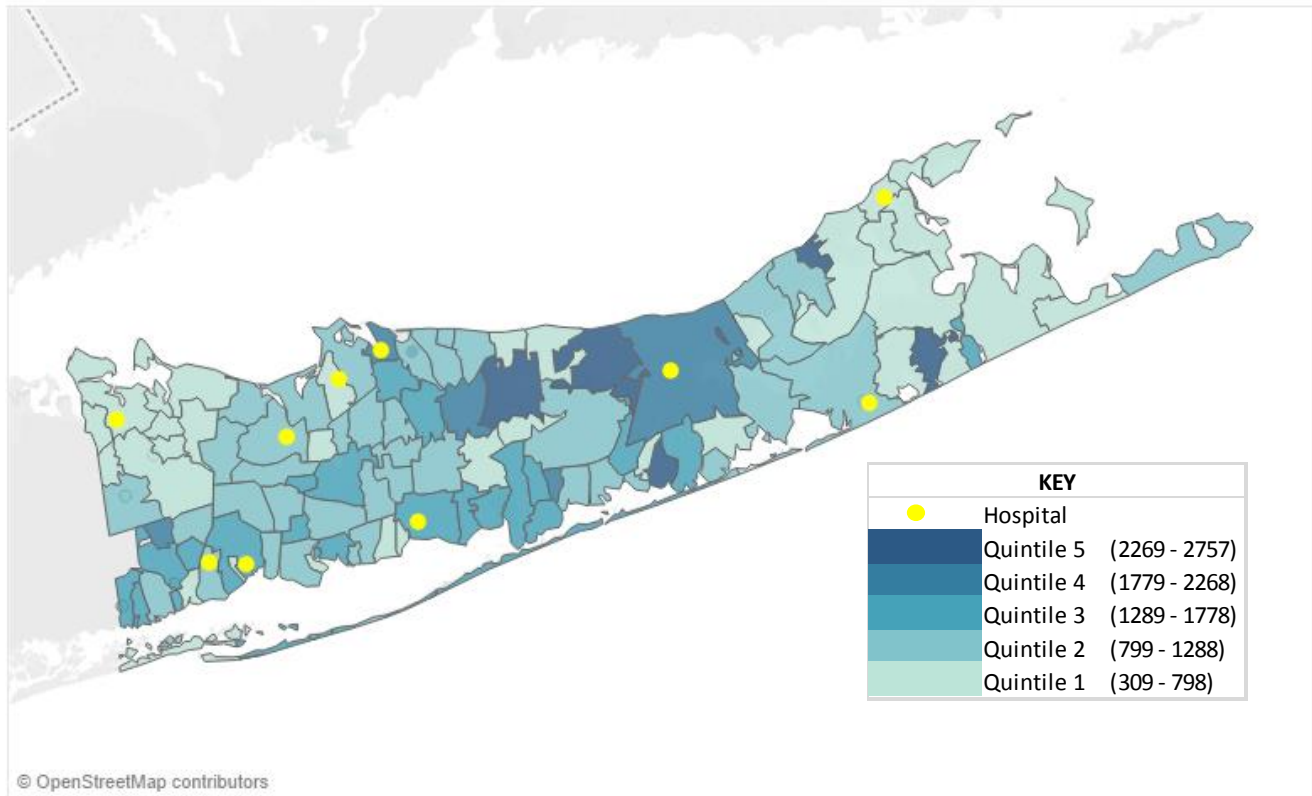




Prevention Quality Indicators

The following map presents a visual of the prevailing chronic conditions that, if treated early and properly in the Community, prevent hospital admissions. PQI 92 is defined as a composite of chronic conditions per 100,000 adult populations. Conditions 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. The Agency for Healthcare Research and Quality draws the indicators from SPARCS data. The map below shows the areas in Suffolk County representing the most significant numbers of preventable cases per 100,000 of the adult population. Quintile 5 represents 2269-2757 per 100,000 adult cases. 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.

PQI 92: Chronic Composite



The Community Health Needs Assessment Survey (*Appendix A*) – a barometer of the perception of health needs and barriers experienced by individuals and communities – provides a snapshot in time of the main health challenges facing communities. From this analysis and the information gleaned from consumer focus groups and key informant interviews with leaders of community-based organizations, we find that social determinants of health related to access to health care, insurance and economics, access to affordable and healthy food, and a clean environment dominate.

Potential barriers people face when getting medical treatment

2018 Rank	Suffolk County	Percentage	Nassau County	Percentage
1	No Insurance**	20.18%	No Insurance**	20.87%
2	Fear**	17.52%	Unable to Pay Co-pays / Deductibles**	16.05%
3	Unable to Pay Copays or Deductibles**	16.16%	Fear**	14.10%
4	There Are No Barriers**	14.70%	Don't Understand Need to See A Doctor**	13.14%
5	Don't Understand Need to See A Doctor**	11.13%	There Are No Barriers**	10.99%
Sum of Column Percentages		79.69%		75.15%

** Indicates an option present in the top five for both counties

What is most needed to improve the health of the community

2018 Rank	Suffolk County	Percentage	Nassau County	Percentage
1	Healthier Food Choices**	15.26%	Healthier Food Choices**	18.11%
2	Drug & Alcohol Rehabilitation Services**	14.71%	Clean Air & Water**	13.46%
3	Clean Air & Water**	12.11%	Mental Health Services**	10.88%
4	Mental Health Services**	11.75%	Drug & Alcohol Rehabilitation Services**	10.05%
5	Job Opportunities	9.87%	Weight Loss Programs	9.55%
Sum of Column Percentages		63.70%		62.06%

** Indicates an option present in the top five for both counties

Focus Groups and In-Depth Analysis Report (Appendix B)

Analysis of responses from focus group participants and interviews with community-based organization leaders supports the results of the quantitative data analyses. The chart below ranks the top five specific health concerns within the Prevention Agenda Priorities by the number of times it was referenced when asked about the highest priorities to be addressed.

Ranking	Specific Health Concern	Number of References	Prevention Agenda Priority
1	Mental health	13	Promote Well-being and Prevent Mental and Substance Use Disorders
2	Violence	12	Promote a Healthy and Safe Environment
3	Substance use disorders	9	Promote Well-being and Prevent Mental and Substance Use Disorders
4	Diabetes	7	Prevent Chronic Diseases
5	Cancer	6	Prevent Chronic Diseases

Looking more broadly, the number of times that the Prevention Agenda Priorities were referenced while discussing the highest priority health concerns yields the following ranking:

Ranking	Prevention Agenda Priority	Number of References
1	Promote Well-being and Prevent Mental and Substance Use Disorders	23
2	Promote a Healthy and Safe Environment	20
3	Prevent Chronic Diseases	18
4	Prevent Communicable Diseases	7
5	Promote Healthy Women, Infants, and Children	2

Assets and Resources

A summary of assets and resources that can be mobilized and employed to address the health issues identified begins with the vast network overseen by the Long Island Health Collaborative. The list below reflects partners with whom the LIHC currently engages throughout the counties of Nassau and Suffolk.

(See Appendix C for the full LICH participant list.)

- 23 hospitals/systems
- 2 county health departments
- 110+ community-based and social service organizations
- 111 libraries
- 5 major academic institutions
- 2 health plans
- 2 school districts
- Media partners
- 27 state parks
- 65 county parks
- 9 YMCAs

- 41 farmers markets
- 100 plus Food pantries
- 20 Federally Qualified Health Centers

We assessed available resources via the participant list maintained by the LIHC, the United Way's 2-1-1 database, the Health Information Tool for Empowerment (HITE) database, New York State Department of Parks and Recreation website, Suffolk County Department of Parks and Recreation website, Nassau County Department of Parks and Recreation website, New York State Department of Agriculture website, Nassau-Suffolk Hospital Council member list, Nassau and Suffolk Cooperative Library System directory, Nassau and Suffolk Counties Superintendent Associations, Suffolk Care Collaborative (Suffolk County's Performing Provider System), NQP PPS (Nassau County's Performing Provider System), Diocese of Rockville Centre Parish Listing, New York Jewish Guide Synagogue listing, Long Island Council of Churches. The LIHC actively promotes the use of 2-1-1 and HITE among community members and health/social service providers who connect individuals with social determinant of health services. The 2-1-1 and HITE site exist in real-time and are routinely updated. Links to these databases and other relevant resource databases are listed on the LIHC website and are available for public use. We invite consumers and health/social service providers to provide feedback on resources to ensure the most timely and comprehensive representation as possible.

Community Health Improvement Plan/Community Service Plan

Methodology for Selection of Priorities. On March 27, 2019, the LIHC distributed results of all its data analyses to all LIHC participants. Large data files were posted on google drive. LIHC participants were asked to review all the quantitative and qualitative data in advance of the Priority Selection Meeting. That meeting took place on Friday, March 29, 2018 at 9:30 a.m. at the offices of the Nassau-Suffolk Hospital Council in Hauppauge, NY. The LIHC's data analyst walked participants through screen shots of the relevant findings. Participants also viewed the Prevention Agenda dashboard, diving deep into the

goals, objectives, and recommended interventions for each priority. Present at the meeting either in-person or via phone were representatives from each of the two local health departments on Long Island and representatives from each of Long Island's hospitals/health systems, as well as staff of the LIHC.

Attendees discussed the results and based the selection of priorities on the following criteria:

- The overwhelming evidence presented by the data, especially the first two questions of the CHAS
- The activities/strategies/interventions currently in place throughout the region
- The feasibility of achieving momentum and success with a chosen priority, taking into account the diversity of partners and community members served

After an official vote, the priorities were selected unanimously.

Goals, Objectives, Interventions, Strategies and Activities. *Please refer to the attached work plan (Appendix E).*

Long Island Community Hospital's Three-Year Plan of Action

The focus of Long Island Community Hospital's Community Service Plan is to provide resources and services to at-risk members of the community and employees of Long Island Community Hospital who are dealing with Chronic Diseases & Substance Use Disorder as well as other health related issues. Long Island Community Hospital will be reaching out to a wide variety of organizations within the community to offer educational programs as well as services to assist in living healthier lives and making better health choices.

Priority 1: Prevent Chronic Disease

Goal: Create community environments that promote and support healthy food and beverage choices and physical activity and to engage community members in regional physical activities and wellness campaigns.

Action Plan:

- Increase community, employee and partner engagement.

- Identify individuals at risk for chronic disease, such as COPD, Diabetes and Heart disease through community health events, community meetings, Hospital visits and free screenings, and provide education classes for the community through Long Island Community Hospital's Diabetes Wellness Program
- Create educational materials and/or classes on nutrition, benefits of increased physical activity, BMI, etc.
- Improve the health of the employee community within Long Island Community Hospital
- Establish walking and running groups for employees and community members
- Provide BMI screenings and integrate a focus on preventive care and management
- Partner with community organizations, including Suffolk County, Town of Brookhaven, YMCA, Bellport boys and Girls club for annual health related events
- Promote Long Island Community Hospital Bariatrics & Diabetes Wellness for those struggling with weight loss
- Identify high risk patients and monitor out of hospital experiences to improve patient outcomes through lung cancer screening program, Breast cancer coalition and coordination with Suffolk Care Coalition programs
- Work with the Long Island Health Collaborative (LIHC) by attending regional meetings, accessing the inventory of services, and utilizing the universal screening tool as appropriate

Evaluation: Programs will be evaluated on a monthly basis by the number of participants who attend. Educational material, health counseling and referral to medical evaluation will be offered to those who attend.

Priority 2: Promote Well-Being and Prevent Mental and Substance Use Disorder

Goal: Promote mental, emotional and behavioral well-being in communities and reducing drug abuse.

Action Plan:

- Educate the community through health forums and free lectures on mental, emotional and behavioral well-being and substance abuse
- Partner with community agencies (such as Suffolk County Department of Health/Division of Community Mental Hygiene Services) and other providers to afford access to treatment of Chemical Dependency problems
- Provide mental health and chemical dependency services in our Long Island Community Hospital Outpatient programs
- Provide education on identification and treatment options for individuals with mental health and substance use issues to Emergency Room staff and Community clinicians
- Identify potential substance abuse patients through use of the Emergency Room screening tool, Screening Brief intervention and referral to treatment, SBIRT tool.
- Implement the Opiate abuse prevention program at the Emergency room to provide Narcan Opiate overdose kits to those in need.
- Long Island Community Hospital Primary Care Practices have become an NCQA Certified Patient Centered Medical Home and will continue to identify and recognize early symptoms of mental illness and substance abuse through the use of evidence based tools. This Integrated care model will enable easy access to the services needed.

Evaluation: Programs will be evaluated on a monthly basis by the number of participants who attend. Free educational class will be offered along with educational material to be distributed.

Dissemination

The LIHC website is designed to engage consumers and to provide transparency in population health initiatives and data analysis efforts. Working documents and data reports developed by the LIHC are available to the public, as they are posted on the LIHC website www.lihealthcollab.org. This Community Health Assessment report is posted on the LIHC website. In addition, Long Island Community Hospital posts its respective report on LICommunityHospital.org. Copies of the LIHC Community Health Assessment report will also be printed and distributed at appropriate community events.

¹https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2018.pdf

² *Quick Stats: Suicide Rates for Teens Aged 15–19 Years, by Sex — United States, 1975–2015*. MMWR Morb Mortal Wkly Rep 2017;66:816. DOI: <http://dx.doi.org/10.15585/mmwr.mm6630a6>

³ <https://www.cdc.gov/nchs/fastats/mental-health.htm>

⁴ Weinberger, A. et al. (August 2017) Trends in depression prevalence in the USA from 2005 – 2015: widening disparities in vulnerable groups. *Psychological Medicine*, 1-10.

⁵ Bitsko, R et al. (2018) Epidemiology and impact of healthcare provider-diagnosed anxiety and depression among US children. *Journal of Developmental and Behavioral Pediatrics*, 1-9.

⁶ <https://www.collectiveimpactforum.org/what-collective-impact>

⁷ https://www.selfmanagementresource.com/docs/pdfs/Programs_History.pdf

⁸ <https://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model>

⁹ <https://www.thecommunityguide.org/>

¹⁰ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates