**Please Tailor Cover Page to meet the need of your Organization**

**Nassau County**

**Community Health Needs Assessment and Improvement Plan**

**2019-2021**

**Nassau County Department of Health**

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

200 County Seat Drive, North Entrance

Mineola, NY 11501

(516) 742-6154

***Catholic Health Services of Long Island***

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

***Northwell Health System***

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

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

**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.

# 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 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.

Question 1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners, including the local health department and hospitals for the 2019 -2021 period?

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*

1. **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 Nassau County there were 191 deaths from any opioid, 58 heroin overdose deaths, and 88 deaths from synthetic opioids (other than methadone).[[1]](#endnote-1) There is also a surge in mental health issues and suicides, particularly among the youth population.[[2]](#endnote-2) [[3]](#endnote-3) [[4]](#endnote-4) [[5]](#endnote-5)

Question 2. What data did you review to identify and confirm existing priorities or select new ones?

**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. P**ublically-available data sets were reviewed to determine change in health status and emerging issues within Nassau 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.

Question 3a. Which partners are you working with and what are their roles in the assessment and implementation processes?

(Name of county or hospital) participates in the Long Island Health Collaborative activities. This includes review of all data collected and analyzed by the LIHC, with Nassau County Department of Health input and consultation offered when appropriate. (Name of county or 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 Nassau 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, (name of county or 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.*

Question 3b. How are you engaging the broad community in these efforts?

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 participates 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 1664 surveys collected in Nassau 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 (Elmont and Hempstead). (*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]](#endnote-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. We encourage 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.

Question 4. What specific evidence-based interventions/strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected?

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]](#endnote-7) The LIHC promotes CDSME workshops offered by its participants. In late 2019, the LIHC will fund a series of CDSME workshops in Nassau 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]](#endnote-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]](#endnote-9)

Question 5: How are progress and improvement being tracked to evaluate impact? What process measures are being used?

The LIHC 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.** Nassau County sits east of the borough of Queens and west of Suffolk County. It is comprised of two cities: Long Beach and Glen Cove and three townships: Hempstead, North Hempstead, and Oyster Bay. Total population: 1,363,069 (48.5% male; 51.5% female) those aged 65+ comprise 16.8% of the population and those aged 35 to 64 comprise 41.1% of the population. In terms of income, 26.5% of the population earn less than $74, 999 with about a third of that group earning less than $34,999 annually. The region is predominately white at 68.9% with 11.5% black/African American, and 9.1% Asian. Hispanic or Latino represent 16.4% of the population. The percentage of the population (5 years and over) that speaks a language other than English is 28%. Of those who speak a language other than English, 42% report they speak English “less than very well.” In terms of education, for those age 25 and over, 23.3% are high school graduates, 24.3% hold a bachelor degree, and 20% hold a graduate professional diploma. The percentage of people with health insurance is 94%.[[10]](#endnote-10) Nassau County is unique in that it presents complex polarity, representing a wide range of both healthy and sick community members from opposite ends of the health spectrum. There are eight select communities in which a variety of socioeconomic factors lead to vast health disparities. These communities are: Elmont, Inwood, Freeport, Glen Cove, Uniondale, Roosevelt, Hempstead, and Westbury.

*Hospitals add specific information about their catchment area/communities served here*

**Data Depiction of Health Status of Community.** The following bar charts illustrate the prevalence of chronic diseases, especially among the 65 plus population. We present SPARCS data on all cancers, type 2 diabetes, and chronic lower respiratory disease.

**SPARCS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Diabetes** |  |  |  |  |  |
|  |  |  |  |  |  |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NASSAU COUNTY | 135.61 | 11.65 | 22.82 | No | No |
| NYS | 174.32 | 13.20 | 25.88 |  |  |
| NYSxNYC | 152.09 | 12.33 | 24.17 |  |  |

**All Cancers**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NASSAU COUNTY | 451.49 | 21.25 | 41.65 | No | No |
| NYS | 380.34 | 19.50 | 38.22 |  |  |
| NYSxNYC | 371.29 | 19.27 | 37.77 |  |  |

**Chronic Lower Respiratory Disease**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NASSAU COUNTY | 250.11 | 15.81 | 31.00 | No | No |
| NYS | 298.25 | 17.27 | 33.85 |  |  |
| NYSxNYC | 271.32 | 16.47 | 32.28 |  |  |

The following bar charts illustrate the issue with mental health and substance misuse.

**Opioid Abuse**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NASSAU COUNTY | 70.94 | 8.42 | 16.51 | No | No |
| NYS | 111.41 | 10.56 | 20.69 |  |  |
| NYSxNYC | 104.54 | 10.22 | 20.04 |  |  |

**Mental Health**

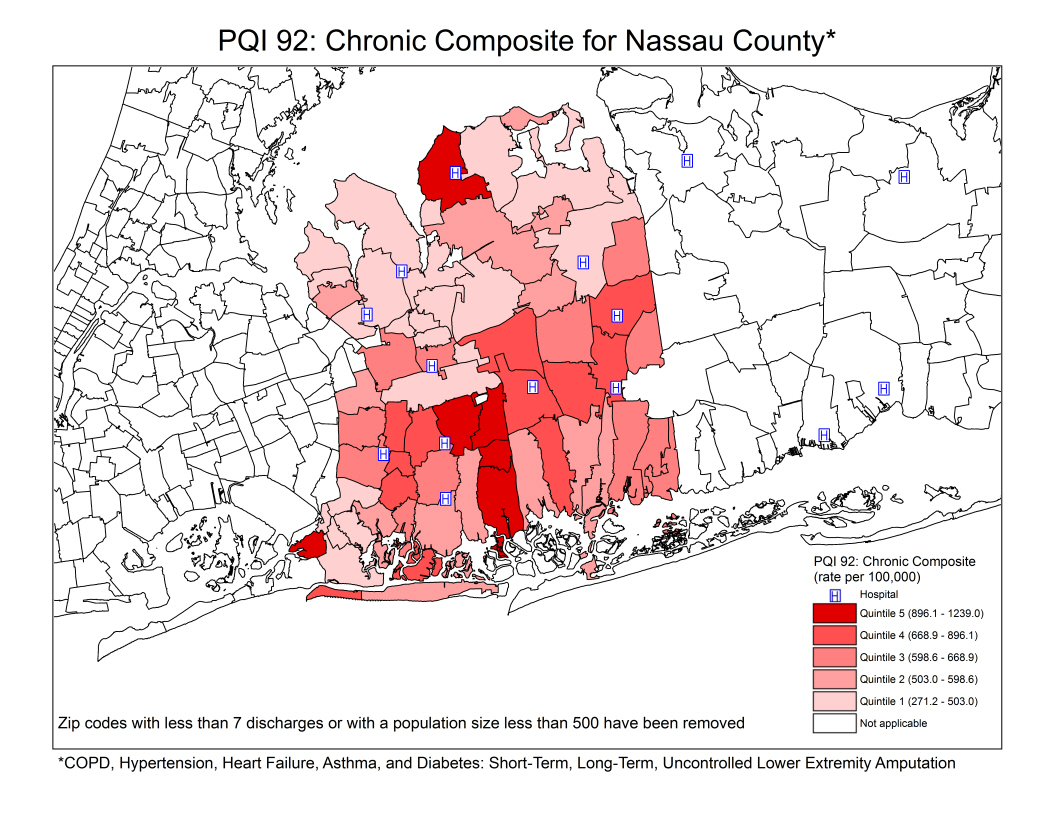
|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NASSAU COUNTY | 27.17 | 5.21 | 10.22 | No | No |
| NYS | 23.47 | 4.84 | 9.50 |  |  |
| NYSxNYC | 19.16 | 4.38 | 8.58 |  |  |

**Prevention Quality Indicators**

Prevention Quality Indicators (PQI), are defined by the Agency for Health Research and Quality\* (AHRQ) and can be useful when examining preventable admissions. Using SPARCS data, the PHIP created a visual representation of preventable admissions related to Chronic Disease at the zip code level (Figure 1).

PQI 92 is defined as a composite of chronic conditions per 100,000 adult population. Conditions, identified by ICD-9 code, included in PQI 92 are: Short and Long-term complications, Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, Heart Failure, Angina, Uncontrolled Diabetes and Lower-Extremity Amputations among patients with Diabetes.

Figure 1 demonstrates the zip codes in Nassau County representing the most significant number of preventable cases per 100,000 adult population. Quintile 5 represents 896.1-1239.0 per 100,000 adult cases, and can be identified by dark red coloring. This quintile demonstrates within which zip codes the largest pockets of potentially preventable hospitals visits related to Chronic Disease fall. As displayed within the PQI Chronic Composite for Nassau County, there is a notable occurrence of Chronic Disease among a majority of communities, particularly those connected to low socioeconomic status.



**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***



***What is most needed to improve the health of the community***



**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 ranksthe 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, 2019 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).*

**Engagement of Local Partners**

The LIHC meets bi-monthly, and its Steering Committee meets quarterly. The LIHC staff regularly reach 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.

**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](http://www.lihealthcollab.org). This Community Health Assessment report is posted on the LIHC website. In addition, (name of county/hospital) posts its respective report on (name of website). Copies of the LIHC Community Health Assessment report will also be printed and distributed at appropriate community events.

1. <https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2018.pdf> [↑](#endnote-ref-1)
2. *QuickStats:* 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> [↑](#endnote-ref-2)
3. <https://www.cdc.gov/nchs/fastats/mental-health.htm> [↑](#endnote-ref-3)
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. [↑](#endnote-ref-4)
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. [↑](#endnote-ref-5)
6. <https://www.collectiveimpactforum.org/what-collective-impact> [↑](#endnote-ref-6)
7. <https://www.selfmanagementresource.com/docs/pdfs/Programs_History.pdf> [↑](#endnote-ref-7)
8. <https://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model> [↑](#endnote-ref-8)
9. <https://www.thecommunityguide.org/> [↑](#endnote-ref-9)
10. U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates [↑](#endnote-ref-10)