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**Suffolk County**

**Community Health Needs Assessment and Improvement Plan**

**2022-2024**

**Suffolk County Department of Health Services**

Gregson Pigott, MD, MPH, Commissioner of Health

3500 Sunrise Highway, Suite 124

P.O. Box 9006

Great River, New York 11739-9006

(631) 854-0100

***Catholic Health***

|  |  |
| --- | --- |
| 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 |

***Long Island Community Hospital***

***Northwell Health System***

|  |  |
| --- | --- |
| Huntington Hospital | 270 Park Ave, Huntington, NY 11743 |
| Mather Hospital  | 75 N. Country Rd., Port Jefferson, NY 11777 |
| Peconic Bay Medical Center  | 1300 Roanoke Ave. Riverhead, NY 11901 |
| South shore University Hospital | 301 E. Main Street, Bay Shore, NY 11706 |

***Stony Brook Medicine***

|  |  |
| --- | --- |
| Stony Brook Southampton Hospital | 240 Meeting House Ln, Southampton, NY 11968 |
| Stony Brook University Hospital | 101 Nicolla Rd, Stony Brook, NY 11794 |
| Stony Brook Eastern Long Island Hospital | 201 Manor Pl, Greenport, NY 11944 |

|  |  |
| --- | --- |
| Veterans Affairs Medical Center | 79 Middleville Rd, Northport, NY 11768 |

**Coalition:** The Long Island Health Collaborative (LIHC) LIHC is a coalition of the region’s hospitals, local health departments, academic institutions, community-based organizations, medical societies, health plans, clinics, and others dedicated to improving the health of all Long Islanders. The LIHC is overseen by the Nassau-Suffolk Hospital Council, the association that represents Long Island’s hospitals. The LIHC provided oversight and management of the Community Health Needs Assessment process, including data collection and analysis.

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# B. 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 quarterly to work collectively toward improving health outcomes for Long Islanders. The LIHC is an initiative overseen by the Nassau-Suffolk Hospital Council, the organization that represents Long Island’s hospitals. 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 2022 -2024 period?

 In 2022, 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 2022-2024 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*

Priorities selected for the 2022- 2024 cycle remain unchanged from the 2019 – 2021 cycle selection. The **health disparity** in which partners are focusing their efforts rests on the inequities experienced by those in low-income communities of color.

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

We reviewed with our partners primary and secondary data. Primary data was obtained from a community health needs assessment sent to individuals and a similar survey to community-based organization leaders[[1]](#footnote-1). Additionally, we looked at results from two qualitative studies to round out our primary data.[[2]](#footnote-2)

**Secondary data were derived from p**ublically-available data sets to determine health issues within Suffolk County.[[3]](#footnote-3)

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 Suffolk 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 Suffolk residents in better managing their chronic diseases and/or preventing the onset of chronic diseases. (Name of county or hospital) also relies upon the LIHC to disseminate information about mental health prevention and treatment services and programming, as well as relevant information about substance misuse. Dissemination of information is achieved through the bi-weekly *Collaborative Communications* e-newsletter, which is sent 588 recipients, and strategic use of social media platforms. These efforts are ongoing. The work plan (*Appendix E)* outlines anticipated measures and activities for 2023. Finally, (name of county or hospital) participates in the LIHC’s quarterly stakeholder meetings and avails itself of LIHC’s extensive network. *See Appendix F for a list of partners.* .A representative from the Suffolk County Department of Health also participated in the monthly 2022 CHNA Workgroup – September 2021 – May 2022. *See Appendix G for list of workgroup members.*

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 Community Health Needs Assessment. This survey is offered online via a Survey Monkey link and is available in paper format to residents at public events, workshops, educational programs, interventions, etc., which are offered by LIHC partners. A paper version is also distributed among physician offices, hospital waiting areas, libraries, schools, federally-qualified health clinics, insurance enrollment sites, and 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. The LIHC provides a social media toolkit with an opportunity for co-branding to facilitate participation. The survey can also be accessed via a QR code. Results from the Community Health Assessment Survey are analyzed yearly. Findings are shared with all LIHC participants, with the media, and posted on the LIHC website. Surveys were distributed by paper and electronically to community members from January 1, 2021 through December 31, 2021 with 883 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 distributed a survey to community-based organization leaders December 1, 2021 through January 15, 2022. Of nearly 600 leaders contacted, 44 completed the survey (25 from Suffolk County, 10 from Nassau County, nine with no location specified.) Organizations typically serve clients from both counties. The results were compiled into a report *CBO Survey Analysis 2022. Appendix B* Of the 44 respondents, 23 expressed interest in a follow-up key informant interview with 12 ultimately offering their input. Interviews occurred via Zoom between February 23, 2022 and March 4, 2022. These responses were qualitatively analyzed by the LIHC staff using the cloud-based Atlas ti 22 platform. That analysis yielded the report *Qualitative Research Analysis of Key Informant Interviews conducted among Community-Based Organizations on Long Island.* Appendix C.

Also for this assessment cycle, LIHC participants were able to consider the report that summarized results of a qualitative research project that had been ongoing with randomly selected public libraries on Long Island. That report, *Long Island’s Libraries: Caretakers of the Region’s Social Support and Health Needs (*Appendix D) looked at the breadth and scope of social support and health needs of library patrons and how well library staff were and are equipped to meet those needs. The analysis considered the socioeconomic differences of communities by location, the influence of social determinants of health, and Prevention Agenda priorities.

For implementation processes, the LIHC capitalizes on its role as neutral convener of diverse partners and follows the collective impact model and framework.[[4]](#footnote-4) 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 programs, workshops, support groups and educational programs offered by LIHC partners, the LIHC’s Walk Safe with a Doc events and Talk with a Doc events (presented in collaboration with AARP-LI), and in LIHC’s quarterly meetings, which are open to the public.

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:

* Awareness Campaign (Live Better) about chronic disease via social media and traditional media platforms (this campaign captures any mentions about chronic diseases and relevant programs/education efforts)
* Awareness Campaign about mental health prevention and treatment programs/education, as well as relevant treatment and prevention programming relative to substance misuse via social media and traditional media platforms ((this campaign captures any mentions about mental health/substance misuse programs/events/workshops, etc.)
* Walk Safe with a Doc are community walking events that combine pedestrian safety education with chronic disease education all while walking. The LIHC maintains an active [Walk with a Doc](https://walkwithadoc.org/) chapter for the region.
* Talk with a Doc are Zoom-delivered educational programs led by physicians from the region’s hospitals covering a variety of chronic diseases.

Collaborative partners embrace walking as a simple, low-cost, easy activity that most anyone of any age can perform. Walking is an evidence-based intervention that offers proven benefits to one’s physical and mental health. The Walk with a Doc chapter is the activity through which LIHC and its partners promote the health benefits of walking. *See Research and Supporting Evidence in Appendix H.* 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). Awareness campaigns utilize 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 H.* 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.[[5]](#footnote-5)

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 at Walk Safe with a Doc
* Number of attendees at Talk with a Doc
* Pre and post knowledge about chronic disease and pedestrian safety (obtained via pre and post survey at above mentioned events)
* Number of clicks on Live Better chronic disease landing page and chronic disease video
* Social media analytics: posts, engagements, mentions
* Number of earned media mentions

**C. Community Health Assessment**

**1.a. Description of Community by demographics.** Suffolk County’s service area is situated east of the Nassau County border, extending through the eastern forks of Long Island. It comprises 10 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. Suffolk County’s total population as of 2020 is 1,481,362 (47.2% male; 50.8% female). Those ages 15-44 represent 35.4% of females; 36.7% of males; ages 60 plus represent 23.7% of males and 25.6% of females; those 18 years and older represent 78.8% of males and 79.8% females. In terms of household income, 35.2% of the population earn less than $74, 999 with 15% of that group earning less than $34,999 annually. Of the population, 8% of those under 18 years of age live in poverty, while 6% of those ages 18 to 64 live in poverty and for those ages 18 -34, 6.7% live in poverty.[[6]](#footnote-6) The region is predominately White at 65.3% with 7.7% Black/African American and 4.4% Asian. Hispanic or Latino represent 22.4% of the population[[7]](#footnote-7), about a four percent increase from the last report. The percentage of the population (5 years and over) that speaks a language other than English at home is 30.3%, with Spanish the dominant foreign language spoken 14.7% followed by other Indo/European languages 8.7% and Asian languages 5.1%. In terms of education, for those age 25 and over, 89.4% are high school graduates or higher, 31.9% hold a bachelor degree or higher. The percent of the total population uninsured is 4.2%. Of that percent, non-citizens represent 32% of the uninsured. Hispanic/Latino represent 42.1% of the uninsured followed by Black/African American 10%, White 63.9%, Asian 6.5%. Of the uninsured, 37.6% earn less than $74,999 household income and 9.1% earn under $25,000 household income. Approximately 9.6% of the total non-institutionalized population is disabled. By race/ethnicity, 10.6% of the Native Hawaiian/Pacific Islander population is disabled, 13.6% of the American Indian/Alaska Native population is disabled, 10% of the White population is disabled, 9.6% of the Black/African American population is disabled, and 7.2% Hispanic/Latino population is disabled. Interestingly, Native American/Pacific Islanders account for less than one percent of the county’s population.[[8]](#footnote-8)

Data presented within this report will demonstrate the existence of 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, age, disabilities, education and income/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 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.

**Income** – one social determinant of health – precludes individuals 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. The inability to afford co-pays and deductibles consistently rises to the top as a barrier to healthcare on the CHAS survey. The median household income in the past 12 months by race is $107,422 (White), $85,840 (Black), $91,711 (Hispanic/Latino). Mean income in the past 12months, per capita by race is $50,352, $33,170 and $28,414, respectively.[[9]](#footnote-9)

 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. As the pandemic illuminated, Black and Hispanic individuals experienced higher rates of COVID disease and death. These higher rates correlated to low-income areas and the higher rate of chronic disease seen in these communities. As we learned, chronic disease is a leading risk factor for COVID morbidity and mortality. The 2021 National Healthcare Quality and Disparities Report[[10]](#footnote-10) notes that significant disparities still exist among racial or ethnic minority groups. Although the report’s most recent data reference is 2018, we can examine one chronic disease – hypertension – and extrapolate that in recent years the incidence has not improved. The report notes that the rate of hospital admissions for hypertension was 212.9 per 100,000 population for Black adults compared with 38.4 per 100,000 cases for White adults and just over 50 cases per 100,000 for Hispanics. The New York State COVID Fatalities Tracker[[11]](#footnote-11) shows that the number one COVID co-morbidity was and is hypertension.

The Long Island Vaccination Hub, the entity charged by the state with ensuring equitable distribution of vaccines, tracked vaccine distribution by the week until the spring of 2022. Consistently, low-income communities of color lagged in vaccination rates. According to a study of electronic health records, conducted by EPIC and the Kaiser Family Foundation, COVID-19 infection rates among Hispanic and Black patients were over three and two times higher, respectively, compared to the rate for White patients. Among patients who tested positive for COVID-19, Black, Hispanic, and Asian patients remained at higher risk for hospitalization and death compared to White patients with similar socioeconomic characteristics and underlying health conditions, suggesting racism and discrimination may affect outcomes.[[12]](#footnote-12)

Mental health issues have soared in the past two years, spurred in part, by the effects of the pandemic. Using data from the U.S. Census Bureau’s COVID-19 Household Pulse Survey (April 23, 2020 – October 26, 2020), a New York State Health Foundation analysis found that more than one-third of adult New Yorkers reported symptoms of anxiety and/or depression, with racial and ethnic groups of color as well as low-income New Yorkers, reporting the highest rates of poor mental health. However, the 18 – 34 year old age group reported the highest rates (49%) of poor mental health.[[13]](#footnote-13) High school students (grades 9 through 12) fared just as worse. A number of studies found poor mental health along with suicide ideation intensified during the pandemic for high schoolers, especially among females. An April 2022 analysis of data from the 2021 Adolescent Behaviors and Experiences Survey revealed that 37.1% of students experienced poor mental health during the pandemic, and 31.1% experienced poor mental health during the preceding 30 days.[[14]](#footnote-14) The pandemic truly made a bad situation worse, especially for our youth, as mental health issues and suicides were already increasing prior to COVID.[[15]](#footnote-15) [[16]](#footnote-16) [[17]](#footnote-17) [[18]](#footnote-18) With the shortage of mental health care workers and the lingering psychological effects of the pandemic, mental health services remain a top priority for the region.

 The county also saw an uptick in opioid-related overdoses and deaths after having made some gains prior to the pandemic. New York State Department of Health statistics report that for 2020 in Suffolk County there were 362 deaths from any opioid, 59 heroin overdose deaths, and 355 deaths involving opioid pain relievers (including illicitly produced opioids such as fentanyl).[[19]](#footnote-19) For 2019, the numbers were 259, 58, and 241, respectively via categories listed above.[[20]](#footnote-20)

The prevalence of chronic diseases is persistent in the county. Nationally, communities of color experience higher rates of chronic disease. Using diabetes as an example, the American Indian/Alaska Native population represents 14.5 percent of adults 18 or older who are diagnosed with diabetes followed by Black, non-Hispanic at 12.1% and Hispanic overall at 11.8% in the United States. Asians and Whites experience the disease at 9.5% and 7.4% respectively.[[21]](#footnote-21) Health providers report that many individuals delayed preventive care and routine screenings due to the pandemic, leading to more complicated cases and unfavorable outcomes. Chronic diseases are preventable conditions sensitive to lifestyle (diet/physical activity) habits, but hampered by the obstacles presented by social determinant of health factors - mainly income/employment, race/ethnicity, food access, housing/neighborhood location, and level of education to name a few. The county and hospitals identified in this report through collaborative efforts and facility-specific programming acknowledge and address these determinants on an ongoing basis.

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

**b. Health Status of Community via data analyses**. According to the CHAS 2022 analysis, Nassau County residents say the greatest health concern for their community is cancer. This was the same result seen in the previous year. The greatest health concern individuals have for themselves is heart disease/stroke.

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 diseases of the heart and circulatory system.

**SPARCS** *(rates presented as per 100,000 of population)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diabetes**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 588.54 | 14.01 | 27.45 | No | No |
| NYSxNYC | 515.81 | 13.11 | 25.70 |   |   |
| SUFFOLK COUNTY | 523.52 | 13.21 | 25.89 |   |   |

 |   |  |  |  |  |
|  |   |  |  |  |  |

**All Cancers**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 1124.22 | 19.36 | 37.94 | No | No |
| NYSxNYC | 1101.27 | 19.16 | 37.55 |   |   |
| SUFFOLK COUNTY | 1273.83 | 20.61 | 40.39 |   |   |

**Disease of the Circulatory System**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 4526.24 | 38.84 | 76.13 | No | No |
| NYSxNYC | 4675.01 | 39.48 | 77.37 |   |   |
| SUFFOLK COUNTY | 5337.18 | 42.18 | 82.67 |   |   |

**Disease of the Heart**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 3041.67 | 31.84 | 62.41 | No | No |
| NYSxNYC | 3190.29 | 32.61 | 63.92 |   |   |
| SUFFOLK COUNTY | 3799.19 | 35.59 | 69.75 |   |   |

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

**Opioid Abuse/Dependence**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 324.18 | 10.40 | 20.37 | No | No |
| NYSxNYC | 297.94 | 9.97 | 19.53 |   |   |
| SUFFOLK COUNTY | 403.83 | 11.60 | 22.74 |   |   |

**Mental and Behavioral Disorders due to psychoactive substance**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 1112.55 | 19.26 | 37.74 | No | No |
| NYSxNYC | 951.94 | 17.81 | 34.91 |   |   |
| SUFFOLK COUNTY | 1153.61 | 19.61 | 38.43 |   |   |

**Rates of Mental, Behavioral and Neurodevelopmental disorders**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 2824.04 | 30.68 | 60.14 | No | No |
| NYSxNYC | 2476.32 | 28.73 | 56.31 |   |   |
| SUFFOLK COUNTY | 2336.19 | 27.91 | 54.70 |   |   |

**Mental disorders due to known physiological conditions**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COUNTY** | **Rate per 100k population** | **SQRT of Variance** | **Margin of Error** | **Sig Dif NYS** | **Sig Dif NYSxNYC** |
| NYS | 70.80 | 4.86 | 9.52 | No | No |
| NYSxNYC | 58.71 | 4.42 | 8.67 |   |   |
| SUFFOLK COUNTY | 66.34 | 4.70 | 9.22 |   |   |

**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 2016 SPARCS data, the LIHC 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. *(This is the most recent PQI data/analysis available from the LIHC.)*

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. 

1. **Main Health Challenges and Contributing Causes**

A combination of quantitative and qualitative primary analyses (total 4) were used to uncover the main challenges facing the individuals residing in Suffolk County. The data consistently reveal that food access, clean air and water, economics, and educational needs affect health outcomes, especially in lower-income, communities of color. That these social determinants of health are predictors of chronic disease incidence is well documented.[[22]](#footnote-22) [[23]](#footnote-23) [[24]](#footnote-24) Respondents referenced some healthcare access issues, most often tied to economics (quality of health insurance, employment, cost-of-living). The need for more mental health services clearly emerged. Additionally, food access, transportation, and health literacy/education continue to be gnawing issues.

**The Community Health Needs Assessment Survey (CHAS)** *Appendix A*

The CHAS is a barometer of the perception of health needs and barriers experienced by individuals and communities. It provides a snapshot in time of the main health challenges facing communities. From this analysis and the information gleaned from a similar survey administered to community-based organization leaders, follow-up key informant interviews with some of those leaders, and results from personnel interviews conducted among randomly-selected libraries to gauge the breadth and scope of health and social support needs facing communities, we find that

 social determinants of health related to insurance and economics (employment), fear (which includes immigration status), housing, transportation, cleaner air and water, and healthier food choices dominate.

 ***What prevents you and your family from getting medical treatment?***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Jan-Dec 2021 Rank** | **Suffolk County** | **Percentage** | **Nassau County** | **Percentage**  |
| **1** | Fear (e.g. not ready to face/discuss health problem; immigration status) | 30.76% | There are no Barriers | 27.70% |
| **2** | Unable to Pay Co-pays/Deductibles | 30.36% | No Insurance | 26.94% |
| **3** | No Insurance | 28.85% | Fear (e.g. not ready to face/discuss health problem; immigration status) | 26.00% |
| **4** | Don’t Understand Need to See a Doctor | 25.03% | Unable to Pay Co-pays/Deductibles | 23.42% |
| **5** | There are no Barriers | 16.81% | Transportation | 13.32% |
|  | **Sum of Column Percentages** | **131.81%** |  | **117.37%** |

***Which is most needed to improve the health of your community?***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Jan-Dec 2021 Rank** | **Suffolk County** | **Percentage** | **Nassau County** | **Percentage**  |
| 1 | Mental Health Services | 33.58% | Mental Health Services | 32.78% |
| 2 | Healthier Food Choices | 28.67% | Clean Air & Water | 30.53% |
| 3 | Clean Air & Water | 23.37% | Healthier Food Choices | 29.64% |
| 4 | Drug & Alcohol Rehabilitation Services | 22.32% | Drug & Alcohol Rehabilitation Services | 22.03% |
| 5 | Job Opportunities | 17.30% | Job Opportunities | 18.38% |
|  | **Sum of Column Percentages** | **125.24%** |  | **133.36%** |

**CBO Community Needs Assessment Survey Analysis Results** *Appendix B*

A needs assessment survey, very similar to the Community Health Needs Assessment distributed to individuals, was distributed to community-based organization leaders. The tables below indicate the prevailing concerns expressed by CBO leaders. See the full report for all results.

***What are the biggest health problems for the people/community you serve?”***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2022 Rank**  | **Suffolk County**  | **Percentage**  | **Nassau County**  | **Percentage**  |
| 1  | Mental Health | 16/25  | Drugs and Alcohol Abuse | 6/10  |
| 2  | Drugs and Alcohol Abuse  | 14/25  | Obesity and Weight Loss  | 5/10  |
| 3  | Cancer  | 11/25  | Nutrition/Eating Habits  | 5/10  |
| 4  | Women’s Health/Wellness  | 8/25  | Mental Health | 4/10  |
| 5  | Care for the Elderly | 8/25  | Women’s Health/Wellness  | 4/10  |

***What would be most helpful to improve the health problems of the people/community you serve?***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2022 Rank** | **Suffolk County**  | **Percentage**  | **Nassau County**  | **Percentage**  |
| 1  | Mental Health Services | 18/25  | Access to Healthier Food Choices  | 7/10  |
| 2  | Drug and Alcohol Services  | 14/25  | Mental Health Services | 6/10  |
| 3  | Health Education Programs  | 14/25  | Affordable Housing  | 6/10  |
| 4  | Affordable Housing  | 11/25  | Transportation | 5/10  |
| 5  | Access to Healthier Food | 8/25  | Health Education Programs  | 5/10  |

**CBO Key Informant Interview Qualitative Analysis Results** *Appendix C*

Of the 44 CBO leaders who completed the above-mentioned CBO community needs assessment, 23 agreed to a follow-up in-depth interview and 12 actually participated. From that analysis, the dominant social determinant of health factors are depicted below. Education, healthcare system (in terms of access) and food are the top three. Kaiser Family Foundation Social Determinant of Health domains used as reference.[[25]](#footnote-25)

**Code Distribution**

Healthcare access followed by education and programs/services were the top three codes that emerged from among the transcripts. See the full report for complete results. Appendix C



**Library Research Project, Results of Qualitative Analysis**

*Appendix D*

This two-year study provides an insider’s look at the social determinants of health at play and the health/social support needs most troubling to residents in Suffolk County. Library personnel at randomly selected public libraries throughout Suffolk County were selected for this study. The top health needs and social needs are summarized in the table below.



1. **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 I for the full LIHC 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, Diocese of Rockville Centre Parish Listing, New York Jewish Guide Synagogue listing, Long Island Council of Churches.

The LIHC promotes the use of 2-1-1 <https://www.211li.org/> and HITE <https://hitesite.org/> among community members and health/social service providers who connect individuals with social determinant of health services. The 2-1-1 and HITE sites 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.

**D. Community Health Improvement Plan/Community Service Plan**

**Methodology for Selection of Priorities.** On April 5, 2022 at 8 a.m., the LIHC posted results of all its data analyses. The members of the 2022 CHNA Workgroup were asked to review the results in advance of the priority selection meeting, which occurred on April 5, 2022 at 1 p.m. via Zoom. The 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 were representatives from each of the two local health departments on Long Island and representatives from 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.

**1.Chosen Priorities**

**Prevent Chronic Disease**

*Focus Area 4: Chronic Disease Preventive Care and Management*

 **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 communities of color. As such, 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. As the pandemic illuminated, Black and Hispanic individuals experienced higher rates of COVID disease and death. These higher rates correlated to low-income areas and the higher rate of chronic disease seen in these communities. As we learned, chronic disease is a leading risk factor for COVID morbidity and mortality. (See the *Description of Community by Demographics* section for a complete discussion of health disparities.)

1. **Goals, Objectives, Interventions, Strategies and Activities**. *Please refer to the attached work plan. Appendix E*
2. **Engagement of Local Partners**

The LIHC meets quarterly and communicates bi-weekly through the *Collaborative Communications,* an electronic newsletter. 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 counties. The Community Health Needs Assessment is the main vehicle through which progress will be observed and measured. This primary data collection tool is analyzed yearly, 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 quarterly collaborative meeting. This feedback also contributes to mid-course corrections in collective strategies.

1. **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 Needs Assessment report prepared by the Long Island Health Collaborative is posted on the LIHC website in template form for use by LIHC members. In addition, (name of county/hospital) posts its respective report on (name of website).

1. Community Health Assessment Survey (CHAS) assessing responses from individuals, summary report and survey instrument *Appendix A*

 CBO Survey Analysis 2022, assessing responses from community-based organization leader, summary report and survey instrument *Appendix B* [↑](#footnote-ref-1)
2. Qualitative Analysis of Key informant Interviews conducted among Community-Based Organization Leaders *Appendix C*

 Long Island Libraries: Caretakers of the Region’s Social Support and Health Needs: Qualitative Analysis *Appendix D* [↑](#footnote-ref-2)
3. Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS), New York State Community Health Indicators by Race/Ethnicity Reports, Community Health Indicator Reports, Prevention Quality Indicators and U.S. Census Bureau. [↑](#footnote-ref-3)
4. <https://collectiveimpactforum.org/> [↑](#footnote-ref-4)
5. <https://www.thecommunityguide.org/> [↑](#footnote-ref-5)
6. U.S. Census Bureau, 2016-2020 American Community Survey, Five-Year Estimates [↑](#footnote-ref-6)
7. U.S. Census Bureau, 2020 Decennial Census [↑](#footnote-ref-7)
8. U.S. Census Bureau, 2016-2020 American Community Survey, Five-year Estimates [↑](#footnote-ref-8)
9. U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates [↑](#footnote-ref-9)
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21. <https://www.cdc.gov/diabetes/health-equity/diabetes-by-the-numbers.html> [↑](#footnote-ref-21)
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