Community Service Plan 2016-2018

South Nassau Communities Hospital
3-Year Community Service Plan 2016 – 2018

Cover Page

1. Identify county/counties or service area covered in this assessment and plan.

The hospital's service area comprises all communities in Nassau County that lie east of the Cross Island Parkway, west of Route 110 and south of the Southern State Parkway. The 10 primary service areas are Oceanside, Rockville Centre, Baldwin, Freeport, Merrick, East Rockaway, Lynbrook, Long Beach, Island Park, and Roosevelt. The 23 secondary communities we serve are Bellmore, Wantagh, Seaford, Massapequa, Massapequa Park, Atlantic Beach, Franklin Square, West Hempstead, Elmont, Hempstead, Lido Beach, Levittown, Garden City, Uniondale, East Meadow, Inwood, Cedarhurst, Hewlett, Lawrence, Malverne, Valley Stream, Woodmere, and Far Rockaway.

2. Participating hospital and contact information

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South Nassau Communities Hospital
3-Year Community Service Plan 2016 – 2018

Executive Summary

Question 1:

What are the Prevention Agenda priorities and the disparity you are working on with community partners including the local health department and hospitals for the 2016-2018 period?

The Prevention Agenda priorities for the 2016-2018 community service plan are 1) to reduce obesity in children and adults and 2) to increase preventive care and management of chronic disease.

Question 2:

What has changed, if anything, with regard to the priorities you selected since 2013 including any emerging issues identified or being watched?

Priorities selected in 2016 remain unchanged from the 2013 selection; however, a stronger emphasis has been placed on the need to integrate Mental Health throughout intervention strategies. As recommended by the New York State Department of Health, South Nassau Communities Hospital, with this three year community service plan, will now be aligned with the State cycle. Therefore, below is a summary of the 1st and 2nd quarters of 2016 during which time year 3 of the original goals and objectives of the 2014-2016 service plan were met.

Screening rates and educational lectures were increased for cardiovascular disease reaching a total of 978 lives. Breast, Cervical, and Colorectal Cancer presentations reached 254 community members. In promotion of self-care for those with Diabetes, programs offered reached 244 people. To improve the health of the communities we serve, South Nassau Communities Hospital conducted smoking cessation programs of which there were 17 attendees. Worksite wellness programs consisting of cardiovascular screening, skin cancer screening, and smoking cessation classes reached 243 employees. In support of healthier lifestyles, participation in local community health fairs with a focus on healthy food choices and increasing physical activity resulted in 537 lives touched. Additionally, laying a strong foundation for our newest community members, South Nassau Communities Hospital's robust breast-feeding initiative resulted in Baby Friendly™ designation on March 24, 2016.

Questions 3:

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

The Long Island Community Health Assessment Survey, the Community-Based Organization (CBO) Summit events and the Long Island Health Collaborative (LIHC) Wellness survey served as the primary data sources. The CBO Summit event had over 120 participating organizations represented. Roundtable facilitated discussions were recorded and transcribed by court stenographers and analyzed using Population Health Management software to identify key themes. Secondary publicly-available data sets have been reviewed to determine change in health status and emerging issues within Nassau County. Sources of secondary data include: Statewide Planning and Research Cooperative System (SPARCS), New York State Prevention Agenda dashboard, County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), Extended Behavioral Risk Factor Surveillance System (eBRFSS) and New York State Vital Statistics.

Question 4:
Which partners are you working with and what are their roles in the assessment and implementation process?

South Nassau Communities Hospital continues to participate in the Long Island Health Collaborative (LIHC). There is an expansive membership of academic partners, community-based organizations, physicians and other community leaders who hold a vested interest in improving community health and supporting the NYS Department of Health Prevention Agenda. This multi-disciplinary entity has been meeting monthly to work collectively toward improving health outcomes for Long Islanders. In 2015, the Long Island Health Collaborative was awarded the Population Health Improvement Program (PHIP) grant by the New York State Department of Health. The PHIP is a data-driven entity, pledged to pursue the New York State of Health's Prevention Agenda, making the program a natural driver for the Community Health Needs Assessment cycle. For specific partner roles and partner resources please see Appendix 3.

Members of the Long Island Health Collaborative reviewed extensive data sets selected from both primary and secondary data sources to identify and confirm Prevention Agenda priorities for the 2016-2018 Community Health Needs Assessment Cycle. Data analysis efforts were coordinated through the Population Health Improvement Program, with the PHIP serving as the centralized data return and analysis hub.

Along with active participation in the Long Island Health Collaborative (for a full list of LIHC partners, see Appendix 1), South Nassau Communities Hospital has also partnered with the following: American Cancer Society, Asthma Coalition of Long Island, New York City Poison Control, YMCA of Long Island, the local Jewish Community Center (JCC), Circulo de la Hispanidad, local school districts, local churches, the Jewish Association for Services for the Aging (JASA), Farmingdale State College, and Molloy College. These organizations played a vital role in the assessment of our surrounding community's health concerns via the CBO Summit and are well-established in the communities we serve, and are thus able to engage community members in improvement strategies.

Question 5:
How are you engaging the broad community in these efforts?

The broad community was engaged in assessment efforts through distribution and completion of the Long Island Community Health Assessment Survey (Appendix 2). This tool was developed in consensus by community partners from the Long Island Health Collaborative and designed using the Prevention Agenda framework. Available in both online and hard copy format, the survey was also available in Spanish. LIHC community partners distributed and promoted the survey to a diverse-range of community members at a variety of locations including hospitals, doctor's offices, health departments, libraries, schools, insurance enrollment sites, community-based organizations and beyond.

Question 6:
What specific evidence-based interventions /strategies/activities will be implemented to address the specific priorities and the health disparity and how were they selected?

Evidence-based interventions to be implemented to address the specific priorities and health disparities selected will include:

- Diabetes Management, Smoking Cessation, Reducing Screen Time (tips for reducing children's television and computer screen time and replacing it with increased physical activity time), Healthy Food/Beverage Choices, Cardiac Disease and Stroke education programs
- Cancer prevention and screening with emphasis on male and female cancers
- "*Are You Ready, Feet?*™" walking campaign and portal
- Physician-driven *Recommendation for Walking Program*
- Stress Reduction and Mental Wellness

These interventions were selected after careful review of evidence based programs available through the following agencies: Center for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ) and The Community Guide, a website that houses the official collection of all Community Preventive Services Task Force (https://www.thecommunityguide.org) findings and the systematic reviews on which they are based.

Question 7:

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

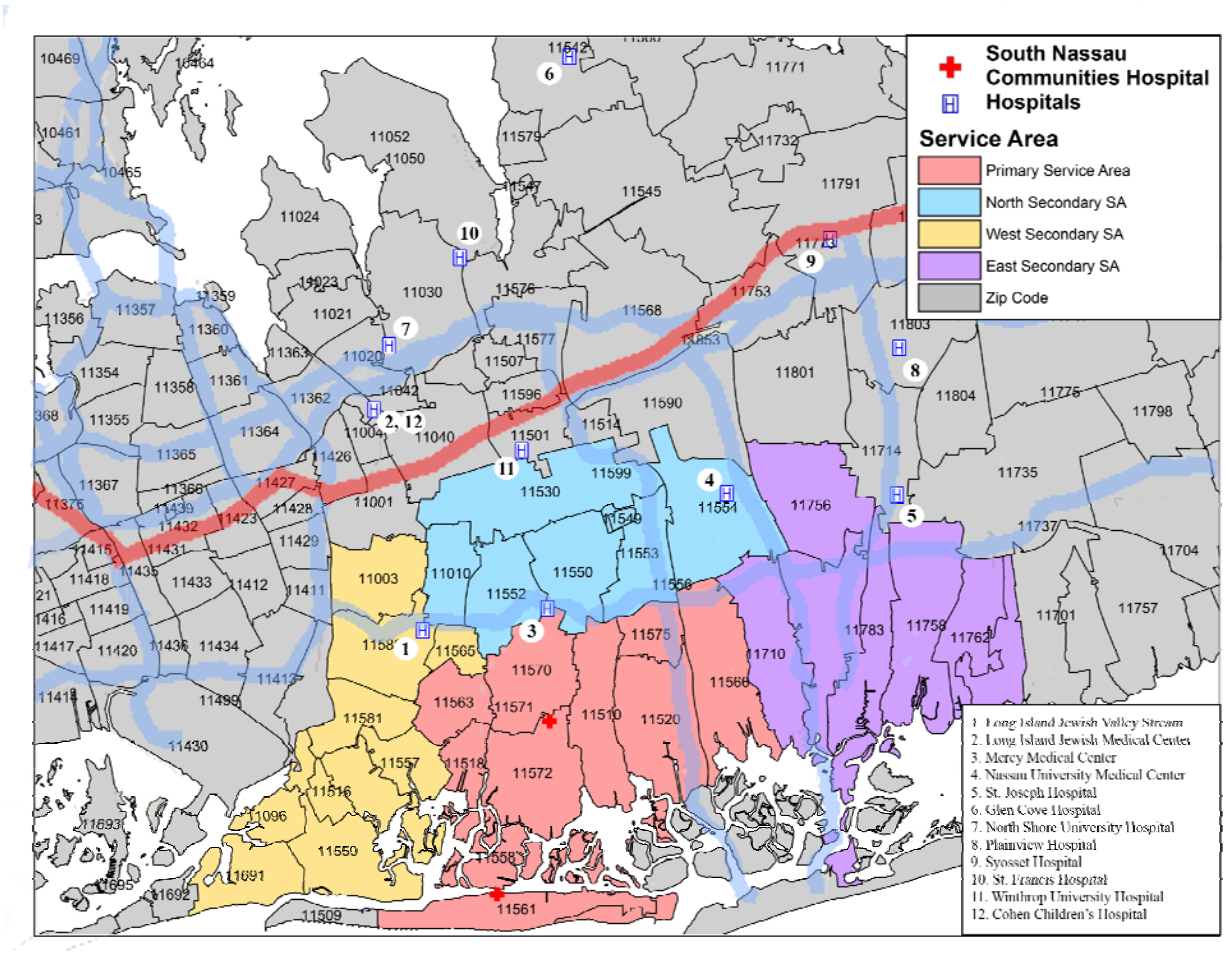
The following process measures will be employed to track the impact of the above evidence based programs:

- Number of community education programs provided
- Number of residents reached
- Pre and Post test scores of program participants
- Increase in the number of blood pressure screenings obtained
- Number of participants that have decreased the number of cigarettes smoked and/or quit
- Participant feedback / program evaluations

Report

Community Served

South Nassau Communities Hospital's service area comprises all villages in Nassau County that lie east of the Cross Island Parkway and south of the Southern State Parkway, including the city of Long Beach, the villages of Levittown, Garden City, Roosevelt, Uniondale, East Meadow, Malverne, and Far Rockaway. The Hospital's service area has not changed. See the complete list of primary and secondary service areas listed below the map. These service areas are defined by zip code as follows:



Primary: Oceanside, Rockville Centre, Baldwin, Freeport, Merrick, East Rockaway, Lynbrook, Long Beach, Island Park and Roosevelt.

Secondary: Bellmore, Wantagh, Seaford, Massapequa, Massapequa Park, Atlantic Beach, Franklin Square, West Hempstead, Elmont, Hempstead and Lido Beach. Levittown, Garden City, Uniondale, East Meadow, Inwood, Cedarhurst, Hewlett, Lawrence, Malverne, Valley Stream, Woodmere and Far Rockaway.

It is the mission of South Nassau Communities Hospital to provide high quality, comprehensive, and easily accessible health care services to all residents of the South Shore communities in a manner which reflects a culture of excellence, personalized culturally competent care and innovation.

The community service plan is in alignment with the Hospital's mission. The mission statement remains unchanged. South Nassau Communities Hospital supports the findings of the data review and proposes the following 3-year plan of action.

Selected Prevention Agenda Priority #1) Reduce obesity in children and adults

South Nassau Communities Hospital's first Prevention Agenda Priority will be addressed through various activities coordinated through the Department of Community Education. These activities will aim to help prevent children and adults from becoming obese as well as reduce risk factors that are associated with

obesity, such as diabetes, cardiovascular disease and stroke. South Nassau Communities Hospital will raise public awareness of the economic and personal impact of obesity and social media will be utilized to advertise upcoming program offerings. Those who are obese will be educated regarding healthier lifestyle choices and South Nassau Communities Hospital will continue to support community environments that promote healthy food/beverage choices and physical activity.

Year 1
Each September, South Nassau Communities Hospital conducts its annual 5K Walk / Health & Wellness Fair. At this important community function there will be a focus on obesity and the potential associated sequela. Activities addressing this health care epidemic will include BMI assessment, Diabetes risk assessment, Blood Pressure screening, Sleep Apnea assessment, Cholesterol screening, Asthma screening, Cancer screening and Cardiac/Stroke risk assessment. Hospital departments will display and distribute educational materials to support these efforts during the fair. Community members will interact directly with health care professionals who can provide one-on-one screening, education, and appropriate referrals. Interpreter services will be available.

Throughout the year, in support of Prevention Agenda Priority #1, additional educational programs will be offered to the community using standardized education, assessment, and pre/post measurement tools using nationally recognized best practices. The following programs are planned for Year 1 and the communities of focus will be Long Beach and Oceanside:

- Promote the "Are You Ready, Feet™" walking initiative
- Provide information and education regarding increasing fruit and vegetable consumption while decreasing high sugar and fat intake
- Conduct "Eat Healthy-Be Active" Community Workshops for adults Participate in community health fairs and/or related activities as appropriate to the above-listed topics

Successful implementation of the above-mentioned strategies will be measured by the following:

- Number of community education programs provided
- Number of residents reached
- Pre- and Post-test scores of program participants
- Participant feedback / program evaluations
- Incorporate "Teach Back" into community presentations

Year 2
South Nassau Communities Hospital will continue to raise public awareness of the economic and personal impact of obesity through community activities and various media outlets. There will be ongoing re-evaluations of screening tools and presentations to ensure effective outcomes for the populations served with resultant program modification as deemed necessary. The communities of focus for Year 2 will be Long Beach and Baldwin.

Process measures utilized in Year 1 will be repeated in Year 2.

Year 3
Risk assessment and educational programs will be ongoing. The Department of Community Education will continue to evaluate the programs offered to redirect education and make any other necessary modifications. The communities of focus for Year 3 will be Long Beach and Freeport.

Selected Prevention Agenda Priority #2) Increase Preventive Care and Management of Chronic Disease

South Nassau Communities Hospital's second Prevention Agenda Priority will be addressed through various activities coordinated through the Department of Community Education. These activities will aim to mitigate the associated conditions and complications of chronic disease. As noted in Prevention Agenda Priority #1, South Nassau Communities Hospital will also incorporate awareness and education regarding the economic and personal impact of chronic disease. Various media networks will be utilized to advertise and increase attendance at upcoming educational program opportunities. Those who are living with a chronic disease will be educated regarding healthier lifestyle choices and the importance of self-care and management.

Year 1
At the annual Fall Health Fair, a large focus will be on chronic disease risk assessment and management. Several tables will be devoted to screening for, and increasing knowledge about, chronic disease including Diabetes risk assessment, Blood Pressure screenings, PSA and Cholesterol screenings, Asthma screening, Head & Neck Cancer screening, and Cardiovascular risk assessment. Community members will interact directly with health care professionals who can provide one-on-one screening, education, and referral to appropriate programs. Interpreter services will be available.

Throughout the year, in support of Prevention Agenda Priority #2, additional educational programs will be offered to the community using standardized education, assessment, and pre/post measurement tools using nationally recognized best practices. The following activities are scheduled for Year 1 and the communities of focus will be Long Beach and Oceanside:

- Increase public knowledge regarding educational programs and screening events through social media reach
- Increase awareness and make referrals to South Nassau's new Diabetes Education Center
- Encourage participation in the "*Are You Ready, Feet?*™" walking initiative
- Engage Primary Care Practitioners in the physician-driven *Recommendation for Walking Program*
- Offer 5-Week Smoking Cessation Programs
- Collaborate with local schools, libraries, community based organizations and legislators to provide educational programs and screenings within their respective communities
- Promote the reduction of chronic disease risk factors through South Nassau Communities Hospital's participation in community health fairs and activities.

Successful implementation of the above-mentioned strategies will be measured by the following:

- Number of community education programs provided
- Number of residents reached
- Pre- and Post-test scores of program participants
- Participant feedback / program evaluations
- Incorporate "Teach Back" into community presentations
- Track the number of participants who attend the Diabetes Education Center and monitor their progress through documented behavior changes and ongoing collection of clinical data

Year 2
South Nassau Communities Hospital will continue to raise public awareness of the economic and personal impact of chronic disease through community activities and various media outlets. There will be ongoing re-evaluations of screening tools and presentations to ensure effective outcomes for the

populations served with resultant program modification as deemed necessary. The communities of focus for Year 2 will be Long Beach and Baldwin.

Year 3
Risk assessment and educational programs will be ongoing. The Department of Community Education will continue to evaluate the programs offered to redirect education and make any other necessary modifications. The communities of focus for Year 3 will be Long Beach and Freeport.

The community of Long Beach has been selected as a focus community for all three years of this service plan due to the closure of its hospital related to Superstorm Sandy and the community's expressed desire for medical services.

Goals, Objectives, Interventions, Strategies, and Activities
Please refer to the attached grid (Appendix 3) which identifies the goals and objectives, as well as the interventions, strategies, and activities to be implemented and the process measures to be utilized over the three year period. Of note, South Nassau Communities Hospital will offer programs in Spanish to our Hispanic communities.

Partner Engagement
Sustained engagement with local partners will be achieved through active listening, clarifying questioning, timely response to requests for programs, and expressed appreciation for the opportunity to partner for healthier communities.

Of note, with the Long Island Health Collaborative continuing to serve as the hub for data collection and analysis, there will be ongoing input and feedback with our partners in community health. For the two identified Prevention Agenda Priorities, a review of key health indicators will guide the modification and delivery for the term of this community service plan.

Dissemination
The plan will be made widely available to the public through the following mechanisms:

- Advertisements on the hospital's Web site, in the community newsletter, physicians' newsletter and employee newsletter
- Dissemination to the public through community organizations and the hospital's External Affairs Department
- Dissemination to the public through South Nassau's Community Advocacy Committee

Appendix 1

LIHC Member List

Hospitals, Hospital Association and Hospital Systems	Website
Brookhaven Memorial Hospital Medical Center	www.brookhavenhospital.org
Catholic Health Services of Long Island	www.chsli.org
Eastern Long Island Hospital	www.elih.org
Glen Cove Hospital	www.northwell.edu
Good Samaritan Hospital Medical Center	www.goodsamaritan.chsli.org
Huntington Hospital	www.northwell.edu
Long Island Jewish Valley Stream	www.northwell.edu
John T. Mather Memorial Hospital	www.matherhospital.org
Mercy Medical Center	www.mercymedicalcenter.org
Nassau-Suffolk Hospital Council	www.nshc.org
Nassau University Medical Center	www.numc.edu
North Shore University Hospital	www.northwell.edu
Northwell Health System	www.northwell.edu
Peconic Bay Medical Center	www.pbmchealth.org
Plainview Hospital	www.northwell.edu
St. Catherine of Siena Medical Center	www.stcatherines.chsli.org
St. Charles Hospital	www.stcharles.chsli.org

St. Francis Hospital	www.stfrancis.chsli.org
St. Joseph Hospital	www.stjoseph.chsli.org
Southampton Hospital	www.southamptonhospital.org
South Nassau Communities Hospital	www.southnassau.org
South Oaks Hospital	www.south-oaks.org
Southside Hospital	www.northwell.edu
Stony Brook University Hospital	www.stonybrookmedicine.edu
Syosset Hospital	www.northwell.edu
Veterans Affairs Medical Center	www.northport.va.gov
Winthrop University Hospital	www.winthrop.org

Local County Health Departments	Website
Nassau County Department of Health	www.nassaucountyny.gov
Suffolk County Department of Health Services	www.suffolkcountyny.gov

Medical Societies and Associations	Website
Long Island Dietetic Association	www.eatrightli.org
Nassau County Medical Society	www.nassaucountymedicalsociety.org
New York State Nurses Association	www.nysna.org
New York State Podiatric Medical Association	www.nyspma.org
Suffolk County Medical Society	www.scms-sam.org

Community-Based Organizations	Website
Adelphi New York Statewide Breast Cancer Hotline and Support Program	www.breast-cancer.adelphi.edu
Alzheimer's Association, Long Island Chapter	www.alz.org
American Cancer Society	www.cancer.org
American Foundation for Suicide Prevention	www.afsp.org
American Heart Association	www.heart.org
American Lung Association of the Northeast	www.lung.org
Association for Mental Health and Wellness	www.mentalhealthandwellness.org
Asthma Coalition of Long Island	www.asthmacommunitynetwork.org
Attentive Care Services	www.attentivecareservices.com
Caring People	www.caringpeopleinc.com
Community Growth Center	www.communitygrowthcenter.org
Cornell Cooperative Extension - Suffolk County	www.ccesuffolk.org
Epilepsy Foundation of Long Island	www.efli.org
Evolve Wellness	www.evolvewellness.net
Family & Children's Association	www.familyandchildrens.org
Family First Home Companions	www.familyfirsthomecompanions.com
Federation of Organizations	www.fedoforg.org
Girls Inc. LI	www.girlsincli.org
Health and Welfare Council of Long Island	www.hwcli.com

Health Education Project / 1199 SEIU	www.healthcareeducationproject.org
Hispanic Counseling Center	www.hispaniccounseling.org
Hudson River Healthcare	www.hrhcare.org
Life Trusts	www.lifetrusts.org
Long Island Association	www.longislandassociation.org
Long Island Association of AIDS Care	www.liaac.org
Long Island Council of Churches	www.liccny.org
Make the Road NY	www.maketheroad.org
Maurer Foundation	www.maurerfoundation.org
Mental Health Association of Nassau County	www.mhanc.org
Music and Memory	www.musicandmemory.org
New York City Poison Control	www.nyc.gov
Options for Community Living	www.optionscl.org
Pederson-Krag Center	www.pederson-krag.org
People Care Inc.	www.peoplecare.com
Pulse of NY	www.pulseofny.org
Retired Senior Volunteer Program	www.rsvpsuffolk.org
RotaCare	www.rotacareny.org
SDC Nutrition PC	www.call4nutrition.com
Smithtown Youth Bureau	www.smithtownny.gov

Society of St. Vincent de Paul Long Island	www.svdpli.org
State Parks LI Regional Office	www.nysparks.com
Sustainable Long Island	www.sustainableli.org
The Crisis Center	www.thecrisisplanner.com
Thursday's Child	www.thursdayschildofli.org
TriCare Systems	www.tricaresystems.org
United Way of Long Island	www.unitedwayli.org
YMCA of LI	www.ymcali.org
School and Colleges	**Website**
Adelphi University	www.adelphi.edu
Farmingdale State College	www.farmingdale.edu
Hofstra University	www.hofstra.edu
Molloy College	www.molloy.edu
St. Joseph's College	www.sjcny.edu/long-island
Stony Brook University	www.stonybrook.edu
Western Suffolk BOCES Creating Healthy Schools and Communities, NYS DOH	www.wsboces.org
Performing Provider Systems (DSRIP PPS)	**Website**
Nassau Queens PPS	www.nassauqueenspps.org
Suffolk Care Collaborative	www.suffolkcare.org

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

Appendix 2

LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY

Your opinion is important to us!

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

1. What are the biggest ongoing health concerns in THE COMMUNITY WHERE YOU LIVE? (Please check up to 3)

☐ Asthma/lung disease
☐ Cancer
☐ Child health & wellness
☐ Diabetes
☐ Drugs & alcohol abuse
☐ Environmental hazards
☐ Heart disease & stroke
☐ HIV/AIDS & Sexually Transmitted Diseases (STDs)
☐ Mental health depression/suicide
☐ Obesity/weight loss issues
☐ Safety
☐ Vaccine preventable diseases
☐ Women's health & wellness
☐ Other (please specify) _____

2. What are the biggest ongoing health concerns for YOURSELF? (Please check up to 3)

☐ Asthma/lung disease
☐ Cancer
☐ Child health & wellness
☐ Diabetes
☐ Drugs & alcohol abuse
☐ Environmental hazards
☐ Heart disease & stroke
☐ HIV/AIDS & Sexually Transmitted Diseases (STDs)
☐ Mental health depression/suicide
☐ Obesity/weight loss issues
☐ Safety
☐ Vaccine preventable diseases
☐ Women's health & wellness
☐ Other (please specify) _____

3. What prevents people in your community from getting medical treatment? (Please check up to 3)

☐ Cultural/religious beliefs
☐ Don't know how to find doctors
☐ Don't understand need to see a
☐ Lack of availability of doctors
☐ Language barriers
☐ No insurance
☐ Unable to pay co-pays/deductibles
☐ There are no barriers
☐ Other (please specify)

doctor ☐ Transportation _____

☐ Fear (e.g. not ready to face/discuss health problem)

4. Which of the following is MOST needed to improve the health of your community? (Please check up to 3)

☐ Clean air & water
☐ Drug & alcohol rehabilitation services
☐ Healthier food choices
☐ Job opportunities
☐ Safe worksites
☐ Mental health services
☐ Recreation facilities
☐ Safe childcare options
☐ Safe places to walk/play
☐ Smoking cessation programs
☐ Transportation
☐ Weight loss programs
☐ Other (please specify) _____

5. What health screenings or education/information services are needed in your community? (Please check up to 3)

☐ Blood pressure
☐ Cancer
☐ Cholesterol
☐ Dental screenings
☐ Diabetes
☐ Disease outbreak information
☐ Drug and alcohol
☐ Eating disorders
☐ Emergency preparedness
☐ Exercise/physical activity
☐ Heart disease
☐ HIV/AIDS & Sexually Transmitted Diseases (STDs)
☐ Importance of routine well checkups
☐ Mental health/depression
☐ Nutrition
☐ Prenatal care
☐ Suicide prevention
☐ Vaccination/immunizations
☐ Other (please specify) _____

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

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

For statistical purposes only, please complete the following:

I identify as: ☐ Male ☐ Female ☐ Other

What is your age? _____

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

What race do you consider yourself?

☐ White/Caucasian ☐ Native American ☐ Multi-racial

☐ Black/African American ☐ Asian/Pacific Islander ☐ Other (please specify)

_____

Are you Hispanic or Latino? ☐ Yes ☐ No

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

☐ English ☐ Portuguese ☐ Spanish ☐ Italian ☐ Farsi ☐ Polish

☐ Chinese ☐ Korean ☐ Hindi ☐ Haitian Creole ☐ French Creole ☐ Other

What is your annual household income from all sources?

☐ $0-$19,999 ☐ $20,000 to $34,999 ☐ $35,000 to $49,999

☐ $50,000 to $74,999 ☐ $75,000 to $125,000 ☐ Over $125,000

What is your highest level of education?

☐ K-8 grade ☐ Technical school ☐ Graduate school

☐ Some high school ☐ Some college ☐ Doctorate

☐ High school graduate ☐ College graduate ☐ Other (please specify)

_____

What is your current employment status?

☐ Employed for wages ☐ Self-employed ☐ Out of work and looking for work

☐ Student

☐ Retired

☐ Out of work, but not currently looking

☐ Military

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

Do you have a smart phone? ☐ Yes ☐ No

PREVENTION AGENDA PRIORITY FOCUS AREA 1: Reduce Obesity in Children and Adults

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To decrease the incidence of obesity in those communities identified as being at risk	To engage community members in physical activity	Encourage participation in the "Are You Ready, Feet?"™ walking initiative	Analysis of registration data by zip code in hospital catchment area	Long Island Health Collaborative will serve as the data analysis hub	Brochures with enrollment instructions
	To increase participation in nutrition/physical activity workshops	Conduct "Eat Healthy, Be Active" community workshops for children and adults	Incorporate the "Teach Back" technique into community presentations Pre-post test scores	School districts, libraries, community centers, civic associations, religious organizations	Provide and audience and assist with logistics of venue Advertise programs and speaking engagements
	To increase the community's perception of SNCH as their partner in health	Increase involvement of SNCH's community outreach via health fairs and related activities	Number of community events Number of residents reached	Community/religious organization partners	Provide an audience and assist with logistics of venue

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To decrease the incidence of obesity in those communities identified as being at risk	To increase consumption of fruits and vegetables and decrease intake of sugar and fat	Conduct the "5-2-1-0: Numbers to Live By" program for elementary school children	Play a "What have you learned?" game that incorporates the "Teach Back" technique	School districts, community centers	Advertise programs and speaking engagements Provide an audience and assist with logistics of venue
	Increase awareness regarding the adverse effects of stress on Obesity and Mental Health	Certified Meditation Specialist to provide classes on meditation and stress reduction techniques This information is to be incorporated into other community educational offerings, as appropriate	Number of participants Participant feedback	Certified Meditation Specialist will provide educational programs and in-service community education staff Assist in the incorporation of stress reduction information in community programs	Content expertise Community education resources

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To decrease the incidence of obesity in those communities identified as being at risk	Increase public knowledge regarding educational programs and screening events through social media reach	Collaborate with the Department of External Affairs to showcase events through the following: • Facebook • SNCH website • Email distribution • SNCH mailings: "Save the Date"- the Hospital's Annual Health and Wellness Fair/5K Walk, Healthy Outlook newsletter distributed 5 times per year, event flyers, and print media	Number of hits to website Number of likes on Facebook page Increase in attendance at scheduled events Participant feedback	Post information regarding upcoming events to both Facebook page and website Include timely community education activities in print media for mailing, newspaper, or press release/public service announcements	Linkages with vendors for advertising space in print media Software programs to create posters, event flyers, and signage

PREVENTION AGENDA PRIORITY FOCUS AREA 2: Increase Preventive Care and Management of Chronic Disease

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Promote the reduction of chronic disease risk factors through participation in community health fairs and activities	Offer chronic disease educational programs and screening opportunities via community venues	Number of community programs provided Number of residents reached Number of referrals made to SNCH providers based on clinical findings Participant feedback Incorporate the "Teach Back" technique	Schools, libraries, community-based organizations, civic associations, legislators, and senators	Advertise programs and speaking engagements Provide an audience and assist with logistics of venue

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Promote the reduction of chronic disease risk factors through participation in SNCH's annual Health and Wellness Fair	Promote SNCH's Annual Health and Wellness Fair/5K Walk	Number of attendees availing themselves of screening and educational opportunities Number of registered walkers	Various SNCH departments distributing health information and conducting screenings	Staff expertise in many areas related to chronic disease and prevention
	Engage community members in the "Are you Ready, Feet?"™ walking initiative	Distribute promotional brochures at community functions	Number of registrants enrolled based on zip code data from hospital catchment area	The Long Island Health Collaborative (LIHC) will provide brochures and walking portal information Data from hospital catchment area	Access to data analyst and brochures, as needed
	Invite other SNCH departments to promote this walking campaign with patients and staff	Promote this initiative at hospital department meetings for dissemination to all staff	Patient and staff feedback	SNCH staff	Patient and family access Employee access

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Increase public knowledge regarding educational programs and screening events through social media reach	Collaborate with the Department of External Affairs to showcase events through the following: • Facebook • SNCH website • Email distribution • SNCH mailings: "Save the Date"- the Hospital's Annual Health and Wellness Fair/5K Walk, Healthy Outlook newsletter distributed 5 times per year, event flyers, and print media	Number of hits to website Number of likes on Facebook page Increase in attendance at scheduled events Participant feedback	Post information regarding upcoming events to both Facebook page and website Include timely community education activities in print media for mailing, newspaper, or press release/public service announcements	Linkages with vendors for advertising space in print media Software programs to create posters, event flyers, and signage

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Provide educational programs and encourage screening regarding men & women's health	Offer educational programs and promote screening regarding cancers that affect women & men	Number of community programs provided Number or residents reached Track number of participants who avail themselves of SNCH screening events	Collaborate with SNCH cancer center staff to conduct educational programs Libraries, schools, civic associations	Content expertise Interactive educational displays Advertise programs and speaking engagements Provide an audience and assist with logistics of venue
		Offer educational programs and screenings regarding cardiovascular health	Number of community programs provided Number of residents reached Track the number of participants who avail themselves of SNCH screening events	Collaborate with cardiac/stroke teams Libraries, schools, civic associations	Content expertise Advertise programs and speaking engagements Provide an audience and assist with logistics of venue

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Implement the Recommendation for walking program within the primary care setting by engaging SNCH participating physicians	Encourage hospital-affiliated medical staff to support the use of the prescription pads to reinforce the Physician recommendation for walking program via the practice managers	Number of SNCH medical offices provided with program information Track number of participants within zip code of medical offices	Report the number of medical offices aware of the walking initiative program LIHC analysis of data from hospital catchment area	Practice managers have access to providers at SNCH medical facilities Access to data analyst
	Provide smoking cessation classes for residents needing assistance in quitting	Offer 5-week smoking cessation programs as needed Refer class participants to SNCH's Early Lung Cancer Action Project (ELCAP) lung cancer screening program, as appropriate	Number of attendees completing programs Number of attendees reporting tobacco status Number of participants screened	SNCH staff SNCH cancer center staff	Smoking cessation specialist New York State Smokers' Quitline Patient access

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Promote SNCH's new Diabetes Education Center (DEC)	Literatures and brochures will be distributed at community events	Number of people requesting information about the center Number of those attending the center based on community outreach referrals	Provide data Provide data	Diabetes-specific materials Include center attendees in mailings for community health events
	Increase knowledge of those with diabetes regarding self-care and minimizing the effects of diabetes	Diabetes self-management programs and workshops conducted by Certified Diabetes Educators	Number of participants completing the program/workshop Number of attendees who have made positive behavior changes due to the program Improvement in A1C results Pre-post test scores	Diabetes center staff will track and report data collected	Dedicated staff assigned to the center Content expertise Easy accessibility of venue

Appendix 3

Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
To raise awareness about risk factors including the importance of screening through education and prevention; to mitigate the complications associated with chronic disease	Increase awareness regarding the adverse effects of stress on chronic disease and mental health	Certified Meditation Specialist to provide classes on meditation and stress reduction techniques This information is to be incorporated into other community educational offerings, as appropriate	Number of participants Participant feedback	Provide educational programs In-service community education staff and assist in the incorporation of stress reduction information in community programs	Content expertise Community education resources