Long Island Community Hospital
Approved and Adopted by the Board of Directors December 15, 2022

Community Health
Needs Assessment | 2022 - 2024

**Long Island
Community Hospital**

OUR PARTNERS

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 University Hospital	1000 Montauk Hwy, West Islip, NY 11795
St. Catherine of Siena Hospital	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 Nicolls 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) 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 processes, including data collection and analysis for the Long Island region (Nassau and Suffolk counties).

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INTRODUCTION

This Community Health Needs Assessment (CHNA) represents a collaboration between Long Island Community Hospital, the Long Island Health Collaborative and its nearly 200 member organizations, the Suffolk County Department of Health Services, and patients/residents served by our hospital. It defines the health needs and barriers expressed by community members and the local community-based organizations that serve this region. It reflects primary data collected during January 2021 through August 2022. Secondary data from 2018 – 2021 was also examined. It is intended to serve as a blueprint for our hospital and collaborating partners to ensure that interventions and strategies address health needs and achieve health equity.

Long Island Community Hospital is a 306-bed acute-care, community hospital located in Patchogue, New York, which is in Suffolk County. We are a Level III Adult Trauma Center and designated Primary Stroke Center. We are known for our excellence in wound care and hyperbaric medicine, chemical dependency services, bariatric services and care, and renal dialysis, among other medical/surgical services. As our name implies, we are community-focused and highly accessible to all via our network of primary care centers, which also provide behavioral/substance misuse services.

EXECUTIVE SUMMARY

Long Island Community Hospital worked with the Long Island Health Collaborative (LIHC) and the Suffolk County Department of Health Services (SCDOHS), and dozens of community-based organizations, libraries, schools and universities, local municipalities, and other community stakeholders to produce this CHNA. SCDOHS representatives offered input and consultation, when appropriate, regarding the data analyses conducted by the LIHC and DataGen. Top, high-level findings include a continued prevalence of chronic disease incidence, particularly heart disease, diabetes, obesity and cancer. Further, surging rates of mental health and substance misuse issues among all demographic categories was found, with disparity seen among youth, and low-income communities of color continuing to experience a higher burden of disease overall. In 2022, members of the LIHC reviewed extensive data sets selected from both primary and secondary data sources to identify and confirm New York State Prevention Agenda priorities for the 2022-2024 Community Health Needs Assessment cycle. Data analysis efforts were coordinated through the LIHC, which served as the centralized data return and analysis hub. As directed by the data results, community partners selected:

1. Prevent Chronic Disease
Focus Area 4: Chronic Disease Preventive Care and Management

2. Promote Well-Being and Prevent Mental and Substance Use Disorders
Focus Area 2: Mental and Substance Use Disorders Prevention

Primary data was obtained from a community health needs assessment sent to individuals and a similar survey to community-based organization leaders[1]. Additionally, we looked at results from two qualitative

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[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)

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studies to round out our primary data.[2] Secondary data was derived from publicly-available data sets curated by DataGen into its proprietary data analytics platform, CHNA Advantage ™, offering 200 plus metrics to determine health issues within Suffolk County.[3] As such, priorities selected for the 2022- 2024 cycle remain unchanged from the 2019 – 2021 cycle selection, and the selected health disparities in which partners are focusing their efforts rests on the inequities experienced by those in historically underserved communities and communities of color. Additional Prevention Agenda priorities/disparities being addressed by Long Island Community Hospital are outlined in the 2022-2024 work plan (See Appendix E).

HANYS — Always There for Healthcare

Long Island Community Hospital
New York's Hospitals and Health Systems Improve the Economy and Community

Economic and Community Benefits

$494,000,000 — Economic activity

3,100 — Jobs generated

$163,000,000 — Payroll expenditures

$80,000,000 — Tax dollars generated

$40,000,000 — Community benefits and investments

Patients Served in 2020

111,000 — Outpatients provided care

39,000 — People treated in the emergency room

8,700 — People admitted to hospitals

State and Federal Funding — **50%** — **Reimbursement from Medicare and Medicaid** — At this hospital, 80% of inpatient discharges and 69% of outpatient visits are covered by Medicare and Medicaid.

Source: Healthcare Association of New York State (2020 Community Benefit)

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[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)
[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, CDC Places, and U.S. Census Bureau. The CHNA Advantage™ data analytics platform includes these and other state and national level indicators. It also encompasses social risk measures offered by Socially Determined, Inc.

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Long lsland Community Hospital works with a broad range of partners to connect with the community, to assess their needs through distribution and promotion of data collection tools, and to provide interventions in collaborative settings, when appropriate. See page 7 for our extensive list of partners. We also rely on the LIHC and its role as neutral convener and regional leader, espousing the collective impact model and framework.[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, and media relations support. LIHC's networking capabilities, its programs around walking and chronic Hospitals and county health departments worked collaboratively on the CHNA.

In addition, our hospital maintains a Community Outreach Committee made up of a group of local community members who meet throughout the year with hospital leadership, offering input about community needs and learn about the services the hospital offers to the community. The committee includes civic leaders, clergy, school representatives, public health advocates, business leaders, service and fraternal club members, consumers, patients and friends of the hospital.

DESCRIPTION OF COMMUNITY

Demographics

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. 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,[5] about a four percent increase from the last report.

Interestingly, according to the Robert Wood Johnson Foundation's 2022 County Health Rankings, Suffolk County ranks 10th for health outcomes and eight for health factors[6]. Health factors represent health issues that can improve length and quality of life. Health outcomes represent how healthy a county is right now.

Geographic description

Suffolk County is 2,373 square miles and is the second largest county in New York. Long Island Community Hospital services this easternmost county in New Yok State. The county is divided into 10 towns: Babylon, Huntington, Islip, Smithtown, Brookhaven, Southampton, Riverhead, East Hampton, Shelter Island and Southold.[7] Suffolk County is an area of growing diversity, cultures, and population characteristics.

Socioeconomic information

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[4] https://collectiveimpactforum.org/
[5] U.S. Census Bureau, 2020 Decennial Census
[6] https://www.countyhealthrankings.org/app/new-york/2022/rankings/suffolk/county/outcomes/overall/snapshot
[7] https://www.ny.gov/counties/suffolk

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.[8]

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 other 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's 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.[9]

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 LIHC's Community Health Assessment Survey year and after year. 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[10] . According to research conducted by the United Way of New York's ALICE report, [11]Long Island residents are earning wages that do not cover life's basic costs. As of 2020, **31.5% of Long Island households fall below the set income threshold needed to live and work**, which equates to 171,921 households in Suffolk County and 130,599 households in Nassau County and that are struggling to afford these basic needs.

Municipalities in target community

Long Island Community Hospital attends to patients and residents throughout Suffolk County's 10 town ships. The hospital's primary service areas and secondary service areas, as defined by zip code and town, are noted below:

Primary Service Area	ZIPS
Bayport	11705
Bellport	11713
Blue Point	11715
Brookhaven	11719
Center Moriches	11934
Davis Park	11772
Holbrook	11741

[8] U.S. Census Bureau, 2016-2020 American Community Survey, Five-Year Estimates
[9] U.S. Census Bureau, 2016-2020 American Community Survey, Five-year Estimates
[10] U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates
[11] https://www.unitedwayli.org/ALICE2020

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| Holtsville	11742
Mastic	11950
Mastic Beach	11951
Medford	11763
Moriches	11955
Patchogue	11772
Sayville	11782
Shirley	11967
Yaphank	11980
Secondary Service Area	
Bohemia	11716
Coram	11727
East Moriches	11940
Eastport	11941
Farmingville	11738
Islip	11751
Manorville	11949
Middle Island	11953
Oakdale	11769
Ridge	11961
Ronkonkoma	11779
Selden	11784
West Sayville	11796

Throughout Suffolk County, there are 17 identified communities in which a variety of socioeconomic factors lead to vast health disparities. These identified communities were determined by the Suffolk County Department of Health Services with concurrence from hospital partners. 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.


Source: https://ontheworldmap.com/usa/state/new-york/long-island/

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Primary Service Area – Long Island Community Hospital

Measure Name	Year	*National Benchmark*	*State Benchmark*	Bayport	Bellport	Blue Point	Brookhaven	Center Moriches	Holbrook	Holtsville	Mastic	Mastic Beach	Medford	Moriches	Patchogue	Sayville	Shirley	Yaphank
Binge Drinking-Percentage	2019	17.86	18.60	20.30	19.20	20.60	16.90	20.60	20.30	20.80	21.20	20.10	19.70	18.60	19.50	19.10	20.50	21.50
Smoking-Percentage	2019	17.44	15.74	13.50	17.10	13.00	18.20	15.30	15.20	16.20	18.80	20.40	16.30	15.80	16.50	13.40	19.50	16.10
No Physical Activity-Percentage	2019	26.97	28.15	22.10	29.10	21.60	30.50	24.70	24.50	25.40	29.10	30.80	27.70	26.70	28.50	23.40	29.90	25.70
Cancer-Percentage	2019	6.56	6.53	7.40	6.10	7.70	8.80	7.10	6.90	6.50	5.40	5.90	6.60	8.40	6.90	8.30	5.70	6.60
COPD-Percentage	2019	6.81	6.61	5.60	6.10	5.50	9.00	5.90	5.90	5.90	6.20	7.20	6.30	6.90	6.60	6.20	6.90	5.90
Coronary Heart Disease-Percentage	2019	5.80	5.55	4.60	4.70	4.60	7.20	4.70	4.60	4.40	4.20	4.90	4.90	5.90	5.20	5.20	4.70	4.60
Diabetes-Percentage	2019	10.51	10.22	7.20	9.10	7.00	10.60	7.60	7.70	7.40	7.80	8.50	8.70	8.70	8.70	7.90	8.20	7.70
High Blood Pressure-Percentage	2019	71.95	74.35	74.30	72.50	75.20	78.70	73.60	73.80	72.20	68.50	71.10	73.30	75.70	74.00	76.50	70.30	72.00
Obesity-Percentage	2019	32.08	28.33	24.90	29.00	24.00	27.90	25.90	25.50	25.80	28.00	29.00	27.50	25.50	27.40	24.60	28.20	26.70
Stroke-Percentage	2019	3.27	3.14	2.40	2.80	2.30	3.70	2.50	2.40	2.30	2.40	2.70	2.70	3.00	2.80	2.70	2.60	2.50
Poor Mental Health-Percentage	2019	14.98	13.89	11.90	14.20	11.60	14.10	12.70	12.80	13.30	15.30	16.00	13.60	12.80	13.70	11.80	15.80	13.10
Poor/ Fair Health-Percentage	2019	19.30	18.72	12.20	17.70	11.80	19.60	13.90	13.70	14.10	17.10	18.60	16.20	15.30	16.90	13.30	17.90	14.50

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Most Recent Data by City
Source: CDC Places
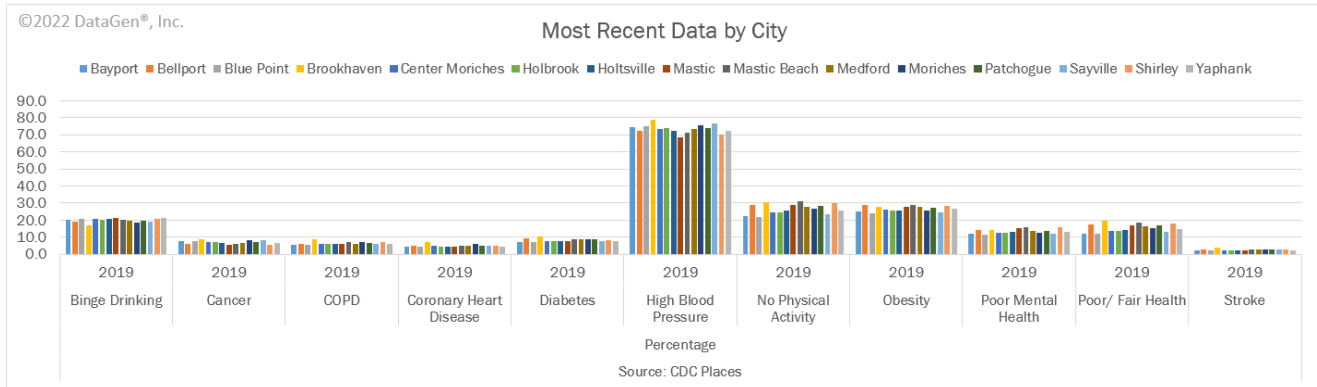
Secondary Service Area – Long Island Community Hospital

Measure Name	Year	*National Benchmark*	*State Benchmark*	Bohemia	Coram	East Moriches	Eastport	Farmingville	Islip	Manorville	Middle Island	Oakdale	Ridge	Ronkonkoma	Selden	West Sayville
Binge Drinking-Percentage	2019	17.86	18.60	19.80	19.50	19.00	18.80	21.20	20.10	19.90	18.40	18.90	15.80	20.10	20.60	18.50
Smoking-Percentage	2019	17.44	15.74	15.50	15.70	15.10	14.10	16.20	14.40	16.40	16.30	12.80	14.70	16.10	16.50	14.50
No Physical Activity-Percentage	2019	26.97	28.15	25.30	26.60	25.30	24.40	25.40	24.10	26.00	28.10	22.90	26.40	26.00	26.40	25.60
Cancer-Percentage	2019	6.56	6.53	7.60	6.60	8.40	8.30	6.20	7.20	7.30	7.70	8.70	10.50	7.00	6.40	8.80
COPD-Percentage	2019	6.81	6.61	6.50	6.00	7.00	6.70	5.80	5.90	6.60	7.10	6.20	6.30	6.10	6.80	6.30
Coronary Heart Disease-Percentage	2019	5.80	5.55	5.10	4.70	5.80	5.70	4.20	4.70	5.10	5.80	5.40	8.00	4.90	4.50	5.90
Diabetes-Percentage	2019	10.51	10.22	8.00	8.40	8.70	8.60	7.30	7.60	8.10	9.40	8.10	10.70	8.00	7.70	8.40
High Blood Pressure-Percentage	2019	71.95	74.35	75.10	73.70	77.30	77.70	71.40	74.30	76.20	78.80	81.20	73.60	76.20	71.70	77.50
Obesity-Percentage	2019	32.08	28.33	25.70	26.80	26.10	25.70	25.80	25.40	26.50	27.40	24.30	25.70	25.90	26.20	25.10
Stroke-Percentage	2019	3.27	3.14	2.70	2.60	3.00	2.90	2.30	2.50	2.70	3.10	2.70	4.00	2.60	2.40	3.00
Poor Mental Health-Percentage	2019	14.98	13.89	12.90	13.10	12.50	12.20	13.60	12.50	13.40	13.40	11.50	12.30	13.30	13.80	12.40
Poor/ Fair Health-Percentage	2019	19.30	18.72	14.30	15.20	14.80	14.10	14.30	13.60	14.90	16.60	12.80	17.70	14.60	15.00	14.50

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Most Recent Data by City
Source: CDC Places
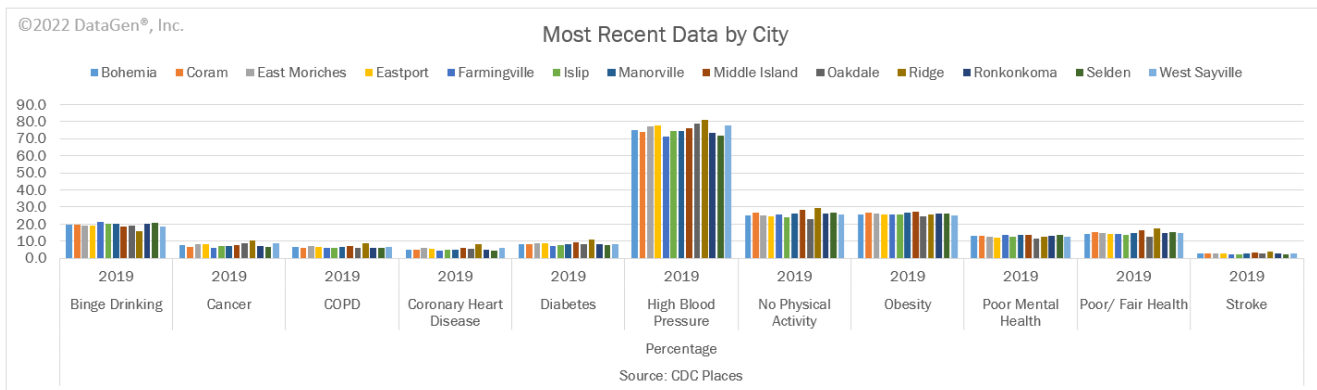
The two previous tables and bar graphs compare Long Island Community Hospital's primary and secondary service areas against state and national benchmarks for 12 selected measures (outcomes, health behaviors). High blood pressure, binge drinking, obesity, no physical activity are all measures exceeding state benchmarks and, in some cases, the national benchmarks for almost all of the zip codes examined.

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Healthcare and other key institutions

Long Island Community Hospital is dedicated to the diverse needs of its many communities, with a special emphasis on diabetes management and mental health/substance misuse needs. We collaborate with a variety of community-based organizations, our local chambers of commerce, libraries and schools, and the Suffolk County Department of Health Services, among many others. The organizations listed below partner with us to reduce the incidence of chronic disease, mental health, and substance misuse in our communities.

- Bellport and Patchogue Head Start
- Bellport Hagerman East Patchogue Alliance
- Bellport Outreach
- Boys and Girls Club of Bellport
- Cornell Cooperative Extension of Suffolk County
- Family and Children's Association
- Family Service League
- Hagerman Fire Department
- Hunter Business School
- Bayport Bluepoint Library
- Lighthouse Mission
- Lions Club of Suffolk County
- NIH HEALing Communities Study (Opioid overdose reduction)
- Ovations Dance Studio
- Patchogue YMCA

- Patchogue-Medford Library
- Patchogue-Medford Union Free School District
- Sachem High School North
- Sachem Library
- Sayville Pantry
- Sayville Union Free School District
- Seafield Recovery Center
- St. Joseph's University
- Substance Abuse Agencies
- Substance Abuse and Mental Health Services Administration (SAMSHA)
- Sun River Health Center Shirley
- The Diabetes Resource Coalition of Long Island
- Victory Recovery Center
- Village Walk at Patchogue (Assisted Living)
- William Floyd School District

Long Island Community Hospital relies on the LIHC to disseminate information about the importance of proper nutrition and physical activity among the general public to assist Suffolk residents in better managing their chronic diseases and/or preventing the onset of chronic diseases. The hospital also relies on 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 to 588 community-based organization leaders, and strategic use of social media platforms. These efforts are ongoing. The work plan *(see Appendix E)* outlines anticipated measures and activities for 2023 supported by the LIHC. Finally, the 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 – April 2022. *(See Appendix G for list of workgroup members)*
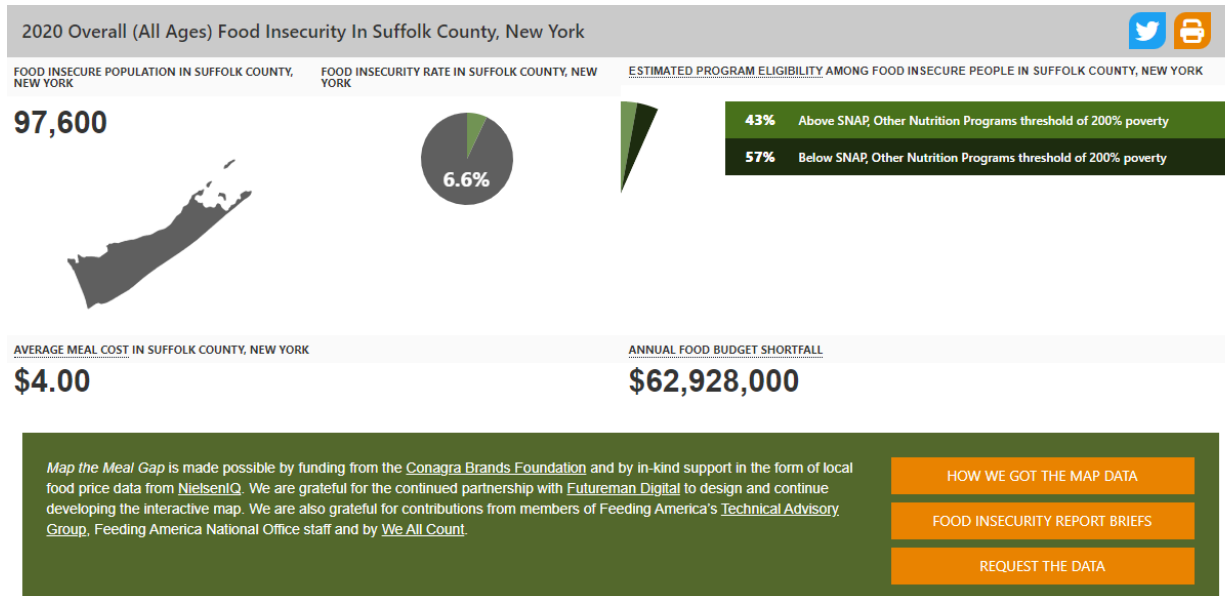
Existing health disparities

Low-income communities of color, especially those in the identified 17 communities, bear a greater burden of chronic disease, which is exacerbated by social determinant of health need factors.

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 every

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chronic disease. Recognizing that a level of food insecurity exists among many of its service zip codes, Long Island Community Hospital holds food drives and works with local food pantries to ensure those most in need have access to food. Our hospital serves seven out of 10 communities with the lowest median income in Suffolk County.

According to Feeding America, **6.6% of Suffolk County residents are food insecure**, which represents 97,600 community members. Another Feeding America study, Map the Meal Gap 2020, examined the cost of food and cost of living in zip codes across the United States. Suffolk County's Annual Food Budget Shortfall represents $62,928,000, according to the study, and 44% of adults are living above the 200% federal poverty level for SNAP.[12]

2020 Overall (All Ages) Food Insecurity In Suffolk County, New York

FOOD INSECURE POPULATION IN SUFFOLK COUNTY, NEW YORK	FOOD INSECURITY RATE IN SUFFOLK COUNTY, NEW YORK	ESTIMATED PROGRAM ELIGIBILITY AMONG FOOD INSECURE PEOPLE IN SUFFOLK COUNTY, NEW YORK
97,600	6.6%	43% — Above SNAP, Other Nutrition Programs threshold of 200% poverty 57% — Below SNAP, Other Nutrition Programs threshold of 200% poverty

AVERAGE MEAL COST IN SUFFOLK COUNTY, NEW YORK	ANNUAL FOOD BUDGET SHORTFALL
$4.00	**$62,928,000**

Map the Meal Gap is made possible by funding from the Conagra Brands Foundation and by in-kind support in the form of local food price data from NielsenIQ. We are grateful for the continued partnership with Futureman Digital to design and continue developing the interactive map. We are also grateful for contributions from members of Feeding America's Technical Advisory Group, Feeding America National Office staff and by We All Count.

HOW WE GOT THE MAP DATA
FOOD INSECURITY REPORT BRIEFS
REQUEST THE DATA

Source: Feeding America, Map the Meal Gap 2020, Suffolk County

Obesity is another health disparity disproportionately affecting Suffolk County. Overall, the county exhibits a higher rate of adult obesity compared to the state. Obesity is a leading indicator for chronic disease. According to the Robert Wood Johnson Foundation's County Health Rankings for Suffolk County,[13] 27% of the population (18 and older) reports a body mass index (BMI) greater than or equal to 30 kg/m.[14] In 2019, *The New England Journal of Medicine* studied what the projected adult obesity rate in the United States will be by 2030 based on today's obese and overweight adult populations.[15] By 2030, the obesity epidemic is projected to impact nearly 1 in 2 adults.

According to the New York State Department of Health, obesity is a significant risk factor for many chronic diseases including type 2 diabetes, high blood pressure, asthma, stroke, heart disease and certain types of cancer. 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

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[12] https://map.feedingamerica.org/county/2020/overall/new-york/county/suffolk
[13] https://www.countyhealthrankings.org/app/new-york/2022/measure/factors/11/map
[14] https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2021-02_ifa_report.pdf
[15] https://www.nejm.org/doi/full/10.1056/NEJMsa1909301

United States. Asians and Whites experience the disease at 9.5% and 7.4% respectively.[16] 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 - income/employment, race/ethnicity, food access, housing/neighborhood location, and level of education. The county and hospitals identified in this report through collaborative efforts and facility-specific programming acknowledge and address these determinants regularly.

OVERVIEW OF IDENTIFIED NEEDS

Reducing chronic diseases and mental health illness/substance misuse have been identified as the top two priorities in our communities. A Long Island Community Hospital representative was a member of the 2022 CHNA Workgroup convened by the Long Island Health Collaborative. The prevailing health/social support needs uncovered through primary and secondary data research were discussed with other workgroup members, one of whom was a local county health department executive, as part of the nine-month CHNA process. Members of the workgroup brought insight learned from the previous CHNA report cycle to the table, including relevant comments from community members. We then confidently and unanimously selected the priorities noted. Embedded within these priorities are areas of need, as revealed by the primary and secondary research.

Areas of Identified Need

Access to care, mental health, health literacy, education, economic security (poverty),
obesity and weight loss, food access, clean air and water.

Primary data and secondary data demonstrate that residents living in Suffolk County are experiencing poor mental health status. The 2021 Robert Wood Johnson Foundation County Health Rankings examining Suffolk County in Quality-of-Life Health Outcomes demonstrates an average of 4.0 poor mental health days per 30 days in Suffolk County.[17] 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.[18] High school students (grades 9 through 12) fared just as badly. 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.[19] The pandemic

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[16] https://www.cdc.gov/diabetes/health-equity/diabetes-by-the-numbers.html
[17] https://www.countyhealthrankings. org/app/new-york/2021/compare/snapshot?counties=36_059%2B36_103
[18] https://nyhealthfoundation.org/resource/mental-health-impact-of-the-coronavirus-pandemic-in-new-york-state/#:~:text=The%20proportion%20of%20New%20Yorkers,health%20throughout%20the%20survey%20period
[19] https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm? s_cid=su7103a3_w

made a bad situation worse, especially for youth, as mental health issues and suicides were already increasing prior to the COVID-19 pandemic.[20] [21] [22] [23] With the shortage of mental healthcare 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. **As of 2019, Suffolk County still exceeds the New York state benchmark of 15.1 in overdose deaths per 100,000 due to opioids.** According to data provided by Suffolk County's Department of Health, the rate of opioid overdoses is currently 19.6. In addition, emergency department visits involving heroin overdoses is extremely high in the county. As of 2019, the Suffolk County rate is 47.2 compared to New York State's benchmark of 31.1 per 100,000 population.[24]

The 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 335 deaths involving opioid pain relievers (including illicitly produced opioids such as fentanyl).[25] For 2019, the numbers were 173, 47, and 163, respectively via categories listed above.[26]
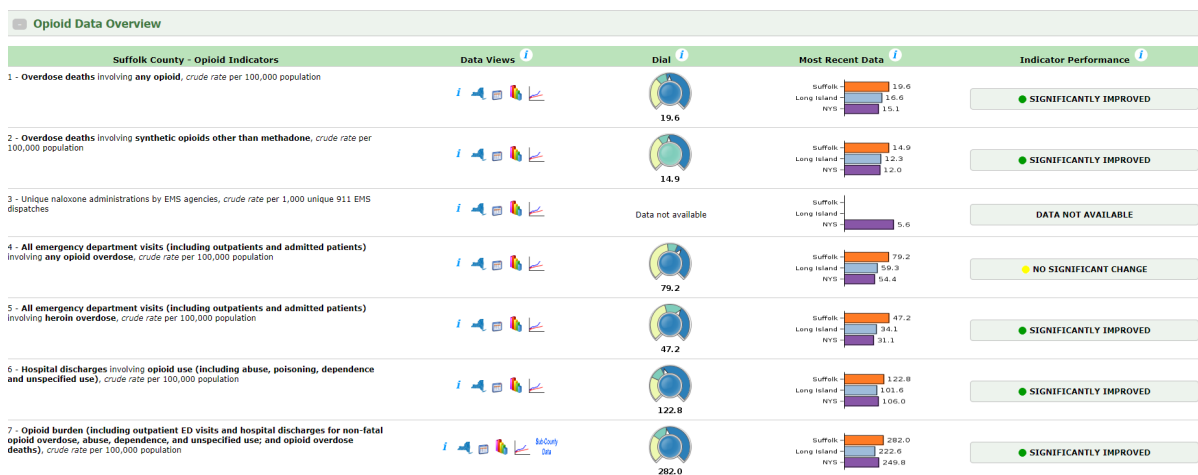
Graphic Source: Suffolk County Department of Health data on opioid, deaths, hospital utilization

The above graph illustrates that Suffolk County has historically been above the state benchmark regarding a number of opioid measures. This remains the case to this day. The Town of Brookhaven has an especially high incidence of opioid use, overdose, and death and this is why the National Institutes of Health selected the 27 zip codes within the township of Brookhaven to participate in a two-year national study and effort to reduce opioid-related overdose deaths by 40 percent. Other goals of the study included increasing access to naloxone, expanding use of medications for opioid use disorder, such as buprenorphine, methadone, and naltrexone, as well as reducing high-risk opioid prescribing. A Long Island Community Hospital representative served on the study's local advisory board and participated in a treatment workgroup. During the study period, Long Island Community Hospital expanded its

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[20] https://www.cdc.gov/mmwr/volumes/66/wr/mm6630a6.htm

[21] https://www.cdc.gov/nchs/fastats/mental-health.htm

[22] 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

[23] 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.

[24]https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/opioid_dashboard/op_dashboard&p=ch&cos=47

[25] https://www.health.ny.gov/statistics/opioid/data/pdf/nys_apr22.pdf

[26] https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jan21.pdf

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suboxone inductions given in the emergency room to include medical units. These interventions continue to this day. Also in line with the study goals and in sync with their work to reduce opioid use, the hospital provides NARCAN kits and training to community members and hospital staff on an ongoing basis. The HEALing Communities Study New York, part of the NIH Heal Initiative, concluded PHASE I – the portion of the study that included Brookhaven Town – in 2022.
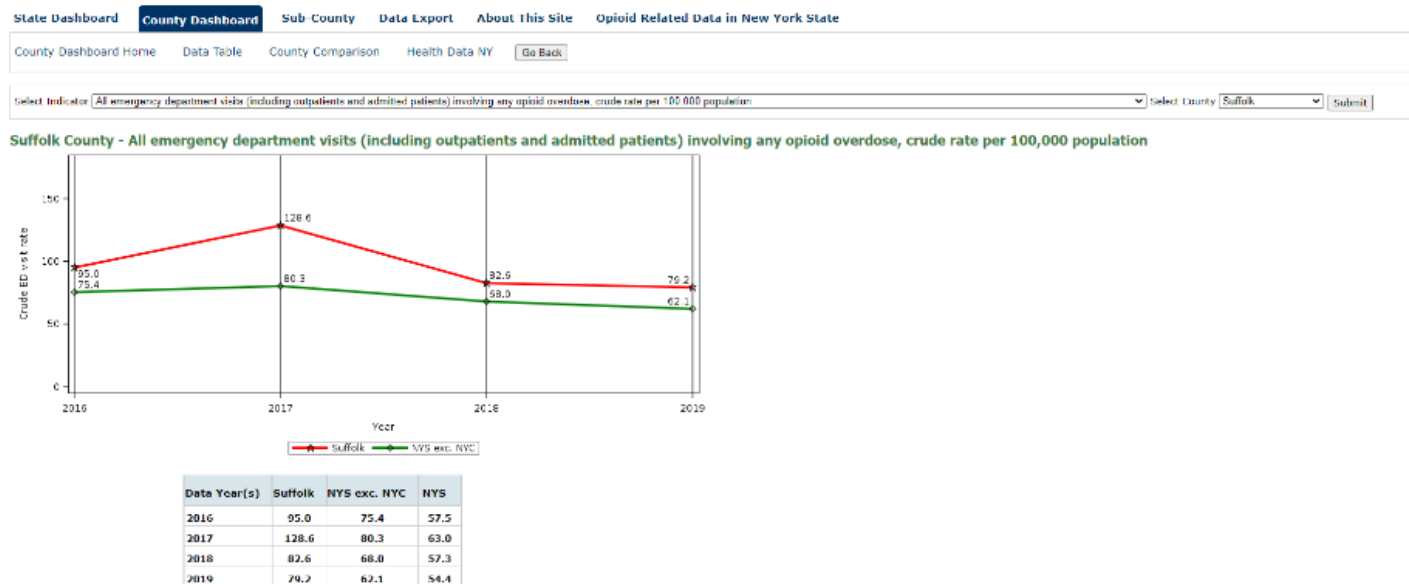
Source: New York State Department of Health, Opioid Data Overview, Suffolk County

Aligned with the HEALing Communities Study goals is our hospital's involvement in a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. We are implementing a five-year grant designed to increase access to medication assisted treatment for patients in the emergency room, inpatient units, and outpatient chemical dependency program.

These are the **main health challenges and contributing causes** affecting residents of the county, especially in low-income communities of color. Poverty, food insecurity, inability to access healthcare services and all the known social determinants of health are predictors of chronic disease, and this is well documented.[27] [28] [29] For our region, healthcare access issues are mostly tied to economics (quality of health insurance, employment, and cost of living). In the mental health/substance misuse space, access is further hampered by a dearth of providers. Fear, which includes immigration status, is also a detriment to healthcare access.

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[27] Cockerham WC, Hamby BW, Oates GR. The Social Determinants of Chronic Disease. Am J Prev Med. 2017 Jan;52(1S1):S5-S12. https://doi.org/10.1016%2Fj.amepre.2016.09.010. PMID: 27989293; PMCID: PMC5328595.
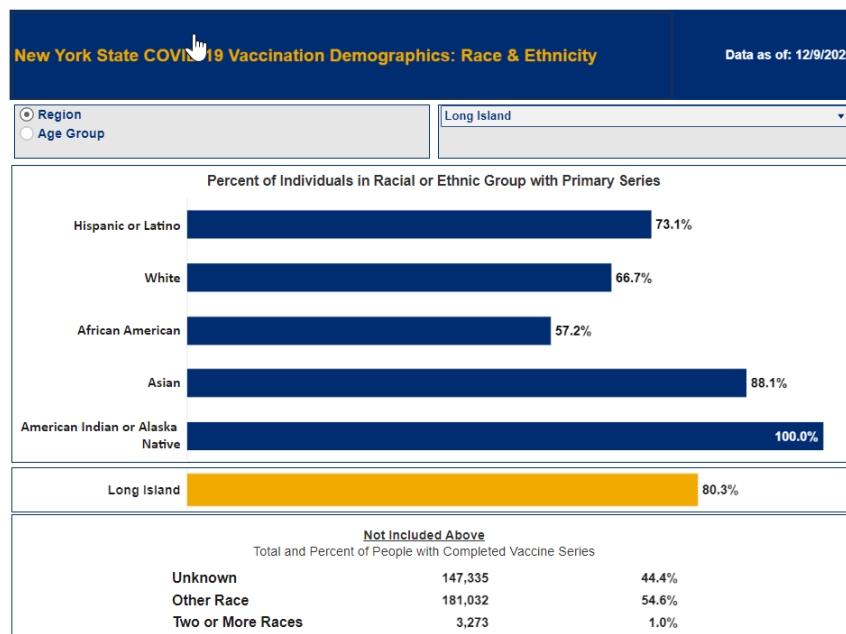[28] Pantell MS, Prather AA, Downing JM, Gordon NP, Adler NE. Association of Social and Behavioral Risk Factors With Earlier Onset of Adult Hypertension and Diabetes. *JAMA Netw Open.* 2019;2(5):e193933. Https://doi:10.1001/jamanetworkopen.2019.3933
[29] Vennu, V., Abdulrahman, T.A., Alenazi, A.M. *et al.* Associations between social determinants and the presence of chronic diseases: data from the osteoarthritis Initiative. *BMC Public Health* **20,** 1323 (2020). https://doi.org/10.1186/s12889-020-09451-5

Pandemic's Toll Exacerbated Health Challenges and Disparities

As the pandemic revealed, Black and Hispanic individuals experienced higher rates of COVID-19 disease and death. These higher rates correlated to low-income areas and the higher rate of chronic disease seen in these communities. According to the Centers for Disease Control and Prevention (CDC), chronic disease is a leading risk factor for COVID-19 morbidity and mortality. The 2021 National Healthcare Quality and Disparities Report[30] 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-19 Fatalities Tracker[31] shows that the number one COVID-19 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. Long Island Community Hospital participated in the HUB, holding point of distribution (POD) sites at the hospital and offsite hospital locations as soon as the vaccine became available to the hospital. 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.[32]

New York State COVID-19 Vaccination Demographics: Race & Ethnicity	Data as of: 12/9/2022

Region
Age Group

Long Island

Percent of Individuals in Racial or Ethnic Group with Primary Series

Hispanic or Latino	73.1%
White	66.7%
African American	57.2%
Asian	88.1%
American Indian or Alaska Native	100.0%
Long Island	80.3%

Not Included Above
Total and Percent of People with Completed Vaccine Series

Unknown	147,335	44.4%
Other Race	181,032	54.6%
Two or More Races	3,273	1.0%

Source: Demographic Vaccination Data | Department of Health (ny.gov)

As of December 9, 2022, 76.5% of Suffolk County residents have received the primary series of vaccine.[33] Race and ethnicity data is available for vaccinated adults living on Long Island. The chart above shows

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[30] https://www.ahrq.gov/research/findings/nhqrdr/nhqdr21/index.html

[31] https://coronavirus.health.ny.gov/fatalities-0

[32] https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/

[33] https://coronavirus.health.ny.gov/vaccination-progress-date

that 73.1% of Hispanic or Latino adults, 66.7% of White adults, and 57.2% of Black adults have received the primary vaccination series. Ongoing partner efforts will continue to promote vaccination, both initial series and boosters to eligible community residents.

As of November 1, 2022, Long Island Community Hospital administered 22,471 COVID-19 vaccines.

SPECIFIC METHODOLOGIES FOR RESEARCH

Guided by the LIHC, Long Island Community Hospital and all regional partners reviewed results from the two qualitative analyses and two quantitative analyses, our sources of primary data, and a variety of secondary data analyses provided by DataGen, which were drawn from national, state, and county publicly available datasets.

The **engagement process** we used to select the two priorities was purposeful and collaborative. 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 screenshots 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 Long Island's two health departments and representatives from Long Island's hospitals/health systems, as well as staff of the LIHC. Attendees discussed primary and secondary data 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 Community Health Assessment Survey
✓ 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
✓ Comments from community members and others regarding the previous CHNA

After an official vote, the priorities were selected unanimously. The April meeting was a culmination of seven LIHC work group meetings held each month, beginning in September 2021 and concluding in April 2022. At these meetings, in addition to representatives noted above, community-based organization leaders from a range of sectors offered input.

Broad Community Engagement

Engagement of the broader community, for **assessment purposes**, is achieved through the LIHC's and its partners' ongoing distribution of the Community Health Needs Assessment – the main primary research tool used to gauge community health needs, social support needs, and barriers to healthcare on an ongoing basis. This survey is offered online via a SurveyMonkey link and is available in paper format to residents at public events, workshops, educational programs, and interventions which are offered by Long Island Community Hospital and other 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 vigilantly promotes the survey through social media and asks LIHC participants 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 and Long Island Community Hospital has availed itself of this service. Long Island Community Hospital posts this survey and the SurveyMonkey link on its website and in electronic and print community newsletters. 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. 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.

Engagement of the broader community, for **implementation purposes**, is assisted by the LIHC's encouragement of community members to participate in programs, workshops, support groups and educational programs offered by Long Island Community Hospital and all LIHC partners. In addition, the LIHC offers limited programming itself, such as the Walk Safe with a Doc events and Talk with a Doc events (presented in collaboration with AARP-LI). All LIHC quarterly meetings are open to the public and recordings of the meetings are housed on its website. The LIHC, on behalf of all its participants and the community members each participant serves, supports the following evidence-based activities and programs:
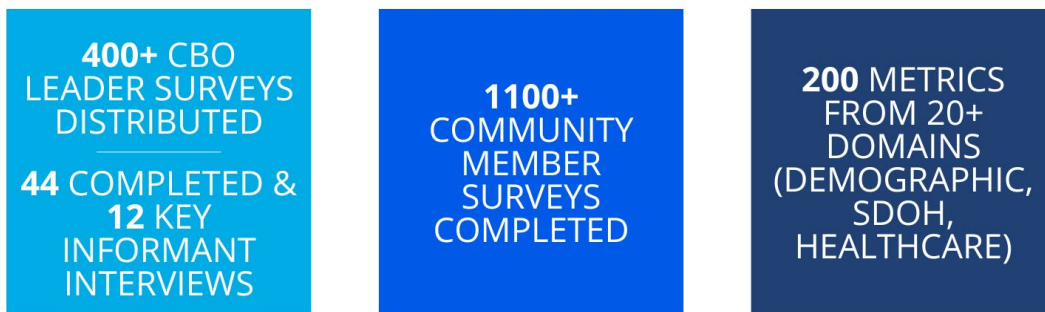
- ✓ Awareness Campaign (Live Better) about chronic disease via social media and traditional media platforms (this campaign captures any mentions about chronic diseases and relevant programs/education efforts)
- ✓ Awareness Campaign about mental health prevention and treatment programs/education, as well 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](#) 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.

When they first gathered in 2013, LIHC partners embraced 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 use 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.[34]

SPECIFIC METHODOLOGIES FOR RESEARCH

Long Island Community Hospital obtained population level and zip code analyses on social determinant of health drivers and health/risk factors dominant in the hospital's service area from its data partner, DataGen. We also looked at hospital utilization data and emergency department data to discern top diagnoses. A survey completed by individual community members, a similar survey completed by community-based organization leaders, key informant interviews with selected leaders, and the results of qualitative research among public library personnel rounded out the research for this cycle's CHNA. The CHNA approach used both quantitative and qualitative research methods designed to evaluate the perspectives and opinions of stakeholders and healthcare consumers. The methodology helped develop a broad, community-based list of needs — in addition to prioritizing the needs and establishing a basis for continued community engagement.

400+ CBO LEADER SURVEYS DISTRIBUTED **44** COMPLETED & **12** KEY INFORMANT INTERVIEWS	**1100+** COMMUNITY MEMBER SURVEYS COMPLETED	**200** METRICS FROM 20+ DOMAINS (DEMOGRAPHIC, SDOH, HEALTHCARE)

Primary Research

Quantitative Methods and Research Tools *(See appendix for full reports and tools)*

Community Health Needs Assessment Survey (CHAS) – measured individual and community level perception of health needs and barriers. A total of 1,143 were completed during the period of January 2021 – December 2021. A subsequent analysis particular to the zip codes in Long Island Community Hospital service area was completed by analyzing 439 surveys collected during the period January 2022 – August 2022. The CHAS provides a snapshot in time of the main health challenges facing communities. It uses the SurveyMonkey platform. Convenience sampling method.

CBO Community Needs Assessment Survey – community-based organization leader perception of health needs and barriers faced by their constituents/patients. A total of 44 surveys were completed (10 from Suffolk County, 25 from Suffolk County, 9 with no location specified). The survey was distributed to 400

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[34] https://www.thecommunityguide.org/

plus leaders during the time period December 1, 2021 - January 15, 2022. It uses the SurveyMonkey platform. Purposeful sampling method.

Qualitative Methods and Research Tools *(See appendix for full reports and tools)*

CBO Key Informant Interviews – 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. The interviews were conducted February 23, 2022, to March 4, 2022, via Zoom and recorded. Atlas Ti version 22 web-based platform used for grounded-theory analysis.

Library Research Project – a two-year study providing an insider look at the health and social support needs of patrons who frequent Long Island's public libraries. Library personnel at randomly selected libraries throughout Suffolk County were selected for this study. A total of 96 interviews (Nassau and Suffolk County libraries) were conducted during the time period December 2017 to February 2020. Interviews were recorded, then transcribed, and analyzed using Dedoose qualitative software (grounded theory) for recurring themes with the report "*Long Island's Libraries: Caretakers of the Region's Social Support and Health Needs*" issued July 2021. Stony Brook University Program in Public Health researchers and students completed the analysis. The analysis considered the socioeconomic differences of communities by location, the influence of social determinants of health, and the Prevention Agenda priorities.

Secondary Research

- ✓ The secondary data research included a thorough analysis of previously published materials/metrics that provide insight regarding the community and health-related measures.

- ✓ *SPARCS (Statewide Planning and Research Cooperative System*) – analysis of hospitalization data 2018, 2019, 2020.
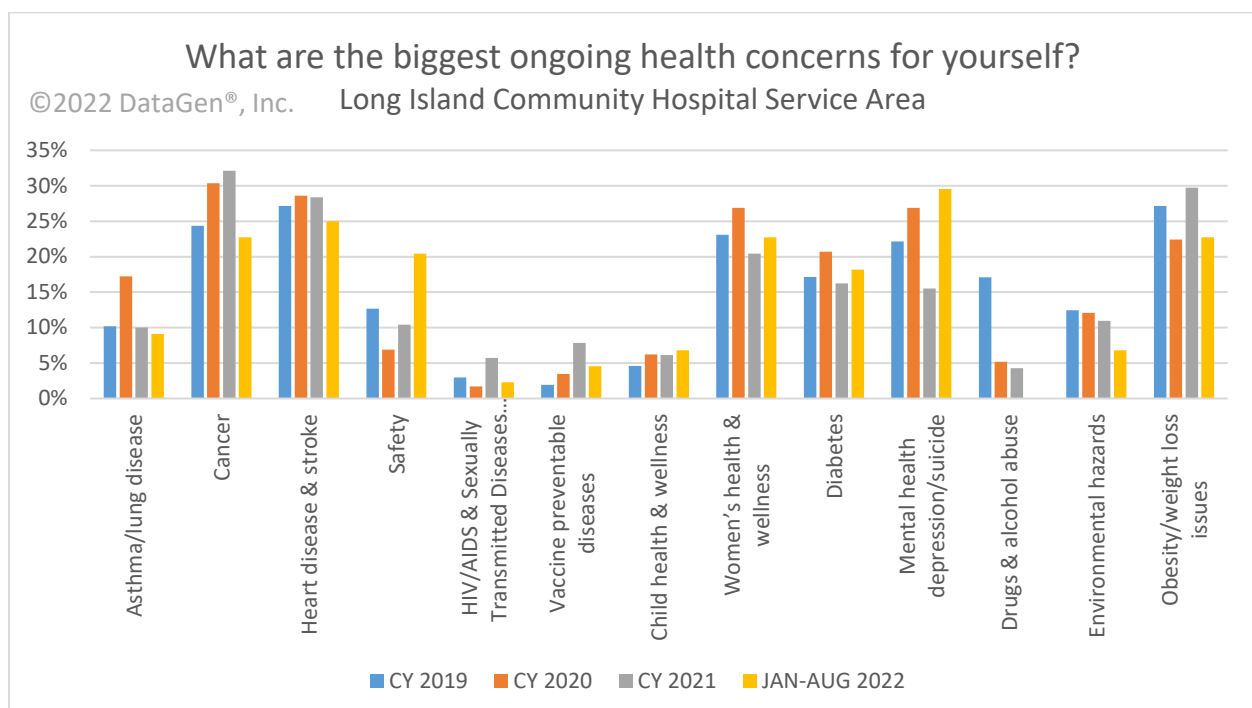
FINDINGS TO SUPPORT IDENTIFIED NEEDS

Using data from both the primary and secondary data sources, the following key themes were revealed. Primary data survey results from hundreds of Suffolk County residents reveal cancer, safety issues, diabetes, mental health, drug and alcohol usage, and obesity/weight loss issues are some of the top concerns for 2022.

What are the biggest ongoing health concerns in the community where you live?
©2022 DataGen®, Inc.
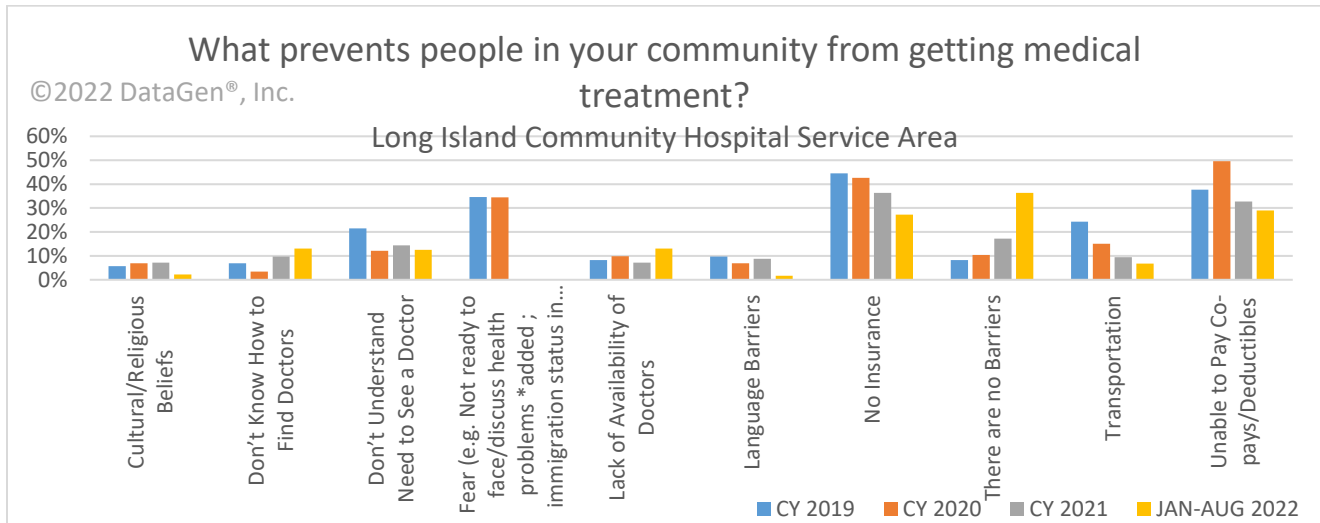Long Island Community Hospital Service Area
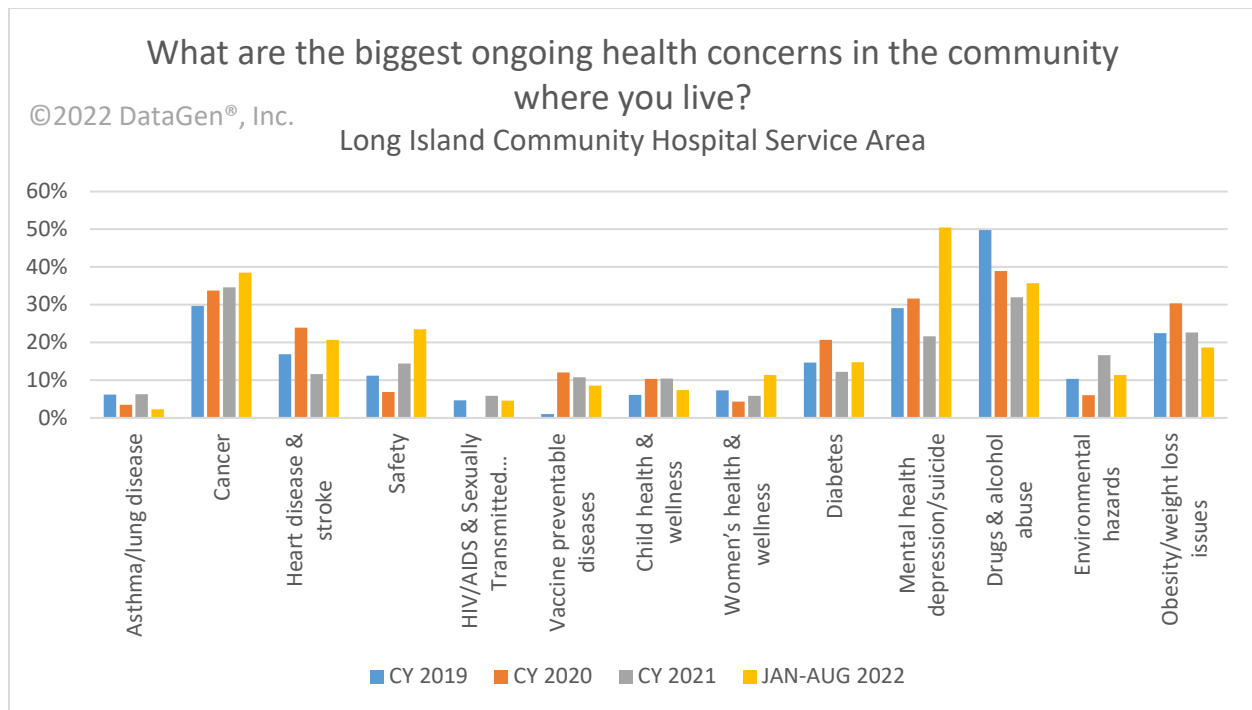
In the above chart, survey respondents answered what their biggest health concerns affecting their community are from their individual perspective. We then compared to annual results from 2019, 2020, 2021 and January – August 2022. The results represent survey responses over three years and eight months for identified health concerns. We focused on the most recent findings – 2022. Concern about mental health and drug and alcohol abuse has increased substantially from the previous year.

Further, when answering questions about individual health, survey takers indicated mental health issues, heart disease and stroke, cancer, safety, women's health, and obesity/weight loss as top concerns. That is illustrated in the chart below.

What are the biggest ongoing health concerns for yourself?
©2022 DataGen®, Inc.
Long Island Community Hospital Service Area

The responses below highlight perceived barriers to care. Interestingly, no insurance and inability to pay co-pays/deductibles are the top two barriers identified. But then no barriers rose as a top response, as well. This may be due to survey responders perceiving that there are adequate providers and services in the region, but cost remains a concern. Poverty and economic distress were also identified in community key informant interviews.

What prevents people in your community from getting medical treatment?
Long Island Community Hospital Service Area
©2022 DataGen®, Inc.

In the following two charts, the need for mental health services is glaringly illustrated. Services, screenings, and education related to heart disease, cancer, and drug/alcohol use are also noted. Healthier food choices, weight loss, safe places to exercise are indicated as important. Respondents also note more awareness around well visits and checkups would benefit the community.

Which of the following is the MOST needed to improve the health of your community?
Long Island Community Hospital Service Area
©2022 DataGen®, Inc.

What health screenings or education/information services are needed in your community?
Long Island Community Hospital Service Area
©2022 DataGen®, Inc.
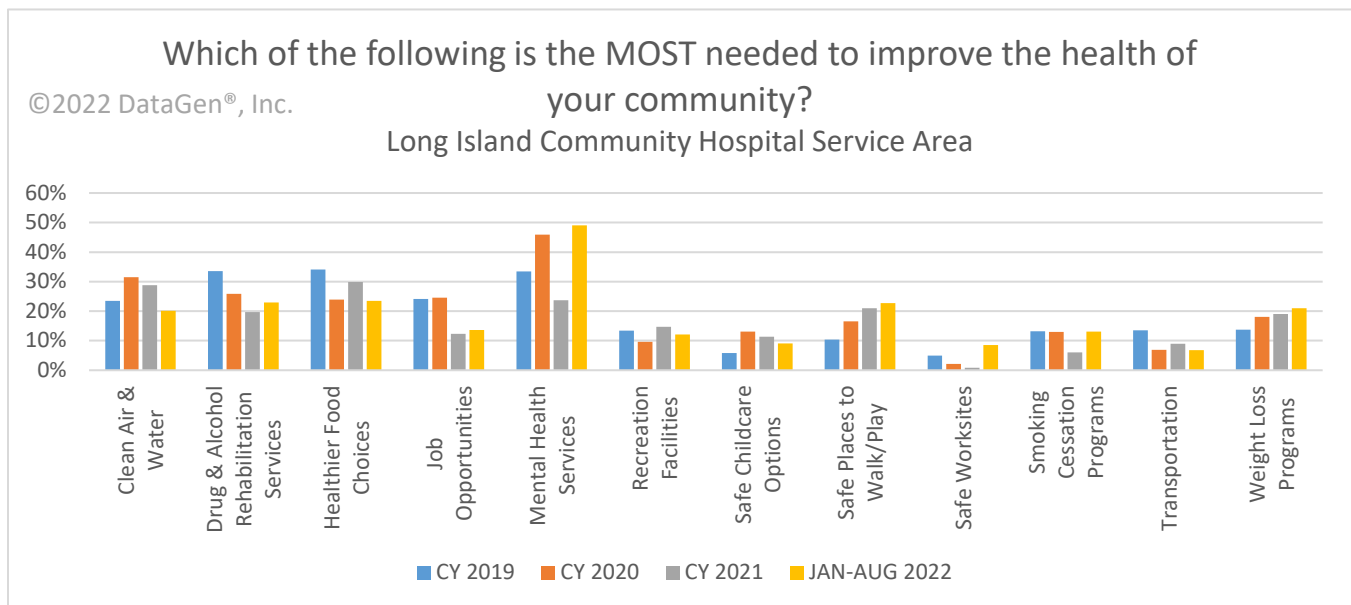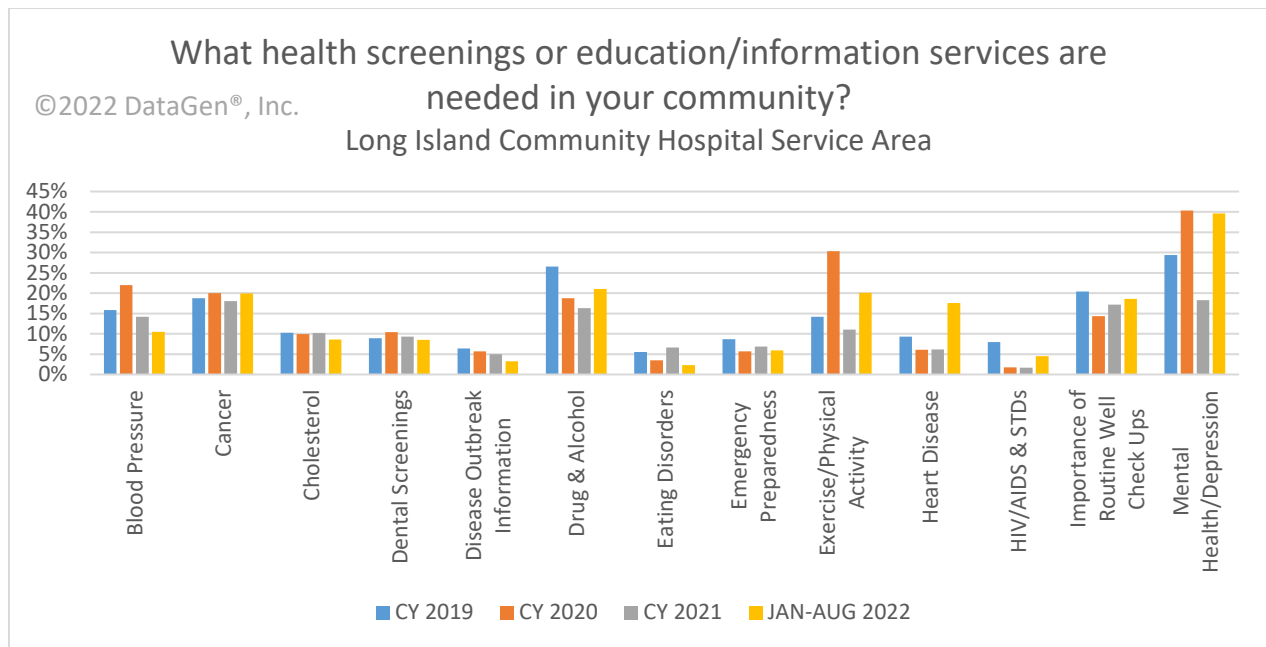
**SPARCS Analyses (Statewide Planning and Research Cooperative System), Suffolk County Hospitalization Data**

SPARCS is a comprehensive all-payer data reporting system established in 1979 as a result of cooperation between the healthcare industry and government. SPARCS currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services.

The following charts present selected towns from within Long Island Community Hospital's service region that show a higher rate of incidence compared to the state and county benchmarks for each measure.
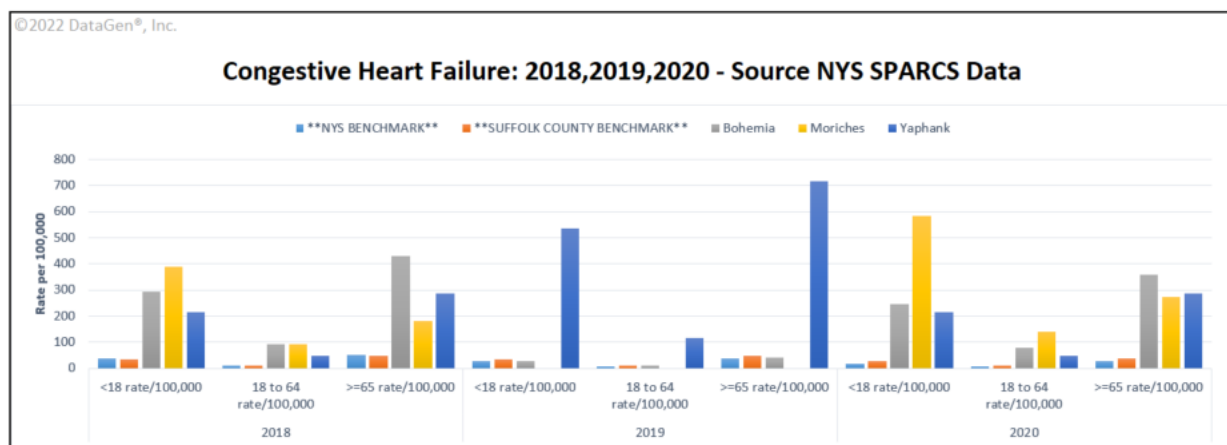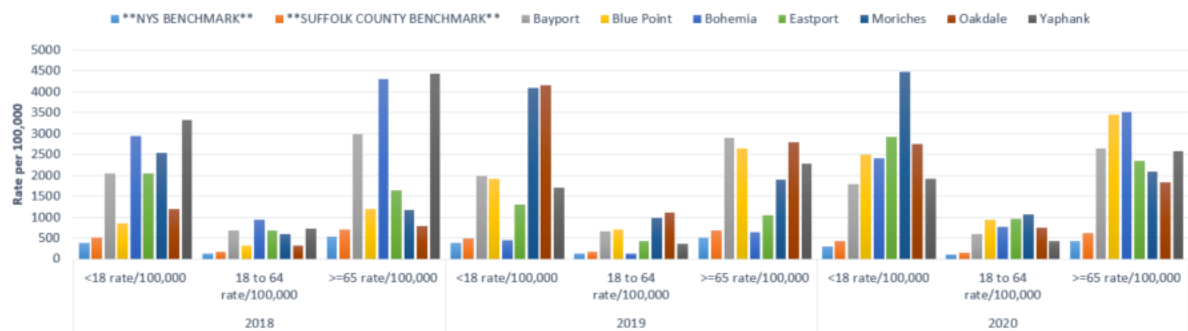

Congestive Heart Failure: 2018,2019,2020 - Source NYS SPARCS Data
©2022 DataGen®, Inc.

Diabetes: 2018,2019,2020 - Source NYS SPARCS Data
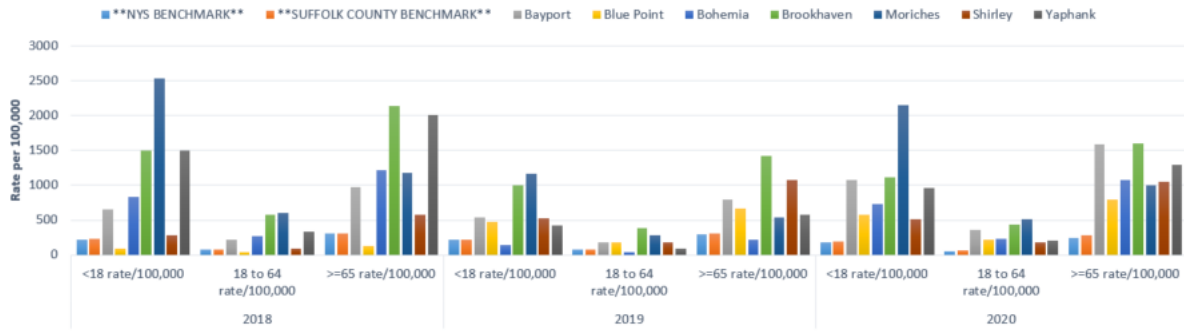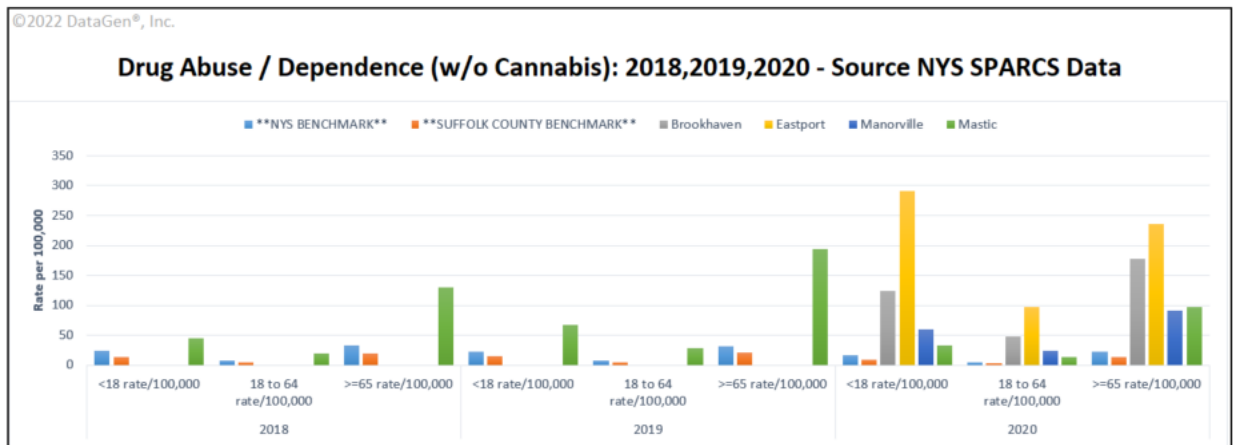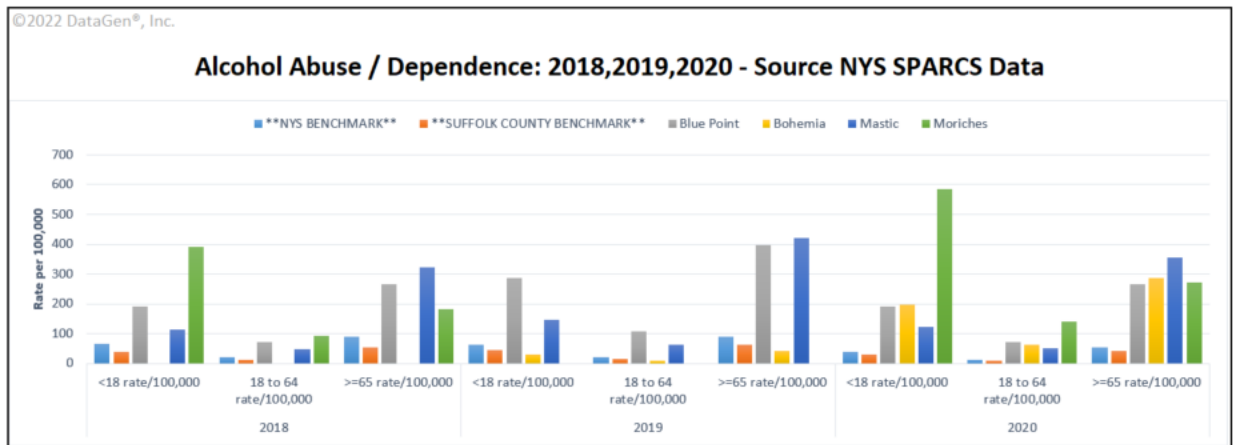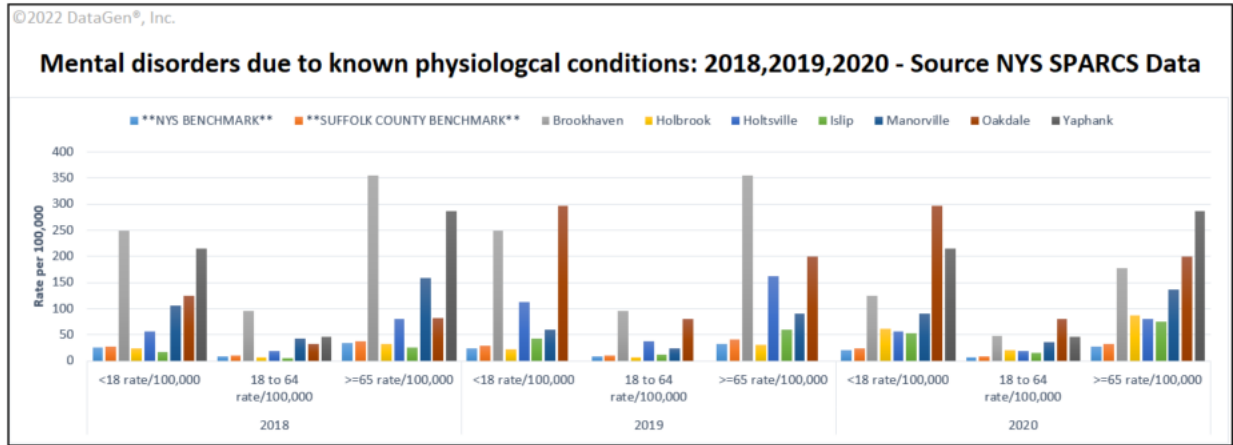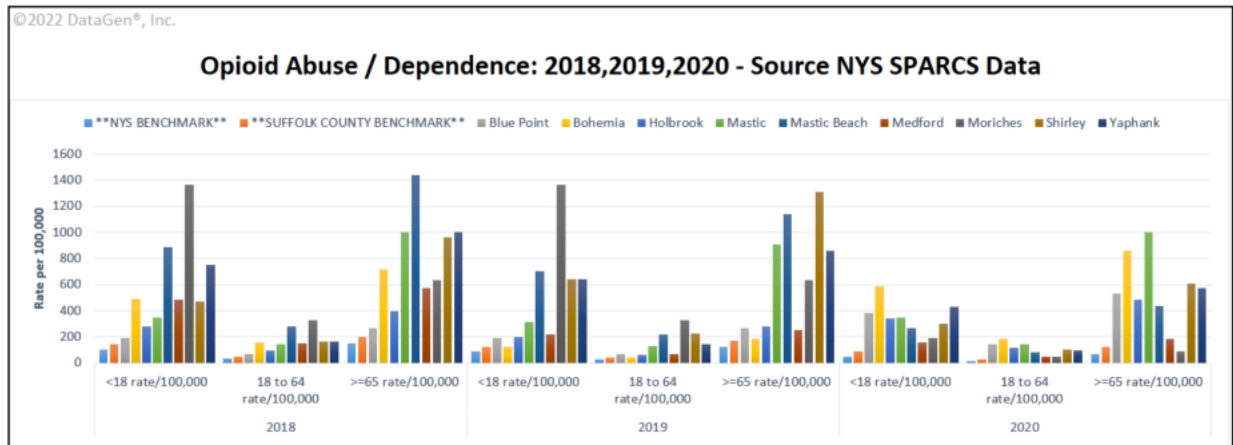

Disease of the Heart: 2018,2019,2020 - Source NYS SPARCS Data
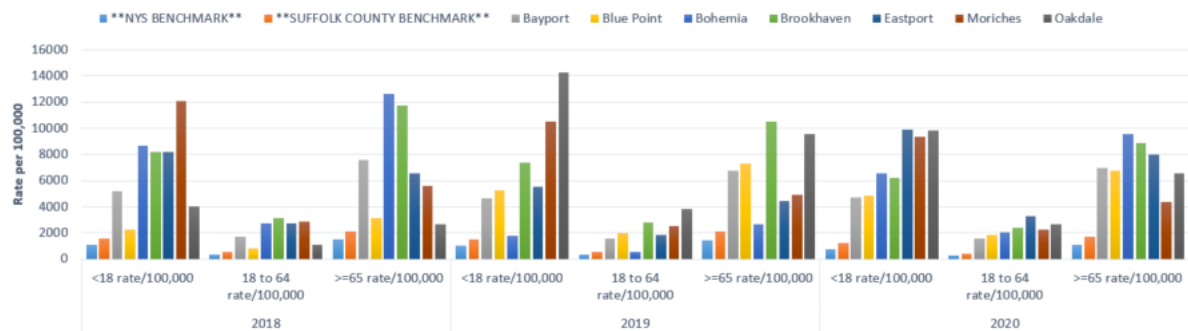
All Malignant Cancer: 2018,2019,2020 - Source NYS SPARCS Data

©2022 DataGen®, Inc.

Opioid Abuse / Dependence: 2018,2019,2020 - Source NYS SPARCS Data

NARCAN training and administration is one way Long Island Community Hospital addresses the high rate of opioid use seen in its service area.

Community-based Organization Needs Assessment Analysis

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

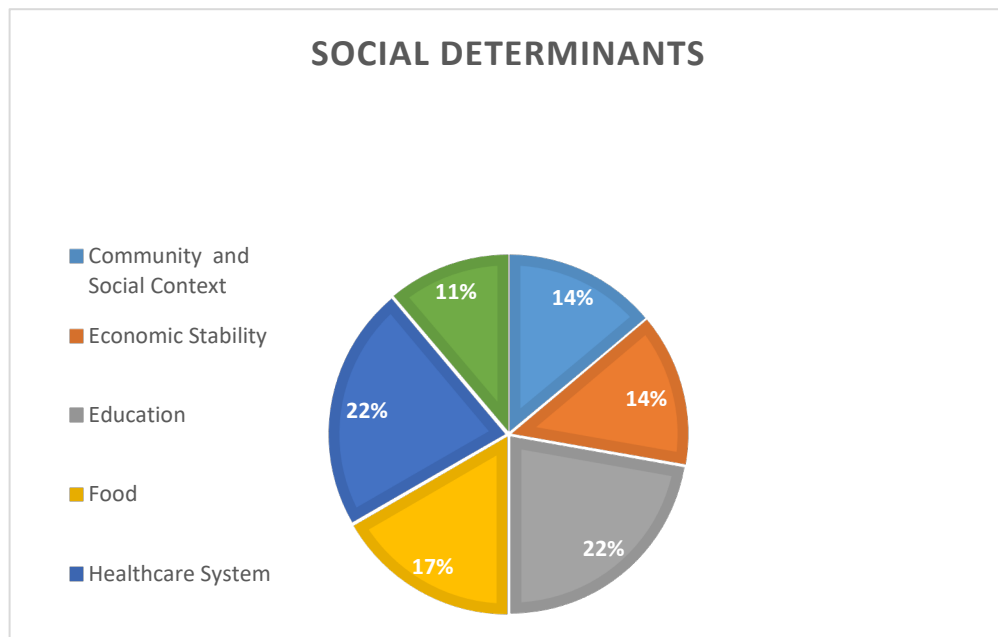| 2022 Rank	Suffolk County	Percentage	Suffolk County	Percentage
1	Mental Health	16/25	Drugs and Alcohol Abuse	6/10
2	Drugs and Alcohol Abuse	14/25	Obesity and Weight Loss	5/10
3	Cancer	11/25	Nutrition/Eating Habits	5/10
4	Women's Health/Wellness	8/25	Mental Health	4/10
5	Care for the Elderly	8/25	Women's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

The results from these two questions reveal that CBO leaders are concerned about food access for their clients and mental health services. They also continue to see drug and alcohol abuse, mental health, and issues related to nutrition and weight loss as major health concerns for their clients.

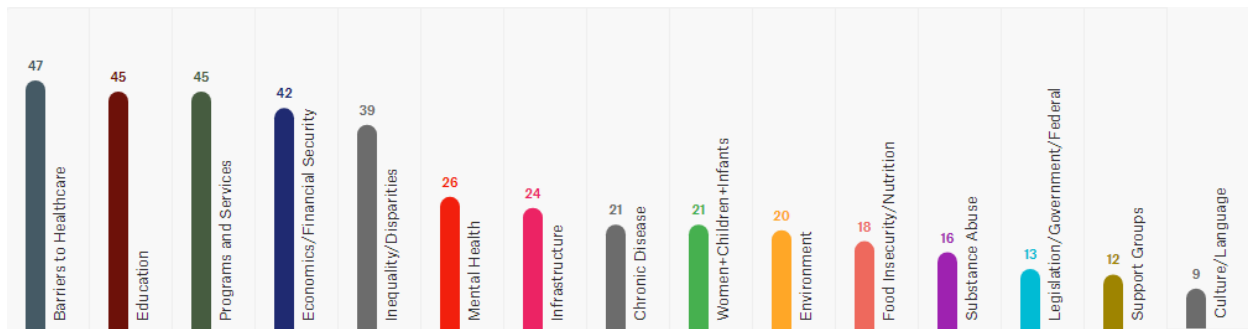**Key Informant Interview Analysis**

The top three social determinant of health factors found via this analysis are education, healthcare system (in terms of access) and food. Kaiser Family Foundation Social Determinant of Health domains used as reference.[35]

SOCIAL DETERMINANTS

Legend:
- Community and Social Context
- Economic Stability
- Education
- Food
- Healthcare System

Values: 14%, 14%, 22%, 17%, 22%, 11%

Healthcare access followed by education and programs/services were the top three codes that emerged from among the transcripts.

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[35] https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Coding Analysis

Library Research Project, Qualitative Analysis

Top 5 identified health needs	Top 5 identified social needs
Mental Health	Homelessness
Exercise	Technology Literacy
Diet	ESL/LOTE
Opioid Use	Unemployment
Personal Health	Food

Library personnel at randomly selected public libraries throughout Suffolk County were interviewed for this study. Mental health is the top health need identified followed by exercise and diet, two lifestyle behaviors that exert a tremendous influence on the incidence of all chronic diseases. Homelessness took the top spot among social needs, possibly because public libraries, especially in low-income, high-need communities, are a haven for the disenfranchised.

COLLABORATING PARTNERS

In addition to working directly with the Long Island Health Collaborative, Long Island Community Hospital has strong relationships with local and regional community-based organizations, libraries, schools, faith-based organizations, the local health department, and local municipalities that support and partner with us to reduce chronic disease, mental health and substance misuse, and to promote health equity. See page 7 for our extensive partner list of healthcare and other key institutions. A shortlist of available assets and resources includes:

22 hospitals
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 farmer's markers
100 plus food pantries
20 Federally Qualified Health Centers

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Each partner offers unique programming and interventions that align with the goals and objectives of Long Island Community Hospital. These assets and resources can be mobilized and employed to address the health issues identified. See the work plan in the appendix E for a detailed description of interventions and our partners with whom we are working.

Community Service Plan and Progress Report

In support of our Community Service Plan, during the past three years, Long Island Community Hospital partnered with community-based organizations in multiple communities to hold diabetes and other chronic disease management educational programs, NARCAN training, support groups, health screenings, and food drives, among other outreach activities. Due to the COVID-19 pandemic, many outreach activities traditionally held in the community were paused. However, as many programs as possible that could be delivered virtually were. In some cases, programs have returned to in-person and/or a combination of in-person and virtual.

PROPOSED INTERVENTIONS

Evidence-based interventions

Long Island Community Hospital remains committed to providing the community with evidence-based and promising practice programs that address chronic diseases and mental health/substance misuse. Our interventions are broad and far reaching. Refer to our work plan for specific interventions, measures, partners, goals and objectives.

Work plan

See Appendix E

SUMMARY

This report is a comprehensive study of the health needs and barriers experienced by the community members served in this region. After extensive research and interaction with partners and the public, the following priorities were selected:

1. **Prevent Chronic Disease**

   Focus Area 4: Chronic Disease Preventive Care and Management

2. **Promote Well-Being and Prevent Mental and Substance Use Disorders**

   Focus Area 2: Mental and Substance Use Disorders Prevention

This report is being made available to the public and will be posted on Long Island Community Hospital's website, as well as the website of the Long Island Health Collaborative.

ATTESTATION OF STATE AND FEDERAL REQUIREMENTS

This CHNA and resulting implementation plan meet the 501(c)(3)(r) federal requirements for conducting a CHNA and implementation plan. The regulations are part of the Affordable Care Act and became effective in 2015. The document also meets New York State guidelines for community health needs assessments and community involvement.

CONCLUSION

Long Island Community Hospital is pleased to provide this comprehensive report to community members and the wider public. It reaffirms our hospital's commitment to meeting the health needs of our communities and working every day to mitigate health disparities. Targeted interventions and strategies, driven by the data outlined in this report, reflect meaningful and reasonable approaches to improving the health of our communities during the next three-year cycle, 2022 - 2024. We will report on the status of these interventions and strategies throughout the implementation period.

SUPPORTING DOCUMENT AND/OR APPENDICES

Please see the appendix at the end of this report for the work plan, survey instruments used, and other supporting documents.