Catholic Health
St. Charles Hospital

Community Health Needs Assessment | 2022 - 2024

Approved and Adopted by the Board of Directors December 15, 2022

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 process, including data collection and analysis.

.

TABLE OF CONTENTS

INTRODUCTION

This Community Health Needs Assessment (CHNA) represents a collaboration between Catholic Health, the Long Island Health Collaborative (LIHC), local community-based agencies, patients living in our community and the Suffolk County Department of Health. Catholic Health retained DataGen in the summer of 2022 to provide research analysis to facilitate this report, which defines the identified community health needs and barriers expressed by community members and the local community-based organizations that serve the region. This report's primary data was collected by the Long Island Health Collaborative from January 2021 through August 2022. It includes input and comments from community members and community leaders. The secondary data used is from years 2018 – 2021. The results from multiple analyses will enable Catholic Health to deploy new and existing chronic disease prevention strategies, address relevant social determinant of health risk factors, and work to reduce the health disparities identified. The COVID-19 pandemic placed a stark spotlight on health inequities in this region and this has reinforced Catholic Health's enduring mission to bring health and social care to all communities. St. Charles Hospital, one of six hospitals in the Catholic Health system, is located in Port Jefferson, New York and offers Long Islanders the highest level of care. Known for physical therapy and rehabilitation, orthopedics, obstetrics and gynecology, sleep disorders, wound care, cardiology, pulmonary, epilepsy, stroke, diabetes, bariatrics and dental care, our doctors, nurses and supporting medical staff deliver clinical excellence and compassionate care in numerous specialties.

At Catholic Health, we are dedicated to addressing the significant health needs of the communities we serve. Catholic Health's six hospitals continue to build community health services and education programs in five core areas: chronic disease management, providing mental health services, treating and reducing substance use disorder, preventing communicable diseases and addressing the social determinants of health. In partnership with our community members and local nonprofits, churches, schools, and health departments, we are creating a healthier community, one patient at a time.

EXECUTIVE SUMMARY

St. Charles, along with Catholic Health's other five hospitals, 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 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 St. Charles are outlined in the 2022-2024 work plan (See Appendix E).

St. Charles 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 9 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 disease awareness, and health messaging efforts reinforce and augment the interventions

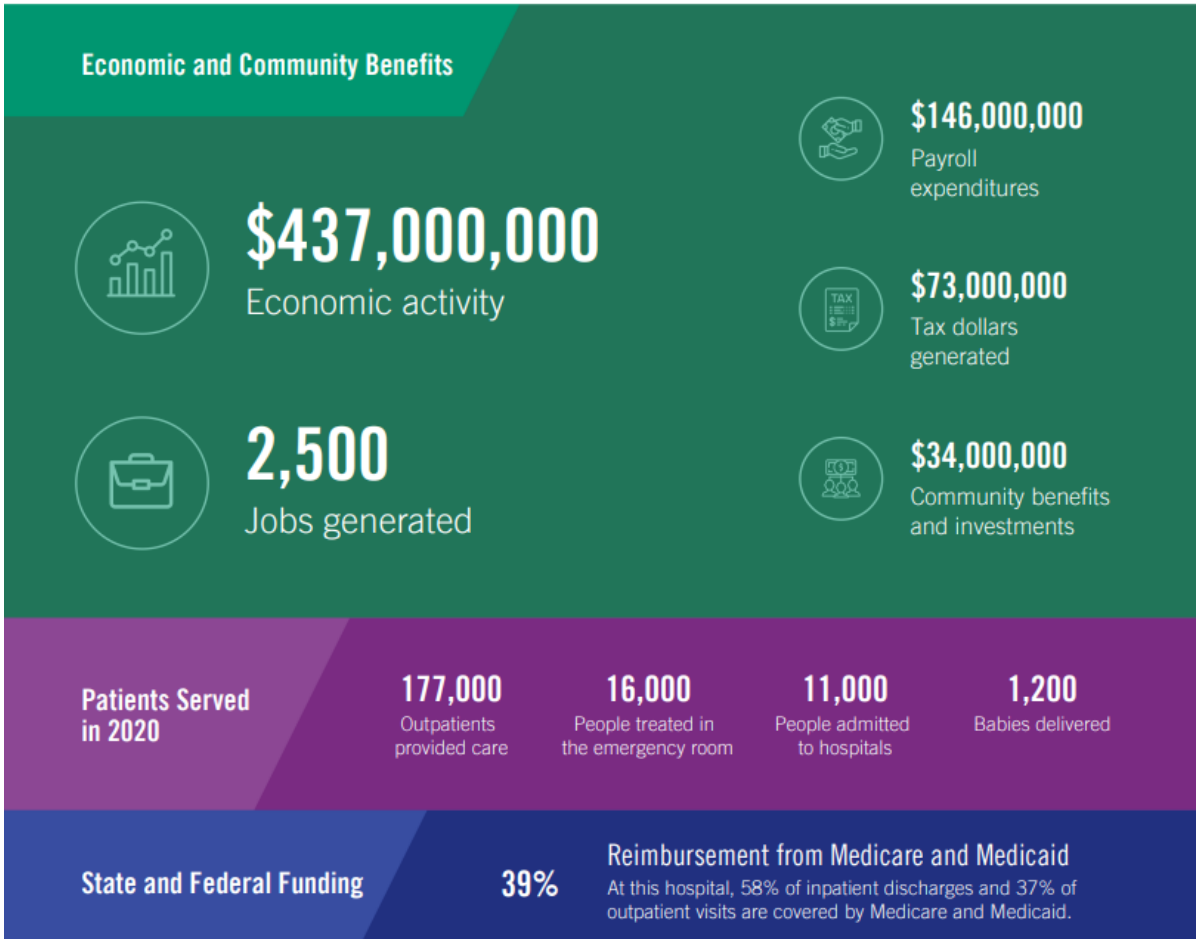
[1] Community Health Assessment Survey (CHAS) assessing responses from individuals, summary report and survey instrument (Appendix A)
CBO Survey Analysis 2022, assessing responses from community-based organization leader, summary report and survey instrument (Appendix B)

[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.

[4] https://collectiveimpactforum.org/

we provide in the chronic disease and mental health needs spaces so that we are continually in touch with the broader community. See Appendix F for a list of LIHC partners.



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

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. Catholic Health's three hospitals in the county service this easternmost county in New Yok State and 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

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 foreign language spoken 14.7% followed by other Indo/European languages 8.7% and Asian languages 5.1%. In terms of education, for those age 25 and over, 89.4% are high school graduates or higher, 31.9% hold a bachelor degree or higher. The percent of the total population uninsured is 4.2%. Of that percent, non-citizens represent 32% of the uninsured. Hispanic/Latino represent 42.1% of the uninsured followed by Black/African American 10%, White 63.9%, Asian 6.5%. Of the uninsured, 37.6% earn less than $74,999 household income and 9.1% earn under $25,000 household income. Approximately 9.6% of the total non-institutionalized population is disabled. By race/ethnicity, 10.6% of the Native Hawaiian/Pacifc Islander population is disabled, 13.6% of the American Indian/Alaska Native population is disabled,

[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
[8] U.S. Census Bureau, 2016-2020 American Community Survey, Five-Year Estimates

10% of the White population is disabled, 9.6% of the Black/African American population is disabled, and 7.2% of the 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 health care 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 to130,599 households in Nassau County and 171,921 households in Suffolk County that are struggling to afford these basic needs.

Municipalities in target community

St. Charles primary service area is Suffolk County. The chart below defines the zip codes and municipalities (towns) comprising St. Charles' service area.

Zip Code	Towns
11719	Brookhaven, Shirley, Yaphank
11733	Setauket-East Setauket, Stony Brook, Old Field, Poquott, Port Jefferson Station, Strongs Neck
11772	Patchogue, East Patchogue, Blue Point, North Patchogue, Fire Island
11776	Port Jefferson Station, Mount Sinai, Terryville, Selden, Coram
11777	Port Jefferson, Port Jefferson Station, Belle Terre, Setauket-East Setauket
11790	Stony Brook, Setauket-East Setauket, Head of the Harbor, Lake Grove
11794	Stony Brook, Saint James
11720	Centereach, Selden, Lake Ronkonkoma, Farmingville
11727	Coram, Gordon Heights
11738	Farmingville, Medford, Selden, Holtsville, Coram
11742	Holtsville, North Patchogue
11763	Medford, Yaphank, Coram, Holtsville, Gordon Heights, North Bellport
11764	Miller Place
11766	Mount Sinai, Coram
11784	Selden, Centereach, Coram, Farmingville
11789	Sound Beach, Miller Place, Rocky Point
11953	Middle Island, Coram, Miller Place, Rocky Point, Gordon Heights

[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

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/

Health behaviors, outcomes, and social determinants of health indicators in the chart below compare St. Charles key outreach communities.

CHNA Advantage™ Analytics Platform

Category	Measure Name	*National Benchmark*	*State Benchmark*	Amityville	Bay Shore	Bellport	Brentwood	Calverton	Central Islip	Copiague	Greenport	Lindenhurst
Behaviors	Binge Drinking-Percentage	17.86	18.60	17.00	18.90	19.20	18.60	16.60	18.30	18.20	15.70	20.50
	Smoking-Percentage	17.44	15.74	16.20	15.70	17.10	16.60	15.90	17.40	18.20	13.50	16.60
Outcomes	Cancer-Percentage	6.56	6.53	7.20	6.00	6.10	4.70	9.40	4.90	6.00	10.00	6.90
	Diabetes-Percentage	10.51	10.22	11.00	9.40	9.10	10.60	10.60	10.60	10.40	10.60	7.90
	Obesity-Percentage	32.08	28.33	30.10	28.70	29.00	31.30	27.50	31.40	30.30	26.00	26.30
	Teen Births-Percentage	2.78	1.78	0.00	1.32	12.04	2.17	0.00	3.96	13.51	0.00	0.00
	Poor Mental Health-Percentage	14.98	13.89	13.60	13.40	14.20	14.30	12.80	14.70	14.90	11.80	13.70
SDOH	Uninsured-Percentage	8.73	5.38	4.50	7.60	3.90	10.80	7.60	7.60	5.90	8.20	3.20
	Health Literacy Risk-Percentage	36.97	40.43	68.00	78.00	60.00	100.00	47.00	100.00	84.00	52.00	14.00
	Health Literacy Risk-Risk Score (1-5)	3.07	3.19	4.20	4.10	3.80	5.00	3.30	4.70	4.40	3.80	3.10
	Food Risk-Percentage	28.30	32.39	13.00	8.00	26.00	2.00	14.00	8.00	24.00	36.00	1.00
	Food Risk-Risk Score (1-5)	2.88	3.05	2.60	2.40	2.70	2.60	2.00	2.80	3.10	3.00	2.50
	Healthy Food Options-Rate (per 10,000)	3.39	4.12	3.51	4.23	4.30	2.05	7.87	1.88	4.64	14.00	1.90
	Unhealthy Food Options-Rate (per 10,000)	16.08	15.78	14.93	18.25	15.89	7.92	22.50	12.41	19.45	41.99	22.15
	Housing Risk-Percentage	28.07	47.89	1.00	2.00	0.00	4.00	0.00	2.00	7.00	24.00	2.00
	Housing Risk-Risk Score (1-5)	2.77	3.38	2.00	2.10	1.60	2.40	1.60	2.00	2.30	2.90	1.90
	Housing Share of Income-Percentage	0.26	0.40	0.34	0.32	0.34	0.34	0.29	0.36	0.37	0.32	0.32
	Median Housing Cost-Dollars	1,245	1,566	2,063	2,091	2,007	1,996	1,583	1,919	1,971	1,339	2,160
	Income After Housing-Dollars	1,463	1,187	1,261	1,191	1,327	852	1,637	1,005	985	1,384	1,539
	Median Household Income-Dollars	70,677	77,814	85,088	97,495	88,173	89,926	69,583	79,432	93,438	66,406	100,915
Utilization	Dentist Visits-Percentage	64.12	66.60	65.70	66.40	65.40	58.90	70.80	59.80	63.20	69.10	70.70

Category	Measure Name	*National Benchmark*	*State Benchmark*	Mastic	Mastic Bea	Patchogue	Ridge	Riverhead	Shirley	West Babylon	Wyandanch
Behaviors	Binge Drinking-Percentage	17.86	18.60	21.20	20.10	19.50	15.80	18.10	20.50	19.10	17.00
	Smoking-Percentage	17.44	15.74	18.80	20.40	16.50	14.70	17.70	19.50	16.00	18.60
Outcomes	Cancer-Percentage	6.56	6.53	5.40	5.90	6.90	10.50	7.50	5.70	7.20	4.90
	Diabetes-Percentage	10.51	10.22	7.80	8.50	8.70	10.70	10.30	8.20	8.80	12.00
	Obesity-Percentage	32.08	28.33	28.00	29.00	27.40	25.70	28.80	28.20	26.80	34.90
	Teen Births-Percentage	2.78	1.78	1.76	0.00	0.00	0.00	0.00	0.00	23.75	0.00
	Poor Mental Health-Percentage	14.98	13.89	15.30	16.00	13.70	12.30	14.10	15.80	13.30	15.20
SDOH	Uninsured-Percentage	8.73	5.38	5.50	3.40	5.00	3.20	9.90	4.60	4.40	5.40
	Health Literacy Risk-Percentage	36.97	40.43	51.00	40.00	37.00	31.00	84.00	48.00	34.00	96.00
	Health Literacy Risk-Risk Score (1-5)	3.07	3.19	3.40	3.40	3.20	3.20	4.40	3.50	3.40	4.80
	Food Risk-Percentage	28.30	32.39	0.00	0.00	27.00	16.00	23.00	4.00	8.00	7.00
	Food Risk-Risk Score (1-5)	2.88	3.05	2.20	2.20	2.80	2.40	2.40	2.00	2.40	2.60
	Healthy Food Options-Rate (per 10,000)	3.39	4.12	2.86	2.57	4.13	0.00	9.20	3.13	3.87	2.77
	Unhealthy Food Options-Rate (per 10,000)	16.08	15.78	11.12	12.29	24.15	10.08	28.62	19.04	16.53	11.52
	Housing Risk-Percentage	28.07	47.89	0.00	0.00	3.00	0.00	15.00	0.00	0.00	8.00
	Housing Risk-Risk Score (1-5)	2.77	3.38	1.60	1.90	2.00	1.50	2.70	1.40	1.70	2.20
	Housing Share of Income-Percentage	0.26	0.40	0.29	0.34	0.33	0.28	0.33	0.33	0.33	0.35
	Median Housing Cost-Dollars	1,245	1,566	1,980	1,787	1,900	1,389	1,559	2,064	2,223	2,021
	Income After Housing-Dollars	1,463	1,187	1,355	1,185	1,447	1,554	1,177	1,205	1,483	912
	Median Household Income-Dollars	70,677	77,814	90,714	83,975	92,249	75,188	69,353	91,139	104,375	84,728
Utilization	Dentist Visits-Percentage	64.12	66.60	65.10	65.90	68.70	70.50	64.20	65.80	69.70	59.60

DataGen Analytics Platform. 2018-2020 Health Outcomes for the 17 Identified Communities Compared to New York State and National Benchmarks

Collaborating Partners: Health Care and Other Key Institutions

As part of our collective impact strategies to promote health and well-being for residents in our communities, St. Charles has strong relationships with local and regional community-based organizations, libraries, schools, faith-based organizations, the local health department, local fire departments and municipalities that support and partner with us to reduce chronic disease, mental health and substance misuse, and to promote health equity. Following is an extensive partner list of health care and other key institutions.

- American Heart Association, LI Chapter
- American Diabetes Association, LI Chapter
- American Lung Association, LI Chapter
- American Parkinson Disease Association
- Association for Mental Health and Wellness
- Asthma Coalition of Long Island
- Bethel AME Church, East Setauket Breton Woods Assisted Living
- Brighton Woods Senior Center
- Cancer Services Program of Suffolk County
- Catholic Charities
- Catholic Faith Network
- Catholic Health Home Care, Farmingdale
- Colette Coyne Melanoma Awareness Campaign
- Comsewogue School District
- Cornell Cooperative Extension of Suffolk County
- Cornell Cooperative Extension/Eat Smart NY
- Fairfield Knolls
- Fidelis Care
- Gerald J. Ryan Outreach Center, Wyandanch
- Good Samaritan University Hospital, West Islip
- Good Samaritan Nursing & Rehabilitation Care Center, Sayville
- Good Shepherd Hospice, Farmingdale
- Heritage Park Foundation, Mt. Sinai
- Hispanic Counseling Center
- Jamesport Fire Department
- Jefferson's Ferry Senior Living
- Leisure Village
- Leisure Knoll
- Long Island Blood Services
- Long Island Health Collaborative (LIHC)
- Longwood High School
- Maryhaven Center of Hope, Port Jefferson
- Mercy Hospital, Rockville Centre
- Middle Country Library
- Miller New York Institute of Technology College of
- Osteopathic Medicine, Old Westbury & Central Islip
- Miller Place Fire Department
- New York State Department of Parks and Recreation
- Our Lady of Consolation Nursing & Rehabilitative Care Center
- Our Lady of Mercy Academy, Syosset
- Port Jefferson Chamber of Commerce
- Port Jefferson EMS
- Port Jefferson Library
- Port Jefferson Rotary
- Port Jefferson School District
- Ridge EMS
- Rose Caracappa Senior Center, Mt. Sinai
- Sachem School District
- Selden Library
- Sisters United in Health
- Society of St. Vincent de Paul
- South Country Library
- St. Catherine of Siena Nursing & Rehabilitation Care Center, Smithtown
- St. Francis Hospital, Roslyn
- St. Gerard Majella R.C. Church, Port Jefferson Station
- St. James Rosary Alter Society, E. Setauket
- St. Joseph Hospital, Bethpage
- St. Frances Cabrini Church, Coram
- St. John the Evangelist Church, Riverhead
- St. Rosalie Church, Hampton Bays
- Stony Brook Medicine/Creating Healthy Schools and Communities
- Stop & Shop
- Suffolk County Office for the Aging
- Suffolk Independent Living Organization
- Suffolk Perinatal Coalition, Patchogue
- Terryville EMS
- Veteran's Administration
- Western Suffolk Boces/Creating Healthy Schools and Communities
- Wisdom Gardens Convent, Sound Beach
- YAM Community Resource, Inc.

St. Charles relies upon 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. St. Charles also relies upon the LIHC to disseminate information about mental health prevention and treatment services and programming, as well as relevant information about substance misuse. Dissemination of information is achieved through the bi-weekly *Collaborative Communications* e-newsletter, which is sent 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, St. Charles 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 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 chronic disease. This is one of the reasons why Catholic Health has embarked on new food insecurity initiatives with community partners Long Island Cares, Catholic Charities, and the Health and Welfare Council of Long Island.

Catholic Health is also collaborating with Catholic Charities and Health and Welfare Council of Long Island to enroll individuals and families identified as food insecure in the Supplemental Nutrition Assistant Program (SNAP).

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]

[12] https://map.feedingamerica.org/county/2020/overall/new-york/county/suffolk

OVERVIEW OF IDENTIFIED NEEDS

Through the CHNA process, reducing chronic diseases and mental health illness/substance misuse have been identified as the top two priorities in our communities. Embedded within these priorities are areas of need, which the primary and secondary research revealed.

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.[13]

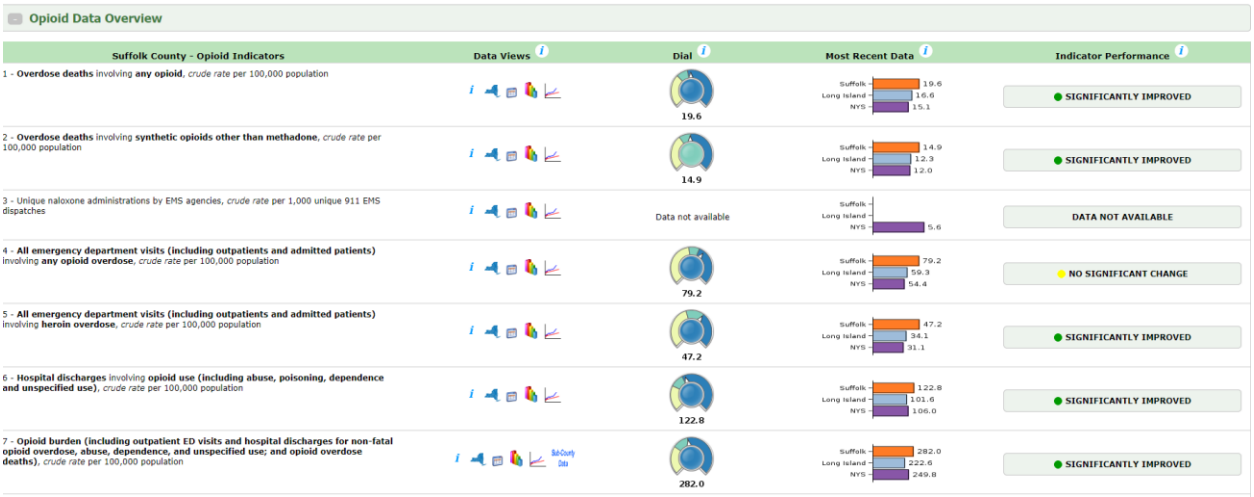
Mental health issues have soared in the past two years, spurred in part, by the effects of the pandemic. Using data from the U.S. Census Bureau's COVID-19 Household Pulse Survey (April 23, 2020 – October 26, 2020), a New York State Health Foundation analysis found that more than one-third of adult New 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.[14]

High school students (grades 9 through 12) fared just as worse. A number of studies found poor mental health along with suicide ideation intensified during the pandemic for high schoolers, especially among

[13] https://www.countyhealthrankings. org/app/new-york/2021/compare/snapshot?counties=36_059%2B36_103
[14] 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

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.[15] The pandemic made a bad situation worse, especially for youth, as mental health issues and suicides were already increasing prior to the COVID-19 pandemic.[16] [17] [18] [19] With the shortage of mental health care workers and the lingering psychological effects of the pandemic, mental health services remain a top priority for the region.

The county also saw an uptick in opioid-related overdoses and deaths after having made some gains prior to the pandemic. 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.[20]



Graphic: New York Department of Health, Opioid Data Overview, Suffolk County

[15] https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm? s_cid=su7103a3_w

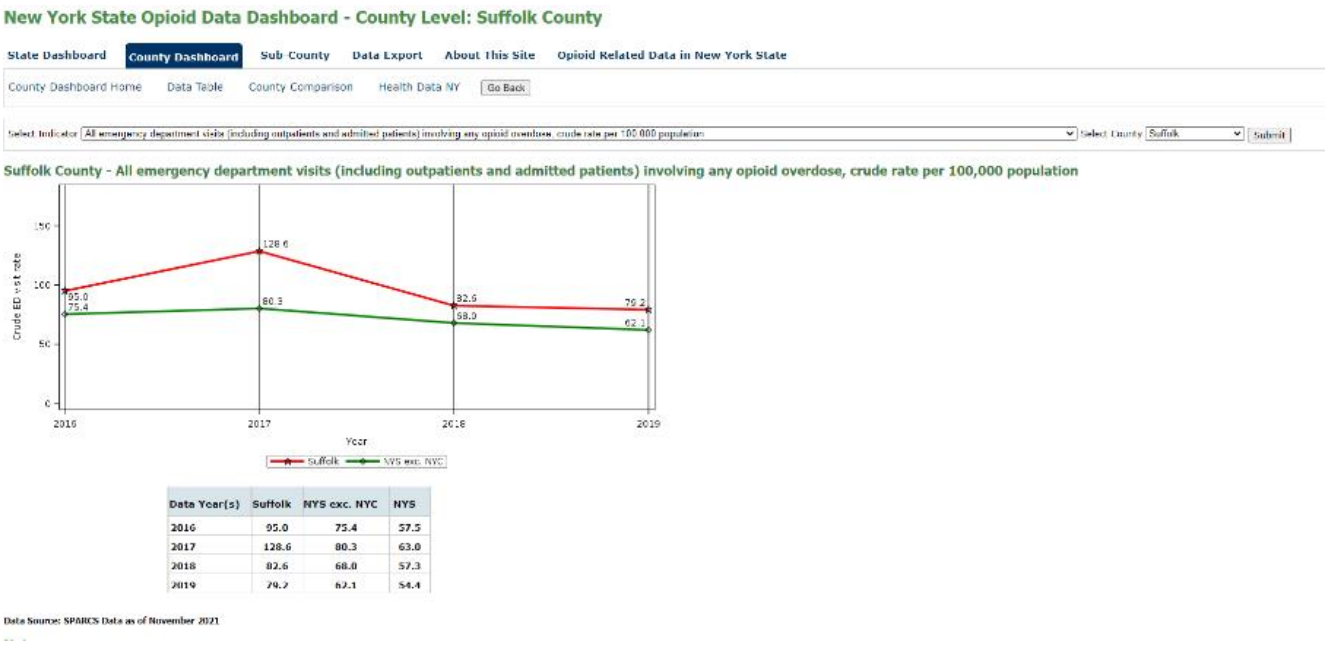
[16] https://www.cdc.gov/mmwr/volumes/66/wr/mm6630a6.htm

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

[18] 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

[19] 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.

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

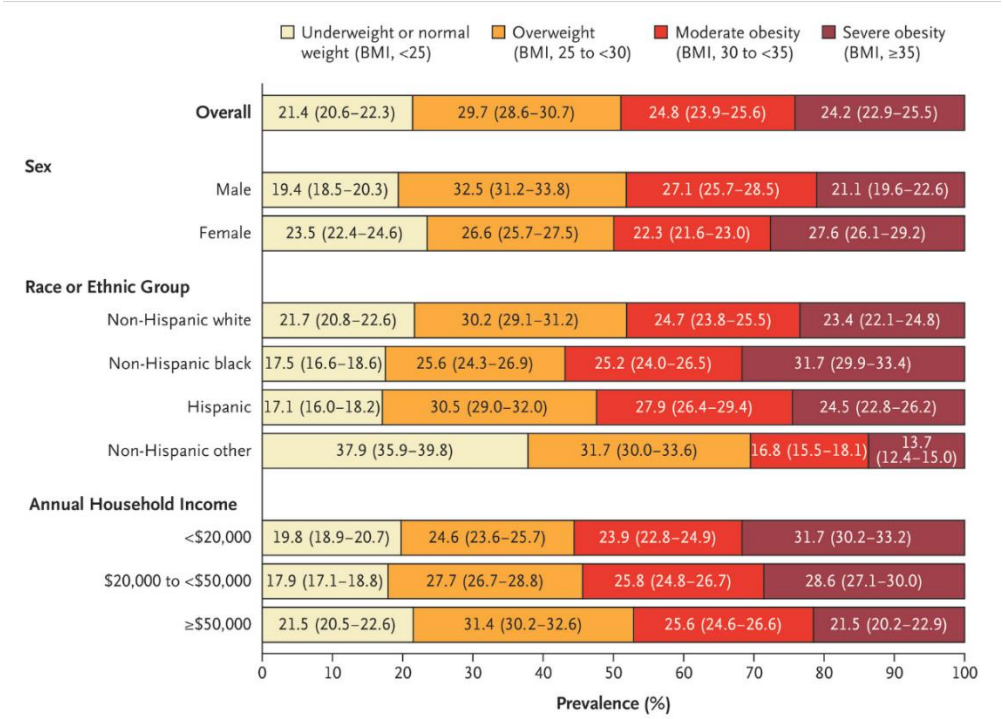


Graphic: Suffolk County Department of Health Data on Opioid overdoses, death, and hospital utilization.

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).[21] For 2019, the numbers were 173, 47, and 163, respectively via categories listed above.[22]

Another health disparity identified in primary and secondary research is adult obesity. According to the Robert Wood Johnson Foundation's County Health Rankings for Suffolk County,[23] 27% of the population (18 and older) reports a body mass index (BMI) greater than or equal to 30 kg/m.[24] In 2019, The New England Journal of Medicine studied projected adult obesity in the United States by 2030 based on today's obese and overweight adult populations.[25] By 2030, the obesity epidemic is projected to impact nearly 1 in 2 adults.

[21] https://www.health.ny.gov/statistics/opioid/data/pdf/nys_apr22.pdf
[22] https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jan21.pdf
[23] https://www.countyhealthrankings.org/app/new-york/2022/measure/factors/11/map
[24] https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2021-02_ifa_report.pdf
[25] https://www.nejm.org/doi/full/10.1056/NEJMsa1909301



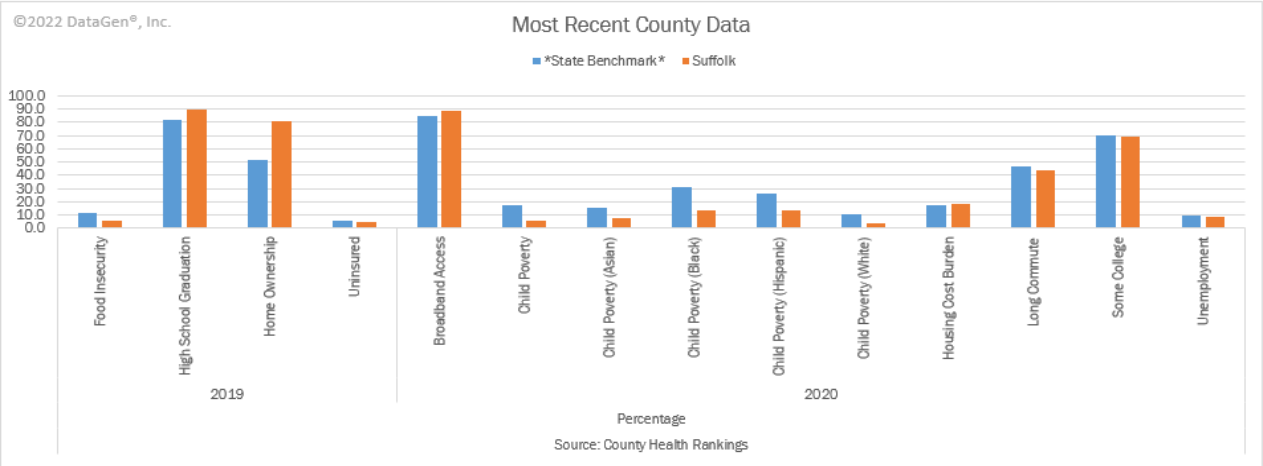
Source: New England Journal of Medicine, Projected U.S. State Level Prevalence of Adult Obesity and Severe Obesity. 2019.

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 United States. Asians and Whites experience the disease at 9.5% and 7.4% respectively.[26] 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.

[26] https://www.cdc.gov/diabetes/health-equity/diabetes-by-the-numbers.html

County Data					
				County	
Category	Topic	Measure Name	Year	*State Benchmark*	Suffolk
Outcomes	Condition Prevalence	Asthma (Medicare)-Percentage	2018	5.73	5.89
		Cancer (Medicare)-Percentage	2018	9.27	10.31
		CKD (Medicare)-Percentage	2018	22.36	23.11
		COPD (Medicare)-Percentage	2018	10.76	11.40
		Diabetes-Percentage	2019	9.40	8.30
		Heart_Failure (Medicare)-Percentage	2018	13.72	14.66
		Hypertension (Medicare)-Percentage	2018	53.32	61.81
		Low Birth Weight-Percentage	2020	7.78	7.83
		Obesity-Percentage	2017	25.84	26.10
		Stroke (Medicare)-Percentage	2018	3.85	4.57
		Teen Birth Rate (Asian)-Rate (per 1,000)	2020	2.61	1.10
		Teen Birth Rate (Black)-Rate (per 1,000)	2020	17.69	12.70
		Teen Birth Rate (Hispanic)-Rate (per 1,000)	2020	23.18	30.29
		Teen Birth Rate (White)-Rate (per 1,000)	2020	8.90	3.08
		Teen Birth Rate-Rate (per 1,000)	2020	13.57	10.05
	Life Quality	Poor Mental Health-Percentage	2019	13.18	12.30
		Poor/ Fair Health-Percentage	2019	17.48	15.30
		Premature Death (Asian)-Rate (YPLL per 100,000)	2020	2,739.24	3,288.07
		Premature Death (Black)-Rate (YPLL per 100,000)	2020	9,287.10	8,814.52
		Premature Death (Hispanic)-Rate (YPLL per 100,000)	2020	5,461.06	5,153.58
		Premature Death (White)-Rate (YPLL per 100,000)	2020	5,331.00	5,824.99
		Premature Death-Rate (YPLL per 100,000)	2020	5,836.36	5,926.07

These are the **main health challenges and contributing causes** affecting residents of the county, especially in low-income communities of color. That these social determinants of health are predictors of chronic disease is well documented.[27] [28] [29] Health care access issues are mostly tied to economics (quality of health insurance, employment, 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 health care access.



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

[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.

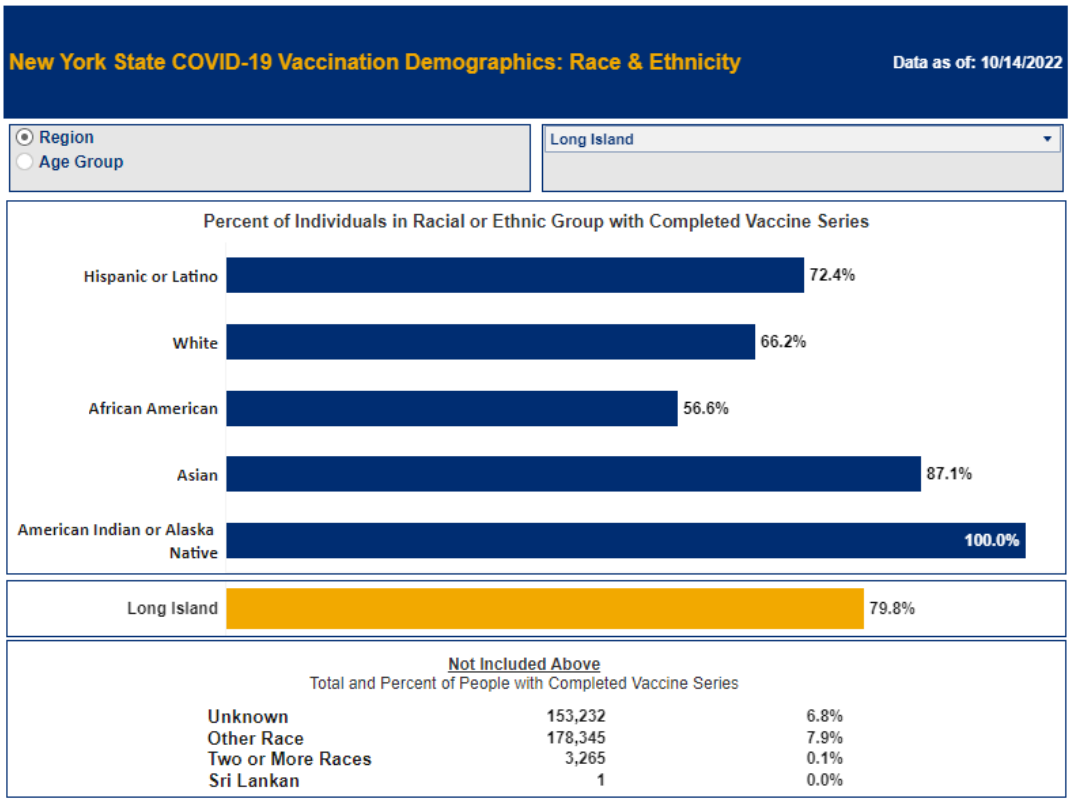
[28] Pantell MS, Prather AA, Downing JM, Gordon NP, Adler NE. Association of Social and Behavioral Risk Factors With Earlier Onset of Adult Hypertension and Diabetes. *JAMA Netw Open.* 2019;2(5):e193933. Https://doi:10.1001/jamanetworkopen.2019.3933

[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

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. Catholic Health participated in the HUB, holding point of distribution (POD) clinics at churches and other community venues. 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]

[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/



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

As of October 14, 2022, 92.5% of Suffolk County residents have received at least one dose. Race and ethnicity data is available for vaccinated adults living on Long Island and shows that 72% of Latino adults, 66% of White adults 56% of Black adults have been fully vaccinated against COVID-19. Ongoing partner efforts will continue to promote booster vaccines to eligible community residents

Guided by the LIHC, Catholic Health 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, as well as proprietary health determinant data metrics from Socially Determined, Inc.

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 diversity 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 health care 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 St. Charles 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 St. Charles has availed itself of this service. St. Charles 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 St. Charles 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.[33]

SPECIFIC METHODOLOGIES FOR RESEARCH

Catholic Health obtained population level and zip code analyses on social determinant of health drivers and health/risk factors dominant in Catholic Health'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 health care 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.

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 St. Charles service area was completed by analyzing 439 surveys collected during the period January 2022 – August 2022. The CHAS

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

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 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.

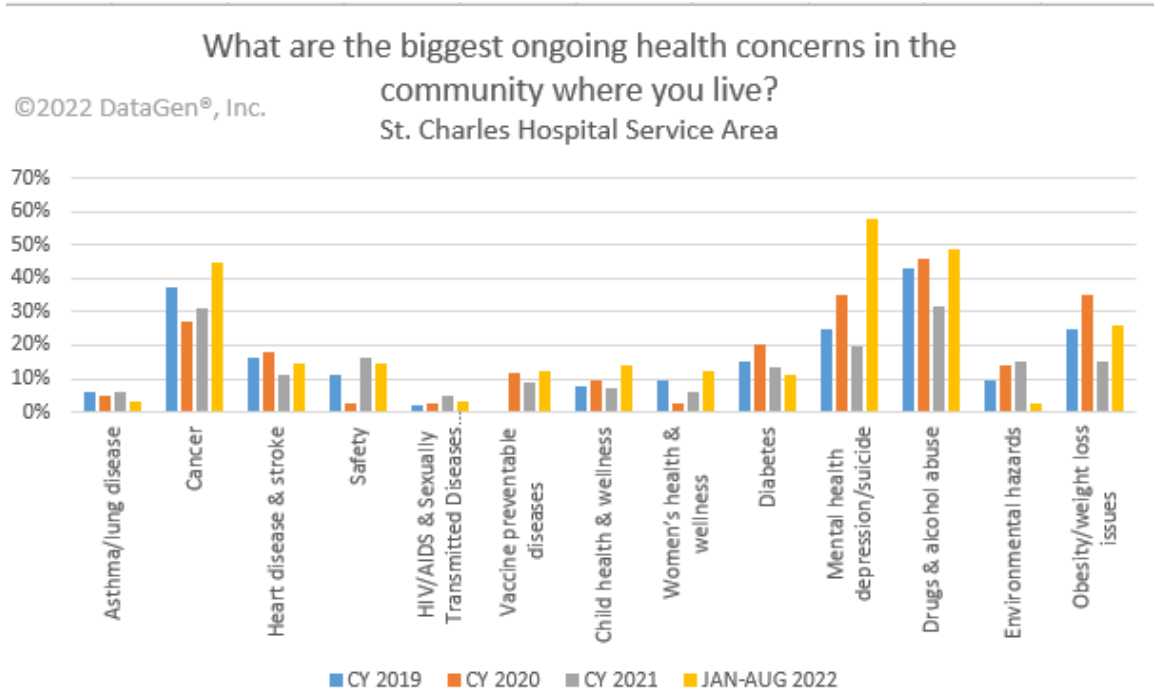
Library Research Project – a two-year study providing an insider look at the health and social support needs of patrons who frequent Long Island's public libraries. Library personnel at randomly selected libraries throughout Suffolk County were selected for this study. A total of 96 interviews (Nassau 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

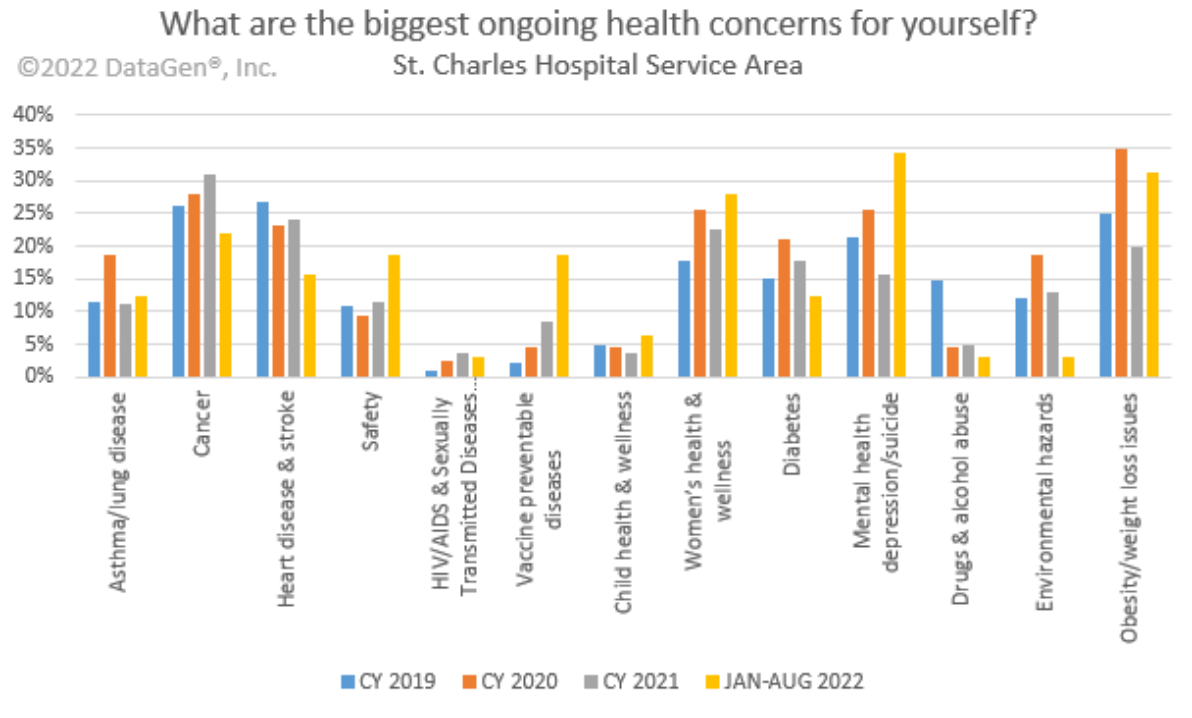
- ✓ The secondary data research included a thorough analysis of previously published materials/metrics that provide insight regarding the community and health-related measures.
- ✓ *SPARCS (Statewide Planning and Research Cooperative System*) – analysis of hospitalization data 2018, 2019, 2020.
- ✓ *Emergency Department Visits* – analysis of St. Charles Emergency Department visits during the time period July 1, 2021, to June 30, 2022, to discern top diagnoses.
- ✓ *Socially Determined*, Inc. social risk analytics spanning 200 metrics drawn from a variety of publicly available national, state, and county datasets. Zip code and census track level data.

FINDINGS TO SUPPORT IDENTIFIED NEEDS

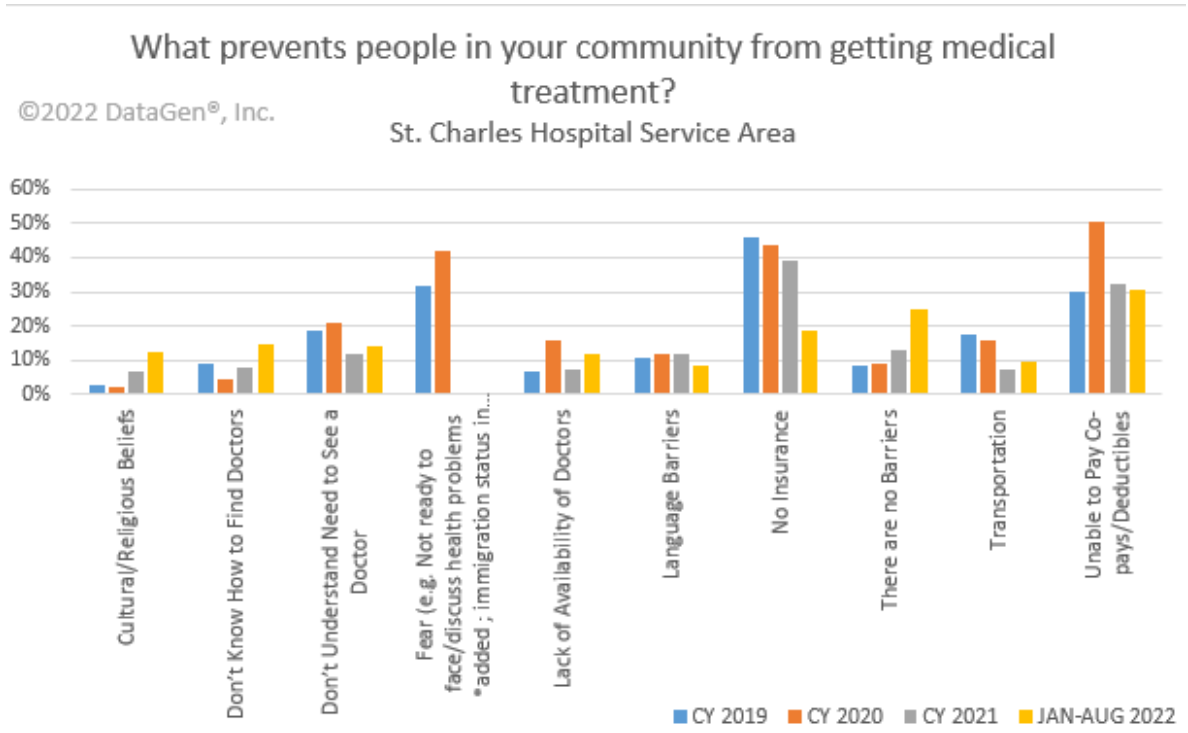
Data from both the primary and secondary research methods revealed the following key themes. Primary data survey results from hundreds of Suffolk County residents reveal obesity, mental health, and drug and alcohol usage, cancer and diabetes as some of the top concerns for 2022.

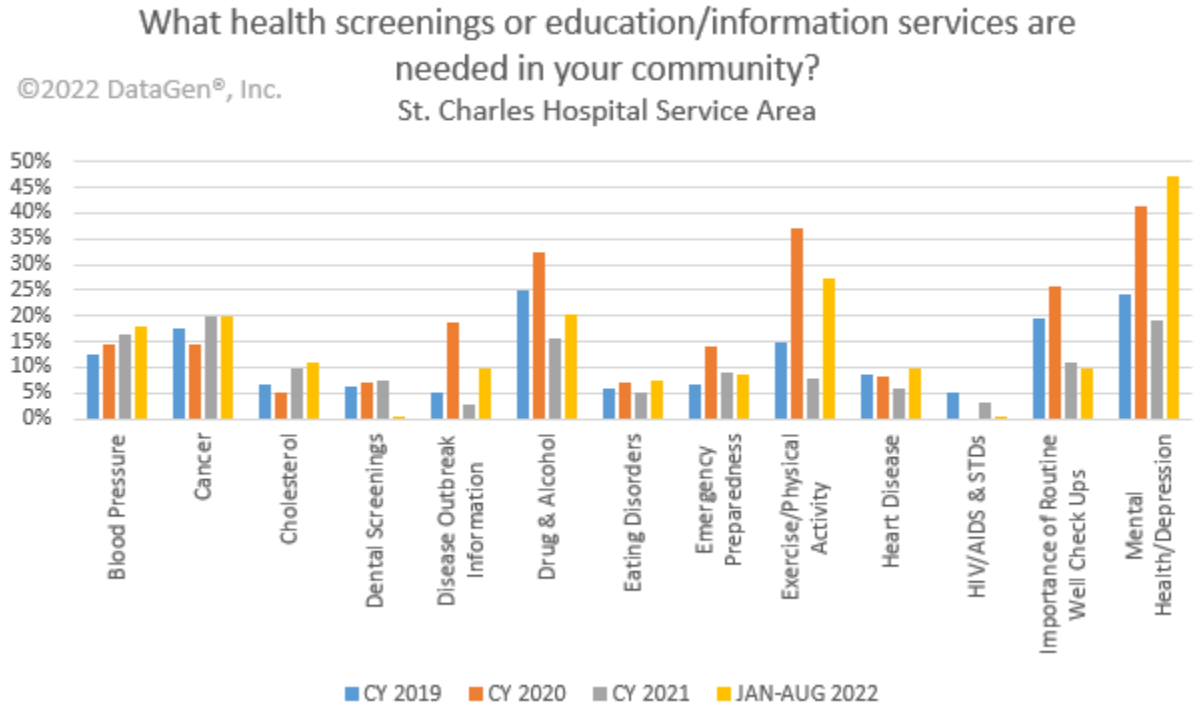


In the above chart, survey respondents answered what their biggest health concerns affecting their community are from their individual perspective. We then compared to annual results from 2019, 2020, 2021 and January – August 2022. The results represent survey responses over three years and eight month for identified health concerns. We focused on the most recent findings – 2022. There is a significant increase in 2022 for mental health, cancer, obesity, depression/suicide and drugs and alcohol abuse. Further, when answering questions about individual health, survey takers indicated mental health/depression again along with obesity/weight loss issues, safety, diabetes, cancer and women's health and wellness. That is illustrated in the chart below.



The responses below highlight perceived barriers to care. In what prevents community members from accessing care, responses ranged from language barriers, to fear of seeing a provider, to the cost of care. Poverty and economic distress were also identified in community key informant interviews.



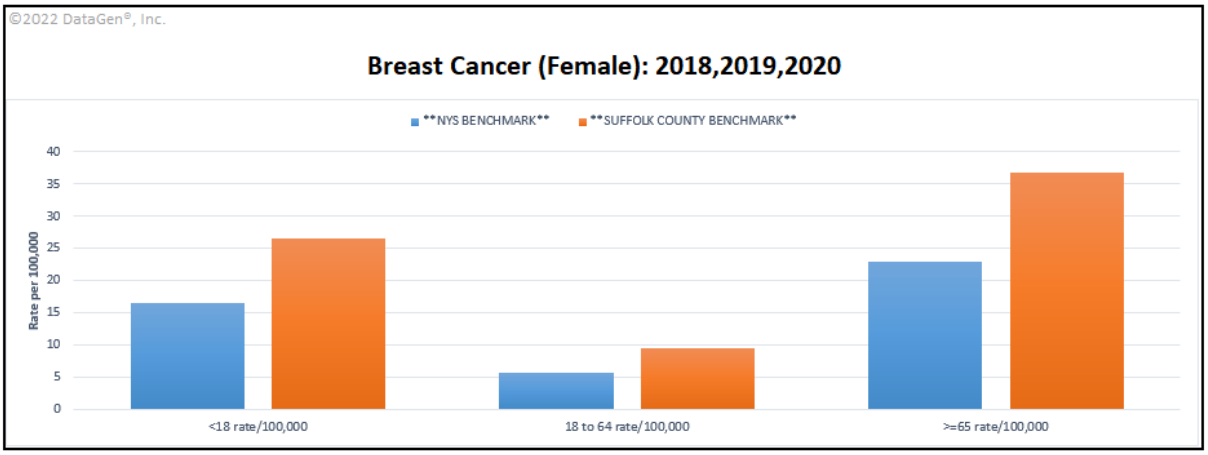


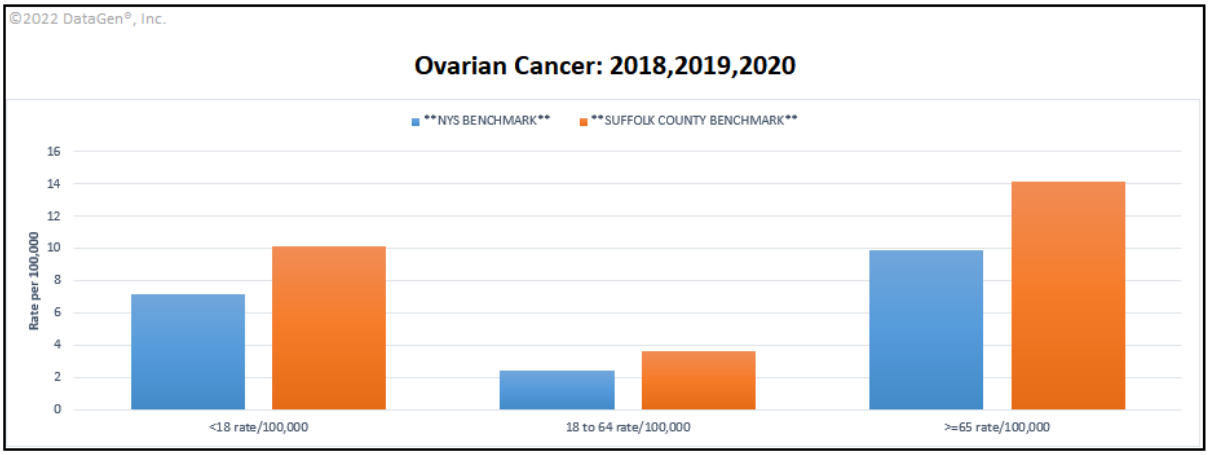
The above chart highlights the needs of community members in important health education services. Top needs include substance abuse services, mental health, exercise and physical activity and chronic disease management.

SPARCS Analyses (Statewide Planning and Research Cooperative System), Suffolk County Hospitalization Data[34]

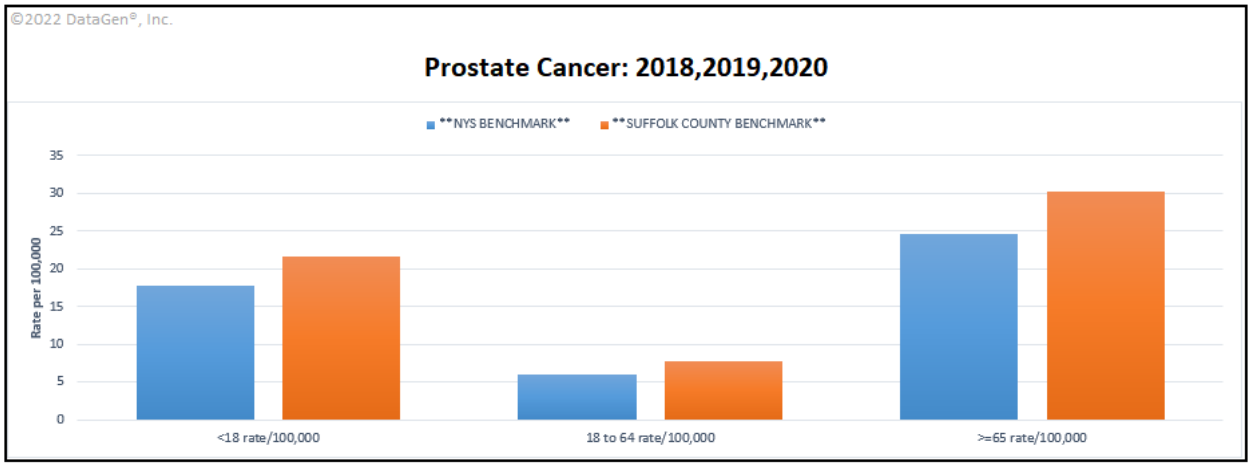
SPARCS is a comprehensive all payer data reporting system established in 1979 as a result of cooperation between the health care industry and government. The system was initially created to collect information on discharges from hospitals. SPARCS currently collects patient level detail on patient characteristics, 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.

In addition to examining the local resident feedback of identified health needs and concerns, Catholic Health also examined Suffolk County inpatient hospital data for the last three years. Hospitalization for breast cancer, prostate cancer, liver disease, heart disease, mental health disorders and substance abuse all are higher in Suffolk compared to New York State.



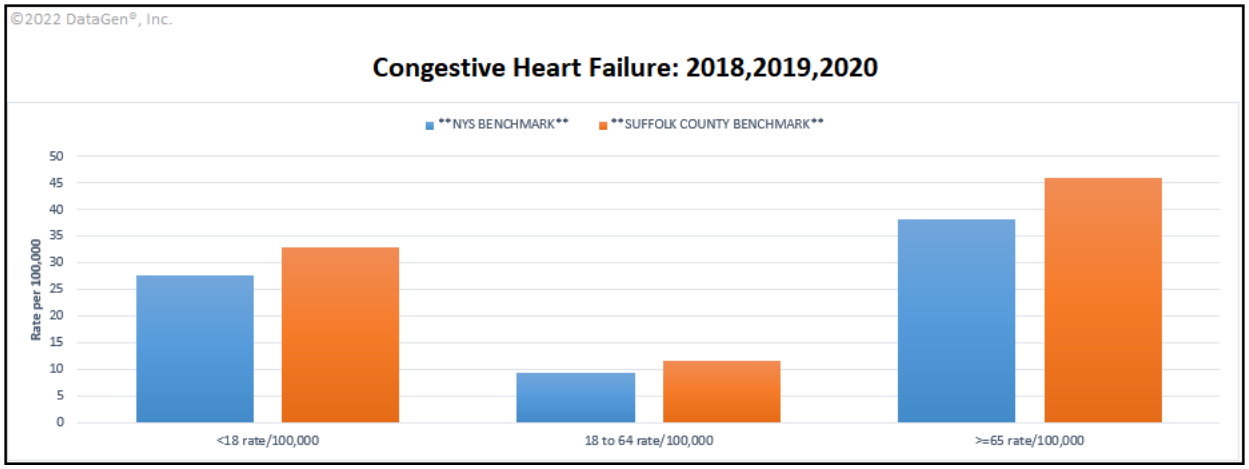


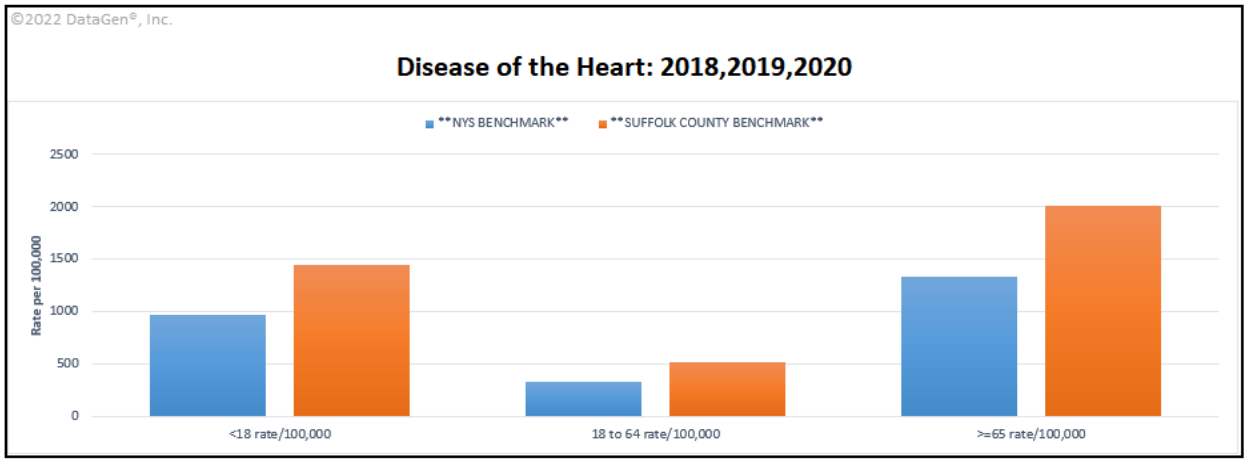
[34] https://www.health.ny.gov/statistics/sparcs/

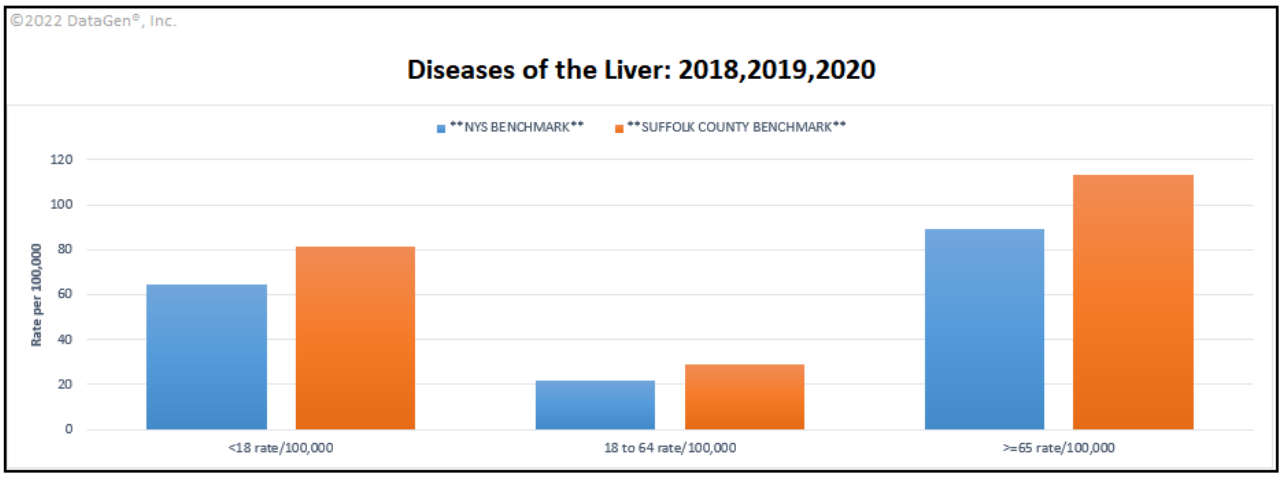


The above hospitalization data for Suffolk County examines types of cancer – breast, prostate and ovarian diagnosis and inpatient rate compared to New York State. Suffolk exceeds the state benchmark having higher rates of cancer inpatient admissions.

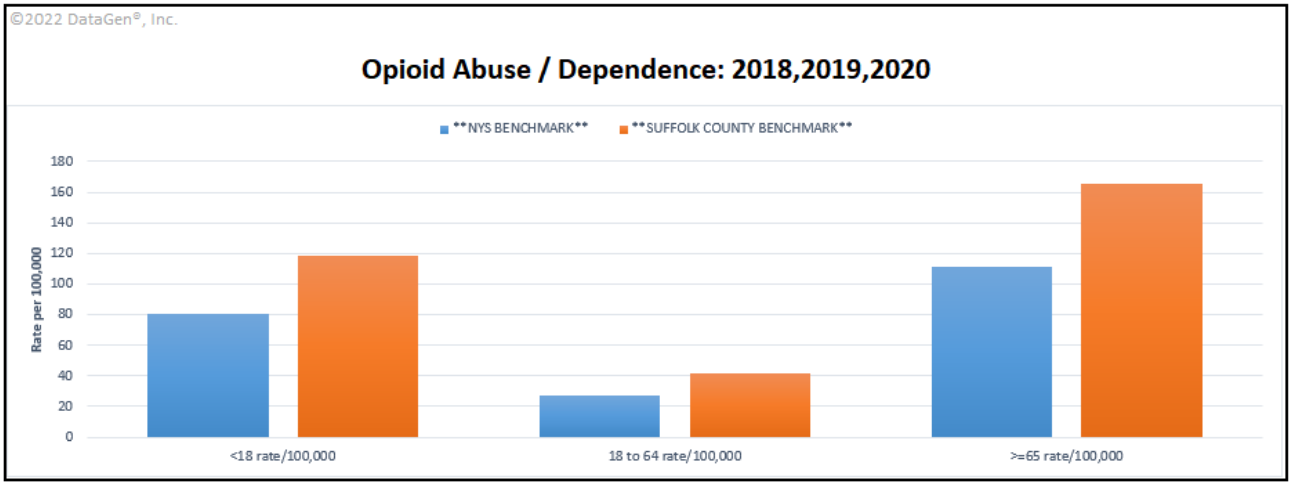
Factors that contribute to chronic disease and hospitization also demonstrate that Suffolk County exceeds New York State in congestive heart failure, diseases of the heart and liver diseases.

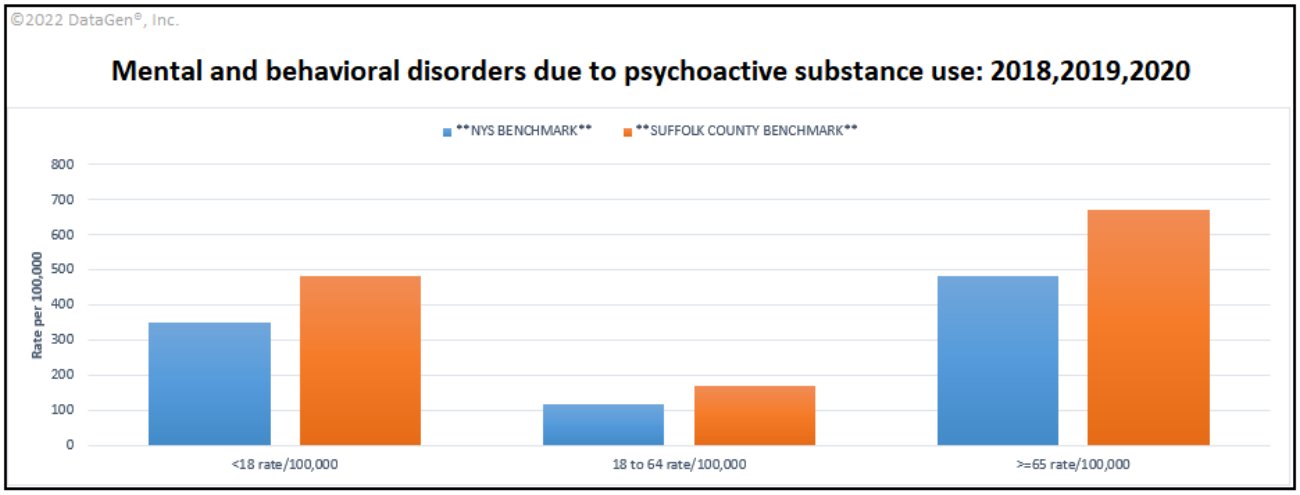


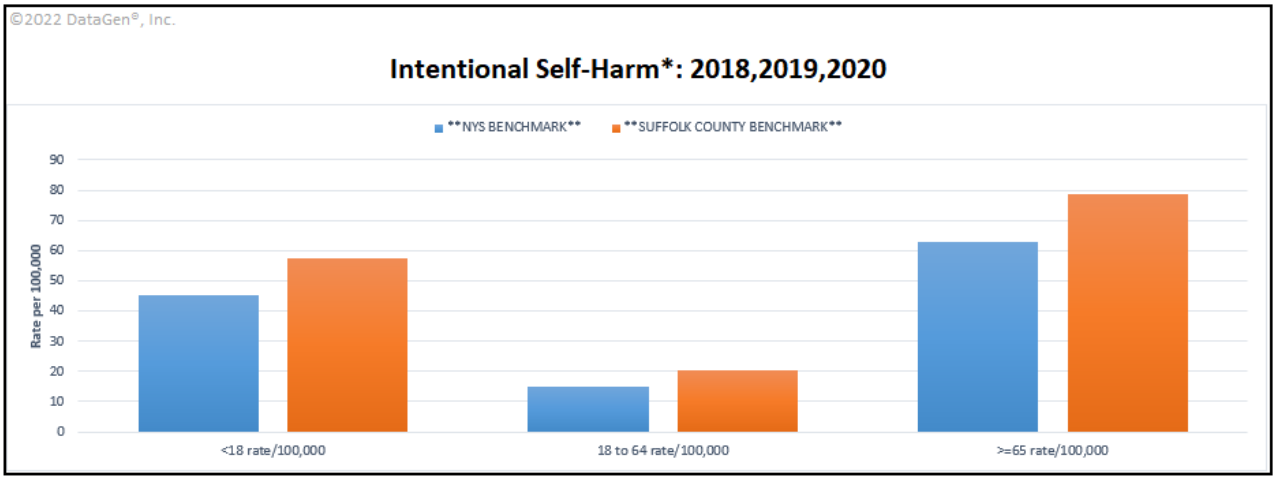




Primary and secondary data findings demonstrated a need for substance abuse and mental health services. The SPARCS data for Suffollk County 2018-2020 also shows high inpatient rates due to opioid abuse and mental health needs.

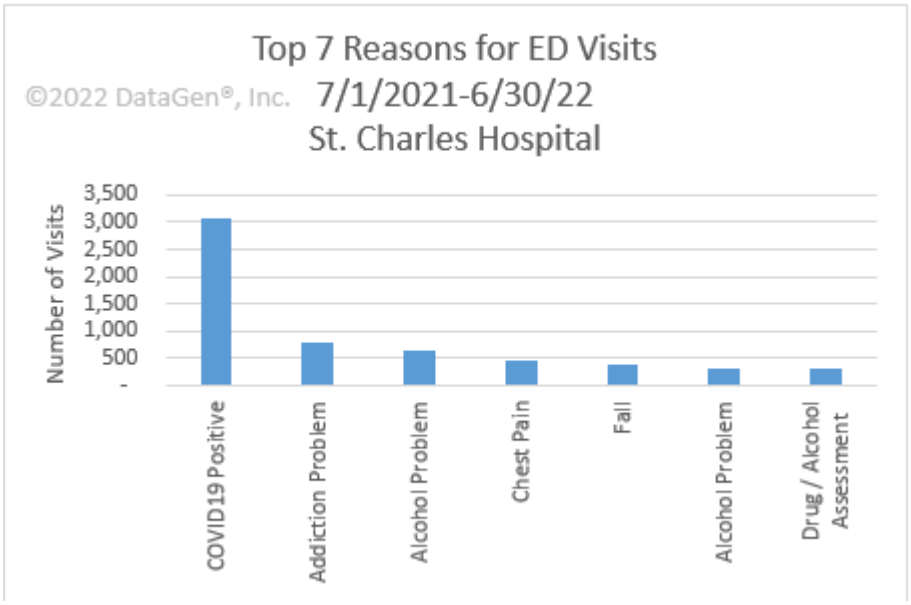




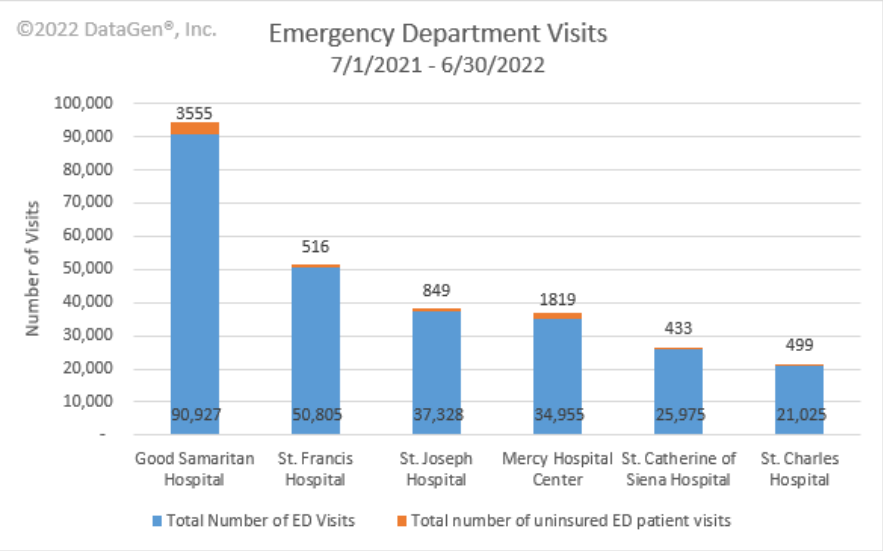


Examining St. Charles emergency department data also highlights the need for community health services that address drug and alcohol rehabilitation as well as mental health and chronic diseases.

St. Charles Hospital 2021-2022 Emergency Department Data, Top Diagnoses



Emergency Department data for St. Charles shows over 21,025 visits from July 2021 to June 2022. Uninsured encounters account for 499 visits. Top ICD-10 diagnosis codes reveal the impact of COVID-19 on the community's health, along with addiction, alcohol, and substance-related disorders.



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

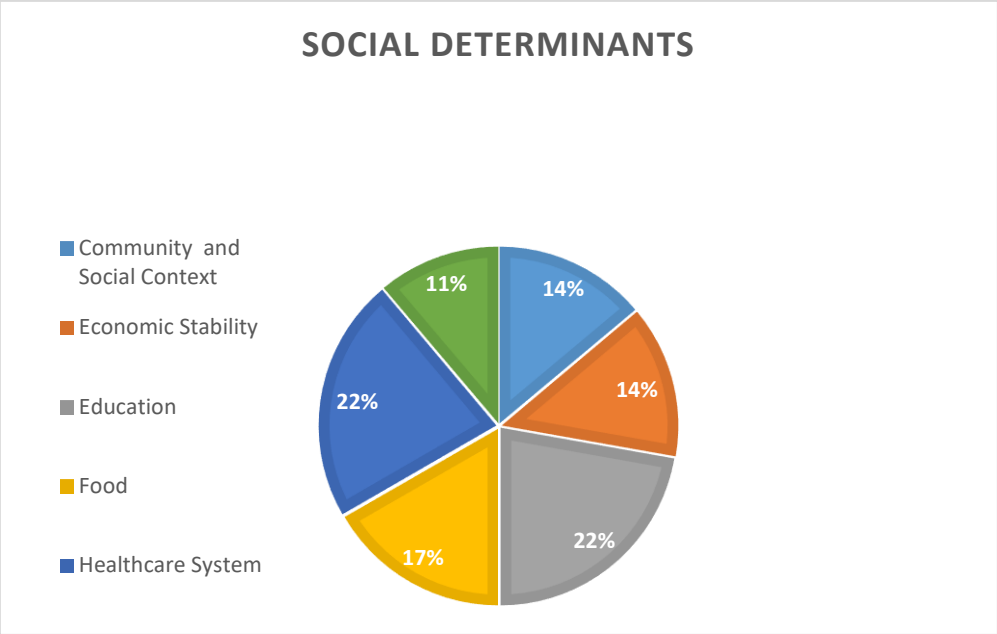
What would be most helpful to improve the health problems of the people/community you serve?

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 particular 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.

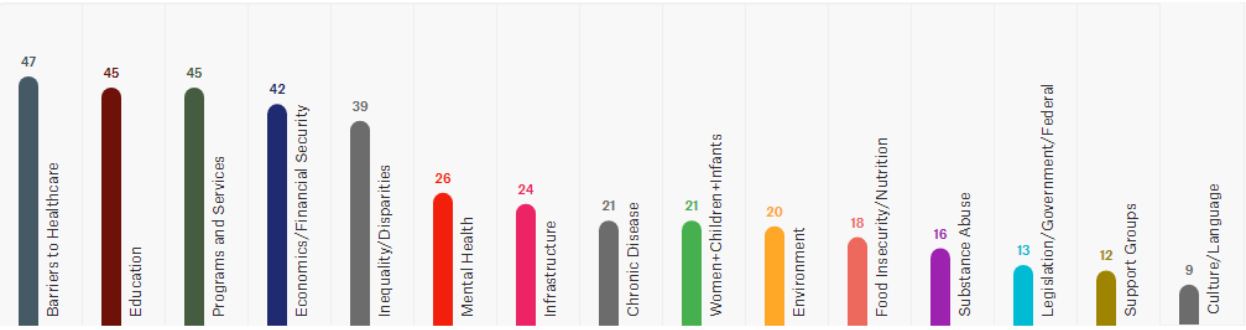
Key Informant Interview Analysis

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



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

Coding Analysis



[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/

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, St. Charles has strong relationships with local and regional community-based organizations, libraries, schools, faith-based organizations, the local health department, local fire departments and municipalities that support and partner with us to reduce chronic disease, mental health and substance misuse, and to promote health equity. See page 9 for our extensive partner list of health care 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

Each partner offers unique programming and interventions that align with the goals and objectives of St. Charles. 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, St. Charles partnered with community-based organizations in multiple communities to hold culturally relevant chronic disease management educational programs, vaccination clinics, support groups, health screenings, emotional wellbeing workshops, and lectures among other outreach activities. Due to the COVID-19 pandemic, many outreach activities traditionally held in the community were paused in March 2020 but resumed in the fall of 2021. With lessons learned, many successful virtual education events still continue.

Mission moment highlights (*Represents community outreach activities for years 2020, 2021, and through August 2022*):

- Screenings (Outreach Bus, Health Sundays Program, Other Locations): 591 individuals
- Vaccination Clinics and PODS: 1,336 administered
- Community Lectures/Workshops: 3,083 attendees
- Trainings (CPR, Stop the Bleed, Narcan): 214 individuals trained
- Support Groups (Condition Specific): 2,517 attendees

PROPOSED INTERVENTIONS

Evidence-based interventions

St. Charles remains committed to providing the community with evidence-based and promising practice programs that address chronic diseases and mental health/substance misuse. Additionally, as a faith-based provider, it has always been our mission to address the social needs of our patients and community members. 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

The public needs to understand the findings of this report and Catholic Health's vision for meeting these priorities and closing the gap in health disparities.

This report is being made available to the public and will be posted on Catholic Health's website.

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

Catholic Health is pleased to provide this comprehensive report to community members and the wider public. It reaffirms each organization'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.


#LIHEARTWALK
FREE
HEALTH
SCREENINGS
Catholic
Health