NASSAU COUNTY DEPARTMENT OF HEALTH

Community Health Improvement Plan

Division of Quality Improvement, Epidemiology and Research

2014-2017

106 CHARLES LINDBERGH BLVD UNIONDALE, NY 11553

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A Note from the Authors

While Nassau County Department of Health is responsible for protecting and promoting the health of its residents, it cannot and does not work alone. The government requires the engagement of strong community partners and stakeholders to address pressing health concerns. The Community Health Improvement Plan (CHIP) is a joint effort amongst county agencies, community-based organizations, hospitals, associations and academia to identify strategies, goals, objectives and metrics to improve health outcomes for Nassau residents. In an effort to establish this plan, a strong collaboration was formed to identify two prevention agenda priorities, *Reducing Obesity in Children and Adults and Increasing Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings.* This document outlines Nassau County Department of Health and its partners' plan for addressing these health concerns.

Chapter 1 describes the collaborative method used to identify the focus areas. The Community Health Assessment results were critical to the public health partners' decision-making process. Ultimately, the combination of both quantitative and qualitative analyses provided the strong evidence for the selection of chronic disease, with particular attention given to those diseases that show disparities across communities, as a priority.

Chapter 2 presents the central core of the CHIP. This chapter details each agency, its programs, metrics and time frame for implementing the interventions. Healthy People 2020 is an important resource.

Chapter 3 outlines all the participatory partners as well as those who are responsible for specific programs. These agencies are further described by the sector they represent, which supports the inclusion of multiple perspectives in the process.

Chapter 4 delineates the Universal Metric developed for standardized evaluation across programs.

Chapter 5 provides examples of best practices currently implemented by Nassau County Department of Health and how lessons learned were integrated into the CHIP.

Chapter 6 discusses the principles that guide a true participatory and collaborative process. Additionally, a schedule of meetings is included to maintain cohesiveness and track progress.

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Chapter 1: Priorities

Prevention Agenda Priorities

When evaluating specific areas for health improvement, Nassau County Department of Health, in collaboration with its hospital partners, community-based organizations, academic institutions and county residents, identified two priorities, (1) *Reducing Obesity in Children and Adults* and (2) *Increasing Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings*. These two selected priorities are considered focus areas within the larger priority of *Prevent Chronic Disease*.[1] In addition, Nassau County Department of Health, with its public health partners, identified *Promote Mental Health and Prevent Substance Abuse* as an important Prevention Agenda item that should be integrated with the two priorities selected—the need for improvement in this realm emerged as common theme throughout the analysis of community response data. Both priorities address health outcome disparities that are distributed by community.

Method Used to Identify Priorities

A collaborative effort among 12 hospitals, Nassau County Department of Health, community- based organizations and academic partners convened to establish collective goals and objectives over the course of several months beginning in October 2012. The timeline is available in Chapter 4 of the CHA. A list of stakeholders is presented below.

Public health partners and agencies have a vested interest in the improvement of the health of community residents and the establishment of goals and strategies to realize such outcomes. Furthermore, as required by Article 6 and Article 28 of state public health law[2] and shaped by Public Health Accreditation Board Standards and Measures,[3] Nassau County Department of Health must submit a Community Health Assessment (CHA) and CHIP to receive state aid reimbursement.

The Affordable Care Act requires non-profit hospitals to conduct Community Health Needs Assessments and establish a plan to achieve its community's needs.[4] Finally, Nassau County, as described in the CHA, is home to a vast and diverse community, and requires aligned efforts to effectively address health disparities. Because of these combined missions and obligations, Nassau County Department of Health and partner agencies decided to join forces and identify priorities and plans together that would benefit the agencies and, more importantly, the 1.3 million county residents

[1] New York State Department of Health, *Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013, (2012) p.4 (fn 9).*

[2] NYS Public Health Law, sections 602 and 2803-1

[3] http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/

[4] ACA, section 9007 and IRS Notice 11-52, section 3.08

Sectors and Stakeholders	
Sector	**Organizations/Agencies**
Healthcare Delivery	Catholic Health Services of Long Island: St. Francis Hospital St. Joseph Hospital Mercy Medical Center
	Long Beach Medical Center
	North Shore LIJ Health System: Franklin Medical Center NSUH Glen Cove NSUH Manhasset NSUH Plainview NSUH Syosset
	NuHealth Healthcare Corporation
	South Nassau Communities Hospital
	Winthrop-University Hospital
	Nassau Suffolk Hospital Council
Media	Long Island Health Collaborative
Academia	Adelphi University
	Hofstra University
	New York Institute of Technology
	SUNY Stony Brook University
Community-Based Health and Human Services	Catholic Charities
	Circulo De La Hispanidad
	FEGS Health & Human Services
	Health and Welfare Council of Long Island
	Hispanic Counseling Center
	Island Harvest
	Jewish Association Serving the Aging (JASA)
	Lions Club
	Long Island Council of Churches
	Long Island GLBT
	Mental Health Association
	National Coalition for Women With Heart Disease- Women Heart Speakers Bureau

Sectors and Stakeholders	
Sector	**Organizations/Agencies**
	Planned Parenthood of Nassau County, Inc. (PPNC)
	Preventive Cardiovascular Nurses Association - Speakers Bureau
	Project Independence
	Sustainable Long Island
	United Way
Government	Nassau County Department of Health
	Nassau County School Wellness Coalition
	Perinatal Service Network
	Suffolk County Department of Health
National Associations	American Cancer Society
	American Diabetes Association
	American Heart Association

Data to identify the priorities was derived from the CHA. As described, it included both quantitative and qualitative measures that reflected hospitalizations, vital statistics, key-informant interviews of community-based organizations and community-wide surveys.

These are discussed in CHA Chapters 1 and 2 and results were presented over the course of several meetings. Prevention agenda priorities were mapped in a priority grid, as they related to the distribution of disease, mortality, and community input. The grid cells were compared to identify overlapping health outcomes (see Priority Grid, below). The collaborating groups reached a consensus on the priorities to be addressed county-wide. In subsequent meetings goals and objectives, improvement strategies and collective program metrics were identified.

The priority grid indicated that chronic disease prevention through improved access to high quality care and management was of paramount concern, according to the community—a finding that was further evidenced by the burden of disproportionate distribution of disease within the county.

Chronic diseases are generally preventable but are responsible for high mortality rates, nationally and locally. Within the realm of chronic disease, diabetes, heart disease and cancer were the most common health concern in Nassau County. The key informant interview participants overwhelmingly reported chronic disease as the most pressing health concern; cancer, according to the community-wide survey, ranked as the leading chronic disease concern. Within the selected communities,

diabetes, a chronic disease, ranked highly as a concern; the incidence rates of type 2 diabetes, COPD, asthma and liver disease morbidity were strikingly higher in those who lived in the selected communities compared to those who lived the rest of the county.

Obesity prevention, as a risk factor for chronic disease and as an outcome itself, ranked second highest as a priority on the Priority Grid. According to the community-wide survey, obesity was one of the most pressing concerns for the county as a whole. Sub-themes that emerged from the key informant interviews from local community-based organizations indicated that overweight and obesity-related conditions as being of prominent concern. Data from the school districts in selected communities further substantiate obesity and overweight as a condition of concern in the county's child population (Please refer to Chapter 2 of CHA).

Improving mental health resonated as a continuous theme throughout the analysis; the community survey and key informant interviews demonstrated that this was topic of great concern in the population. Substance abuse was also ranked as a high priority within the selected communities as per the community-wide survey. Key informants from community-based organizations also discussed the need for mental health services. Therefore, including *Promoting emotional and behavioral health* and *Preventing substance abuse* are relevant issues for the public health system to incorporate within its health improvement focus. Other prevention agenda items remain critical core functions of the health department.

Prevention Agenda Items	**Morbidity Data**	**Vital Statistics**	**Community Wide Survey**	**Key Informant Interviews**
1. Prevent Chronic Disease				
1a: Obesity prevention in adults and children				
1b: Increase access to high quality chronic disease preventive care and management in both clinical and community settings				
2. Promote Health and Safe Environment				
3. Promote Healthy Women, Infants and Children				
4. Promote Mental Health and Prevent Substance Abuse				
5. Prevent HIV, STD, Vaccine Preventable Diseases and Healthcare-Associated Infections				

Chapter 2: Priority Goals, Strategies, Metrics and Timeline

Preventing Chronic Disease was chosen as the priority by Nassau County Department of Health in collaboration with the county hospitals, community input, community-based organizations and academic partners. Within this priority and consistent with the charge from New York State Department of Health,[5] two focus areas were identified as a result of the Community Health Assessment: *Reduce Obesity in Children and Adults and Increase Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings.* Furthermore, Promoting Mental Health and Preventing Substance Abuse was an important priority that the partnership wished to integrate within the focus areas.

The goals of reducing obesity in children and adults include 1) creating community environments that promote and support health food beverage choice and physical activity; 2) preventing childhood obesity through early child care and schools; 3) expanding the role of healthcare, health service providers, and insurers in obesity prevention; 4) expanding the role of public and private employers in obesity prevention. The goals of increasing access to chronic disease preventive services are 1) increasing the screening rates for cardiovascular disease, diabetes, breast cancer, cervical cancer, colorectal cancers; 2) promoting evidence based care to manage chronic disease; and 3) promoting culturally relevant chronic disease self-management education.

Objectives for each goal are aligned with the Healthy People 2020 targets. The obesity prevention target is increasing the proportion of healthcare providers who regularly measure BMI by 10%, increasing the proportion of healthcare providers who include counseling and education related to nutrition or weight by 10%, increasing the proportion of worksites that offer nutrition or weight management classes by 10%, reducing the proportion of individuals who are obese by 10%, increasing the contribution of fruits and vegetables to the diet by 50% and 25%, respectively. The physical activity to prevent obesity objective is increasing the proportion of individuals who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity by 10%. The access to chronic disease preventive care and management target is increasing screening rates of chronic disease markers, as per Healthy People 2020 targets; for example, increasing blood pressure screenings by 2%. Chronic disease management objectives include increasing the proportion of healthcare provider visits made by patients diagnosed with a chronic disease that include counseling, or education related to diet, nutrition, physical activity and self-management by 10%. To

[5] Directions for Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013, footnote 9.

address the goals for promoting mental health, target objectives include increasing screening of mental health issues by 10%.

Additional measurements will be conducted for each priority. Trend analysis will contribute an important temporal element to the evaluation. Correlation analysis between pre and post analyses will be conducted when available. Over the course of the next five years, programmatic endpoints can be measured to identify change over time, or cumulative area under the curve analysis, when possible. Multiple evidence-based improvement strategies are implemented to address these priorities and focus areas. A detailed description of these programs is found on the Nassau County Program Inventory (see Chapter 3). In general, the strategies for obesity prevention include methods to increase physical activity, improve nutrition and make available healthy choices within the community. The strategies for improving chronic disease management include linking individuals to clinical care, providing educational resources to prevent chronic disease, promoting access to care for chronic disease and encouraging chronic disease self-management. The strategies for promoting mental health include the provision of mental health screening, crisis counseling, for both groups and individuals, and treatment programs for those suffering from mental illness and substance abuse.

As Nassau County suffers from health inequities, programs that address both focus areas and include mental health evaluation as a component will concentrate in the selected communities. Therefore, strategies will be culturally competent and available in languages other than English. End trend analyses, when possible, will be stratified by selected communities.

Metrics developed for each program are found on the Program Inventory. There is a range of outcome measures used and, therefore, analysis, as discussed earlier, will be limited to trends over time. The partnership is committed to continually improve metrics and means to capture program impact on residents.

Together, Nassau County and neighboring Suffolk County recognized that they had identified the same priorities through independent methodology and process. To that end, throughout the island, numerous programs exist to address these shared focus areas. As a region, with the partnership from the health departments, hospitals, community-based organizations, academic partners and Nassau-Suffolk Hospital Council, collectively have joined efforts in the Long Island Health Collaborative (LIHC). This region-wide effort is directed to maintain web-based resources for Long Islanders that address obesity prevention and improve chronic disease management. In addition, this resource will enable community partners to maintain connections and networks to initiate evidence-based or promising practices. Finally, the continuous collaboration enables stakeholders from the entire region to

pool resources and develop strategies collectively.

The LIHC will launch a walking initiative region-wide, "Walk! Long Island." This program's degree of expansion into the community will be based on current resources and additional funds sought through grants. The goals of this program are to improve health, fitness, and quality of life through daily physical activity. Program objectives are: 1) increase the proportion of adults who not engage in leisure time physical activity by 10%; and, 2) increase the proportion of physician office visits that include counseling or education related to physical activity by 10%. As part of the region-wide LIHC, the activities will encompass three levels of intervention: healthcare system, which includes the hospitals and healthcare providers; the community, which includes community-based organizations and residents; and the media, which include efforts by the full collaborative.

At the healthcare system level, *Rx for Walking*[6] is a program that emphasizes the importance of walking to good health and has been tested in San Diego, CA, among other locations. It is an effective measure to integrate physical activity into daily lives. All current healthcare providers will be able to write these prescriptions for appropriate patients. The providers will refer patients to the LIHC website where patients can find walking groups in their communities as well as other resources. At the community level, *Walk and Talk* is an initiative to link individuals to existing walking groups and encourage new walking groups to form. Residents will find resources and groups on the LIHC website. Walking clubs are a well-established method to promote health. [7] Residents will track their progress by registering their miles or steps walked and will have the opportunity to form new groups. Community-based organizations will support walking groups through promotion and linking individuals to them. Associations that fundraise through walking will be incorporated into *Walk and Talk.* Through the media, LIHC will advertise this initiative on its website. Press releases and PSAs will be released by health departments, hospitals and community-based organizations. This program's impact has the potential to reach the adult population in Nassau and Suffolk Counties. Metrics used include: the number of hits on the website; number of people who register and log in steps/miles; number of steps/miles walked; number of walking groups; number of prescriptions for walking; and the means by which residents became aware of program. Progress will be measured by using BRFSS data as baseline for walking groups. Metrics will be tracked over time to evaluate trends. Once residents begin to walk together and establish friendships and connections, these groups will self-sustain. Socialization,

[6] http://www.walksandiego.org/our-work/community-support/walking-a-prescription-for-better-health/

[7] http://www.mywalkingclub.org/

accountability to other members, sense of well-being and personal relationships will maintain participation.

Chapter 3: Stakeholders

The designation of those organizations responsible for implementing strategies is found in the Program Inventory below. Specific individuals from these agencies are responsible for the implementation of each program. The names and contact information of these individuals are on file for Nassau County Department of Health and Long Island Health Collaborative use, but are not available publically. The agencies and organizations span several sectors. The current list is dynamic and, over the course of the next five years, will expand as the Collaborative reaches further and further into the community and interacts with additional organizations. The Program Inventory describes each organization that has accepted responsibility for implementing strategies.

PROGRAM INVENTORY

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
Catholic Health Services of Long Island	Healthy Sundays	Free BMI, cholesterol, blood pressure, dental and other health screenings, education and immunizations delivered to residents in partnership with 35+ parishes and other community-based organizations.	Medically underserved populations of Nassau and Suffolk counties	Obesity, Chronic Disease	Data (including types of screenings completed, results, sex, age and referrals) from every event tracked
	Bishop McHugh Health Centers	Hospital-supported primary care health centers providing free immunizations, physicals, well woman care, lab work, X-rays, diabetes education, etc.	Uninsured and other medically underserved in Nassau and Suffolk	Obesity, Chronic Disease	Physicians monitor their patients' health; Physician Quality Reporting and National Quality Forum indicators; use of EMR
	Diabetes Education Centers	Hospital-based outpatient program teaches self-management skills for improved health.	Diabetics in Nassau and Suffolk	Chronic Disease	Participants' weight and blood sugar levels recorded at start and then 3 months later
FEGS Health & Human Services	NoBody's Perfect-Eating Disorder Program	School and community based eating disorder prevention and education programming, professional training and resources.	School Age Children/ Nassau and Suffolk County	Obesity	Pre/Post Survey of participating students
	Partners in Dignity- Long Island Regional Care Center	Provide individuals and families services and support they need when facing a chronic, serious and life-limiting and terminal illness. Services offered: medical navigation, care management, spiritual care, supportive and bereavement counseling, information & referral and advocacy and volunteer services.	People coping with Chronic, Life-limiting and terminal illness/ Nassau and Suffolk County	Chronic Disease	Track success of navigation including access to care, services and benefits; Post program educational survey tool; Annual consumer satisfaction survey.
	Project Independence NNORC Program	Neighborhood Naturally Occurring Retirement Community (NNORC) - in partnership with the Town of North Hempstead, North Shore-LIJ Health System and JASA, provide programs to mobilize communities to bring comprehensive counseling, case management, health, social, recreational and volunteer services to help seniors age in place.	People over 60 in North New Hyde Park in the Town of North Hempstead NNORC catchment area	Obesity, Chronic Disease and Mental Health	Track success of navigation including access to care, services and benefits; post workshop educational survey tool; Annual consumer satisfaction survey.
	Positive SPACE Mental Health Services	Provide licensed MH services including individual, group and family counseling, psychiatric evaluations, med and crisis intervention.	People infected or affected with HIV/AIDS and LGBT/ Nassau and Suffolk Counties	Mental Health and Chronic Disease (HIV)	Review of treatment plan conducted on an individual basis.
	Positive SPACE Substance Abuse-Recovery Readiness	Provide substance abuse-recovery readiness services to HIV+ people regardless of where they fall in the spectrum of their recovery.	HIV/AIDS-Nassau and Suffolk Counties	Mental Health and Chronic Disease (HIV)	Review of service plan conducted on an individual basis.
	Positive SPACE Medical Case Mgmt	To provide support to HIV+ people who need assistance staying connected to medical care, including chronic disease management	HIV/AIDS-Nassau and Suffolk Counties	Chronic Disease (HIV)	Review of service plan conducted on an individual basis.

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Nassau Wellness Partners - Health Homes	Provide care coordination to Medicaid recipients with multiple complex chronic conditions to improve wellness.	Adults with Medicaid and one or more chronic health/behavioral health conditions	Obesity, Chronic Disease and Mental Health	Metrics established by NYS DOH
Hispanic Counseling Center	Mental Health Outpatient Program	A licensed bilingual, bicultural mental health clinic providing individual, group and family psychotherapy.	From age 5 to Geriatrics	Mental Health	Psychiatric Evaluations and Treatment Plans
	Domestic Violence Program	Education/prevention and treatment to youth and children who witness domestic violence or victims of child abuse. Individual/group/family counseling, case management, crises intervention, psycho-education, and psychiatric services.	Youth and children	Mental Health	Varied
	Parenting Education	Parenting skills groups offered to parents in need of education and advocacy.	Adults and legal guardians of children	Mental Health	Varied
	Chemical Dependency Outpatient Program	Provides treatment of both Alcoholism and Drug use. Counseling for families affected by their loved one's use of substances. Services provided: chemical dependence and psychiatric assessments, individual/group/family/ and marital counseling. Chemical dependency education and parent/family workshops.	Those affected by substance and chemical use	Mental Health	Toxicology reports
	Ryan White Part A Mental Health Services for People with HIV/AIDS	Mental health treatment services to individuals affected by HIV/AIDS. Individual/family/and group therapy. Support groups, crises intervention, medication, referrals, home and hospital visits.	Individuals affected by HIV/AIDS	Mental Health	Varied
	Domestic Violence Batterers Accountability Program	24 week psycho-educational program to educate individuals referred by courts and child welfare agencies due to charges stemming from domestic violence and child abuse.	Referred residents	Mental Health	Varied
	Youth and Family Program	Enable newly arrived families with limited English skills to become integrated members of the community with greater knowledge of the culture of their new environment.	Newly arrived families that are limited in English language	Mental Health	Varied
	Teen Drop in Center	Prevention program offered to youth ages 13-17.	Youth	Mental Health, Obesity	Program participation
	Children and Family Support Services Respite Program	Provide temporary care of children in order to support families with children who have emotional and behavioral issues and who are severely emotionally disturbed.	Nassau County residents	Mental health	Varied

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Kinship Care Program	Services coordinated with the Nassau County Department of Social Services, Department of Senior Citizen Affairs, Youth Board, and other community-based organizations. Program provides those services that families need and are eligible for, such as financial advocacy, TANF and Medicaid benefits, legal assistance, mental health counseling, support groups, child care, and afterschool care to help the children adapt successfully with their peer, family, and school relationships.	Nassau County residents	Mental Health	Weekly attendance
	Comprehensive Intensive Prevention Program	Serves TANF eligible families residing in high need communities who are at high risk of child abuse or maltreatment and/or foster care or out of home placements,	Nassau County	Mental Health	Varied
	Medicaid Service Coordination Program (MSC)	Advocacy, case management to developmentally disabled adults and children (3+) who waive the right to live in an institution and choose to live at home with their families.	Nassau County	Mental Health	Varied
	Non-Medicaid Service Coordination	Services to developmentally disabled consumers not Medicaid eligible.	Nassau County	Mental Health	Varied
	Housing	Supported Housing Program (SHP)- Designed to provide permanent housing to individuals 18+ with serious mental illness, and who are experiencing difficulties with their housing situation and receive treatment in any mental health program. The SHP provides financial assistance according to individual needs, case management, Home Visits, Education and Support/Recreational Groups.	Nassau County	Mental Health	Varied
	HCC ADA Initiative	Collaboration with the American Diabetes Association.	Nassau County	Chronic Disease, Obesity	To be developed: Understanding a1C and caloric intake
Hofstra University, School of Health Sciences and Human Services, Department of Health Professions and NuHealth	Let's Move! Roosevelt	Program provides enhanced healthy lifestyle education appropriate to the community's culture, through curriculum changes and family events at the school. Program provides community health worker to reach out to high risk students and families to raise the percent of those who have access to and utilize primary care services in the community.	Middle school students and their families in Roosevelt	Obesity	BMI measurements, Annual YRBS-based Survey on physical activity and nutrition

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
Long Island Gay and Lesbian Youth (LIGALY)	HIV Prevention Education - Many Men, Many Voices (3MV)	Comprehensive sexual health education program designed for gay and bisexual men of color to address the combined effects of racism and homophobia as a cultural approach to HIV prevention.	Gay and bisexual young men of color ages 16-24	Chronic Disease (HIV)	# of participating youth; qualitative feedback from youth participants
	Comprehensive Risk Counseling Services (CRCS)	CRCS is a client-centered HIV prevention activity that provides intensive, ongoing, individualized prevention counseling, support, and service brokerage.	GLBT youth ages 13-24	Chronic Disease (HIV)	# participating youth; qualitative feedback from youth participants
Long Island GLBT Community Center (The Center)	Mental Health Counseling	Mental health services for GLBT people, their significant others, and their families that address a range of mental health challenges stemming from homophobia, transphobia, and challenges related to coming-out including high rates of substance abuse. Free for youth. Sliding scale fee for adults ages 22+.	GLBT people of all ages.	Mental Health	# Of unduplicated clients completing intake, and accessing mental health counseling sessions; # of return sessions.
	Mental Health Support Groups	Mental health support groups for GLBT people	GLBT people of all ages.	Mental Health	# Groups delivered; # of unduplicated clients served; # of contacts with each client.
Long Island (SAGE-LI) - Services and Advocacy for GLBT Elders	Health and Wellness Programming	Monthly programming for GLBT older adults focused on chronic disease prevention and management, including diabetes, arthritis, Alzheimer's, cancer, and others.	GLBT older adults.	Chronic Disease	# Sessions delivered; # unduplicated clients served; # of contacts with each client.
Long Island Health Collaborative (LIHC)	Walk! Long Island	A two-part walking initiative: Rx for Walking and Talk and Walk. Rx for Walking is where healthcare providers will write walking "prescriptions" for appropriate patients. Patients will refer to the LIHC website to find walking groups in their communities as well as other health resources. Walk and Talk is an initiative to link individuals to existing walking groups and encourage new walking groups to form. Residents will find resources and groups on the LIHC website. LIHC will advertise this initiative on its website. Press releases and PSAs will be released from health departments, hospitals and CBOs.	Nassau and Suffolk County adult residents	Obesity and Chronic Disease	Metrics will include: # of hits on the website, # of participants registered and logging steps, # of steps walked, # walking groups, # of Rx for walking written, means by which residents are informed of program. Progress will be measured by using BRFSS data as baseline for walking groups. Metrics will be tracked over time to evaluate trends.
Mental Health Association	Gathering Place Personalized Recovery Oriented Services (PROS)	Day program focusing on PROS , where adults with mental illnesses actively participate in skill development toward employment, housing, education wellness, self-management and community integration.	Adults with mental illnesses	Mental Health	N/A

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Community Outreach	Provides information and educational materials to increase public awareness about mental health issues and community-based resources.	Community members	Mental Health	N/A
	Consumer Link	A peer support, advocacy and outreach program, fully staffed by current and former recipients of mental health services.	Adult with mental health services	Mental Health	N/A
	Health Home Case Management	Provides help to at-risk adults who are navigating the mental health system. In addition, links at-risk adults to needed services and supports in areas of health, financial entitlements, housing, education and vocational needs.	At-risk adults	Mental Health	Varied
	Medicaid Service Coordination	Assists adults with disabilities to develop life goals, make informed choices and achieve self-reliance and community inclusion.	Adults with developmental disabilities	Mental Health	N/A
	Veterans Health Alliance of L.I.	Collaborative effort of over 80 organizations to promote the health and well-being of L.I. veterans and their families. Advocates for improved care for vets and provides peer support for the vets and their family members.	LI Veterans and their families	Mental Health	Varied
	Adult Residential Services	Provides homes for adults who have mental illnesses with supports to focus on recovery, and supportive supervision. Includes housing for individuals and families with a history of mental illness and homelessness.	Adults with mental illnesses	Mental Health	Participation
	Crisis Respite for Families	Provides an out-of-home residential stay for children in need of some time apart from their family, who all may benefit from a short respite.	Children in need of respite	Mental Health	Participation
	The Terrace	A housing program for 10 children with autism to live in a family-like setting with behavioral interventions and staff support.	Children with autism	Mental Health	collected daily behavior goals, academic skills, activities of daily living done on a program level done daily
	Hospital Discharge Coordination	Coordinates all children's psychiatric discharges from Nassau Co. hospitals to ensure comprehensive community linkages and supports.	Children with psychiatric discharges	Mental Health	N/A
	Compeer Program	Matches consumers with volunteer mentors to work towards recovery.	Adults in recovery	Mental Health	Post survey of participants

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Education & Training for Mental Health Professionals	Nassau County's "mental health university" provides information and skills certification that is reflective of the changing needs of professionals, advocates, government workers and academics.	Mental Health Professionals	Mental Health	N/A
Mercy Medical Center	Mental Health Clinic	Mental Health Clinic provides treatment for patients that have mental illness.	Adults with chronic and acute mental illness	Mental Health	Varied
	Chemical Dependency	Chemical Dependency Program provides treatment for patients with substance abuse issues.	Adults with co-occurring mental health and chemical dependency	Mental Health	Varied
	Partial Hospital Program	Psychiatric Day hospital provides treatment five days a week for five hours a day for patients who are mentally ill and/or chemical dependent that are experiencing "severe psychiatric symptoms."	Adults with chronic and acute mental illness	Mental Health	Varied
	Bariatric Surgery Center of Excellence	Provides weight loss surgery, supervised weight loss maintenance, support group meetings and nutritional counseling.	Morbidly obese adults - ages 18 - 65. Patient population is mostly New Yorkers with many others from out of state.	Obesity	Body Mass Index (BMI) and obesity related medical conditions
	Teddy Bear Clinics	Grade school children are invited to the hospital for health and wellness fair. Children learn about exercise, smoking, disease prevention, nutrition, etc.	Grade school students	Chronic Disease (smoking), Obesity	N/A
	Diabetes Education Center	Outpatient diabetes education program, taught by Certified Diabetes Educators (CDE), is recognized by the American Diabetes Association and the American Association of Diabetes Educators.	Adult residents in Nassau County	Chronic Disease	PI Indicators: missed appointments, hand washing, pain management, medicine reconciliation, patient satisfaction, patient education, fasting blood sugar monitoring, eye exam, foot exam
	Community Outreach	Community lectures (topics such as diabetes, heart and stroke health, nutrition) presented by physicians and clinical staff such as nurses, dietitians, physician assistants. Also includes participation in community health fairs where literature is presented and distributed.	Residents in Nassau County	Chronic Disease	N/A

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Post Discharge Patient Phone Calls	Nursing staff makes phone calls to CHF patients to see how they are doing, make any follow up physician appointments if needed, give guidance if needed, refer to home care if needed (Telehealth services available), etc. in order to help prevent re-admissions.	Post discharged Mercy patients	Chronic Disease	Varied
Nassau County DOH	Women Infants and Children (WIC) Program Healthy Lifestyles and Fit WIC	Nutrition education, breastfeeding support, physical fitness and supplemental food program	Pregnant, postpartum and breastfeeding women and their 0-5yo children at or below 185% of the federal poverty level residing in New York State	Obesity	BMI/National Guidelines
	Perinatal Mood Disorder (PMD) Task Force Identification and referral service	Safety net for perinatal women that promotes screening and access/referral to mental health services	Childbearing women in Nassau County	Mental Health	training programs for peer groups and calls to referral numbers for service
	Hewlett House cancer support services	Informed decision making, individual and group therapeutic services and adaptive products provided in a private and supportive setting	All Nassau County residents	Chronic Disease	number of people served and services provided
	Social Health Initiatives	Outreach community centered events that educate the underserved population in multiple health issues including obesity prevention and chronic disease	All Nassau County residents concentrating in Selected Communities	Obesity, Chronic Disease	Pre and post survey to determine if information was gained
	In collaboration with New York Institute of Technology	Nutrition Lunchtime Series and Walking Initiative	Nassau County health department employees	Obesity, Chronic Disease	Post survey to determine if lunchtime series was informative; pre and post survey for walking initiative
Nassau County School Wellness Coalition	Teen Wellness Trainers	Peer leadership training program that seeks to educate high school students about nutrition and exercise to deliver lesson plans at the elementary level.	High School and Elementary School Students	Obesity	Pre/Post Survey of participating students and faculty confirmation of lesson plan delivery at elementary school
National Coalition for Women With Heart Disease-Women Heart Speakers Bureau	Women Heart Support Group Lecture series (Community Lectures)	Cardiovascular prevention lecture series tailored towards women. Audience is women living with heart disease support group	Women living with heart disease	Chronic Disease	Pre/post survey of attendees

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
North Shore LIJ Health System	Kohl's Cares For Kids Pediatric Obesity Prevention Program	Staff from Cohen Children's Medical Center partners with school districts which have a population of high percentage of free and reduced school lunch recipients to deliver nutrition and physical activity programs.	Elementary Students	Chronic Disease	Surveys of patient participation
	NYSDOH Prevention of Pediatric Obesity in Primary Care Settings	Train primary care providers to screen, identify and treat youth for pediatric overweight/obesity through health system changes.	Youth 2-18	Chronic Disease	Chart Reviews (Chart review includes screening, identification and treatment. Information is then aggregated and provider outcomes are determined)
Planned Parenthood of Nassau County, Inc. (PPNC)	Health Services	Health Services program takes height, weight and calculates the BMI of every patient. Depending on the patient's BMI, the patient may receive brief nutritional counseling and an information sheet known as "Tips for Losing Weight."	All patients that come to a PPNC health center for healthcare.	Obesity	BMI measurements
		Health Services collects a detailed history on women receiving their Well Woman Exams (medical examinations provided at PPNC). Preventive education is provided and referrals for primary care are given when necessary.	All patients that come to a PPNC health center for healthcare.	Chronic Disease	N/A
		Health services also provide mental health and substance abuse assistance. Patients are asked questions about depression and other mental health issues and substance use. Short term counseling is provided in house by Social Workers. Referrals are made for patients requiring more intense case management and treatment.	All patients that come to a PPNC health center for healthcare.	Mental Health	N/A
Preventive Cardiovascular Nurses Association - Speakers Bureau	PCNA Heart-Health Workshops (Community Lectures)	Lecture series developed by PCNA addressing cardiovascular risk factors	community-at-large; clinicians	Chronic Disease	Pre/post survey of attendees
Project Independence	Project Independence	Project Independence is the town's aging in place initiative designed to support and assist residents of the Town of North Hempstead who are age 60 or older to remain in their own homes and familiar communities with maximum self sufficiency, if this is their wish. (Social work and nursing services, home maintenance, volunteering, social and recreational, transportation, educational, radio show and many other programs)	Residents of the Town of North Hempstead aged 60 or over	Obesity, Mental Health, Chronic Disease	The Town has partnered with Rostra University to evaluate the program. Studies have been done on the food shopping and medical transportation programs, and on the impact of Project Independence on seniors in the Town.

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
South Nassau Communities Hospital	CATCH (Check-in And Take Charge of your Health)	Community education and outreach program for assessing weight, BMI, waist circumference, and blood pressure.	Community-dwelling adults in Nassau County Long Island with added emphasis on reaching low income/minority populations within our primary service area	Chronic Disease, Obesity	Track total # of individuals screened; # of referrals for follow-up
	Project Hope	Individual and group crisis counseling, wellness/support groups, resource linkage, public education and outreach.	Individuals in Nassau County (adults, adolescents and children who have been affected by Hurricane Sandy	Mental Health	Track number of encounters and individuals using/attending programs
St. Francis Hospital	Community/ Outreach	Community outreach program transports nurses via mobile bus to community site locations to assess cardiac history, blood pressure, and check levels of cholesterol/HDL/blood glucose.	Adults - Long Island community. Special efforts are made to screen in areas of the medically underserved who have difficulties accessing healthcare.	Chronic Disease	# of patients screened/month and who was referred for additional care & management
	Diabetes Education	Diabetes comprehensive educational program that provides non-insulin and insulin dependent diabetics and their families information emphasizing knowledge of disease, treatment, self management, awareness of complications and prevention strategies.	Adults - Long Island community	Chronic Disease	# of patients that attended individual nutritional diabetes counseling & group classes/month;
	Student Athlete Screening	The student athlete screening program accesses the risk of congenital heart disease and the implications of high impact exercise by performing EKGs, echocardiograms and physician assessments of high school athletes.	High School athletes in grades 9 - 12; Long Island community	Chronic Disease	# that screened positive for showing evidence of congenital heart disease/total # of adolescents screened
St. Joseph Hospital	Diabetes Education Center	Diabetes support group meetings.	Adults and young adults	Chronic Disease, Obesity	Post survey of participants
	Diabetes Education Center - Nationally Recognized Core Curriculum Program	Four session (10 hour) diabetes self management program. This program includes an individual assessment visit with a Certified Diabetes Educator, as well as 3 (3 hour) group classes. This also includes an individual meal plan.	Adults and young adults	Obesity	Post survey of participants
	Overeaters Anonymous	Program that provides support and recovery for compulsive eaters	Adults and young adults	Obesity	Anonymous Program

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Free Community Seminars: Healthy Living	Seminars that cover various health topics held throughout the year. For example, "Is Your Child A Picky Eater?", "Early Detection and You: Colon Cancer Screenings", "Back to Basics: Diabetes Fundamentals and Management Tools", etc.	Adults	Chronic Disease, Obesity	Post survey of participants
	Healthy Sundays	Participation in Blood Pressure screenings, Flu vaccine distribution, healthy eating choices	Adults	Obesity, Chronic Disease	N/A
	Prostate Cancer Screening	Annual Free screening provided - PSA and exam.	Adult Men	Chronic Disease	N/A
	Fall Health Fair	Free Blood Pressure check, education, healthy eating tips, information on wellness programs and services provided by the hospital.	Families	Obesity, Chronic Disease	N/A
Sustainable Long Island	Food Equity	Designed as a collaborative effort between SLI and community partners across the region, Food Equity provides increased access to healthy, affordable food. Includes SLI's youth-staffed farmers' markets.	Low- to moderate-income communities in Nassau and Suffolk Counties.	Chronic Disease	Farmers' market customer survey that measures market performance over the course of the season.
Winthrop-University Hospital	Lifestyle Balance to Prevent Diabetes: A Pre-Diabetes Program	The Winthrop Diabetes Education Center team of nurse and dietitian specialists has developed a program designed to help people with pre-diabetes prevent or delay type 2 diabetes. The Pre-diabetes Program is offered in day or evening sessions. The first two group sessions are offered one week apart. Participants must attend both sessions in order to benefit from the program. A follow-up session is scheduled following the second group session.	Adults with fasting blood glucose 100 to 125 mg/dl, or A1C 5.7-6.5 %, or high cholesterol/triglyceride levels	Chronic Disease (Diabetes Prevention)	Changes in weight, fasting glucose and patient satisfaction survey
	Diabetes Education Center	Comprehensive, accredited program that provides people with diabetes knowledge, skills and tools. The staff takes a personal approach to help you navigate through the wealth of information. Core group sessions, personalized individual sessions, meal planning classes, refresher courses, insulin pump, sensor training and dining out with diabetes programs are offered.	Anyone with diabetes who lives in the Metropolitan area. Because there are no physicians at the Diabetes Education Center, your personal physician receives a letter summarizing recommendations.	Chronic Disease	Patient Satisfaction Survey, Behavior Change goals, A1C and Weight
	Comprehensive Center for Diabetes Care	Provides adult endocrinology and diabetes education within the medical office. Education program includes diabetes self-management education plus insulin pump and sensor training.	Adults who are seen by the physicians in the Adult Endocrinology Practice.	Chronic Disease	Patient Satisfaction Survey, Behavior Change goals, A1C and Weight

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Pediatric Diabetes Program	Provides pediatric endocrinology and diabetes education within the medical office. Education program includes nutrition, management plus insulin pump and sensor training.	Children and Adolescents who are seen by the physicians in the Pediatric Endocrinology Practice.	Chronic Disease	Patient Satisfaction Survey, Behavior Change goals, A1C and Weight
	Community Outreach for Seniors	Community Training and Educational Program to raise awareness to prevent falls; improve balance and to make lifestyle changes related to smart food choices to maintain weight and remain healthy.	All senior adults and caregivers in the community and community-based organizations	Chronic Disease	Pre/post surveys of participating attendees with a follow-up telephone call or mailed survey of the healthy lifestyle changes made and the impact on their health
	Tobacco Cessation program for all Nassau County residents, offered at the Winthrop Wellness Center and various community locations	The Tobacco Cessation Program is an interactive four-week workshop. The sessions are motivational and supportive for all attendees. The focus is to assist attendees to become non-smokers, using behavior modification, Nicotine Replacement Therapies and/or hypnosis, thereby improving their health and living a healthier lifestyle.	Long Island Community	Chronic Diseases	Support group meetings and post surveys of participating attendees. Follow-up phone calls documenting data collected
	Center for Chronic Conditions	Nurse navigation provided to patients with chronic disease - includes guidance with disease management, coordination of services including education, support and physician visits. Also available for presentations and speaking engagement for community groups on chronic disease management and related subjects.	Adults & seniors	Chronic Disease	N/A
	Depression Screening and Contraceptive education.	Psychosocial screening	Teen and Childbearing population	All	Pre/post survey of patients
	Healthy Kids	Group sessions - for children and parents - are formatted into a 10-week series. Each weekly session, conducted by a certified instructor, lasts 2 hours. Each participant must be accompanied by a parent. Gaming activities and effective weight management techniques, including nutritional guidance, exercise and behavior modification strategies create a communal and supportive "Learning-is-fun" environment that provides a forum for participants to manage their weight and build healthier lives. Participants are grouped by age. Private family sessions with the nutritionist may be arranged. Follow-up sessions are offered for a full year following participation.	Overweight children	Obesity	Changes in weight

ORGANIZATION	PROGRAM	INTERVENTION STRATEGY	TARGET POP/ AREA SERVED	PRIORITY/FOCUS AREA	MEASURE/ METRIC
	Center for CV Lifestyle Medicine	Newly created. Program components include but are not limited to both primary and secondary prevention programs with the aim to optimize cardiovascular risk reduction, foster healthy behaviors and compliance to these behaviors, reduce disability, and promote an active lifestyle for individuals with or at risk for cardiovascular disease.	In development - individuals with or at risk for cardiovascular disease	Chronic Disease	In development- Working on patient-centered outcomes
	Winthrop Medical Weight Management Program	A full continuum of weight loss and weight management is provided in this medically-supervised weight management program. While structured, the program provides lots of variety. There is also an option for those who want to achieve significant weight loss without the need for medical supervision.	Overweight and obese adults who are interested in achieving significant weight loss supported by medical intervention to adjust medication dosages.	Obesity	Changes in weight, blood pressure, blood glucose and patient satisfaction
	Winthrop Bariatric Surgery Program	Comprehensive team provides thorough preparation and support. All bariatric procedures and revision surgery are offered as part of this Bariatric Center of Excellence. Free educational seminars and support group meetings are offered.	Obese adults who seek a surgical solution to weight management	Obesity	Changes in weight, blood pressure, blood glucose and patient satisfaction

Chapter 4: Outcomes and Process Measures

In addition to the outcome metrics listed on the Program Inventory in Chapter 3, the Long Island Health Collaborative has developed one collective metric that can be used for programs that address obesity, access to quality chronic disease management and mental health as it relates to obesity and chronic disease while meeting specific criteria discussed below. Each program must convene at least two sessions in a group setting. The program must consist of healthy eating education, including increasing fruit and vegetables, fiber and low fat dairy foods, decreasing the intake of sweetened beverages and increasing water consumption, providing nutritional label education and encouraging awareness of personal BMI. Physical activity education should concentrate on regular exercise and exercising safely. To promote physiologic wellbeing, relaxation strategies, stress management and mental health awareness will be promoted. Finally, to promote responsible health practices, information on chronic disease, how to contact healthcare providers, when to contact health providers, medication management and preventing tobacco and alcohol use will be provided.

A wellness universal metric questionnaire will be used pre and post program. It is currently being piloted and a final version is expected to be implemented January 2014 (See appendix). Stony Brook University's Program in Public Health has agreed to provide on-going analysis of the data collected from this survey. Each hospital or organization will establish the necessary memorandum of understanding (MOU) with the University, which will dedicate MPH candidates with proper professor mentorship to analyze the data and then report back to the Long Island Health Collaborative. Nassau County Department of Health already has a MOU in place with Stony Brook University. Each site will be responsible for data entry, program information, and other site-specific information. The metrics will be evaluated as they align with the Healthy People 2020 objectives as outlined in Chapter 2 of the CHIP. This partnership will monitor progress and refine strategies. The piloted questionnaire is available in the appendix and will be revised as needed.

Once data collection begins and Stony Brook is able to report findings, the LIHC will evaluate the intervention strategies. The collaborative plans to meet quarterly.

Chapter 5: Strategies and Practices

The Program Inventory details each program and strategy. The interventions fall into four main areas: education, screening, access to managed care and coordinating services for patient care. The programs listed in the inventory will be promoted through the Long Island Health Collaborative; the website will include links to the details of the programs. Several programs will be discussed below as examples of lessons learned that were incorporated into the design of "Walk! Long Island," the region-wide walking initiative (See Chapter 2).

The Nassau School Wellness Coalition is a collaborative program that administrates the obesity prevention program, Teen Wellness Trainers. The Coalition consists of Adelphi University, Asthma Coalition of Long Island, Nassau BOCES, Nassau County Dental Society, Nassau County Department of Health, Nassau County Council of School Superintendents, Nassau Region PTA, North Shore LIJ Health System, NuHealth Health Care Corporation, Stony Brook University Family Medicine and Student Support Services Western Suffolk BOCES. Nassau County School Wellness Coalition was formed to support school districts in the region in the reevaluation, or formation local wellness policies, as mandated by the WIC Reauthorization Act of 2004. School districts that participated in the Coalition's activities received assistance in accessing resources, identifying grant money for program implementation, performing school assessments and were granted formal recognition. The Coalition's goal is to establish strategies to help schools succeed in creating a sustainable, healthy, environment for the children of Nassau County by: engaging school staff, parents, students and the community in promoting health-enhancing behaviors and wellness; partnering with school districts to improve the nutrition, physical activity, and well-being of our children, working to make Nassau County healthy. The Teen Wellness Trainer program is a peer leadership training program that seeks to educate our youth about food, nutrition, and exercise with the goal of obesity prevention—a department of health priority. It is modeled after the evidence based peer education programs. [8] Schools play a large role in promoting healthy food choices through Health and Physical Education Curricula, as well as by creating and maintaining School Wellness Policies and Committees. To augment efforts within school districts, Nassau County School Wellness Coalition experts educate high school students on nutrition,

[8] http://www.fhi360.org/sites/default/files/media/documents/Evidence-Based%20Guidelines%20for%20Youth%20Peer%20Education%20Brief_0.pdf

body image, physical activity and food marketing and prepare them to "teach" age-appropriate lessons to these school districts' elementary students. High school students who complete the program by attending the workshop and delivering their lesson plan to elementary age children will receive Certificates of Completion. They may also receive community service hours if desired. Students and teachers complete pre and post surveys to evaluate knowledge gained. Coalitions members conduct observation of one elementary school lesson in each participating school district. Trends in improvement are evaluated. Additionally, the tracking of the number of school districts and repeat school district participants is continuous. This program has gained traction over the course of the past three years—its improved quality is the product of the changes made based on lessons learned over time. For example, attendance is best gained by using Nassau BOCES as a facilitator for registration, information and resources. Program changes include providing healthy lunches for students to take needed breaks. Teen Wellness Trainers may, in the future, incorporate mental health components related to body image and over/under eating.

Nassau County Department of Health is deploying a worksite wellness program, Healthy Health Department consisting of a lunchtime lecture series and a walking initiative for its employees.[9] This voluntary program was developed and implemented with New York Institute of Technology with which the department has a MOU. The program provides a monthly lunchtime series conducted by professors from New York Institute of Technology. The series addresses the priorities through topics like healthy snacking choices, fad diets, workplace stress, etc. The audience receives a post survey that evaluates program relevance and participant satisfaction. New York Institute of Technology is supporting and participating in the walking initiative. This is a team competition where participants track steps using a pedometer. The program will encourage staff to walk approximately four miles/day. In order to participate, staff must complete a pre-assessment, which measures some general behavioral questions relating to activity level and a baseline steps/day. The initiative will take place over the course of five months in the hopes of changing behavior for the long term. Metrics will include participation rates, improvement from the baseline measures over time, increases in knowledge and changes in behavior.

Chronic disease prevention and improved access to managed care is addressed within the health department's program of Social Health Initiatives and

[9] http://www.startwalkingnow.org/start_workplace_walking_program.jsp

Minority Health. This program follows a "Disease of the Month" schedule and provides outreach to minority populations in selected communities to address various diseases and conditions, such as cancer, diabetes, cardiovascular disease and asthma. Small community meetings are designed to educate and provide tools to the population who is at most risk, and provide information about linking residents to healthcare in the community.[10] A post survey assessing information gained is administered at the end of these sessions. This program was rolled out in 2013 and improvements occur on a continuous basis. For example, programs are conveyed with additional literature that is culturally accessible to the community. Participatory incentives are also offered, when available, to increase in the program.

Lessons learned from these programs, led to the development of "Walk! Long Island." The process of a successful and sustained collaboration was modeled after the School Wellness Coalition. Partners must share common goals and recognize the need for pooling resources. In addition, consistent representative attendance was necessary to maintain continuity since the Coalition's inception. The employee wellness walking initiative provides an instructive example of the benefits of motivation through team building, competition and socialization. Further, the internal desire to improve, changes behavior to improve health. Outreach through the minority health initiative has reinforced the need for culturally competent programs to elicit participation in the selected communities by providing accessible walking groups close to home.

[10] http://www.cdc.gov/minorityhealth/

Chapter 6: Maintaining Engagement

The regional collaborative, known as the Long Island Health Collaborative, is committed to maintaining its relationship for programmatic efforts and community engagement. The Nassau County Department of Health, in concert and aligned with the larger collaborative, will follow the following principles.[11]

Principle #1: Development of true partnerships, means creating relationships of mutual cooperation, benefits, and responsibility to ensure that results are achieved

This principle, while providing the foundation for creating partnerships, is also important to the maintenance of relationships and the expansion of the number of engaged stakeholders; formulating group consensus and committee decision are standard to the process.

Principle #2: Attention to community diversity and its role in engagement

Partners should represent a cross-section of the health community and the partnership will expand to continue to include other sectors that are not currently represented. Diversity of perspectives and experiences are necessary for the collaboration to remain strong. Even with diversity in perspectives, it is still necessary to maintain common ground and goals; the prevention agenda provides those shared priorities.

Principle #3: Identification and mobilization of community and stakeholder assets

Each stakeholder has different tools and resources that can be used collectively to address the prevention agenda priorities. Therefore, each stakeholder must be acknowledged for its role and the unique perspective that it brings to the process.

Principle #4: Evaluation of leaders' roles over time

The collaboration process is a long-term effort that requires each stakeholder and representative to remain flexible to the needs of the effort, as they may change during this process.

Principle #5: Participation is a long-term commitment to the collaboration

To maintain participation, in addition to other principles, each member needs opportunities to learn from its counterparts. Designating meetings to facilitate learning and information exchange will encourage each member's continuous engagement.

Principle #6: Participation in review and evaluation

[11] http://www.cdc.gov/phppo/pce/

In an effort to ensure that goals and objectives are being met, the collaborative group will schedule meetings during which such metrics and strategies will be discussed and improvements based on lessons learned will be implemented.

Principle #7: Coordination and schedule of meetings

The collaboration has decided that quarterly meetings will be held and organized by the Nassau-Suffolk Hospital Council. In some cases, smaller groups will be established, *ad hoc*. Examples of workgroups include the metric workgroup, the walking initiative workgroup, etc. These meetings will be prescheduled. The agenda will vary but will cover a plan that includes defining strategies for the prevention agenda, evaluating metrics, adjusting methods or programs, increasing resources for the network and the residents and identifying grants that will further support the collaboration.