Nassau County Department of Health and Long Island Health Collaborative: Interventions, Strategies and Activities, CHIP 2016-2018

Priorities: Reduce Obesity in Children and Adults and Improve Chronic Disease Management

Additional Focus Area: Improve Mental Health and Reduce Substance Abuse

Goal	***Outcome Objectives***	***Interventions/ Strategies/ Activities***	***Process Measures***	***Nassau County Department of Health Role***	***Resources from Nassau County***	***By When***	***Will action address disparity***
Engage community members in regional physical activity and wellness campaigns	1. Increase community and partner engagement through social media tactics 2. Promote the Are You Ready, Feet? ™ Campaign within community networks and increase participation in this region-wide physical activity campaign 3. Launch a consumer-facing website providing education and resources to the community 4. Launch a volunteer working group of students who will leverage social media expertise and existing personal networks to further engage community members 5. Host at least two public, consumer-focused walking events annually 6. Implement the recommendation for walking program within the primary care setting and engage participating physicians.	1. Social media reach 2. Engage community members in Are You Ready, Feet? ™ Campaign 3. Provide updated consumer-facing information on LIHC webpage 4. Establish LIHC Engagement Activation Partnership (LEAP) 5. Host community walking events 6. Establish physician Recommendation for Walking Program	1. Identify and track participation in effective social media strategies launched by the LIHC to promote the goal; collect analytics to reflect community engagement 2. Develop, distribute and track promotional tools; engage participants via social media strategies 3. Identify evidence-based resources for health information, collect input from LIHC members and clinical experts to build and continuously improve website. 4. Promote opportunity among networks, identify role and responsibility, and support LEAP team as they carry out goals and objectives; track student involvement 5. Involve key leaders including State and County officials, identify dates, locations and promote events. 6. Coordinate mailing to Long Island providers, work with Nassau County Medical Society to build programs	The Nassau County Department of Health has been a founding and instrumental member of the LIHC/PHIP. As such, the department staff provides leadership, guidance and active participation in the LIHC	Staff, distribute LIHC social media and Are You Ready, Feet? ™ campaign information to residents; promote LIHC website; distribute LEAP information to student interns and academic partners; attend, contribute by speaking, participate and promote walking events; research and lead in the design of recommendation for walking program with Commissioner endorsements.	The Population Health Improvement Program was initially established as a two-year program. In 2016, funding from New York State Department of Health was secured through January 2018, extending the program to three years. Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.	All LIHC activities are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they are CLAS appropriate and meet health literacy skills. LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes. The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.

Prevent or reduce childhood obesity in the underserved population	Well Play Hard is prevention initiative in the WIC program designed to help prevent childhood obesity and reduce long-term risks for chronic disease through the promotion of targeted dietary practices and increased physical activity.	Promote use evidence based and on-line educational resources available for WIC clients including the BMI Calculator, My Plate, Fit WIC, Breastfeeding and Community Programs; activities may be one-one or group counseling, as well	BMI information entered into database system; BMI tracked when placed on a High Risk Care Plan	NCDOH staff supervise and work in three WIC sites in the county	Nursing and dietetic staff provide obesity prevention education through counseling sessions available; material includes hard copy literature and resources.	The WIC program is ongoing and the Eat Well Play Hard prevention program is a USDA federally funded program; funding provides ongoing efforts.	WIC addresses health disparities as part of its function; the WIC program serves families with incomes at or below 185% of the federal poverty level
Improve an individual's under-standing, control and management of his/her cancer diagnosis, treatment and continuing care options. Support family members	Increase an individual's control over the disease diagnosis, decrease the sense of alienation, reduce anxiety about treatment, reduce misinformation and feelings of isolation and helplessness through individual and support activities	Nassau County Department of Health's Hewlett House is a community learning resource center for cancer concerns. Programs are free to all cancer patients, their families and friends.	Reporting on distribution of products such as wigs, bras, head coverings, prosthetics etc.; numbers of individuals attending group and individual sessions; new support groups and activities for cancer patients; educational materials	NCDOH staffs and supports Hewlett House activities	The Director of Hewlett House is fully supported in the NCDOH budget. Nassau County resources include maintenance of Hewlett House and continued commitment to maintain the County owned buildings and property to the organization	Nassau County is committed to serving this cancer patient population; The program is ongoing.	Hewlett House provides free products and educational information to those who are underserved or who do not have access to these support services.

Increase community awareness of Mental Health/Substance Abuse	1. Establish workgroup, identify strategies, meet regularly to address the need for increased awareness and focus on Mental Health and Substance abuse 2. Promote program to community partners and identify where/which organizations are certified to lead training 3. Commit to addressing mental health as a priority area by attesting and contributing to PPS strategies	1. Development of a mental health focused LIHC sub-workgroup 2. Increase availability of Evidence-Based Mental Health First Aid USA ™ training program for community members and front line healthcare workforce 3. Position strategies to support DSRIP Domain 4 projects related to addressing mental health	1. Identify leaders and advocates for those living with mental health and substance abuse issues, host first meeting, review data in support of strategies 2. Host evidence based program for LIHC members or employees of organizations who work with this population 3. Ensure PPSs are represented on Mental Health/Substance Abuse workgroup, communicate and present Domain 4 milestones related to MH/SA and identify strategies that the LIHC can support	Nassau Department of Health, while not the agency responsible for mental health and substance abuse issues, does promote mental health well-being for its staff and residents; NCDOH participates staff training and partners as appropriate with Nassau County Office of Mental Health, Chemical Dependency and Developmental Disabilities which charged with this oversight.	Nassau County Department of Health offered Mental Health First Aid to its staff; serves as a coordinating agency for the Nassau County Perinatal Network addressing mood disorders and links residents in need to partner agencies;	The Population Health Improvement Program was initially established as a two-year program. In 2016, funding from New York State Department of Health was secured through January 2018, extending the program to three years. Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.	All LIHC activities are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they are CLAS appropriate and meet health literacy skills. LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes. The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.

Leverage partnerships and achieve collective impact among LIHC community-partner network	1. Communicate with partners to understand activities occurring within communities 2.Identify potential partnerships and introduce compatible partners through Community Summits and other forums 3. Align objectives with organizations currently engaged in Complete Street work to increase sustainable, built environments 4. Ensure central locale for grant-partners to collaborate and streamline grant activities that support healthy eating and physical activity	1. LIHC will assess resource availability through network of community-partners 2. LIHC will promote collective impact strategies by leveraging existing resources and identifying partnerships 3. Support and participate in Complete Streets Policy work 4. Engagement of two synergistic grants in region: Eat Smart NY (USDA) and Creating Healthy Schools and Communities (NYS DOH)	1. Develop efficient surveys and polls which will capture information about parallel projects within Nassau County Communities. 2. Manage an ongoing involvement in partnerships with continued effort to streamline activities 3. Work closely with Local Health Departments and organizations engaged in Complete Street work, identify opportunities for partnership or support 4. PHIP to participate in grant-partner meetings, share initiatives which can be used to meet grant deliverables and identify community-partners who may be working in at risk communities on similar projects	The Nassau County Department of Health has been a founding and instrumental member of the LIHC/PHIP. As such, the department staff provides leadership, guidance and active participation in the LIHC	Nassau County Department of Health facilitated partnership between LIHC and Department of Public Works in Nassau County to implement Complete Streets Policy; encouraged participation of health department's partners in community networks; participated in Complete Streets, nutrition and wellness workgroup	The Population Health Improvement Program was initially established as a two-year program. In 2016, funding from New York State Department of Health was secured through January 2018, extending the program to three years. Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.	All LIHC activities are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they are CLAS appropriate and meet health literacy skills. LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes. The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.

Support and increase Evidence-Based Community-Programming Efforts	1. Promote and advance evidence-based community programs 2. Support DSRIP efforts to increase programming throughout the region	1. Connect members with providers of Stanford Model programs including: Diabetes-Self Management Program and Chronic Disease Self-Management program 2. Partner with DSRIP PPS to increase program availability.	1. Establish relationship with key providers of this program, PHIP staff member to become trained as a DSMP peer-leader and lead programs within the community setting 2. Work in partnership with PPS to identify community locations where Stanford Model programs will take place	The Nassau County Department of Health Commissioner supports DSRIP activities;	Staff engages in identifying and developing evidence based, model practices and promising practice programming	The Population Health Improvement Program was initially established as a two-year program. In 2016, funding from New York State Department of Health was secured through January 2018, extending the program to three years. Activities extending beyond the January 2018 timeframe will be executed, with limitations, by way of the Long Island Health Collaborative without funding support from the Population Health Improvement Program.	All LIHC activities are developed with elimination of health disparities as an overarching goal, essential to increasing quality of life for all individuals in Nassau County. Prevention strategies are reviewed by a CLAS workgroup to ensure they are CLAS appropriate and meet health literacy skills. LIHC partners work within communities which have been identified as being at high risk for health disparities. Community-partners work together in these communities to combine efforts leading to better outcomes. The PHIP data workgroup is collecting and analyzing data which will reinforce collective efforts to reduce health disparities.