

# COMMUNITY HEALTH NEEDS ASSESSMENT 2025 - 2027



**Northwell**  
Health®

*Prepared by*

The Institute for  
**COMMUNITY HEALTH  
AND WELLNESS**  
Northwell Health

# MESSAGE FROM OUR LEADERS



John D'Angelo, MD

A handwritten signature in black ink, appearing to read "John D'Angelo".

President and CEO  
Northwell Health



Debbie Salas-Lopez, MD, MPH

A handwritten signature in black ink, appearing to read "Debbie Salas-Lopez".

Executive Vice President  
Institute for Community  
Health and Wellness  
Northwell Health

Dear Neighbor,

We're writing to our neighbors and partners because our health—and our future—is shared. Our community is strongest when everyone has what they need to thrive. Health is more than medicine; it's caring for the whole person and making sure people can get the right care at the right time, close to home.

We are not doing this alone. Our progress is powered by partners—community organizations, faith leaders, local government, and Northwell teams across clinical, digital, data, and operations—working side by side to “Raise Health for All.” Since our 2022 Community Health Needs Assessment (CHNA), we have listened and acted. You told us about the impact of chronic disease, challenges in accessing routine care, and the rising need for mental health, maternity, and child health services. We responded by expanding school-based behavioral health, integrating behavioral health into maternal programs, and strengthening access to primary care and chronic disease management in our neighborhoods.

We formally established Northwell's Institute for Community Health and Wellness (ICHW), marking a significant step in strengthening our partnerships with the community. This commitment underscores our shared vision of improved health outcomes and thriving neighborhoods. By aligning our health system with your expertise, we aim to be more visible and accessible, ensuring seamless collaboration on the issues that matter most to your community.

We also recognize that health is shaped in everyday life—in homes, schools, and workplaces—so we are investing upstream, co-creating long-term solutions with you and our partners. We have increased efforts to build local capacity: expanding educational opportunities for youth, growing workforce pathways, and strengthening community resilience.

This year's CHNA findings confirm these needs and the work ahead. In the pages that follow, you will see what we have learned and the programs and partnerships we are advancing to meet your health care needs. Our efforts are data-driven, evidence-based, and aligned with New York State public health strategies. While the programs in this Executive Summary are representative, additional site-specific initiatives can be found in each hospital's Community Service Plan and in our Implementation Plan.

Together—with you—we will keep removing roadblocks and building practical solutions so every person and family can live their healthiest life.

Thank you for your partnership.

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# WHO WE ARE

**We are Northwell Health. A different kind of health system.**

We play a leading role in keeping New Yorkers healthy and employ clinical, human, intellectual and financial resources to make life better for the individuals, families, and communities we serve.

## OUR MISSION

Provide world-class services and patient-centered care for the people and communities we serve.

## OUR VISION & BRAND PROMISE

Our vision is to be recognized as a world-class leader in delivering the highest quality, compassionate, and innovative medical care.



## CULTURE OF C.A.R.E.

Our foundation—grounded in Connectedness, Awareness, Respect and Empathy.

## OUR EMPLOYEE PROMISE

It's our promise to each other. It's what you get, for what you put in. Built by the people, for the people.

In pursuit of this mission and vision, Northwell is focused on patient experience, and the principles of inclusivity that places patients and our communities first. While we may be New York's largest health system, advancing health care for all means more than just patient care. It means community health, access to care, education, research, innovation, and partnering with like-minded organizations—all with the idea of advancing better health for all.

# OUR VALUES AND COMMITMENT

Value	Truly <i>Compassionate</i>	Truly <i>Innovative</i>	Truly <i>Ambitious</i>	Truly <i>Together</i>	Truly <i>Inclusive</i>
<b>Our commitments</b>	<b>Care deeply</b>	<b>Be actively curious</b>	<b>Take the initiative</b>	<b>Support each other</b>	<b>Cultivate belonging</b>
<b>How we do it</b>	We deliver care that values the whole person and their unique needs ----- We're respectful and kind to each other	We seek new solutions and challenge the status quo ----- We learn from our errors and make improvements	We stay focused and flexible in the face of uncertainty ----- We view change as opportunity to learn and grow	We're reliable and help each other ----- We're one team	We're open to learning from each other ----- We value each other's unique backgrounds, experiences and perspectives
<b>How we lead</b>	<b>Model kindness and empathy</b>	<b>Empower every team member</b>	<b>Unlock potential</b>	<b>Build trusting teams</b>	<b>Foster a safe and inclusive environment</b>

# WHO WE ARE

## We are the largest not-for-profit health care provider in the Northeast.

We are the largest not-for-profit health system in the northeast. With 28 hospitals, over 1,050 primary and specialty care ambulatory facilities and more than 13,500 affiliated physicians, Northwell is New York State's largest health care provider and private employer. Our 104,000 team members—including over 22,000 nurses, and over 7,300 employed doctors and over 3,700 volunteers -- are committed to redefining the standard of care.

We have one of the largest emergency response, transport (air/land), and emergency management programs on the East Coast, that supplement and support local public health responses. Our systemwide core laboratory has a capacity and throughput that rivals the largest commercial operations in the region.

We operate our own mail-order/retail pharmacies and a group purchasing organization to ensure competitive pricing, and an internal flexible staffing agency to help mitigate labor shortages. We are a major economic engine for our region, generating more than 50% of our revenue outside the walls of our hospital.

We are truly a dynamic, innovative, integrated health care learning organization, whose ability to adapt, reach and impact individuals and communities stretches far beyond our hospital doors, research labs, and classrooms. Our influence and commitment to care is found in our neighborhoods, addressing health crises throughout the nation and providing global health initiatives throughout the world.



## We are caring for people at every stage of life.

Under the Institute for Community Health and Wellness, we are leading community and population health initiatives to offer a full spectrum of care to meet the most vulnerable among us, and advance health for all. Northwell has developed one of the largest networks of patient centered medical homes in the nation and is the second largest Medicaid and behavioral health provider in New York.

We deliver more cancer care to New Yorkers than any other health care provider, deliver more babies than any other provider in the state, and have one of the largest medical residency and fellowship programs in the country.

# WHO WE ARE

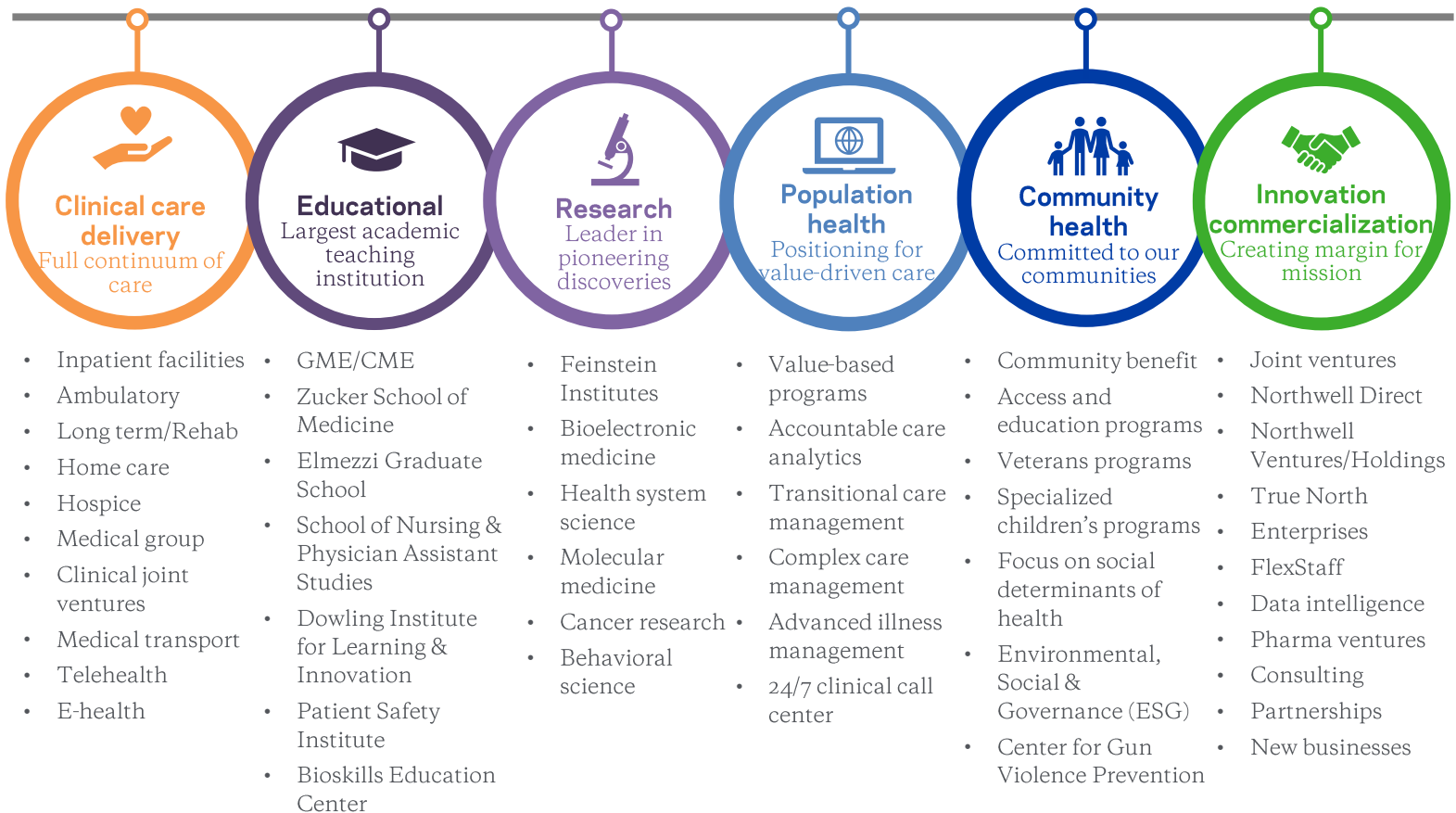
## We are an ever-evolving organization.

In addition to our hospitals, we have a coordinated network of primary, urgent, and specialty ambulatory care, as well as hospice, emergency, and long-term care provided in the home, community, and specialized facilities.

We are making new and innovative breakthroughs in science and medicine, through our Feinstein Institute for Medical research (FIRM) and we're training the next generation of health care professionals at the Zucker School of Medicine at Hofstra/Northwell and the Hofstra/Northwell School of Nursing and Physician Assistant Studies.

Our health system is a robust educational institution always aspiring to expand its academic endeavors to include innovative professional training and educational programs. It is a community-based social services organization and an incubator of new companies exploring new technologies to improve the health and wellbeing of our communities.

## Shared clinical and management services



# OUR FOOTPRINT

## ECONOMIC IMPACT



**28 hospitals**

**\$22.6 billion**

annual operating budget

**104,000+**

employees

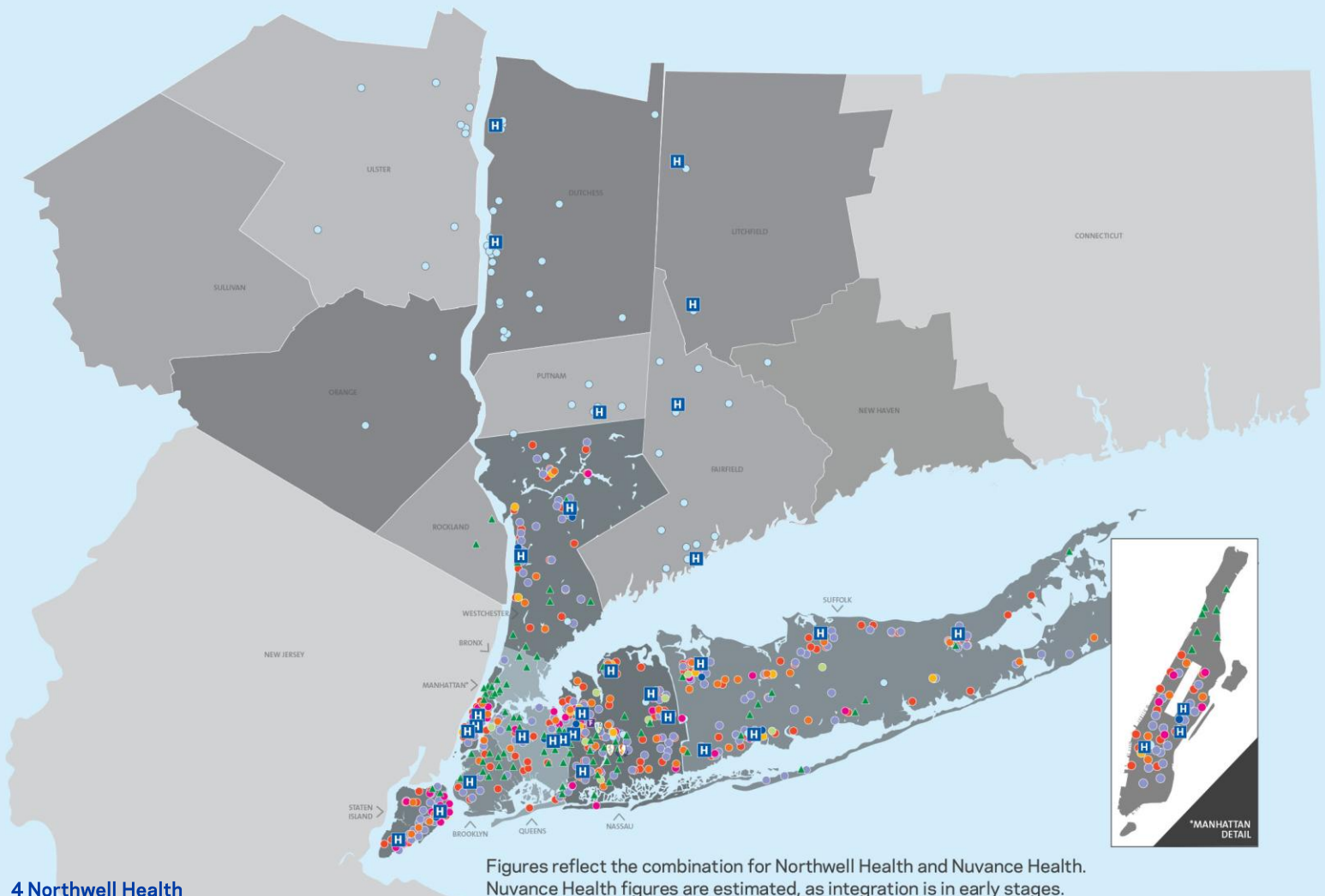
Largest private employer in New York State

**11** Magnet<sup>®</sup>-designated hospitals

**1,050+**  
ambulatory facilities

**\$1.6 billion**  
capital budget

**13.2 million**  
total service area population



Figures reflect the combination for Northwell Health and Nuvance Health. Nuvance Health figures are estimated, as integration is in early stages.

## CAREGIVERS



**13,500+**  
credentialed  
physicians

**7,300+**  
employed physicians  
Largest Physician Group  
in the New York Area

**4,500+**  
advanced  
care providers

**22,000+**  
nurses

**2,400+**  
residents & fellows  
in 220+ programs

**3,700+**  
volunteers

## OPERATING STATS



**1.1 million+**  
emergency visits

**280,000+**  
ambulatory surgeries

**37,000+**  
births

**5,000+**  
active clinical  
research studies

## COMMUNITY IMPACT



**\$2.7 billion**

Total benefit to  
the community  
(including  
charity care)



# ACHIEVING SYSTEMNESS

**We have been successful because for the past two decades, we have focused on achieving “systemness.”**

Systemness is the ability of a multi entity health system to operate as one coordinated organization—sharing goals, data, standards, and resources—so patients experience seamless, consistent, high-quality care wherever they enter the system. In practice, it means common clinical pathways and business policies, unified leadership and accountability, and the flexible movement of people, expertise, and supplies across sites to meet need.

**Systemness is an essential and foundational component of Northwell’s vision, culture, operating model, and identity.**

In the formative years of our health system, we realized that achieving scale is not enough. Most importantly, we understood the ability to use that scale to its full advantage was based on a need to develop an integrated sense of systemness and hardwire that concept into our culture.

Pursuing a culture of systemness required Northwell to foster integration across its clinical service lines. That integration allowed us to consolidate functions, standardize best practices and move team members and resources wherever and whenever needed. Systemness is the reason we operate as a team-oriented matrixed organization with unified leadership. We are aligned through systemwide policies, procedures, and processes to ensure we are providing the right care in a consistent and standard approach—promoting quality and safety while also providing the best experience possible for our patients, providers and team members.



**Mission driven**



**Philosophy & culture**



**Collaborative & team-based**



**Clinically integrated continuum of care**



**Social responsibility**



**Single standard of care**



**Broad geography**



**Unified governance**



# OUR STRATEGIC PRIORITIES



## *Broadening our mission*

Deepening and expanding partnerships with community and faith-based leaders, formalizing our efforts establishing an Institute for Community Health and Wellness, to integrate our efforts, raise long-term funding, and educate our workforce to advance health for all.

## *Reimagining and redesigning care delivery*

Enhancing transitions of care across the continuum, implementing more age-friendly programs, improving access to patient care, reimagining digital solutions to improve clinician and patient experience.

## *Creating lifelong customer-patient loyalty*

Optimizing care access and convenience, promoting transparency, and enhancing team member training.

## *Marketing our brand*

Differentiating ourselves through our mission work, selectively drive thought leadership, building a national brand through physician-to-physician reputation-building, and promoting our Raise Health story.

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# OUR STRATEGIC PRIORITIES

## *Enhancing performance by optimizing technology*

Driving rapid and continuous delivery of technology solutions; build an experience-driven, hyper-connected, and intelligent health care ecosystem to enable innovation and reimagine care delivery models to be coordinated, simple, intuitive through advanced and innovative digital solutions.

## *Advancing our culture of continuous learning and human capital investment*

Evolving our ecosystem for learning and development; advancing strategies that promote inclusion, engagement and productivity.

## *Accelerating the advancement of research, discovery and innovation*

Bringing research and clinical trials to all communities we serve; building the “next generation” curricula educating scientists, researchers and medical professionals; expanding the breadth and scope of successful research and academic collaborations.

## *Broadening our footprint and impact*

Targeting growth in current service areas and entering new ones; grow in core areas such as cancer, cardiac, neurosciences and orthopedics; and build partnerships, joint ventures, and collaborations.

## *Business diversification and value creation*

Continuing to accelerate business diversification and enhance margin—and build new structures and policies that facilitate such expansion; expand investments in companies that enhance clinical care and program development.

## *Infrastructure modernization*

Aiming to design and build world-class healing environments, as well as building systems that reduce carbon footprint and enhance sustainability; incorporate an asset management program; continue to develop alternative delivery systems to maximize capital investment and modernization.

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# NORTHWELL'S INSTITUTE FOR COMMUNITY HEALTH AND WELLNESS

Our commitment to the health of our communities is what defines us. We seek to provide the best possible care to all, regardless of their ability to pay with a focus on education and prevention. Aligned with our strategic priority to broaden our mission, we established Northwell's Institute for Community Health and Wellness (ICHW, or the Institute). We at the Institute are dedicated to co-creating solutions with our communities to measurably improve the health and wellbeing of those we serve. Our work is embedded in Northwell's mission, vision, values, and culture to Raise Health for All.

**We are going upstream, proactively addressing health concerns while working towards lasting change and building resilience within our communities.**

As the largest integrated provider network in the nation's Northeast region, we are uniquely positioned to advance greater access to high-quality, culturally responsive, acute and preventive care for our communities, including the economically disadvantaged, and our neighbors with higher health care burdens, access barriers, and high unmet social needs.

**And we are not doing this alone.**

We have built a foundation of trust and a network of partnerships who are aligned with our mission. With community leaders, faith leaders, local government, educators, tribal nations, law enforcement, and most importantly, our community members, we are developing and implementing innovative and evidence-based programs across our communities.

We are meeting our neighbors where they are, focusing on co-creating solutions to improve access to primary, preventive, and specialty care, and addressing the health-related social needs of the communities we serve.



# NORTHWELL'S INSTITUTE FOR COMMUNITY HEALTH AND WELLNESS

Our work is organized into four key pillars:



...both inside and outside our walls

**We have a presence in many unexpected places, including:**

- Middle schools and high schools, providing behavioral health, anti-bullying, violence intervention and other educational programs while also introducing young people to potential careers in healthcare - creating a pipeline for the physicians, scientists and healthcare professionals of tomorrow.
- Community centers dispensing flu shots and vaccines.
- Senior centers and caregiver wellness programs, where we advise those who are burdened by ill health and have nowhere else to turn.

- Churches and other faith-based institutions, where we meet with religious leaders and their congregants to better understand and offer solutions to the issues impacting their communities.
- Street fairs, parades and special events, presenting health and wellness information, addressing food insecurity, and ensuring access to needed services.

By expanding our reach and developing relationships within the communities we serve, we can embrace the endless changes throughout the healthcare industry and seek opportunities in multiple arenas because of the long-established culture, mission and leadership values that continue to serve as a guiding light.

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# WHAT IS THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)?

The Community Health Needs Assessment (CHNA) is a foundational, data-driven, and community-engaged process that informs us how we identify significant health needs, set priorities, and develop the companion Implementation Strategy to address those health needs and priorities. This has been a regulatory requirement since the Affordable Care Act (ACA) was signed into law on March 23rd, 2010, where all tax-exempt not-for-profit hospitals and health systems are required to conduct a Community Health Needs Assessment (CHNA) every three years and develop an Implementation Strategy to address those needs. Beyond a requirement, it is an important initiative to help us listen, learn, prioritize, and partner with our communities to set direction and co-create solutions to address our major health needs.

## **Listen. Learn. Prioritize. Partner.**

We align our efforts with the New York State Prevention Agenda, the state's six-year health improvement plan (SHIP), which sets shared priorities and objectives to improve health and reduce disparities across New York. The Prevention Agenda framework for 2025-2030 has a strong emphasis on prevention and social determinants of health, provides a roadmap for integrated action between local health departments, hospitals, health systems and community partners. The NYSDOH Prevention Agenda framework aligns closely with Healthy People 2030, the United States' 10-year national plan for improving health and well-being, as led by the US Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

Northwell's CHNA process is led by the Institute for Community Health and Wellness (ICHW) with a dedicated CHNA Steering Committee. The CHNA and its companion Implementation Strategy are reviewed and approved by executive leadership and Northwell's Board of Trustees. It is also publicly posted and shared with our community partners. Our progress on the Implementation Strategy is monitored and reported annually, consistent with NYSDOH guidance and the IRS 501(r) requirements.

# SINCE OUR 2022 CHNA

## Building the infrastructure

In direct response to what we learned in 2022, we elevated our community health work from a department to Northwell's Institute for Community Health and Wellness (ICHW)—our systemwide hub for community engagement, population health programs, and development of our community health improvement strategy through the CHNA and Implementation Plan process. In collaboration with site partners, the Institute now coordinates over 145 programs across in more than six counties. This structure enables more strategic and flexible community partnerships, faster program execution, and closer alignment with community priorities.

## Addressing our 2022 priorities

The 2022 CHNA identified three priority health needs: disruptions in chronic care, worsening mental health, and barriers to maternal and child health. Below is a summary of what our strategic response has been.

### Chronic Care Continuity

- Expanded partnerships with community health centers and Federally Qualified Health Centers (FQHCs) to increase access and care navigation across our service area.
- Strengthened the Health Management division to enhance care continuity and reduce preventable ED use and unnecessary hospitalization among high-need patients.
- Advanced upstream efforts to address health-related social needs, including nutrition security, to better manage hypertension, diabetes, COPD, and cardiac disease.

### Maternal and child health

- Expanded antepartum education to promote prenatal health.
- Embedded screening protocols and integrated behavioral health services into perinatal care.

### Youth and behavioral health

- Expanded our school-based behavioral health clinic network.
- Partnered with educational institutions to build internships, apprenticeships, and career pathways to support long-term economic vitality.



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# COMMUNITY BENEFIT AND PARTNERSHIPS

In 2024, Northwell invested approximately \$2.7 billion in community benefit -including charity care and financial assistance, community health programs, workforce education and training, and research—across New York City, Long Island, and Westchester.

We continue to advance this work with our Community Health Advancement Taskforce (CHAT), a network of community-based organizations, schools, local and county agencies, tribal nations, and community advocates, and our faith leaders' group (comprising of over 250 interdenominational members).

**Northwell  
invested \$2.7  
billion in  
community  
benefit in 2024.**

## LOOKING AHEAD...

We will continue to collaborate with partners, break down barriers to care, and expand access and opportunities, so that individuals and families in our communities have the foundation to reach their fullest potential for health and well-being. The sections that follow provide:

- An overview of our 2025 CHNA process; and
- Representative community health programs from our Implementation Plan.

Additional hospital-specific initiatives are detailed in each hospital's Community Service Plan and in the systemwide Implementation Plan.



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# NORTHWELL HEALTH CHNA 2025

We view the CHNA as more than a step toward compliance. It is a framework for listening and learning from our communities so we can set priorities and partner to co-create effective, lasting solutions. For this cycle, we focused on the six counties in our downstate New York service area: Nassau, Suffolk, Queens, Staten Island (Richmond), Manhattan (New York), and Westchester.

In February 2024, Nuvance Health became part of Northwell Health, bringing new opportunities to work together and strengthen community health across a broader region. As part of regulatory requirements, this 2025 Community Health Needs Assessment (CHNA) filing includes only those hospitals that were part of Northwell Health prior to the Nuvance integration.

As Northwell and the newly integrated teams continue to move forward together, we are committed to working side by side to understand the needs of all communities we serve. This expanded partnership will allow us to co-create solutions, share best practices, and scale innovative programs to improve the health of individuals and families across new markets, helping to ensure sustainable, long-term impact for our communities.

## **Establishing our CHNA Steering Committee**

We began preparations in early 2025 after submitting our 2024 annual update to NYSDOH. In January, the Institute for Community Health and Wellness (ICHW) reconvened our CHNA Steering Committee. The committee includes leaders from public health, research, operations, strategic planning, community health, and hospital sites.

We also engaged subject matter experts and internal partners from the Office of Patient and Customer Experience (OPCE), Office of Strategic Planning, and the Feinstein Institutes for Medical Research (FIMR) and its Institute of Health System Science (IHSS). Externally, we participated in and supported the CHNA/CHA processes of key partners such as the Long Island Health Collaborative (LIHC) and the Westchester County Department of Health. Together, we set the CHNA roadmap to align with national best practices, the NYS Prevention Agenda (2025–2030), and federal 501(r) requirements.

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# NORTHWELL CHNA 2025

## Gathering Information

We used a mixed-methods approach, combining what we heard from residents and community leaders with existing health and social data to build a clear picture of community needs.

### Direct Community Input (*Primary Analysis*)

1. *Community Health Survey (CH Survey)*: We designed a brief, 34-question survey for adults (18+) to capture health experiences and top concerns. We deployed it through Press Ganey patient lists, Innovaire kiosks, GoHealth Urgent Care Centers, and with support from the Community Health Advancement Taskforce (CHAT) and hospital community teams.
2. *Focus group discussions*: We held 12 in-depth focus groups. Six were county-specific across our service area. Six focused on specific topics and populations: women and children; LGBTQIA+ individuals; climate and health; faith leaders; Healthier Communities initiatives; and tribal nations. Participants included community health experts and leaders from community-based organizations.
3. *Community leader survey (CBO survey)*: We fielded a targeted survey with our community-based organization partners to complement the CH Survey and focus groups and to ensure we reached stakeholders who needed a stronger voice.
4. *Listening tours*: We continued ongoing listening tours—participating in community groups, events, workshops, and classes—to stay close to changing needs and perspectives.

### Health and Social Data (*Secondary Analysis*)

We reviewed health status and hospital/ED utilization trends; epidemiology and vital statistics; social and climate vulnerability indices; and reports from local, state, and national agencies. These sources helped us understand broader patterns of access and need, and how our communities compare with benchmarks and targets.

## Prioritizing Health Needs

After gathering input and data, we reviewed our findings and applied established frameworks to determine the health needs that would define our priorities and shape our Implementation Strategy.

## Reporting and Approval

We compiled the findings and recommendations into the CHNA and the companion Implementation Plan for executive and Board approval, followed by public posting and sharing with community partners. We complete a CHNA every three years and provide annual progress updates consistent with NYSDOH guidance and IRS 501(r) requirements.



# VOICES FROM OUR COMMUNITIES

Key Findings  
from our 2025  
CHNA Survey  
and Focus  
Groups

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# COMMUNITY FOCUS GROUP DISCUSSIONS

## Community Voices at the Center: Our Focus Group Process

We sought to place community voices at the center of our CHNA. With this intention as a guiding principle, Northwell's Institute for Community Health and Wellness convened focus group discussions to learn from a broad range of community leaders. We organized 12 focus groups: one for each of county of our service area (Westchester, Suffolk, Nassau, Queens, New York (Manhattan), and Richmond (Staten Island)); and six additional groups focused on specific themes or populations: Women & Children's Health, Climate & Environment, LGBTQ+ Health, Immigrant Communities, Faith Leaders, and Tribal Nations.

## Participant Recruitment

Focus group participants were recruited in collaboration with Northwell team members, including our employee resource groups, and community partners. Each group aimed to include around six participants representing a diversity of perspectives and experiences. Participants received invitations by email and Microsoft Teams, with attendance and contact information managed securely to ensure confidentiality. A total of 72 individuals participated in the focus groups. Many spoke as advocates or professionals engaged with underserved communities, offering insights drawn from their daily interactions with children, families, newcomers, seniors, and other vulnerable populations.

## Qualitative Data Collection

Each focus group followed a structured moderator guide to promote open discussion of community needs and solutions. Groups were held virtually and moderated by two trained facilitators. Informed consent was obtained prior to participation, with assurances of confidentiality and anonymity. All sessions were video recorded and transcribed for analysis.

Transcripts underwent rigorous review to ensure accuracy and the removal of identifying information. Participants' comments were entered individually into a digital spreadsheet for analysis. Using a codebook based on the New York State Department of Health Prevention Agenda, and refined to include emerging themes, each comment was systematically categorized to capture major topics and concerns.

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# COMMUNITY FOCUS GROUP DISCUSSIONS

## Thematic Analysis

A total of 56 distinct themes emerged from the discussions. The analysis generated detailed summaries of recurrent themes and high-priority community issues. To further enhance insight, de-identified transcripts and codebooks were explored using advanced large language models (LLMs) including GPT-4.1 and Gemini 2.5 Pro. Key findings were then validated and refined by the research team before being compiled for inclusion in this system-wide report and county-specific CHNA reports.

This multi-step approach ensured that the perspectives of community leaders are authentically represented and provide valuable guidance for Northwell's ongoing work to advance community health. By listening to a broad cross-section of community leaders and residents—from faith leaders in Queens, to tribal representatives on Long Island, to LGBTQ+ advocates in Manhattan—this assessment goes beyond statistics to illuminate the daily realities, persistent struggles, and sources of hope that shape community health. What follows are the key insights and lived stories that emerged when people were given space to speak in their own words.

### 6 Counties



Queens, Manhattan,  
Richmond, Nassau,  
Suffolk, Westchester

### 6 Thematic Discussions



Women & Children,  
LGBTQ+, Climate &  
Health, Faith Leaders,  
Healthier Communities &  
Tribal Nations

### 72 Community Leaders



# COMMUNITY FOCUS GROUP FINDINGS

## Cost and Affordability: A Persistent Challenge

Focus group discussion participants from every corner of the region shared that people in their communities' health care decisions are often shaped by financial concerns. The cost of insurance, out-of-pocket expenses, and even uncertainty surrounding pricing can act as powerful deterrents to seeking and obtaining needed care. As a participant from Westchester put it: "People say, 'Don't call an ambulance because I can't afford the bill'... the hard economic factors are a big, big driving force." (Westchester County)

Another participant observed, "Even if you get health insurance, the costs and co-pays are significant for so many of our patients." (Immigrant Communities) For a participant from Queens, the tug-of-war between basic needs and health care was summed up by, "If it's between paying rent or going to the doctor, people are going to choose surviving."

*People say, 'Don't call an ambulance because I can't afford the bill'... the hard economic factors are a big, big driving force.'*  
(Westchester)

Similarly, participants working with older adults described financial constraints leading to hard choices for many in this population group: "Seniors choose which medications to buy each month because they can't afford them all." (Westchester County)

*"If it's between paying rent or going to the doctor, people are going to choose surviving."* (Queens)

These reflections from those who serve communities on the frontlines highlight *the ripple effect of financial uncertainty on decisions to seek health care* for those in our communities who have limited resources. Several participants called out the lack of universal medical care as a root cause of poor health for people with limited care access.

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# COMMUNITY FOCUS GROUP FINDINGS

## Barriers Beyond Cost: Navigating Systems, Language, and Culture

### Accessing Care Depends on Trust

Beyond affordability, participants described additional barriers that make the healthcare system hard to navigate—particularly for immigrant families, those with limited English, and other chronically underserved groups. Bureaucratic hurdles like confusing documentation or eligibility requirements leave some people unsure of where to turn. As one participant who supports immigrant families explained, “A lot of our community is scared to go for checkups or to the emergency room.” The hesitation isn’t always about cost; fear of other risks when seeking care can also erect a barrier to access.

### Cultural and Linguistic Responsiveness are Crucial

Cultural and linguistic factors can further complicate timely access to care. A participant in the Women and Children’s Health group expressed, “Even when families have insurance, they struggle to find a provider who speaks their language, is nearby, and can see them quickly.” Mental health services in languages other than English were described as especially hard to access.

Participants across groups highlighted that true access isn’t only about translation, but about cultural understanding. One advocate observed, “It’s not just language, it’s cultural barriers. Patients don’t always feel comfortable or understood by providers who don’t share their background.” Trust in the healthcare system, especially for LGBTQ+ community members, often depends on whether care is affirming and responsive: “People are still hesitant after past treatment. They want to know their identity and experience matter.”

### Customized and Timely Health information

Some participants voiced concern over the lack of tailored health information regarding environmental risks that compound health inequities. They noted that issues such as air quality, pollution, extreme heat, and climate events are often “invisible” drivers of poor health—and that the most impacted communities frequently lack access to practical information on these risks. As one Climate and Health focus group participant put it, “Air quality is important, but a lot of our community isn’t getting messaging—language is a huge barrier.” Environmental factors add another layer to the challenge of building trust and navigating care barriers, particularly where information is not translated or accessible.

In summary, participants emphasized that insurance alone may not ensure timely and appropriate health care. *A web of administrative, linguistic, cultural, and environmental factors can also stand between people and the health services they need.*

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# COMMUNITY FOCUS GROUP FINDINGS

***“A lot of our community is scared to go for checkups or to the emergency room.”***  
*(Healthier Communities)*

***“Even when families have insurance, they struggle to find a provider who speaks their language, is nearby, and can see them quickly.”*** *(Westchester)*

***“Air quality is important, but a lot of our community isn’t getting messaging—language is a huge barrier.”*** *(Climate & Health)*

***“It’s not just language, it’s cultural barriers. Patients don’t always feel comfortable or understood by providers who don’t share their background.”*** *(Maternal & Child Health)*

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# COMMUNITY FOCUS GROUP FINDINGS

## Transportation: Obstacles on the Road to Care

In addition to the systemic and relational barriers discussed above, lack of transportation emerged as a significant factor impacting health care access in several communities. Participants in Westchester, Suffolk, and Staten Island described how unreliable transportation—whether due to limited public transit options or geographic isolation—can prevent individuals from seeking both routine and specialized medical care.

*“Public transportation is a huge obstacle...sometimes you arrive late and can’t be seen.” (Suffolk)*

As a service professional working in Westchester explained, “To get to the doctor in northern Westchester without a car or ride... that’s huge.” (Westchester County) The challenge is similar in Suffolk County, where “Public transportation is a huge obstacle...sometimes you arrive late and can’t be seen.” (Suffolk County) On Staten Island, one participant summed up the local reality: “Staten Island is a transit desert. If you don’t drive, it’s next to impossible to keep specialist appointments.” (Richmond)

These statements highlight that, despite the theoretical availability of healthcare services, lack of reliable transportation can transform accessibility into an urgent health access problem. When individuals are cut off from reliable transit, delays and missed opportunities for preventive care become unavoidable. People may seek emergency services only when absolutely necessary—often waiting until health problems worsen and become unmanageable. Ultimately, *the region’s transportation gaps help create a healthcare environment that prioritizes crisis management over prevention*, amplifying barriers for those living in transportation “deserts.”

*“Staten Island is a transit desert. If you don’t drive, it’s next to impossible to keep specialist appointments.” (Richmond)*

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# COMMUNITY FOCUS GROUP FINDINGS

## The Impact of Unmet Social Needs

Participants repeatedly drew attention to the central importance of basic necessities. Housing instability and food insecurity were described as pervasive, daily obstacles affecting the health and lives of many community members struggling to get by.

### Housing Burden

One Queens County participant observed, “[Lack of] affordable housing is at an all-time high. If you’re unhoused or in unstable housing, everything else falls apart.” (Queens County). A Manhattan participant described the isolating effect of rising costs: “We have a lot of families that have been priced out so...the parents stay because they’re in these rent-stabilized or they own their place, but the families can no longer afford to live here. So, they [elderly parents] are in the hospital by themselves.” (Manhattan)

### Food Insecurity

Food insecurity—described as a challenge of both access and affordability—was frequently raised as a concern. One participant shared, “We have a lack of fresh food in our communities. Diabetes and hypertension are ravaging southeast Queens.” Another concurred, “Our pantries are definitely understocked and it’s affecting families’ health.” (Queens County) These challenges, several noted, are not limited to urban settings but affect families in many neighborhoods, especially seniors on fixed incomes families with children. Participants also reported that, even when community food pantries or assistance programs are available, the scale of need often far surpasses what local supports can provide. For many families, the high cost of nutritious food—and the presence of “food deserts”—push healthy diets out of reach, making the management and prevention of chronic diseases even more difficult.

In response to these challenges, several participants recognized the critical role of existing community assets—including faith leaders, local organizations, and informal networks. They described how, despite fragmented systems, these trusted figures outfit support beyond formal services. As one faith leader shared, “we see the needs week in and week out—mental health, housing, food. Sometimes we’re the first call, not the last.” These partnerships help fill gaps and often serve as anchors for those struggling with poverty, loss, or trauma. These testimonies from those who serve affected populations reinforce how social and economic barriers shape health on every level. *The cumulative effect: health outcomes determined less by personal choice and more by whether basic resources are within reach.*

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# COMMUNITY FOCUS GROUP FINDINGS

*“[Lack of] affordable housing is at an all-time high. If you’re unhoused or in unstable housing, everything else falls apart.” (Queens)*

*“We have a lot of families that have been priced out so...the parents stay because they’re in these rent-stabilized or they own their place, but the families can no longer afford to live here. So, they [elderly parents] are in the hospital by themselves.” (Manhattan)*

*“We have a lack of fresh food in our communities. Diabetes and hypertension are ravaging southeast Queens.” ...“Our pantries are definitely understocked and it’s affecting families’ health.” (Queens)*

*“We see the needs week in and week out—mental health, housing, food. Sometimes we’re the first call, not the last.” (Faith Leaders)*

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# COMMUNITY FOCUS GROUP FINDINGS

## Mental and Behavioral Health: Crisis and Access

No theme resonated more strongly across the focus groups than the urgent need for mental and behavioral health services, especially for young people and families. Participants from nearly every community described a rise in anxiety, depression, and mental health crises, especially among youth, since the onset of the COVID-19 pandemic. One leader from Staten Island captured the gravity by stating, “We’re seeing a crisis among our youth and young adults—higher [suicidal] ideation and attempts at very young ages.” (Staten Island) This sense of alarm was echoed by a participant from Queens, who noted, “Mental health crises are getting younger. Guidance counselors alone aren’t enough.” (Queens County)

***“Mental health crises are getting younger. Guidance counselors alone aren’t enough.” (Queens)***

Meeting these growing needs has proven challenging, particularly in communities where linguistic and cultural barriers make support even less accessible. As described in Suffolk County, “There’s a major need for bilingual counselors. That’s been the biggest difficulty.” These hurdles can be compounded by stigma and long wait times, leaving many without timely care. As one participant shared, “People who want help end up on waiting lists they can’t afford to get off.” (LGBTQ+ Health Group)

Beyond mental health, several participants raised growing concerns about substance use and overdose since the pandemic began. These challenges are felt acutely in certain neighborhoods. A leader in Queens shared a stark picture: “Overdose deaths in our community are extremely high. Black men over 50 are dying at five times the rate.” (Queens County)

Together, these perspectives reveal ongoing challenges in mental and behavioral health care. Persistent gaps in access and culturally responsive resources mean that many—especially young people—struggle to get timely, appropriate support. Community leaders underscored the need for more accessible and inclusive mental health services that truly meet the needs of those they serve.

***“We’re seeing a crisis among our youth and young adults—higher [suicidal] ideation and attempts at very young ages.” (Staten Island)***

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# COMMUNITY FOCUS GROUP FINDINGS

## Collaboration, Partnership, and Northwell's Role

Many participants recognized Northwell as a present, accessible, and trusted partner in their communities' efforts to advance health. As a Westchester County participant shared, "It's been an amazing partnership and we're very lucky to have that." (Westchester County) Others echoed this sentiment, emphasizing Northwell's reliability and commitment: "Northwell has always, you know, come through in your promise of being a nonprofit and helping the communities that you serve." (Suffolk County)

***"Northwell has always, you know, come through in your promise of being a nonprofit and helping the communities that you serve." (Suffolk)***

Northwell's involvement was highlighted in the practical ways community members experienced support—such as through direct service initiatives, preventive screenings, and co-hosted events. Community leaders noted how, "Providers come in and do regular blood pressure screenings and workshops. Those preventive workshops have been really helpful." (Westchester County) This proactive approach was recognized in other locations as well: "Northwell came in with doctors and nurses to our center to do health fairs and blood pressure screenings." (Queens County) Another participant summed up the ongoing engagement, highlighting consistent presence: "We have the Community Health Outreach team coming to us each month, providing information and education." (Westchester County)

Some participants also expressed a desire for even deeper collaboration and expanded services. As one participant urged, "We need Northwell to be an advocate when boards are making decisions—people need you, people appreciate you." (Immigrant Communities) Similarly, there were suggestions to increase the broad availability of services: "I wonder if, as a county, we could have more services more easily available at no cost." (Westchester County) Overall, focus group participants expressed both appreciation for Northwell's current community presence and a call for continued growth in partnership and advocacy.

# COMMUNITY FOCUS GROUP FINDINGS

## Listening to the Community: Key Focus Group Findings

The participants in these focus group discussions make clear that health in our region is influenced by a complex mix of factors—including environmental risks, economics, transportation, housing, food, trust, and cultural identity. Their experiences as community leaders highlight both the barriers faced by many community members and the practical ways local organizations, faith communities, and advocates are working to address unmet needs. As a Faith Leader group participant said, “We’re all in this together—our health, our families, our neighborhoods. When you listen, when you partner with us, you show that we matter.”

These conversations point to specific areas where Northwell Health and its partners need to focus: improving access, building relationships, and delivering care that reflects the everyday realities of people’s lives. Taken together, the views expressed in these discussions offer direction for shaping future programs and collaborations across the region.

***“We’re all in this together—our health, our families, our neighborhoods. When you listen, when you partner with us, you show that we matter.” (Nassau)***





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# COMMUNITY HEALTH SURVEY PROCESS

## Survey Design:

The 2025 CHNA survey was meticulously designed by Northwell's CHNA Steering Committee in close collaboration with the Feinstein Institutes for Medical Research (FIMR) to capture a comprehensive, multi-dimensional view of community health. The instrument was structured to move beyond clinical data alone and gather robust information on the social and economic factors that influence well-being.

## Thematic Focus

The full survey instrument consisted of 33 questions organized into five key thematic areas:

- **Health Status and Community Concerns:** These questions focused on self-reported health conditions (such as diabetes, hypertension, and cancer) and residents' perceptions of the most significant health challenges facing their communities.
- **Access to Care and Barriers:** This section explored health insurance status, instances of delayed or forgone medical treatment, and the specific financial, logistical, and systemic barriers that prevent residents from accessing care.
- **Healthcare Utilization:** Questions in this area identified where and how residents receive care, including their use of specific hospitals, outpatient care settings (like FQHCs and clinics), telehealth, and emergency departments.
- **Social Determinants of Health (SDOH):** A significant portion of the survey was dedicated to understanding living conditions, including housing stability, food security, transportation challenges, and financial strain related to paying for essentials like rent, utilities, and medication.
- **Respondent Demographics:** This section collected key demographic information to allow for a detailed analysis of health needs across different population subgroups.

To ensure rich data collection, many questions employed a "Select all that apply" format, allowing respondents to report on the multiple, often overlapping, challenges they face. The instrument used conditional logic to allow for detailed follow-up questions based on participant responses. Open-text fields were limited to 120 characters. The inclusion of "Other, please specify" fields further provided an opportunity for residents to share concerns not captured in the predefined categories, ensuring their voices were fully heard.

## Language Access

To ensure wide-ranging and inclusive community participation, the survey was designed in multiple languages, including English, Spanish, Bengali, Chinese (Traditional and Simplified), Haitian-Creole and Russian

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# COMMUNITY HEALTH SURVEY PROCESS

## Survey Deployment

To gather quantitative data on community health needs, Northwell Health deployed a wide-reaching community health survey between *May 1, 2025, and July 1, 2025*. The strategy was intentionally multi-channel, designed to reach a diverse cross-section of residents through both large-scale digital outreach and grassroots community engagement.

## Distribution Channels and Reach

The survey targeted a broad population that included Northwell patients and employees, as well as the wider community. This multi-pronged approach involved several key channels to maximize participation:

- ✔ **Direct Email:** Sent to over 1.4 million Northwell patients.
- ✔ **GoHealth Urgent Care Patient Network:** Outreach conducted to approximately 885,000 patients.
- ✔ **Community Newsletters:** Survey links and QR codes were shared with over 14,000 subscribers.
- ✔ **On-site Kiosks:** QR codes were placed at 34 physical kiosk locations throughout Northwell facilities.

Outreach was coordinated through a network of trusted community partners part of the **Community Health Advancement Taskforce (CHAT)** and additional strategic partners including:

- Faith-Based Organizations (FBOs)
- Community-Based Organizations (CBOs)
- Federally Qualified Health Centers (FQHCs)

Respondents could access the survey through these QR codes, a direct web link, or a user-friendly URL on the Northwell website ([Northwell.edu/2025HealthSurvey](https://Northwell.edu/2025HealthSurvey)), with all data collection managed through the Press Ganey HX Platform.

## Data Collection and Final Sample

This comprehensive, community-integrated distribution strategy resulted in a total of 14,318 completed surveys, providing a substantial dataset for analyzing community health needs and priorities.

# COMMUNITY HEALTH SURVEY

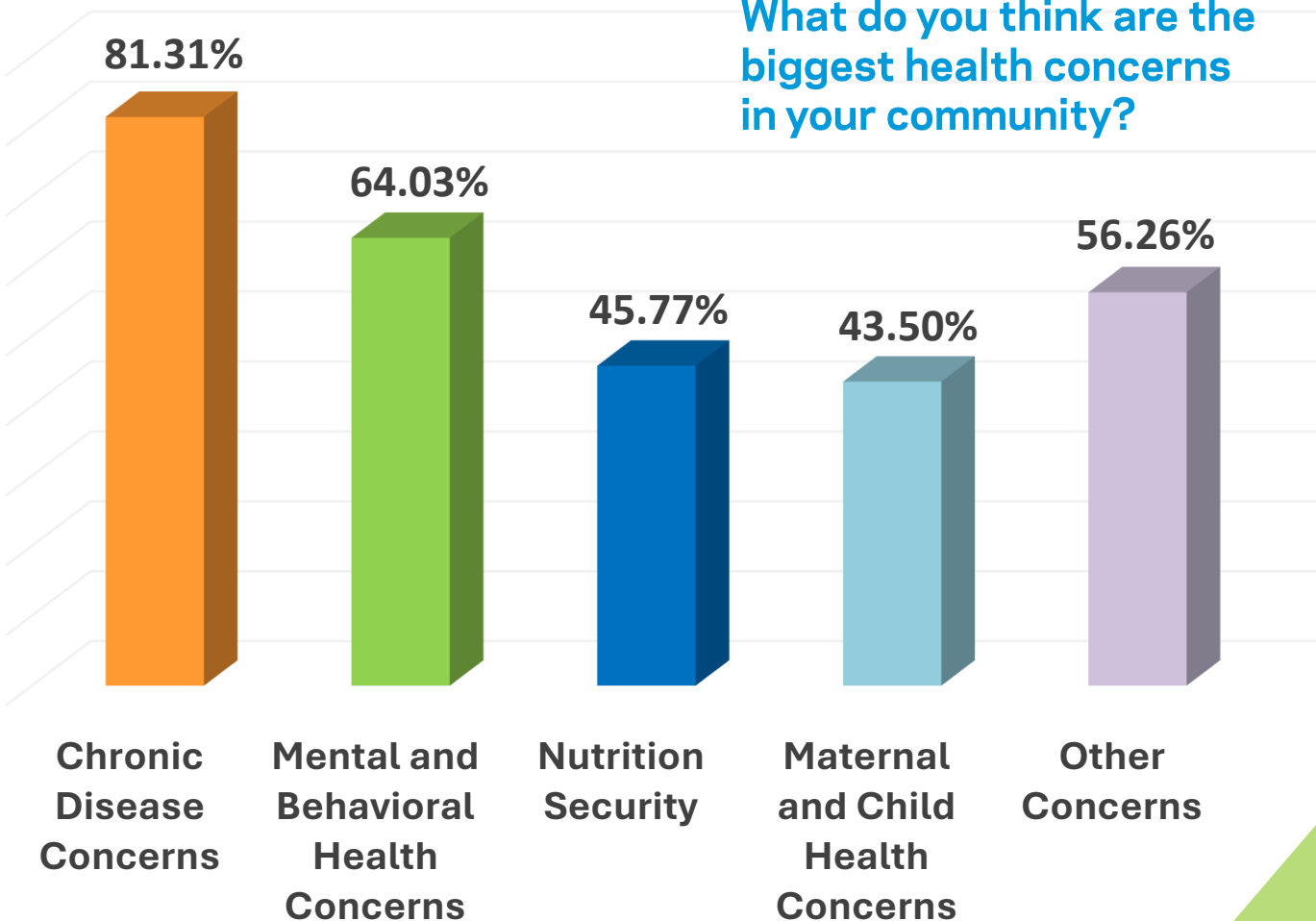
Our Community Health Survey captured insights from 14,318 residents across Downstate NY and provided a strong view of health priorities and concerns. The demographics of our survey respondents leaned towards older, Medicare-insured individuals, so we strengthened our understanding of the findings by also analyzing results by Medicare (as a proxy for age) and non-Medicare groups to better understand differences.

## 14,318 completed survey responses

### Overall Perceptions of Community Health

When asked about their biggest health concerns for their community, chronic disease topped the list (81.31%), followed by mental and behavioral health concerns (64.03%). Other common concerns included nutrition security (45.7%), and maternal and child health (43.5%)

What do you think are the biggest health concerns in your community?



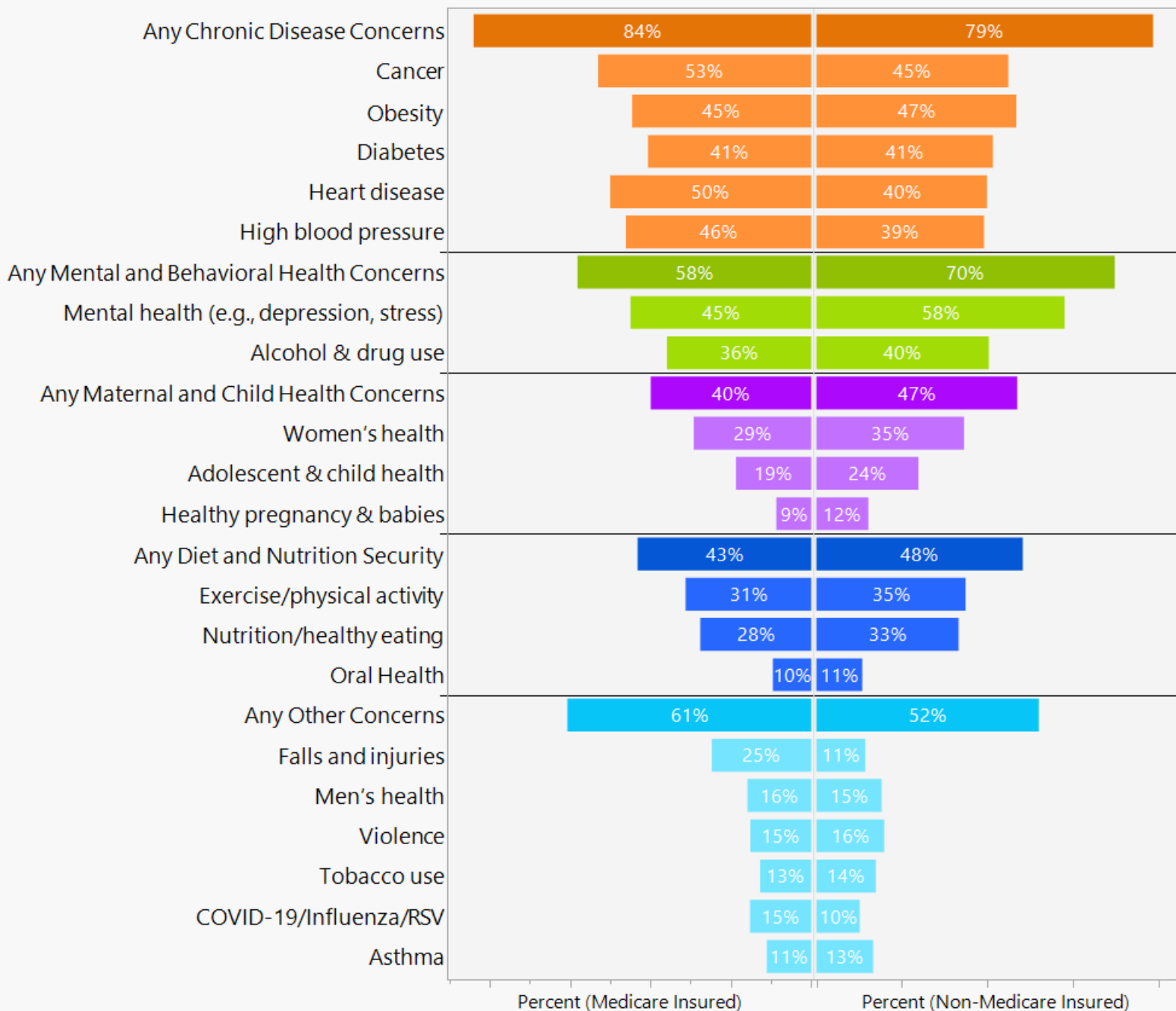
Prepared by the ICHW and FIMR at Northwell Health; Note: Responses are multiselect options

# COMMUNITY HEALTH SURVEY

## Different Realities for Older and Younger Adults

Because many surveys did not have age filled out, we used Medicare coverage as a proxy for older adults. We saw clear differences in health concerns and conditions when we compared responses from Medicare and non-Medicare respondents.

**What do you think are the biggest health concerns in your community?**  
*by Medicare and non-Medicare status*



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# COMMUNITY HEALTH SURVEY

## Older Adults (Medicare recipients):

Older adults represented 1 out of 2 (51%) of our survey respondents. We learned that for seniors, continuity of care and social supports (transportation, affordable care, social connection, healthy food access) are important.

### Health Conditions

Their self-reported health conditions were concentrated around chronic disease—hypertension (56%), high cholesterol (46%), and arthritis (44%) were the top three.

### Community Concerns

Their leading community concerns closely mirrored their health conditions: Cancer (53%), heart disease (50%), and high blood pressure (45%). While mental health (e.g., depression, stress, and anxiety) was not a top personal health condition for older adults, it still ranked high as a community concern at 45%.

### Social Needs

Nearly 1 in 5 worried about housing or utility costs (19%), and 29% reported delaying care—often due to out-of-pocket costs. Many called for more social spaces for seniors (38%), better access to healthy food (37%), and action to address homelessness (37%). Implication: For seniors, continuity of care and practical supports (transportation, affordable care, social connection, healthy food access) are important.

## Younger Adults (non-Medicare recipients):

Younger adults represented 49% of survey respondents. For younger adults, mental health access, timely appointments, and healthy food availability are central needs—alongside prevention for cardiometabolic conditions.

### Health Conditions

Hypertension (33%) and high cholesterol (29%) were notable lower among younger adults, compared to 45% of younger survey respondents reporting obesity, prediabetes, or diabetes.

### Community Concerns

Mental health was the top concern (58%) among younger adults; 28% reported anxiety, depression, or other mental health issues. Two in five (40%) non-Medicare respondents flagged alcohol and drug use as a concern.

### Social Needs

Thirty percent (30%) reported challenges with housing and utility burden; 51% wanted better access to healthy and nutritious foods. Over one out of five (28%) reported delayed care, the leading reasons being lack of available appointments, and long wait times—pointing to access barriers beyond cost.

# COMMUNITY HEALTH SURVEY

## Overview of Access Barriers

When survey respondents were asked about barriers to care during the last year, 1 out of 4 reported they had experienced delays or lack of care.

### 1 out of 4 people experienced delays and lack of care

Respondents' reasons for delays or lack of care were grouped into three categories as shown below:

#### System or Provider Factors

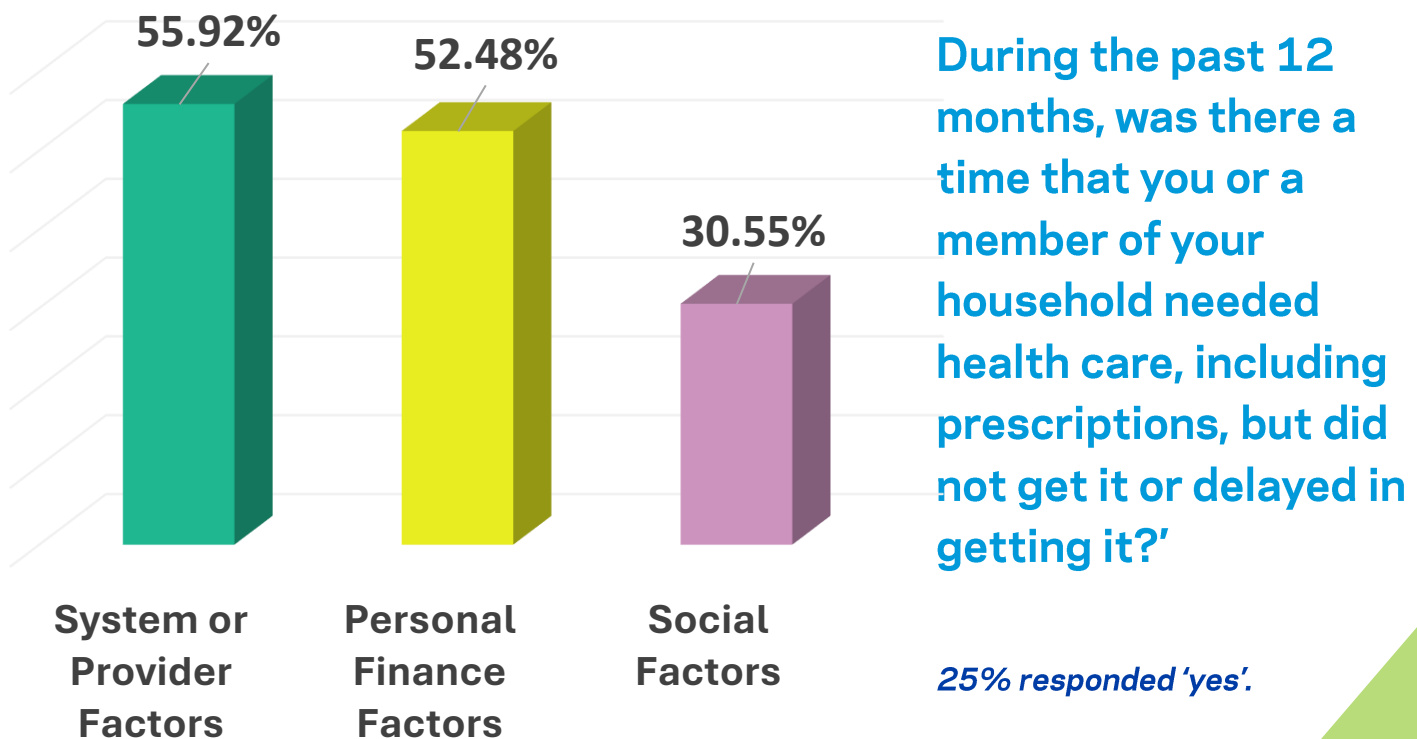
Many respondents reported difficulty getting care due to system barriers like unavailable appointments, long wait times, or issues with medications and provider trust.

#### Personal Finance Factors

Cost was a major concern, with respondents citing unaffordable copays, high out-of-pocket expenses, and lack of insurance as reasons for delaying or missing care.

#### Social Factors

Social challenges such as inability to get time off work, lack of transportation, caregiver responsibilities, and fear of treatment also prevented some from accessing needed healthcare.



Prepared by the ICHW and FIMR at Northwell Health; Note: Responses are multiselect options

# COMMUNITY HEALTH SURVEY

## Reasons for Delay and Lack of Care

Survey findings reveal that barriers within the healthcare system are the most common reasons people delay or avoid needed care, with 56% of respondents reporting issues such as unavailable appointments, long wait times, or trouble accessing medications. Negative past experiences with healthcare and a lack of trust in providers were also meaningful system factors that prevented timely access.

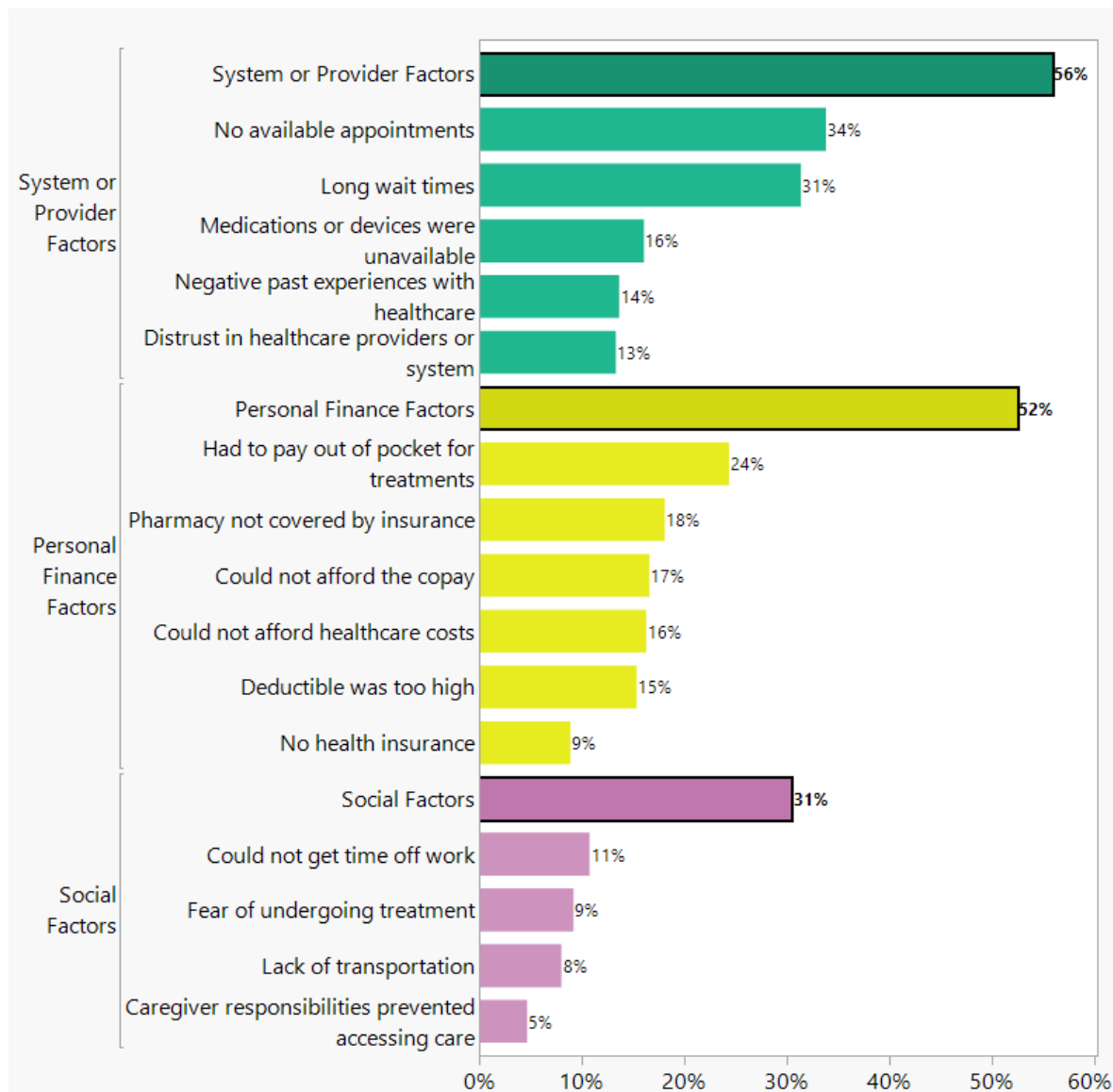
Personal finance challenges were nearly as prevalent, affecting 52% of those with access concerns. Many reported having to pay out-of-pocket for treatments, encountering costs not covered by insurance, or facing copays and deductibles that were too high.

Social factors also played a role, with 31% citing difficulties like being unable to get time off work, fear of treatment, lack of transportation, or caregiving responsibilities as reasons they could not get the care they needed. These findings underscore that access to care is shaped by a combination of healthcare system constraints, financial pressures, and everyday social challenges.

**During the past 12 months, was there a time that you or a member of your household needed health care, including prescriptions, but did not get it or delayed in getting it?**

**25% responded 'yes'.**

Prepared by the ICHW and FIMR at Northwell Health;  
Note: Responses are multiselect options



# COMMUNITY LEADER SURVEY (CBO)

## Community Leader Survey (CBO-Survey)

We leveraged our partners of the Community Health Advancement Taskforce (CHAT), sharing our survey with over 100+ member organizations. Of the respondents that completed the survey, 87% indicated working with Medicaid participants and communities of lower socioeconomic status.

### Top health concerns

Two out of three (67%) respondents indicated mental health and nutrition security as the top health concerns, respectively. This was followed by concerns about adolescent/child health (60%), obesity (60%), diabetes and high blood pressure (53%), plus cancer, women's health, heart disease and men's health. Four out of five respondents (80%) indicated a gap in services to address depression and other mental health needs. Three out of four respondents (73%) reported access delays driven by insurance, language, and navigation barriers.

Across our multiple research methods in engaging the community, several consistent themes emerged. Chronic disease and mental health were the top community concerns overall. Challenges in access to health care continue to be shaped by cost, and barriers to social needs such as housing, food, transportation.

**100+**

**CHAT Members Surveyed**

Comprehensive outreach to community-based organizations

**87%**

**Serve Spanish-Speaking Communities**

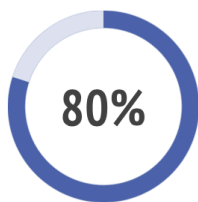
High engagement with Hispanic populations

**87%**

**Work with Medicaid Participants**

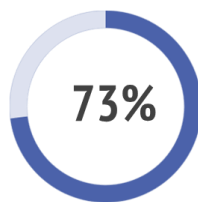
Strong connection to vulnerable populations

## Identified Service Gaps and Barriers



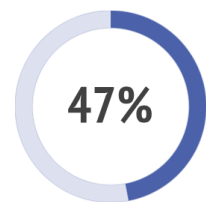
**Depression Services Gap**

Critical shortage in mental health support



**Access Delays**

Due to insurance, language, and navigation barriers



**Provide Youth Programs**

Nearly half offer after-school and mentoring services

Prepared by the ICHW and FIMR at Northwell Health; Note: Responses are multiselect options

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# IMPLICATIONS OF OUR CHNA FINDINGS

The converging findings point to practical considerations to improve the health of the communities across our service area:

## ✔ Improve access to care

- Expand appointment availability, reduce waiting times and increase options for primary care.
- Add community-based lower-acute access points in collaboration with our partners; co-located services in schools/faith-based organizations, and closer to where people live).
- Strengthen transportation supports and referrals.

## ✔ Address affordability and navigation

- Increase visibility and ease-of-use and access to financial assistance and charity care options.
- Provide greater navigation assistance for insurance and benefits access.

## ✔ Strengthen services for health-related social needs

- Improve and scale access to programs for nutrition security.
- Integrate housing navigation and resource linkages into clinical and community settings.

## ✔ Expand mental health services

- Grow school-based services and community counseling, with a focus on youth and families.
- Increase bilingual and culturally responsive mental health services.

## ✔ Focus on prevention of chronic conditions:

- Enhance chronic disease management and self-care support (e.g., hypertension, diabetes, COPD).
- Pair clinical care with nutrition, physical activity, social services to reduce risk and improve outcomes.

## ✔ Partner deeper with community organizations

- Formalize collaboration to extend reach and trust with schools, faith leaders, CBOs.
- Co-design programs and communication in preferred languages; tailor environmental health information for high-risk neighborhoods.



# OUR FRAMEWORK FOR ACTION

To guide our CHNA, we relied on two proven frameworks:

- ▶ The Association of Community Health Improvement's (ACHI) Community Health Assessment (CHA) framework, developed by the American Hospital Association
- ▶ The New York State Prevention Agenda 2025-2030 - the State Health Improvement Plan/SHIP).

These frameworks helped us organize our CHNA findings into our selected priorities and informed our community health strategy and Implementation Plan.

# OUR FRAMEWORK FOR ACTION

## ACHI Community Health Assessment (CHA) framework<sup>1</sup>

ACHI's CHA framework provides a clear, step-by-step way to understand and respond to community health needs. It emphasizes:

- A data-driven process using both quantitative and qualitative information.
- Meaningful community involvement throughout the process
- A nine-step path for assessment and prioritization to action planning and evaluation.

We used ACHI's criteria to select our top health needs and shape our Implementation Plan. In partnership with community leaders and partners, we considered the following:

- Magnitude: How widespread is the issue?
- Severity: How serious are the outcomes?
- Community readiness: Is there capacity and willingness to act?
- Measurable impact: Can we track and show change?
- Available resources: Do hospital and community partners have the tools to respond?
- Existing efforts: Are there programs we can scale or align with?
- Root causes: Does the issue drive other problems?
- Community priority: Do residents and local leaders identify this as a top need?

We also applied additional criteria in our prioritization efforts:

- Alignment with our mission and system priorities, including high-quality care for all patients.
- Our ability to contribute staff, expertise, and infrastructure.
- Likely barriers or challenges to addressing the need.
- Opportunity to act upstream (prevention and early intervention).
- Evidence that proposed interventions can be effective.



Source: ACHI Community Health Assessment Framework

# OUR FRAMEWORK FOR ACTION

## Aligning with the New York State Prevention Agenda<sup>2</sup>

We aligned our efforts with the NYSDOH Prevention Agenda 2025-2030, the State’s Health Improvement Plan (SHIP). The Prevention Agenda:

- Is New York State’s public health plan for the next six years.
- Focuses on factors beyond clinical care that shape health (social and environmental drivers).
- Calls for prevention across the lifespan and collaboration across sectors and at the local level.
- Organizes 24 priorities across five domains (e.g., Economic Stability; Social and Community Context; Neighborhood and Built Environment; Health Care Access and Quality; Education Access and Quality).

NYSDOH asks hospitals and health systems to align with at least three of the twenty-four priorities.

- Using ACHI’s framework and the NYS Prevention Agenda, we:
- Identified the most pressing needs across our six downstate counties.
- Built an Implementation Plan that combines clinical programs and community-based interventions.
- Will report progress annually and update priorities every three years as required.

Domain	Priorities
Economic Stability	<b>Economic Wellbeing</b> <input type="checkbox"/> Poverty <input type="checkbox"/> Unemployment <input type="checkbox"/> Nutrition Security <input type="checkbox"/> Housing Stability and Affordability
Social and Community Context	<b>Mental Wellbeing and Substance Use</b> <input type="checkbox"/> Anxiety and Stress <input type="checkbox"/> Suicide <input type="checkbox"/> Depression <input type="checkbox"/> Drug Misuse and Overdose Including Primary Prevention <input type="checkbox"/> Tobacco/ E-cigarette Use <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Adverse Childhood Experiences <input type="checkbox"/> Healthy Eating
Neighborhood and Built Environment	<b>Safe and Healthy Communities</b> <input type="checkbox"/> Opportunities For Active Transportation and Physical Activity <input type="checkbox"/> Access to Community Services and Support <input type="checkbox"/> Injuries and Violence
Health Care Access and Quality	<b>Health Insurance Coverage and Access to Care</b> <input type="checkbox"/> Access to and Use of Prenatal Care <input type="checkbox"/> Prevention of Infant and Maternal Mortality <input type="checkbox"/> Preventive Services for Chronic Disease Prevention and Control <input type="checkbox"/> Oral Health Care (e.g., routine preventive care, community water fluoridation, dental sealants, and access to dental services for Medicaid covered population) <b>Healthy Children</b> <input type="checkbox"/> Preventive Services (e.g.; immunization, hearing screening and follow up, and lead screening) <input type="checkbox"/> Early Intervention <input type="checkbox"/> Childhood Behavioral Health
Education Access and Quality	<b>PreK-12 Student Success And Educational Attainment</b> <input type="checkbox"/> Health and Wellness Promoting Schools (e.g.; timely immunization, healthy school meals, social emotional learning, and counselling and mentoring including avoidance risky substances) <input type="checkbox"/> Opportunities for Continued Education (e.g.; high school completion programs, transitional and vocational programs, literacy initiatives, and reskilling and retraining programs)

Source: NYS Prevention Agenda 2025-2030

# OUR COMMUNITY HEALTH PRIORITIES

## TURNING INSIGHT INTO ACTION

Our CHNA efforts—combining survey input from more than 14,000 residents, insights from 72 community leaders, listening sessions and a review of public health data—gave us a clear picture of the most pressing needs across our service area. In alignment with the NYSDOH 2025-2030 Prevention Agenda, we identified at least 15 priorities across all five domains that reflect what we heard from our communities.

### Health Care Access and Quality

Our CHNA findings surfaced persistent barriers to timely, high-quality care. Among seniors and Medicare respondents, chronic conditions were prevalent (e.g., hypertension, high cholesterol, arthritis), alongside concerns about social isolation and access to services for cancer and heart disease. Among younger adults, obesity and diabetes were prominent. Across all age groups, access challenges were compounded by financial constraints, limited appointment availability and long wait times, language, and cultural barriers.

### Social and Community Context

Mental and behavioral health emerged as a top community concern, with high self-reported anxiety and depression, particularly among younger adults. Focus groups described a worsening crisis, rising suicidal ideation among youth, and a shortage of culturally and linguistically responsive mental health services.

### Economic Vitality

Financial instability directly affects health decisions and care continuity. Focus groups reported frequent tradeoffs between basic needs (rent, utilities, food) and medical care. Survey data showed 30% of non-Medicare respondents and one in five Medicare respondents worried about housing/utility costs. Nutrition security was a significant concern—51% of younger respondents wanted better access to affordable, healthy foods—mirroring focus group narratives about food deserts and overwhelmed pantries. These needs intersect with coverage limits and provider availability, hindering overall well-being.

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# OUR COMMUNITY HEALTH PRIORITIES

*TURNING INSIGHT INTO ACTION*

## ► Educational Access & Quality

While not a single health condition, educational access and quality are foundational social determinants of health—especially for youth and long-term community vitality. Community feedback and our ongoing initiatives at the Institute point to educational pathways as essential to addressing the mental health and chronic disease challenges, as well as the health-related social needs identified in our CHNA.

## ► Social and Community Context

Mental and behavioral health emerged as a top community concern, with high self-reported anxiety and depression, particularly among younger adults. Focus groups described a worsening crisis, rising suicidal ideation among youth, and a shortage of culturally and linguistically responsive mental health services.

## Putting priorities into practice

Our prioritization efforts—grounded in what we learned from our CHNA process and ongoing community efforts—guide our strategic initiatives and systemwide community health improvement plan. Our findings lead us to align with all five domains of the NYSDOH 2025-2030 Prevention Agenda and at least 15 of its 24 priorities to help form our collective Implementation Plan.



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# NEIGHBORHOODS OF FOCUS

## How We Prioritized Where to Act

To target resources where they can do the most good, we updated our neighborhood prioritization approach for the 2025 CHNA. Building on our 2022 methods, we updated our methodology by replacing the CDC Social Vulnerability Index (SVI) with more recent and actionable indices, expanding our view from social vulnerability to include climate vulnerability and childhood opportunity. In addition, we layered local census demographics and social data, as well as local health care utilization data to determine preventable ED visits and hospitalizations. These data measures complement our organization's existing network for partnerships and community assets, which were also a major decision factor in the selection of these neighborhoods.

## Data sources and measures:

We applied a layered methodology at the census tract and zip code levels across the six counties of our downstate service area (Nassau, Suffolk, Queens, Staten Island, Manhattan, and Westchester):

### ✔ Vizient Vulnerability Index (VVI)

System-oriented composite that integrates clinical, social, and access factors. Used as our primary vulnerability screen to identify concentrated areas of social vulnerability and health risk.

### ✔ NYS Climate Justice Working Group - Disadvantaged Community (DAC) designation

State-defined methodology capturing exposure and sensitivity to climate risks (e.g., extreme heat, air quality, flood risk). Used to flag climate-vulnerable neighborhoods to guide resilience-oriented interventions.

### ✔ Child Opportunity Index (COI)

Neighborhood-level measure of access to conditions that support healthy child development (education, health/environment, social/economic). It is used to highlight areas where children face lower opportunities and to prioritize youth-focused strategies.

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# NEIGHBORHOODS OF FOCUS

## Data sources and measures

### ✔ American Community Survey (ACS)

Standard demographic and social measures (e.g., age, language, income, poverty, education, employment, housing, transportation) to describe populations at the local level.

### ✔ NYSDOH Statewide Planning And Research Cooperative System (SPARCS)

- Analyze preventable utilization, defined by
  - Prevention Quality Indicators (AHRQ PQIs) for preventable hospitalizations (acute and chronic composites).
  - NYU ED Algorithm for potentially avoidable ED treat-and-release visits.
  - Used to quantify avoidable use and signal gaps in timely outpatient care, continuity, and access.

## Methodology

- Screen and rank neighborhoods using the VVI to identify areas of high vulnerability.
- Overlay NYS DAC climate vulnerability for compounded health and environmental risk.
- Incorporate COI to identify low child opportunity areas and align youth/family interventions.
- Profile each neighborhood with ACS census data to understand language, cultural, economic, and other demographic variables.
- Quantify avoidable utilization using SPARCS, comparing neighborhood rates to county benchmarks to target access and continuity gaps.
- Validate with community input to confirm local relevance, assets, and readiness to act.

## Neighborhood Profiles

For each neighborhood of focus, we produced a one-page profile. Neighborhoods were selected based on a combination of high overall, social, and climate vulnerabilities; childhood opportunity scores; community input and existing assets; and alignment with Northwell programs and the NYS Prevention Agenda domains.

# BAY SHORE

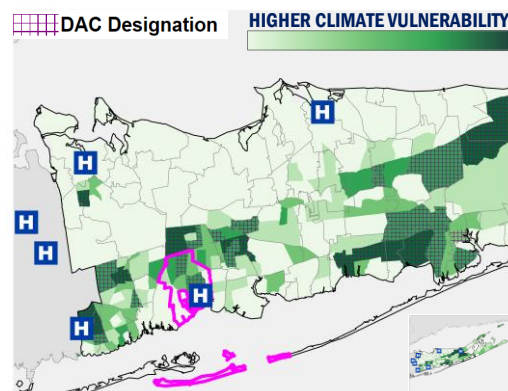
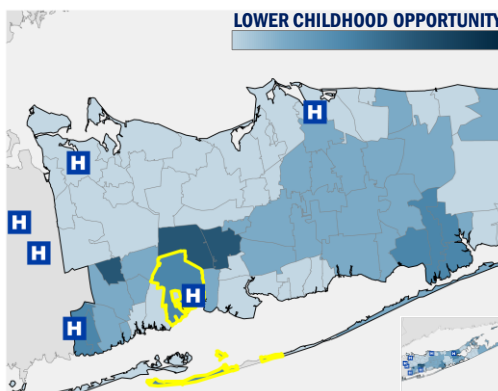
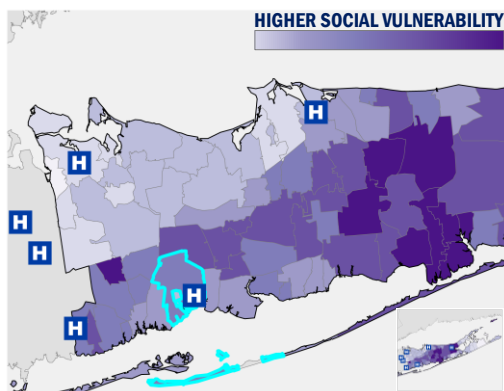


**POPULATION**  
68,648

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### BAY SHORE

### SUFFOLK

### BAY SHORE

### SUFFOLK

### BAY SHORE

### SUFFOLK



**EDUCATION**  
% of 25+ population with less than high school diploma



**UNEMPLOYMENT**  
% of 16+ population unemployed



**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income



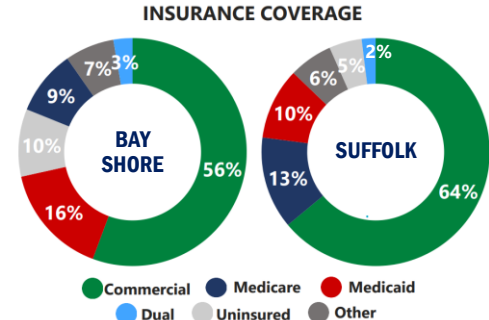
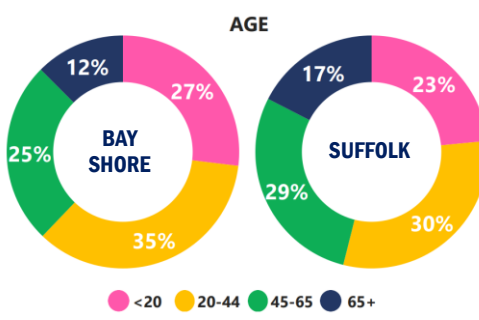
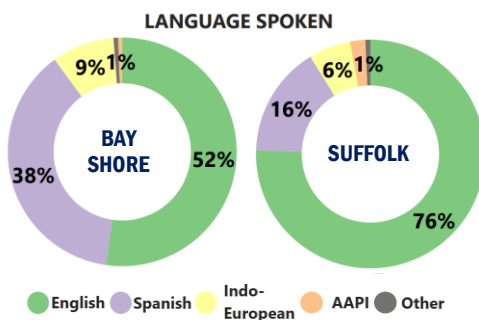
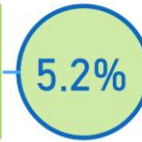
**POVERTY**  
% of People below 100% Federal Poverty



**NUTRITION**  
% of households receiving food stamps/SNAP

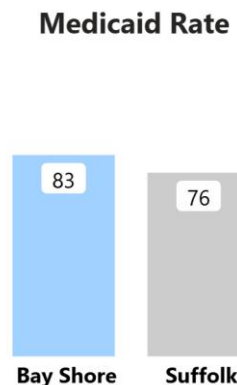
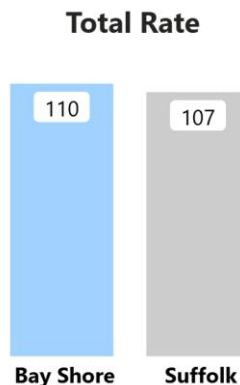
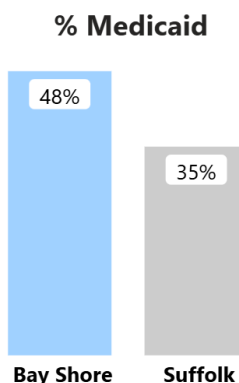
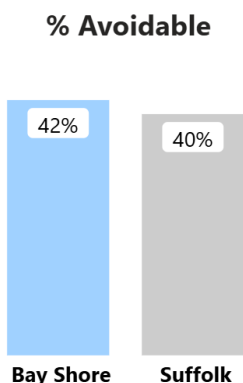


**TRANSPORTATION**  
% of households with no vehicle available



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS



# BRENTWOOD

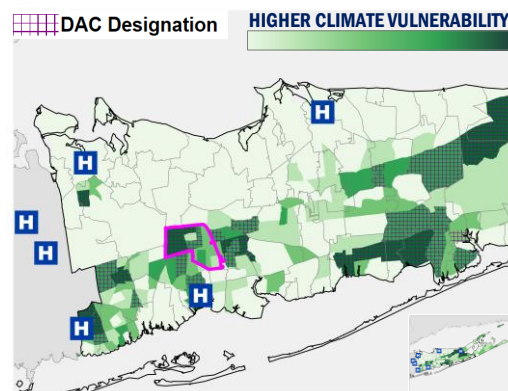
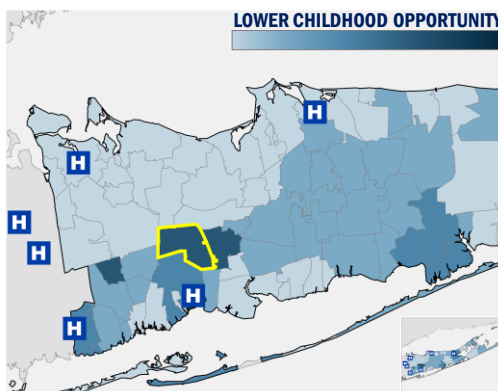
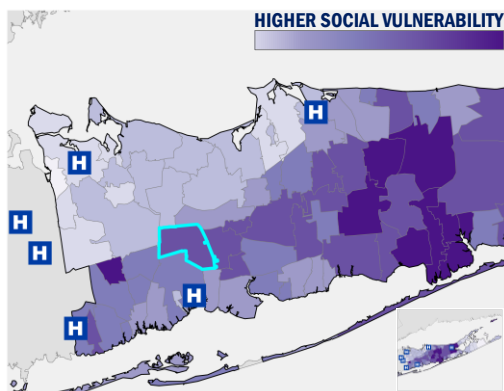


**POPULATION**  
64,969

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### BRENTWOOD

### SUFFOLK

### BRENTWOOD

### SUFFOLK

### BRENTWOOD

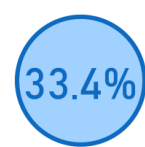
### SUFFOLK



**EDUCATION**  
% of 25+ population with less than high school diploma



**UNEMPLOYMENT**  
% of 16+ population unemployed



**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income



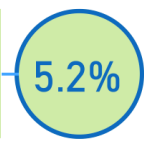
**POVERTY**  
% of People below 100% Federal Poverty



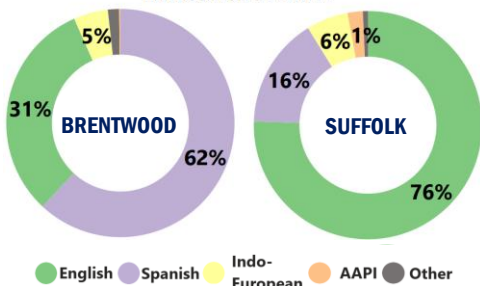
**NUTRITION**  
% of households receiving food stamps/SNAP



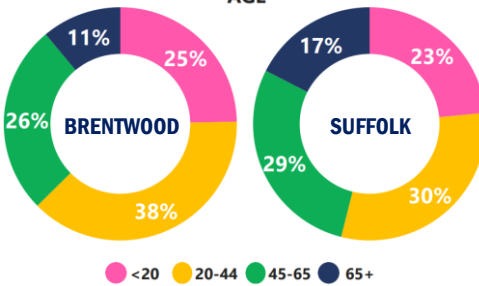
**TRANSPORTATION**  
% of households with no vehicle available



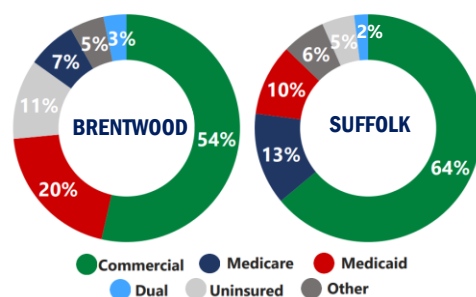
### LANGUAGE SPOKEN



### AGE



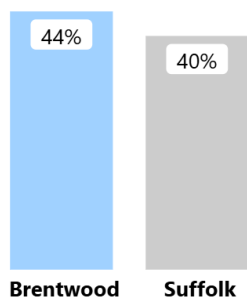
### INSURANCE COVERAGE



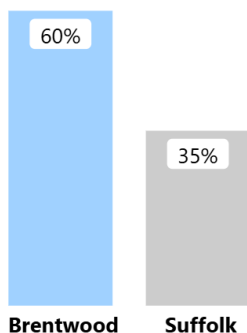
## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

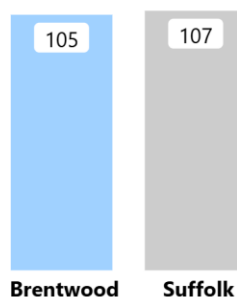
### % Avoidable



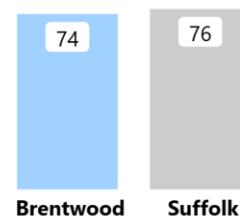
### % Medicaid



### Total Rate



### Medicaid Rate



Prepared by the Office of Strategic Planning at Northwell Health | Source(s): Vizient Vulnerability Index, Child Opportunity Index (2.0 release), New York State Energy Research and Development Authority, U.S. Census Bureau: American Community Survey 5-Year Estimates (2023), Statewide Planning and Research Cooperative System (2023); NYU Emergency Room Algorithm & AHRQ Preventable Quality Indicator Overall Composite 90) | Note(s): Brentwood defined as zip code(s) 11717; slight variations in totals are due to rounding

# CENTRAL ISLIP

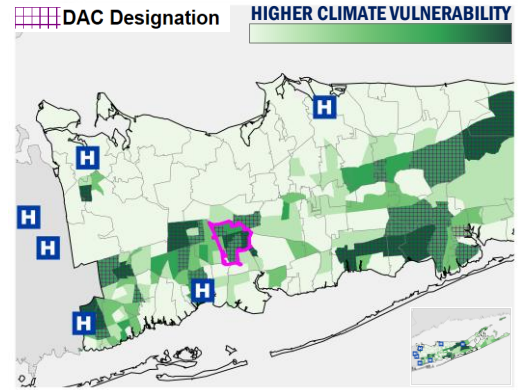
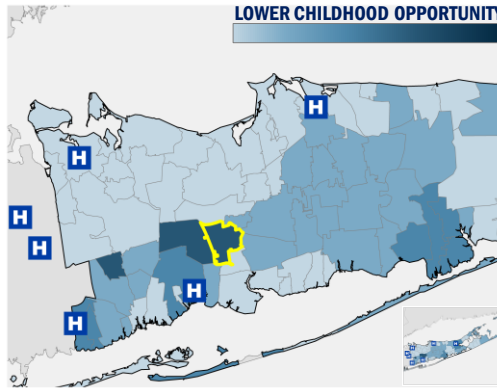
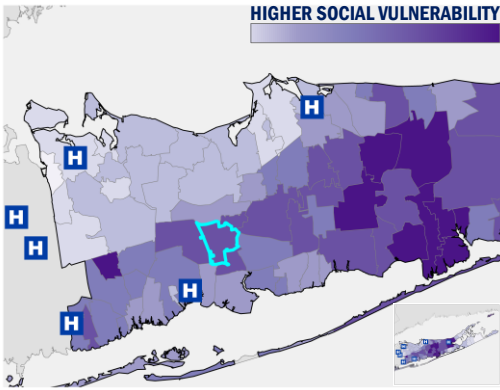


**POPULATION**  
**38,443**

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### CENTRAL ISLIP

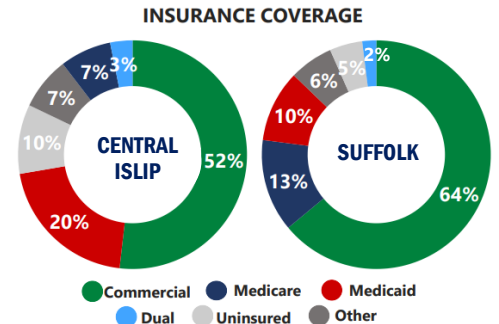
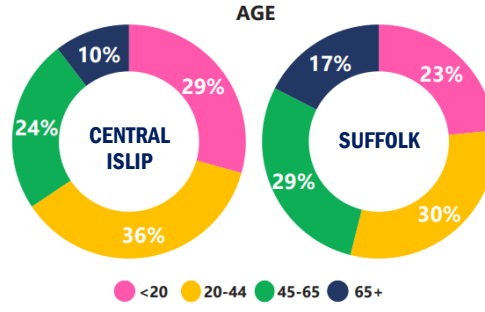
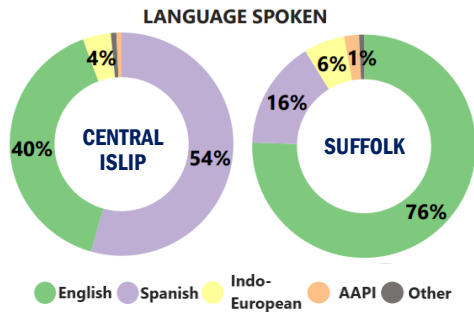
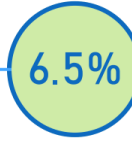
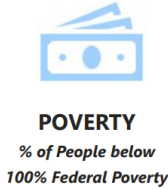
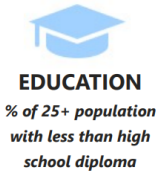
### SUFFOLK

### CENTRAL ISLIP

### SUFFOLK

### CENTRAL ISLIP

### SUFFOLK



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

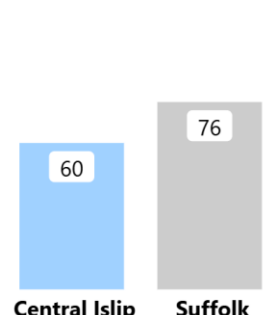
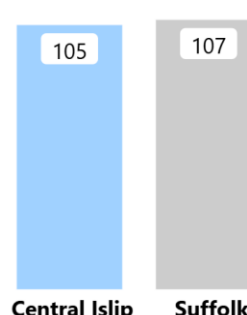
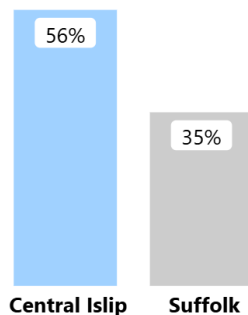
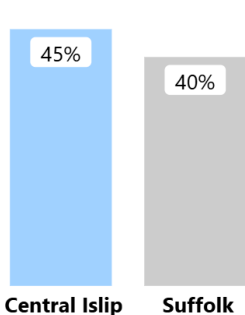
## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

### % Avoidable

### % Medicaid

### Total Rate

### Medicaid Rate



# HUNTINGTON STATION

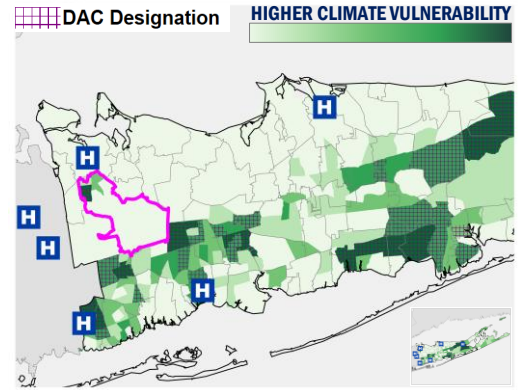
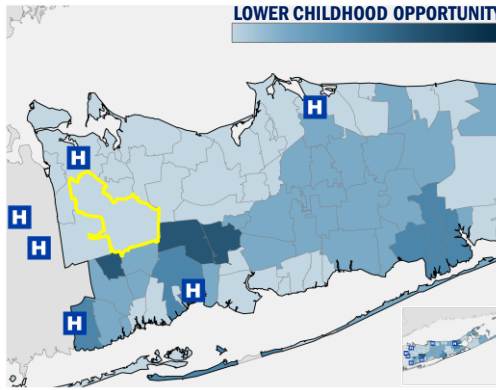
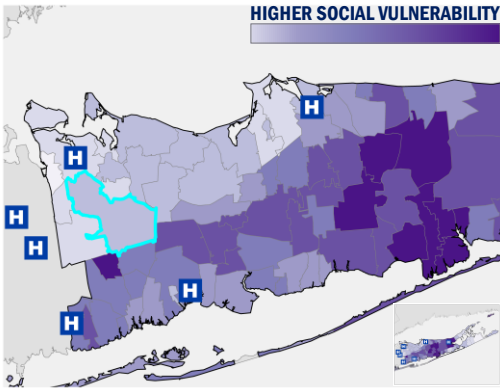


**POPULATION**  
66,883

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### HUNTINGTON STATION

### SUFFOLK

### HUNTINGTON STATION

### SUFFOLK

### HUNTINGTON STATION

### SUFFOLK

9.6%



**EDUCATION**  
% of 25+ population with less than high school diploma

9.5%



5.1%

**UNEMPLOYMENT**  
% of 16+ population unemployed

4.6%



32.0%

**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income

36.9%

6.9%



**POVERTY**  
% of People below 100% Federal Poverty

6.4%



6.9%

**NUTRITION**  
% of households receiving food stamps/SNAP

6.5%

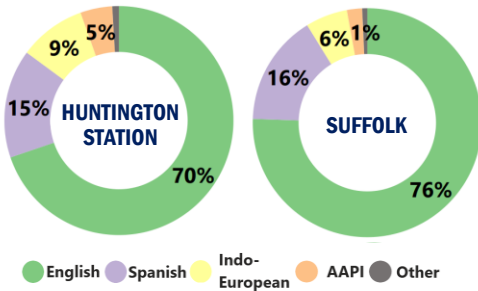


6.2%

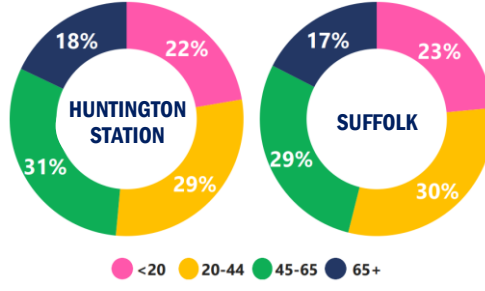
**TRANSPORTATION**  
% of households with no vehicle available

5.2%

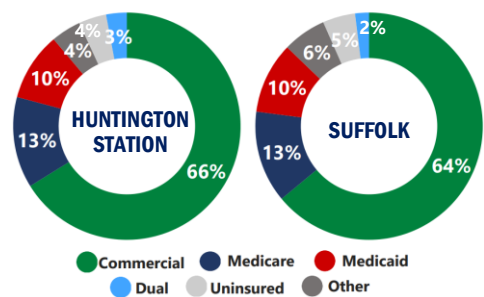
### LANGUAGE SPOKEN



### AGE



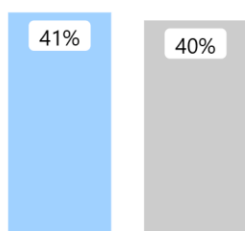
### INSURANCE COVERAGE



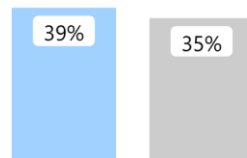
## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

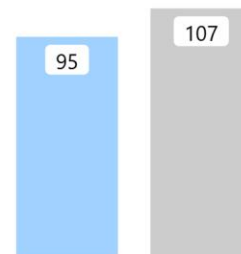
### % Avoidable



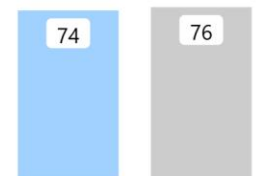
### % Medicaid



### Total Rate



### Medicaid Rate



# RIVERHEAD

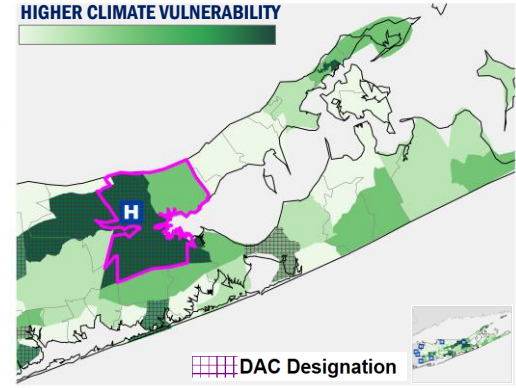
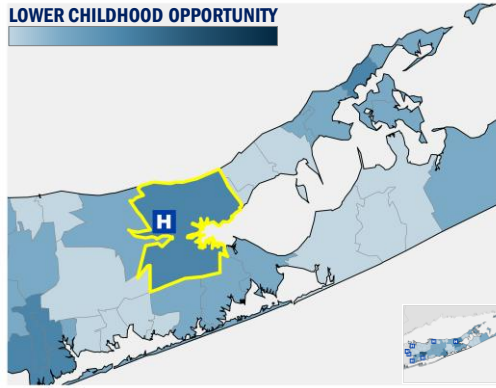
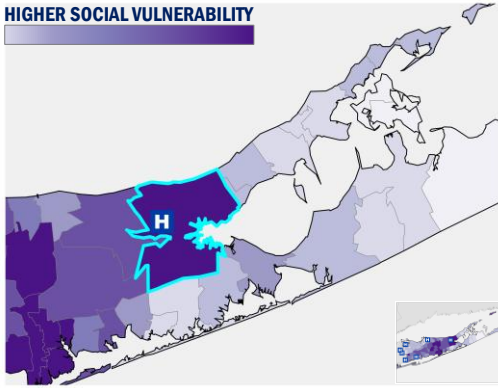


**POPULATION**  
**32,921**

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### RIVERHEAD

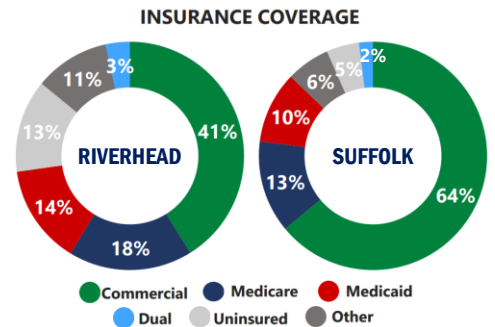
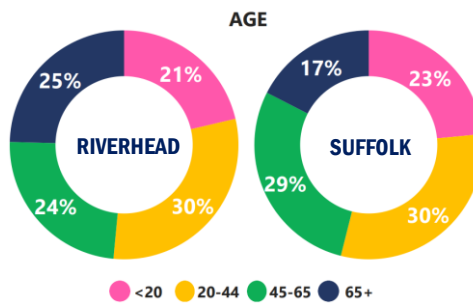
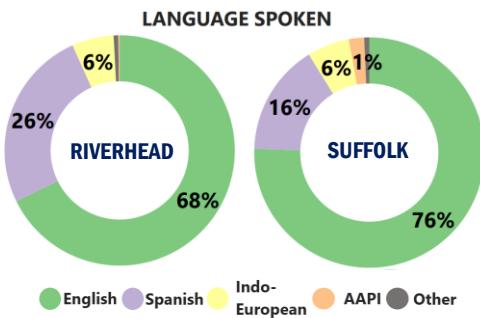
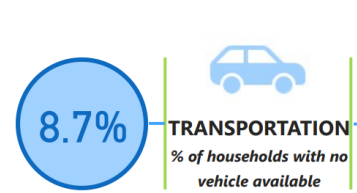
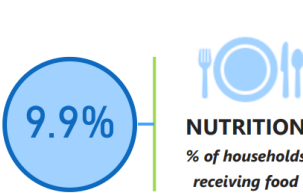
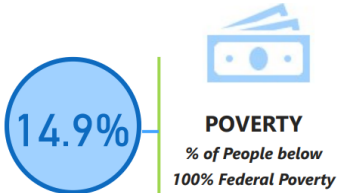
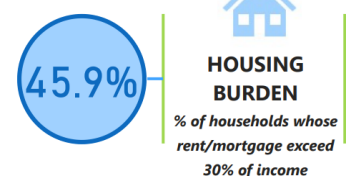
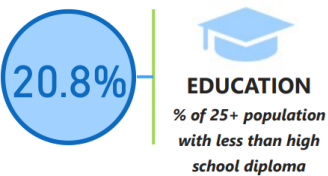
### SUFFOLK

### RIVERHEAD

### SUFFOLK

### RIVERHEAD

### SUFFOLK



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

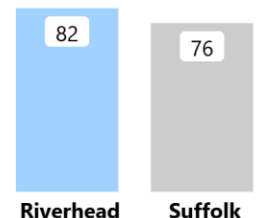
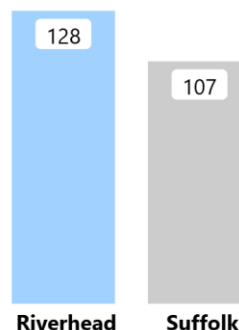
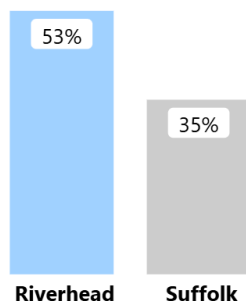
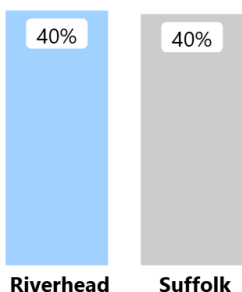
## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

### % Avoidable

### % Medicaid

### Total Rate

### Medicaid Rate

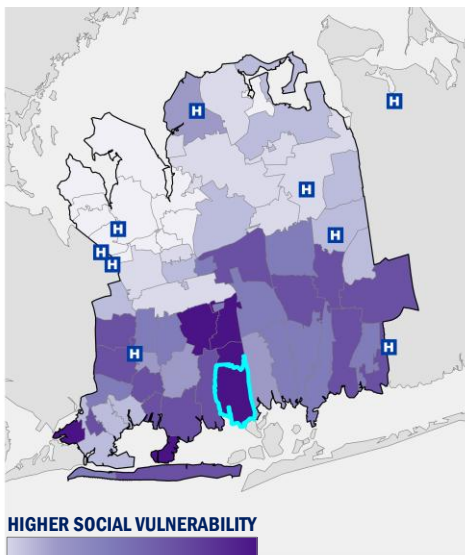


# FREEPORT

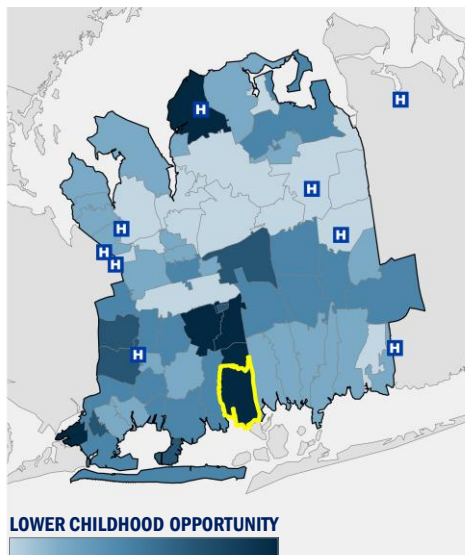


**POPULATION**  
44,873

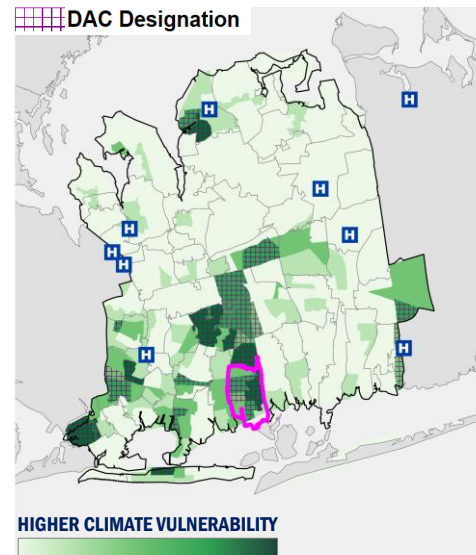
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



### FREEPORT

### NASSAU

14.1%

**EDUCATION**  
% of 25+ population with less than high school diploma

7.9%

### FREEPORT

### NASSAU

5.8%

**UNEMPLOYMENT**  
% of 16+ population unemployed

4.8%

### FREEPORT

### NASSAU

42.0%

**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income

37.2%

6.2%

**POVERTY**  
% of People below 100% Federal Poverty

5.3%

7.8%

**NUTRITION**  
% of households receiving food stamps/SNAP

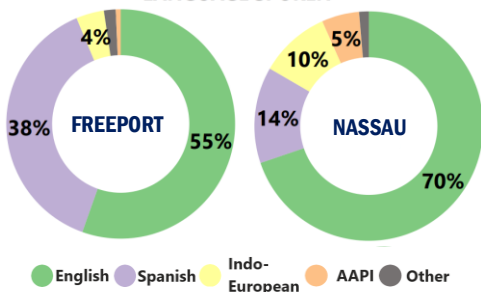
4.7%

9.8%

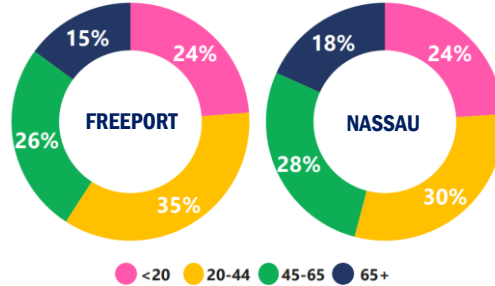
**TRANSPORTATION**  
% of households with no vehicle available

6.7%

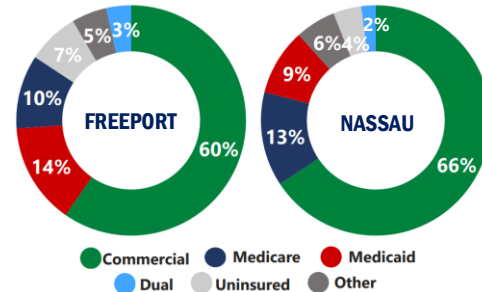
### LANGUAGE SPOKEN



### AGE



### INSURANCE COVERAGE



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

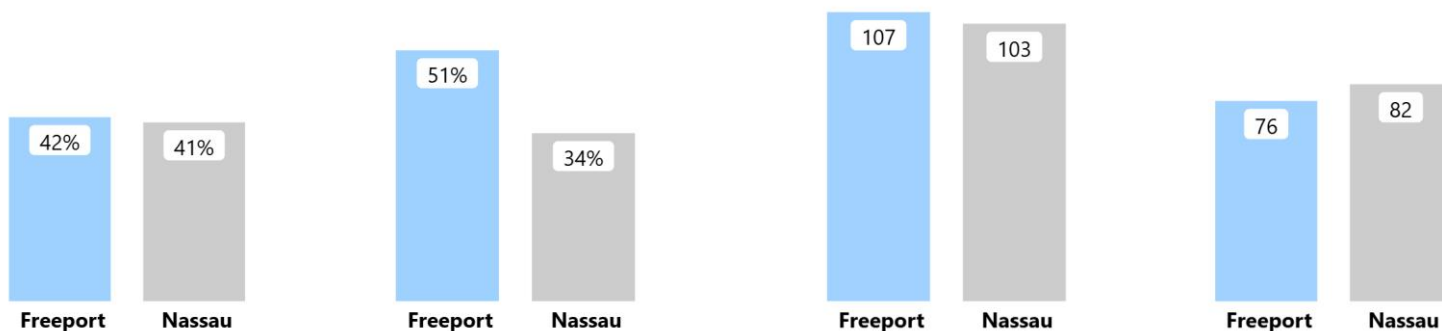
## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

### % Avoidable

### % Medicaid

### Total Rate

### Medicaid Rate



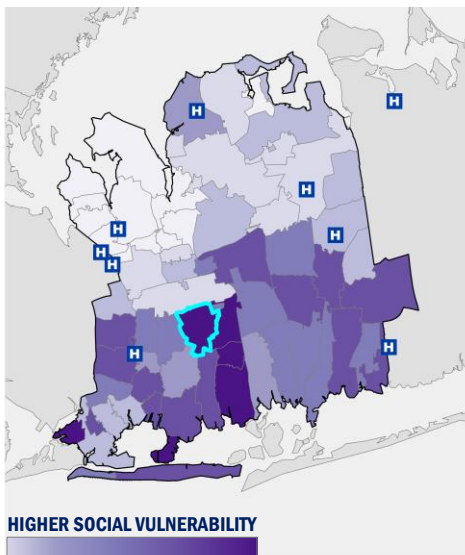
Prepared by the Office of Strategic Planning at Northwell Health | Source(s): Vizient Vulnerability Index, Child Opportunity Index, New York State Energy Research and Development Authority, U.S. Census Bureau: American Community Survey 5-Year Estimates (2023), Statewide Planning and Research Cooperative System (2023); NYU Emergency Room Algorithm & AHRQ Preventable Quality Indicator Overall Composite 90 | Note(s): Freeport defined as zip code(s) 11520; slight variations in totals are due to rounding

# HEMPSTEAD

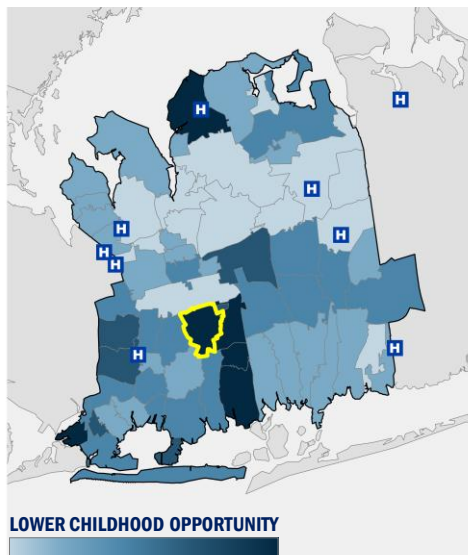


**POPULATION**  
60,658

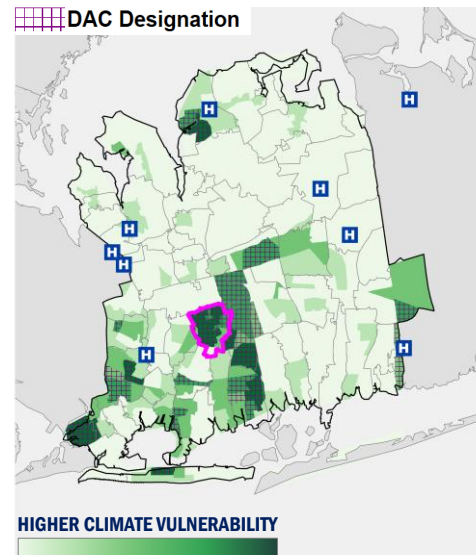
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



### HEMPSTEAD

### NASSAU

22.9%

**EDUCATION**  
% of 25+ population with less than high school diploma

7.9%

14.3%

**POVERTY**  
% of People below 100% Federal Poverty

5.3%

### HEMPSTEAD

### NASSAU

9.3%

**UNEMPLOYMENT**  
% of 16+ population unemployed

4.8%

20.3%

**NUTRITION**  
% of households receiving food stamps/SNAP

4.7%

### HEMPSTEAD

### NASSAU

49.6%

**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income

37.2%

21.9%

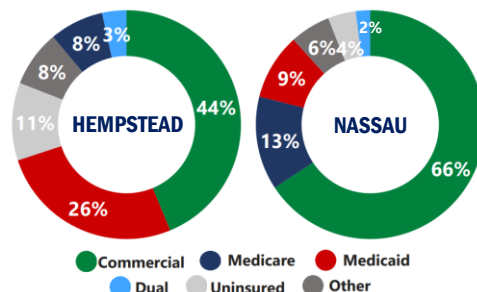
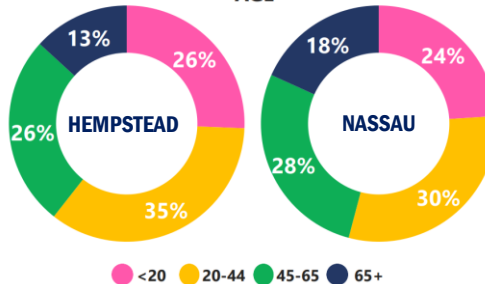
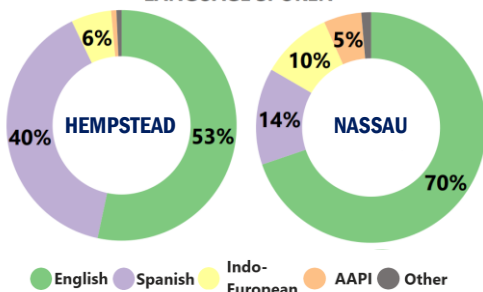
**TRANSPORTATION**  
% of households with no vehicle available

6.7%

### LANGUAGE SPOKEN

### AGE

### INSURANCE COVERAGE



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS

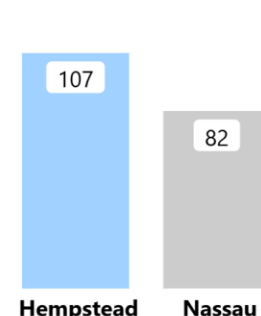
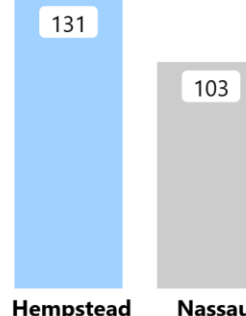
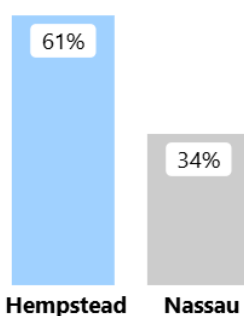
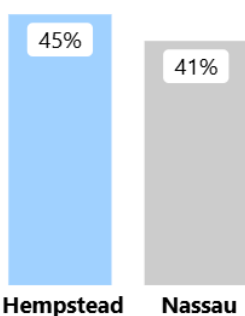
RATE PER 1,000 PATIENTS

% Avoidable

% Medicaid

Total Rate

Medicaid Rate

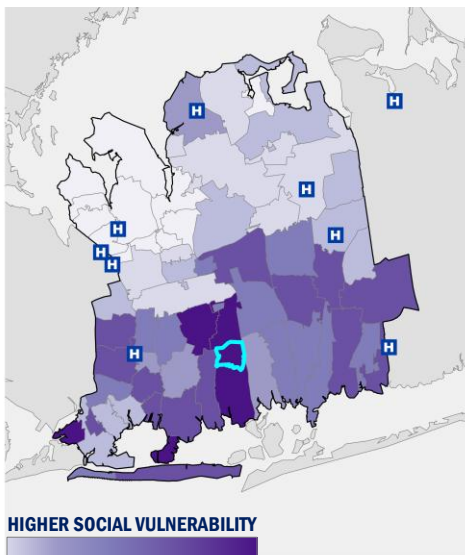


# ROOSEVELT

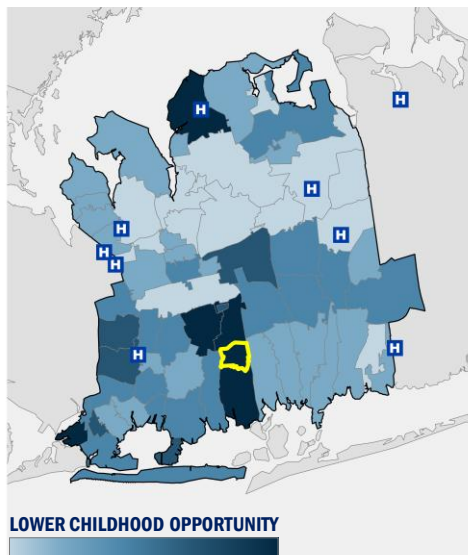


**POPULATION**  
**19,430**

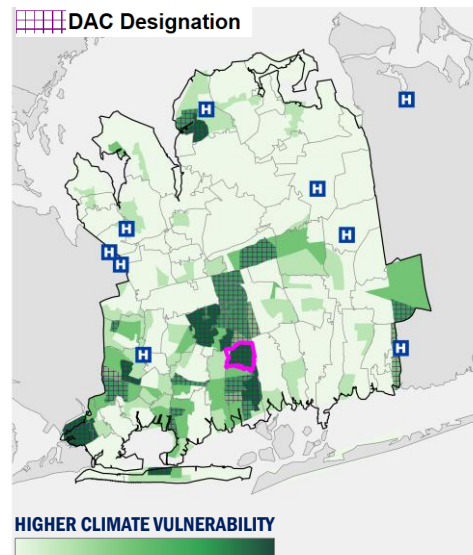
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



### ROOSEVELT

### NASSAU



### ROOSEVELT

### NASSAU



### ROOSEVELT

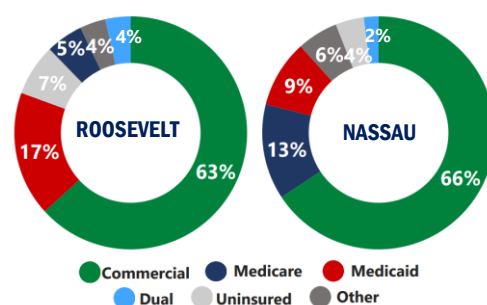
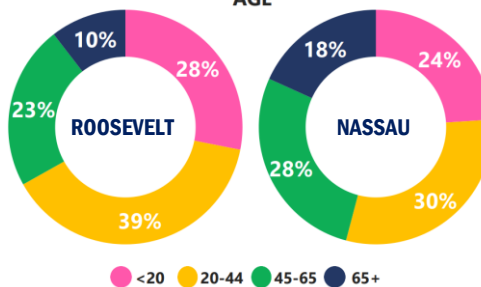
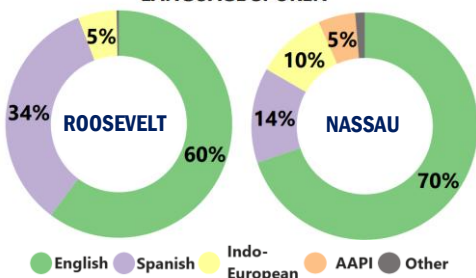
### NASSAU



### LANGUAGE SPOKEN

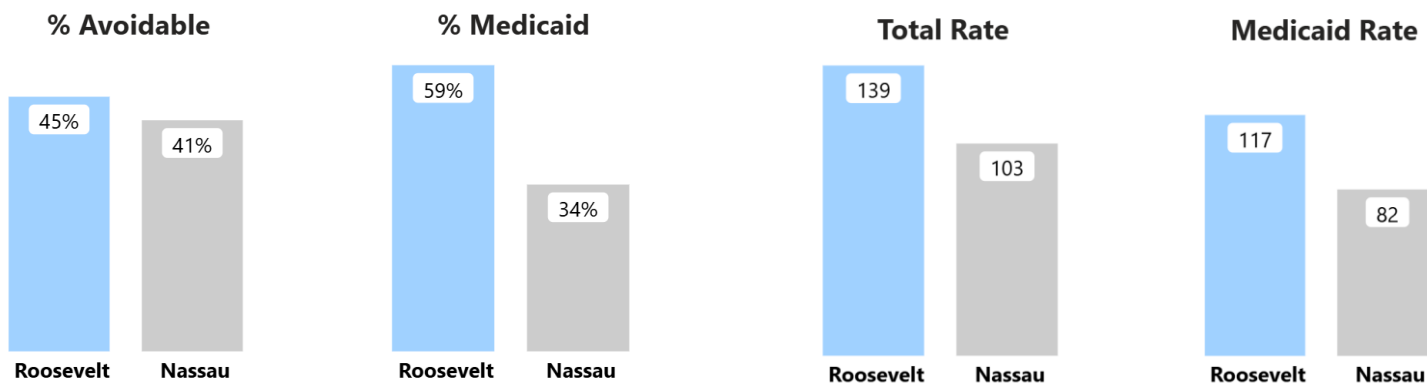
### AGE

### INSURANCE COVERAGE



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS



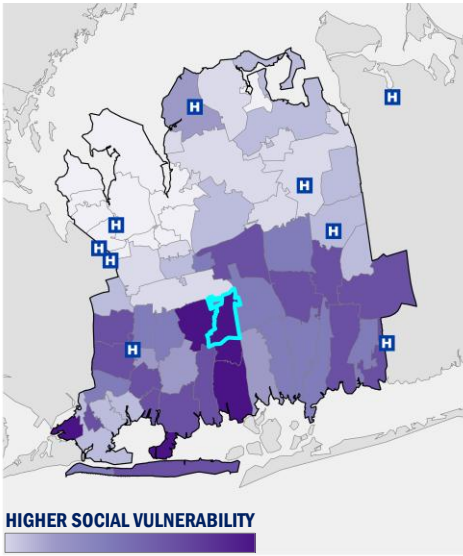
Prepared by the Office of Strategic Planning at Northwell Health | Source(s): Vizient Vulnerability Index, Child Opportunity Index, New York State Energy Research and Development Authority, U.S. Census Bureau: American Community Survey 5-Year Estimates (2023), Statewide Planning and Research Cooperative System (2023); NYU Emergency Room Algorithm & AHRQ Preventable Quality Indicator Overall Composite 90) | Note(s): Roosevelt defined as zip code(s) 11575; slight variations in totals are due to rounding

# UNIONDALE

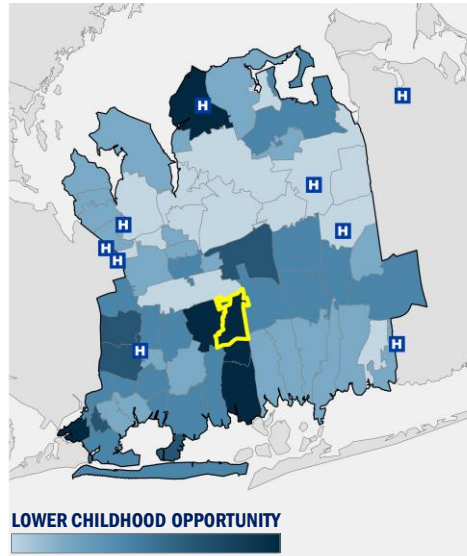


**POPULATION**  
**28,344**

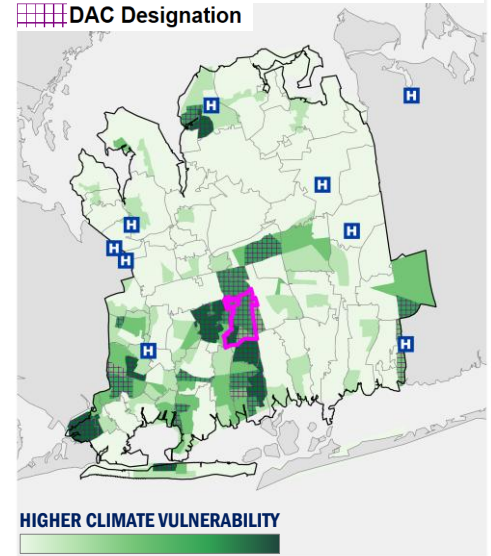
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



### UNIONDALE

### NASSAU



### UNIONDALE

### NASSAU

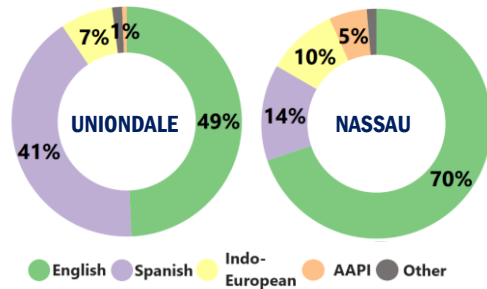


### UNIONDALE

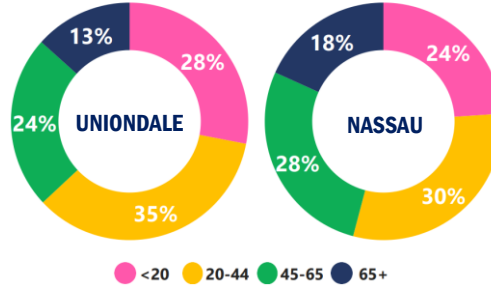
### NASSAU



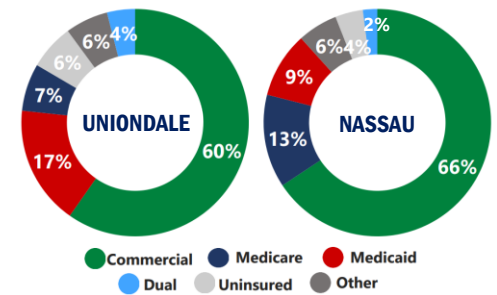
### LANGUAGE SPOKEN



### AGE



### INSURANCE COVERAGE



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

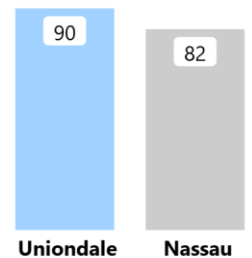
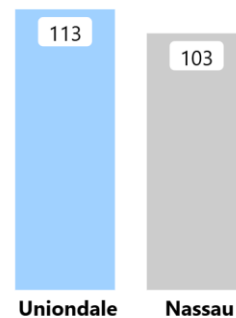
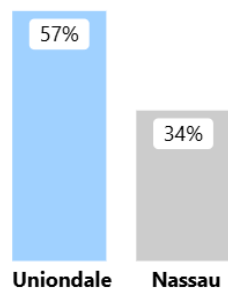
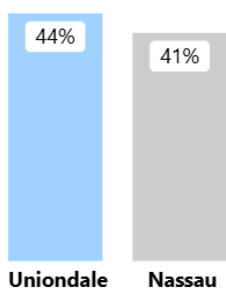
## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

### % Avoidable

### % Medicaid

### Total Rate

### Medicaid Rate



# LITTLE GUYANA, QUEENS

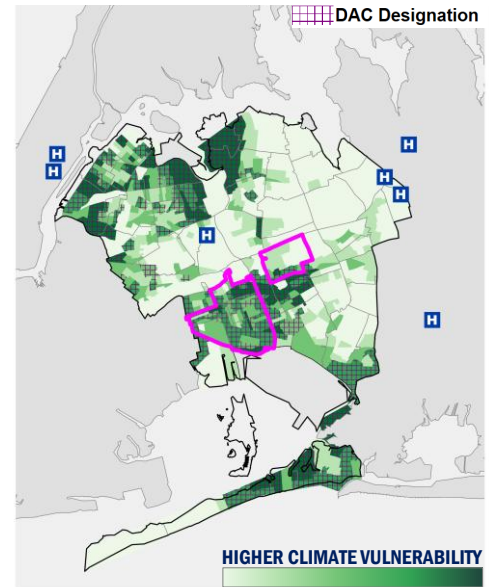
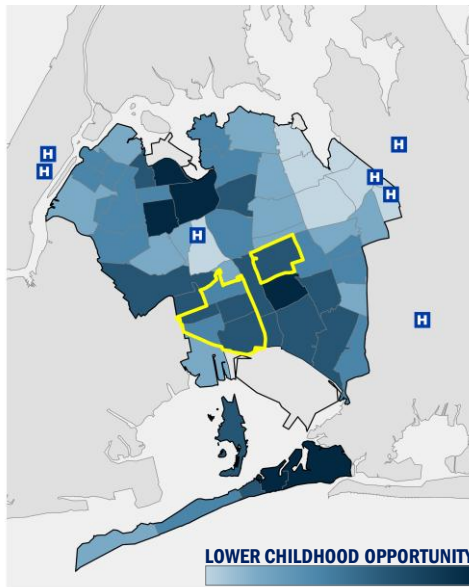
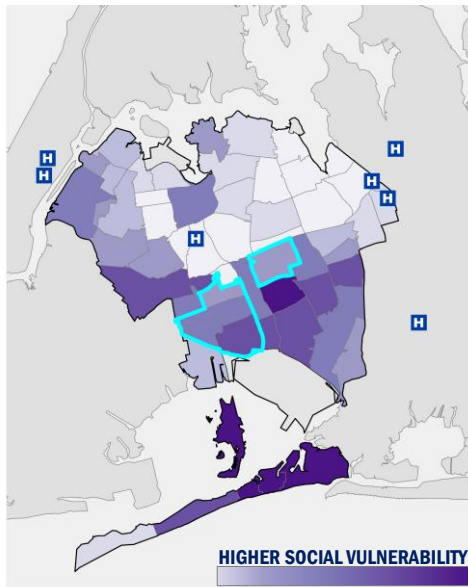


**POPULATION**  
253,783

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



**LITTLE GUYANA**

**QUEENS**



**LITTLE GUYANA**

**QUEENS**



**LITTLE GUYANA**

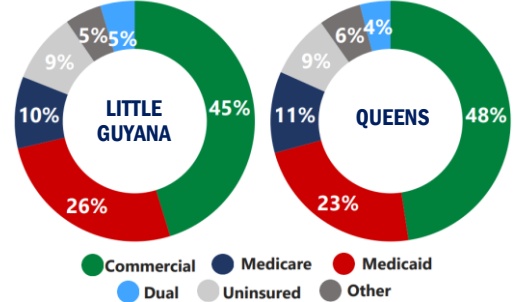
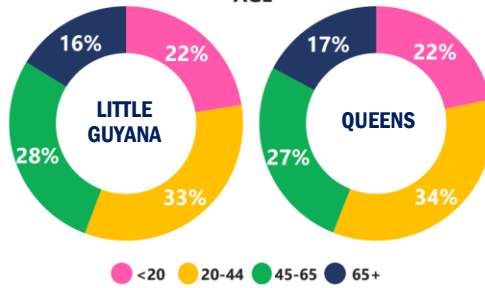
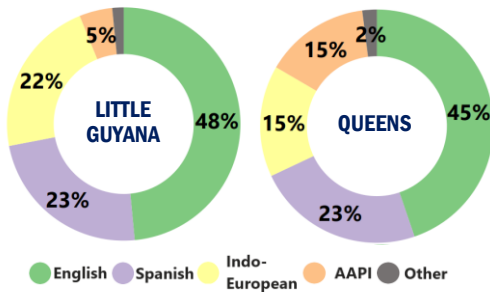
**QUEENS**



### LANGUAGE SPOKEN

### AGE

### INSURANCE COVERAGE



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

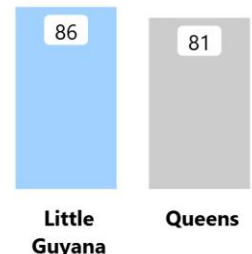
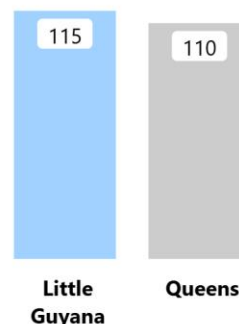
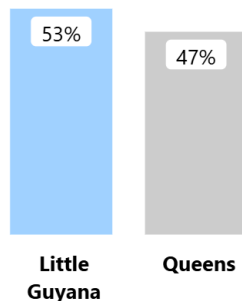
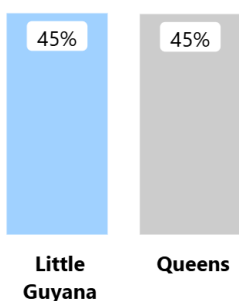
## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

% Avoidable

% Medicaid

Total Rate

Medicaid Rate



# SOUTHEAST JAMAICA

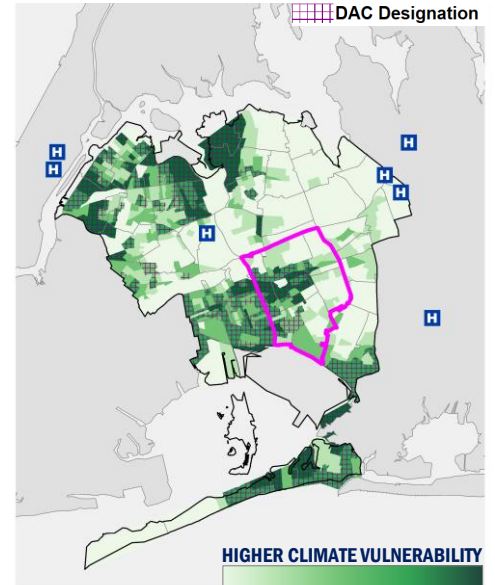
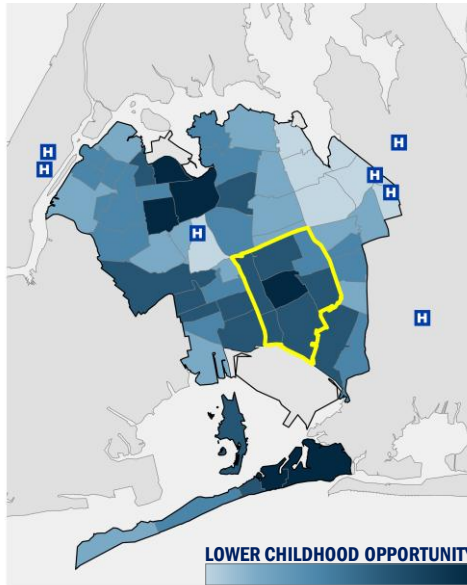
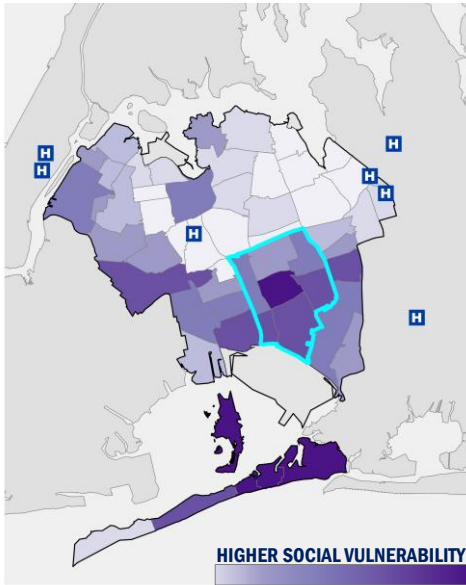


**POPULATION**  
**319,361**

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### SOUTHEAST JAMAICA

### QUEENS

17.0%

**EDUCATION**  
% of 25+ population with less than high school diploma

17.3%

### SOUTHEAST JAMAICA

### QUEENS

9.2%

**UNEMPLOYMENT**  
% of 16+ population unemployed

7.0%

### SOUTHEAST JAMAICA

### QUEENS

48.8%

**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income

45.4%

12.6%

**POVERTY**  
% of People below 100% Federal Poverty

12.2%

17.0%

**NUTRITION**  
% of households receiving food stamps/SNAP

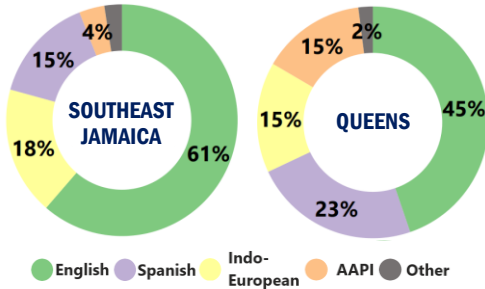
14.7%

32.1%

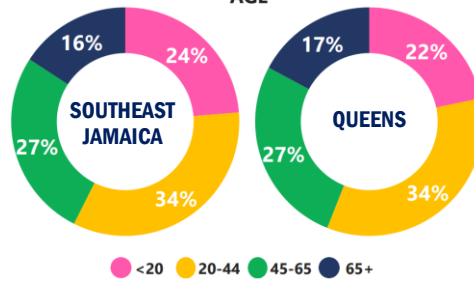
**TRANSPORTATION**  
% of households with no vehicle available

36.9%

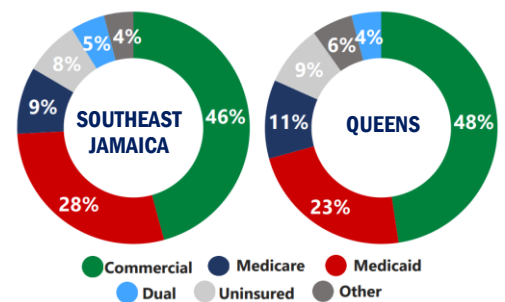
### LANGUAGE SPOKEN



### AGE



### INSURANCE COVERAGE



## EMERGENCY ROOM

### TREAT & RELEASE INDICATORS

% Avoidable

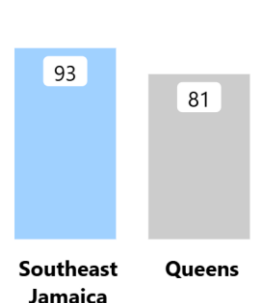
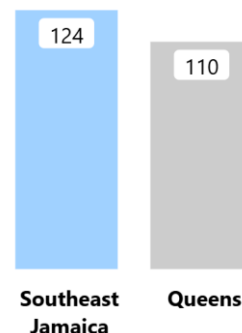
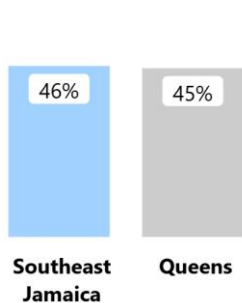
% Medicaid

## PREVENTABLE HOSPITALIZATIONS

RATE PER 1,000 PATIENTS

Total Rate

Medicaid Rate

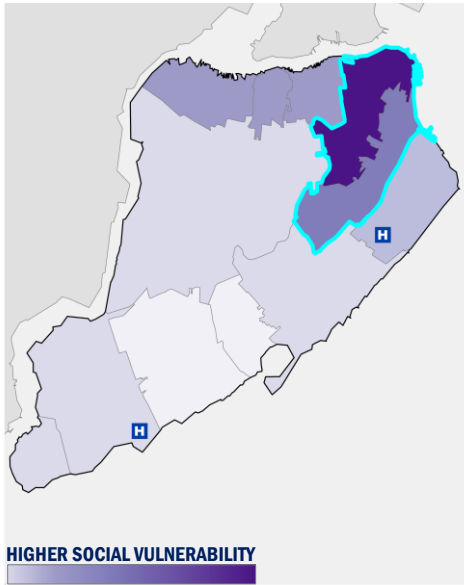


# STAPLETON, STATEN ISLAND

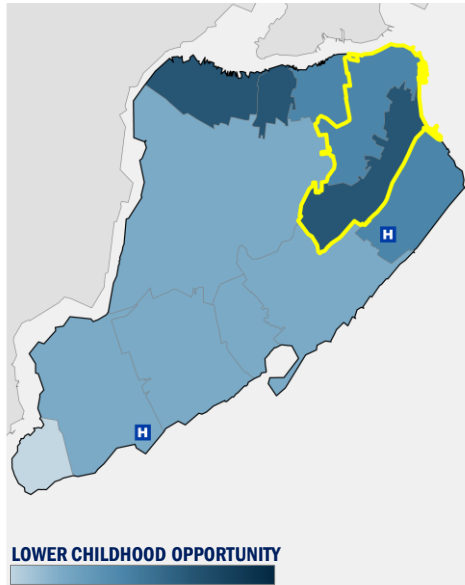


POPULATION  
**85,642**

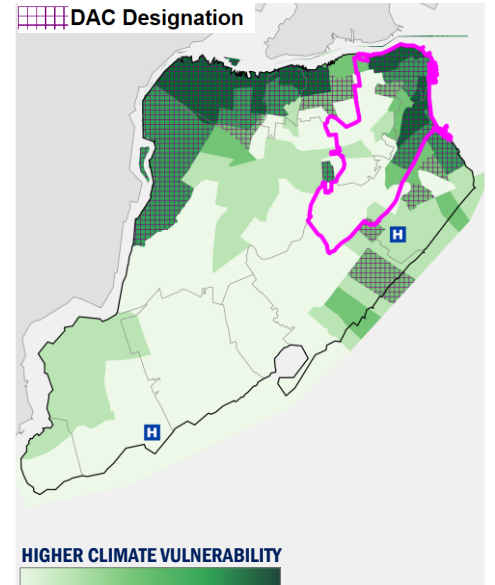
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



### STAPLETON

### STATEN ISLAND



### STAPLETON

### STATEN ISLAND

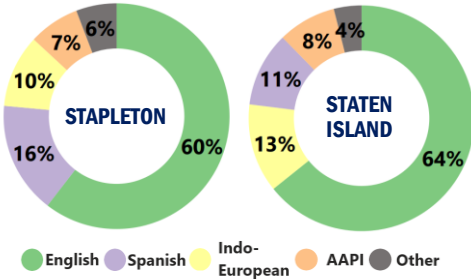


### STAPLETON

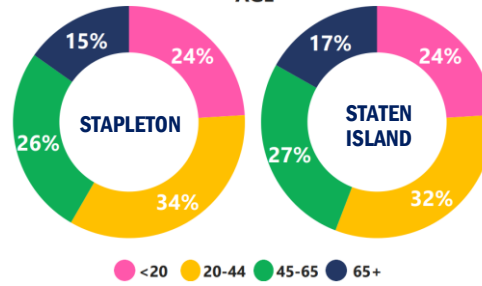
### STATEN ISLAND



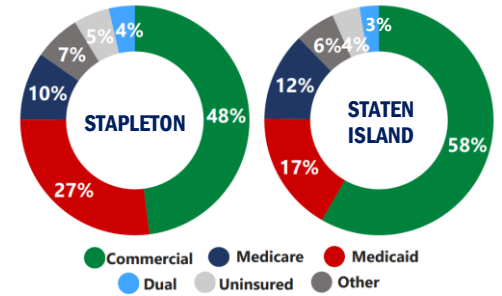
### LANGUAGE SPOKEN



### AGE

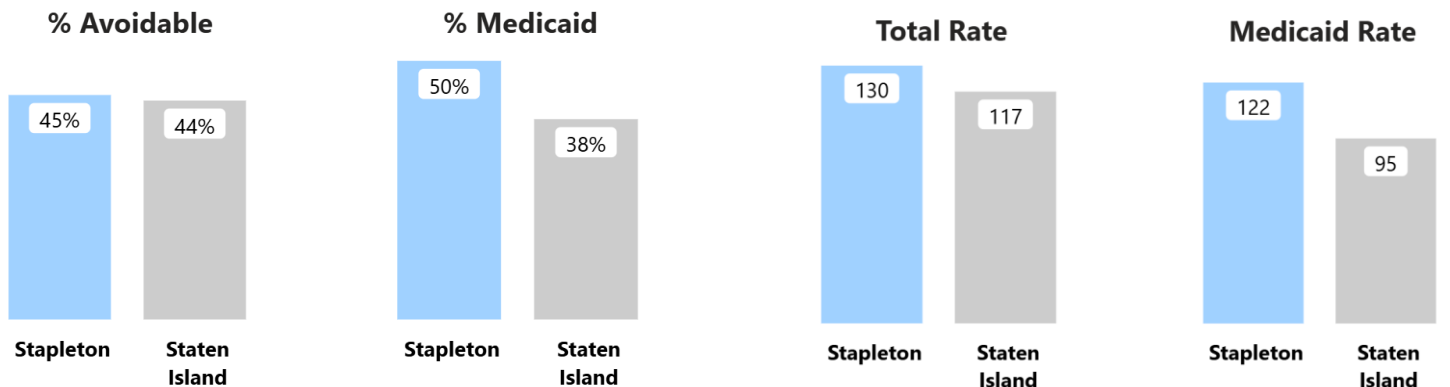


### INSURANCE COVERAGE



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS



# CENTRAL HARLEM

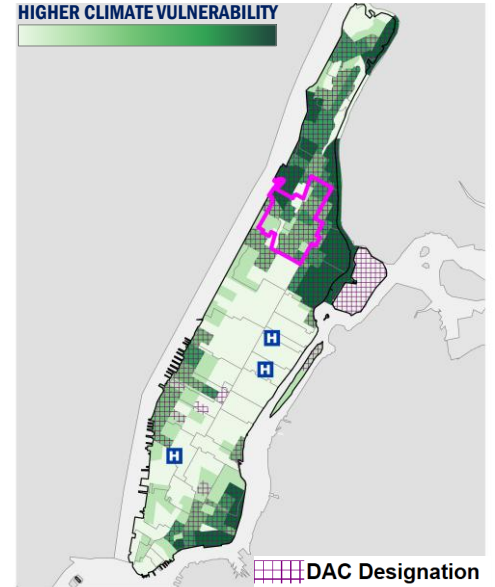
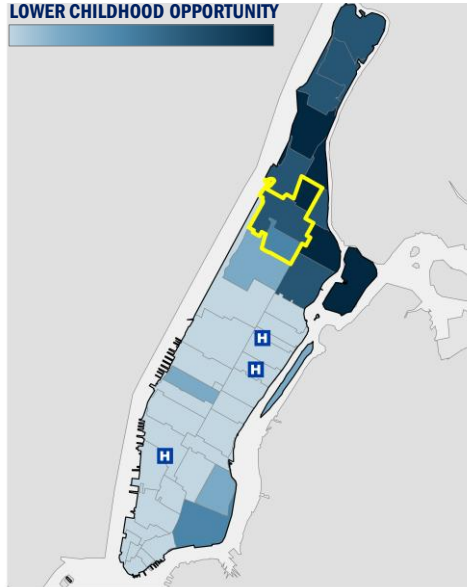
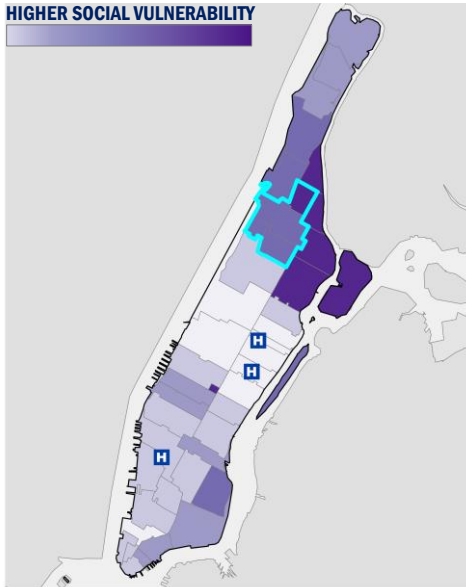


**POPULATION**  
**132,962**

## SOCIAL VULNERABILITY

## CHILD OPPORTUNITY INDEX

## DISADVANTAGED CLIMATE (DAC)



### CENTRAL HARLEM

### MANHATTAN



**EDUCATION**  
% of 25+ population with less than high school diploma



### CENTRAL HARLEM

### MANHATTAN



**UNEMPLOYMENT**  
% of 16+ population unemployed



### CENTRAL HARLEM

### MANHATTAN



**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income



**POVERTY**  
% of People below 100% Federal Poverty



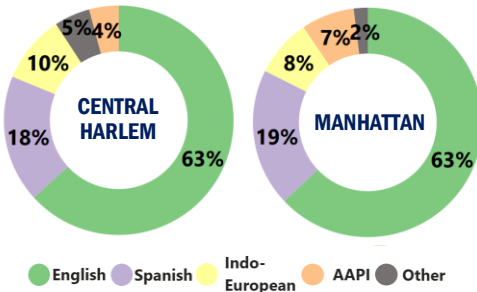
**NUTRITION**  
% of households receiving food stamps/SNAP



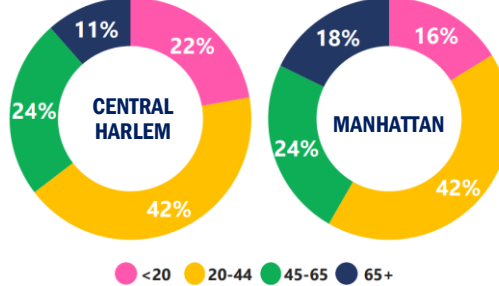
**TRANSPORTATION**  
% of households with no vehicle available



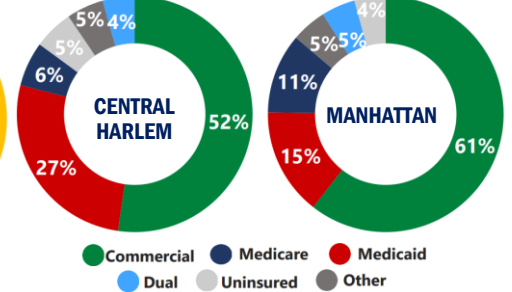
### LANGUAGE SPOKEN



### AGE



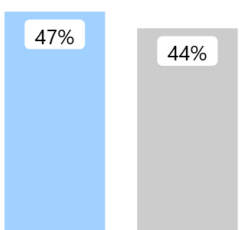
### INSURANCE COVERAGE



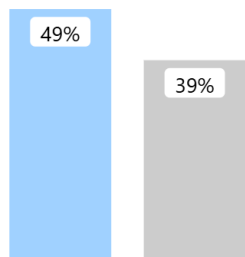
## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS

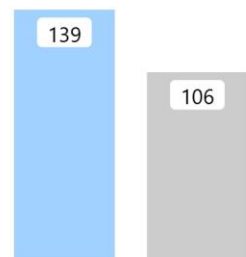
### % Avoidable



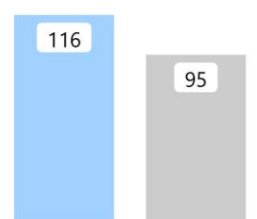
### % Medicaid



### Total Rate



### Medicaid Rate

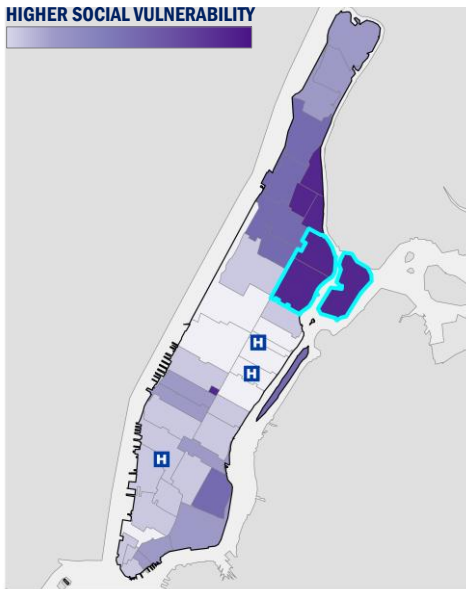


# EAST HARLEM

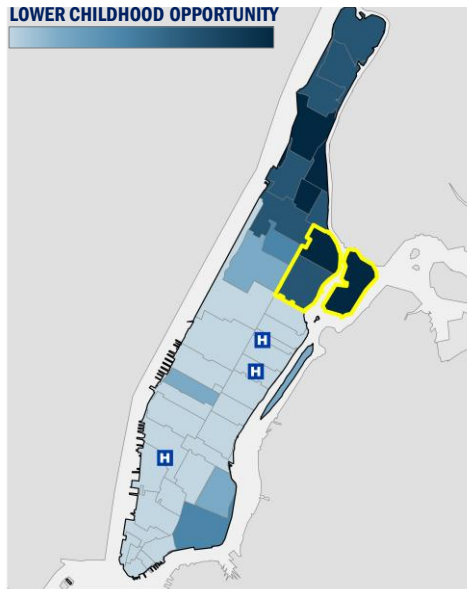


**POPULATION**  
113,930

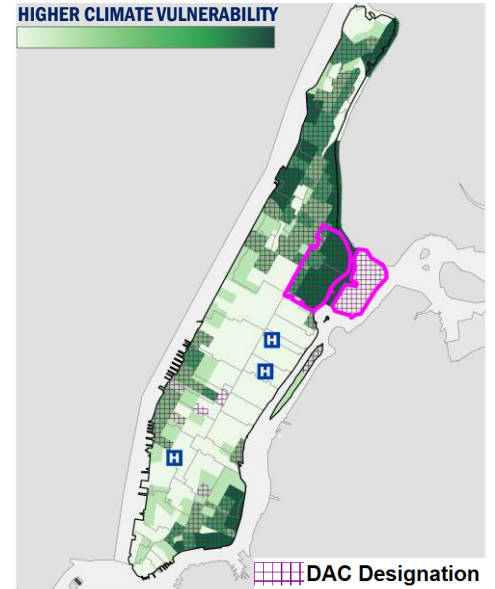
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



**EAST HARLEM**

**MANHATTAN**

22.5%

**EDUCATION**  
% of 25+ population with less than high school diploma

10.8%

**EAST HARLEM**

**MANHATTAN**

10.7%

**UNEMPLOYMENT**  
% of 16+ population unemployed

7.0%

**EAST HARLEM**

**MANHATTAN**

52.9%

**HOUSING BURDEN**  
% of households whose rent/mortgage exceed 30% of income

41.3%

32.9%

**POVERTY**  
% of People below 100% Federal Poverty

15.8%

30.7%

**NUTRITION**  
% of households receiving food stamps/SNAP

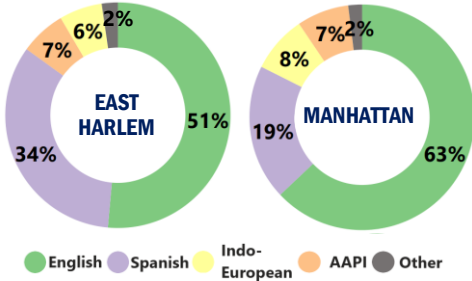
13.8%

84.8%

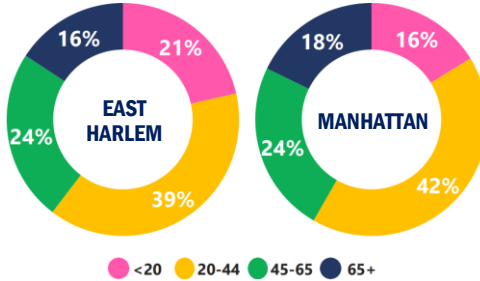
**TRANSPORTATION**  
% of households with no vehicle available

77.7%

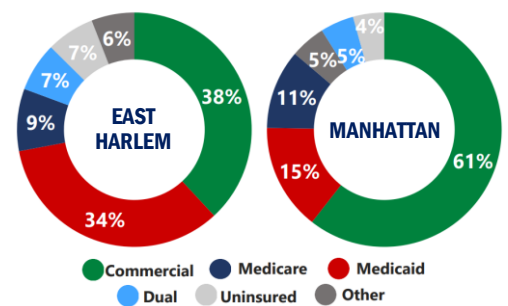
### LANGUAGE SPOKEN



### AGE



### INSURANCE COVERAGE



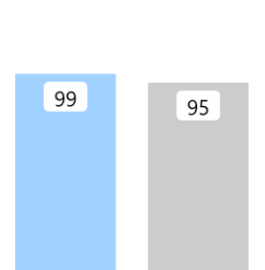
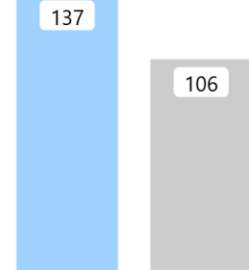
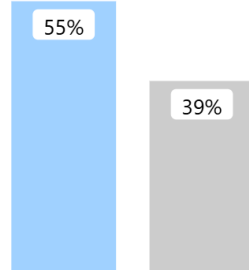
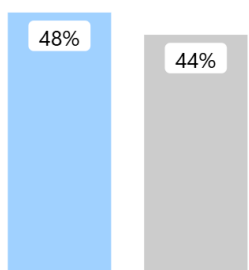
## EMERGENCY ROOM TREAT & RELEASE INDICATORS

**% Avoidable**

**% Medicaid**

**Total Rate**

**Medicaid Rate**

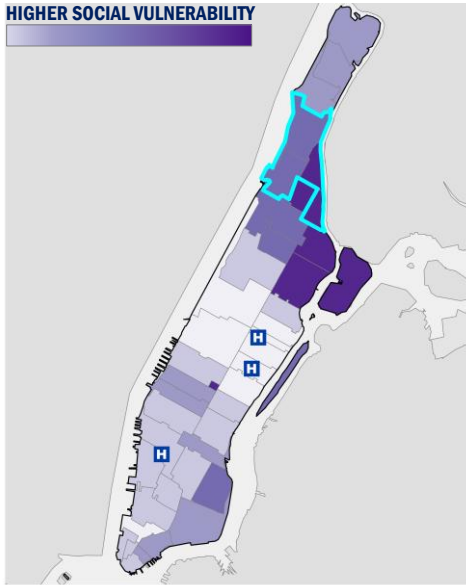


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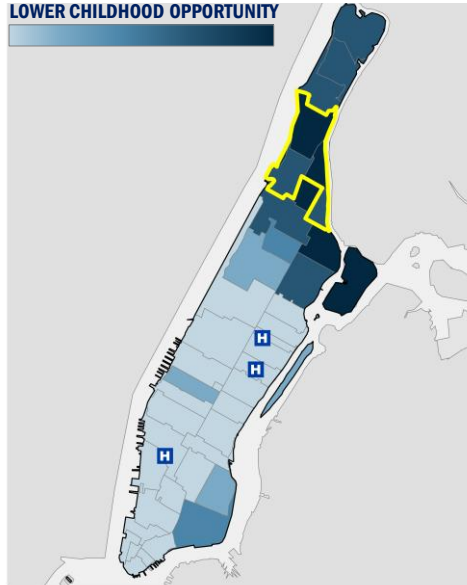


**POPULATION**  
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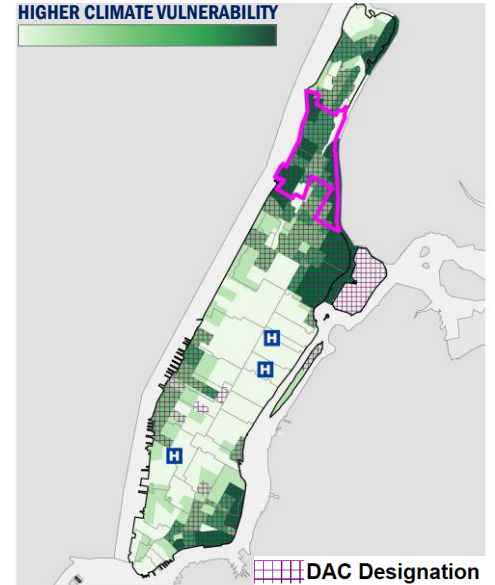
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX

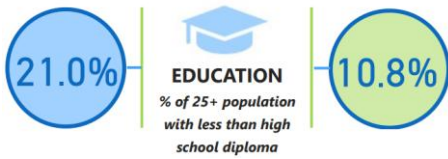


## DISADVANTAGED CLIMATE (DAC)



### WEST HARLEM

### MANHATTAN



### WEST HARLEM

### MANHATTAN

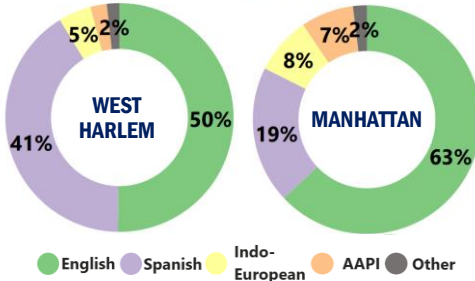


### WEST HARLEM

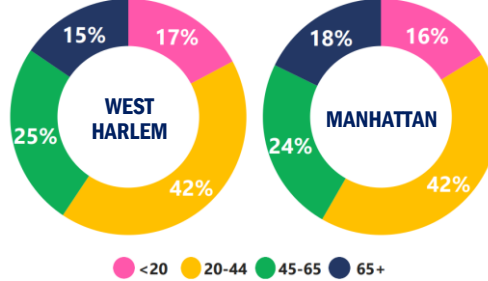
### MANHATTAN



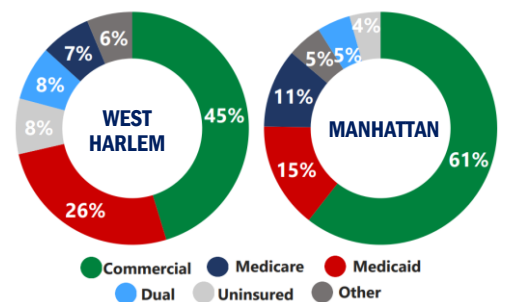
### LANGUAGE SPOKEN



### AGE

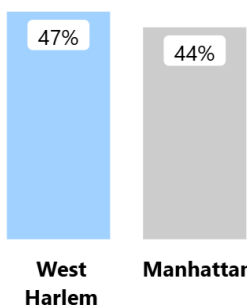


### INSURANCE COVERAGE

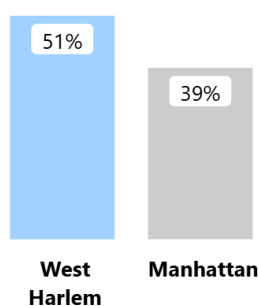


## EMERGENCY ROOM TREAT & RELEASE INDICATORS

### % Avoidable



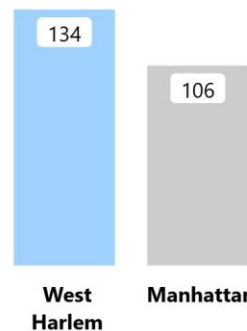
### % Medicaid



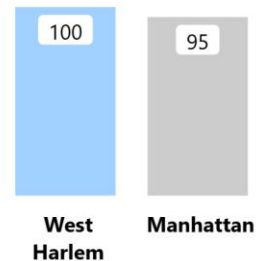
## PREVENTABLE HOSPITALIZATIONS

RATE PER 1,000 PATIENTS

### Total Rate



### Medicaid Rate

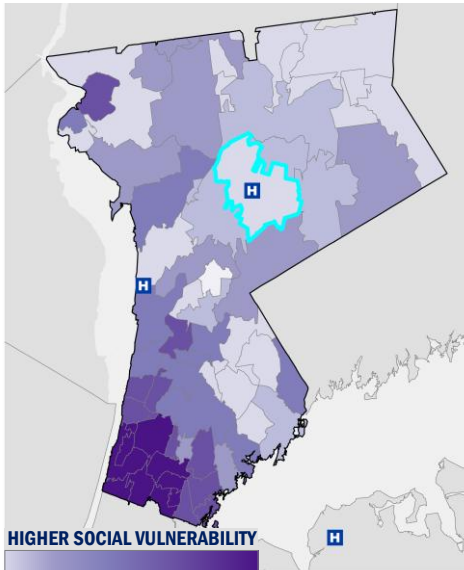


# MOUNT KISCO

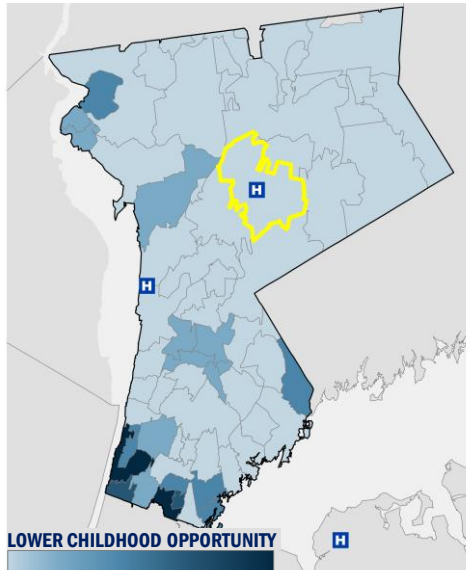


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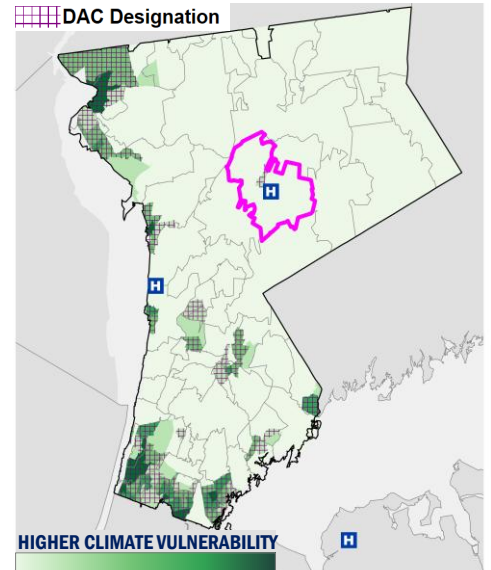
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



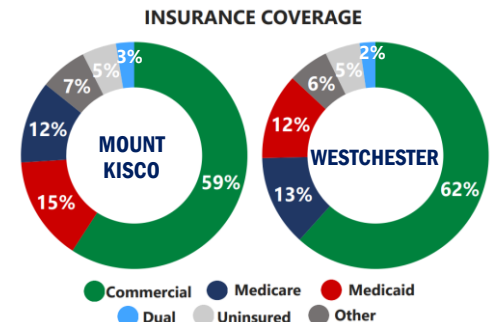
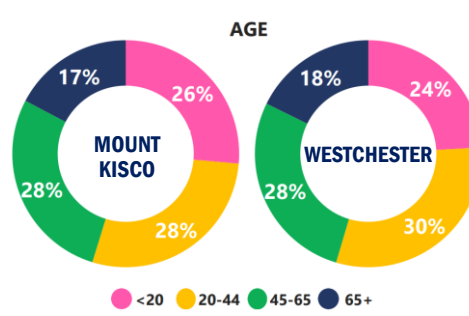
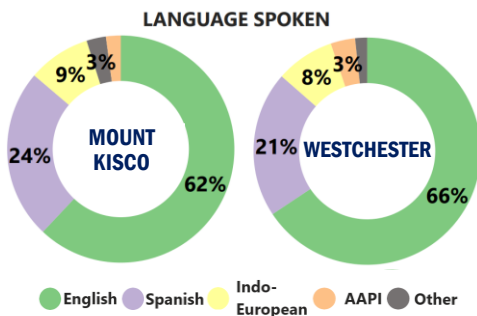
### MOUNT KISCO WESTCHESTER



### MOUNT KISCO WESTCHESTER

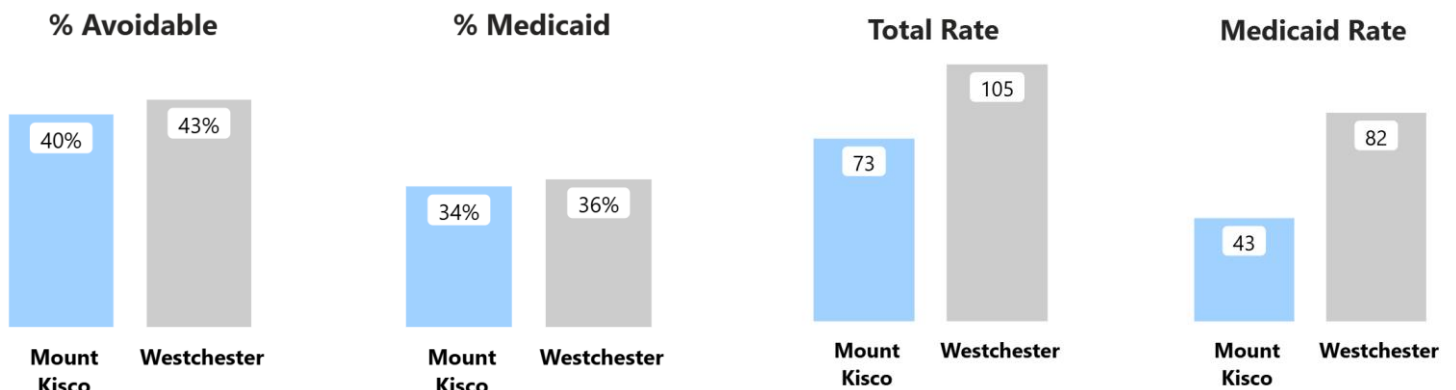


### MOUNT KISCO WESTCHESTER



## EMERGENCY ROOM TREAT & RELEASE INDICATORS

## PREVENTABLE HOSPITALIZATIONS RATE PER 1,000 PATIENTS



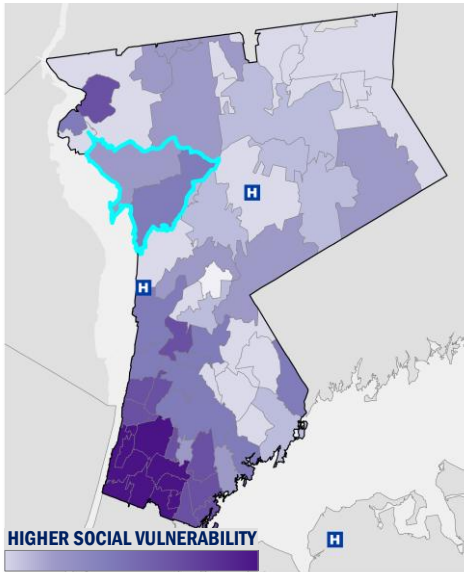
Prepared by the Office of Strategic Planning at Northwell Health | Source(s): Vizient Vulnerability Index, Child Opportunity Index, New York State Energy Research and Development Authority, U.S. Census Bureau: American Community Survey 5-Year Estimates (2023), Statewide Planning and Research Cooperative System (2023); NYU Emergency Room Algorithm & AHRQ Preventable Quality Indicator Overall Composite 90) | Note(s): Mount Kisco defined as zip code(s) 10549; slight variations in totals are due to rounding

# OSSINING

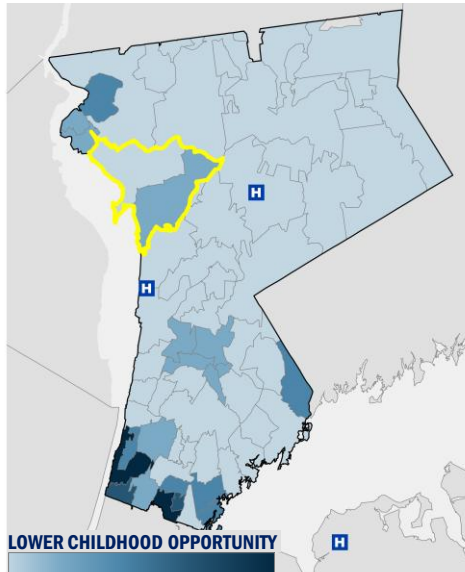


**POPULATION**  
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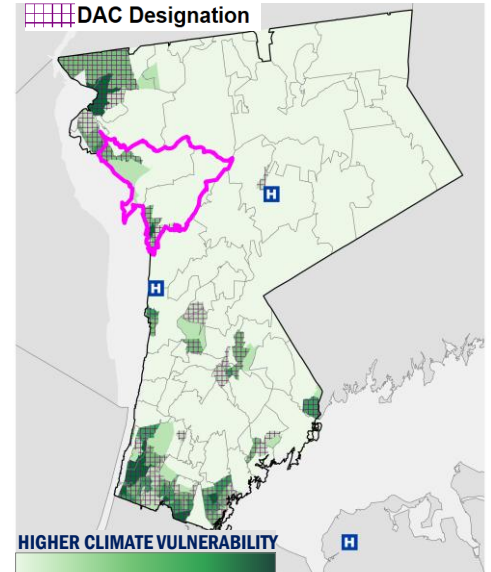
## SOCIAL VULNERABILITY



## CHILD OPPORTUNITY INDEX



## DISADVANTAGED CLIMATE (DAC)



### OSSINING

### WESTCHESTER

### OSSINING

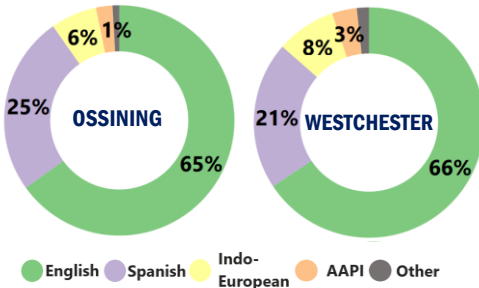
### WESTCHESTER

### OSSINING

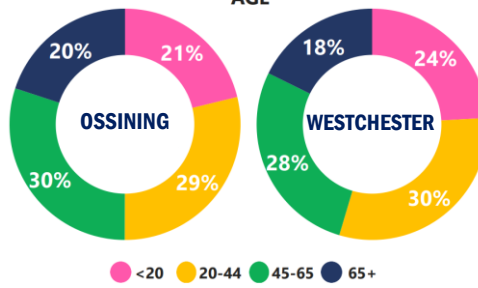
### WESTCHESTER



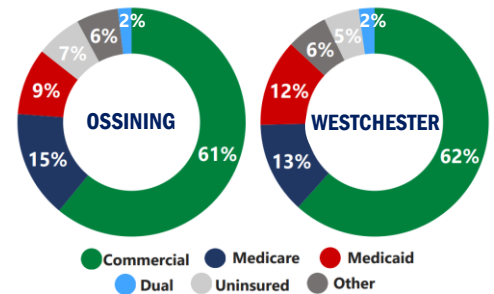
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### AGE

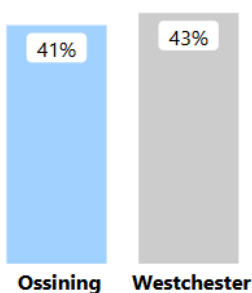


### INSURANCE COVERAGE

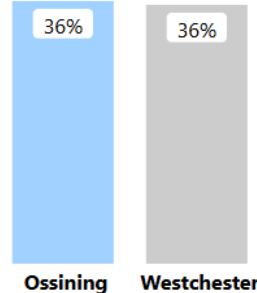


## EMERGENCY ROOM TREAT & RELEASE INDICATORS

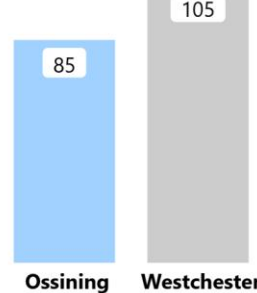
### % Avoidable



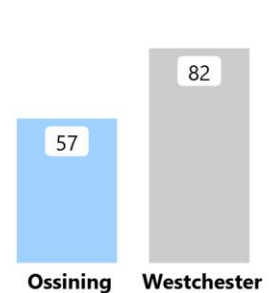
### % Medicaid



### Total Rate



### Medicaid Rate



## PREVENTABLE HOSPITALIZATIONS

RATE PER 1,000 PATIENTS



# OUR IMPLEMENTATION AND SERVICE PLAN

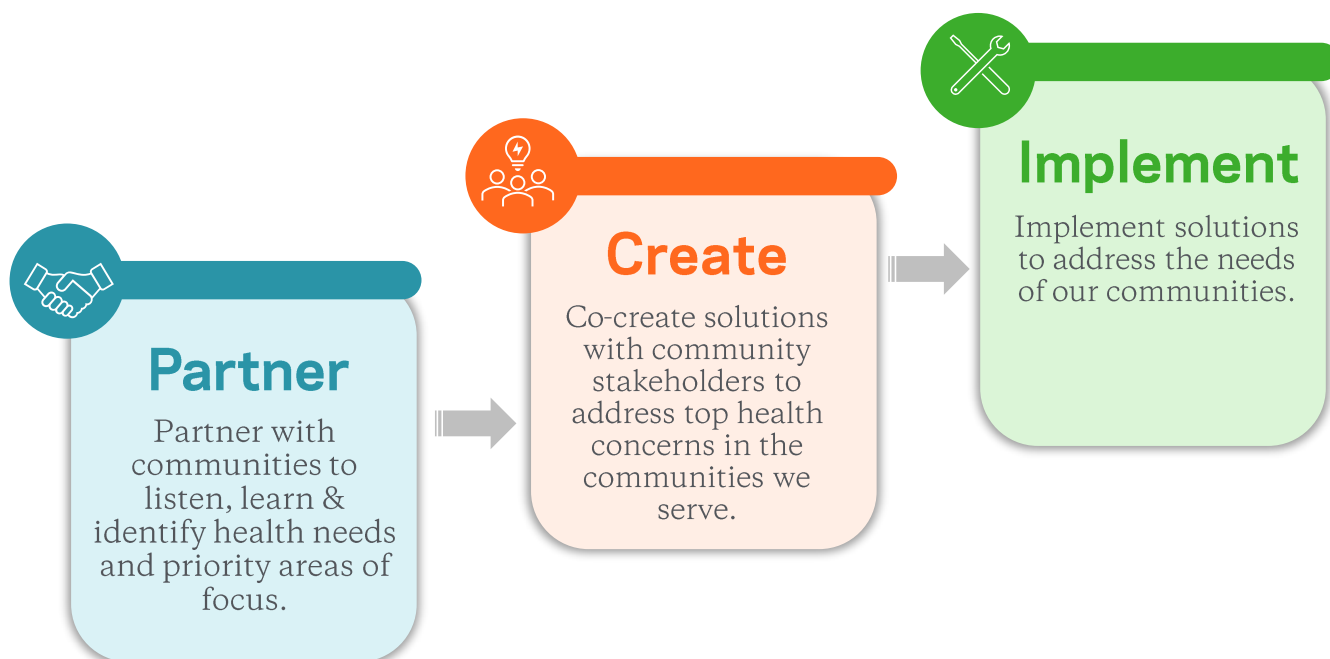
## From Assessment to Action

This next chapter introduces organizational wide programs that address the health needs identified through our CHNA. What makes this work possible is Northwell’s culture of systemness—working as one, with unified clinical and administrative leadership. Instead of siloed efforts, we operate within a matrixed organization that enables team-oriented development of policies, care pathways, and community health programs—so the right services show up in the right places, consistently, to improve community health.

The sections that follow highlight programs within our Implementation Plan and are designed to meet CHNA identified needs across cancer, cardiac, maternal and child health, behavioral health, aging, and community-based care. Cocreated with strategic partners, these initiatives address unmet health related social needs and make care easier to access in the communities we serve.

Our programs are data-driven and evidence-based, organized under New York State’s 2025-2030 Prevention Agenda. We align with all five domains of the Prevention Agenda, drawing clear lines from need to action—what the data surfaced, where we are focused, and how services are delivered. Many of these efforts are already underway in our neighborhoods of focus, in close collaboration with our community partners and our internal partners.

The following pages highlight representative systemwide programs led by, or in partnership with, Northwell’s Institute for Community Health & Wellness (ICHW). Additionally, site-specific initiatives, and their specific measures of success are further detailed in our system Implementation Plan, and in each hospital’s Community Service Plan. Together, these programs and partnerships show how we are leveraging our systemness to turn assessment into action—linking local work with a coordinated, systemwide approach to improve the health and wellbeing of our communities.



# HEALTHCARE ACCESS AND QUALITY

Access challenges to health care consistently surfaced as a priority during our CHNA process. The following section highlights programs within our Implementation Plan that are focused on improving timely access to effective, person-centered care across the lifespan of our community members. Priorities that are addressed within this domain are improving prenatal care access, education, and awareness, maternal health, preventive services, and disease management pathways for chronic conditions.

Our efforts to increase health care access would not be possible without our partners that are aligned with our mission and serve our communities with us. We have partnered with many Federally Qualified Health Centers (FQHCs) across our regions, to increase primary care access points and reduce preventable emergency room visits. Since our last CHNA, we have also partnered with the Long Island Coalition for the Homeless, our partner in increasing access to care for our unhoused community members.

We also continue to deepen our partnership with internal stakeholders across the organization, working together to address the needs of a changing population. Partnered with our Northwell Cancer Institute, we are increasing education, screening, and access to support groups, for our patients and communities affected by the rising rates of cancer. As part of our Institute, and through our Health Management team, we have designed and implemented programs to care for our patients and community members with complex health needs. Similarly, in partnership with Northwell's OB-GYN service line, and our Center for Maternal Health, we are working to increase access to evidence-based education and support to improve pregnancy and birth outcomes.

It is worth noting that while many of our programs prioritize addressing direct health needs, we see links and overlaps between access challenges and health-related social needs, several of which are reflected in the remaining domains of the new framework of the NYS 2025-2030 Prevention Agenda.



# IMPROVING PRIMARY CARE ACCESS THROUGH FQHC PARTNERSHIPS

Establishing hospital-to-community-center partnerships has proven to augment access points to primary and preventive care within communities, and lower preventable emergency room visits and disruptions to routine care.<sup>3,4,5</sup> Our CHNA findings surfaced the need to increase access points, specifically to primary care, behavioral health, maternal health, and prevention services. To minimize gaps in these services, Northwell has forged strong strategic partnerships with Federally Qualified Health Centers (FQHCs) and community providers across our catchment area.

Our partnerships with the FQHCs are powered by real-time data exchanges and shared clinical workflows. This enables timely follow up and coordinated care of our mutually shared patients. Our model ensures that patients discharged from Northwell hospitals—especially those without an established primary care relationship—are referred to nearby FQHCs for timely follow up, medication reconciliation, and ongoing care.

For maternal health, we maintain bi-directional communication for patients who deliver at Northwell hospitals, aligning with OBGYN service lines on education, navigation, and access to resources. For behavioral health, we have embedded processes to support screening, referrals, and continuity with FQHC care teams.

The partnership benefits the community by expanding access, shortening wait times for specialty services (cardiology, GI, cancer, maternal), and supporting coordinated care close to home. The model also provides direct scheduling assistance for vulnerable patients, integration with FQHCs for access to specialty care providers and referrals, ED referral pathways for non-Northwell designated patients to establish primary care; and linkage to social needs programs (food, nutrition, diabetes management, smoking cessation). In partnership with three of our FQHC partners, we have measurably reduced preventable ED usage among our co-shared patients.



**61%**

**Of patients reduced ED usage**

**18%**

**Reduction in ED visits (by 2,400+)**



# PREVENTIVE HEALTH SCREENINGS, IMMUNIZATIONS, AND COMMUNITY EDUCATION

Through the work of the Institute, *in 2024, Northwell implemented 204 preventive screenings events for over 21,000 community members.* The largest reach was in school-based clinics where over 10,000 students were screened. We also provided mammography and breast cancer screenings (3,770), as well as screenings for blood pressure (2,668) and oral health (1,006). Additional screening events covered overall health and fitness, colorectal and skin cancer, diabetes, cholesterol, vision, cardiovascular health, HIV/AIDS, asthma, hepatitis, and Alzheimer's disease. To also reduce the spread of the flu virus, Northwell also held nearly 80 immunization events, administering over 2,700 flu shots. These neighborhood and school-based efforts help make preventive care easier to access within the communities by bringing it closer to home. This is especially advantageous for residents facing transportation, cost, or scheduling barriers.

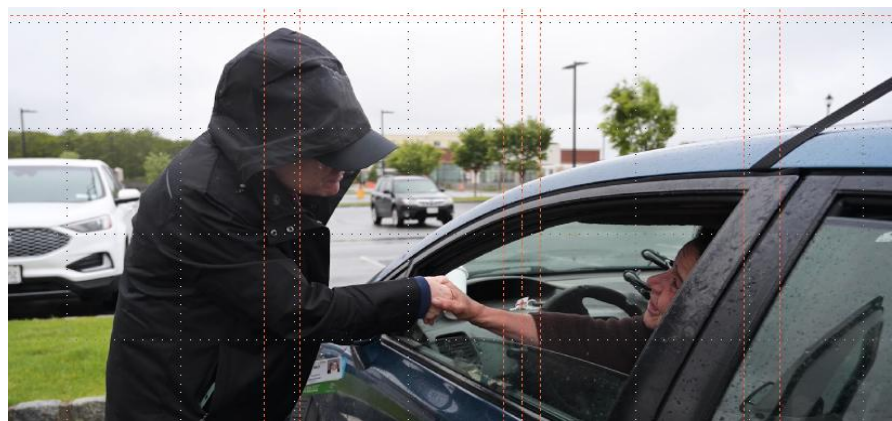
We also delivered extensive outreach and prevention efforts by providing over *3,300 community health education events engaging more than 2 million people.* Education topics addressed a wide range of health needs including wellness, cancer, school-based health, mental health, nutrition and weight management, women's health, heart disease, pediatric wellness, and substance abuse. Additional sessions focused on safety, CPR, family and parenting, chronic and infectious disease and other specialized health topics—demonstrating a strong commitment to raising health awareness and promoting disease prevention within our communities.

# NORTHWELL HEALTH STREET MEDICINE

Northwell Street Medicine was created to “go to the people,” reducing access barriers for unhoused neighbors by delivering safe, high-quality, person-centered care in nontraditional settings and unsheltered spaces such as streets, parking lots, parks or in shelters. Evidence from street medicine programs has shown that delivering care directly within encampments, shelters and where the unhoused are located increases access and continuity to reliable preventive and primary care. It also helps reduce avoidable acute and emergent care, while increasing linkages to housing and other social services.<sup>6</sup> Built on trust, inclusiveness, and person-centeredness, Northwell’s Street Medicine program pairs essential preventive services with further connections to social supports, linking individuals to Northwell’s Patient Access Services and community partners like the Long Island Coalition for the Homeless. The program has been incredibly successful based on the measures highlighted below and has even earned statewide recognition from the Healthcare Association of New York State’s (HANYS) Community Health Improvement Award (CHIA).

As of November 2025, teams have completed:

- **283 patient encounters**
- **93 unique patients served**
- **12 hospitalizations coordinated**
- **59 specialist referrals made**
- **85 connections facilitated to Patient Access Services (PAS)**
- **16 clients secure housing, with additional links to employment and talent acquisition**
- **6 referrals to Northwell Talent Acquisition**
- **57 communities reached**
- **~3,600 miles driven**



To watch our video on  
Street Medicine:

Scan QR Code or visit  
[qrco.de/StreetMedicine](https://qrco.de/StreetMedicine)

# NORTHWELL'S CANCER COMMUNITY EDUCATION PROGRAM

Cancer was a major health concern and condition among our senior populations throughout our CHNA process. In partnership with Northwell's Cancer Institute, the ICHW's Cancer Community Education Program (CCEP) focuses on reducing cancer incidence and burden in high-risk communities through ongoing screening, education, health promotion and navigation to treatment. Community-based, culturally tailored education coupled with patient navigation have shown to increase cancer screening uptake and timely follow-up, strengthening access and research participation to all populations.<sup>7,8,9,10</sup> Guided by clear outreach priorities, CCP expands screening efforts by standardizing protocols, concentrating in neighborhoods with low screening rates, and pursuing grants to increase capacity. The program delivers branded, culturally appropriate patient and community education to increase awareness and health promotion against cancer. CCP measures impact through metrics and dashboards that track event effectiveness, screening outcomes, and cancer burden in our catchment area.

To improve representation in cancer research participation, CCP provides clinical trials education and supports inclusive enrollment, with community representation on the Cancer IRB. The program integrates with Cold Spring Harbor Laboratory (CSHL) Cancer Center on meaningful community outreach and strengthens partnerships with community organizations and payors—maintaining existing relationships while building new ones to address local gaps and needs. A Cancer Ambassador Program leverages trained ambassadors to volunteer at events and offer feedback that shapes outreach effectiveness, while a Community Advisory Board coordinates the voice of our communities on implementing proposed interventions.

CCEP's collaborative model has demonstrated significant impact, connecting residents to education, screening, navigation, and research opportunities that improve prevention, early detection, and treatment access.



## SCREENING & EARLY DETECTION

700+ Rides Provided  
60+ Screening Events



## ACCESS TO CANCER CARE

300+ Rides Provided  
200+ Patients Supported

## COMMUNITY ENGAGEMENT

700+ Screened  
60 Screening Events



## COMMUNITY PARTNERSHIPS

74 Community Partners across  
Northwell Markets



# NORTHWELL'S HEALTH MANAGEMENT DIVISION

Health Management brings together programs that help patients navigate care, recover after hospital stays, manage complex needs at home, and connect to resources that improve everyday health. The team partners with clinicians across Northwell and community organizations to deliver practical, patient-centered care.

## Health Home (Adults and Children)

Evidence shows that Medicaid care coordination models—especially when they include patient navigation and social needs linkage—significantly increase cancer screening uptake and timely follow-up among high need populations, improving access to prevention and care.<sup>11,12</sup> Health Home (HH+) is New York State's Medicaid care coordination program, delivered by Northwell's Health Management team, for adults and children with chronic conditions and behavioral health needs. Care Management Coordinators (CMCs) provide comprehensive, longitudinal support—linking members to medical, mental health, substance use treatment, and social services; closing preventive care gaps; and coordinating transitions of care. Northwell embeds Associate Patient Access Service Representatives (APASRs) in emergency departments to identify and enroll eligible members and partners closely with Northwell's Behavioral Health Service Line to deliver HH services for those with serious mental illness. Members are eligible if they meet the following criteria:

- Two or more chronic conditions (examples include diabetes, asthma, heart disease, hypertension, obesity, COPD, HIV/AIDS, SUD, serious mental illness), or
- One chronic condition plus risk of developing another, or
- HIV/AIDS, or
- Serious Mental Illness (SMI) or
- Serious Emotional Disturbance (SED) for children.



## Impact and highlights

- ▶ 5,706 lives served, of which 3,174 were children from Jan–Nov 2025
- ▶ Enrollment growth: 29% (children) and 107% (adults) from 2024 to 2025 YTD
- ▶ 28.4% reduction in ED visits after 12 months enrolled; \$1.4M ED-related cost savings (Healthfirst analysis, 2021–2022)
- ▶ 78% lower inpatient hospitalizations and 75% lower ED visits vs. eligible but unenrolled populations (12-month cohort, 2020–2024 analysis); ~\$1.2M cost savings
- ▶ NCQA Case Management accreditation; strong HEDIS gap-closure performance, including market-leading FUA-7 follow-up for alcohol use and sustained statewide outperformance on IET for SUD
- ▶ Reduced inpatient length of stay at Zucker Hillside Hospital

## Transitional Care Management (TCM)

Health Management's Transitional Care Management (TCM) program provides 30–90 days of structured, episodic care management after hospital discharge. Research has shown that, for Medicare beneficiaries, structured transitional care management that includes early post discharge contact, medication reconciliation, and coordinated follow-up, significantly reduces 30-day readmissions and improve health outcomes. <sup>13,14</sup> The TCM program serves recently discharged patients across adult and pediatric populations, including those with cardiac, pulmonary, neurological, endocrine, and behavioral health needs. The TCM program is based on a team-based model—Advanced Care Providers (ACPs), RNs, CMCs, social workers—working together to deliver early post-discharge outreach, medication reconciliation, education, risk-based follow-up, and rapid escalation when needed. The program is integrated across all Northwell acute care hospitals and is NCQA accredited for Case Management, with 24/7/365 after-hours clinical support via the Clinical Call Center.

- ✔ **13,000+ TCM enrollments in 2025**
- ✔ **Reduction in hospital readmissions**
- ✔ **Consistent timely post-discharge contact and follow-up**



## House Calls Program

Northwell Health House Calls is a value-driven, home-based primary care program that delivers care to homebound older adults in Manhattan, Richmond, Queens, Nassau, Suffolk and Westchester counties in downstate New York. The program typically serves adults 65+, homebound, with multiple chronic conditions and activities of daily living (ADL) dependencies, frequent hospitalizations, and skilled nursing needs. For homebound, medically complex older adults, interdisciplinary home-based primary care programs—providing urgent assessments, in-home diagnostics, telehealth, and 24/7 clinical support—have been shown to reduce 30-day readmissions and ED visits while lowering total Medicare costs and improving outcomes.<sup>15,16</sup> The House Calls program is made up of an interdisciplinary team that provides comprehensive care to high-risk patients, and aligns care with our value-based contracts to improve outcomes and reduce avoidable utilization.

For the ninth consecutive year, the US Centers for Medicare and Medicaid Services (CMS) recognized Northwell's House Calls program for its best-in-nation performance in producing high-quality care and cost saving measures. It will be receiving over \$5 million from CMS through the Independence at Home demonstration program. The award is based on data from 2022, the most recent year available. Northwell's costs for treating its patients was 30% lower than the projection by CMS, which led to the cost-saving award.<sup>17</sup>

## Comprehensive care to vulnerable patients:

- ▶ Patient centered longitudinal care
- ▶ Urgent care assessments
- ▶ Telehealth visits
- ▶ 24/7 Community Paramedicine
- ▶ Interdisciplinary care team
- ▶ In-home diagnostics
- ▶ Homebound vaccinations
- ▶ 24/7 RN Clinical Call Center



## Employee Care Management

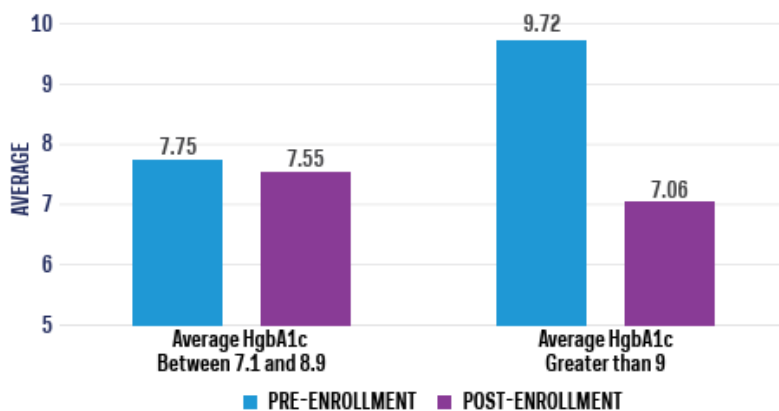
Health Management’s Employee Care Management program offers complex care management services to eligible team members, including Northwell Direct insurance plans and Northwell Health’s Employee Plan (EHP), representing approximately 24,000 enrolled members. In 2022, the PATH program designed and developed a care management program tailored to meet the needs of individuals diagnosed with Type 1 and Type 2 diabetes. The program aims to reduce and/or eliminate diabetes progression and associated comorbidities by empowering patients to improve their self-management skills through care coordination, targeted clinical education and individualized clinical support.

The program’s interdisciplinary team (IDT) consists of Centers for Disease Control and Prevention (CDC) certified health coaches (including registered nurses), care management coordinators, dietitians and certified diabetes educators. Each patient receives an individual health assessment that contributes to the development of a comprehensive, patient-centered care plan. The care plan incorporates the patient’s unique health goals and clinical needs, leveraging their strengths and disease management support needs. It also focuses on preventive care and closing gaps-in-care with an aim of slowing or reversing disease progression. The IDT facilitates patient navigation of the healthcare system, mitigates barriers to care and connects patients with specialized providers and services, ensuring coordinated and comprehensive support. Collaborating with the patient’s primary care provider and/or specialist, the IDT provides information to empower patients in managing their diabetes and any associated complications throughout their healthcare journey.

Since 2022, Employee Care Management’s diabetes care management program has enrolled 2,285 patients, with 637 enrolled in 2024. Program success is measured by HgbA1c reduction, comparing pre- and post-enrollment levels. Reducing HgbA1c levels has been known to reduce the risk and/or prevalence of cardiovascular disease, neuropathy, nephropathy, peripheral vascular disease and other diabetes-associated comorbidities. Outcome analysis demonstrates that patients entering the program in 2024 with pre-enrollment HgcA1cs between 7.1 and 8.9 experienced a post-enrollment percent reduction rate of 2.58%. Patients with HgbA1cs greater than 9 had a post-enrollment relative reduction rate of 27.38%.

### Northwell Health

#### Pre- and post-enrollment average HgbA1c January 2024–November 2024



Source: Laboratory and Claims Data,  
Care Tool Care Management System  
Lower is better  
Data as of January 2025



## Maternal Outcomes (MOMs) Navigation Program

Evidence shows that maternal care navigation—combining social needs screening, behavioral health assessment, and structured prenatal to postpartum follow-up—improves access and continuity for high-risk birthing people and can reduce readmissions and severe maternal morbidity.<sup>18,19</sup> Health Management’s Maternal Outcomes Navigation Program (MOMs) is a clinically validated, high-touch navigation program that extends provider reach for pregnant and postpartum patients, with emphasis on those at higher risk for serious maternal morbidity (SMM). Navigators offer telephonic support, care coordination, and connections to behavioral health, specialty care, doulas, and community services across the Northwell footprint. The model shifted in 2025 to payor-agnostic care coordination with Health Home integration, allowing consistent support regardless of coverage. The program serves pregnant and postpartum patients, including Medicaid members and those identified with SMM risk factors, across all Northwell birthing facilities on the Sunrise EMR.



The MOMs program has had the following successes:

- ▶ **47% reduction in readmissions versus non-navigated patients**
- ▶ **15% reduction in total cost per member per month**
- ▶ **44% program improvement in Medicaid outcomes since the 2024 model change**
- ▶ **Community Health Worker (CHW) adjunct: screening, doula connections, and education across trimesters and alternative pregnancy outcomes**
- ▶ **OBGYN collaboration on anesthesia education beginning at 30 weeks**

## Maternal Behavioral Health Partnership

The Maternal Behavioral Health Partnership integrates with the MOMs Navigation Program to make mental health a core part of maternal care. Through systematic screening during pregnancy and postpartum, the team identifies depression, anxiety, and other concerns early. Education helps patients understand mental health in pregnancy and motherhood, while navigators create clear pathways to care. The partnership also works to reduce common barriers—such as scheduling challenges and limited access—so patients can connect to the right services and sustain treatment.

- Between 2020 and 2025, 10% of MOMs patients (389) received behavioral health referrals
- 13.2% (521 patients) were successfully connected to care following positive screenings
- Expanded treatment access for postpartum depression, anxiety, and other mental health conditions

Looking forward, continued integration of behavioral health with maternal navigation aims to provide more comprehensive support, reduce readmissions, and improve outcomes for mothers and families.

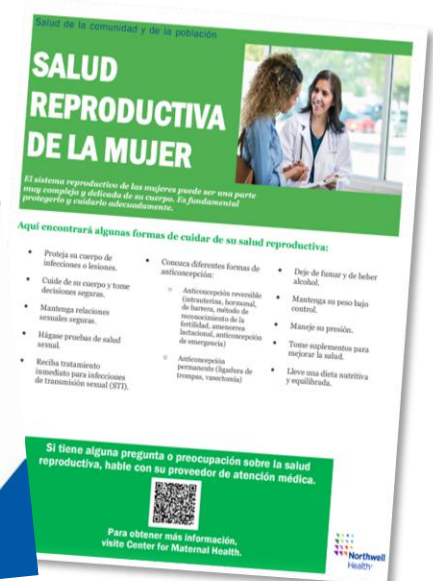
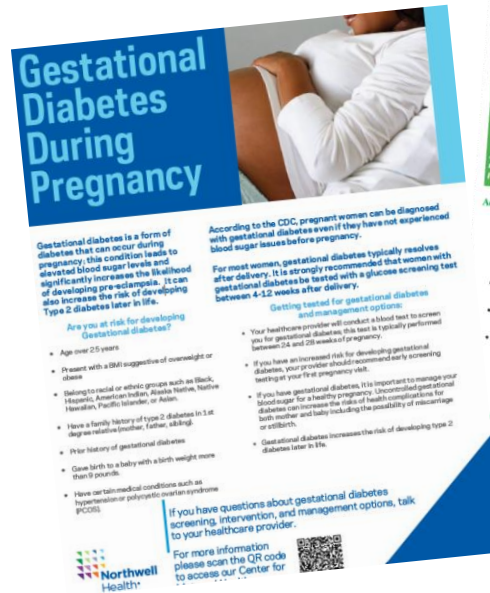
# MATERNAL HEALTH COMMUNITY OUTREACH INITIATIVE

In partnership with Northwell's Center for Maternal Health, the Institute for Community Health & Wellness (ICHW) developed an antepartum program to improve birth outcomes through education, outreach, and access to care. Antepartum education and outreach have been shown to improve preventive adherence and lead to better maternal-fetal outcomes.<sup>20</sup> Our antepartum outreach initiative offers practical, evidence-based education and support across key areas that influence pregnancy and birth outcomes. It provides low-dose aspirin education and distributes low-dose aspirin and birthing kits to patients at risk for preeclampsia.

Education and outreach address negative risk factors that can affect pregnancy, while mental health resources explain how psychological distress may impact outcomes and connect patients to support. Nutrition guidance helps patients choose appropriate foods to support maternal health and optimal fetal development. Sexual health education covers STDs, birth control options, and informed personal decision-making, complemented by family planning education on effective methods of contraception. For patients with diabetes, the program teaches strategies to promote healthier birth outcomes. Pain management education explains effective approaches to comfort and the appropriate use of anesthesia during delivery and after medical procedures to support safe recovery.

## Over 80 resources and education materials for the community on:

- ▶ Blood Pressure
- ▶ Pre-Pregnancy Health
- ▶ Maternal Mental Health
- ▶ Sexual Health
- ▶ Family Planning
- ▶ Diabetes
- ▶ Nutrition
- ▶ Pain Management



# NORTHWELL SOCIAL DETERMINANTS OF HEALTH SCREENING, REFERRAL AND TREATMENT PROGRAM

Health outcomes are shaped by more than medical care—social and economic conditions, health behaviors, and the physical environment play a major role.<sup>21,22</sup> Standardized screening for social needs helps identify unmet needs and connect patients to community resources, especially when it is built into clinical workflows and referral platforms like health information exchanges.<sup>23</sup> Nearly a decade ago, Northwell began screening for health-related social needs (HRSNs) in targeted care settings. That work evolved into a systemwide SDH Screening, Referral, and Treatment Program designed to identify needs early and connect patients—especially those at higher risk—to community resources.

Led by the Institute for Community Health & Wellness (ICHW) and the Health Management team, and supported by clinical and operational partners across Northwell, the program has *completed more than 1.2 million SDH screenings to date*. Screening is embedded in every Northwell hospital’s electronic medical record (EMR) and linked to Unite Us, our external social service referral platform. This integration helps match identified needs—such as food insecurity, housing instability, transportation barriers, or utility assistance—with appropriate community supports, improving patient well being.

Looking ahead to 2026 and beyond, Northwell will scale coordinated SDH screening and referral across all care settings, including more than 1,000 outpatient sites, and extend efforts to Nuvance locations in the Hudson Valley and Western Connecticut. Our goal is straightforward: identify social needs earlier, close access gaps, and support healthier individuals and more resilient communities.





# SOCIAL AND COMMUNITY CONTEXT

The following section centers on social and relational conditions shaping our health and wellbeing. Priorities include mental health challenges such as anxiety, stress, depression, suicide, substance use, and adverse childhood experiences. The aim of our programs within this domain is to build resilience, expand prevention and early intervention, and strengthen support to stem the rising tide of mental health challenges across our communities.



# COMMUNITY HEALTH ADVANCEMENT TASKFORCE (CHAT)

Our work is only possible through our network of partnerships with stakeholders aligned with our mission. Formed in January 2021, Northwell convened the Community Health Advancement Taskforce (CHAT), a 100+ member group comprised of leaders and representatives of community- and faith-based organizations, tribal nations, state and county representatives and local health departments. The group was formed to initially address and mitigate the exposure of COVID-19 among our high-risk communities in Nassau and Suffolk counties. Since then, the CHAT network has expanded beyond the Long Island region and has pivoted its focus to identify and address the rising mental health challenges of our communities.

Faith leaders through our CHAT network have served as key pillars of our communities. Through our CHAT partnerships, Northwell also established the Clergy Advisory Council, an interdenominational group composed of faith-based leaders, coming together to provide guidance and perspective on how mental health challenges have surfaced especially for our youth, within the specific context of their communities. The sections below will highlight initiatives we have implemented to address mental health needs and build youth resilience across our communities. In addition to our partners from the Clergy Advisory Council, we are guided by the clinical expertise for our internal partners from Cohen Children's Medical Center, Northwell's Health Home team, and the Northwell Behavioral Health Service Line.



# FAITH LEADERS MENTAL HEALTH FORUM | FAITH IN ACTION

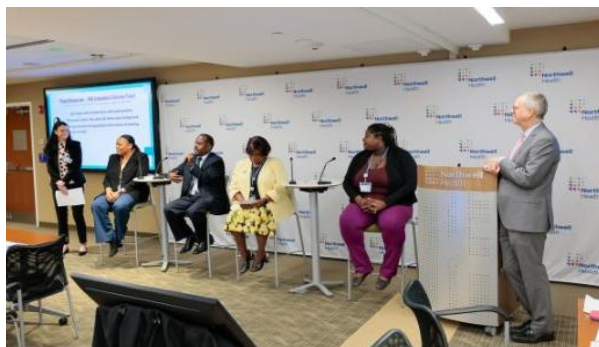
## Healing Hands and Hearts

The Faith Leaders Mental Health Forum is Northwell’s annual gathering of clergy and community partners dedicated to strengthening the response to mental health needs across New York City, Long Island, and Westchester. Part V marked the fifth year of this convening and drew more than 100 attendees. The event underscored Northwell’s commitment to working alongside faith communities to reduce stigma, expand access, and create clear pathways to care. It was planned and delivered by the Institute for Community Health & Wellness in partnership with the Behavioral Health Service Line, with leadership participation highlighting the priority placed on community collaboration.

Attendees represented diverse religious traditions and cultures. The program centered on learning from behavioral health clinicians embedded within partner houses of worship—an approach that brings consultation and care directly to congregations. Clinicians and faith leaders shared practical strategies to recognize distress, respond safely, and make warm referrals to services. Building on insights gathered over prior years, the forum served as the launchpad for a suite of community training resources shaped by faith leaders’ feedback.

These resources—including Stress First Aid (SFA), Mental Health First Aid (MHFA), Soul Shop suicide prevention, and the Lay Counselor Academy, originated from needs voiced at the forum and are now offered across our faith partnerships. Partnering with faith communities and equipping leaders through MHFA/SFA has been shown to reduce stigma, increase recognition and early support, and improve closed loop referrals to culturally responsive care.<sup>24,25,26,27</sup> The following sections provide brief overviews and outcomes for these trainings, with details on participation, reach, and impact.

Together, the forum and its training portfolio reflect a sustainable, community-embedded model: equip trusted leaders, embed clinical expertise where people gather, and coordinate closed-loop referrals to timely, culturally responsive care. The momentum from this fifth annual meeting will carry forward through expanded multilingual trainings, on-site consultation, and strengthened connections between faith partners, schools, and health services.



# COMMUNITY MENTAL HEALTH TRAINING

## Why Community Training Matters

Community mental health training equips trusted local leaders—faith leaders, educators, and community members—with practical skills to recognize distress, respond safely, and connect people to care. Northwell’s Institute for Community Health & Wellness, in partnership with faith-based organization (FBO) leaders and the Community Health Advancement Taskforce (CHAT), has designed and implemented evidence-based trainings that are cost-effective and scalable. These efforts expand early recognition, reduce stigma, and connect community members to timely, culturally responsive mental health care.

### Soul Shop: Suicide Prevention

Soul Shop is a faith-centered gatekeeper training that helps congregations talk about suicide, recognize warning signs, and build safe, supportive pathways to help. Gatekeeper trainings increase participants’ knowledge, self-efficacy, and likelihood of identifying and referring people at risk. In some settings, they are associated with reduced suicide attempts and improved linkage to care. <sup>28,29,30,31</sup> The program is offered in partnership with the American Foundation for Suicide Prevention (AFSP) and leverages the prominent role of churches and clergy in addressing this public health crisis. More than 40 faith-based leaders and community leaders have completed training in suicide prevention with Soul Shop and plan to incorporate these skills into their community outreach, and pastoral care.

Soul Shop was originally developed with Black churches in mind and is tailored to community religious and cultural contexts. Northwell sponsored 25 clergy and community members to receive training at Calvary Baptist Church in White Plains, Westchester County. Northwell also sponsored the first Soul Shop training on Long Island at Tabernacle of Joy Church in Uniondale.

To meet growing need in Hispanic communities, Soul Shop now offers a customized curriculum for Hispanic churches in Spanish. This expands access to multilingual, culturally responsive suicide prevention training. Northwell sponsored 35 clergy and community members to receive training.



# COMMUNITY MENTAL HEALTH TRAINING

## Stress First Aid (SFA)

Stress First Aid (SFA) is a practical step-by-step approach to recognizing stress, promoting self-care, and providing peer support. It uses an easy *Ready—React—Repair* framework and simple tools leaders can use every day. Developed by trauma experts, SFA improves recognition of stress injuries and helps build resilience in high-stress communities and organizations.<sup>32</sup>

*More than 200 faith leaders and community members completed SFA training* in partnership with Northwell’s Center for Traumatic Stress, Recovery, and Resilience, part of Northwell’s Behavioral Health Service Line. The trainings focused on supporting clergy and community self-care and on building a culture of resilience. Participants reported greater ability to spot early signs of distress, check in with compassion, and make supportive referrals before a crisis escalates.



## Mental Health First Aid (MHFA)

Mental Health First Aid (MHFA) teaches how to identify, understand, and respond to signs of mental health and substance use challenges. This evidence-based program increases mental health literacy, reduces stigma, and improves intentions and behaviors to support someone in crisis, with effects sustained over time.<sup>33,34</sup>

*More than 280 faith leaders and community members have earned the three-year MHFA certifications.* Northwell ICHW select staff members have also trained as facilitators to expand access across neighborhoods and communities. In partnership with the National Hispanic Chamber of Commerce on Health, our MHFA Certification training has had expanded reach, with 60 participants in our first MHFA training conducted entirely in Spanish.

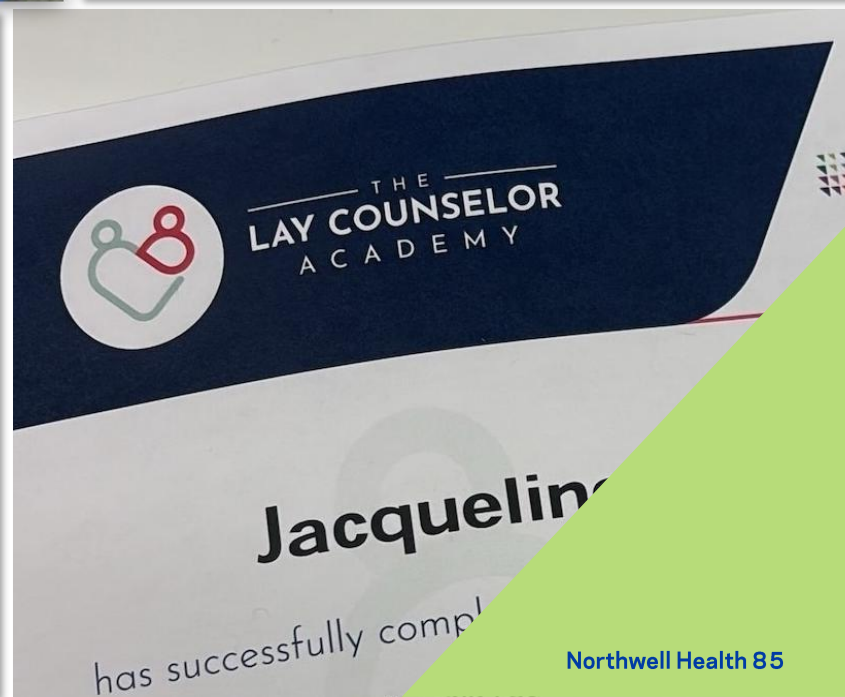
- **A — Assess for risk of suicide or harm**
- **L — Listen nonjudgmentally**
- **G — Give reassurance and information**
- **E — Encourage appropriate professional help**
- **E — Encourage self help and other supports**



# COMMUNITY MENTAL HEALTH TRAINING

## Lay Counselor Training

Northwell's Behavioral Health Service Line, in partnership with Northwell's Institute for Community Health & Wellness (ICHW), developed a formal program for Lay Counselor training program. Lay counselors provide training to non-specialist community members who provide basic psychosocial support, active listening, and guided referrals under clinical supervision.<sup>35</sup> Evidence shows that models like lay counseling improve access, reduce symptoms, and increase engagement in care, especially in medically underserved settings.<sup>36,37</sup> *Fifteen faith leaders have been trained to be Lay Counselors* with a formalized Lay Counselor program implementation, helping to expand mental health access in trusted community settings.



# WORLD MENTAL HEALTH DAY YOUTH CONFERENCE



Northwell's Institute for Community Health & Wellness, in collaboration with the Behavioral Health Service Line and Cohen Children's Medical Center, launched the World Mental Health Day Youth Conference in October 2024. The conference brought practical skills, resources, and inspiration to high school students, inviting them to self-select workshops led by Northwell and partner faculty and blending education with hands-on activities that promote mental wellness and resilience.

The inaugural event, held at Hofstra University, drew about *150 high school students in grades 9–12 from 11 local schools, along with more than 25 school staff*. Students chose from 11 workshops, ranging from Social Media Resilience and Gun Violence to Art Therapy and Therapy Dogs, each designed and led by subject-matter experts from Northwell and Hofstra. At the end of the conference, 90% of participants reported feeling more informed about mental health, learning a new skill or strategy, and indicated they were more likely to reach out for help when needed.

Our second annual conference took place in October 2025 at Suffolk County Community College, again in partnership with the Behavioral Health Service Line and Cohen Children's Medical Center, with support from M&T Bank. About 100 high school students from six schools participated, receiving tools to support their mental wellness. Students selected from 12 workshops—spanning Social Media Resilience, Mental Health and Climate Change, Stress First Aid, Therapy Dogs, and more.

Across both years, the conferences *emphasized practical coping strategies, peer connection, and pathways to care*. Schools reported that students left with concrete skills and a clearer understanding of when and how to seek support. Building on this momentum, Northwell will continue to partner with districts to expand workshop offerings, incorporate bilingual sessions, and align the event with ongoing school-based services, ensuring students can translate conference learning into everyday practice and access timely help when needed.

# NORTHWELL SCHOOL-BASED MENTAL HEALTH PROGRAM: A DISTRICT COLLABORATION

Youth mental health needs remain high and have likely worsened since the pandemic and our last CHNA. Recent data indicates that nearly one in five adolescents experienced a major depressive episode nationwide in 2023, and only about half received treatment.<sup>38</sup> Suicide remains among the leading causes of death for ages 10–24; in 2022, it was the second leading cause nationally.<sup>39</sup> Two out of five (42%) high school students reported persistent sadness or hopelessness between 2021 and 2023 and one out of five students seriously considered attempting suicide.<sup>40</sup> Pediatric mental health ED visits remain elevated compared with pre-pandemic levels.<sup>41</sup> National organizations—including the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children’s Hospital Association—have issued joint statements affirming a national emergency in child and adolescent mental health.<sup>42</sup>

Schools report sustained increases in demand for counseling, crisis response, and coordinated referrals—especially for bilingual and culturally responsive care. Communities simultaneously face ongoing mental health workforce shortages. In this context, Northwell’s School-Based Mental Health program brings care closer to where students learn, live and play. The program aims to reduce avoidable ED use for mental health crises, close access gaps, and improve mental health outcomes for children and adolescents. Its offerings include rapid access to crisis evaluation; short-term, school-based treatment at on-site Behavioral Health Centers (BHCs); strengthened crisis pathways; and ongoing capacity-building for educators and families. The program is a collaboration between Northwell’s Behavioral Health Service Line, Cohen Children’s Medical Center (CCMC), and more than 65 regional school districts. A few of its program offerings are as follows:

## Prevention

- **Teacher & Administrator Training**
- **Parent Support & Mental Health Literacy**
- **School Clinician Professional Development**
- **Customized curricula**

## Early Recognition

- **Suicide Screenings**
- **Behavioral Consultations (Psychiatry, Neuropsychology)**
- **Care Coordination & Ongoing Care**

## Treatment

- **Short-term Care at School BHC**
- **Crisis Evaluation**
- **ED & Hospital Navigation**



# NORTHWELL HEALTH HOME BEHAVIORAL HEALTH RAPID TRANSITION (BHRT) PROGRAM

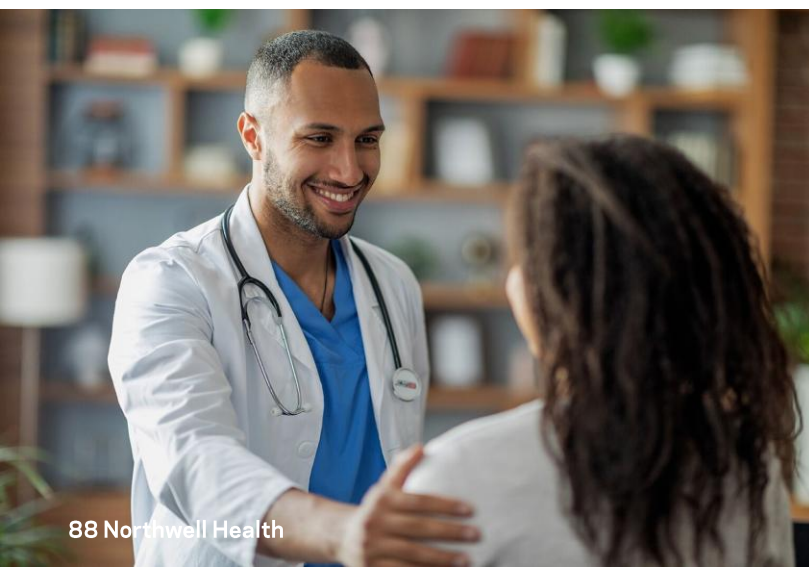
The first month after psychiatric discharge is a high-risk period. <sup>43</sup> People often face symptom changes, medication adjustments, and barriers to follow-up. Without support, the risk of readmission, ED use, and suicide increases—especially in the first 7–30 days. <sup>44</sup> Northwell Health Home’s Behavioral Health Rapid Transition (BHRT) program delivers intensive, person-centered support for Health Home-enrolled individuals during the 30 days post-discharge.

- **Multidisciplinary team:** social workers, peer advocates, and Health Home care managers.
- **Focused first month:** bridge to outpatient care, stabilize medications, address social needs, and reinforce safety plans.
- **System integration:** launched at Zucker Hillside Hospital; expanding to Lenox Hill Hospital, Staten Island University Hospital, and South Oaks Hospital.
- **Expanded capacity:** a 2024 Center of Excellence grant supports growth and adds trained lay counselors to extend navigation and engagement.

Core services include rapid outreach within days of discharge, home or telehealth visits, peer support, appointment and medication reminders, help with transportation and benefits, linkage to counseling and community resources, and coordination with outpatient clinicians.

## Impact

- ✔ **331 individuals served as of July 2025; projected 540 by year end.**
- ✔ **Lower psychiatric readmission rates and higher 7–30-day outpatient follow-up among participants.**
- ✔ **Improved community reintegration, with peers and lay counselors helping address social needs that can derail recovery.**



# ECONOMIC VITALITY

The following section highlights some of our programs that address barriers to nutrition security, conditions of poverty, affordability, and unemployment. We understand that stable access to affordable, nutritious, and culturally appropriate food supports better chronic health, learning, and productivity. As a health system, we are well positioned to partner with organizations across our community to expand access points for nutritious and health food, promote evidence-based “food as health” approaches to address nutrition security and healthy eating. We’re also supporting efforts towards better workforce readiness for our communities, and working to ensure financial assistance is available—so cost is not a barrier to better health and well-being.

We are advancing this work in collaboration with our partners that span the food system, payers, public agencies and community anchors. Across our Food as Health programs, we are collaborating with regional food banks such as Island Harvest, and providers of medically tailored meals, such as Gods Love We Deliver, and grocery delivery and pickup platforms such as Instacart, to promote healthy choices. In parallel, we are partnering with county youth services, local workforce and labor departments, and our internal finance teams and community navigators, to strengthen career pathways and remove financial barriers to care.



# NUTRITION SECURITY

## Northwell's Food as Health Initiative

Not having access to enough food, or "food insecurity" as defined by the U.S. Department of Agriculture (USDA), is a major health problem. It's strongly linked to chronic illnesses like diabetes and heart disease, worse mental health, and more frequent hospital visits. Because of this, helping people get enough healthy food has been a key part of making our communities healthier, going beyond just doctor visits.

In collaboration with the Office of Patient and Customer Experience at Northwell, we launched the *Food as Health (FAH)* initiative to address barriers to food access to improve health and wellbeing. Launched in 2018 at LIJ Valley Stream hospital, the FAH program was New York State's first ever hospital-based initiative to comprehensively address food insecurity among hospitalized patients. Since then, the FAH initiative has successfully expanded into a portfolio of programs to address food insecurity, across all six of our counties, several of our hospitals.

The initiative aims to help patients struggling to get enough food and connect them with resources within the community. Our approach involves regular screening for food insecurity and working to change the landscape to allow patients better access to food. So far, Northwell has screened over 14,000 patients for food insecurity, and more than 900 have joined our FAH programs. In addition to local hospital food pantry programs below are a few of the organization-wide programs that we have successfully scaled within our Food as Health initiative.

## Nutrition Pathways Program (NPP)

The Nutrition Pathways Program (NPP) helps patients with diet related chronic illnesses by giving them a "prescription" for fresh fruits and vegetables. It connects medical care with health food access, to improve patient outcomes. The research shows that programs that implement "produce prescriptions" and nutrition education programs like the NPP have been associated with improved diet quality and food security, as well as clinically meaningful reductions in A1c and blood pressure among adults with diet-related chronic disease. 45,46 In 2022, the NPP gave out over 30,000 pounds of produce to almost 500 patients across five locations. Our main partners to promote this program across our communities are Northwell Family Health Center at Huntington, followed and Island Harvest.

In September 2024, as part of the NPP, we launched Fare Meals, an 11-week program that combines interactive group sessions (both in-person and virtual) focusing on nutrition education, budget-friendly recipes, and community engagement to empower community members to maintain healthy eating habits.



# NUTRITION SECURITY

## Instacart Partnership

Northwell's ICHW partners with Instacart to make nutritious food more accessible for patients and families experiencing food insecurity. Through the Healthy Choices hub on Instacart, Northwell curates culturally relevant, dietitian-informed grocery lists aligned to common clinical needs (heart health, diabetes, maternal/child health, general wellness) and simplifies ordering from local retailers for delivery or pickup. The program reduces barriers to healthy food access for food insecure households supporting better management of chronic conditions and maternal/child nutrition.

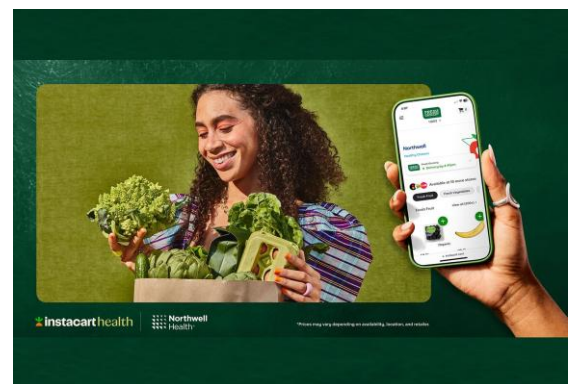
- Clinically aligned “smart” shopping lists and nutrition guidance that translate care plans into practical groceries
- Convenient ordering, digital coupons, and budget-friendly substitutions to stretch food dollars
- Delivery and pickup options to reduce transportation barriers
- Seasonal recipes, pantry staples, and produce-forward bundles to support sustained healthy eating
- Ability for care teams and community partners to share links and enroll families quickly

## Northwell–Healthfirst Maternal Food Security Program – powered by Instacart

Powered by Instacart’s platform, Northwell and Healthfirst have partnered to design and implement a Maternal Food Security Program. Launched in December 2024 with \$200,000 from the Healthfirst Foundation, the program enrolls eligible patients in a bundled package of services: nine months of Fresh Funds stipends redeemable on Healthy Choices, three months of diapers delivered via Instacart, a nutritional survey with tailored guidance, added patient navigation and referrals for unmet social needs, and enrollment in Northwell Pregnancy Chats for AI enabled education and risk monitoring. Research shows that bundled maternal ‘food is medicine’ support—including produce stipends, diapers, tailored nutrition guidance and patient navigation—are associated with improved food security, healthier purchasing and dietary patterns and better maternal-infant outcomes. 47,48

Early results show strong engagement and practical impact:

- **122 patients enrolled to date**
- **Approximately 99% utilization of Fresh Funds (exceeding the 80% target)**
- **Average monthly spend of about \$100 of Fresh Funds out of the \$125 benefit**
- **Improved food purchasing behaviors concentrated in essentials like fresh vegetables, frozen fruit, protein, milk, and pantry staples**



# NUTRITION SECURITY

## Medically Tailored Meals

Northwell partners with God's Love We Deliver (GLWD) to provide medically tailored meals (MTMs) to patients for whom food access and nutrition are barriers to recovery and disease management. Medically tailored meals, are known to be associated with improved adherence and disease control, fewer hospitalizations and emergency visits, and better care continuity among high-risk patients.<sup>49,50</sup> Designed and overseen by Registered Dietitian Nutritionists using evidence-based dietary therapy, MTMs are initiated via a provider referral and personalized following an RDN assessment that accounts for medical diagnosis, symptoms, allergies, medication management, and treatment side effects.

The partnership delivers personalized meals to patients—and, when eligible, their caregivers—at home, supporting conditions such as diabetes, heart failure, cancer, HIV, and renal disease. GLWD dietitians provide ongoing counseling and adjust plans in coordination with Northwell care teams, while reliable, ready-to-eat deliveries reduce the burden of shopping and cooking during illness or recovery, improving adherence to prescribed nutrition therapy. Culturally appropriate options and consistent schedules further promote stability, dignity, and sustained engagement in care.

- **Improves disease management and recovery by aligning meals to clinical goals, which can reduce hospitalizations, complications, and emergency visits.**
- **Enhances food security for high-risk patients, supports medication tolerance, and stabilizes weight and biomarkers associated with chronic disease control.**
- **Strengthens continuity of care: dietitians share progress and needs with Northwell clinicians, enabling timely adjustments and wraparound supports (e.g., social needs referrals).**



# NUTRITION SECURITY

## The Healthy Choices Grocery Store Education Program

Northwell's Healthy Choices Grocery Store Education program is a five-week supermarket tour series that equips community members to make healthier food choices where it matters most—at the store. Led by Northwell Registered Dietitians, the curriculum provides the following:

- **Week 1: MyPlate basics and healthy habits**
- **Week 2: Reading nutrition labels and understanding fats, salt, and sugar**
- **Week 3: Selecting fruits and vegetables and building healthy snacks**
- **Week 4: Fiber, hydration, and flavoring with spices instead of excess sodium.**
- **Week 5: In-store teaching kitchens for practical skill building and program graduation**

Since June 2025, five program tours have been completed with 60 graduates. Participants report greater confidence navigating aisles, comparing products, stretching food budgets, and preparing balanced meals at home. By transforming grocery shopping into a hands-on learning experience, the program helps reduce risk factors for chronic disease, supports culturally relevant meal planning, and builds lasting habits that improve nutrition for families across the communities we serve.



# NUTRITION SECURITY

## Northwell Tower Gardens

Northwell supports vertical, aeroponic tower gardens in schools and senior centers to grow fresh produce year-round in small indoor spaces. Students construct and maintain the towers, integrating them into STEM lessons, classroom salad bars, and service projects that share harvests with peers and local pantries. Evidence from school and community hydroponic garden programs shows gains in STEM engagement and nutrition knowledge, increased fruit and vegetable intake, and sustainable, year-round production in small indoor spaces. <sup>51,52</sup>

The Tower Garden program began in 2024 with 4 towers in the Bay Shore School District. In 2025, with support from the Rite Aid Healthy Futures grant, 14 new towers were installed across the Brentwood and Bay Shore school districts and at Babylon Senior Centers; replenishment supplies were also provided for four existing towers at Bay Shore High School to ensure continued growth throughout the year. Towers are assembled and cared for by the students throughout the school year. Each tower holds 28 plants and harvests are about every 8 weeks. Students gain hands-on learning by building and operating the tower gardens, applying science, nutrition, and entrepreneurship skills through real cultivation and harvest cycles. The efficient, soil-free system supports sustainable food access, yielding consistent produce for classroom tastings, salad bars, and donations to community pantries. Because the towers are durable and replenishable, the infrastructure can be used year after year, expanding impact as programs rotate through grades and schools.

- **14 Aeroponic Towers**
- **~1,500 students engaged**
- **~200 seniors engaged**
- **Reached 1,127 students and 14 educators reached across four buildings, including 400 10th-grade biology students at Bay Shore High School (7 towers) and Brentwood Middle Schools serving 6th-7th graders at North, South, East, and West campuses.**



# POVERTY AND UNEMPLOYMENT

## Northwell Financial Assistance Program

Northwell's Financial Assistance Program and policy are designed to remove cost barriers so more people in our communities can get the care they need, when they need it. The program offers income-based discounts and charity care for eligible patients across hospitals, physician practices, and ambulatory services, helping uninsured and underinsured individuals access primary, specialty, and emergency care without delaying treatment due to expense.

Support is available to all patients—regardless of coverage or residency circumstances—and applications can be completed year-round. Dedicated financial counselors guide patients through the process, explain options, and help connect them to coverage programs, payment plans, and assistance resources. The program offers:

- Simple, multilingual application support with trained counselors who provide personalized guidance.
- Help evaluate insurance eligibility, enrolling in coverage, and setting up interest free payment arrangements when needed.
- Clear, transparent policies so patients understand costs and assistance options upfront.

## Potential Impacts on the Community:

- ▶ **Increase access to preventive, chronic, and acute care by easing financial stress.**
- ▶ **Reduce avoidable delays in treatment and improve health outcomes in high-need communities.**
- ▶ **Strengthen trust and continuity of care through compassionate, confidential financial support.**



# COMMUNITIES@WORK

Communities@Work is Northwell's neighborhood-based career preparedness initiative that connects local residents to real employment pathways across our health system led by our Human Resources department in partnership with the Institute for Community Health and Wellness. Launched in 2023 with anchor sites in Harlem and Huntington, the program delivers on-site workshops in trusted community settings, pairing one-on-one coaching with résumé and interview skill-building, application support, and direct access to hiring events. In 2024, Communities@Work expanded to Staten Island, multiple Queens neighborhoods (Corona, Jamaica, Richmond Hill), and Long Island communities including Brentwood, Central Islip, Bayshore, Uniondale, and Freeport—with planned expansions to Westchester, Roosevelt, and Hempstead. Since launch:

510

**Community members have participated;**

146

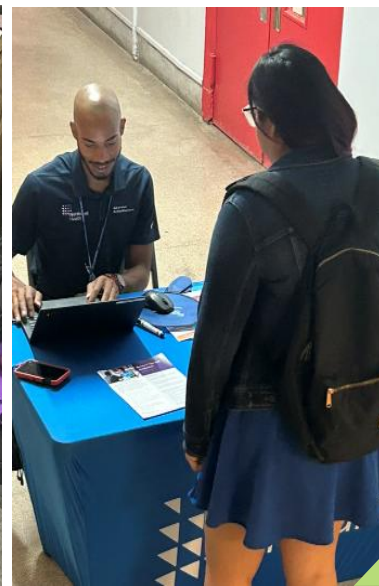
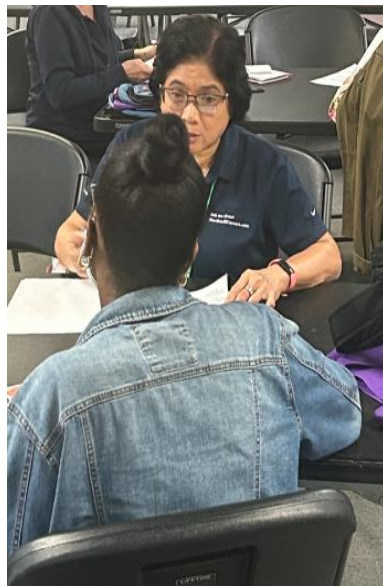
**Job offers were extended within Northwell, yielding 96 active hires;**

8

**Participants secured roles with external employers.**



Workforce development and community-based employment programs for the health sector show that on-site coaching, skills training, and direct employer linkages can increase job placement and retention and advance economic mobility for local residents.<sup>53</sup> Career development opportunities are built into the model. Highlights include the first Medical Assistant Bootcamp, where two community participants completed training and accepted Medical Assistant offers, and a CNA Earn & Learn interview day in September 2024 that integrated candidates into the Sterns and Huntington facilities, resulting in two offers extended to community members. By meeting people where they are and streamlining the path from preparation to hire, Communities@Work strengthens the local talent pipeline, advances economic mobility, and ensures our workforce reflects the communities we serve.



# EDUCATION ACCESS AND QUALITY

While our CHNA findings did not directly center on school-aged youth, we learned across several methods that mental health, and health related social needs remain significant challenges for young people. We view our community efforts and investments in education as part of our long-term strategy to improve community health and wellbeing. This section highlights initiatives that position learning environments as foundational to lifelong health.

Building skills, credentials, and career pathways early can strengthen families, build resilience, grow local talent, alleviate workforce constraints, and improve access to care over time. That's why we're investing upstream - partnering with schools, public agencies and community organizations to expand opportunity and capacity in our local neighborhoods. In partnership with the Dowling Institute for Learning and Innovation and our Human Resources department, initiatives such as the Northwell Community Scholars program, the Northwell School of Health Sciences, FutureReadyNYC and our workforce development programs, all increase opportunities for educational attainment and expand career pathways. Our education access initiatives are enabled by deep partnerships across K-12 school districts, including the NYC Public Schools, colleges in Long Island, city and state agencies, philanthropy, community organizations, and our own clinical and learning enterprises.



# NORTHWELL COMMUNITY SCHOLARS (NCS)

Northwell Community Scholars (NCS) is a workforce development and education program launched in 2022 to create pathways for students from economically challenged neighborhoods and high schools into college, healthcare careers, and future employment. Evidence shows that health-sector workforce and education initiatives with dedicated pathways increase post-secondary completion, accelerate entry into family-sustaining healthcare roles, and improve local hiring and retention.<sup>54</sup> Accepted scholars receive comprehensive support—including mentorship, college and career advising.

The program is now active in 10 high school districts (Brentwood, Bay Shore, Harlem, Hempstead, Freeport, Jamaica, Central Islip, Bedford-Central, Ossining, and Uniondale), with 12 high schools and 7 partner colleges planned at full scale.

*The program is now active in 10 high school districts (Brentwood, Bay Shore, Harlem, Hempstead, Freeport, Jamaica, Central Islip, Bedford-Central, Ossining, and Uniondale), with 12 high schools and 7 partner colleges planned at full scale. 323 students accepted; at full scale NCS will serve 660 students annually. As of June 2025:*

58

**Students received Associate's degrees;**

33

**Completed high school through the program;**

9

**Students are employed at Northwell;**

2

**Students began Northwell's EMT certificate program.**



*Education attainment: Increased Associate's degree and certificate completion among local students, shortening the path to family sustaining careers.*

*Local talent pipeline: Early employment opportunities at Northwell support stable hiring for critical roles while keeping talent in the community.*

*Economic mobility: Paid internships and targeted scholarships reduce financial barriers and accelerate workforce entry.*

*Health system readiness: Students trained in core safety and patient care competencies enhance the future healthcare workforce capacity.*

# NORTHWELL SCHOOL OF HEALTH SCIENCES (NSHS)



The Northwell School of Health Sciences is a new, career-connected public high school in Woodside, Queens that prepares students for the healthcare careers of tomorrow through immersive, industry aligned learning. Created in collaboration with NYC Public Schools, the Fund for NYC Public Schools, Bloomberg Philanthropies, NSHS bridges the gap between future health professionals and employers by integrating real world experiences, mentorship, and early college credit. The initiative is led by Northwell's Dowling Institute for Learning & Innovation and the Institute for Community Health & Wellness.

The school launched on September 4, 2025, with an inaugural class of 216 students and will ultimately serve up to 900 students across grades 9–12.

The intended impact is a stronger regional talent pipeline, faster entry into family sustaining careers, and improved community health through a workforce that reflects and serves local neighborhoods.<sup>55</sup> Students gain early college credit, paid internships, Northwell mentors, and exclusive postsecondary supports for NSHS graduates—aligning education with employment and reducing time to credential.

- **Pre Nursing:** rigorous foundation culminating in the Licensed Practical Nurse (LPN) credential exam and preparation for roles such as CNA, RN, NP, and PA
- **Medical Assisting:** training in terminology, phlebotomy, and clinical procedures leading to the Certified Clinical Medical Assistant credential
- **Behavioral and Mental Health:** skills for clinical and non-clinical roles in a high need field prioritized by city and state leaders.
- **Healthcare Management:** competencies in medical administration, billing/coding, operations, and documentation, culminating in the Certified Medical Administrative Assistant credential.

## Key Highlights and Metrics

- **Location:** Woodside, Queens.
- **Demand:** 2,000+ applications—among the most in NYC Public Schools history.
- **216 students enrolled with 96% attendance.**
- **100% participation in Advanced Placement (AP) classes.**
- **Over 50% are interested in the Nursing Assistant track.**
- **Model features:** immersive learning; career aligned tracks leading to industry credentials and college credit; mentorship and internships; employer embedded experiences.
- **Community impact:** preparing students to thrive while raising the health of their communities through direct pathways into nursing, medical assisting, behavioral health, and healthcare management.



# FUTUREREADYNYC

The FutureReadyNYC program is a public-private partnership transforming education and career pathways for New York City students. As the first anchor partner in the healthcare pathway, Northwell's Dowling Institute for Learning & Innovation and the Institute for Community Health & Wellness collaborate with NYC Public Schools to prepare the healthcare workforce of tomorrow. The program launched in Fall 2022 and operates a continuum of experiences—Career Discovery Week (fall), Workplace Challenge (winter), and an 8 week spring internship—across four NYC high schools (two in Manhattan, two in Queens) and three Northwell hospitals (Lenox Hill, Northwell Greenwich Village Hospital, LIJ Forest Hills). The internship programs provide hands-on, real-world experiences, creating pathways into healthcare careers.

- **12,700+ internship hours completed, providing hands on, real world experience;**
- **7,000+ community benefit hours contributed by Northwell team members;**
- **2,500+ students impacted, creating pathways into healthcare careers;**
- **350+ Northwell team members engaged as facilitators, educators, and role models;**



# WORKFORCE DEVELOPMENT PROGRAMS

Northwell's Youth Workforce Development initiative creates clear, supported pathways into healthcare for middle and high school students in partnership with Northwell Human Resources and the Dowling Institute for Learning and Innovation. Through coordinated exposure, skill-building, hands-on experience, and digital learning, the program connects curiosity to real careers, strengthens the local talent pipeline, and equips young people with practical competencies and professional networks that lead to college, credentials, and entry-level employment in healthcare.

## Medical Career Day

Medical Career Days bring Northwell Health to a high school for a day, to expose each participating student to over 50 careers. Students with Northwell team members through interactive panels, demonstrations, and direct conversations with clinicians and operational leaders. To date, *14 Medical Career Days have been held across the counties we serve, and over 32,000 students* have attended these events. The all-day events expand student awareness of health care careers beyond commonly known positions and help young people connect interests to concrete pathways in care delivery, research, technology, and administration.



## Stickball Platform

Stickball is a learning platform that *extends career exploration and skill-building beyond the classroom*. Students access AI-driven career exploration tools, virtual workforce modules, and financial literacy education that prepares them for college, training programs, and entry-level employment. By meeting youth where they are—online—Stickball increases reach, engagement, and virtual workforce skill building opportunities.



# Stickball

# WORKFORCE DEVELOPMENT PROGRAMS

## Pathways for Aspiring Teen Health Scholars (PATHS) Program

Pathways for Aspiring Teen Health Scholars (PATHS) is a highly selective, cohort-based experience that immerses students in healthcare operations and career pathways. In 2024, 32 students participated; nearly 100 applications were received for 2025, reflecting strong demand. Scholars gain guided exposure to departments, mentorship from professionals, and early insights into clinical and non-clinical roles—*translating curiosity into actionable next steps in education and employment.*



## Summer Youth Employment Program (SYEP)

Since 2022, Northwell Health has partnered with both Nassau County Office of Youth Services and Suffolk County Department of Labor to provide valuable summer work-experiences for youth (16-21 years old) in Long Island through a paid summer internship. Through SYEP, students are placed in hospital departments for paid, hands-on work experience. Participants receive mentorship from healthcare professionals, develop workplace skills through real tasks and projects, and build networks that support future internships and jobs. The program strengthens the local talent pipeline while giving youth meaningful opportunities to contribute to patient care and hospital operations.



Together, these initiatives build a pipeline of future healthcare professionals, address community workforce needs with local talent, and provide meaningful exploration and experience for youth. By combining exposure, skills training, practical experience, and digital access, the program increases readiness for college and credentials, improves employment prospects, and supports a more resilient, community-connected healthcare workforce. Community-based health workforce initiatives such as the programs above are known to increase local hiring and career progression over time.<sup>56</sup>

# NEIGHBORHOOD AND BUILT ENVIRONMENT

Helping to build more resilient neighborhoods and environments where our community members live, work, play, and learn is a top organizational priority. We see positive impacts on community health and well-being, and this reflects our commitment to address upstream drivers of health. The following section highlights evidence-based, community-partnered approaches that reduce climate and environmental risks, prevent injury and violence, and build safer communities.

Our resilience work is powered by a broad network of partners spanning community organizations, faith leaders, public agencies, and internal teams. For climate resilience, we leverage our partners within our cross-sector networks such as the Community Health Advancement Taskforce (CHAT), partner with faith leaders to raise awareness, and support neighborhood gardens to strengthen local food systems and mitigate heat. Our human trafficking initiatives are delivered in partnership with survivor-serving nonprofit organizations and law enforcement, while our gun violence prevention efforts work closely with Northwell clinical teams to advance awareness, screening, safe-storage education, and referrals across care settings.





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# CLIMATE RESILIENCE AND ENVIRONMENTAL SUSTAINABILITY

Northwell's mission is to improve the health of the communities we serve—and to uphold that mission amid external challenges such as the climate crisis. Climate change is driving extreme weather, hotter temperatures, and other health risks. We are building climate resilience, so care remains uninterrupted, and community health is protected.

Recognizing that many neighborhoods face disproportionate climate risk, Northwell's Institute for Community Health and Wellness, in partnership with the Office of Environmental Sustainability, is actively: identifying and anticipating community needs; providing education and awareness on climate-health impacts; leveraging the Community Health Advancement Taskforce (CHAT) and other partners to hear directly from community leaders; developing interventions to address climate vulnerability and extreme weather; and monitoring climate-related health trends to guide clinical responses.

This work forms the foundation of our community resilience efforts. We use an upstream-to-downstream framework to connect structural drivers of climate risk with neighborhood-level solutions. Upstream, we address environmental burdens and social determinants—pollution exposures, land use shaped by historic disinvestment, and climate hazards—alongside factors that amplify vulnerability (income, access barriers, housing conditions, baseline health). Downstream, we translate insights into practical supports that improve daily living conditions, strengthen local food systems, and build social cohesion—so communities can prepare for, withstand, and recover from climate events.

Our approach is data-driven. Using New York State's Climate Justice Working Group (CJWG) methodology to identify Disadvantaged Communities (DACs), we integrate more than 45 environmental, social, and health indicators at a granular geographic level. Through this analysis, we identified over 30 communities across our service area with varying degrees of climate vulnerability. These findings inform program design, resource allocation, strategic partnerships, and a multiyear roadmap to improve climate resilience in our communities.

Our model blends upstream policy and stakeholder engagement, with practical, community-led action to protect health amid rising heat, storms, and environmental exposures. The programs detailed below are supported by evidence that urban greening and community food initiatives help reduce heat exposures, flood risk, and improve food security and social cohesion. They are also associated with measurable public health benefits—including reduced heat-related morbidity and mortality.<sup>57,58</sup>

# CLIMATE RESILIENCE AND ENVIRONMENTAL SUSTAINABILITY

## Climate, Faith, & Justice

We convened the Climate Justice and Faith forum on April 4, 2025, to advance preparedness, communication, and cross-sector collaboration—creating practical, community-led pathways from upstream policy change to downstream benefits.

## Community Resilience Initiatives – Gardening and Food Distribution

Recent initiatives include community gardens and food distribution projects that reduce heat- and storm-related food insecurity and strengthen local networks.

### Greater Springfield Community Church Garden

- Launched July 1, 2024, with 4 raised beds and 28 plants.
- Supports weekly Food Pantry distribution.
- Forecast: 150 lbs. of fresh vegetables; Winter 2025 education session on front stoop/container gardening.

### Belmont Garden (2023)

- 19 Northwell team members contributed 93 volunteer hours.
- 610 lbs. of food harvested (rule of thumb: ~1 lb. = 1 person fed).

### Kennedy Park Community Garden

- Expanding existing garden with raised beds, new plantings, and ongoing volunteer support.



# CLIMATE RESILIENCE AND ENVIRONMENTAL SUSTAINABILITY

## Trees For Babies

Northwell's Trees for Babies program celebrates every birth by planting a tree for each of the 30,000 babies born annually in our hospitals. Launched on Arbor Day 2022, the program symbolizes new life while advancing climate resilience and community well-being. In partnership with the Office of Sustainability and Resource Stewardship and the Arbor Day Foundation—aiming to plant 500 million trees by 2027—we prioritize neighborhoods with low canopy coverage to maximize health, environmental, and quality-of-life benefits. To date, Northwell has provided over 250 trees across the communities we serve.

Trees for Babies supports Northwell's goal for net zero emissions by 2050 through natural carbon capture and measurable environmental co-benefits. A single mature tree can absorb more than 48 pounds of CO<sub>2</sub> per year, help prevent flooding during extreme storms, and cool urban areas by up to 10 degrees—benefits linked to improved health outcomes, including lives saved annually in New York City. The program is also expanding beyond New York: *Northwell has planted 30,000 trees in Florida to restore canopy, improve soil and water conservation, reduce wildfire risk, and enhance wildlife habitat.* Community donations through the Arbor Day Foundation further accelerate local plantings and deepen neighborhood resilience.



# NORTHWELL'S HEART FOR HUMAN TRAFFICKING

Human trafficking is a global public health crisis with nearly *50 million victims worldwide*.<sup>59</sup> It is a \$150 billion<sup>60</sup> industry worldwide, where *1 in 4 victims are children*, and over *72% of women are sexually exploited*.<sup>61</sup> *Nationwide, over 403,000 victims*<sup>62</sup> are subject to human trafficking, and *New York State is among the top five states*<sup>63</sup> based on reported cases. Addressing human trafficking at the community level requires ongoing cooperation between health care, law enforcement, and community-based organizations.

Created in 2018, the mission of the *Northwell Health Human Trafficking Education Advocacy Response and Training (HEART)* program is to provide a medical safe haven for survivors, those at risk, and those with lived experiences of human trafficking. The program is designed to serve all patients with dignity, while recognizing that certain populations may face heightened vulnerability to exploitation. Our program takes a patient-centered approach that is sensitive to the needs of all individuals regardless of age, race, ethnicity, sex, gender identity, sexual orientation, religion, disability, and socioeconomic status. It offers trauma informed clinical care to survivors and individuals at risk and other vulnerable populations through comprehensive screening, care coordination and supportive services to address both their health and safety needs.

As of December 2024, the program has *trained 26,116 Northwell team members* through human trafficking education. The program has prepared and distributed human trafficking education materials for all Northwell Emergency Departments and Labor & Delivery services lines to display within their sites. Additionally, the program has had over *8,000 participants at external education events* and symposiums.

This work is possible through strategic partnerships that help to prevent exploitation, protect survivors and create an informed community. Northwell partners with Nomi Networks, Restore NYC, ECLI/VIBES and The Safe Center L.I to support identified and suspected victims of human trafficking with local resources.

It is important to know the signs of someone who might be trafficked. Below are some of the signs our health care providers are trained on:

- **Sharing a scripted or inconsistent history;**
- **Not willing to answer questions about their injury or illness;**
- **Accompanied by someone who won't let them speak for themselves;**
- **Cannot provide their address or identification, and are not aware of their location.**



# NORTHWELL'S GUN VIOLENCE PREVENTION PROGRAM

Firearm-related injuries are a leading cause of death and disability for Americans across their life course. Addressing this public health crisis requires investment in healthcare-driven prevention and intervention strategies. The Northwell Center for Gun Violence Prevention (CGVP) spearheads over 100 local, state, and national initiatives alongside healthcare and community champions.

CGVP mobilizes health professionals to act, equips families with practical tools, and advances prevention where it matters most. Working across clinical care, research, education, and community engagement, the CGVP implements evidence-based strategies including the nation's first universal screening program for firearm access and community violence risk, safe storage counselling, hospital-based violence intervention, and trauma-informed support for patients and families impacted by violence. These efforts translate into fewer injuries, stronger bidirectional referral pathways with trusted community partners, and earlier interventions for those at risk.

To accelerate adoption nationally, the CGVP also leads initiatives such as the Gun Violence Prevention Learning Collaborative for Health Systems and Hospitals, a national forum of 600+ health institutions developing and implementing best practices for firearm injury prevention; the CEO Council on Gun Violence Prevention that leverages executive leadership to tackle gun violence; and the annual Gun Violence Prevention Forum, that mobilizes cross-sector action and innovation.



# OUR INTEGRATED TEAM OF PARTNERS

This section highlights Northwell's Institutes, Service Line, Centers, Offices, Departments, and all system partners and signature initiatives that enable coordinated, high-quality care across the continuum and into the community. Together, our collective assets span emergency and urgent care, behavioral health and trauma services, women's and maternal health, cardiovascular and cancer care, aging and home-based care, global health, patient experience, access, and navigation, digital enablement, compliance and legal support, and workforce education.

By integrating their expertise and insight into our community-facing programs and initiatives, we ensure people receive the right care, at the right time, in the right place—while advancing resilience and raising health for all of the communities we serve.



# NORTHWELL HEALTH EMERGENCY MEDICINE

Northwell's Emergency Medicine service line delivers 24/7, high acuity care across hospitals, and community settings—treating adults and children with illnesses and injuries from minor to life-threatening. Multidisciplinary teams—board-certified emergency physicians, nurses, advanced practice providers, and specialists—use evidence-based protocols and advanced diagnostics to assess, stabilize, and treat patients quickly and safely.

## Services include:

- **Comprehensive adult and pediatric emergency care in tertiary and community ERs**
- **Trauma and stroke readiness with rapid activation pathways**
- **Cardiac, respiratory, and sepsis care, including critical care stabilization**
- **On site imaging and lab testing for fast diagnosis**
- **Coordination with EMS, urgent care, inpatient units, and specialty services**
- **Telehealth and transfer services to ensure timely access to the right level of care**

The program's aim is rapid, reliable care with clear communication, seamless handoffs, and continuous quality improvement—so people in every community receive the right treatment, at the right time, in the right place.



# CENTER FOR EMERGENCY MEDICAL SERVICES (CEMS)



Northwell's Center for Emergency Medical Services (CEMS) provides round-the-clock prehospital care and medical transport across the region. Highly trained paramedics, EMTs, critical care transport specialists, flight crews, and dispatchers deliver fast, coordinated responses for 911 calls, interfacility transfers, and specialty transports, supported by real-time medical oversight and advanced lifesaving equipment.

Services include 911 emergency response and community paramedicine; ALS, BLS, and critical care transport; specialty transport for cardiac, neonatal/pediatric, high-risk obstetric, stroke, and trauma; the Sky Health air medical program with helicopter and fixed-wing capabilities; event medicine, disaster preparedness, and incident command; centralized communications with GPS-enabled deployment and telemedicine consultation; and education, training, and quality programs for prehospital providers. CEMS aims to provide rapid, reliable care from the field to the hospital, with seamless handoffs and the right level of ground or air transport so patients receive timely, expert care close to home.

# NORTHWELL GOHEALTH URGENT CARE

Northwell Health GoHealth Urgent Care provides convenient, same-day care in neighborhood centers seven days a week with extended hours. Experienced providers, nurses, and radiology staff treat non-life-threatening illnesses and injuries and coordinate smoothly with Northwell hospitals and specialists when higher-level care is needed.

Services include walk-in and same-day visits for adults and children; care for colds, flu, COVID-19, sore throat, ear infections, rashes, minor cuts and burns, sprains, and simple fractures; on-site X-ray, rapid tests, and labs; sports, school, and work physicals; vaccines; common medication refills; virtual visits; and easy online check-in to save your place in line. The goal is quick, high-quality care close to home, with clear communication, short wait times, and seamless follow-up so people get the right care at the right time.





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# NORTHWELL BEHAVIORAL HEALTH

Northwell's Behavioral Health service line provides comprehensive care for mental health and substance use disorders in communities across the region. Multidisciplinary teams—psychiatrists, psychologists, therapists, nurses, social workers, addiction specialists, and peer support—deliver evaluation, treatment, and ongoing care for adults, adolescents, and children.

## Services include:

- **Outpatient therapy and psychiatry for anxiety, depression, bipolar disorder, PTSD, ADHD, and other conditions**
- **Substance use care: assessment, medication-assisted treatment (such as buprenorphine and naltrexone), withdrawal management, outpatient and residential programs, intensive outpatient groups, and relapse prevention**
- **Inpatient, partial hospitalization, and crisis services for higher levels of support**
- **Co-occurring care that addresses mental health and substance use needs together**
- **Specialized programs for youth, older adults, perinatal mental health, and trauma**
- **Integrated behavioral health in primary care and medical clinics, plus care navigation and family education**

The aim is to provide timely, evidence-based care close to home—with clear communication, personalized plans, and smooth transitions between levels of care—so people in every community can access the right help at the right time.

## CENTER FOR TRAUMATIC STRESS RECOVERY AND RESILIENCE (CTSRR)

Northwell's Center for Traumatic Stress Recovery and Resilience (CTSRR) provide specialized, trauma-informed care and resilience training for individuals, families, and communities. Multidisciplinary teams—clinicians, peer specialists, and trainers—deliver evidence-based treatment, education, and support with a focus on accessibility and practical skills people can use in daily life.

Services include comprehensive trauma assessment and individualized treatment planning; evidence-based therapies such as Cognitive Processing Therapy, Prolonged Exposure, and EMDR; acute stress and post-traumatic stress care with support for co-occurring mental health and substance use; and Stress First Aid, a peer-to-peer framework that helps teams and community members recognize stress reactions early, provide immediate support, and promote recovery.

The CTSRR also offers resilience programs, workshops, and trauma-focused training for community partners, schools, and organizations, plus peer support, family education, caregiver resources, and coordinated care across outpatient, inpatient, and community services—reducing the impact of trauma and helping people recover more fully.

# NORTHWELL OBSTETRICS AND GYNECOLOGY

Northwell's OB/GYN service line delivers comprehensive care across all stages of life, from routine checkups to complex treatment. Multidisciplinary teams—obstetricians, gynecologists, maternal-fetal medicine specialists, urogynecologists, reproductive endocrinologists, gynecologic oncologists, midwives, and nurses—coordinate care across the network.

## Services include:

- **Routine gynecology:** annual exams, Pap tests, contraception, menopause care, and treatment for fibroids, endometriosis, and pelvic pain
- **Obstetrics:** preconception counseling, prenatal care, labor and delivery, postpartum support, and care for high-risk pregnancies
- **Reproductive medicine:** fertility evaluation and treatment, IVF, and fertility preservation
- **Pelvic floor care:** incontinence, prolapse, and other disorders, with surgical and nonsurgical options
- **Gynecologic oncology:** advanced diagnostics, surgery, and medical therapies
- **Minimally invasive and robotic surgery** for many gynecologic conditions

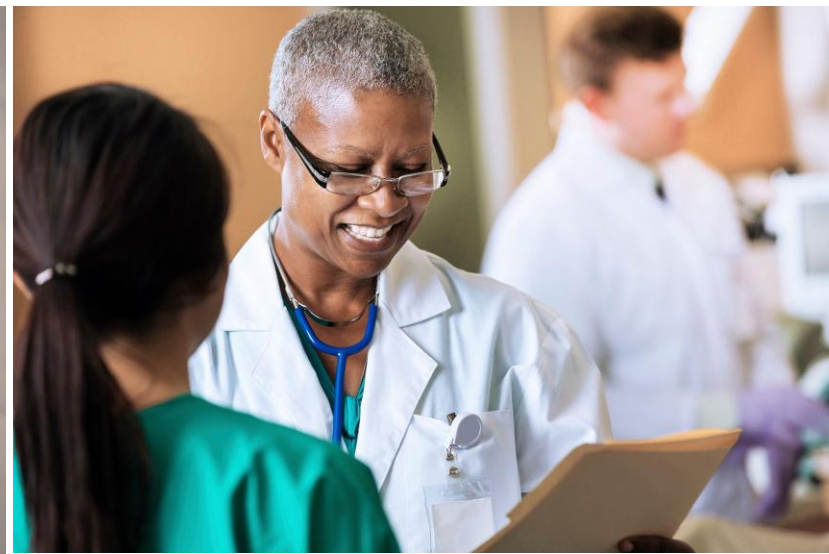
The program's aim is to provide safe, evidence-based, patient-centered care—emphasizing prevention, early detection, clear communication, and innovative therapies to support the best possible outcomes.



# KATZ INSTITUTE FOR WOMEN'S HEALTH (KIWH)

The Katz Institute for Women's Health is Northwell Health's comprehensive program dedicated to the unique health needs of women across the lifespan. It brings together experts in primary care and specialty services—such as cardiology, breast health, obstetrics and gynecology, pelvic floor and urogynecology, behavioral health, bone health, and menopause care—under one coordinated system. The KIWH offers personalized care plans, same-day or rapid appointments at multiple locations across our service area, and access to advanced diagnostics, imaging, and minimally invasive treatments.

Beyond clinical care, the Katz Institute provides education, risk assessments, and navigation to help women understand their health and make informed decisions. Women's health nurse practitioners, care coordinators, and wellness educators connect patients to preventive screenings, lifestyle programs, and supportive services, including mental health and nutrition. By integrating specialty care with outreach and education, the Katz Institute improves access, addresses disparities, and supports better outcomes for women and their families in the communities we serve.



# KATZ INSTITUTE FOR WOMEN'S HEALTH (KIWH)

## Go Red For Women

Go Red for Women is the Katz Institute for Women's Health's annual campaign to prevent heart disease and stroke in women and to improve access to lifesaving care. Each February, Northwell partners with community organizations, employers, and care sites to raise awareness of women's heart health, promote risk assessments, and connect women to convenient blood pressure checks, cholesterol screenings, and cardiology referrals. The campaign highlights that symptoms can differ for women and encourages prompt action through education on warning signs, prevention, and healthy lifestyle changes.

Funds and partnerships generated through Go Red for Women support outreach in high-risk neighborhoods, patient navigation, and programs tailored to women—such as pregnancy-related heart care, cardio-oncology, and women's preventive cardiology. By bringing education and screenings into communities and linking women to expert care close to home, Go Red for Women helps reduce disparities and improves heart health for women and their families.

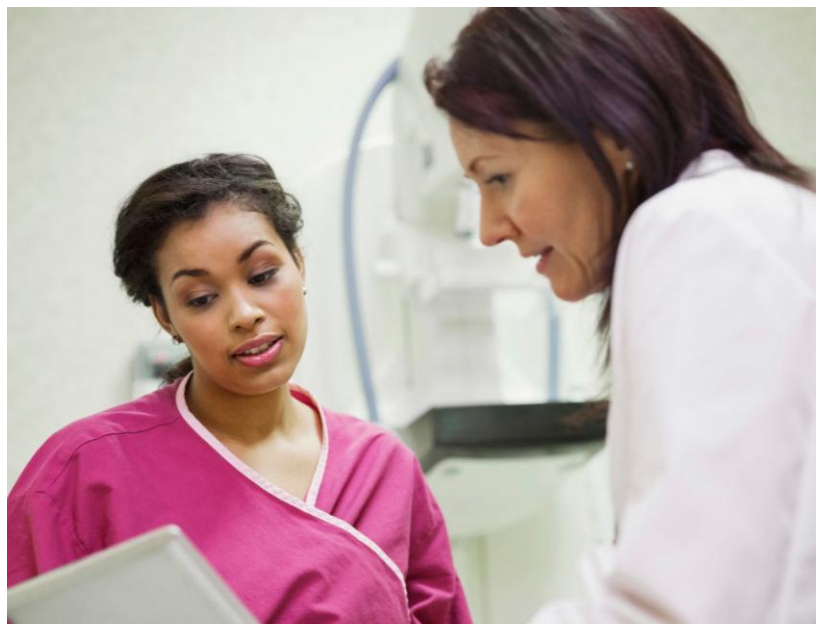


# KATZ INSTITUTE FOR WOMEN'S HEALTH (KIWH)

## Go Pink

Go Pink is the Katz Institute for Women's annual breast cancer awareness and fundraising campaign. It mobilizes Northwell team members, patients, and community partners each October to promote early detection and expand access to lifesaving care. The initiative supports education on breast health, encourages regular screening mammograms, and raises funds for programs that help women navigate care—such as patient education, support groups, transportation assistance, and outreach in high-risk neighborhoods.

Through Go Pink, the institute partners with Northwell imaging centers, primary care, and community organizations to offer convenient screening opportunities and share practical information on risk, prevention, and early signs. Funds raised help remove barriers to care and connect more women to timely diagnostics and treatment close to home. By combining awareness, access, and support, Go Pink advances health for all and improves outcomes for women across our communities.



# NORTHWELL CARDIOVASCULAR INSTITUTE

The Northwell Cardiovascular Institute expands access to high-quality heart and vascular care across the communities we serve. With locations throughout New York City, Long Island, and Westchester, patients can get timely appointments close to home, including same-day and second-opinion visits. Community cardiology practices are linked to tertiary hospitals and specialized programs—such as structural heart, electrophysiology, women’s heart health, cardio-oncology, and vascular surgery—so people can move seamlessly from local evaluation to advanced procedures when needed.

Teams of cardiologists, cardiac surgeons, electrophysiologists, and vascular specialists coordinate care with primary care doctors, community clinics, and rehabilitation programs. Services include preventive cardiology and risk assessments, advanced imaging and diagnostics, minimally invasive and open-heart procedures, medication management, and cardiac rehab. By bringing leading expertise into neighborhood sites and building clear referral pathways to specialty centers, the institute helps residents prevent disease, manage chronic conditions, and receive lifesaving care without leaving their community.



# NORTHWELL CANCER INSTITUTE



The Northwell Cancer Institute delivers comprehensive, community-centered cancer care across New York City, Long Island, and Westchester. Patients can access multidisciplinary teams—medical, surgical, and radiation oncologists, pathologists, radiologists, genetics experts, and supportive care specialists—through a network of hospitals and outpatient centers close to home. The institute offers advanced screening and diagnostics, precision medicine and genomic testing, minimally invasive and robotic surgery, leading radiation therapies, immunotherapy and targeted treatments, and access to clinical trials.

Care is coordinated through disease-specific programs (such as breast, lung, colorectal, prostate, gynecologic, hematologic, and pediatric cancers) and supported by nurse navigators who guide patients from diagnosis through survivorship. Support services include palliative care, nutrition, social work, behavioral health, rehabilitation, financial counseling, and community outreach. By bringing expert teams and innovative treatments into neighborhood sites and building clear pathways to specialized centers, the Northwell Cancer Institute improves access, reduces travel burdens, and helps patients and families receive timely, high-quality cancer care where they live.

# NORTHWELL AGING INSTITUTE

The Aging Institute engages directly with the community through education, activation, and partnership. It facilitates public learning events and outreach that promote healthy aging, prevention, and longevity, and shares practical age-friendly tools like the 4Ms (What Matters, Medication, Mobility, Mentation) to help individuals and families navigate care. At the same time, the Institute co-designs solutions with local organizations—linking patients to food and material security programs (SNAP, Senior Farmers' Market, meal services), collaborating with legal aid and social services on housing, transportation, and insurance barriers, and expanding home- and community-based care through mobile clinics and home-based primary care. These efforts also strengthen ties with assisted living, skilled nursing, retirement communities, and hospice to support aging with dignity across settings.

The Northwell Aging Institute is a systemwide initiative transforming how we care for and advocate with older adults by advancing interdisciplinary, age-friendly care, research, education, and innovation across the continuum. Our vision is to promote health span—the years lived with vitality, independence, and purpose—by raising health, wellness, safety, and quality of life, and by supporting longevity through coordinated, person-centered care in every setting.

- ✔ **Community: Healthy aging, prevention, and longevity outreach**
- ✔ **Clinical care: Interdisciplinary, person-centered care for complex needs**
- ✔ **Education: Age-friendly training and advanced certificates for providers**
- ✔ **Research: Studies and tech-enabled innovations in elder care**
- ✔ **Quality: Routine measurement and reporting to drive improvement**



# CENTER FOR GLOBAL HEALTH

Northwell's Center for Global Health (CGH) partners with communities locally and around the world to improve access to high-quality care, strengthen health systems, and advance health for all. The CGH focuses on priority areas such as surgery, maternal and child health, infectious diseases, noncommunicable diseases, emergency and trauma care, family medicine, rural medicine and mental health. Through long-term collaborations with ministries of health, hospitals, universities, and non-governmental organizations (NGOs), teams provide clinical mentorship, workforce training, program design, and quality improvement that help local providers deliver sustainable care.

The CGH's network spans core sites across Africa, the Caribbean, Latin America, and South Asia, including enduring partnerships in countries such as Kenya, Guyana, Ecuador, the Dominican Republic, and India. These sites support bidirectional learning, community outreach, and capacity-building with local clinicians and public health leaders. By combining evidence-based practice with community engagement across this global network, the Center for Global Health reduces barriers to care, strengthens local infrastructure, and improves health outcomes for vulnerable populations in New York and worldwide.





## NORTHWELL HEALTH AT HOME

Northwell Health At Home brings skilled care to patients where they live, helping them recover, manage chronic conditions, and stay safe at home. Services include nursing visits, physical, occupational and speech therapy, medical social work, home health aides, wound care, IV/infusion therapy, and medication management. The program also supports telemonitoring for vital signs, palliative and hospice care, and coordination with physicians to adjust treatment plans promptly.

Care teams assess needs, create personalized care plans, and teach patients and caregivers how to manage symptoms, use equipment, and prevent complications. They help arrange supplies, durable medical equipment, and follow-up appointments, and provide transition support after a hospital stay. By delivering professional care and education at home and linking patients to community resources, Northwell Health At Home improves access, comfort, and continuity of care for patients and families.

# MILITARY LIAISON SERVICES

Northwell's Military Liaison Services help active-duty service members, veterans, and their families navigate care and access support across the health system. The program connects patients to primary and specialty care, mental health services, rehabilitation, and social support, and coordinates benefits and referrals to community and VA resources. Key offerings include care navigation for appointments and referrals; behavioral health support for counseling, PTSD and trauma care, substance use services, and peer support; medical and surgical coordination across specialties; guidance on TRICARE, VA benefits, financial counseling, housing and transportation assistance, and caregiver support; and education and outreach through workshops and events.

Recognized with a Military Friendly designation, Northwell demonstrates a strong commitment to meeting the needs of military communities. By providing a single point of contact and partnering with community organizations and the VA, Military Liaison Services make it easier for military families to receive timely, coordinated care close to home..



# OFFICE OF PATIENT AND CUSTOMER EXPERIENCE

Northwell's Office of Patient and Customer Experience aim to improve, challenge and lead the design of experiences that our patients and their families truly want. The OPCE team focuses on four key strategies to drive patient and customer experience forward with exceptional customer service and delivering the highest quality care: culture, care delivery, hospitality and accountability.

Grounded in Northwell's Culture of C.A.R.E. (Connectedness, Awareness, Respect, and Empathy), each core element supports an exceptional patient experience and reflects our steadfast dedication to providing world-class services and patient-centered care. Led by trained facilitators, the dynamic Culture of C.A.R.E. curriculum focuses on effective communication, verbal and nonverbal empathy, service recovery and patient experience best practices. It is grounded in our philosophy that "every role, every person, every moment matters."

Northwell is proud to have more than 60 passionate leaders focused on elevating the patient experience. Called culture leaders, they are responsible for assessing, implementing and sustaining programs, initiatives and projects that improve the patient and family experience. Culture leaders serve as on-the-ground champions of the Culture of C.A.R.E. They lead unit-based efforts to improve communication and service, facilitate huddles and peer coaching, and help teams apply patient feedback to daily practice.



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# OFFICE OF THE CHIEF MEDICAL OFFICER

The Office of the Chief Medical Officer drives the system's commitment to clinical excellence, quality and patient safety, regulatory compliance, and the work of the physicians and clinicians. Critical oversight and leadership for all clinical operations originate from this office, which establishes and upholds the rigorous standards deemed necessary for high-quality, effective care. This pivotal function encompasses the strategic guidance and supervision of other Chief Medical Officers and Medical Directors across the system, ensuring clinical practices are consistently aligned with the best medical evidence and that clinical teams are adequately equipped and supported. This cultivates an environment where patient well-being is considered paramount and services provided are seen to directly contribute to the health goals articulated in this Community Health Needs Assessment.

Integral to the system's operational efficiency and strategic growth, the CMO office is perceived as instrumental in driving key initiatives aimed at enhancing integrated care and overall system performance, with significant milestones anticipated for 2025. This scope of work encompasses the strategic advancement of the entire Clinical Enterprise, a dedicated focus on optimizing the Epic electronic health record system to improve data integrity and care coordination, and the provision of essential clinical leadership for significant mergers, such as the Nuvance Integration. Moreover, the prioritization of Leadership Development for medical staff and comprehensive Wellness programs within this framework is recognized as crucial for fostering a resilient and highly skilled workforce, a requirement deemed indispensable for managing complex health challenges and delivering coordinated care across the expanding clinical footprint to meet diverse community health requirements.

## CENTER FOR ADVANCING HEALTH FOR ALL

The Center for Advancing Health for All is dedicated to ensuring the delivery of high-quality, patient-centered care that is culturally responsive and linguistically appropriate, addressing the unique and individualized needs of every patient. We are actively advancing and implementing strategies to improve health for all—in partnership with our patients, our teams, and communities.

### Language & Communication Access Services

Northwell provides free language access and communication support to ensure every patient and family can understand their care and make informed decisions. Services include 24/7 qualified medical interpreters (in person, video, and phone) in over 200 languages; American Sign Language interpreters; translated materials; and assistive devices or services for vision, hearing, and speech needs. Staff are trained to identify communication preferences and arrange services at no cost, with priority on privacy, accuracy, and cultural respect. These resources are available across hospitals, outpatient sites, emergency departments, and community settings to reduce barriers and improve access, safety, quality, and patient experience.



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# OFFICE OF LEGAL AFFAIRS

The Office of Legal Affairs (OLA) provides Northwell legal guidance that supports safe, compliant, and reliable care across Northwell Health's communities. The team advises on the legal aspects of access to care, insurance coverage, patient rights and clinical ethics, provider arrangements and reimbursement, emergency preparedness, disease prevention and treatment, and vendor contracts—helping remove barriers, clarify coverage, and strengthen protections for patients and families.

OLA also offers expertise in tax; corporate matters for nonprofit, for-profit, and joint ventures; insurance and ERISA; employment and labor; privacy and security; regulatory compliance; clinical research; and real estate. By partnering with clinical, operational, and community-facing teams, OLA helps ensure services are delivered lawfully and transparently, supports responsible growth of care sites, and promotes clear communication so residents can understand and access the care available to them.

# OFFICE OF CORPORATE COMPLIANCE

Northwell's Office of Corporate Compliance supports the health system's mission by promoting ethical conduct, preventing violations of law and policy, and maintaining robust compliance programs. Facility Compliance Directors at each site help implement regulations and privacy requirements, including HIPAA, and serve as local contacts for questions and concerns.

The Office develops policies and training to detect and prevent fraud, abuse, and inappropriate conduct; analyzes and communicates healthcare laws and guidelines; and provides safe, retaliation free reporting channels. It coordinates preemployment screening, manages compliance reviews and audits, and independently investigates issues—taking corrective action when needed. The Office reports on program effectiveness to the governing body and key executive committees, helping ensure patients, employees, and visitors receive care and services in a lawful, trustworthy environment.

# OFFICE OF STRATEGIC PLANNING

The Office of Strategic Planning advances health for all by delivering timely, accurate, and actionable information to support decision making around business strategy and investment. The Office helps improve health care access by proactively identifying opportunities to grow within strategic markets, and to establish innovative programs needed by our communities. The Office also supports our hospitals and service lines ensuring that our work is aligned with state and federal regulations.

# OFFICE OF SUSTAINABILITY AND RESOURCE STEWARDSHIP

Northwell's Office of Environmental Sustainability advances health by reducing the environmental impacts of healthcare across our hospitals and community sites. Initiatives focus on energy efficiency and renewable power; waste reduction and responsible sourcing; safer chemicals and green building; climate resilience and emergency preparedness; and sustainable food and transportation. The team engages staff, patients, and community partners through education, metrics, and transparent reporting—driving measurable progress toward lower greenhouse gas emissions, reduced waste and single-use plastics, and healthier indoor environments. By embedding sustainability into operations and care delivery, Northwell promotes prevention, and access—creating safer, more resilient communities and a healthier future.

Climate resiliency is the ability to prepare for, recover from, and adapt to impacts of climate change. For health care organizations, it's about the ability to maintain reliable health care, no matter what. Resilient health care systems are anchors for healthy, sustainable communities.

Climate change is a direct threat to the health of the communities we serve, and Northwell will continue to work to combat it. We always put public health at the forefront of what we do.

Understanding that many of our communities may be at disproportionate risk to climate related we plan to do the following:

- **Identify & anticipate the needs of these communities/groups**
- **Provide education & awareness on how climate effects health**
- **Leverage our already established Community Health Advancement Taskforce (CHAT) to hear directly from our community leaders on ways for us to aid**
- **Monitor and track health trends related to climate change and provide clinical interventions as appropriate**



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# NORTHWELL HEALTH PHYSICIAN PARTNERS (NHPP)

Northwell Health Physician Partners is a network of dedicated doctors and medical professionals employed by Northwell Health, delivering care in hundreds of locations throughout New York City and Nassau, Suffolk, and Westchester counties – including within all Northwell Health hospitals. Our team encompasses experts in more than 100 specialties, working collaboratively to bring the most advanced medical knowledge and treatments to our patients. We utilize Northwell's leading resources and research to continuously elevate the standard of healthcare. Committed to exceptional, integrated, and quality care, we prioritize our patients and operate on core values of caring, excellence, innovation, and integrity, ensuring every role and moment contributes to positive outcomes.



# INSTITUTE FOR CLINICAL EXCELLENCE, QUALITY, AND PATIENT SAFETY

Northwell Health is deeply committed to providing every patient with an exceptional experience, characterized by the highest levels of quality and safety, across all care settings and throughout every healthcare encounter. This commitment is directly aligned with the national healthcare agenda, reflecting the organization's dedication to leading the way in providing innovative and effective care. The Institute for Clinical Excellence, Quality, and Patient Safety serves as the driving force behind this commitment. It is a network of dedicated professionals and programs focused on continuously improving the care provided throughout the Northwell Health system. The Institute demonstrates a focus on exceptional quality service to every patient, in every care setting during each healthcare encounter. Its capacity to measure and report healthcare outcomes, realize cost efficiencies, and ensure patient safety through adherence to best practices are instrumental in providing high-quality medical care to the communities Northwell Health serves.

# PATIENT ACCESS SERVICES



Patient Access Services (PAS) is Northwell Health’s community-facing front door, helping people quickly find and schedule care across the system. PAS improves the patient experience by making navigation simple and reliable. Agents complete a three-month training program in technology, health terminology, and customer service. A strong quality program—based on the Culture of C.A.R.E.—records all calls to check accuracy and consistency, guide coaching, and strengthen communication. PAS connects patients to the right clinician and service—primary care, specialty care, diagnostics, and follow-up—and supports referral management so care is coordinated and timely.

# ENTERPRISE DIGITAL SERVICES

Northwell’s Enterprise Digital Services (EDS) is Northwell’s systemwide hub for digital strategy, delivery, and governance, unifying clinical and consumer digital solutions, enterprise data and information intelligence, digital innovation and transformation, and digital IT and services. It empowers patients and caregivers with person-centric tools while improving the practice of medicine through optimized EHRs and interoperability, standardized data, high-value analytics and predictive models, and rapid solution delivery. Product families span access and referrals, consumer identity, patient/clinician interactions, care planning and administration, care team coordination, health data access and insight, and financial health. Highlights include a strong digital front door across mobile, web, bedside, text and email; centralized communications and unified consumer profiles; automation to reduce administrative burden; greater interoperability to minimize duplication and improve continuity of care; and streamlined processes that increase speed to market and align portfolios with clinical and business priorities.

# NORTHWELL HEALTH LGBTQ CENTER

Northwell is committed to inclusive care to advance health for all. Northwell’s LGBTQ Transgender Program offers comprehensive, affirming care for LGBTQ+ individuals, with a strong focus on gender-affirming services for transgender and gender-diverse people. A multidisciplinary team—primary care, specialty clinicians, surgeons, and behavioral health providers—coordinates personalized care plans across Northwell’s network. The program emphasizes respectful, confidential care and helps patients with resources, insurance guidance, and follow-up to ensure continuity.

Northwell’s commitment to inclusive care has been recognized nationally: in 2024 the system was named a leader in LGBTQ+ inclusiveness by the Human Rights Campaign’s Healthcare Equality Index. This marks Northwell’s ninth appearance on the survey and growth from eight recognized locations in 2014 to 26 sites this year.



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# NORTHWELL HUMAN RESOURCES

Human Resources (HR) at Northwell serves as a strategic partner to the organization, dedicated to delivering comprehensive and innovative strategies, programs, policies and experiences that empower our people at Northwell to thrive in all aspects of life and provide outstanding care and service. Northwell HR supports the full team member experience and includes recruitment, career mobility and development; comprehensive wellbeing and benefits; compensation; alumni services; employee and family assistance; community, inclusion and belonging programs; and more.

## NORTHWELL BUSINESS EMPLOYEE RESOURCE GROUPS (BERGs)

Northwell's Business Employee Resource Groups (BERGs) offer a practical way for team members to amplify Northwell's mission, build community, grow professionally, and advance inclusion and health for all. These employee-led groups connect colleagues across roles and locations, create leadership and mentoring opportunities, and partner with the community on initiatives that reflect our values and business priorities. Participation is open to all team members.

### BERGs

- **Bridges (African American/Caribbean, Asian, Hispanic/Latino, Mosaic): Culture, inclusion, and community engagement**
- **Caregiver: Support, resources, and workplace flexibility for family caregivers**
- **Expressions (LGBTQIA+): Inclusion, allyship, and access to affirming care for the LGBTQ+ community**
- **GreenBERG: Sustainability, recycling, transportation, and energy efficiency**
- **N-Able: Disability inclusion, accessible employment, and patient/team experience**
- **VALOR (Veterans and Allies): Connection, empowerment, and engagement for the military community**
- **Women at Northwell: Community of support, leadership development, and women's health education and advocacy**
- **Gift of Life: Organ, blood, stem cell, tissue, and eye donation awareness and education**
- **Multifaith and Spiritual Care (Jewish, Muslim segments): Respect, understanding, learning, and compassionate, faith-informed care**
- **Intergenerational: Mentorship and knowledge-sharing across generations**
- **WellConnected: Community and growth for remote and hybrid team members**

# FEINSTEIN INSTITUTES FOR MEDICAL RESEARCH

The Feinstein Institutes for Medical Research is Northwell Health's scientific home, advancing discovery and innovation that translate into better care for the communities we serve. With interdisciplinary institutes spanning neuroscience, cancer, autoimmunity, bioelectronic medicine, and health outcomes, Feinstein investigators conduct basic, translational, clinical, and implementation research that informs prevention, diagnosis, and treatment across the lifespan.

The Institutes support more than a thousand clinical studies annually in partnership with Northwell hospitals and community sites, accelerate breakthroughs through core facilities and data science, and train the next generation of clinician-scientists. By integrating research with care delivery and community priorities, Feinstein helps bring evidence-based solutions to pressing local health needs identified in the CHNA—reducing disease burden, advancing health for all, and improving outcomes across our region.



Institute for  
Cancer  
Research



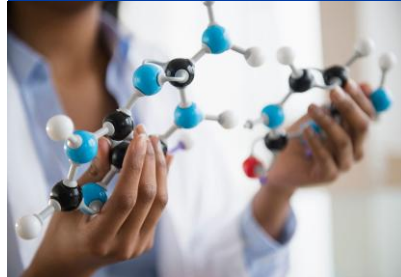
Institute for  
Behavioral  
Science



Institute for  
Bioelectronic  
Medicine



Institute for  
Health System  
Science



Institute for  
Molecular  
Medicine



Institute for  
Translational  
Research



**6,300**

Researchers &  
staff

**5,000**

Clinical research  
studies

**250+**

Patents filed

**2,700**

Papers published  
annually

# NORTHWELL'S DOWLING INSTITUTE FOR LEARNING AND INNOVATION

Northwell Health's Dowling Institute for Learning and Innovation is the health system's corporate university, created to help team members continually develop the skills and leadership needed to deliver high-quality care and meet organizational goals. Established in 2002 and built on partnerships with GE Medical Systems and Harvard, the Dowling Institute fosters a culture of innovation, continuous improvement, and teamwork by leveraging leaders as teachers and offering an interactive learning environment. Each year, thousands of employees complete hundreds of thousands of learning hours through enrichment courses, technical workshops, just-in-time/on-demand curricula, leadership development, and high-fidelity clinical simulations—building workforce capabilities that directly benefit patients and communities.

The Dowling Institute's specialized centers expand training depth and ensure practice-ready skills. The Bioskills Education Center provides hands-on surgical training and continuing education with advanced equipment and cadaveric specimens across disciplines such as general surgery, orthopedics, cardiothoracic, neurosurgery, and more. The Clinical Skills Center uses standardized patients to strengthen communication, clinical reasoning, and empathy; collaborates with the Zucker School of Medicine and the Hofstra-Northwell School of Nursing and Physician Assistant Studies to conduct OSCE assessments; and extends simulations to non-clinical teams to build essential business and interpersonal skills. Together, these programs support workforce readiness, consistent quality, and compassionate care—advancing Northwell's vision and improving health outcomes for the communities we serve.



# DONALD AND BARBARA ZUCKER SCHOOL OF MEDICINE AT HOFSTRA/NORTHWELL

The Zucker School of Medicine partners with Northwell Health to train physicians and advance community health through education, research, and service. Programs emphasize prevention, access to care, and hands-on learning—featuring early, longitudinal clinical experiences in neighborhoods and clinics; public and population health threads; and interprofessional education with nursing, PA, and other trainees.

The School of Medicine is consistently recognized nationally for research and noted for primary care training. Highlights include pipeline and pathway programs for high school, college, and post-baccalaureate learners; community-engaged research and health services studies; and regional partnerships with Northwell hospitals and practices that expand access to primary and specialty care, including mobile outreach and telehealth. Its graduates are prepared to deliver compassionate, evidence-based care that strengthens community health through prevention, early intervention, and timely access to high-quality services.



DONALD AND BARBARA  
ZUCKER SCHOOL *of* MEDICINE  
AT HOFSTRA/NORTHWELL®

# HOFSTRA NORTHWELL SCHOOL OF NURSING AND PHYSICIAN ASSISTANT STUDIES

The Hofstra Northwell School of Nursing and Physician Assistant Studies (SONPAS) prepares future health-care leaders through innovative, team-based learning. Its programs emphasize collaboration, critical thinking and compassionate care, educating nurses and physician assistants who improve health through prevention, access, and community-based care.

Highlights include comprehensive degree pathways—BS (traditional and second degree), RN-to-BS, MSN and advanced practice tracks, DNP, and Physician Assistant MS—along with interprofessional education, broad clinical placements, and strong transition-to-practice preparation. Pipeline initiatives, scholarships, and academic support entry into nursing and PA careers, while faculty and students work in quality improvement, patient safety, and community health aligns training with Northwell’s priorities. Graduates are practice-ready to deliver compassionate, evidence-based care and improve prevention, early intervention, and timely access to high-quality services.



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# CHNA/CSP 2025-2027

## GOVERNANCE & DISSEMINATION

### Governance

Northwell Health is a non-profit organization overseen by its Board of Trustees. The supervision of care delivered by Northwell Health is overseen by the Board of Trustees, which is responsible for establishing policy, overseeing management, and evaluating and improving patient care. The Board of Trustees is also responsible for the review of the Community Health Needs Assessment and Community Service Implementation to ensure that these efforts best meet the needs of our community.

On September 10th, 2025, the Board of Trustees reviewed and unanimously ratified and approved the Community Health Needs Assessment and the selection of the NYSDOH Priority Areas. On October 7th, 2025, the Community Health Needs Assessment was reviewed and approved by the Committee on Community Health, a committee overseen by the Board of Trustees. The Community Service Plan & Implementation Plan relating to each hospital will be presented to the Board of Trustees for approval in early 2026.

### Dissemination

Northwell is committed to ensuring our community members have easy access to our 2025-2027 Community Health Needs Assessment (CHNA), Community Service Plan (CSP), and implementation plan. To ensure that the reports are accessible and easy to navigate, the CHNA and CSP are posted on the Northwell Community Health Investment website with instructions for downloading. There is no need to create an account or submit any personally identifying information to access the reports. The reports can be accessed at the following URL: (<https://www.northwell.edu/education-and-resources/community-engagement/community-health-investment/needs-assessment-community-health-implementation-plan>).

The Institute for Community Health and Wellness also provides hard copies of the CHNA and CSP available to anyone who requests them at no charge. To request a hard copy of the reports, please email [CommunityHealth@northwell.edu](mailto:CommunityHealth@northwell.edu) with 'CHNA/CSP hard copy request' in the subject line and indicate in the email which reports(s) you would like and to what mailing address they should be sent. Hard copies of the CHNA and CSP can be distributed to community-based organizations, faith-based organizations, community board members, policymakers, local health centers, community members, patients, and other interested stakeholders. Furthermore, Northwell will actively solicit feedback from the public and key stakeholders on the effectiveness of our CHNA/CSP and integrate insights into ongoing and future planning.

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# AWARDS AND RECOGNITIONS

- *100 Most Influential People in Healthcare, Modern Healthcare:* Michael J. Dowling, President and CEO of Northwell Health, ranks among the most influential people in the healthcare industry.
- *“A” Rated, Hospital Index for Social Responsibility, Lown Institute*
- *Age-Friendly “Committed to Care Excellence,” John Hartford Foundation, Institute for Healthcare Improvement (IHI), and others:* 17 Northwell Health entities attained this highest designation.
- *AHA’s Quest for Quality Prize:* Recognized as the first health system in the country to receive this prize for achievements in improving access to care and addressing social determinants of health.
- *Always Ready for Children, New York State Department of Health (NYSDOH):* Recognized as the first health system in New York State to have every emergency department in its hospitals earn this certification.
- *Bariatric Surgery Center Accreditation, Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP):* 9 hospitals received this accreditation.
- *Best 200 Innovations of 2024, TIME:* The Feinstein Institutes were recognized for two innovations.
- *Best Children's Hospital, U.S. News & World Report (2024-2025):* Cohen Children's Medical Center was named the top children's hospital on Long Island and earned top-50 national rankings in 10 pediatric specialties.
- *Best Hospitals, U.S. News & World Report (2024-2025):* Seven hospitals received top-50 national ratings in 30 adult medical specialties and 11 top-20 rated programs.
- *Best Places to Work in Healthcare, Modern Healthcare*
- *Best Workplaces in Healthcare, Fortune*
- *Case Management Accreditation, National Committee for Quality Assurance: Awarded to Northwell Health Management (formerly Health Solutions).*

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# AWARDS AND RECOGNITIONS

- *Centers for Medicare & Medicaid Services (CMS) Recognition, Best in the Nation: Northwell's House Calls program was recognized for its best-in-nation performance for the ninth consecutive year.*
- *College of American Pathologists (CAP) Accreditation: 14 hospitals and the Northwell Health System Laboratories received this accreditation.*
- *Davey Award, Silver, 2025: Awarded in the General Health & Fitness category for the Prostate Cancer Panel Discussion Video.*
- *EMS Agency of the Year Award, New York State EMS Conference: Awarded to the Center for Emergency Medical Services (CEMS).*
- *Fourth largest academic teaching institution in the US*
- *Global medical and scientific home of bioelectronic medicine*
- *Healthcare Association of New York State (HANYS) Community Health Improvement Award (CHIA), 2025: Awarded to Northwell's Street Medicine Program.*
- *Healthiest 100 Places to Work in America, Healthiest Employers*
- *Joy in Medicine Health System, silver recognition, American Medical Association: Recognized for the health system's commitment to supporting the well-being of its physicians.*
- *Lantern Award, Emergency Nurses Association (ENA): 11 hospital emergency departments were honored for exceptional and innovative performance.*
- *Largest hospital-based laboratory in North America*
- *Leapfrog's Hospital 2024 Fall Grade report, "A" rating: 11 hospitals received an "A" rating.*
- *LGBTQ+ Healthcare Equality Leader, Healthcare Equality Index (HEI): 26 Northwell facilities were recognized.*

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# AWARDS AND RECOGNITIONS

- *Magnet® Designation for Nursing Excellence, American Nurses Credentialing Certification (ANCC): 11 hospitals attained this designation.*
- *National Humanism in Medicine Medal, Gold Foundation: Awarded to Michael J. Dowling, President and CEO of Northwell Health.*
- *Network of Excellence in Hernia Surgery, Surgical Review Corporation (SRC): Northwell is the first health system in the United States to achieve this accreditation, with 3 hospitals recognized.*
- *New York State's Most Awarded Health System, U.S. News and World Report Best Hospitals Ranking: Includes North Shore University Hospital ranked #1 in NY State and Cohen Children's Medical Center ranked #1 on Long Island.*
- *One of America's Most Innovative Companies, Fortune*
- *Pain and Addiction Care in the Emergency Department (PACED) designation, American College of Emergency Physicians (ACEP)*
- *System-wide accreditation, Intersocietal Accreditation Commission (IAC): 63 echocardiography sites across the system earned this accreditation.*
- *Target: BP, Type 2 Diabetes and Check.Change.Control. Cholesterol., Gold, AHA*
- *Telly Award, Bronze, 2025: Awarded in the General – Fitness, Health & Wellness (Social Video) category for the Prostate Cancer Panel Discussion Video.*
- *Top Ten Military Friendly Employer, 2025 (Military Friend Gold Awardee)*
- *Verified Trauma Center, American College of Surgeons (ACS): 5 hospitals are recognized as Verified Trauma Centers.*
- *World's Most Ethical Companies, Ethisphere: Northwell is one of four health systems in the nation to be named.*

RAISE  HEALTH

**NY'S MOST  
AWARDED  
HEALTH SYSTEM  
TWO YEARS IN A ROW**

[Northwell.edu/LeadTheWay](http://Northwell.edu/LeadTheWay)



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# ACKNOWLEDGEMENTS

The successful completion of this Community Health Needs Assessment was a collaborative effort made possible by the dedication and expertise of numerous individuals across Northwell Health and our community partners. We extend our sincere gratitude to the following people for their invaluable contributions.

## **Executive Leadership**

- ❖ Debbie Salas-Lopez, MD, MPH, Executive Vice President, Institute for Community Health and Wellness
- ❖ Edward Fraser, MHA, Vice President, Deputy Senior Vice President, Institute for Community Health and Wellness

## **Community Health Needs Assessment Steering Committee**

- ❖ Mitchell Cornet, MPP, MHSA, Vice President, Community Strategic Partnerships, Institute for Community Health and Wellness
- ❖ Jerald Chandy, MScPH, MBA, MSc, Senior Director, Community Health Strategy, Institute of Community Health and Wellness & the Office of Strategic Planning
- ❖ Jack Tocco, PhD, MPH, Senior Advisor, Institute for Community Health and Wellness,
- ❖ Erica Omar, MPA, PP, Senior Advisor, Operations, Community Health, Institute for Community Health and Wellness
- ❖ Kimeka Randall, MSCH, Executive Program Director, Institute for Community Health and Wellness
- ❖ Sabrina Lutchman, MPA, Senior Project Manager, Community Health, Institute for Community Health and Wellness
- ❖ Noah Adelman, BS, Program Manager, Community Health, Institute for Community Health and Wellness
- ❖ Eileen Allnach, MBA, Senior Project Manager, Community Relations, Institute for Community Health and Wellness
- ❖ Richard LaRoche, Principal, Institute for Community Health and Wellness

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- ❖ Jason Brinkley, PhD, Associate Professor, Office of Clinical Research Statistics, Research Intelligence
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- ❖ Frank Delguercio, MBA, Director, Business Intelligence, Office of Patient & Customer Experience
- ❖ Doni Patel, MBA, CPXP, Knowledge Management Specialist, Office of Patient & Customer Experience
- ❖ Kinnari Trivedi, MPH, Senior Business Strategy Analyst, Office of Strategic Planning
- ❖ Vinod Kumar, PharmD, DHPM, MS, Strategy Analyst, Office of Strategic Planning
- ❖ Léah Marsot Shiffman, MPH, Strategy Analyst, Office of Strategic Planning
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- ❖ Jason Vinciguerra, Data Analyst, Northwell FlexStaff
- ❖ Kenneth Haskell, Lead Business Strategy Analyst, Office of Strategic Planning
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- ❖ Simryn Desai, Intern, Hofstra University
- ❖ Katherine Cornet, Intern, Gettysburg College
- ❖ Cayla Skeete, Intern Hofstra University, School of Health Sciences.
- ❖ Ria Kataria, Consultant, Patient Experience, Strategic Consultant, Press Ganey

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## CHNA - Community Health Site and Program Leadership

- ❖ Albanese, Nicole, Patient & Customer Experience Specialist, Glen Cove Hospital
- ❖ Alfonso, Ileana, Senior Patient & Customer Experience Specialist, Long Island Jewish Valley Stream Hospital
- ❖ Belanger, Courtney, Program Manager, Institute for Community Health and Wellness
- ❖ Berkman, Sarah A., LCSW, Director of Social Work, Huntington Hospital
- ❖ Bernstein, Henry, MD, Pediatrics General Pediatrics, Cohen's Children Medical Center
- ❖ Brick, Faiga, Senior Manager, Child Life, Cohen's Children Medical Center
- ❖ Burns, Daniella Monaco, MS, LMHC, Director, Program Management, Behavioral Health Service Line
- ❖ Butler, Peg, Vice President, Marketing, Lenox Hill Hospital
- ❖ Chin, Juleigh, Associate Project Manager, Community Outreach, Patient & Family Centered Care, North Shore University Hospital
- ❖ Conti, Emily, Senior Community Outreach Specialist, Cohen's Children Medical Center
- ❖ Escobar, Elsy, Care Management Coordinator, Cohen's Children Medical Center
- ❖ Esposito, Marybeth, Senior Advisor, Public Affairs, Mather Hospital
- ❖ Farber, Kacey, LMSW, Program Manager, Social Work, Huntington Hospital
- ❖ Feuer, Evan, MA, LMHC, Senior Manager, Zucker Hillside Hospital
- ❖ Feuer, Vera, MD, VP, Child and Adolescent Psychiatry, BHSL, Cohen's Children Medical Center
- ❖ Gazemar, Natcha, P-MHNP, RNC, CM, Senior Manager, Care Management, Institute for Community Health and Wellness
- ❖ Goenka, Praticchi, MD, Pediatric Hospitalist, Cohen's Children Medical Center
- ❖ Gomez, Julizann, GME Training Program Administrator, Glen Cove Hospital
- ❖ Goodman, Sharon, Director, Clinical Professional Development, Cohen's Children Medical Center
- ❖ Green, Wilonda, Senior Program Manager, Institute for Community Health and Wellness
- ❖ Greer, Catherine, Senior Marketing Project Manager, Lenox Hill Hospital
- ❖ Grella, Jessica, MPH, CPSTI, Community Health Educator, Cohen's Children Medical Center

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## CHNA - Community Health Site and Program Leadership

- ❖ Hill, Claudette, BSN, RN, Director, Operations, Community Health, Staten Island University Health
- ❖ Isaacson, Stacey, Program Director, Northwell Community Scholars, Institute for Community Health and Wellness
- ❖ Jan, Sophia, MD, Chief, Division - Pediatrics General Pediatrics, Cohen's Children Medical Center
- ❖ Jardine, Shari, MPH, MA, Assistant Vice President, Center for Global Health
- ❖ Jokhakar, Vaidehi, Supervisor, Social Work Services, Cohen's Children Medical Center
- ❖ Kapoor, Sandeep, MD, MS-HPPL, Vice President, Emergency Medicine Addiction Services
- ❖ Keber, Barbara A. Paino, MD, Chair, Family Medicine, Glen Cove Hospital
- ❖ Keogh, Marie, MPH, RD, RN, IBCLC, Perinatal Clinical Program Manager, South Shore University Hospital
- ❖ Lark, La'Dreamer, Project Manager, Institute for Community Health and Wellness
- ❖ Mahoney, Mary E., MSN FNP-BC, Vice President, Emergency Management and Clinical Preparedness
- ❖ Mancini, Anita, LCSW, Advisor Business Development, Zucker Hillside Hospital
- ❖ Mandelos, Angela, MBA, Director, Community Health, South Shore University Hospital
- ❖ Martin, Amy Ferraro, Senior Manager, Community Relations, Phelps Hospital
- ❖ Meacher, Peter, MD, Director of LGBTQ+ Care for the Western Region, Northwell Health, Western Region
- ❖ Mendez, Maliq, Program Manager, Northwell Greenwich Village Hospital
- ❖ Montes, Jorge, Supervisor, Outreach Services, Cohen's Children Medical Center
- ❖ O'Shaughnessy, Grace, Senior Director, Community Health, Northern Westchester Hospital

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## CHNA - Community Health Site and Program Leadership

- ❖ Patino, Amber, Director, Program Management, True North Administration
- ❖ Patti, Christine, Manager, Outreach Services, Patient & Family Centered Care, North Shore University Hospital
- ❖ Paulus, Santhosh MD, Senior Program Director, Human Trafficking Program
- ❖ Pecorella, Maureen, Advisor, Business Development, South Oaks Hospital
- ❖ Pettinicchi, Marina, MPH, CHES, Manager, Outreach Services, Cohen's Children Medical Center
- ❖ Pittarelli, Meadow, LGBTQ Community Administrative Support Coordinator, Northwell Health, Western Region
- ❖ Raider-McQuillan, Michelle, Senior Director, Operations, Behavioral Health Urgent Care
- ❖ Rieber, Danielle, Manager, Social Work Services, Glen Cove Hospital
- ❖ Rosario, Samantha, Director, Program Management, Center for Advancing Health
- ❖ Rosenthal, David, DO, PhD, AAHIVS, Medical Director, Center for Young Adult, Adolescent and Pediatric HIV, Cohen's Children Medical Center
- ❖ Roy, Sharmilee, Infection Prevention Specialist, Long Island Jewish Medical Center
- ❖ Salvatore, Lauren, Director, Behavioral Health, Cohen's Children Medical Center
- ❖ Sanji, Stancy, Community Outreach Program Manager, Long Island Jewish Forest Hills Hospital
- ❖ Scaparro, Jessica, Director, Operations, Health Home
- ❖ Silver, David, MD, ED Nocturnist, Glen Cove Hospital
- ❖ Superior, Shayla, Community Relations Program Manager, Plainview & Syosset Hospitals
- ❖ Tarone, Tara L., Program Manager, System Food & Nutrition Services, Office of Patient and Customer Experience
- ❖ Thomas, Mary, Community Outreach Program Manager
- ❖ Uzo, Nancy, Vice President, Public Affairs, Mather Hospital
- ❖ Van der Veer, Anne, MPH, Program Manager, Cohen's Children Medical Center
- ❖ Wilches, Paola, Manager, Patient Care, Glen Cove Hospital

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## Community Health Needs Assessment - System Contributors

- ❖ Chuang, Peiyun, Business Strategy Project Manager, Office of Strategic Planning
- ❖ Conklin, Madalyn, MHA, Senior Director, Operations, Western Region-Northern Region
- ❖ Contreras, David L., MHA, MPH, CPH, Executive Program Director, Office of the Chief Medical Officer
- ❖ De Geronimo, Marcella, MS, Vice President, Informatics, Quality and Population Health, Analytics & Solutions, Enterprise Digital Services
- ❖ Dufort, Caitlynn, MPH, Executive Program Director, HR Office of the Chief People Officer
- ❖ Frank, Olivia, MPH, Violence Prevention Outreach Manager
- ❖ Hickey, Susan, Finance and Operations Management Associate, Eastern Region
- ❖ Hoffman, Emily, Assistant Vice President, Operations, West Regional Expenses
- ❖ Kenny, Megan, Vice President, Administration, Metro Market
- ❖ Khan, Cynthia, MBA, Senior Vice President, Office of Strategic Planning
- ❖ Kozlowski, Michael, MHA, Senior Manager, Operations, Central Region
- ❖ Lima, Dianne, Senior Director, Corporate Finance
- ❖ McCort, Michael, MS, Director, Fair Employment Practices, Office of Legal Affairs
- ❖ Mieres, Jennifer, MD, FACC, MASNC, FAHA, Senior Vice President, Center for Advancing Health For All
- ❖ Morgan, Catriona, Assistant Vice President, Office of Legal Affairs
- ❖ Parada, Jessica L., JD, Vice President, Operations, Northwell System Administration, Office of the President & CEO
- ❖ Piccolo, Annalisa, MHA, Director, Operations, Ambulatory Admin, Eastern Region
- ❖ Scully, Alyssa, MHA, PMP, Assistant Vice President, Operations, Northwell Aging Institute
- ❖ Spitzer, Danielle, Director, Experience Strategy, Experience
- ❖ Trinkoff, Alexandra, Esq, Deputy General Counsel, Office of Legal Affairs

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