COMMUNITY SERVICE PLAN & IMPLEMENTATION PLAN

Mather Hospital
2025 – 2027

Northwell Health®

TABLE OF CONTENTS

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 Compassionate	Truly Innovative	Truly Ambitious	Truly Together	Truly Inclusive
Our commitments	Care deeply	Be actively curious	Take the initiative	Support each other	Cultivate belonging
How we do it	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
How we lead	Model kindness and empathy	Empower every team member	Unlock potential	Build trusting teams	Foster a safe and inclusive environment

ECONOMIC IMPACT

28 hospitals

$22.6 billion
annual operating budget

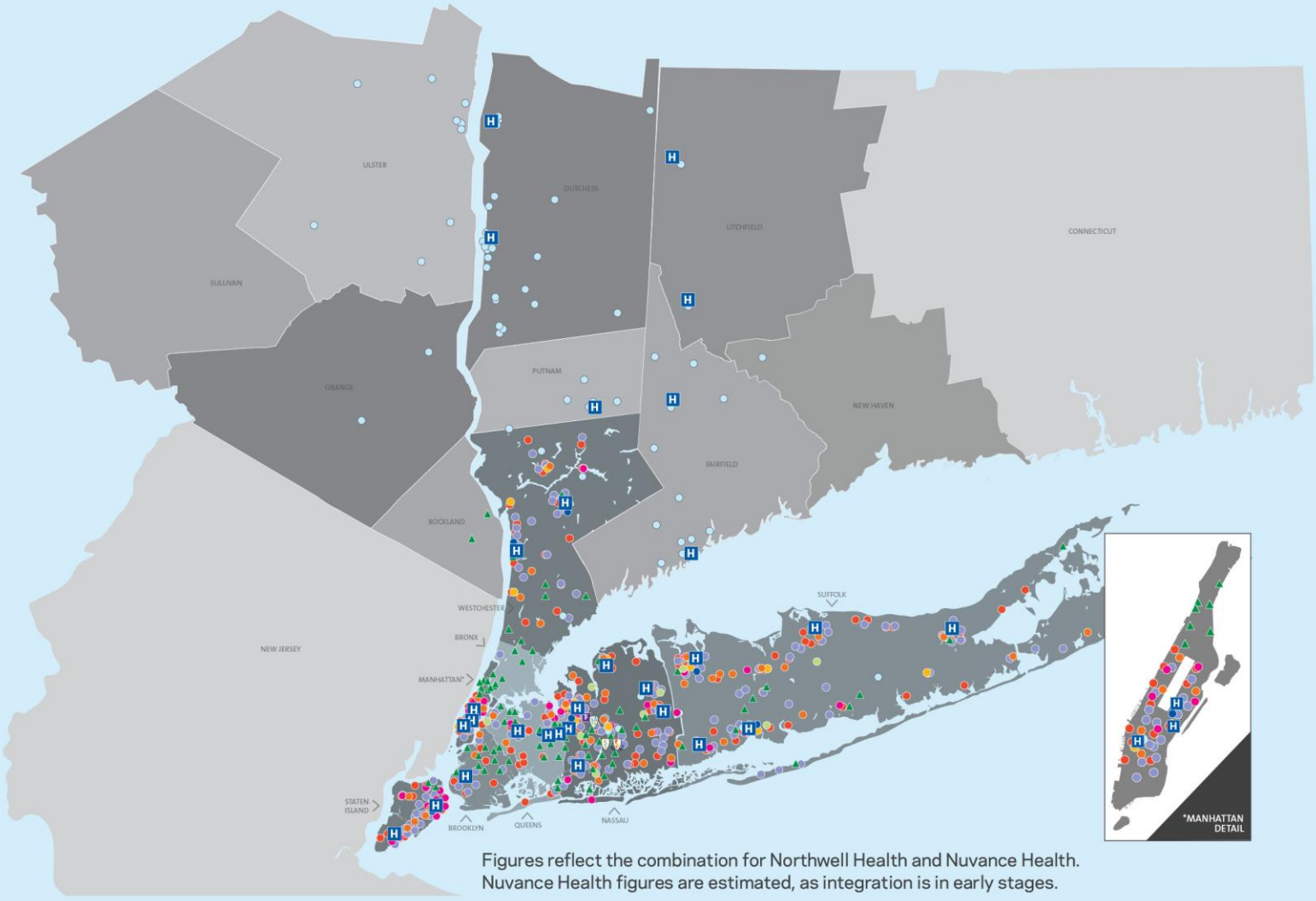
104,000+
employees
Largest private employer in New York State

11 Magnet®-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)

Northwell Health®

MISSION STATEMENT

We are dedicated to providing the highest quality clinical care, educating the current and future generations of health care professionals, promoting health education, and caring for the community regardless of the ability to pay.

Our mission is to meet or exceed each patient's expectations through the continued collaborative efforts of each and every member of the Mather Hospital Family. To be recognized in New York State as the best community teaching hospital for the highest quality, compassionate, and innovative care.

Northwell℠ Mather Hospital

WHO WE ARE

Mather Hospital is a 249-bed community teaching hospital and a recognized leader in outstanding patient care and clinical quality. Since it opened its doors in 1929 as the first general hospital in the Town of Brookhaven, Mather Hospital's legacy of excellence and innovation in health care has earned regional and national recognition. Backed by the resources of New York's largest health system, we pair the personal attention of a neighborhood hospital with seamless access to Northwell's specialty expertise, advanced diagnostics, and coordinated care across the continuum.

Mather has received the top five-star rating from the Centers for Medicare & Medicaid Services for patient experience, safety, and timely and effective care measures three years in a row and was designated one of the Top 250 hospitals in the nation by Healthgrades for 2023, 2024 and 2025. Mather also has earned Magnet® designation for nursing excellence from the American Nurses Credentialing Center three times as well as 22 top A grades for patient safety from the Leapfrog Group in the Fall 2025 ratings, the most of any hospital in Suffolk County. Leapfrog is a national nonprofit organization driving a movement for giant leaps forward in the quality and safety of American health care.

Operating Stats

- **People Admitted: 11,000**
- **% Medicaid & Medicare: 73%**
- **Treated in the ER: 39,000**
- **Outpatient care: 150,000**
- **Team Members: 2,360**
- **Licensed Beds: 249**
- **Community Benefit: $84.9M**

- Ambulatory Surgery (Multi-Specialty)
- Audiology
- Bariatric Surgery (Comprehensive Center)
- Cardiac Catheterization
- Coronary Care / Coronary Intervention
- Chemical Dependence
- Clinical Laboratory Services
- Electrophysiology
- Emergency Department
  - Geriatric Emergency Department
- Gastroenterology / GI Care
- Intensive Care / Critical Care (Critical Care Excellence Award)
- Lithotripsy
- Medical/Surgical Inpatient Care
- Nuclear Medicine (Diagnostic)
- Orthopedics (including Advanced Total Hip & Knee Replacement)
- Primary & Specialty Medical Care
- Primary Stroke Center
- Psychiatric Services
- Pulmonology (Pulmonary Care Excellence Award)
- Radiology (Diagnostic & Therapeutic)
- Rehabilitation & Therapy Services (Outpatient)
- Occupational Therapy
- Physical Therapy
- Speech-Language Pathology
- Renal Dialysis (Acute)
- Social Services

ABOUT THE COMMUNITY SERVICE PLAN

The Community Service Plan (CSP), part of the overall Community Health Needs Assessment (CHNA) process, focuses on how we translate identified health needs into concrete actions that improve health at the local level. The programs and initiatives outlined in this report are hospital-specific—whether designed on site or system initiatives successfully scaled and implemented at the hospital—to address the health needs of its local communities. Hospital-specific CSP reports align with the New York State 2025-2030 Prevention Agenda domains and priorities.

As we follow the evidence and leverage our systemness, we have developed an integrated CHNA process and identified health needs across our hospitals. The section below provides a summary of our CHNA process and findings, and the prioritized health needs. For additional information on our CHNA efforts, please refer to our CHNA 2025 Executive Summary Report, as well as detailed reports organized by county, which include more on our methodologies and findings.

The sections that follow describe how the hospital is specifically addressing the identified needs of its communities. We outline programs and initiatives—both local to the hospital and system programs scaled and implemented locally—alongside partnerships and, where applicable, relevant measures to track progress.

CHNA PROCESS OVERVIEW

Northwell's 2025 Community Health Needs Assessment (CHNA) is a framework for listening and learning from our communities to co-create lasting solutions to improve health and well-being in our service area. Led by Northwell's Institute for Community Health and Wellness (ICHW), a cross-functional CHNA Steering Committee reconvened in early 2025 and aligned the roadmap with national best practices, New York State's 2025–2030 Prevention Agenda, and IRS 501(r) requirements. The process used mixed methods research, combining direct community input with analysis of health and social data to build a clear picture of the top health needs across the service area.

Primary input included 12 focus groups, a targeted survey of community-based organizations, and a 34-question Community Health Survey implemented across the hospital service area, as well as ongoing listening tours. Secondary analysis reviewed health status and utilization trends, vital statistics, social and climate vulnerability indices, and agency reports. Findings were prioritized using established frameworks to shape the Implementation Strategy. Results and recommendations were compiled into the CHNA Executive Summary and the companion Community Health Implementation Plan (CHIP), and they informed the hospital's Community Service Plan (CSP) as well as the CSPs of every other Northwell hospital. Northwell completes a CHNA every three years, with annual progress updates per state and federal requirements.

We grounded the CHNA in two proven frameworks: the Association for Community Health Improvement's Community Health Assessment model and New York State's 2025–2030 Prevention Agenda (the State Health Improvement Plan). ACHI's data driven, nine step approach centers on meaningful community involvement and the use of both quantitative and qualitative inputs. The Prevention Agenda provides a statewide structure across five domains and 24 priorities. Together, these frameworks organized our findings, shaped the selection of priorities, and informed an Implementation Plan to design and roll out community health programs and interventions at the system and hospital level.

Source: ACHI Community Health Assessment Framework

COMMUNITY INSIGHTS & SELECTED PRIORITIES

Grounded in the CHNA's mixed-methods findings and aligned with the NYSDOH 2025–2030 Prevention Agenda, Northwell identified a set of community health priorities that reflect what residents, community leaders, and local partners voiced across our service area. These priorities are organized by the five Prevention Agenda domains to provide a clear, actionable structure for hospital and system planning, while recognizing that needs often intersect across domains.

Health Care Access & Quality:

Findings highlighted persistent barriers to timely, high-quality care across age groups, including chronic condition burden, limited appointment availability, long wait times, financial constraints, and language/cultural barriers. Access to specialty services (e.g., cancer, cardiac) and primary care capacity were recurring themes.

Social & Community Context:

Mental and behavioral health needs surfaced as a top concern, with elevated anxiety and depression, particularly among youth and young adults. Stakeholders emphasized rising suicidality and the need for culturally and linguistically responsive services, school-based supports, and community counseling.

Economic Stability:

Affordability and navigation emerged as core issues influencing care decisions and continuity. Communities cited trade-offs among basic needs (housing, utilities, food) and medical care, as well as the need for clearer pathways to financial assistance, insurance benefits, and nutrition security.

Education Access & Quality:

Educational access and quality were identified as foundational drivers of health, especially for youth. Feedback underscored the importance of educational pathways to address mental health, chronic disease prevention, and social needs, linking schools to broader health improvement strategies.

Neighborhood & Built Environment:

Place-based influences on health were noted across communities—including transportation challenges, environmental risks, proximity to services, and concerns around injuries and violence—pointing to the role of local context in shaping access and outcomes.

Our strategic priorities align with all five domains of the NYSDOH 2025–2030 Prevention Agenda and inform our collective Implementation Plan. The next section outlines how these priorities are addressed through [the hospital's] Community Service Plan (CSP), detailing programs and partnerships.

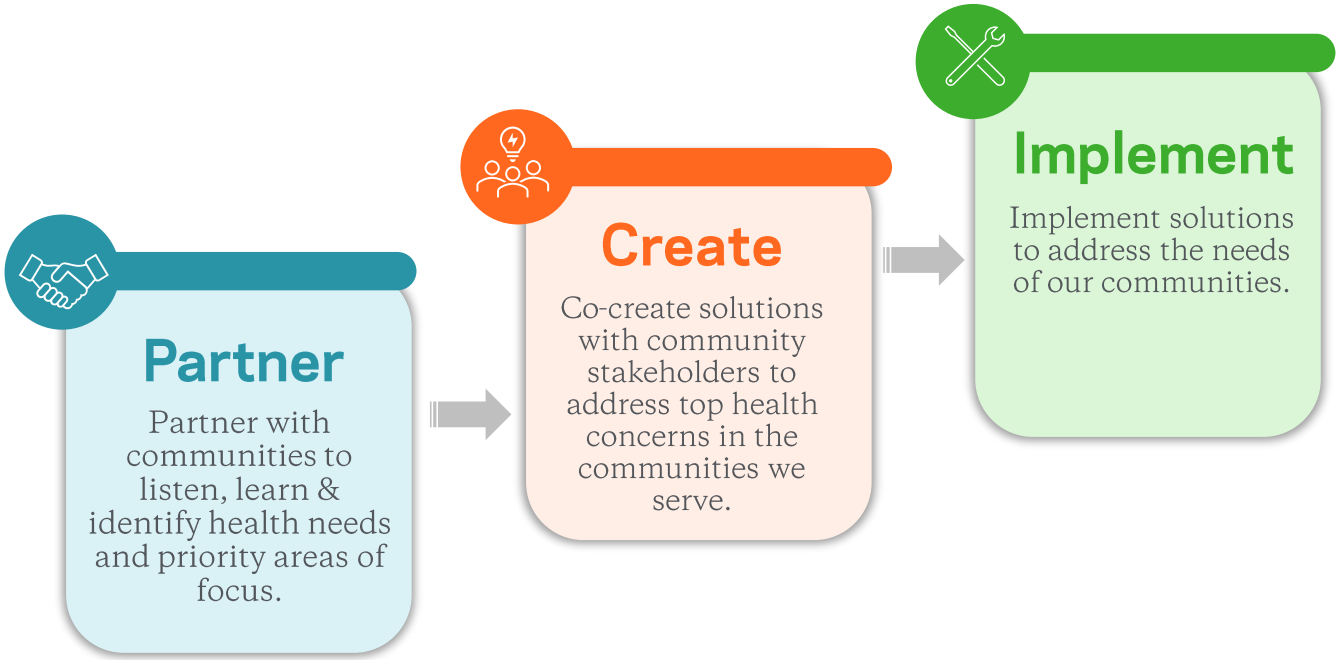
OUR IMPLEMENTATION AND SERVICE PLAN

From Assessment to Action

This chapter introduces the Community Service Plan for Mather Hospital, detailing the programs and partnerships we have designed to address the health needs identified in our Community Health Needs Assessment (CHNA). Our ability to deliver this robust plan is powered by Northwell Health's culture of "systemness"—a commitment to working as one integrated team. This allows us to bring the scale and expertise of New York's largest health system directly to the communities we serve, ensuring the right services show up in the right places to improve health for all.

The following sections highlight specific initiatives from our Implementation Plan that are designed to meet locally identified needs in areas such as cancer, cardiac care, maternal and child health, and behavioral health. These programs are a blend of system-wide efforts customized for our community and site-specific initiatives cocreated with our strategic partners. They are all data-driven, evidence-based, and organized under New York State's 2025-2030 Prevention Agenda, drawing a clear line from community need to measurable action.

Many of these initiatives are led by or developed in close partnership with Northwell's Institute for Community Health & Wellness (ICHW) and are already underway in our neighborhoods of focus. The following pages show how Mather Hospital is leveraging our unique position within the health system to turn assessment into action—linking our local work with a coordinated, system-wide approach to improve the health and wellbeing of our community.



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.[3,4,5] 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+)

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. [11,12] 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. [13,14] 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. [15,16] 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. [17]

Comprehensive care to vulnerable patients:

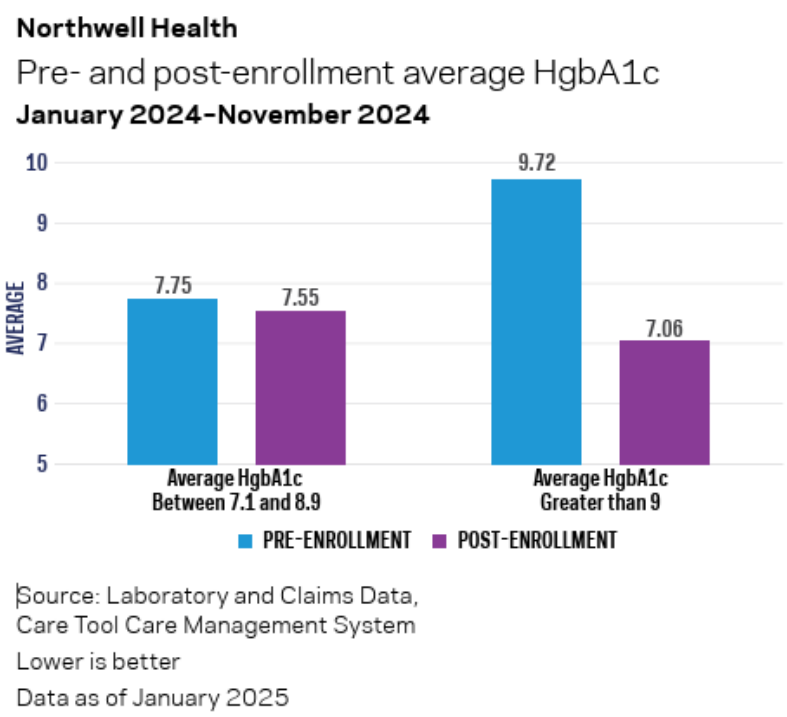
- Patient centered longitudinal care
- Urgent care assessments
- Telehealth visits
- 24/7 Community Paramedicine
- Interdisciplinary care team
- In-home diagnostics
- Homebound vaccinations
- 24/7 RN Clinical Call Center

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, dieticians 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%.



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.[18,19] 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.

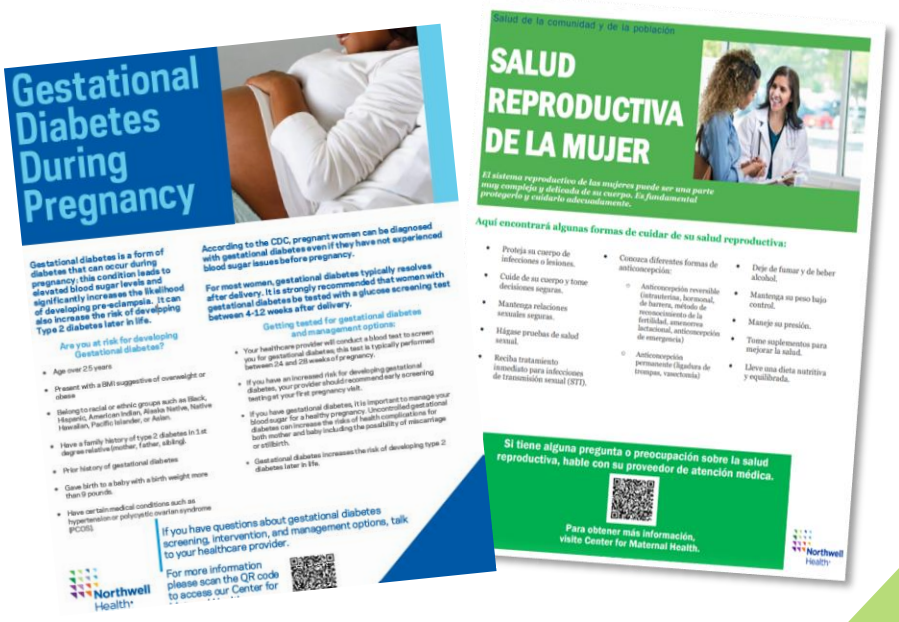
MATERNAL HEALTH COMMUNITY OUTREACH INITIATIVE

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. [20] 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. [21,22] 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.[23] 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.

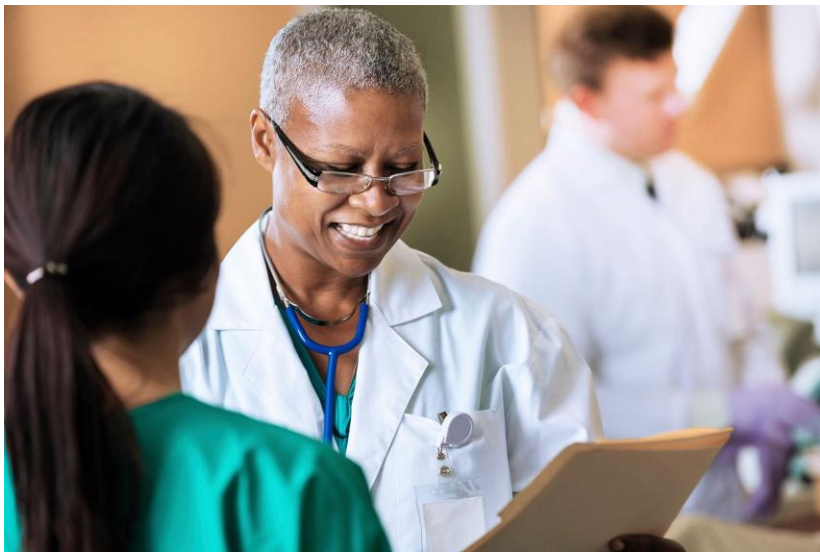
Led by the Institute for Community Health & Wellness (ICHW) and the Health Management team, and supported by clinical and operational partners across Northwell, the program has ***completed more than 1.2 million SDH screenings to date***. Screening is embedded in every Northwell hospital's electronic 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.

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.

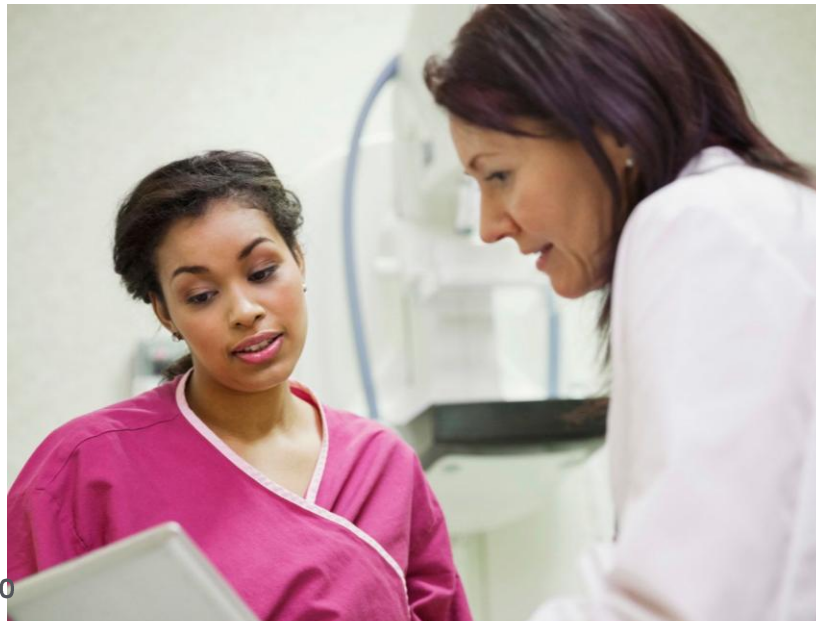
Funds and partnerships generated through Go Red for Women support outreach in high-risk neighborhoods, patient navigation, and programs tailored to women—such as pregnancy-related heart care, cardio-oncology, and women's preventive cardiology. By bringing education and screenings into communities and 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.

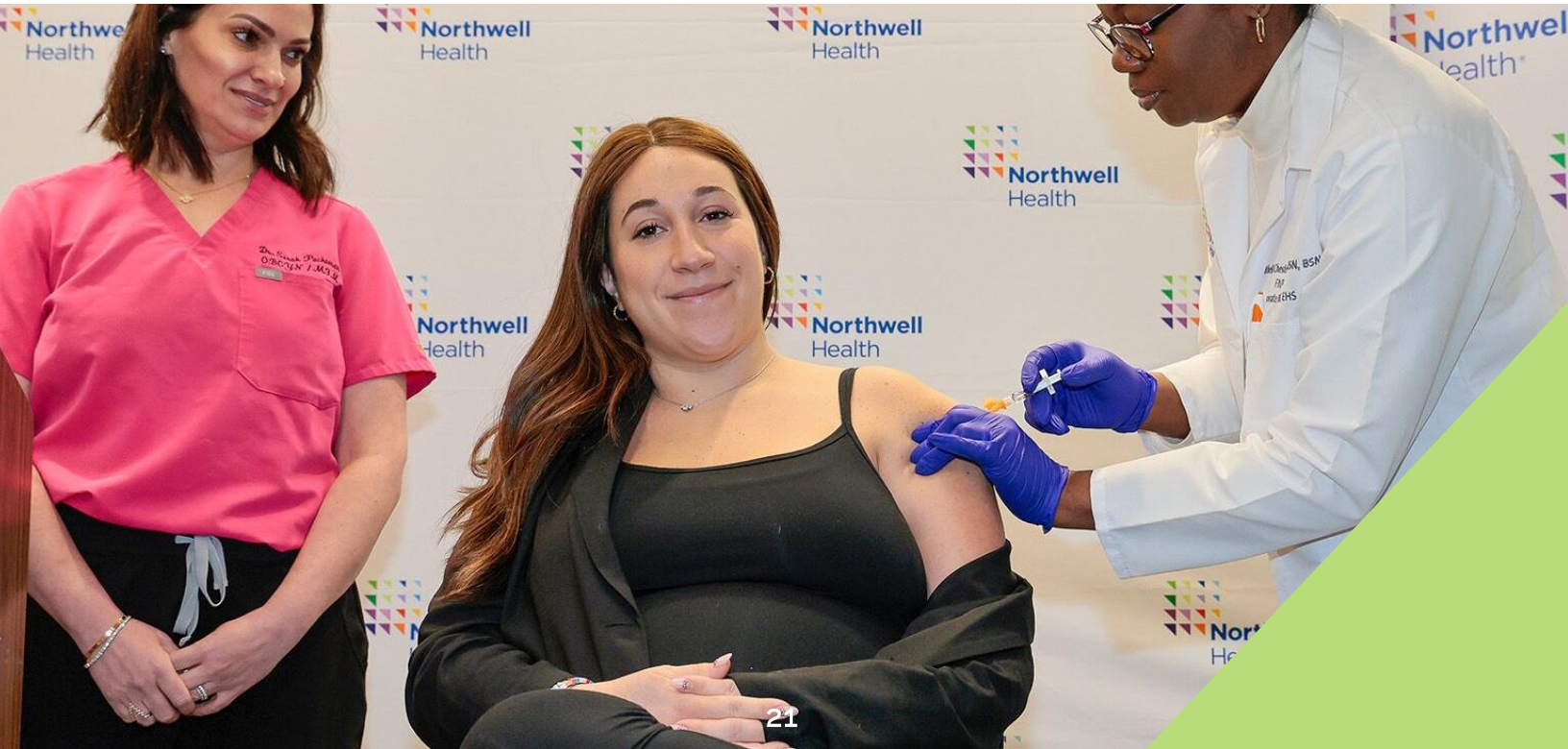
Through Go Pink, the institute partners with Northwell imaging centers, primary care, and community organizations to offer convenient screening opportunities and share practical information on risk, prevention, and early signs. Funds raised help remove barriers to care and connect more women to timely 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.



Community Outreach Education, and Screening

In 2024, Mather Hospital demonstrated its commitment to community wellness through a robust program of outreach, preventive health screenings, immunizations, and health education events. Over the course of the year, preventive screening and immunization events reached our communities across more than 580 member encounters. Screenings included, but were not limited to, mammography and breast cancer detection, blood pressure checks, oral health assessments, diabetes, cholesterol, vision, cardiovascular health, and other chronic and infectious disease screenings. Immunization events provided convenient access to vaccines such as the seasonal flu shot. These initiatives help increase access to essential preventive care by offering services in neighborhood and school-based settings, particularly benefiting those who face barriers related to transportation, cost, or scheduling. These efforts also work to reduce the spread of communicable disease and help protect the health of vulnerable community members.

Beyond clinical screenings and immunizations, Mather Hospital staff and partners led several health education and outreach events, resulting more than 141,000 encounters with community members across our service area. Education topics encompassed a wide range of health priorities, such as cancer prevention, wellness and nutrition, weight management, women's health, heart disease, pediatric wellness, mental health, substance abuse prevention, and safety skills like CPR. Other sessions addressed family health, parenting, chronic disease management, and community-specific health concerns. Mather Hospital also supported its community through a multitude of support programs to broaden access to health care and services to help address health related social needs within the community. In 2024, the hospital held several events resulting in over 4,500 encounters with community members. These events ranged from blood drives, food donations, meals on wheels, mental health support, transportation to and from health care settings, legal aid, and insurance coverage enrollment. By bringing preventive care, education, and resources directly into the communities we serve, Mather Hospital strives to reduce health disparities, promote disease prevention, and empower our neighbors to take charge of their health.



Breast and Colon Cancer Screening Outreach Events

Mather Hospital partners with Sepa Mujer and the Cancer Services Program of Suffolk to organize outreach events that provide critical cancer screening services targeted at underserved and uninsured populations. At these community events, participants can access free breast clinical exams, mammography, FIT kits, and colonoscopies, supporting early detection and intervention for breast and colon cancers.

Skin Cancer Screening and Sun Safety Promotion

To promote skin health and prevent cancer, Mather Hospital works with the Port Jefferson Chamber of Commerce, the Village of Port Jefferson, and the Town of Brookhaven to deliver free skin cancer screenings. Board-certified dermatologists conduct these exams at the Port Jefferson Health & Wellness Fest using Northwell's mobile health unit. Additionally, free sunscreen dispensers are installed at local parks and recreation sites to encourage sun safety throughout the community.

Paint Port Pink & EmpowerHER Women's Health Events

Each October, Mather Hospital leads Paint Port Pink—a month-long breast cancer awareness initiative—which unites the community through educational activities, outreach efforts, and the promotion of annual breast cancer screenings. The initiative's dedicated website provides resources and information about accessing screening, including for those who are uninsured. As part of this campaign, the EmpowerHER panel brings together physicians and clinical experts to address women's health topics, such as the link between ovarian and breast cancer and women's mental health. Partners include the Village of Port Jefferson, Port Jefferson and Port Jefferson Station businesses, the Middle Island Fire Department, and the Port Jefferson School District.

HealthyU and Community Health Education Sessions

Mather Hospital, in collaboration with partners such as the American Cancer Society, local libraries, senior centers, and faith-based organizations, provides a variety of in-person and virtual community health education programs. Topics span cancer screening, heart health, nutrition, exercise, mental health, and substance use disorder. Virtual sessions are also archived online for community access.

Preventive Health and Weight Management Blogs

Mather Hospital offers two public educational blogs. The "Wellness at Mather" blog informs community members about preventive care and chronic disease management, with real-world tips such as "walking for a healthier heart" and "can you prevent colon cancer?" The "Weight Loss Matters" blog, authored by dietitians and clinicians, offers healthy recipes, advice on physical activity, and guidance on sustainable weight management. Contributions are drawn from hospital providers and clinical experts.

National Diabetes Prevention Program

Mather Hospital hosts the year-long National Diabetes Prevention Program in partnership with the Suffolk County Department of Health Services. Led by a trained lifestyle coach, participants attend regular sessions focused on healthy eating, physical activity, and realistic lifestyle changes that help prevent or delay the onset of Type 2 diabetes.

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

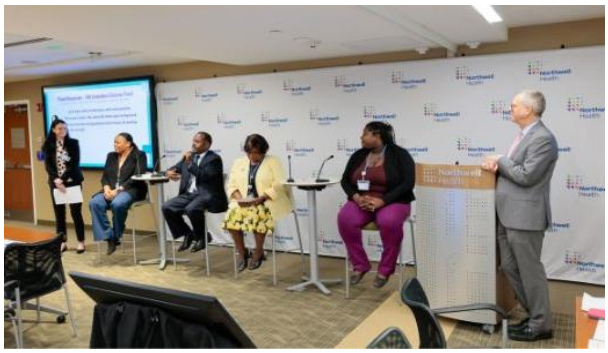
Healing Hands and Hearts

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. [24,25,26,27] 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. 28,29,30,31 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.

soul shop

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. [32]

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. [33,34]

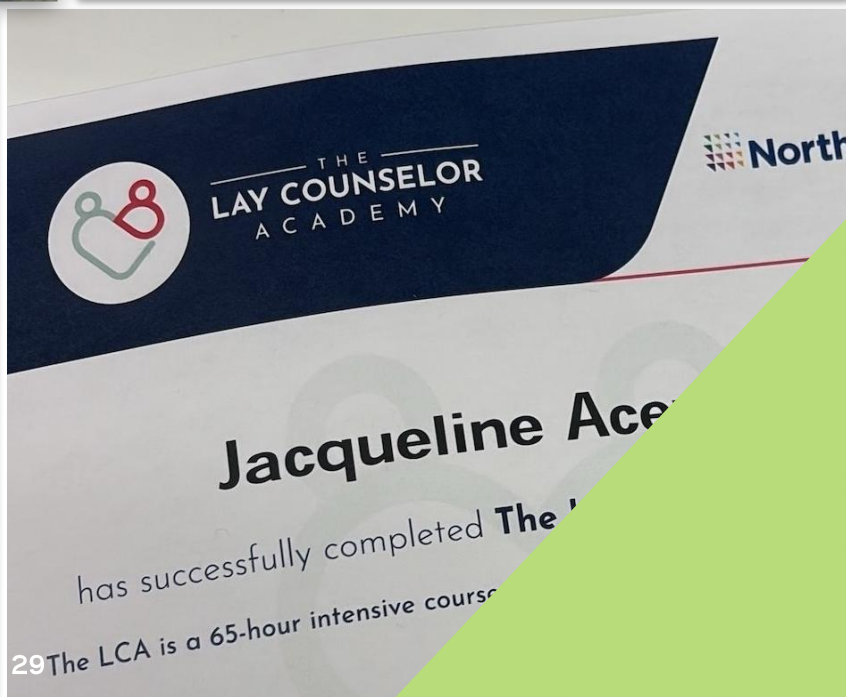
More than 280 faith leaders and community members have earned the three-year MHFA certifications. Northwell ICHW select staff members have also trained as facilitators to expand access across neighborhoods and communities. In partnership with the National Hispanic Chamber of Commerce on Health, our MHFA 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.[35] Evidence shows that models like lay counseling improve access, reduce symptoms, and increase engagement in care, especially in medically underserved settings. [36,37] ***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.

Social and Community Context – Hospital Programs

Caregivers Center & Community Resource Guide

Mather Hospital's Caregivers Center provides vital support to individuals caring for loved ones, both in the hospital and the community. Staffed by a licensed clinical social worker (LCSW) and trained volunteer coaches, the Center offers one-on-one guidance, a caregiver support group, and assistance in connecting caregivers to needed services. To broaden its outreach, the Center maintains a comprehensive online Community Resource Guide (https://communityresources.matherhospital.org), which connects community members with resources for food security, housing, health, mental health, and other essential needs. This program is offered in partnership with the Mather Community Coalition.

Rapid Access Center & Adolescent Partial Hospitalization Program Expansion

To improve access to mental health and substance use disorder care, Mather Hospital has launched a Rapid Access Center that provides same-day appointments for assessment, brief treatment, and referral for adults, with plans to expand to adolescents. In addition, the hospital has expanded the capacity of its Adolescent Partial Hospitalization Program, offering more psychiatric and substance use disorder services to youth in crisis and their families. These initiatives are provided in collaboration with the New York State Department of Health (NYS DOH), New York State Office of Mental Health (NYS OMH), and Suffolk County Department of Health Services (SC DHS).

NARCAN Training & Kit Distribution

In an effort to prevent opioid overdoses, Mather Hospital offers both in-person and online sessions to educate the community about opioid use disorder and naloxone (Narcan) administration. Participants receive free Narcan kits and learn life-saving skills to intervene in overdose situations. This program is provided in partnership with the Gordon Heights Fire Department and the Village of Port Jefferson.

Community Prescription Drug Collection

Mather Hospital provides a safe prescription drug collection service in partnership with Northwell Health Environmental Sustainability. Community members can drop off unused or expired medications at the hospital's main entrance, helping to prevent misuse, reduce the risk of substance use disorder, and protect the environment through responsible disposal.

Smoking Cessation Course

A comprehensive, seven-week Smoking Cessation course is offered at Mather Hospital, administered by the Suffolk County Department of Health Services. The course covers stress management, behavioral strategies, relaxation techniques, and cessation medications to help community members successfully quit tobacco use.

Suicide Prevention Hotline Promotion

To raise awareness and reduce stigma around suicide, Mather Hospital displays signage in its parking lots promoting the national 988 Suicide & Crisis Lifeline. This highly visible initiative is designed to reach individuals at vulnerable moments, connect them with immediate help, and foster hope in the community. The project is made possible in partnership with Brixmor Signs of Hope and Vibrant/SAMHSA.

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.

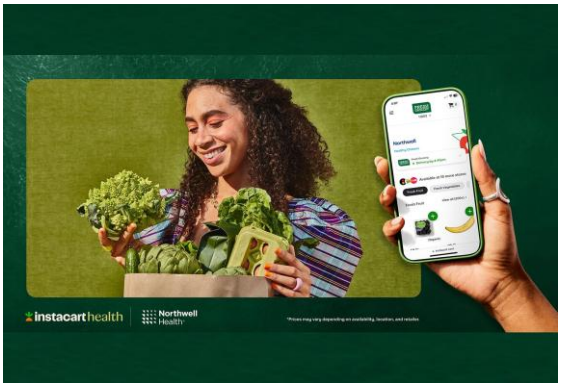
- Clinically aligned "smart" shopping lists and nutrition guidance that translate care plans into practical groceries
- Convenient ordering, digital coupons, and budget-friendly substitutions to stretch food dollars
- Delivery and pickup options to reduce transportation barriers
- Seasonal recipes, pantry 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

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. [51,52]

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.**

Support for Meals on Wheels and Local Food Pantries/Soup Kitchens

Mather Hospital is committed to addressing food insecurity in the community by supporting local organizations that provide direct meal assistance. The hospital provides meals at below cost to support the efforts of Three Village Meals on Wheels, ensuring vulnerable seniors and homebound individuals receive nutritious daily meals. Additionally, Mather Hospital organizes food drives, donates food items, and contributes staff time to local food pantries and soup kitchens, including Welcome Friends Soup Kitchen and St. Frances Cabrini Church food pantry. These collaborative efforts help ensure that individuals and families facing food insecurity have ongoing access to essential nutrition and support.

Community Food Distribution

Mather Hospital, in collaboration with Northwell's Institute of Community Health & Wellness, co-hosts regular food distribution events at Comsewogue High School in Port Jefferson Station. These events are designed to support families in underserved areas by providing bags of nutritious groceries—including dairy products, fresh fruits and vegetables, and a healthy meal kit. Additionally, families receive information about local food pantries and soup kitchens to help address ongoing food insecurity. This initiative is made possible in partnership with the Suffolk Women's Alliance to End Food Insecurity, Comsewogue High School, and Healthfirst.

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. 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. [54] 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.

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.

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. [57,58]

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_2 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.

LEADERSHIP, AWARDS AND RECOGNITIONS

AWARDS & HONORS

- "A" rating, Hospital Safety (Spring and Fall) — The Leapfrog Group
- "A" rating, Lown Institute Hospital Index for Social Responsibility — Lown Institute
- Accredited Practice Transition Program (ANCC)
- Advanced Primary Stroke — The Joint Commission
- Advanced Total Hip and Knee Replacement — The Joint Commission
- America's 100 Best Hospitals for Coronary Intervention — Healthgrades
- America's 100 Best Hospitals for Pulmonary Care — Healthgrades
- America's 250 Best Hospitals — Healthgrades
- Beacon Award (AACN)
- Breast Imaging Center of Excellence (ACR)
- Center of Excellence in Metabolic & Bariatric Surgery (SRC)
- Center of Excellence in Robotic Surgery (SRC)
- Comprehensive Community Cancer Program (ACoS, COC)
- Coronary Intervention Excellence Award, Healthgrades
- Critical Care Excellence Award — Healthgrades
- Diagnostic Imaging Center of Excellence (ACR)
- Five-Star Distinction, Outpatient Total Knee Replacement — Healthgrades
- Five-Star Rating — Centers for Medicare & Medicaid Services
- Fortunato Breast Health Center (National Accreditation Program for Breast Centers)
- Four-Star Rating for Patient Experience — CMS Hospital Compare
- Geriatric Emergency Department Accreditation, Level 1-Gold — ACEP
- Get With The Guidelines® - Coronary Artery Disease NSTEMI Gold award
- Get With The Guidelines® - Coronary Artery Disease STEMI Receiving Center Gold award
- Lantern Award (Emergency Nurses Association)
- Magnet Designation for Nursing Excellence — American Nurses Credentialing Center
- Outstanding Patient Experience Award — Healthgrades
- Pulmonary Care Excellence Award — Healthgrades
- Stroke Gold Plus — Get With The Guidelines-Stroke — American Heart Association
- Target: Stroke Elite Honor Roll — American Heart Association
- Target: Type 2 Diabetes Honor Roll — American Heart Association
- U.S. News & World Report 2025-2026 Best Hospitals Ranking: High Performing

OUR LEADERSHIP

Margaret Crotty

Chair, Board of Trustees, Northwell Health

John D'Angelo, MD

President & CEO, Northwell Health

Michael J. Dowling

CEO Emeritus, Northwell Health

Debbie Salas-Lopez, MD, MPH

Executive Vice President, Institute for Community Health and Wellness, Northwell Health

Kerri Scanlon, MSN, RN, FAAN

Executive Vice President & President, Eastern Market

Kevin McGeachy, FACHE

Senior Vice President & President, Mather Hospital


Northwell
Health®

Implementation Plan

Community Serviced: Suffolk County

NYSDOH Implementation Plan for the following hospitals: Huntington Hospital, Mather Hospital, Peconic Bay Medical Center, South Oaks Hospital, and South Shore University Hospital in coordination with other Health System resources, including other partners, has addressed each significant health need identified through the Suffolk County CHNA report.

The CHNA Implementation Strategy was conducted in fulfillment of the requirements of 501(r) or the Affordable Care Act applicable to a 501(c)(3) hospital organization.

Domain	Priority	Objective	Intervention	Northwell Site	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
							Start Date (mm/dd/yyyy)	Completion Date (mm/dd/yyyy)		
Economic Stability	Priority 3: Nutrition Security	3.0 Increase consistent household food security from 74% to 79%.	**Community Food Distribution:** Food distribution event at Comsewogue High School in Port Jefferson Station, in coordination with Northwell's Institute of Community Health & Wellness. Provides families in an underserved area with nutritious food items that are more difficult for those impacted by food insecurity to obtain. Bags of dairy products, fresh fruits and vegetables are distributed, along with a healthy meal kit, and information on local food pantries and soup kitchens.	Mather Hospital	Nutrition Security Poverty	Number of events Number of bags of food distributed	5/7/2022	Ongoing	Community-based organizations	Suffolk Women's Alliance to End Food Insecurity Comsewogue High School Healthfirst
Economic Stability	Priority 3: Nutrition Security	3.0 Increase consistent household food security from 74% to 79%.	**Support for Meals on Wheels and Local Food Pantries/Soup Kitchens:** Provide meals at below cost for Meals on Wheels, and support local soup kitchens and food pantries through food drives, donation of food, and staff time.	Mather Hospital	Nutrition Security Poverty Healthy eating Access to community service and support	Number of meals prepared Number of community organizations receiving donations Number of items donated	1/1/2018	Ongoing	Community-based organizations	Three Village Meals on Wheels Welcome Friends Soup Kitchen St. Francis Cabrini Church food pantry
Economic Stability	Priority 3: Nutrition Security	3.0 Increase consistent household food security from 74% to 79%.	**Bellmore Kiwanis Thanksgiving Packing Event:** South Oaks leaders volunteer their time to help prep, cook and pack Thanksgiving meals for over 10,000 community members in need.	South Oaks Hospital	Poverty Nutrition security	Number of volunteers	11/25/2025	11/26/2025	Community-based organizations	Bellmore Kiwanis
Economic Stability	Priority 3: Nutrition Security	3.0 Increase consistent household food security from 74% to 79%.	**Food as Health Program:** created to help connect the patients health and nutrition to improve their overall wellness. Patients who screen positive for food insecurity, receive access to nutritious foods from the on site health food pantry, provided by the Nutrition Department, referrals to community resources, and assistance with SNAP.	Huntington Hospital	Food Security Access to community resources and programs	Number of enrollees	1/1/2025	Ongoing		
Healthcare Access & Quality	Priority 4: Oral Health Care	4.6 Increase the percentage of adults ages 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80%.	**Breast and Colon Cancer Screening outreach events:** In partnership with CBOs, reach underserved and uninsured populations with breast clinical exams and mammography, and FIT kits and colonoscopy, to screen for cancer.	Mather Hospital	Preventative services for chronic disease prevention and control	Number of women receiving clinical breast exams Number of individuals receiving FIT kits Number of individuals referred for mammography Number of individuals referred for colonoscopy	9/1/2025	Ongoing	Social Services	Soul Joy Wellness UZO Felix Health Foundation Early Screening Saves Lives Assembly District 22
Healthcare Access & Quality	Priority 4: Oral Health Care	4.0 Increase the percentage of adults ages 35+ who had a test for high blood sugar in the past year from 78.1% to 82.4%.	**HealthyU and other community health education sessions:** In-person and virtual community health education events on topics including screening for cancers, heart health, healthy eating, physical activity, mental health, and substance use disorder. Virtual events are available online for viewing.	Mather Hospital	Preventative services for chronic disease prevention and control Anxiety and stress Drug misuse and overdose including primary prevention Suicide Healthy eating Injuries and violence	Number of educational sessions Number of attendees Number of webinar views	1/1/2018	Ongoing	Community-based organizations	Sepa Mujer Cancer Services Program Suffolk
Healthcare Access & Quality	Priority 4: Oral Health Care	4.0 Increase the percentage of adults ages 35+ who had a test for high blood sugar in the past year from 78.1% to 82.4%.	**National Diabetes Prevention Program:** The National Diabetes Prevention Program is led by a trained lifestyle coach from the Suffolk County Department of Health and held at Mather Hospital over the course of a year. Sessions cover healthy eating, physical activity, and lifestyle changes to help participants achieve the goals that lead to the prevention or delay of a diabetes diagnosis.	Mather Hospital	Preventative services for chronic disease prevention and control	Number of sessions held Number of program participants	1/1/2023	Ongoing	Community-based organizations	American Cancer Society Local libraries Senior centers and residences Faith-based organizations
Healthcare Access & Quality	Priority 5: Preventative Services	4.6 Increase the percentage of adults ages 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80%.	**Paint Port Pink & EmpowerHER:** Through Paint Port Pink, Mather provides a month of community awareness activities and education events promoting the importance of breast cancer screening. Held in October, Paint Port Pink brings the community together in the fight against breast cancer by spreading awareness, encouraging annual screenings, and providing information/education. The Paint Port Pink website provides community members with information on screening including how to access screening if you are uninsured. As part of Paint Port Pink, EmpowerHer, a panel discussion on women's health issues, is held at a community site. Women learn from physicians and other clinical experts on multiple topics, with topics such as ovarian & breast cancer: the unseen link, and women's mental health.	Mather Hospital	Preventative services for chronic disease prevention and control Anxiety and stress Depression	Number of events Number of participants Number of community partners Number of website visits	1/1/2018	Ongoing	Local health department	Suffolk County Department of Health Services
Healthcare Access & Quality	Priority 4: Oral Health Care	4.4 Increase the percentage of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.	**Preventive health and weight management blogs:** Mather has two blogs: one educates community members on disease preventive care and management with topics such as walking for a healthier heart, and can you prevent colon cancer? https://www.matherhospital.org/our-blogs/wellness-at-mather-blog/ A Weight Loss Matters Blog educates the community on healthy eating and physical activity. It features articles by dietitians and other clinicians, with occasional healthy recipes. Recent posts included cardiovascular training, preventing falls with functional fitness, and the difference between physical hunger and emotional hunger. https://www.matherhospital.org/our-blogs/weight-loss-matters/	Mather Hospital	Preventative services for chronic disease prevention and control Healthy eating Opportunities for active transportation and physical activity Injuries and violence	Number of posts Number of readers	1/1/2019	Ongoing	Educational institution	Village of Port Jefferson Businesses in Port Jefferson and Port Jefferson Station Middle Island Fire Department Port Jefferson School District
Healthcare Access & Quality	Priority 5: Preventative Services	4.6 Increase the percentage of adults ages 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80%.	**Skin cancer screening and community site sunscreen provision:** Free skin cancer screenings are performed by a board-certified dermatologist utilizing Northwell's mobile health unit at the Port Jefferson Health & Wellness Fest. In addition, Mather provides a free sunscreen dispensing services at park and outdoor recreation sites in partnership with the Town of Brookhaven and Village of Port Jefferson.	Mather Hospital	Preventative services Preventative services for chronic disease prevention and control	Number of screenings conducted Number of sunscreen applications provided	1/1/2020	Ongoing	Providers	Health providers
Healthcare Access & Quality	Priority 1: Access to and Use of Prenatal Care	1.0 Increase the percentage of birthing persons who receive prenatal care during the first trimester from 80.7% to 83.0%.	**Birth Preparation Class:** Free birthing class to discuss your pelvic floor, breathwork, labor positions and your partners role. We will practice breathing, pushing, partner techniques, and early recovery exercises. Population is pregnant SSUH patients and their partners.	South Shore University Hospital	Access to and use of prenatal care	Number of attendees	11/22/2025	Ongoing	Hospital	Internal

Healthcare Access & Quality	Priority 4: Oral Health Care	4.5 Increase the percentage of adult Medicaid members ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.	**Healing Hearts Support Group:** Offering ongoing educational programs and support for those wanting or trying to maintain a heart healthy lifestyle. Connecting those with cardiac disease.	South Shore University Hospital	Preventative services Preventative services for chronic disease prevention and control	Number of participants	9/16/2025	Ongoing	Community-based organizations	American Heart Association
Healthcare Access & Quality	Priority 1: Access to and Use of Prenatal Care	1.0 Increase the percentage of birthing persons who receive prenatal care during the first trimester from 80.7% to 83.0%.	**Prenatal Labor and Delivery Tour and Class:** This program is offered in both English and Spanish. It is a tour of the labor and delivery unit and the mother baby unit followed by a lecture style course on what to expect during labor in the hospital and a few other topics related to the postpartum experience after birth. It is free of charge.	South Shore University Hospital	Access to and use of prenatal care	Number of attendees	2/1/2005	Ongoing	Local government	Country Pointe Plainview
Healthcare Access & Quality	Priority 3: Preventative Services for Chronic Disease Prevention and Control	3.2 Decrease percentage of birthing persons who experience depressive symptoms after birth from 11.9% to 9.9%.	**Circle of Caring Postpartum Depression Support Group:** This is a brand-new program that began 3 weeks ago at SSUH for moms experiencing postpartum depression and anxiety. It is a support group run by inpatient RN's that were trained through The Postpartum Resource Center of New York, Inc.	South Shore University Hospital	Prevention of infant and maternal mortality Anxiety and stress Depression	Number of attendees	8/28/2025	Ongoing	Community-based organizations	The Postpartum Resource Center of New York Inc.
Healthcare Access & Quality	Priority 4: Oral Health Care	4.4 Increase the percentage of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.	**Unity Baptist Church Friends & Family presentation:** Provided comprehensive education and resources to over 50 community members, covering critical health topics such as Stroke awareness, Stop the Bleed, Overdose awareness, and Nutrition.	Peconic Bay Medical Center	Preventative services Health and wellness promoting schools Injuries and violence	Number of attendees	8/2/2025	8/2/2025	Faith-based organization	Unity Baptist Church
Healthcare Access & Quality	Priority 3: Preventative Services for Chronic Disease Prevention and Control	4.4 Increase the percentage of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.	**Chelsea at Brookhaven:** Provides Independent Living, Assisted Living, Memory Care and short term stays). Addressed residents on Stroke awareness which detailed critical preventative measure, immediate action that can significantly reduce the impact of a stroke. In addition to understanding what a stroke is, recognizing its signs and symptoms, identifying risk factors, and The difference between a stroke and transient ischemic attack (TIA). Participants received educational information and an overview of the hospital's services and resources.	Peconic Bay Medical Center	Preventative services for chronic disease prevention and control Access to community service and support		3/18/2025	5/20/2025		
Healthcare Access & Quality	Priority 4: Oral Health Care	4.4 Increase the percentage of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.	**Alive on 25**: Blood pressure screening and pulmonary and respiratory care education	Peconic Bay Medical Center	Health and wellness Preventative services	Number of attendees Number of screenings	7/18/2025	8/1/2025	Local health department	Town of Riverhead
Healthcare Access & Quality	Priority 4: Oral Health Care	4.4 Increase the percentage of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.	**Cardiac Support Group:** This free support group is offered to all members of the community to help them adjust to new normal if they had a cardiac procedure or diagnosis— anything from stent placement to heart failure. Discussion on any and all heart healthy behaviors.	Peconic Bay Medical Center	Health and wellness Preventative services	Number of attendees	1/30/2023	Ongoing	Hospital	Internal
Neighborhood & Built Environment	Priority 2: Access to Community Services and Support	2.0 Increase the number of completed Climate Smart Communities certification actions that support community resilience to help communities across New York mitigate and adapt to climate change from 363 to 382.	**Earth Day Clean Up Leadership Give Back Day:** South Oaks leaders volunteer to partner with the Town of Babylon to clean up a Town of Babylon Park and Pond.	South Oaks Hospital	Climate resilience & environmental sustainability	Number of volunteers	4/30/2025	4/30/2025	Community-based organizations	Greenburgh Library
Neighborhood & Built Environment	Priority 2: Access to Community Services and Support	2.0 Increase the number of completed Climate Smart Communities certification actions that support community resilience to help communities across New York mitigate and adapt to climate change from 363 to 382.	**Operation Splash Leadership Give Back Day:** South Oaks leaders volunteer to a Leadership Give Back Day with Operation Splash. Our team cleaned up garbage and pollutants on the marsh off the waters of Freeport.	South Oaks Hospital	Climate resilience & environmental sustainability	Number of volunteers	6/20/2025	6/20/2025	Hospital	Internal
Neighborhood & Built Environment	Priority 3: Injuries and Violence	3.0 Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 4.7 to 4.5.	**Impact teen driving:** Impact Teen Drivers develops, promotes, and facilitates evidence-based education to stop the number one killer of teens-car crashes, particularly those caused by reckless and distracted driving.	South Shore University Hospital	Preventative services Injuries and violence Health and wellness promoting schools	Number of attendees	1/1/2021	Ongoing	Local government	Town of Babylon

Neighborhood & Built Environment	Priority 3: Injuries and Violence	3.0 Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 4.7 to 4.5.	**Strength For Life:** fall prevention program	South Shore University Hospital	Preventative services Health and wellness promoting schools Injuries and violence	Number of attendees	9/4/2025	Ongoing	Local government	Suffolk County
Neighborhood & Built Environment	Priority 3: Injuries and Violence	3.0 Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 4.7 to 4.5.	**Stepping On:** In just 7 weekly, 2-hour sessions, Stepping On gives participants strategies for avoiding falls including balance and strength exercises, home safety modifications, medication review and more. Guest experts including a physical therapist, pharmacist and others visit over the course of the seven sessions providing falls prevention information and strategies for avoiding a fall. The workshop is designed specifically for people who are aged 60 or older and have fallen or have a fear of falling. Participants can expect to finish the program with more strength, better balance and a feeling of confidence and independence.	South Shore University Hospital	Preventative services Health and wellness promoting schools Injuries and violence	Number of attendees	1/1/2021	Ongoing	Hospital	Internal
Neighborhood & Built Environment	Priority 3: Injuries and Violence	3.0 Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 4.7 to 4.5.	**Stop the Bleed:** Participants in the course will learn how to recognize life-threatening bleeding and act quickly and effectively to control it with three quick techniques. The ACS Stop the Bleed training course will empower you to make a life-or-death difference when a bleeding emergency happens.	South Shore University Hospital	Preventative services Health and wellness promoting schools Injuries and violence	Number of attendees	1/1/2020	Ongoing	Hospital	Internal
Neighborhood & Built Environment	Priority 1: Opportunities for Active Transportation and Physical Activity	1.0 Increase the prevalence of physical activity among all adults ages 18 years and older from 73.9% to 77.6%.	**Walk With Ease:** The Arthritis Foundation Walk with Ease Program is an exercise program that is proven to reduce pain and improve overall health. If you can be on your feet for 10 minutes without increased pain, you can have success with Walk with Ease.	South Shore University Hospital	Preventative services Injuries and violence Health and wellness promoting schools	Number of attendees	1/1/2021	Ongoing	Hospital	Internal
Neighborhood & Built Environment	Priority 1: Opportunities for Active Transportation and Physical Activity	1.0 Increase the prevalence of physical activity among all adults ages 18 years and older from 73.9% to 77.6%.	**Westhampton Pines (55+ active adult community):** Senior Living Facilty which was given presentations on senior nutriton and solutions for hip and knee pain. Presentations emphasized nutrient density, disease prevention, and process. ``	Peconic Bay Medical Center	Preventative services for chronic disease prevention and control Healthy eating Nutrition security Access to community service and support	Number of attendees	9/4/2025	9/11/2025	Senior Center	Westhampton Pines
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Stroke support group:** support, resources, education, socialization for stroke survivors.	South Shore University Hospital	Anxiety and stress Depression Access to community service and support	Number of attendees	9/1/2015	Ongoing	Community-based organizations	Operation Splash
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Reichert Family Caregiver Center:** free hospital-based program where we provide in hospital and community support to caregivers. Several support groups are offered for caregivers, educational and well-being webinars, resources, bereavement support, and ongoing support to family caregivers whether their loved one is in the hospital or home in the community.	Huntington Hospital	Access to community service and support Anxiety and stress	Number of attendees	1/1/2025	Ongoing	Hospital	Internal
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Caregivers Center & Community Resource Guide:** Mather's Caregivers Center will provide support to caregivers of patients and community members. A LCSW Caregiver Coordinator and trained volunteer coaches will help caregivers to access vital support services to assist in caring for their loved ones. A support group will be provided. The Caregiver Center will maintain a community resource guide at https://communityresources.matherhospital.org that connects community members with resources for food security, housing, health, mental health, and other needs.	Mather Hospital	Preventative services for chronic disease prevention and control Drug misuse and overdose including primary prevention Depression Access to community service and support Housing stability and affordability Nutrition Security	Number of caregiver interactions Number of support group sessions Number of support group attendees	11/15/2025	Ongoing	Community-based organizations	Mather Community Coalition
Social & Community Context	Priority 8: Healthy Eating	8.2 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.	**Northwell Family Health Center: Adopt-A-Community:** The Northwell Family Health Center organized the adoption and support for needy families during the December holiday season. Identified families received gift cards to supermarket and clothing stores for much needed items. One off event. Breastfeeding Friendly Hospital Initiative: The Northwell Family Health Center has been a NYSDOH Breastfeeding Friendly Practice since 2016. This includes: maintaining a breastfeeding-friendly office policy, training all staff to promote, support and protect breastfeeding, discontinuing the distribution of infant formula samples, creating a breastfeeding friendly environment, discussing breastfeeding benefits and management during the prenatal and postpartum periods, encouraging exclusive breastfeeding and providing support, assistance and education to breastfeeding mothers. An RN who provides nursing care in our OB/GYN department is an International Board Certified Lactation Consultant (IBCLC) and a Certified Pediatric NP who provides primary care in our Pediatric department is a Certified Lactation Counselor (CLC). The health center's ability to provide expert breastfeeding guidance and counseling to our patients is a tremendous asset in our continued effort to encourage our patients to exclusively breastfeed, emphasizing the benefits of the first and best nutrition available to babies. Prenatal patients were offered private breastfeeding educational/support sessions with our lactation specialists. Virtual breastfeeding visits via telephone and telehealth have been initiated and offered to our patients in light of COVID-19 practice changes. Reach Out and Read: The Northwell Family Health Center participates in the Reach-Out-and-Read Program since 2000. This program links literacy with early pediatric visits. Pediatric health care providers provide parents/guardians with information about the importance of reading to their children and age/culturally appropriate books are given to children at well check-ups from six months to five years of age. School Supply Drive: Northwell Family Health Center's Annual School Supply Drive was a Drive-Thru event on a Saturday morning in August, 2025. Dolan pediatric patients who completed their physical exams within the year were invited to participate in this outreach program. The majority of our patients identify as being in need of basic supplies and this event helps students start the school year	Huntington Hospital	Access to and use of prenatal care Childhood behavioral health Early intervention Oral health care Preventative services Preventative services for chronic disease prevention and control Prevention of infant and maternal mortality Anxiety and stress Alcohol use Drug misuse and overdose including primary prevention Tobacco/e-cigarette use Depression Suicide Healthy Eating Opportunities for active transportation and physical activity Access to community service and support Injury and violence Climate resilience & environmental sustainability Human trafficking Gun violence prevention Crisis management and clinical preparedness Health and wellness promoting schools Opportunities for continued education Housing stability and affordability Nutrition Secuirty Poverty Unemployment	Number of families	9/2/2024	9/2/2024	Community-based organizations	Island Harvest
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Perinatal Bereavement and Support Program:** support groups, events, and resources are offered to those that have experienced a perinatal loss.	Huntington Hospital	Anxiety and stress Depression Access to community service and support	Number of attendees	7/1/2025	Ongoing	Hospital	Internal

Social & Community Context	Priority 2: Suicide	2.0 Reduce the suicide mortality rate from 7.9% to 6.9%.	**Suicide prevention hotline promotion:** Mather is posting signs in its parking lots promoting the 988 suicide prevention hotline. High visibility promotion is expected to increase community awareness, reduce stigma, and reach individuals at vulnerable times in their lives.	Mather Hospital	Suicide Access to community service and support	Number of signs posted	1/1/2025	Ongoing	Community-based organizations	Brixmor Signs of Hope Vibrant/SAMHSA
Social & Community Context	Priority 4: Primary Prevention, Substance Misuse, and Overdose Prevention	4.9 Reduce the rate of overdose deaths involving drugs per 100,000 people from 32.3 to 22.6.	**Community Prescription Drug Collection:** Mather Hospital collects unused prescription drugs from community members for safe disposal. This limits access to drugs by community members who may have or develop a substance use disorder. Safe disposal also prevents pollution. Drugs can be dropped off in the main entrance of the hospital.	Mather Hospital	Drug misuse and overdose including primary prevention Climate resilience & environmental sustainability	Pounds of drugs collected	1/1/2019	Ongoing	Hospital	Northwell Health Environmental Sustainability
Social & Community Context	Priority 4: Primary Prevention, Substance Misuse, and Overdose Prevention	4.11 Increase the number of naloxone kits distributed from 401,856 to 602,784	**NARCAN Training & Kit Distribution:** To Prevent Opioid overdoses, webinars and in-person sessions educate the community on opioid disorder and the use of naloxone to reverse opioid overdose. Narcan kits are distributed to participants.	Mather Hospital	Drug misuse and overdose including primary prevention	Number of trainings Number of participants Number of Narcan kits distributed to trained community members	1/1/2021	Ongoing	Local government	Gordon Heights Fire Department Village of Port Jefferson
Social & Community Context	Priority 2: Suicide	2.0 Reduce the suicide mortality rate from 7.9% to 6.9%.	**Rapid Access Center & Adolescent:** Partial Hospitalization Program Expansion Mather's new Rapid Access Center is increasing access to mental health and substance use disorder treatment by providing same day appointments in which individuals receive comprehensive assessment, brief treatment, and referral. Currently the program serves adults with plans to expand to adolescents. In addition, Mather expanded its census for the Adolescent Partial Hospitalization program, increasing access for community members to vital psychiatric treatment. A focus on co-occurring substance use disorder also addresses adolescents' needs, improving outcomes.	Mather Hospital	Childhood behavioral health Anxiety and stress Alcohol use Drug misuse and overdose including primary prevention Depression	Number of visits	1/21/2025	Ongoing	Local health department	NYS DOH NYS OMH SC DHS
Social & Community Context	Priority 5: Tobacco/E-Cigarette Use	5.0 Reduce the percentage of adults who use tobacco products from 9.30% to 7.91%.	**Smoking Cessation:** A Smoking Cessation course is held at Mather Hospital, run by the Suffolk County Department of Health. The seven week course covers stress management techniques, behavior modification, relaxation, techniques, medication.	Mather Hospital	Preventative services for chronic disease prevention and control Tobacco/e-cigarette use	Number of sessions held Number of program participants	1/1/2019	Ongoing	Local health department	Suffolk County Department of Health Services
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Suffolk County Mental Health Subcommittee Meeting:** Suffolk County hosts a monthly virtual monthly meeting that Lucy St. Hilaire, Manager of Social Work attends.	South Oaks Hospital	Anxiety and stress Depression Suicide Access to community service and support	Number of attendees	1/8/2025	Ongoing	Local government	Suffolk County
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**6th Annual School Symposium:** This is a virtual Symposium where South Oaks clinicians educate school professionals on behavioral health topics.	South Oaks Hospital	Childhood behavioral health Anxiety and stress Adverse childhood experiences Depression Health and wellness promoting schools	Number of participants	11/4/2025	11/4/2025	Educational institution	School districts
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Athletes Program:** While participating in sports can have a positive impact, the very nature of the competition produces unique stressors and mindset that can create or exacerbate mental health issues in athletes.	South Oaks Hospital	Anxiety and stress Adverse childhood experiences Depression Health and wellness promoting schools	Number of athletes	2/2/2024	Ongoing	Educational institution	School districts in suffolk and nassau counties
Social & Community Context	Priority 8: Healthy Eating	8.2 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.	**Baby Cafe Outpatient:** Free postpartum breastfeeding support group for moms and babies offered every Tuesday year-round and facilitated by an RN, IBCLC on staff at SSUH. Future plans for a Spanish speaking group are in progress.	South Shore University Hospital	Access to community service and support Nutrition Security	Number of moms and babies	5/1/2008	Ongoing	Community-based organizations	Baby Cafe USA
Social & Community Context	Priority 8: Healthy Eating	8.2 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.	**Prenatal Breastfeeding Class:** This class is for pregnant women in the community that want to breastfeed after birth. It is a free, in-depth 2.5-hour class. Breastfeeding education is not only prenatal care, but nutrition security and healthy eating for infants and has health benefits for the mom too.	South Shore University Hospital	Access to and use of prenatal care Nutrition security Healthy eating	Number of attendees	1/12/2010	Ongoing	Hospital	Internal
Social & Community Context	Priority 8: Healthy Eating	8.0 Decrease the percentage of adults who consume no fruits or vegetables daily from 33.8% to 32.1%.	**Garden to Table: Community Gardening Workshop Series:** Garden to Table is a seasonal community outreach program designed to connect local residents with hands-on gardening experiences. Through a series of interactive workshops, participants will learn practical techniques that align with the natural gardening cycle-from planting to harvest-while promoting a healthy, plant-based lifestyle. Session 1: Planting Workshop • Learn soil prep, planting techniques, and optimal growing conditions • Plant in the community garden and receive seedlings to grow at home • Get tips on plant selection and seasonal care • Hear from our Chef about selecting herbs and veggies perfect for plant-based meals Session 2: Pruning & Support Workshop • Master pruning and trellising techniques for healthy plant growth • Practice plant support methods in the garden • Learn how to use fresh summer produce in simple, nutritious plant-based dishes Session 3: Harvest Workshop • Learn how to identify ripeness and harvest produce properly • Enjoy a hands-on harvest experience • Get creative in the kitchen with our Chef and RD as they share easy ways to turn your harvest into plant powered meals	South Shore University Hospital	Preventative services for chronic disease prevention and control Healthy eating Nutrition security Access to community service and support	Number of attendees	6/10/2025	9/16/2025	Community-based organizations	Home Organic Gardening Service
Social & Community Context	Priority 4: Primary Prevention, Substance Misuse, and Overdose Prevention	4.9 Reduce the rate of overdose deaths involving drugs per 100,000 people from 32.3 to 22.6.	**DEA Drug Take Back Day:** Twice a year, the last Saturday in April and October, South Shore University Hospital in partnership with Suffolk County Police and the Drug Enforcement Agency collect unused and unwanted medications from the general public for proper and safe disposal. This is in addition to the Med Safe receptacle which resides in the Hospital Lobby 24 hrs a day and 365 days a year for the same purpose. Narcan treatment kits and education are also provided if requested.	South Shore University Hospital	Preventative services for chronic disease prevention and control Drug misuse and overdose including primary prevention	Pounds of drugs collected	4/27/2019	Ongoing	Legal services	Suffolk County Police Department DEA
Social & Community Context	Priority 3: Depression	3.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.6% to 5.6%.	**Footprints on the Heart:** Infant Loss Bereavement Support Group	South Shore University Hospital	Anxiety and stress Depression Access to community service and support	Number of attendees	1/2/2024	Ongoing	Hospital	Internal

Social & Community Context	Priority 3: Depression	3.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.6% to 5.6%.	**Trauma Survivors Support Group:** Trauma support groups provide a powerful sense of community and can significantly aid in recovery. They are not a replacement for professional therapy, but they can be a highly beneficial addition.	South Shore University Hospital	Preventative services for chronic disease prevention and control Anxiety and stress Suicide Access to community service and support Health and wellness promoting schools Unemployment	Number of attendees	5/21/2025	Ongoing	Hospital	Internal
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Caregivers Center:** Brick and mortar location in hospital and virtual workshops/resources provide family caregivers with information and comfort they need to help support them in their time as a caregiver. Over 70 caregiver supported by social workers and caregiver coaches. Monthly "Tuesday Talks" detailing resources available to caregivers in the community. In person Caregivers support group meets 1st Wednesday of every month. Virtual Caregivers support group meets 1st Thursday of every month.	Peconic Bay Medical Center	Access to community service and support Anxiety and stress	Number of attendees Number of educational workshops	1/1/2025	Ongoing	Hospital	Internal
Social & Community Context	Priority 8: Healthy Eating	8.1 Decrease the percentage of adults with an annual household income less than $50,000 who consume no fruits or vegetables daily by 5% (data available starting 2024).	**Health Choices Program:** This five-week educational program targeted 12 participants from our Hispanic/underserved ethnic community, empowering them with critical knowledge in healthy eating. The programs was designed to foster holistic well-being and chronic disease prevention, the curriculum provided essential skills for navigating food choices, including understanding nutrition labels and adapting preferred dishes into healthier options.	Peconic Bay Medical Center	Preventative services for chronic disease prevention and control Healthy eating Nutrition security Access to community service and support	Number of participants	1/1/2025	Ongoing	Business	Eastern Region Marketing, Rural Migrant Ministries, Gala Gresh Supermarket
Social & Community Context	Priority 8: Healthy Eating	8.1 Decrease the percentage of adults with an annual household income less than $50,000 who consume no fruits or vegetables daily by 5% (data available starting 2024).	**Mastic Beach Homemakers Club:** Supported members' awarensss of nutriton and weight management as fundamental pillars of overall health, well-being, and disease prevention. Presentation on rehabilitation equipped with education and available reources to navigate the path of regaining function	Peconic Bay Medical Center	Preventative services for chronic disease prevention and control Healthy eating Nutrition security Access to community service and support	Number of attendees	3/25/2025	5/20/2025	Community-based organizations	Mastic Homemakers Club
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Stroke Support Club:** Stroke Support Club provides stroke survivors and their family caregivers an opportunity to support each other as they strive to rebuild their lives and promote health, independence, and well-being. Meetings are held monthly. Meetings include, but are not limited to: - Socialization of new and established members - Topics of interest - Rehabilitation - Guest presenters - Mindfulness exercises	Peconic Bay Medical Center	Health and wellness Preventative services Access to support groups and services	Number of workshops Number of attendees	2/22/2022	Ongoing	Hospital	Internal
Social & Community Context	Priority 1: Anxiety & Stress	1.0 Decrease the percentage of adults who experience frequent mental distress from 15.9% to 15.0%.	**Parkinson Support Group:** Provides coomunity members and caregivers education and support. The group creates an environment where shared experiences, understanding, and mutual support can significantly improve quality of life. Meetings are held 3rd Friday of each month.	Peconic Bay Medical Center	Anxiety and stress Depression Health and wellness Access to support groups and services	Number of workshops Number of attendees	11/10/2023	Ongoing	Hospital	Internal
Social & Community Context	Priority 8: Healthy Eating	8.2 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.	**Prenatal Breastfeeding Classes:** Baby Friendly Hospital Initiative and Designation is an ongoing quality assessment and improvement program focused on adhering to the 10 Steps to Successful Breastfeeding as advised by the WHO, NYS DOH, JCAHO and the accrediting body; Baby Friendly USA.	Peconic Bay Medical Center	Anxiety and stress Depression Health and wellness Access to support groups and services	Number of workshops Number of attendees	7/13/2021	Ongoing	Community-based organizations	Baby Friendly USA