



NYU Langone Hospitals

Community Health Needs Assessment and Implementation Plan/Community Service Plan 2019-2021

Adopted June 2019
NYU Langone Hospitals Board of Trustees

Copies of this document can be downloaded from the NYU Langone Health website at:
<http://www.nyulangone.org/our-story/community-health-needs-assessment-service-plan>

The Executive Summary of our Community Health Needs Assessment and Community Service Plan (available [here](#)) shares our analysis and conclusions in a more accessible format for a broader constituency. This document, which is written at an 8th grade literacy level, has been translated into Arabic, Chinese, and Spanish. It is available at all of NYULH inpatient locations.

We welcome your questions and comments. Please feel free to contact Sue A. Kaplan, JD, Research Associate Professor, Department of Population Health, NYU Langone at: sue.kaplan@nyulangone.org or Kathleen Hopkins, Vice President for Community Programs, Family Health Centers at NYU Langone at: kathleen.hopkins@nyulangone.org.

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Mission

NYU Langone Health is one of the nation's premier academic medical centers. Composed of NYU Langone Hospitals ("NYULH") and NYU School of Medicine ("NYUSoM"), NYU Langone Health has a trifold mission: to serve, teach and discover. Located in the heart of Manhattan, with additional facilities throughout the New York City area, NYULH currently operates the following five inpatient facilities:

- Tisch Hospital, the acute care facility located on the main campus
- Kimmel Pavilion, a newly opened, state-of-the-art healthcare facility on the main campus
- NYU Langone Orthopedic Hospital (formerly known as Hospital for Joint Diseases), an orthopedic, neurologic and rheumatologic specialty hospital, which also houses Rusk Rehabilitation
- Hassenfeld Children's Hospital at NYU Langone, which provides pediatric inpatient care, outpatient care, procedural and surgical services, the KiDS Emergency Department on the main campus and multiple ambulatory services
- NYU Langone Hospital–Brooklyn (formerly known as NYU Lutheran Medical Center), a full-service teaching hospital and Level I Trauma Center located in Sunset Park, Brooklyn

Its inpatient facilities will soon include the 591-bed NYU Winthrop Hospital in Mineola, Long Island.

Ambulatory facilities number over thirty, with the majority located in Manhattan and Brooklyn, including the Perlmutter Cancer Center, a National Cancer Institute-designated cancer center; the Ambulatory Care Center; the Center for Musculoskeletal Care; and NYU Langone Cobble Hill, a free-standing Emergency Department in Cobble Hill.

In addition, Sunset Park Health Council, Inc., an affiliate of NYULH, is a Federally Qualified Health Center network, which includes nine primary care health centers in Brooklyn and over 40 school- and shelter-based extension clinics, under the name Family Health Centers at NYU Langone (FHCs).

NYULH is the principal teaching hospital for NYUSoM, which has trained thousands of physicians and scientists since its founding in 1841. The School of Medicine owns and operates a faculty group practice that delivers patient care at more than 375 practice sites and has affiliations with the Manhattan campus of the Veterans Affairs New York Harbor Health Care System and with the NYC Health and Hospitals facilities Bellevue and Gouverneur in Manhattan, and Woodhull in Brooklyn.

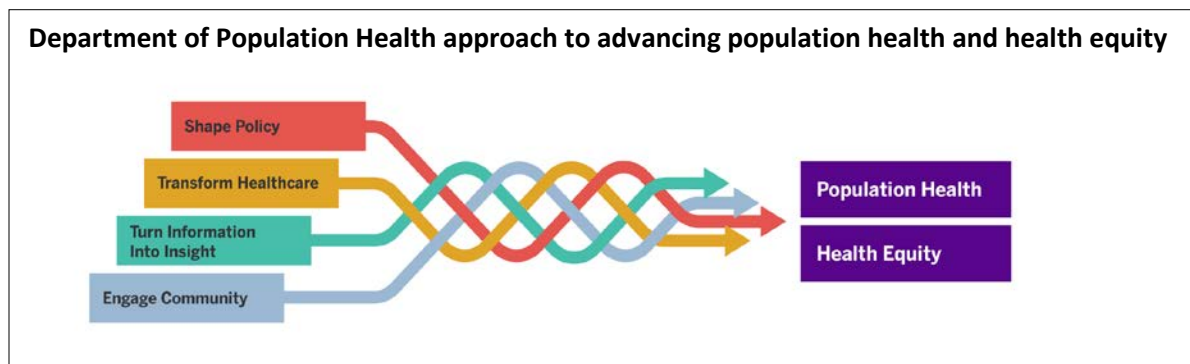
Financial assistance

Throughout NYU Langone Health, we provide financial assistance for patients with limited income, regardless of their insurance status. Our charity care policy reflects our strong commitment to providing comprehensive and high-quality healthcare services to all of our patients. Financial counselors inform patients whether they qualify for free or low-cost insurance, such as Medicaid, Child Health Plus, and Family Health Plus. If the finance counselor finds that the individual does not qualify for low-cost insurance, they facilitate applications for a discount on copays, deductibles, and charges based on a sliding scale. Patients may apply regardless of immigration status. Financial assistance notices and applications are available at each inpatient location in Arabic, Bengali, Chinese, English, Greek, Italian, Korean, Polish, Russian, and Spanish. Additionally, Family Health Centers assist uninsured individuals with enrollment into public benefits like Medicaid and Medicare.

For information about the NYULH financial assistance program go to: <https://nyulangone.org/insurance-billing-financial-assistance>

Overview

Growing out of our Community Health Needs Assessment (CHNA) and aligning with the New York State Prevention Agenda and New York City public health priorities, the NYU Langone Hospitals (NYULH) three-year implementation plan (the Community Service Plan, “CSP”) focuses on **Preventing Chronic Diseases** by reducing risk factors for obesity and cardiovascular disease and decreasing tobacco use and exposure to secondhand smoke, and on **Promoting Healthy Women, Infants and Children** through parenting, early childhood and teen pregnancy prevention programs. Our Community Service Plan programs span multiple sectors: early childhood settings and schools, primary care, housing, and community settings, such as faith-based organizations and social service providers.



Drawing on its expertise in developing and implementing effective approaches to health promotion at the community level, the Department of Population Health (DPH) has served as the architect for the CHNA and Plan since 2013. Since 2016, DPH and the Family Health Centers at NYU Langone have worked together to develop a CSP designed to create synergies across programs and to take advantage of the combined expertise of our larger institution, the strong foundation of work under both of our previous Plans, and the strengths of our community partnerships.

The Family Health Centers at NYU Langone (FHC) is a federally qualified health center network with a longstanding history of serving underserved and immigrant communities of Brooklyn and throughout New York City. The FHC provides high-quality primary and preventive outpatient care to adults and children regardless of their ability to pay or their immigration and health insurance status. With over 100,000 patients, the FHC network handles over 600,000 medical, dental, and behavioral health visits each year. The mission of the FHCs is to improve the overall health of the communities we serve by delivering high-quality, culturally competent health and human services in community-based settings.

The FHCs are nationally recognized for innovative, affordable, high-quality care and are one of the largest employers within the communities they serve. As true health and community revival innovators, the FHCs established the nation’s largest dental residency program, the largest school health program in New York, a community medicine program serving more than 7,000 homeless New Yorkers, and one of the first health-focused AmeriCorps programs. In fiscal year 2018 alone, the FHCs provided 1,245 families with direct assistance to obtain public benefits, adult literacy classes, legal services, health referrals, and emergency food.

Through its Community Service Plan, NYULH brings to bear a wide range of expertise: in obesity prevention, health literacy, parenting, family and community engagement, smoking cessation, prevention science, and population health. The programs and priorities remain consistent with NYULH prior years' Community Service Plans, but under the current CSP, existing programs have been extended and new initiatives added. The CSP's geographic scope includes the Lower East Side and Chinatown in Manhattan, and Sunset Park in Brooklyn; we recently also completed a needs and asset assessment in Red Hook, Brooklyn and are beginning to implement CSP programs there as well.

Priority Areas of Focus

Preventing Chronic Diseases:

- **Tobacco Free Community** includes an array of programs to address high smoking rates among immigrant populations, particularly Asian American men: a community navigator program, a pilot financial incentive program, a policy initiative to facilitate access to smoking cessation treatment, and a program to educate youth about e-cigarettes. These programs are being implemented in partnership with Asian Americans for Equality, the Charles B. Wang Community Health Center, and the New York City Housing Authority.
- The **Health+Housing Project**, a housing-based Community Health Worker program, was implemented in two low-income buildings on the Lower East Side, and is being continued by building management, in partnership with Henry Street Settlement.
- **Healthy Habits/ Programa de Hábitos Saludables**, an intervention that encourages healthier living in order to address obesity for pre-adolescent children using group education and activities for the entire family, is being implemented in Family Health Centers sites and in school settings.
- **Greenlight**, a program to improve health literacy and foster healthful behavior, is being adapted and implemented in partnership with the Charles B. Wang Community Health Center to lower rates of childhood obesity in the Chinese American community and is being extended to the Seventh Avenue Family Health Center at NYU Langone in Sunset Park.
- **Racial and Ethnic Approaches to Community Health for Asian and Arab Americans (REACH FAR)**, an evidence-based program designed to prevent cardiovascular disease by increasing access to healthy foods and providing culturally tailored health coaching and messages, is being implemented in mosques on the Lower East Side and in Sunset Park, which are also implementing a lay health worker-led breast and cervical cancer screening program.

Promoting Healthy Women, Infants and Children:

- The **ParentChild+ (PC+)**, a national, evidence-based early literacy, parenting and school-readiness program, is being expanded in Sunset Park to serve additional low-income immigrant families. The program provides intensive home visiting to families who are challenged by poverty, low levels of education, language and literacy barriers and other obstacles, and with children between two and four years old.

- The [Video Interaction Project \(VIP\)](#), an evidence-based parenting program that uses videotaping and developmentally-appropriate toys, books and resources to help parents strengthen early development and literacy in their children, is being expanded into Sunset Park.
- [Project SAFE](#), a peer education program employing an evidence-based youth development approach to prevent teen pregnancy and HIV/AIDS, is being implemented in Sunset Park and other Brooklyn communities.
- [ParentCorps](#), an evidence-based family-centered early childhood intervention to improve child health, behavior and learning, will continue to provide support to University Settlement Society programs on the Lower East Side and in Brooklyn, and is expanding to assess needs and provide digital supports to Pre-K for All in Sunset Park in Brooklyn.

Cross-sector capacity building initiatives:

Several new cross-cutting initiatives have grown out of our work and partnerships:

- NYULH has launched the [Brooklyn Health and Housing Consortium](#) to develop relationships and infrastructure, and build capacity to support people with health and housing needs, with an initial focus on Southwest Brooklyn. This initiative is an outgrowth of the CSP Health+Housing Project, a housing-based Community Health Worker Program in two low-income buildings on the Lower East Side.
- NYULH has established the [Community Health Worker Research and Resource Center \(CHW-RRC\)](#) to serve as a resource to community-based organizations, health systems, municipal agencies, and research organizations that are planning, or seeking to strengthen, CHW initiatives. The CHW-RRC will help develop, support and evaluate programs that use lay health workers to enhance care, link services, and improve community health.
- NYULH has created a [Brooklyn Data Station](#) to support partnerships and foster collaborations that aim to improve population health in Sunset Park, Red Hook and other parts of Brooklyn. The Data Station serves as a shared data and resource repository, supporting a knowledge network and a forum to translate findings into action to improve health.
- The [Red Hook Community Health Network](#) initiative will address residents' health and social service needs through organizational capacity-building and linkage to resources within and beyond Red Hook. The initiative is being designed in close partnership with The Alex House Project, Good Shepherd Services, Red Hook Community Justice Center, and Red Hook Initiative following an in-depth Red Hook Community Health Needs and Assets Assessment completed in fall 2018.
- Recognizing the strong connection between health status and socio-economic factors, NYULH is developing an initiative to address [social determinants of health \(SDOH\)](#), which will pilot a system throughout the FHC network to provide assessment, referral and follow-

up services, engaging a wide array of community agencies, including economic development and legal services.

Through the Community Health Needs Assessment and partnerships embedded in the Community Service Plan, we aim to create a platform for evidence-based health promotion and disease prevention at the neighborhood level with a focus on issues of high priority to the public's health.

Community Health Needs Assessment

I. Definition and Brief Description of Communities Served

As a major academic medical center, NYU Langone Health serves a broad community of diverse populations with a wide range of healthcare needs. Its primary service area includes Manhattan, Brooklyn, and Queens, and the secondary service area extends into Staten Island, Long Island, Westchester, and New Jersey. With 235+ outpatient locations and 6+ million outpatient visits in 2017, NYU Langone's community extends beyond its contiguous boundaries.

To understand the needs of our primary service areas, we reviewed all of the Community Health Profiles for New York City provided by the NYC Department of Health and Mental Hygiene, as well as other health and demographic data (see Appendix A). Based on that review (described for each community below) and in light of our commitment to continuing our CSP partnerships and work, the 2019-2021 Community Service Plan continues to focus on the communities served through the previous Plans: the Lower East Side and Chinatown in Manhattan, and Sunset Park in Brooklyn. In addition, over the course of the past year-and-a-half, we have worked closely with partners in Red Hook, Brooklyn to understand the needs and priorities of this vibrant but under-resourced and medically underserved community. Our 2019-2021 Plan extends to that community as well.

These communities – the Lower East Side and Chinatown in Manhattan and Sunset Park and Red Hook in Brooklyn – were selected based on the need for service as evidenced by social determinants of health, health disparities, risk factors, and utilization data. Although these communities are not geographically contiguous, they share important similarities, including the diversity of their populations, an infrastructure of strong community-based organizations, and pockets of poverty amidst gentrification.

II. Public Participation

Public participation in assessing community need and setting priorities has been a continuous process over the past three years. We have engaged a range of stakeholders – with a particular focus on medically underserved residents – to assess community needs; set priorities; develop, design, and implement programs; and share and celebrate progress and results. We employ diverse, often multi-pronged strategies and rely on our extensive network of community partners and advisory boards and committees to provide ongoing outreach and program development. The Family Health Centers at NYU Langone advisory structure includes the Sunset Park Health Council as the community governing board; culturally-specific advisory groups; and

program-specific councils, including the Teen Health Council. The NYULH Community Service Plan Coordinating Council, which brings together NYU Langone faculty and staff, community partners, and policymakers, meets quarterly to oversee program implementation, share findings, provide insight into community need, and identify priorities.

In addition, we regularly consult with public health and policy experts in the City and State Health Departments, the State Office of Mental Health, the City Department of Education, the New York City Housing Authority, the NYC Office of Housing Preservation and Development, and other agencies and organizations with expertise on the needs of low-income populations, including community leaders, resident associations, community-based organizations, advocacy groups, and members of Community Boards. A list of organizations and individuals consulted is attached as Appendix B.

Collection, analysis, presentation and discussion of data

- To support our CHNA, we bring the analytic capacity of the Department of Population Health (through our Data Station described below), to obtain and analyze existing databases, as well as any data that have been collected by community partners (see Appendix A).
- Thoughtful and accessible presentation of these findings often serves as a catalyst for discussion with community members and partners about needs and priorities.
- We use – and strengthen – our existing relationships with partners to engage in a review of data, to identify unanswered questions, and to obtain input – through a variety of methods, including surveys, group discussions, and focus groups. Data are always made available to community partners for their own use.
- We continually use data that are collected through existing projects, and the experience of our partners in providing services, to shed light on unmet need, to strengthen programs, and organically to develop new priorities and initiatives.
- As issues arise, we work with our partners to collect additional data on needs and assets. For example, we are working with the NYULH Brooklyn Arab Community Advisory Council (19 community-based organizations) to learn more about the health needs and priorities of that community.

To understand more about community need and to support policymakers, providers and community groups in understanding community demographics, and housing and health outcomes (a high community priority), we undertook a comprehensive analysis of existing

sources of data, including the NYC Department of City Planning Population Fact Finder; the NYC Department of Health Neighborhood Health Atlas; and the NYULH City Health Dashboard. (See Appendix A for a list of data sources.)

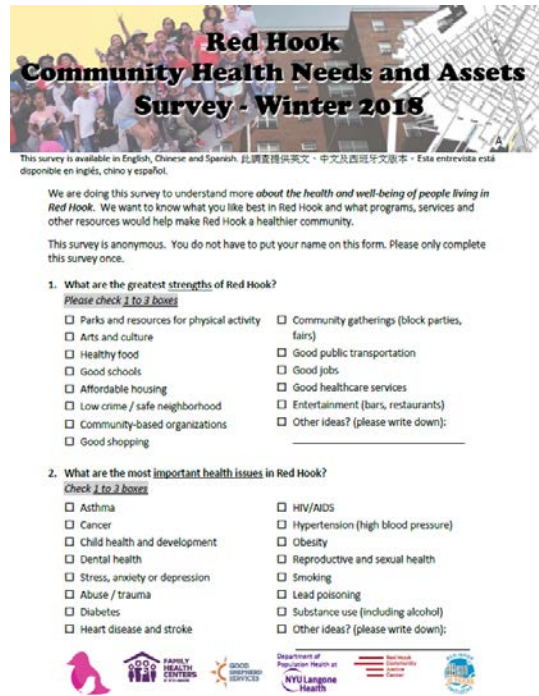
The City Health Dashboard: a CHNA Resource

The City Health Dashboard (cityhealthdashboard.com), a collaboration among the Department of Population Health at the NYU School of Medicine, the Wagner Graduate School of Public Service, the National League of Cities, the National Resource Network, and the International City/County Management Association, is an interactive website to track health and health-related metrics at the city level. The goal of this major initiative, funded by the Robert Wood Johnson Foundation, is to equip cities with a one-stop resource allowing users to view and compare data from multiple sources on health and the factors that shape health to guide local solutions that create healthier and more equitable communities.

Summaries of community health, social, and economic data, as well as updates on the CHNA and CSP, were shared with Brooklyn Community Board 7 and Manhattan Community Boards 3 and 6. These meetings included residents, as well as representatives from businesses, and

government and community-based organizations. These summaries were also used to inform and solicit input from NYULH – Brooklyn and Family Health Centers at NYU Langone advisory groups and frontline staff and from the CSP Coordinating Council.

Similar summaries were compiled in partnership with Red Hook organizations. Over 600 people who live or work in Red Hook participated in the Red Hook Community Health Needs and Assets assessment, which included a review of community data from different agencies and organizations and primary data collection through dot voting, a survey, and small group conversations (the latter two available in English, Cantonese, and Spanish). Notice and outreach was facilitated through a network of over 20 community-based organizations and public posting of tools, data, and reports (<https://redhookchna.wordpress.com>). Participants who provided contact information received individual outreach for additional opportunities to share feedback and review findings and next steps.



We have solicited written comments from the public on our previous CHNA and implementation plan both through our website and at public meetings. Although no written comments were received, comments and discussion followed public presentations at community meetings.

Through this in-depth and community-engaged process, we have compiled and updated our profile of the health needs and strengths of the Lower East Side and Chinatown, Sunset Park and Red Hook. This analysis has, in turn, informed the priorities and partnerships that comprise our Community Service Plan.

Below, we describe CHNAs for each community. We begin with a description of the demographics of Sunset Park and the Lower East Side/Chinatown

and a summary of the process and findings from our CHNA for Red Hook, Brooklyn. This is followed by an in-depth assessment of specific health needs related to **preventing chronic diseases** by reducing risk factors for obesity and cardiovascular disease and decreasing tobacco use and exposure to secondhand smoke, and on **promoting healthy women, infants and children** through parenting, early childhood and teen pregnancy prevention programs.

A. Sunset Park Needs Assessment

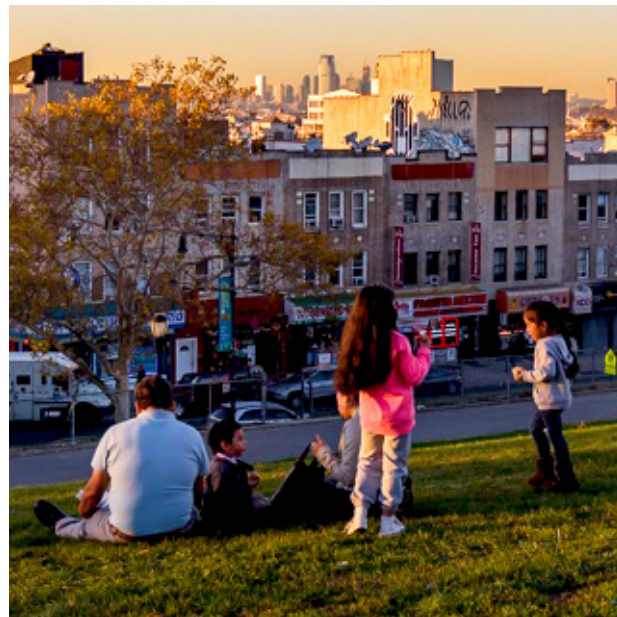
Sunset Park residents make up the highest percentage of residents who use NYU Langone Hospital – Brooklyn and Family Health Centers at NYU Langone. Sunset Park is a mixed residential, industrial, and commercial neighborhood in Southwest Brooklyn, adjoining the waterfront. The Sunset Park Community District (Brooklyn CD 7)*, which includes neighboring Windsor Terrace, is home to about 150,000 residents. More than one-quarter of its residents (26%) are under the age of 20.

For nearly 200 years, Sunset Park has served as a first destination for immigrants – today, 47% of residents are foreign born. Two crowded and vibrant commercial corridors of shops, restaurants, and small businesses serve the large Latinx (41%) and Asian (32%) communities.

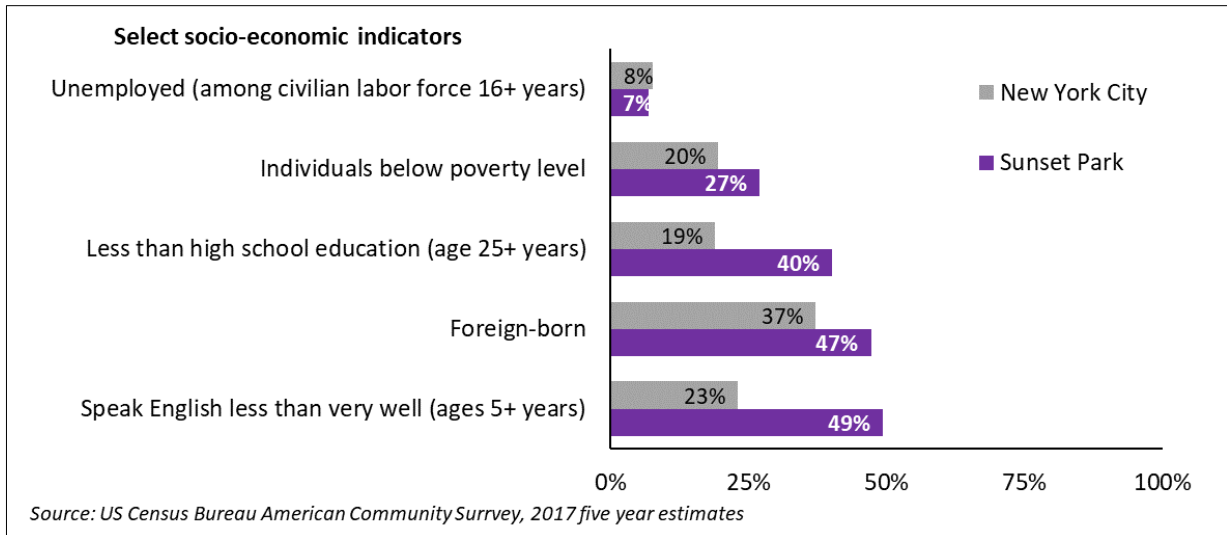
About 40% of the Latinx residents are of Mexican origin, and about 90% of the Asian residents are of Chinese origin.

With a network of community- and faith-based organizations and local industries that provide entry level service and factory jobs, the neighborhood has supported and provided a foothold for many new immigrants.

Access to and awareness of culturally-appropriate health and social services in the community are consistently identified as top needs and priorities by community members.



* Data for this report uses the US Census Bureau Public Use Microdata Area (PUMA) approximation for Sunset Park Brooklyn Community District 7, unless otherwise noted.



Social, economic, and environmental issues impacting the community continue to be top areas of need and top priorities identified by community members. Sunset Park is a community that grapples with high levels of poverty, low educational attainment, and health disparities. Twenty-seven percent of residents live below the Federal Poverty level compared to 20% of residents in New York City; 24% of families live below the Federal Poverty level compared with 16% of families in New York City as a whole. Poverty is particularly acute among families with children – 31% of families with children under 18 live below the poverty level. The median household income is \$51,714. Sunset Park ranks among the neighborhoods with the highest percent of adults 25 years and older with less than a high school education – 40% have less than a high school education, including 21% who have less than a 9th grade education. Unemployment is slightly lower in Sunset Park (7%) than in NYC (8%), yet many workers lack health insurance (24% in Sunset Park compared with 13% citywide). A high percent of the Sunset Park population has access to health insurance through Medicaid—with nearly two out of three (65%) children under age 19 years and about one out of three (32%) adults ages 19-64 years covered only by Medicaid.

English language proficiency is a major barrier for Sunset Park residents: 74% of residents ages 5 years and older speak a primary language other than English at home. Forty-nine percent of residents ages 5 years and older have limited English proficiency.

In addition, as discussed in more detail below, Sunset Park has the second oldest housing stock in New York City and residents often have no choice but to rent units in poor condition. One out of three renter households is severely rent burdened, meaning that their gross rent is more than one half of their household income. Sunset Park ranks 3rd in the City for severe overcrowding and community members are concerned about housing stability and being displaced from the community.

B. The Lower East Side and Chinatown Needs Assessment

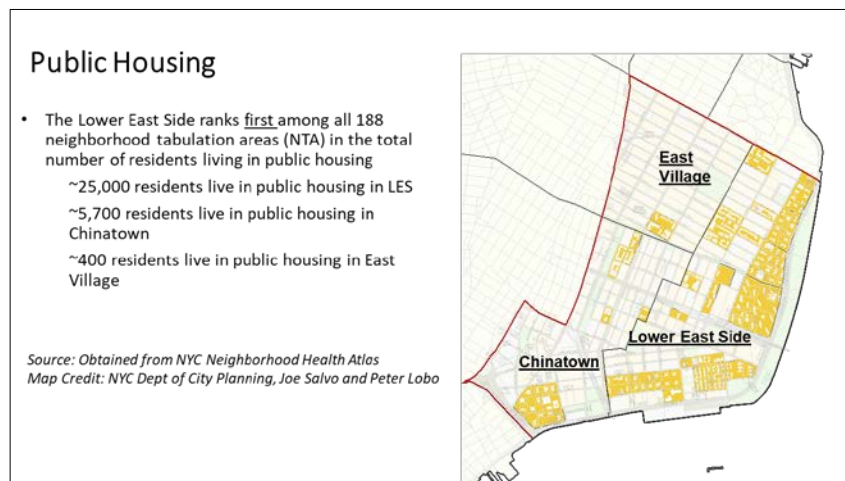
To increase our impact and create opportunities for synergy across programs, starting with the 2013-2016 CHNA, NYULH focused on the area closest to the Manhattan campus with the greatest need: the Lower East Side and Chinatown. The Lower East Side/Chinatown Community District, which includes neighboring East Village (Manhattan Community District 3), is a community with concentrated pockets of poverty and a high percentage of Latinx and Asians – groups that experience disparities in many health outcomes.

Located along the eastern shore of lower Manhattan, this neighborhood is one of the earliest areas settled in New York City and was a historic stop for immigrants in the 19th and early 20th century. Today, the Community District is home to about 160,000 residents, including 35% foreign-born. Immigrant populations comprise a large percentage (52%) of residents in the Chinatown neighborhood. In recent years, the Asian population has declined while there has been an increase in white residents. Today, the population is about 33% white, 32% Asian, and 25% Latinx

Overall, 29% of the population in Manhattan CD 3 have limited English proficiency. Among the Chinese language speakers, 77% speak English “less than very well” compared with 60% for Chinese language speakers in Manhattan as a whole. Manhattan CD 3 ranks among the neighborhoods with the highest percent of adults ages 65 years and older—17% of the population overall, with higher percents in the Lower East Side and Chinatown neighborhood areas. In its most recent Needs Statement, the Community Board highlighted the growing need for senior services.

With 26% of individuals living below poverty, the Lower East Side/Chinatown stands in stark contrast to the surrounding neighborhoods in Lower Manhattan – the Financial District and Greenwich Village/SoHo – which rank among the neighborhoods with the lowest poverty rates in all of New York City (8%). Yet even within the Community District, there are areas of wealth, with 26% of residents having incomes five times higher than poverty level. Newer wealthier developments are arising alongside older housing stock home to residents with lower incomes.

Nearly 27% of all public housing units in Manhattan are located in Community District 3 (about 8% of the total for NYC), yet as the neighborhood continues to gentrify, there is growing community concern about access to affordable housing.

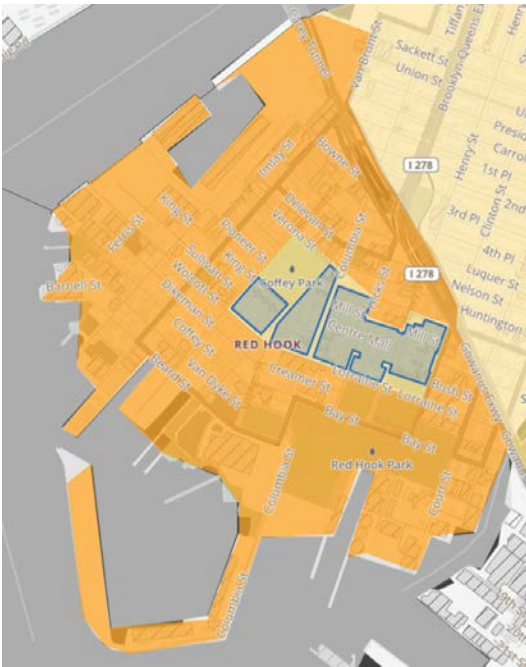


C. Red Hook Needs Assessment

Over the past year-and-a-half, we conducted a Community Health Needs and Assets Assessment (CHNAA) and are collaboratively developing a plan to prioritize and address pressing health concerns and issues in Red Hook, Brooklyn. The assessment was particularly important because readily available data for Red Hook – such as the NYC Department of Health and Mental Hygiene Community District Profile – are often aggregated with more affluent neighboring communities, thereby masking Red Hook’s poverty and need. The in-depth assessment was planned by a team of six organizations: The Alex House Project, Family Health Centers at NYU Langone, Good Shepherd Services, NYULH Department of Population Health, the Red Hook Community Justice Center, and the Red Hook Initiative. During the assessment process, the CHNAA team:

- Reviewed data from organizations and agencies, and identified missing data needing further exploration;
- Collected additional information from people who live and work in Red Hook through dot voting, surveying, and small-group conversations;
- Identified strengths and existing programs and resources; and
- Identified potential future actions to address top health concerns.

Red Hook is a resilient, diverse and lively waterfront community in Brooklyn. The neighborhood is home to New York’s second largest public housing complex, the Red Hook Houses. More than half of Red Hook residents live in public housing. The majority of Red Hook residents are racial and ethnic minorities. Forty-one percent identify as Latinx, 33% African American, 19% white, and approximately 4% Asian. Twenty-three percent of Red Hook’s approximately 11,000 residents are under the age of 18.



Map created in “[DATA2GO.NYC](#),” Measure of America of the Social Science Research Council.

Like many NYC neighborhoods, Red Hook is experiencing gentrification. The percentage of residents with incomes below the federal poverty level stayed about the same from 2006 to 2016, but the percentage of the wealthiest residents (incomes at least five times higher than poverty level) increased in the areas surrounding the Red Hook Houses. Poverty, high unemployment, and low educational attainment are challenges in the community. Forty-four percent of children under the age of 18 Red Hook live in poverty. Nineteen percent of residents 16 and older are unemployed, compared with 9% of residents citywide. Thirty-five percent of adults have not completed high school.

Red Hook is geographically isolated. Many residents live far from the subway system and the neighborhood is cut off from the rest of Brooklyn by the Brooklyn Queens Expressway, causing difficulty in accessing resources not available in the community. Community concerns about

access to healthcare and affordable food has increased with the closures of Long Island College Hospital in 2013 and Pathmark in 2015. This isolation, however, also lends to social cohesion, neighborhood pride, and resiliency. Red Hook has a connected network of community organizations, and residents are engaged in the neighborhood. We reached over 600 people who live and work in Red Hook through over 20 organizations.

Participating community members' top health concerns align with the health needs and risks the CHNAA team identified through hospital, NYC Department of Health and Mental Hygiene, and other data: asthma, stress and anxiety, diabetes, smoking and substance use. (See Appendix C for the full report.)

III. Assessment and Selection of Public Health Priorities

Aligning with the New York State Prevention Agenda and New York City public health priorities, the Community Service Plan focuses on **Preventing Chronic Diseases** by reducing risk factors for obesity and cardiovascular disease and reducing tobacco use and exposure to secondhand smoke, and on **Promoting Healthy Women, Infants and Children** through parenting, early childhood and teen pregnancy prevention programs.

A. Priority Area: Preventing Chronic Diseases

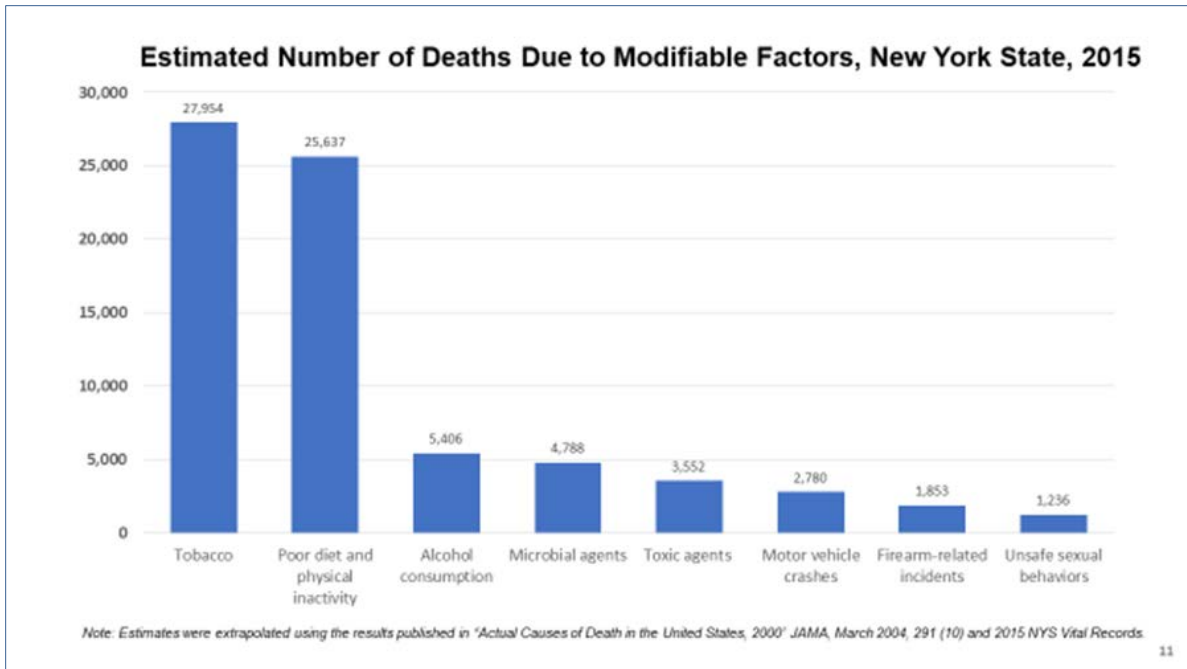
→ Needs and Assets: reducing tobacco use

Reducing tobacco use is a key public health priority for New York City and New York State. Despite the existence of effective tobacco dependence treatments, cigarette smoking remains the leading cause of morbidity and mortality in the U.S., responsible for over 400,000 premature deaths annually and 8.6 million people living with a serious smoking-related illness, including many forms of cancer, heart disease, stroke, and lung diseases.

According to the National Cancer Institute, lung cancer is the leading cause of cancer death among both men and women in the United States, and approximately 90% of lung cancer deaths among men and 80% among women are due to smoking. Smoking also causes many other types of cancer, including cancers of the throat, mouth, nasal cavity, esophagus, stomach, pancreas, kidney, bladder, and cervix, and acute myeloid leukemia.

In New York State, annual smoking-related health care costs and lost productivity in New York total \$14.2 billion and the annual health care expenditure in the State directly caused by tobacco use amounts to \$8.17 billion. The economic burden extends to smokers, who are now paying over \$11 per pack. Given that the smoking prevalence is highest among those with the lowest incomes, there is an even more compelling reason to implement strategies to ensure that smoking cessation resources reach this population.

These concerns are reflected in the State's most recent *Prevention Agenda* data, which identifies smoking as the leading "modifiable factor" responsible for nearly 28,000 deaths in NY State a year.



In response to the heavy toll of tobacco use, New York State and New York City have implemented aggressive tobacco control agendas. Included in this comprehensive package of policies and programs are efforts to increase access to evidence-based treatment for smokers and an emphasis on developing strategies to reduce the toll of secondhand smoke exposure, particularly among children. Research underscores the urgent need to address smoking in housing in New York City. Even among children who did not live with someone who smoked in the home, cotinine levels (a measure of exposure to secondhand smoke) of children living in apartments were 45% higher than among those living in detached houses. Living in multi-unit housing is placing many children at risk of secondhand smoke related health consequences.

New York City has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 13.4% in 2017. But the rates of reduction across populations have been uneven and income-related and racial and ethnic disparities persist. Despite the high cost of cigarettes, the smoking prevalence among low-income New Yorkers is 16%. Of particular concern is the smoking rate among Asian/Pacific Islander men in NYC (23%). Among Chinese men in particular, the rate is even higher – 28% – which, by contrast with other populations, is higher now than it was in 2002.

The NYC Department of Health and Mental Hygiene (DOHMH) now recognizes smoking among Asian American men as a health disparity. On June 28, 2017, in collaboration with our City-wide Asian American Tobacco Free Community Initiative (described below), DOHMH released an *Epi Data Brief* on the leading causes of death among Chinese New Yorkers. Commissioner Dr. Mary T. Bassett noted that although heart disease is the leading cause of death for New Yorkers overall, cancer has been the leading cause of death among for Chinese New Yorkers, reflecting the persistently high rates of smoking among Asian American men. In response, the DOHMH is launching an Asian language public awareness campaign. The NYULH Community Service Plan and the Asian American Tobacco Free Community Initiative will continue to play a key role in disseminating this information.

Understanding needs and barriers for Chinese American smokers:

In order to develop a more nuanced understanding of the needs of Chinese American smokers, we conducted 30 in-depth interviews with Chinese American smokers and administered 49 surveys. We sought to understand their quitting experience and challenges, perceptions about the existing available smoking cessation services, barriers to accessing and using these services, and perspectives about what might assist them in quitting.

Most of the participants were in the precontemplation stage. Reasons for the low intention to quit included low health literacy about the harms of smoking, misconceptions about quitting (several cited famous Chinese politicians who seemed to fall ill after quitting), and smoking as an important part of their social life and a way to relieve stress. Among the smokers who had tried to quit in the past 12 months, only three had visited smoking cessation clinics and no one had called a quitline. Smokers experienced barriers to using cessation services, including a low awareness about the services, skepticism about the effectiveness, concerns about their English proficiency, and time constraints.

To optimize engagement in smoking cessation treatment, smokers suggested that the cessation services must be convenient to use at any time, be free of charge, require minimal amount of time, and provide detailed information about the treatment process and how to use the services. In addition, the services should provide knowledge about the harms of smoking (particularly the short-term health effects), stress and craving management skills, and refusal and resistance skills.

Not surprisingly, in the Lower East Side/Chinatown and Sunset Park, communities with large and relatively poor Asian populations, smoking continues to be a top health concern among our community partners. For example, in the *Manhattan Community Board 3 Need Statement for 2020*, the Board recognizes the smoking disparity for Chinese American men and calls on the City to build on its anti-tobacco campaign “by funding smoking cessation programs with counseling and nicotine replacement therapy aimed at people from countries/regions without strong tobacco control policies and programs.” Smoking was also rated as a top health concern by Red Hook community members.

One in five adults who live in NYC public housing smoke. With the implementation of the U.S. Department of Housing and Urban Development’s new smoke-free public housing policy, there is a growing demand for information and access to services to help support public housing residents quit or reduce their dependence on tobacco. Given the large public housing developments in Red Hook and on the Lower East Side, community partners are interested in building their capacity to meet this need.

→ **Needs and Assets: addressing the intersection of health and housing**

In recent years, there has been a growing recognition of the intersection of housing and health. Indeed, the *State Prevention Agenda 2019-2024* cites access to safe housing as a key determinant of well-being. A recent report by the American Hospital Association entitled *Housing and the Role of Hospitals*, succinctly summarizes the association between housing instability and poor health and increased health care utilization:

Types of Housing Instability and Related Health Conditions		
Housing Issue	Examples	Related Health Conditions
Homelessness	<ul style="list-style-type: none"> • Total lack of shelter • Residence in transitional or emergency shelters 	<ul style="list-style-type: none"> • Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis) • Mental health issues, including depression and elevated stress • Developmental delays in children
Lack of affordable housing	<ul style="list-style-type: none"> • Severe rent burden • Overcrowding • Eviction or foreclosure • Frequent moves 	<ul style="list-style-type: none"> • Stress, depression and anxiety disorders • Poor self-reported health • Delayed or diminished access to medications and medical care
Poor housing conditions	<ul style="list-style-type: none"> • Structural issues • Allergens like mold, asbestos or pests • Chemical exposures • Leaks or problems with insulation, heating and cooling 	<ul style="list-style-type: none"> • Asthma or other respiratory issues • Allergic reactions • Lead poisoning, harm to brain development • Other chemical or carcinogenic exposures • Falls and other injuries due to structural issues

Health Research & Educational Trust. (2017). *Social Determinants of Health Series: Housing and the Role of Hospitals*. Chicago: Health Research & Educational Trust.

Housing instability and quality are priority social determinants of health in all of our CSP communities and for each, we reviewed data and explored community concerns relevant to this issue. We undertook more detailed assessments in Brooklyn.

Health and housing in Sunset Park

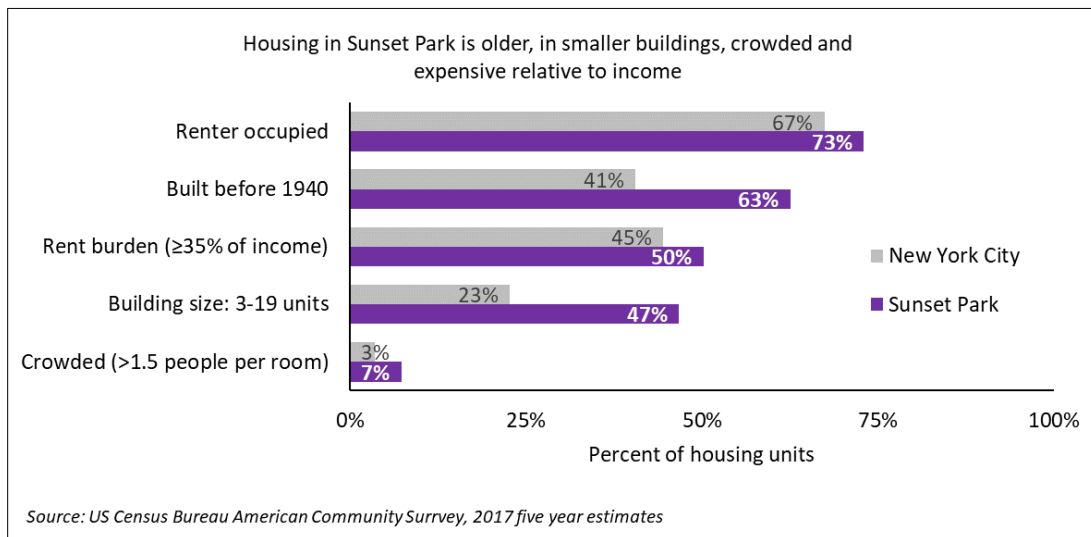
Our methodology included analysis of secondary data and the collection and analysis of primary data. Secondary data from population-based surveys, reports, and administrative data were used to describe the current snapshot of housing and demographics in Sunset Park (see Appendix D for data sources and indicator descriptions). These population-based data helped to characterize the overarching housing landscape in Sunset Park, and provided context for the themes raised during focus group discussions.

Primary data collection consisted of key informant interviews and focus groups. In late June 2017, consultants Bonnie Mohan and Henie Lustgarten, founders of the Bronx Health and Housing Consortium, first met with the community-based organizations that are partners in the NYU Langone Brooklyn Performing Provider System to introduce the project and to hear their perspectives. Following this introduction, from July to September they held 11 focus groups (lasting from 60 to 90 minutes) with a mix of supervisory and direct care staff. They also conducted seven interviews with key informants from the NYU Langone Hospital - Brooklyn and from the Family Health Centers at NYU Langone. (See Appendix D for a list of participants.) Preliminary findings were presented at a large meeting on October 2, 2017 to a group that included representatives from across NYU Langone Health, the Brooklyn Health Home, CAMBA, Enterprise Community Partners, LISC, policy makers and government officials, and the Robin Hood Foundation.

Small residential buildings, generally two to three floors with basements, dominate the housing landscape in Sunset Park. Most housing units are renter-occupied. There are no public housing units in the neighborhood, and the use of federally subsidized housing choice vouchers is low in Sunset Park. Properties tend to be owned by individuals or entities that own a single property in Sunset Park. Sunset Park has the second oldest housing stock in New York City, with nearly two out of three housing units built before 1940.

More than one out of three renter households are severely rent burdened, meaning that gross rent is more than one half of household income, despite about one out of two rental units being rent-controlled or rent-stabilized. In 2016, the median asking rent was \$2,100 per month, yet the median annual household income amounted to \$3,256 per month for renter-occupied households. An average household in Sunset Park has 3.25 people, compared with 2.74 in Brooklyn overall. Sunset Park ranks third highest in severely crowded households among New York City neighborhoods, with nearly one out of ten renter households having more than 1.5 people per room.

Sunset Park has the second oldest housing stock in New York City and residents often have no choice but to rent units in poor condition. More than one out of four households see roaches on a typical day and one out of five households have seen mice or rats in their building. Due to inadequate heating, about one out of six households has used a supplemental source of heat in the winter such as a kitchen stove, fireplace or portable heater.



In the focus groups and interviews, we found a strong consensus among health care providers and CBO staff:

- Housing is a key social determinant of health;
- There is a need to have systems to identify patients and clients who are experiencing housing instability;
- There is a need to develop pathways, and build knowledge and relationships across the health and housing sectors;
- Patients’ lack of safe or appropriate housing can create barriers to safe discharge.

These findings are discussed in more depth in the attached report (see Appendix D).

Health and housing in Red Hook

Red Hook community members identified “home repairs” as the most essential service needed to improve health and wellbeing in Red Hook, and in small group conversations, participants made a strong connection between the top health concerns identified in the community survey and poor quality housing. For example, 45% of survey participants rated asthma as one of the most important health issues in Red Hook. In focus groups, residents noted the impact that inconsistent heating and cooling, mold, and cockroaches and pests can have on people with asthma. Similarly, 35% of survey respondents rated stress, anxiety and depression as one of the most important health issues in Red Hook. Focus group participants cited needed home repairs, rent increases, and housing insecurity as key causes of stress, anxiety and depression. Frequent mental distress is higher among Red Hook residents than NYC residents as a whole. Approximately one in five adults who live in Red Hook Houses reported frequent mental distress.

→ **Need and Assets: preventing and addressing obesity and cardiovascular disease**

Obesity continues to be epidemic: more than half of adult New Yorkers are overweight (32%) or obese (25%). Data show that obesity begins early in life: One out of five NYC public school children in grades K-8 is obese, putting these children at risk for hypertension, elevated lipid levels and diabetes – referred to as “adult onset” prior to the obesity epidemic. These risks escalate as obese children become adults, when they also become at risk for heart disease, stroke, arthritis, and cancer.

For these reasons, the *NY State Prevention Agenda* data slides list “poor diet and physical activity” just below tobacco use as a “modifiable factor” for mortality responsible for over 25,000 deaths a year.

Disadvantaged urban communities are disproportionately affected by obesity, in part due to lack of neighborhood resources, such as the availability of healthy food and safe places for physical activity. In New York City, as in the rest of the country, there are clear income and racial disparities with regard to obesity. Obesity prevalence is nearly twice as high among adults who live in very high poverty neighborhoods compared with adults who live in low poverty neighborhoods (33% vs. 18%).

Obesity-related disparities:

- Adult Latinx and African American New Yorkers have obesity rates of 34%, compared with White adults, 19% of whom are obese.
- Latinx NYC public school children have the highest prevalence of overweight (47%), followed by blacks (40%). Whites (34%) and Asians (31%) are less likely to be overweight.
- Although the rates of overweight and obesity are lower among Asian American groups, given emerging evidence that Asian populations are more vulnerable to insulin resistance at lower weights, preventing obesity is a high priority.
- In addition, Asian Americans experienced the largest increase in obesity (from 20.1 percent to 29.2 percent) from 2004 to 2014.
- South Asians are particularly vulnerable. A recent *Epi Brief* by the NYC DOHMH found that among Asians, 51% of South Asians were overweight or obese.

Obesity prevention beginning in early childhood is important as a way to affect the health trajectory typically seen for immigrants, where each subsequent generation is at increased risk of obesity and the development of diabetes. There is substantial evidence that the roots of obesity are established in early childhood and that effective obesity prevention efforts need to target families and children early in life. Children who are already overweight by ages 3 to 7 are at much greater risk of becoming overweight adults. Moreover, young children are able to self-regulate eating in response to feelings of hunger and fullness, but by age 5, they become increasingly influenced by negative environmental factors. Finally, health behaviors (such as eating habits and physical activity patterns) that contribute to obesity become established in early childhood and hard to change thereafter. These developmental patterns make early childhood a critical time for obesity prevention.

The pre-teen years are also a critical moment for stabilizing and reducing obese children's weight and Body Mass Index (BMI) scores. This period marks a time when children are beginning to develop better abstract reasoning ability, are better able to consider the consequences of their actions, have more control over what they eat and how they spend their time, and begin making their own decisions. Overweight adolescents with metabolic syndrome have a sevenfold greater risk for developing diabetes and twice the risk for developing cardiovascular disease. Multidisciplinary programs that include nutrition education, behavior modification, and promotion of physical activity have been shown to be the most effective in addressing the needs of children who are already struggling with overweight or obesity.

Parents play a critical role in the prevention of obesity among children. However, there are substantial challenges to engaging low-income families, who are often at greatest risk, in obesity prevention efforts – including difficulties in reaching out to populations that may have low levels of education and health literacy, who may face competing priorities and other stressors, or who may not have access to healthy foods and safe play spaces. Research also highlights the importance of alignment with the local context and family's cultural beliefs and practices to increase family engagement and increase initiation of healthy behaviors in the home. Successful efforts to engage parents and other key family members in obesity prevention need to address these challenges.

Obesity continues to be a concern among community residents and leaders in the Lower East Side/ Chinatown and Sunset Park. In the Lower East Side/Chinatown, adult and childhood obesity rates are lower than City rates, and Sunset Park obesity rates are similar to citywide rates. Yet, these rates are still high and low-income children in both communities remain vulnerable.

B. Priority Area: Promoting Healthy Women, Infants and Children

→ Needs and Assets: Supporting families through parenting, early childhood, and teen pregnancy prevention programs

Although the *NY State Prevention Agenda NY State Health Assessment 2018* notes that “[w]e are making good progress in some maternal and infant health indicators including teen pregnancy and breastfeeding,” disparities remain. Indeed, the NYC DOHMH *Take Care New York 2020* highlights the need to reduce rates of teen pregnancy, noting the higher rate among low-income

populations. Sunset Park has the 10th highest teen birth rate among the 59 community districts in the City, with 26.1 births per 1000 girls ages 15-19.

Of particular concern for low-income populations is maternal/child exposure to adversity, which is increasingly recognized as a major public health issue. In New York State, 15% of children experience two or more adverse childhood events (ACE), defined as traumatic experiences occurring before the age of 18, such as poverty, parental mental illness, parental substance abuse, neglect or abuse, exposure to domestic violence, and other traumas. Poverty, which is the most common and pervasive ACE, disproportionately affects immigrant families, which comprise a large part of the Lower East Side/Chinatown and Sunset Park communities. In addition, NYULH providers and community partners report that recent federal policies and rhetoric have increased the stress levels for many immigrant New Yorkers.

Complementing a grant from the Bezos Family Foundation to improve the health and well-being of infants, children and their families in Sunset Park, the Brooklyn Data Station has done an extensive review of existing data sources to understand relevant community demographics, birth outcomes, health, child welfare, and patterns of early childhood school enrollment. We have also spoken to families and other community stakeholders in the Lower East Side/Chinatown, Sunset Park, and Red Hook about their needs, assets and priorities.

Children born into poverty are at risk for far-reaching negative physical and mental health effects, perpetuating cycles of disadvantage into adulthood. Maternal stressors during the prenatal period increase the risk of pre- and postnatal depression, the likelihood of pregnancy complications and adverse birth outcomes, and decreased responsiveness in the newborn, as well as reduced mother-child interactions, harsh discipline, lower initiation of breastfeeding, over feeding, and increased emergency department visits. Fetal exposure to maternal stress in pregnancy negatively impacts a child's neuro-development and increases the likelihood of poor health outcomes, such as delays in communication, socioemotional competence, cognitive functioning, behavioral problems, and chronic conditions. These adverse early influences in turn

Understanding the needs and priorities of families with young children:

In interviews with key informants and meetings with community-based organizations, key themes emerged that are relevant to families in all of our CSP communities:

- Many people spoke of the value of having inter-generational families, which gives perspective, emotional support and assistance to children and families. This also has implications for how services are provided and families are engaged.
- Closely knit sub-communities, often from the same home towns, provide a trusted group of neighbors and a source of support.
- Parents have multiple jobs, often including shift work, limiting time that can be spent with family.
- Financial challenges make it difficult to find childcare and Pre-K programs that are both affordable and compatible with busy schedules.
- Work schedules and a lack of proficiency with the English language can be barriers to parental involvement in the schools.
- Community Board members and community partners highlighted the need to prevent and address mental health issues early and noted a dearth of mental health services, particularly for children needing assessments or evaluations for school.
- The impact on families of the stress of poverty and poor quality or unstable housing – particularly amidst gentrification – is of grave concern.

set the stage for subsequent impaired scholastic achievement, conduct disorder, criminal justice system involvement, and a continuation of intergenerational disadvantage.

For these reasons, as described below, several of our programs that are directed at promoting healthy women, infants and children address issues across the birth-line in order to improve outcomes for two generations.

C. Community needs not addressed and why

Across New York City and within our selected neighborhoods, there are, of course, many health needs that are beyond the scope of this plan. Indeed, the New York City Department of Health and Mental Hygiene *Take Care New York 2020* identifies twenty-three key indicators under four overarching themes.

Selecting priority areas for NYULH's Community Service Plan and using resources efficiently and effectively necessarily means concentrating on some specific challenges and affording less attention to others. Access to culturally and linguistically competent mental health services, senior services and facilities, drug overdose services, homelessness prevention, traffic safety, and diabetes prevention and management were all identified as concerns. While some of these needs are being met by other NYULH programs, others are being addressed by the many valuable community organizations and health care providers in the community.

Over the duration of the CSP, we will coordinate our efforts with community organizations so that we continue to have a comprehensive and up-to-date understanding of community needs and resources, enabling us to maximize our collective impact to improve the communities' health.

D. Information gaps that limit NYULH's ability to assess communities' health needs

As noted above, although the New York City DOHMH provides a wide array of data about the health of the City and its neighborhoods, the diversity within the Lower East Side/Chinatown and Sunset Park and Red Hook – economically and in terms of race and ethnicity – necessitates a more granular, on-the-ground approach to understanding community needs and assets. Similarly, data is sparse about the needs of subpopulations.

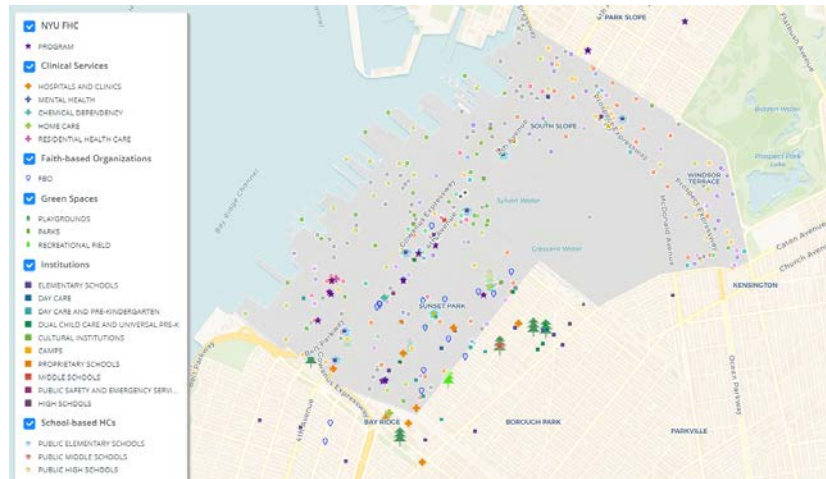
Our engagement with community partners and meetings with community residents and organizations have greatly enhanced our understanding of community needs and priorities.

As described below, this process will continue throughout the next three years of the Community Service Plan. Indeed, we are currently working with the NYULH Brooklyn Arab American Advisory Council (19 community-based organizations) to conduct needs assessment in 2019.

E. Existing assets, facilities, and resources

To develop an inventory of existing facilities and resources, we reviewed listings of *Selected Facilities and Program Sites* prepared by the NYC Department of City Planning as part of the *Community District Profile* for Manhattan CD 3, Brooklyn CD 7, and Red Hook. The NYC Department of City Planning NYC CityMap portal (<http://www1.nyc.gov/site/planning/community/community-portal.page>) and Capital Planning Platform (<https://capitalplanning.nyc.gov/facilities>) were also used to catalog assets and resources – such as schools, day care centers, senior centers, libraries, and healthcare facilities and services. For issue- and program-specific needs, we also relied on information provided on the Greater New York Hospital Association Health Information for Empowerment website (<http://www.hitesite.org/Default.aspx>), which provides information about free and low-cost health and social services by zip code. These sources are a useful guide and checklist.

In order to have a better understanding of the available resources in the Sunset Park neighborhood, we created an asset map that visualizes the distribution and the capacity of the facilities. The asset map includes data retrieved from NYC Department of City Planning and the information gathered from the community partners. Facilities and resources collected from the community are organized



Screenshot of Asset Map

into the following categories: Family Health Centers at NYU Langone programs, local clinical services, faith-based organizations, green spaces, public transportation, institutions, school-based health centers, and community based organizations. Where data were available, we added program aim, capacity, age range of population served, languages offered, and other related information.

NYU Langone Hospital – Brooklyn has a long history of strong collaborative relationships with community partners to create integrated service delivery systems that empower individuals and families and provide them with the skills they need to improve their health and effect change within the community. Many of these organizations, like NYULH – Brooklyn (formerly Lutheran Medical Center), developed from faith-based organizations. The Center for Family Life and Good Shepherd Services are multi-service, child-welfare organizations with deep roots in southwest Brooklyn. Southwest Brooklyn Industrial Development Corporation works in partnership with the local Community Board to drive the economic empowerment of Sunset Park’s waterfront industry. Workforce development providers such as Opportunities for a Better Tomorrow and Brooklyn Workforce Innovations focus on building the work readiness and skills of local residents.

NYU Langone Hospital – Brooklyn plays a unique role in the community as both a major health care and human services provider. Family Health Centers at NYU Langone Department of Community-Based Programs provides community engagement, family strengthening and educational programming to address social determinants of residents' health. Services include adult education, family literacy, youth development, workforce development, case management and supportive services, early childhood services, services for older adults, and community service opportunities.

The Lower East Side and Chinatown, home to waves of immigrants over several generations, have many strong and enduring community organizations that provide a wide array of services, including education, housing, health and wellness, and advocacy. Some of these partner organizations, including University Settlement Society and Henry Street Settlement, grew out of the social reform movements of the 1800s. Others, including Asian Americans for Equality and the Charles B. Wang Community Health Center, began as grassroots groups of volunteers in the mid-1970s and have since grown into treasured multiservice agencies. Manhattan CD 3 also has many valued health care providers, including the William F. Ryan-NENA Community Health Center, the Betances Health Center, and Gouverneur Health, among others. Many smaller grassroots groups continue to serve this neighborhood and will continue to be invaluable partners in our prevention initiatives. The Community Board is active and engaged in a wide range of health and wellness issues. We have met with many organizations and individuals as part of the Community Health Needs Assessment and we will continue this outreach over the course of the Plan.

Red Hook is home to a dedicated network of non-profits, arts and cultural organizations, religious institutions, and resident-led community building activities. Residents rated community-based organization as a top strength in the neighborhood, and also value the community's affordable housing, parks, community gatherings, schools, and public transportation. The Alex House Project is a peer-led social service and leadership development organization that supports pregnant and parenting young mothers and fathers. Good Shepherd Services provides a wide array of services to children, youth and families. The Red Hook Community Justice Center is the nation's first multi-jurisdictional community court and addresses neighborhood problems in southwest Brooklyn through programs that work to improve public safety and trust in justice. The Red Hook Initiative offers youth development and community-building programs, including oversight of Brooklyn's largest urban farm as of 2018.

We continually deepen our understanding of community assets through interviews and meetings with community leaders and from ongoing partnerships, some of which span decades. These relationships give us a deep understanding of the history and resources of the communities.

Community Service Plan/Implementation Strategy

Building on the clinical and scientific expertise and capabilities of NYU Langone Hospitals and the Family Health Centers at NYU Langone, NYULH's three-year Community Service Plan takes a family-centered, multi-sector and holistic approach to improving health in Manhattan's Lower East Side and Chinatown (Manhattan Community District 3), and the Sunset Park neighborhood

of Brooklyn. With the needs and assets assessment now complete, we will also be launching a program in Red Hook, Brooklyn, currently being planned with our community partners.

I. New York State and New York City Public Health Priorities

Aligning with New York State Prevention Agenda and New York City public health priorities, the Community Service Plan focuses on **Preventing Chronic Diseases** by reducing risk factors for obesity, cardiovascular disease and reducing tobacco use and exposure to secondhand smoke, and on **Promoting Healthy Women, Infants and Children** through parenting and early childhood programs and teen pregnancy prevention. Each of our Community Service Plan programs is supported by a strong evidence base. Please see Appendix E for a description of the evidence for each initiative, together with relevant citations.

II. Addressing Health Disparities

Each of the programs we are implementing addresses a health disparity: the high risk for obesity among Latinx and other immigrant and low-income populations; high risks of hypertension and barriers to care for South Asian populations; high rates of smoking among Asian American men; high rates of teen pregnancy and risk for sexually transmitted disease among low-income youth; and increased risk of maternal depression and child development problems among families who experience the stresses of poverty.

The programs span multiple sectors, including community-based early childhood education settings and schools; primary care; housing; and community settings, including faith-based organizations and social service providers.

In the sections that follow, we briefly describe our programs, our progress to date, and our goals under the 2019-2021 Plan.

See Appendix F for a table that summarizes project components, together with anticipated impact and performance measures.

See Appendix E for a description of the evidence base for each program.



III. Programs, Progress and Plans: Preventing Chronic Diseases

A. Tobacco Free Community

Progress and Impact

Smoker Navigator Program

Despite the wide availability of evidence-based smoking cessation treatment resources, only a small proportion of smokers use these resources. This is particularly true among Chinese Americans, a population with disproportionately high smoking rate. In New York City, the current smoking rate among Chinese American men is significantly higher than the general male population (28.2% vs. 17.5%). Most Chinese American smokers who attempt to quit smoking do not use evidence-based smoking cessation aids. To address the disparities in tobacco use among Chinese Americans, in 2014, experts from NYULH Department of Population Health in collaboration with Asian Americans for Equality (AAFE) and the Asian Smokers' Quitline (ASQ) launched a Smoker Navigator Program. Prior study has demonstrated that community-based navigation is an acceptable and efficacious intervention to address the barriers to accessing tobacco cessation treatment services among low-income smokers. Our Smoker Navigator Program trains lay workers (i.e., AAFE staff) to (1) identify smokers through community outreach, (2) educate and motivate smokers to quit or try to quit, and (3) refer smokers to evidence-based smoking cessation resources (e.g., ASQ).



AAFE staff screen for tobacco use among their clients (people who use AAFE's services including housing, insurance, and small business development) and identify smokers through community outreach activities. Smokers are then encouraged to quit, provided with brief cessation counseling and nicotine replacement therapy (NRT), and referred to ASQ for more intensive cessation counseling. In addition, AAFE incorporates anti-smoking education in a variety of community outreach activities (e.g., workshops) which are developed to meet the needs of Chinese community with a particular focus on housing rights and fire safety. Anti-smoking education and information regarding the Smoker Navigator Program are incorporated into these outreach activities. For example, in the workshops, AAFE educates community members about the harms of smoking and the dangers of secondhand smoke exposure, and offers guidance on how to make homes and buildings smoke-free

From September 2016 to December 2018, AAFE reached out to and informed over 3,000 people about the Smoker Navigator Program. The navigators provided free smoking cessation counseling to 215 smokers including 189 smokers who had never previously tried to quit or cut down, provided NRT to 171 smokers, and successfully referred 122 smokers to ASQ. Data from a 6-week follow-up survey showed that 65% of smokers reported that they had made at least one quit attempt, 34% reported that they had quit (defined as being abstinent for at least 7 days), and 60% reported that the Smoker Navigator Program was helpful. Supported by the CSP, two of AAFE's staff members completed the Rutgers Certified Tobacco Treatment Specialist Training program. Building capacity among AAFE staff to offer expert education and treatment services has been a core goal of this program and a key accomplishment.

Asian Americans for Equality

Since its founding in 1974, Asian Americans for Equality (AAFE) has evolved into a nationally recognized affordable housing developer and social service provider, serving New York City's one million Asian American residents. Services include community development and housing preservation, housing legal services, community education, citizenship preparation, and social services.

AAFE has led campaigns to promote equal employment, affordable housing, fair housing, transportation equity, local economic development, community lending, civic participation, healthcare access, immigrant rights, and educational access. As a partner of the NYC Coalition for a Smoke-Free City, AAFE provides culturally competent and linguistically accessible smoking prevention education and smoking cessation to Asian American communities, and leads grassroots advocacy campaigns to build support for key initiatives such as smoke-free outdoor air and smoke-free housing.

Asian American Tobacco Free Community Initiative (AATFCI)

Growing out of our CSP partnership and with the support of the RCHN Community Health Foundation, the Charles B. Wang Community Health Center (CBWCHC) launched a City-wide Asian American Tobacco Free Community Initiative (AATFCI), which worked with the New York City Department of Health and Mental Hygiene to recognize smoking among Asian American men as a health disparity and to commit resources to a culturally relevant and language-accessible campaign to reduce smoking in the Asian American community. AATFCI aims to reduce tobacco use and exposure to secondhand smoke among Asian Americans in NYC through multisector stakeholder collaborations. In addition to NYULH and CBWCHC, AATFCI partners include: three Federally Qualified Health Centers (including CBWCHC, the Family Health Centers at NYU Langone, and Community Healthcare Network), HealthFirst, AAFE and Korean Community Services, the Chinese American Medical Society, the Chinese American Independent Practice Association, NYC Smoke-Free at Public Health Solutions, NYC DOHMH, NYCHA, and ASQ.

Charles B. Wang Community Health Center

For more than 40 years, Charles B. Wang Community Health Center (CBWCHC) has been a leader in providing high quality, affordable, and culturally competent primary care and support services to medically underserved Asian Americans and other disadvantaged populations in the New York metropolitan area. In addition to providing comprehensive primary care, CBWCHC promotes the overall health of the community through innovative health education and disease prevention programs.

In 2018, CBWCHC, in collaboration with NYLH, supported AATFCI partners in seeking City Council funding to expand the Smokers Navigator program, resulting in funding for the Korean Community Services of Metropolitan New York, Inc. to expand the Navigator Program to Korean Americans.

In addition, to continue to strengthen community partners' capacity to provide information about tobacco use and smoking cessation services, the CSP hosted a 2-day workshop in March 2017. CBOs who are partners in the CSP and AATFCI participated in the workshop. The feedback was excellent and

demonstrated the need to continue to provide training to CBO leaders and staff to create a cadre of experts in the community to guide smokers toward evidence-based treatment.

The combined efforts of the AATFCI and the CSP Tobacco Free Community program has had an impact at a City level. Through our efforts, the NYC DOHMH recognized smoking as a health disparity among Asian American men. On June 28, 2017, in collaboration with AATFCI and hosted by CBWCHC, NYC DOHMH released an Epi Data Brief on the leading causes of death among Chinese New Yorkers. Commissioner Dr. Mary T. Bassett noted that although heart disease is the leading cause of death for New Yorkers overall, according to 2014 data, cancer was the leading cause of death among for Chinese New Yorkers, largely a result of the persistently high rates of smoking among Asian American men.



Leadership from the Charles B. Wang Community Health Center and NYU Langone Health at a press conference at which Commissioner Mary Bassett and Dr. Wenhui Li of the NYC Department of Health and Mental Hygiene released a report highlighting the need to address smoking rates among men of Chinese descent.

In response, the NYC DOHMH launched an Asian language public awareness campaign in June, 2018 to encourage Chinese men to quit smoking and to link them to ASQ. The CSP will continue to play a key role in disseminating this information.

Financial Incentive Cessation Project

To address the high smoking rate among Chinese Americans and low utilization of smoking cessation services, in partnership with CBWCHC, in 2018 the CSP Tobacco Free Community program implemented a financial incentive cessation program. This program aims to increase

engagement and retention in CBWCHC’s existing smoking cessation program by offering financial incentives for those who enroll in the smoking cessation counseling program and incentives for attending the three sessions (in person or by phone) and for taking the NRT they are provided. Financial incentive programs for smoking cessation have been demonstrated to address both of these issues and to promote sustained smoking abstinence rates. We are evaluating the program to examine whether financial incentives are effective to promote Chinese American smokers’ engagement and retention in smoking cessation treatment and cessation rates. From September 1st to December 31st 2018, CBWCHC screened 35 adult Chinese American smokers and successfully enrolled five smokers into the incentive program; those who do not agree to enroll can still receive cessation counseling through CBWCHC. All five smokers completed the smoking cessation treatment and took the dispensed NRT. We plan to collect follow-up data on the cessation outcomes this year.

Smoke-free Public Housing Focus Groups

On July 30th, 2018, the U.S. Department of Housing and Urban Development’s (HUD) new smoke-free public housing policy went into effect. The primary rationale for the new smoke-free policy is to protect residents from environmental tobacco smoke (ETS) exposure which is responsible for a wide range of serious health problems among adults and children. Public housing residents are particularly susceptible to ETS exposure because most of them live in multiunit housing.

In collaboration with NYCHA, we conducted 10 focus groups with 91 NYCHA residents (including both smokers and non-smokers) from June and July 2017, one year before the new policy took into effect, to explore NYCHA residents’ attitudes toward HUD’s new smoke-free policy and perceived barriers to policy implementation, and to elicit suggestions for optimizing policy implementation, including how to best offer cessation services. The focus groups were conducted in multiple languages (4 in English, 3 in Spanish, 2 in Cantonese, and 1 in bilingual Mandarin and Cantonese) and in five NYCHA developments located in Lower East Side of Manhattan (i.e., Baruch Houses, Smith Houses, Gomper Houses, Meltzer Houses, and Educational Alliance).

New York City Housing Authority
New York City Housing Authority (NYCHA) is the largest housing authority in the United States. NYCHA has the mission to increase opportunities for low- and moderate-income New Yorkers by providing safe, affordable housing and facilitating access to social and community services. More than 400,000 New Yorkers reside in NYCHA’s 326 public housing developments across the NYC’s 5 boroughs.

Findings from this project provided important information that informed NYCHA’s policy development and strategies for optimizing the implementation process. The data from the focus groups resulted in a publication “Perceptions about the federally mandated smoke-free housing policy among residents living in public housing in New York City” which appeared in the *International Journal of Environmental Research and Public Health*.

Plans

Expansion of Smoker Navigator Program to reach out to NYCHA residents

From 2019 to 2021, we will expand the Smoker Navigator Program to reach out to NYCHA residents in Lower East Side of Manhattan. Public housing residents represent a predominantly minority low-income population with higher smoking rates than the general population. Because of HUD's new smoke-free public housing policy, there is growing demand and need for smoking cessation services among NYCHA residents. We will leverage our existing program, led by AAFE, to address this need. This expansion will be accomplished by leveraging AAFE's large network and collaboration with CBOs that also work with NYCHA residents and are located in Lower East Side of Manhattan near NYCHA housing (e.g., Hamilton Madison Senior Center, Grand Street Settlement, and Henry Street Settlement). The CBOs will refer their clients who need cessation services to AAFE. The navigators at AAFE will provide bilingual smoking cessation counseling services (English and Chinese) to these referrals, as well AAFE's clients; provide NRT patches and gums; and refer smokers to ASQ (for those who speak Chinese) or the New York State Smokers' Quitline and the Smokefree Text Messaging Programs (for those who speak English).

The Smoker Navigator Program will (1) enroll at least 85 smokers (including 10 or more NYCHA residents) to the Smoker Navigator Program each year; (2) provide NRT to at least 50 smokers; and (3) refer at least 35 smokers to ASQ or New York State Smokers' Quitline. (Please see Appendix F for a full list of targets.)

Expansion of community outreach activities

AAFE's current community outreach activities are primarily implemented in the Chinatown area. In the next three years, we plan to expand community outreach activities to include NYCHA developments in the Lower East Side and to extend further east (where the population of Chinese Americans is growing). Some examples of community outreach activities include (1) partnering with local CBOs in NYCHA developments to plan community outreach activities (e.g., education) in order to engage NYCHA residents in the Smoker Navigator Program; (2) developing flyers with CBOs and tenant organizers, and place in senior centers and other relevant locations; and (3) continuing to conduct outreach activities in Chinatown to engage smokers in the navigator program and delivering workshops that integrate an anti-smoking education session in the outreach activities.

For each year in the next three years, the outreach program will reach at least 1,500 people and collaborate with at least 7 CBOs to increase reach of the Navigator Program and awareness of dangers of ETS (3 of the CBOs must work with NYCHA developments). (Please see Appendix F for a full list of targets).

The Asian American Tobacco Free Community Initiative (AATFCI)

Under the umbrella of the AATFCI, we will continue to partner with CBWCHC to strengthen the network members' capacity to implement programs to reduce tobacco use among Asian Americans in NYC. In the next three years, AATFCI will focus on: (1) expanding the coalition to include more CBOs that serve immigrant populations that are experiencing disparities in tobacco use and related illnesses; and (2) seeking New York City Council discretionary funding to support

AATFCI partners' tobacco control interventions and activities. CBWCHC will engage AATFCI partners and other organizations that serve immigrant populations in applying for community-based tobacco control funding from the New York City Council, facilitate and participate in the meetings between partners and City Council members, and provide partners with technical support in grant applications and renewals.

For each year, CBWCHC will (1) organize and lead four quarterly partner meetings, (2) identify and invite at least two new organizations that serve immigrant populations to join AATFCI per year, and (3) identify at least five community partners to collaborate in the development of a coalition that is jointly seeking funding to develop smoking cessation and prevention programs. (See Appendix F.)

Education on e-cigarette use among youth

E-cigarettes, particularly JUUL (a brand of e-cigarette that is shaped like a USB flash drive), have become increasingly popular among youth. Data from the National Youth Tobacco Survey showed that, from 2011 to 2018, current (past 30-day) e-cigarette use increased from 1.5% to 20.8% among high school students, and increased from 0.6% to 4.9% among middle school students. The significant increase is believed to be in part due to the popularity of JUUL. Since 2014, e-cigarettes have replaced cigarettes as the most commonly used tobacco product among middle and high school students. Of major concern is the emerging evidence that e-cigarette use leads to cigarette smoking initiation and increased smoking intensity. Both a meta-analysis and a recent report from the National Academies of Sciences present findings from longitudinal studies that show elevated cigarette initiation rates among youth who use e-cigarettes. The growing e-cigarette use is largely related to the low risk perceptions.

Teen Resource Center

The Teen Resource Center was founded in 2003 to supplement the Pediatrics Department of Charles B. Wang Community Health Center. The mission of the Center is to provide a safe space for Asian American and other underserved youth to learn new skills, develop confidence, build support networks, and serve as community health advocates. Teen Resource Center staff serve as mentors and educators, working to improve adolescent biopsychosocial health.

To prevent youth from initiating e-cigarette use (including Juul), it is important to raise awareness about the potential harms of e-cigarettes and the marketing tactics e-cigarette companies have used to target the younger generation. The NYULH Ronald O. Perelman Department of Emergency Medicine's Prevention and Education Partnership (PEP) Talks program will partner with CBWCHC's Teen Resource Center to conduct a series of workshops that engage youth in conversations about e-cigarettes and to share the latest evidence on the potential harmful and addictive

nature of e-cigarette use. This program will target adolescents who live, recreate, or attend school in Lower East Side and Chinatown of Manhattan, and Sunset Park in Brooklyn. The Teen Resource Center employs a peer-to-peer model to engage youth in the discussion of important health issues (e.g., risky sexual behaviors, tobacco use, substance abuse, and stress). The Center is staffed by a group of young professionals who are passionate and experienced in conducting educational workshops and outreach activities among youth. The PEP Talks program is dedicated to decreasing high-risk behaviors (e.g., drug use and sexual behavior) among youth in NYC. The PEP Talk curriculum includes a series of health education talks (including "Nicotine

and Juul”) which target middle school students and are expertly tailored to engage that age group in meaningful conversations about drugs and sex. We will leverage the strong partnerships between CBWCHC’s Teen Resource Center and schools located in Lower East Side and Chinatown of Manhattan, and Sunset Park in Brooklyn, as well as the strong experience of the PEP Talks team in nicotine education. Together we will develop a tobacco and e-cigarette educational and advocacy toolkit. The toolkit will contain educational materials (e.g., presentation slides, role play cards, and worksheets), user manual (i.e., an instruction on how to use the toolkit), and assessment tools.

In the first year of the CSP, we will tailor the PEP “Nicotine and Juul” curriculum to target high school students, develop other educational toolkit materials (e.g., user manual, assessment tools), deliver at least 6 workshops in high schools and reach out to at least 120 teens and adolescents in Lower East Side and Chinatown of Manhattan, and Sunset Park of Brooklyn. In years two and three of the CSP, we will refine the tobacco and e-cigarette educational and advocacy toolkit based on feedback from students who have attended the

workshop, educators from CBWCHC’s Teen Resource Center, and experts from NYU Department of Population Health and the PEP Talks program. We will continue to conduct at least 6 workshops and reach out to at least 120 teens and adolescents each year. (See Appendix F for a full list of targets.)

Prevention and Education Partnership (PEP) Talks program

Founded in 2015, PEP is dedicated to decreasing the incidence of preventable illnesses and injuries commonly seen in the emergency department. Taught by physicians and toxicologists, the PEP Talk curriculum is expertly tailored to engage students in meaningful conversations about drugs and sex. With a focus on delivering factual information, enhancing risk assessment skills, and providing access to healthcare resources, PEP Talks seeks to transcend traditional models of teaching about drugs, alcohol and sex.

WeChat Quit Coach Pilot Program

The interviews and surveys we conducted with Chinese American smokers suggested that there is potential for using a social media platform to reach Chinese American smokers and deliver smoking cessation services. Our primary survey data (N=49) showed that WeChat was the most popular (94%) social media platform. (WeChat, the most popular social media site among Chinese globally, has 1.08 billion monthly active users as of the third quarter of 2018.³³) Among WeChat users, 96% reported daily use, mainly for communication (daily instant messaging to individuals 76% or in groups 50%) and acquiring information (daily news/articles reading: 67%).

In the coming year, we will launch a WeChat Quit Coach Pilot Program to examine the feasibility of using WeChat to deliver smoking cessation intervention among Chinese American smokers. In collaboration with CBWCHC, we plan to enroll adult Chinese American smokers who are interested in quitting in a 4-week WeChat Quit Coach Pilot Program. We will create WeChat groups with 4-6 smokers for each group. In each group, two experts (including a faculty member from NYU Department of Population Health and a certified tobacco treatment specialist from CBWCHC) will coach the group. During the 4-week intervention period, each group will receive a daily message with evidence-based smoking cessation strategies developed based on the US Clinical Practice Guidelines for smoking cessation, and one daily question (related to craving and stress management skill and resistance skill) designed to stimulate group

discussion (e.g., “One of the best ways to combat a nicotine craving is to keep your hands busy! How do you plan to keep your hands occupied when you get hit with a sudden urge to smoke?”). Smokers can ask questions either in group or directly to the coaches (without being seen by other group members) for in-time support. Post-program assessment will be conducted to assess feasibility (e.g., enrollment rate, retention rate, and reasons for ineligibility, refusal, and fail to quit), acceptability (e.g., response rate to daily group questions, proportion of messages read, and satisfaction level), and cessation outcomes (e.g., self-reported 7-day abstinence rate, quit attempt and intention).

In year one, we plan to develop the message and question library, and enroll 20 smokers to the WeChat Quit Coach Pilot Program. In years two and three, we will refine the message/question library based on the feedback from smokers who have participated in the program, and enroll another 30 smokers to the program each year. The ultimate goal is to launch this platform to increase engagement of Chinese American smokers in treatment and to increase cessation rates.

B. Health + Housing Project

As we learned in our CHNA, housing instability and quality are priority social determinants of health in all of our CSP communities. People who are homeless, housing insecure or living in poor quality housing suffer disproportionately from physical and mental health conditions. Furthermore, poor health is often concentrated within the same neighborhoods that face concentrated poverty and other social ills. People living in such neighborhoods have high levels of chronic disease, mental illness, and exposure to environmental risks such as injury and violence. Not surprisingly, they concomitantly have high use of costly health care services, including frequent emergency department visits and hospitalizations.

With the growing gentrification of CD 3, people living in subsidized, low-income apartment buildings – who are more likely to have multiple health risks and needs – are in danger of becoming increasingly isolated. This is of great concern in the community. To address these needs, in April 2016 we launched a pilot Community Health Worker (CHW) program in two low-income buildings in partnership with Henry Street Settlement, the NYU Furman Center for Real Estate and Urban Policy, the New York City Housing Authority (NYCHA), the NYC Department of Housing Preservation and Development (HPD), Hester Street Collaborative, the Chinatown YMCA and with support from the Robin Hood Foundation.

Henry Street Settlement

Founded in 1893 by Lillian Wald, Henry Street Settlement opens doors of opportunity to enrich lives and enhance human progress for Lower East Side residents and other New Yorkers through social services, arts, and health care programs.

Each year, Henry Street Settlement serves 60,000 individuals through social services, arts and health care programs.

The program was place-based (located in the two buildings); addressed social, environmental, and structural determinants of health in addition to promoting healthy behaviors and effective use of the healthcare system; and was tailored to the specific needs of building residents.

Progress and impact

Prior to the start of the program, community surveyors collected 390 baseline surveys from residents 18 years and older in 266 of 450 apartment units (48% response rate; 59% apartment unit response). The surveys provided crucial information on resident health conditions and behaviors, as well as their social and economic needs. Survey results were presented back to residents of both buildings.

The NYU Furman Center for Real Estate and Urban Policy

The Furman Center is a joint center of NYU's Robert F. Wagner Graduate School of Public Service and School of Law. Since its founding in 1995, the NYU Furman Center has become a leading academic research center devoted to housing and land use policy. The mission of the Furman Center is to provide objective academic and empirical research on the legal and public policy issues involving neighborhood change, land use, housing, and mortgage finance in the United States; promote frank and productive discussions about those issues; and present essential data and analysis about the state of housing and neighborhoods in the nation's leading urban areas.

Of the 390 residents who completed baseline surveys, 226 (58%) went on to complete an intake with a bilingual CHW (Chinese/English and Spanish/English). The majority were 45-64 years old (37.8%), female (61.3%) and Latinx (68.6%). Over 40% had less than a high school degree (43.3%), 32.0% were unemployed or unable to work, and 62.7% had a household income of less than \$20,000. Nearly 40% of participants reported being diagnosed with hypertension (37.3%), while 17.7% reported being diagnosed with diabetes, and 24.4% reported being diagnosed with asthma. The majority of participants were covered by Medicaid (50.7%). Despite having access to subsidized housing, participants reported a high degree of housing insecurity, as 21.4% reported being unable to pay rent on time in the past 6 months.

CHWs used motivational interviewing techniques to guide participants through a goal-setting activity, and then together they developed an action plan for the resident to achieve their goals. Participants ranked disease management, employment or job readiness skills, and access to care as their top three goals. CHWs provided coaching on health behaviors, helped residents navigate environmental and structural issues in their apartments, and connected residents to health and social services, making over 400 informal referrals, half of which were to Henry Street Settlement (our community partner).



Over the course of the 15-month intervention (April 2016-June 2017), CHWs recorded more than 2,400 in-person visits with participants, averaging 11 visits per participant. Residents worked with CHWs for an average of 9.5 months.

Periodic workshops were held in the community rooms of both buildings to address residents' needs and priorities. NY Common Pantry provided two nutrition workshops (in Spanish, English and Cantonese) and Hester Street Collaborative led two Healthy Homes workshops focusing on the use of non-toxic materials to clean and deal with pests. In addition, two of the CHWs organized regular group sessions with residents, including a nutrition/wellness group and a physical activity class.

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- Reading all labels on cleaning supplies.
- Searching the Environmental Working Group's product report card to see if a product is bad for your health: <http://www.ewg.org/guides/categories/2-AllPurpose>

CLEANING INGREDIENTS

<p>LEMONS</p> <ul style="list-style-type: none"> ✓ Powerful antibacterial ✓ Stain lifter ✓ Low-cost ✓ Fresh scent 	<p>SODIUM CARBONATE (WASHING SODA)</p> <ul style="list-style-type: none"> ✓ Stain lifter ✓ Kills mold and mildew ✓ Great alternative to bleach * May cause skin irritation, wear gloves when handling.
<p>WHITE VINEGAR</p> <ul style="list-style-type: none"> ✓ Powerful antibacterial ✓ Low-cost ✓ All-purpose cleaner 	<p>HYDROGEN PEROXIDE</p> <ul style="list-style-type: none"> ✓ Disinfecting properties ✓ Stain lifter ✓ Low-cost

Example of materials provided to residents during the Healthy Homes workshop (April 2017)



As the intervention was winding down, CHWs connected residents still in need of care coordination and support to a Health Home. At the end of the program, we held a recognition ceremony in June 2017 for participants of both buildings. CHWs handed out certificates of achievement to the residents they worked with, and CHWs were recognized for their work with residents.

From June-October 2017, community surveyors conducted a follow-up survey with 440 residents (54%) in 263 of 450 apartments (58%). Of the 226 program participants, 172 completed both a baseline and post-survey (76.1%). In October 2017, we also conducted five focus groups with approximately 40 participants to get more personalized in-depth feedback on the program.

Pre-post survey results indicated that, compared with baseline, more participants reported having a personal doctor after the CHW program (84.0% baseline vs. 92.3% post-survey, $p < 0.01$). The percent of participants covered by health insurance increased (94.7% vs. 98.2%), however the difference was not statistically significant ($p = 0.06$). There was also a significant increase from baseline in the number of participants who saw their primary care provider 4 or more times in the past 6 months (24.7% vs. 34.1%, $p = 0.03$). There was a decrease in participants who visited an ED 3 or more times in the past 12 months (14.5% vs. 10.5%), but this was not statistically significant ($p = 0.13$).

Compared with baseline, fewer participants reported being food insecure (53.5% vs. 41.8%, $p < 0.01$), needing food benefits (13.5% vs. 31.8%, $p < 0.01$), unable to access job training or employment programs (12.3% vs. 6.4%, $p = 0.02$), education/GED/ESL programs (8.2% vs. 2.3%, $p = 0.02$), a place to exercise (24.0% vs. 16.4%, $p = 0.01$), or unable to pay their rent on time (22.2% vs. 13.2%, $p < 0.01$).

Residents reported high levels of satisfaction with the CHW program. Over three-quarters said they were “very” or “extremely comfortable” speaking with their CHW about their issues (76.5%), and almost all were “satisfied” or “very satisfied” with their individual CHW (96.6%) and the CHW program overall (96.6%). The focus groups conducted confirmed these findings, with many participants recounting heartfelt stories of how meaningful working with their CHW had been for them. Overall our findings suggest that CHWs were successful in helping participants make connections to resources and gain access to needed benefits. While we did not see improvements in a number of health indicators, we did see significant improvement in social determinants of health. Consistent with other studies of social determinants of health interventions and our own theoretical model for how the CHW intervention would work, our findings indicate that health benefits from this type of program could take longer to manifest themselves.

We have published our baseline and participant assessment findings from this project in a special issue of *Cityscape* on the housing-health connection (Vol. 20, Number 2, 2018), and are in the process of finalizing a paper summarizing the pre-post analysis findings to be published in 2019.

Growing out of this pilot project, Henry Street Settlement was asked to continue the CHW program in one of the intervention buildings and to expand it to two additional buildings in the same development under the same ownership. Building management is supporting this effort, which includes two full-time CHWs and one full-time supervisor, who carries a 50% caseload. NYULH continues to provide technical assistance to support this work.

Plans

As part of the continued evaluation of the Health + Housing Project, in 2019 we will be analyzing Medicaid claims and SPARCS data to measure objective changes in residents’ emergency department use and hospitalizations a year prior, during, and after the CHW intervention. Following completion of these analyses we will publish our results.

Several of our partners – DOHMH, NYCHA, HPD, the Archdiocese of New York and Wavecrest Management – have expressed interest in the Health + Housing Project as a potentially

replicable model for other low-income housing developments across the City. We are exploring implementing a similar CHW model in NYCHA buildings in Red Hook, Brooklyn focused on both asthma and social determinants of health more generally. Our partners there include the Family Health Centers at NYU Langone, Red Hook Initiative, Red Hook Community Justice Center, Good Shepherd Services, and Alex House Project. We have also provided technical support to NYCHA in their efforts to pilot a CHW training program for their residents in other developments in the City.

Finally, the Health + Housing Project has provided the foundation for the launch of two other CSP initiatives: the Southwest Brooklyn Health & Housing Consortium and the CHW Research and Resource Center described below.

C. Healthy Habits Program/Programa de Hábitos Saludables

Stemming from the 2013 CHNA, the Family Health Centers' Department of Community Based Programs convened a design team to develop a pediatric obesity program to address the high rates of obesity among children in Sunset Park, supplementing the care and referrals routinely provided by pediatric primary care providers. The program design team – consisting of a medical doctor, nutritionists, community planners, and social workers – used child and adolescent intervention design recommendations from the US Preventive Services Task Force (USPSTF) as a guideline for the intervention and adopted concepts from the following evidence-based, multi-component programs and curricula: *Media Smart Youth*; [We Can! Energize Our Families](#); [Nutrition to Grow On](#); and [Eat Healthy, Be Active](#). Community members representing the targeted audience also participated in the design and implementation plans. The program was piloted in 2015 and has been adjusted based on program evaluations and a NYU Langone Health Department of Population Health Center for Healthcare Innovation and Delivery Science (CHIDS) research study.

Healthy Habits Program/Programa de Hábitos Saludables (formerly called Healthy Families Program/ Programa de familias saludables) consists of 12 multi-disciplinary sessions for 9–11 year olds and their parents. The intervention focuses on this age group because it is the time when children become more independent from their parents and are able to evaluate and alter their dietary habits and attitudes. Parents are included as participants since evidence shows that programs that engage family members have greater success in stabilizing or reducing children's BMI. The program is culturally relevant to the local Latinx population and is conducted in English and Spanish. Each session consists of three components:

- Customized nutrition education, including family meal preparation facilitated by a trained chef;
- Support groups for parents and children; and
- Physical fitness activity.

The customized nutrition education component is facilitated by a nutritionist and focuses on the 5-2-1-0 model, a nationally recognized, research-validated childhood obesity prevention program based on evidence-informed recommendations from the [American Academy of Pediatrics](#) and the [U.S. Department of Health and Human Services](#). The family meal preparation component was added to the program in 2018 through a partnership with [Common Threads](#). Their research-based methodology addresses the many factors that influence a child's decision-making: personal, interpersonal, and environmental, in order to effect long-term behavior

change. The organization's family cooking classes have shown promise in improving family vegetable consumption (a goal of the Healthy Habits program), which can lead to long term positive health outcomes. Separate support groups for children and parents offer opportunities to address questions and challenges, help them adopt strategies for setting limits and promoting healthy behaviors, and build peer support. The physical fitness component focuses on low- or no-cost activities that can be done in the home or through local community resources.

The program is offered in two models: once weekly (over 12 weeks) and twice weekly (over six weeks) to accommodate family and program implementation partner schedules. It is held at a Family Health Centers site and at P.S. 503/506, in close collaboration with a local preventive service agency, the [Center for Family Life's after school program](#); school administration; and the Family Health Centers' School-based Health Center, which provides medical and mental health services on-site, offering a unique opportunity to reach children where they spend many hours of the day. Children and families are recruited through referrals from primary care and school-based health providers, referrals from community programs, and direct outreach to community residents via mailing, flyering and calling.

Healthy Habits Program/Programa de hábitos saludables is designed to:

- Stabilize the participating child's BMI; and
- Support child and family behavior change based on 5-2-1-0:
 - Fruit and vegetable consumption (5 or more fruits and vegetables per day);
 - Daily screen time (2 hours or less of recreational screen time per day);
 - Physical activity (1 hour or more of daily physical activity); and
 - Sugar-sweetened beverage consumption (0 sugary drinks).

Progress and impact

Since September 2016, six program cycles have been conducted reaching 77 children and families. Participation was less than anticipated, but increased during this time period. In the last cohort served, 54% of families attended nine sessions or more (26+ intervention hours). BMI data indicates the likelihood of long term stabilization for all program participants. This outcome will be measured at the one-year follow up sessions.

New evaluation tools were developed and tested with the target population in summer 2017 in collaboration with NYU Langone Department of Population Health. The new tools incorporate several validated measures, including the 5-2-1-0



Healthy Habits Questionnaire, Family Nutrition and Physical Activity Screener, and the NIH PROMIS measure. These measures are better aligned with program outcome goals and the instruments are more accessible to program participants. The revisions to the assessment tools were successful and have informed program design and implementation.

Overall, program participants have been satisfied with the program. There was a statistically significant improvement in children's healthy eating scores (amount or frequency of eating fruits and vegetables, breakfast, fast food, and dinner as a family), based on the revised pre/post assessments used with four cohorts (25 children with pre and post assessments) starting in November 2017. Parent responses also suggest behavior change in food choices. Of the 25 parents who completed pre and post assessments, 14 (56%) reported their family never eats "ready-to-eat" foods, compared to 19 (76%) at the end of the program. Survey results also indicated the following:

- Improvements in daily servings of fruits and vegetables: The percentage of children eating 4 or more servings of fruits and vegetables each day remained about the same before and after the program (5 before, 6 after), but there was a notable improvement in those reporting an average daily intake of 0-1 servings. 8 children (32%) reported eating only 0-1 servings of fruits and vegetables every day before the program, compared to only 2 children (8%) at the end of the program;
- Improvements in child's screen time: Parent responses indicated an improvement, with 12 parents (48%) reporting their child very often or always had less than 2 hours of screen time, compared to 9 (36%) before the program;
- Improvements in daily physical activity: The number of children engaging in physical activity 6-7 days per week increased between the beginning and end of the program, with 6 children (25%) before compared to 12 children (48%) at the end; and
- Improvements in sugary drinks consumption: There was an improvement in reducing sugary beverage consumption to 0-1 per day. 15 children (60%) reported consuming 0-1 sugary beverages each day before the program, compared to 18 children (72%) at the end of the program.



Plans

In 2019-2022, the Healthy Habits Program will conduct 15 program cycles reaching 150 children and families. The program will continue to develop plans to meet target enrollment and retention numbers (60% attending 9 or more sessions in 2019, 65% in 2020 and 2021).

We will continue our partnerships with Common Threads, expand to one additional Family Health Center site, and continue to use process and outcome data gathered during and after the program to monitor our progress and inform program design and implementation. In the long-term, we hope to reduce the percentage of children and adolescents who are obese and create measurable sustained change in behaviors and attitudes towards healthy living in both children and parents.

D. Greenlight early child obesity prevention program

Taking advantage of the frequency of primary care pediatric visits in the early years of life, beginning with the 2014-2016 Community Service Plan, the Department of Pediatrics at NYULH, in partnership with the Charles B. Wang Community Health Center (CBWCHC), adapted and implemented Greenlight, an evidence-based program that teaches families about healthy eating and activity in order to prevent early childhood obesity in the Chinese-American community.

The Greenlight program, which was developed as part of an NIH-funded grant in settings that serve predominantly low-income black and Hispanic families, trains pediatricians and other health care providers on how to communicate effectively with families using toolkits that contain culturally-tailored educational materials that are easy-to-understand. The use of these plain language principles benefit all individuals, but are especially helpful for those with low literacy.

Greenlight focuses on improving health literacy and fostering family engagement through three core components:

- Low literacy toolkits to support physician counseling around diet and activity-related behaviors at well-child visits starting at 2 months of age, which include booklets containing age-specific recommendations and ‘tangible tools’ to support evidence-based obesity prevention messages (e.g., portion size snack cups);
- Training of providers in evidence-based health communication strategies (use of plain language, supplementing counseling with written information, along with teachback and goal setting);
- Waiting room program where health educators promote family engagement in care as they introduce and support Greenlight messages.

The importance of health literacy

Approximately 90 million Americans—or 45 percent of the population—have basic or below basic literacy skills, and 110 million have basic or below basic quantitative skills; these low literacy populations struggle with understanding and acting on health information, referred to as low health literacy. Nearly 30% of US parents are categorized as having low health literacy. Minority and immigrant families are at increased risk for having low health literacy. Low health literacy and numeracy is associated with worse health outcomes; with respect to issues related to obesity, low health literacy and numeracy have been associated with lower rates of breastfeeding, difficulty understanding food labels and portion sizes, higher rates of obesogenic behaviors like pressuring feeding, decreased physical activity, and screen time, as well as higher rates of obesity.

As part of the NIH-funded multi-site cluster randomized study, children who received Greenlight had a lower BMI z-score at 6, 12, and 18 months of age. There were also reductions in obesogenic behaviors, including less juice consumption by children, among families who

received Greenlight. A cohort of children are continuing to be followed through age 5, to see the impact of Greenlight at later timepoints.

The Greenlight intervention incorporates evidence-based messages related to child obesity. Prior to developing the Greenlight toolkit, a comprehensive literature review was conducted and published by the study team to inform toolkit content. The original Greenlight program was

developed through an iterative process that included engagement from a diverse array of families, pediatric providers, nutritionists, and experts in pediatric obesity, child development, health literacy/numeracy, health communication, linguistic/cultural competence, behavioral health, and graphic design. The intervention includes “core” booklets that are given out at each well-child visit, which introduce or reinforce three age-appropriate parent behaviors thought to be most

strongly associated with preventing obesity during early childhood based on the peer-reviewed literature. These behaviors are highlighted on the cover of each Core booklet within a green “traffic light.” Additional “supplemental” booklets provide more in-depth guidance on topics known to be important to address in obesity prevention, including breastfeeding, sleep, healthy eating for the whole family, and screen time.

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给宝宝尝试以下的小食..... 每次只给一点点!

现在宝宝能用自己的手指, 拿起一些小东西放进嘴里。这是宝宝成长过程中的重要一步。他已经准备好自己吃东西了! 他开始时也许会造成脏乱, 但自己吃东西是需要很多练习的。

我可以给宝宝什么食物?

宝宝会想要吃其他人正在吃的食物 — 就给他做适合九个月大宝宝吃的食物。

你需要把食物煮熟、压烂、切丝、或切成小块。水果的皮要削掉。

宝宝可以吃这些食物:

- (煮熟的) 蔬菜 — 例如胡萝卜、甜薯、豌豆、或青豆角
- 水果 — 例如香蕉、木瓜、或梨子
- 蛋白质 — 例如鸡肉、瘦肉、鱼肉、豆腐、或鸡蛋。鸡蛋的蛋黄和蛋白都可以给宝宝吃。
- 谷类 — 例如麦片、面条、米饭或饼干

如果任何家庭成员有食物过敏, 请告诉你的医生。

记住: 用汤匙喂宝宝吃糊状的食物还是很重要, 给宝宝一汤匙, 这样他可以学习自己吃东西。

宝宝正在学习自己吃东西! 给他少量健康、柔软的手抓小食品!

Progress and impact

Greenlight has now been fully implemented in CBWCHC Chinatown site, where it is integrated as part of routine care in the pediatric clinic. In addition, we are planning for the implementation of the program at the Seventh Avenue Family Health Center in Sunset Park, Brooklyn – one of the sites of the Family Health Centers at NYU Langone. We have also laid the groundwork for broader dissemination of the program across the Family Health Center network, and beyond, by

与你的宝宝一起“动”起来

看屏幕的时间, 不是“动”的时间

每天跟你的宝宝试着趴着玩!

很多父母认为宝宝还不能趴着玩 — 其实大部分宝宝是可以的! 这是如何开始的方法.....

- 你可以仰面躺下来, 然后让宝宝趴在你的身上。他能够抬起头来几秒钟吗? 跟他讲话, 让他看着你。
- 当他强壮一点以后, 放一张毛毯在地上, 让宝宝趴在上面。很快他就可以把头抬起来, 而且可以保持姿势十秒钟! 你可以放一个玩具在他面前给他看着。
- 每次趴着玩的时间大概两分钟。一天试着玩三次。

记住: 当宝宝睡觉的时候, 他应该经常保持着仰卧的姿势, 不是趴着的姿势。

看屏幕时间是指观看下列物件:

- 电视 (影片)
- 电脑
- 平板电脑 (iPad)
- 智能手机

看太多屏幕会让成年人和小孩增加体重。做个好榜样 — 限制你和宝宝看任何屏幕的时间。你的宝宝会学习你的榜样。

每天让宝宝有趴着玩的时间。随着锻炼, 宝宝会茁壮成长!

看屏幕的时间, 不是“动”的时间。选择一些能与宝宝一起活动的项目!

updating toolkit information with the latest American Academy of Pediatrics recommendations, refining translations, and setting up a website where parents can easily access and share educational materials.

Adaptation of the model

The process of adapting the Greenlight program for use with Chinese-American immigrant families was part of the 2014-2016 Community Service Plan, and was done in close partnership with the Charles B. Wang Community Health Center. The cultural adaptation process involved a multi-step process, which included outreach to over 160 parents, and went far beyond simple language translation and changing the ethnicity of individuals in photographs. Rather, the team sought to achieve semantic, conceptual, item-level and operational equivalence as part of the adaptation process. A key part of the process involved three focus groups conducted with parents (two groups in Mandarin and one group in Cantonese; 25 parents involved) and two focus groups with 20 providers/health educators. In addition to focus groups, providers (physicians, nurses, nutritionists) and health educators gave individual feedback on the materials throughout the translation and adaptation process. The materials – some of which are shown here – reflect the judgment and care of many participants.

Implementation at CBWCHC

The full set of Greenlight materials at CBWCHC (core and supplemental booklets translated into Simplified and Traditional Chinese), along with ‘tangible’ tools, have fully been rolled out at CBWCHC since May 2016, with 20 health care providers and 4 health educators trained in the use of the tools.

We have also enrolled 200 children/caregivers as part of an evaluation cohort and completed a total of 436 surveys with them (comparing them to a baseline group of children/caregivers, $n \sim 80$ per age group of 6, 12, 24, 36 month old children and their caregivers enrolled pre-Greenlight program implementation).



Since the complete roll-out of the program at the CBWCHC in May 2016, we have distributed a total of 4000 booklets and 3615 tangible tools (including sippy cups, portion size snack cups, divided plate). Annually, we have reached ~ 700 unique children and families ($\sim 90\%$ of unique eligible patients visiting each year). Of the 4049 well-child visits of children 2 to 24 months of age that took place between September 2016-August 31, 2018, 77% received Greenlight health education by a health educator or provider (70% from a provider, 40% from a health educator).

Dissemination

Over 600 Greenlight booklets have been distributed to the CBWCHC site in Flushing Queens, and we have begun the process of extending the comprehensive program to the NYU Langone Family Health Centers' 7th Avenue site in Sunset Park. A part-time health educator is assisting in program implementation and evaluation and the Greenlight team has worked to understand the workflow at the 7th Avenue site to maximize the efficiency of intervention delivery; and revise, pilot, and implement evaluation assessments.

Seventh Avenue Family Health Center at NYU Langone

First opened in 2002, the Seventh Avenue site (formerly known as the Brooklyn Chinese Family Health Center) is part of FHC's network of federally qualified health centers affiliated with NYU Langone Health. It was one of the first medical facilities to open in Sunset Park to serve the needs of medically underserved Asian-Americans in the area. The site serves both the medical, rehabilitation, and dental needs of the community, with over 28,000 patient visits per year, including over 6,000 pediatric patient visits. The team of health care providers includes family medicine providers, pediatricians, and an Ob/Gyn. The majority of family seen at the clinic are recent immigrants from Fuzhou, in southern China.

Evaluation

Enrollment of our cohort of children and caregivers at CBWCHC has allowed us to look at the impact of Greenlight on health behaviors. At the 6 and 12 month well-child visit, we found that parents post-Greenlight intervention implementation had significantly reduced juice/sweet drink intake (6 months: 4 vs. 12%, $p=0.03$; 12 months: 7 vs. 54%, $p<0.001$), reflecting a 10-fold and 20-fold decreased odds of giving juice for those time points, respectively. At 12 months of age, children had a 3-fold increased odds of using cups, an important step to transitioning from the bottle (post vs. pre: 86 vs. 65%, $p=0.01$).

At 12 months, there was also a 2-fold increased odds of consuming fruits/vegetables 4x or more per day (post vs. pre: 41 vs. 25%, $p=0.02$), and a ~2-fold reduction in any consumption of sugary snacks (post vs. pre: 33 vs. 55%, $p=0.005$); there was a trend for reduction in any junk food consumption. At 6 and 12 months, there was a greater than 5-fold increased odds of meeting physical activity recommendations. No differences were seen in rates of breastfeeding or screen time.

Our evaluation study has also allowed us to look at changes in self-efficacy and empowerment. Parents were asked about their level of agreement with 4 statements (e.g. "I can do many things to keep my child from being overweight," "I know how to prevent my child from becoming overweight"). Parents of 6 and 12 month olds had an increased odds of choosing "strongly agree" to these statements (3-fold and 10-fold, respectively); differences in self-efficacy was especially strong in parents of 12 month olds.



An abstract based on the evaluation component of the program was accepted for a platform presentation at the Pediatric Academic Societies meeting (considered the premier annual national pediatric research meeting), and was presented at the American Academy of Pediatrics Presidential Plenary in May 2018; a manuscript describing the findings is now in progress.

At CBWCHC, there have also been annual meetings with health care providers to keep them engaged and review core concepts related to the delivery of the Greenlight intervention. During these meetings, updates were provided to providers regarding findings from the program evaluation to date and feedback was obtained to inform future program improvements (each meeting involved participation of 7-10 physicians and 5-9 ancillary staff (e.g. health educators, nurses, nutritionists)).

Over the past year, all the Greenlight booklets have also been updated to incorporate the most recent American Academy of Pediatrics recommendations (in particular, related to recent updates to screen time and juice recommendations). The Simplified and Traditional Chinese booklets were also reviewed and revised for accuracy, clarity, and readability. The main Greenlight website was launched in July 2018 (<https://www.greenlight-program.org/>), and houses the Greenlight booklets as well as additional resources for parents, including an interactive activity that allows parents to identify questions and review answers related to diet- and nutrition-related topics. The Chinese version of the website is currently being built, with a plan to launch in spring 2019.

Plans

As part of the 2019-2021 CSP, we plan to reach over 2000 children and parents/families, by continuing to implement the Greenlight early child obesity intervention at the Manhattan Chinatown site of the Charles B. Wang Community Health Center and the Family Health Center's Seventh Avenue site in Brooklyn, delivering the intervention to underserved, low-income Chinese-American families through health care providers at well-child visits in the primary care

Participating families have been enthusiastic about the program:

- Many families at CBWCHC return to their native country within the first year of their child's birth. Some of these families have requested to bring whole sets of booklets (core & supplements) back with them to help maintain healthier eating habits and activity for their child.
- A few primarily English-speaking parents have asked for booklets in both Chinese and English to facilitate the sharing of Greenlight information with older family members at home; these family members are often the ones who take care of the child when the child's parents are at work.
- Parents who are participating in Greenlight have recommended the program to others in the waiting room.

setting, and through health educators as part of the associated waiting room program. This will include continued, routine engagement and training of providers at these sites (training/informational sessions annually at minimum, and more frequently, if needed). We will also continue to provide Greenlight materials to CBWHC's two Flushing, Queens sites.

In addition, we plan to enhance the reach of Greenlight through technology enhancements, including exploring how to promote the use of and expand Greenlight website resources, as well as leveraging social media platforms to make Greenlight messages accessible to more families.

We will also explore implementation of the Greenlight program, including the waiting room component, at other Family Health Centers at NYU Langone sites, beginning with the Sunset Park location (in years two and three), which serves a predominantly low-income Hispanic population. Our Greenlight materials are already culturally adapted and translated for use with Spanish-speaking families, and this will allow us to further expand the reach of the Greenlight messages to another population known to be at-risk for the development of obesity in early childhood.

The intermediate goals of our project relate to improving parent/family knowledge, attitudes and practices related to their child's diet and physical activity (e.g. less juice/sugary snack/junk food consumption, increased physical activity, decreased screen time), and increasing parents' confidence/empowerment related to the care of their child, with a long term goal of reducing child weight trajectories and child overweight/obesity. We also seek to increase staff/provider knowledge and engagement, as well as improve provider use of recommended health communication practices during well-child visits.

Over the upcoming 3 years, we will continue to monitor delivery of Greenlight materials at the CBWCHC site, which is being documented in the electronic health record system, including provider/health educator counseling, booklet delivery, tangible tool provision, and goal-setting; weight/height data is also being tracked in the EHR. At the CBWCHC site, we will complete the follow-up of the cohort of 200 parent/child dyads (previously enrolled as infants and followed at their 6, 12, 24, and 36 month well-child visits) during Years 1 and 2. This will allow us to look at improvements in child diet- and activity-related knowledge, attitudes, behaviors, and outcomes, as well as parent confidence/self-efficacy, at the time points in which the children have reached 2 and 3 years of age. We will continue to track provider/staff knowledge, engagement and satisfaction during this time. During Year 1, recognizing that the cohort will be completing their 24 and 36 month assessments and that the program evaluation will be ending, we will begin to explore alternate methods to track child diet- and activity-related outcomes, with a plan to build this into the health educator/waiting room program in Years 2 and 3, so that surveillance at the site can continue in a less intensive fashion. Over the 3 years, however, we will continue to track child BMI Z-scores and overweight status using data collected from the EHR, allowing us to assess the impact of the intervention on rates of overweight/obesity.

At the Seventh Avenue site, during Year 1, we will enroll a new cohort of 200 parent/child pairs that we will follow at their 6, 12, 24, and 36 month well-child visits. This will allow us to evaluate the program in this new setting, which serves predominantly low-income immigrants from Fuzhou, in southern China, an especially vulnerable population. Our program evaluation will allow us to look at child diet- and activity-related knowledge, attitudes, behaviors, and outcomes in this unique group; we will also obtain height/weight data from the EHR so that we can look at program impacts on weight status over the 3 years of the Community Service Plan.

Providers and staff will also be surveyed at the start and end of the 3 years to assess knowledge, engagement, and satisfaction. We will also explore the feasibility of tracking delivery of the Greenlight program and Greenlight materials in the electronic health record.

E. REACH FAR Brooklyn: Racial and Ethnic Approaches to Community Health for Asian and Arab Americans in Brooklyn

Asian Americans experience a large burden from cardiovascular disease (CVD), hypertension and diabetes, with substantial variation in prevalence rates across subgroups, particularly South Asian populations. Certain Asian American subgroups also report poor nutritional practices, further elevating CVD risk. Studies have demonstrated low medication adherence in some Asian American subgroups, a critical component of diabetes and hypertension management. Each of these risk factors is further exacerbated by barriers to accessing culturally and linguistically appropriate care and tailored health information for Asian Americans. Similar risk factors have been documented in Arab American communities, though there is a paucity of research on this population due to limitations in local and federal data collection race and ethnicity standards.

Although diabetes and hypertension prevention and self-management programs that enable lifestyle changes and enhance linkage to healthcare have been shown to be an effective method of promoting prevention and control of these chronic conditions, there is a lack of culturally tailored programs to promote diabetes and hypertension prevention and management and existing programs are limited in their sustainability and scalability.



Our program, Racial and Ethnic Approaches to Community Health for Asian and Arab Americans in Brooklyn (REACH FAR Brooklyn) recognizes the important role that faith- and community- based organizations can play in improving the health of immigrants and racial and ethnic minority populations. REACH FAR Brooklyn partners with mosques, social service agencies, and primary care settings in Brooklyn neighborhoods with substantial concentrations of South Asian and Arab American communities to improve cardiovascular risk factors (including obesity, hypertension control, and diabetes management) and promote healthy eating.

Specifically, we:

- Enhance and promote systematic and sustainable linkages to culturally and linguistically tailored community- and clinically-based resources to improve diabetes and hypertension prevention and management in South Asian and Arab communities;
- Implement reinforcing and integrated evidence-based approaches to improve access to environments promoting nutrition in South Asian and Arab communities by introducing education and changes to communal food practices in faith settings; and

- Enhance City-wide campaigns on by disseminating culturally tailored communications and education on CVD risk reduction to Brooklyn South Asian and Arab communities.

Progress and impact

REACH FAR Brooklyn builds upon our team’s success in implementing culturally tailored community-clinical linkage program for Asian Americans and other immigrant communities over the past several years.

With support from the Centers for Disease Control, REACH FAR has worked with community partners (United Sikhs, DREAM Coalition, Korean Community Services, and Kalusugan Coalition) and 12 faith-based organizations to increase access to healthy food and beverage options and deliver culturally and linguistically appropriate health coaching for management and prevention of high blood pressure in Asian American communities. As part of this effort, REACH FAR



has adapted Keep on Track, an evidence-based train-the-trainer program developed by the NYC Department of Health and Mental Hygiene, to screen, monitor, and provide counseling to people with high blood pressure. REACH FAR activities are supported by a comprehensive social marketing campaign to raise awareness of hypertension prevention and treatment and to promote hypertension screening events at faith-based and other organizations. REACH FAR has also culturally adapted and disseminated materials on hypertension and nutrition created by the New York City Department of Health and Mental Hygiene and the Centers for Disease Control Million Hearts initiative and distributed these materials in a variety of community venues such as health care settings, grocery stores, restaurants, and faith-based and community-based organizations.



As a result of these efforts, Keep on Track has been implemented in 18 faith-based organizations and CBO settings across NYC, and established a trained cohort of 19 faith-based organizations leaders and CHWs in these settings. Additionally, the REACH FAR Coalition has worked closely with NYCDOHMH to scale and implement diabetes prevention and diabetes management program in South Asian communities over the past four years, offering a prime opportunity to enhance referral to and support sustainability mechanisms for existing programs

As part of the Community Service Plan, beginning in 2015, we partnered with two mosques on the Lower East Side, Manhattan – Assafa Islamic Center and Madina Masjid – and two mosques

in Sunset Park, Brooklyn – Muslim Community Center and Jame Mohammadia – to extend the REACH FAR program. Specifically, our efforts were designed to improve blood pressure control and promote healthy eating using a three-pronged approach: (1) implementing the Keep on Track program in mosques within our CSP’s catchment area; (2) implementing nutritional strategies, including education and changes to communal food practices; and (3) providing culturally tailored communications and education.

Assafa has a total of 1500 congregants and average weekly attendance at Friday Jummah prayers of 250 congregants. Madina Masjid has a congregation of 2000 and average weekly attendance at Friday Jummah prayers of 400 congregants. Muslim Community Center has a congregation size of 500 and average weekly attendance at Friday Jumma prayer is about 200. Jame Mohammadia has a congregation size of 200 and average attendance at Friday Jumma prayer is about 100.

To implement the Keep On Track program, REACH FAR’s community health workers trained 24 volunteers from these four mosques. These 24 volunteers are now providing free monthly blood pressure screenings and basic hypertension reduction and management strategies to the mosque congregants. Close to 400 mosque congregants received free blood pressure screening and consultations from the Keep on



Track volunteers. From all four mosques, a total of 207 Keep on Track baseline surveys were collected. Participants were followed up at 6-months at all four sites and 12-months follow-ups were conducted at Madina Masjid and Assafa Islamic Center, with ongoing 12-month data collected at MCC and Jame Mohammadia to be collected in February, 2019. Preliminary results from baseline and 12-month Keep on Track data at Assafa and Madina (n=25) show that mean systolic blood pressure (SBP) decreased from 128.8 at baseline to 120.2 at 12 months ($p=0.027$). Mean diastolic blood pressure (DBP) decreased from 79.0 at baseline to 77.3 at 12-months ($p=0.415$). BP control (using cutoff of 140 for SBP and 90 for DBP) was 72% at baseline and 80% at 12-months ($p=0.508$). Health related self-efficacy (range of 1-4, 4=highest self-efficacy) also increased between baseline and 12 month follow-up; the mean score increased from 3.46 to 3.74 ($p=0.002$).

The program has also implemented nutrition strategies at all four mosques:

- During the month of Ramadan, REACH FAR community health workers conducted six nutrition workshops, reaching about 1,000 congregants, where they discussed easy ways of adopting healthy foods;
- Program staff held more than 50 fruit distribution events at these sites, as a way to introduce different foods and to interest people in the program;
- Staff provided individual counseling on healthy eating and distributed healthy messages; and

- Culturally tailored health materials such as approximately 250 plate planners, and 80 Keep on Track booklets were distributed.

Mosque leaders warmly hosted the events and provided assistance throughout.

A total of 153 cross-sectional surveys were collected from four mosque sites at baseline; to date, a total of 97 follow-up surveys have been collected from two sites with remaining follow-up surveys will be collected by May, 2019. Survey participants are predominantly men (99%), reflecting the demographics of the mosques' congregations. Preliminary results found improvements in self-reported measures related to health and healthy food availability. At baseline, 28.9% participants responded "very good" or "excellent" to the question "How healthy is your overall diet", and at the 12-month follow-up, 32.3% responded "very good" or "excellent" ($p=0.637$). At baseline, 13.5% of the respondents agreed with the question "It is difficult to choose healthy food options served at my mosque," while at follow-up, 8.5% agreed ($p=0.298$). For the question "The meals at my mosque do not serve healthy options," at baseline, 21.1% agreed with this statement, and at follow-up, 8.5% agreed ($p=0.021$). Additionally, at baseline, 83.9% reported that fruit was always or usually available, compared to 89.7% at 12-month follow-up ($p=0.297$).

As a result of congregants' enthusiastic response to our monthly fruit distribution events, Madina Masjid is now sponsoring free fruits on a Friday each month. We plan to encourage the other three mosques to follow this example by continuing and sustaining this programmatic piece.

Recognizing that program participants face an array of health issues and barriers, REACH FAR staff have connected congregants to community resources as well as providing the following services directly:



- Health insurance enrollment;
 - A total of six health insurance information and outreach events held at the mosques and about 250 members received health insurance related information. 12 people were enrolled into NY State of Health Insurance Marketplace by the staff members who are also certified IPA/Navigators
- Smoking/tobacco use cessation;
 - One of the staff members received training on smoking cessation assistance and provided direct assistance to mosque members who smoke.
- Diabetes prevention and control activities and group exercise sessions.
 - Staff led periodic group physical activity sessions at the mosques as well as diabetes management workshops.

The program activities and health information were disseminated through two ethnic media newspapers. Each newspaper has about 10,000 weekly circulations. In addition, through their

own social media channels, two of the four mosques disseminated information, reaching about 10,000 viewers.

Plans

Building upon the success of Keep on Track implementation through REACH FAR and our previous CSP-supported efforts, in year one of this Community Service Plan, REACH FAR Brooklyn will work with the two additional mosques in Brooklyn. Brooklyn Islamic Center is one of the largest mosques in Brooklyn, providing religious services for over 1,500 predominantly South Asian congregants per week. The



mosque provides Koranic classes, a youth leadership program, monthly family gatherings, and social and spiritual services. On a Friday Jummah prayer, it has an attendance of about 250 congregants. We will also work with Darul Jannah Jame Masjid, which has a congregation size of about 1000, with about 200 people attending Friday Jummah prayer. In years two and three, we plan to extend the reach of the program by engaging two additional mosques serving the South Asian and Middle Eastern community: Al-Aman Masjid and Baitul Jannah Masjid.

Working with mosque leadership, we will identify a health champion or committee, administer a baseline survey and organizational assessment and then collaboratively develop a plan to: (1) introduce policies and practices regarding serving healthy foods during communal meals or enhancing existing menus to incorporate healthy meal options (e.g., lower fat dairy products, serving brown rice); (2) implement a volunteer-led blood pressure screening program (using the Keep on Track model); and (3) support program efforts with a communication strategy to inform community members about program activities and to increase awareness of the risk of cardiovascular disease. All program elements will be monitored to track progress, fidelity and satisfaction, as well as behavior change.

We also plan to build on a related program: the DREAM Initiative, a National Institute of Health-funded program that is testing the effectiveness of a culturally tailored community health worker intervention to improve diabetes prevention and management outcomes in South Asian communities. Five of the 20 participating community-based primary care practices are located in Brooklyn, serving more than 5,000 patients with diabetes or pre-diabetes. The initiative is guided by input from community-based organizations in Brooklyn, including Council of People's Organizations, serving 13,000 primarily South Asian clients annually; Arab American Family Support and Resource Center, serving 20,000 clients annually; and Bangladeshi American Community Development and Youth Services, serving 7,500 clients annually.

Our plan over the next three years is to increase linkages to evidence-based diabetes prevention and management programs by: 1) increasing referral from faith-based organizations to existing culturally tailored diabetes prevention and management programs offered in community

settings in Brooklyn; and 2) in partnership with DOHMH, training faith-based leaders and CHWs to implement these tailored programs in faith-based organizations and CBO settings where current programming does not exist. In the first year, we will:

- Conduct an assessment and environmental scan of existing diabetes prevention and management program tailored for the South Asian and Arab communities currently offered in Brooklyn;
- Develop a referral network to diabetes prevention and management classes including those offered by DREAM Initiative CHWs; and
- Offer culturally tailored nutrition and physical activity demonstrations and videos at CBO and faith-based sites.

During Years 2 we will establish a new diabetes prevention or management program in at least one new site in Brooklyn. In Year 3, we will disseminate information about available program through ongoing outreach efforts.

IV. Programs, Progress and Plans: Promoting Healthy Women, Infants and Children

A. ParentChild+

The two critical aspects of young children’s early literacy – social-emotional development and language development – are challenged when a child lives in a home environment that is stressful, unpredictable, or unstimulating. The ParentChild+ (PC+ - formerly known as the Parent-Child Home Program), a national, evidence-based early literacy, parenting and school-readiness program serves low-income immigrant families in Sunset Park.

PC+ makes a significant difference in the lives of in-need young children and their families by:

- Building positive parent-child verbal and non-verbal interaction;
- Developing and promoting positive parenting skills;
- Developing early literacy skills that are essential for school readiness; and
- Enhancing the child’s conceptual and social-emotional development.

The program provides intensive home visiting to families who are challenged by poverty, low levels of education, language and literacy barriers and other obstacles, and with children between the ages of two and four years old. PC+ families participate in two, 30-



minute home visits per week over a two-year period, and receive educational materials to support positive interactions and development.

A trained Home Visitor brings a book or educational toy as a gift for the family and uses it to model, for the parent and child, play, verbal interaction, and reading activities that help to create a language-rich home environment.

PC+ meets all the best practice criteria set forth in the most recent research: it is an early intervention/prevention model; it focuses on early literacy both within a social-emotional and cognitive/language development context; and it emphasizes parental responsibility. It also honors each family's culture, uses developmentally appropriate books and toys, connects the family with the local school district and other community agencies to address family support needs, and emphasizes the importance of training and supervision of Home Visitors. Services are delivered in the home languages of the families by staff that reflect the cultures and languages of participants. The program's design and activities also reduce risk factors associated with child abuse, maltreatment and neglect, and introduce or increase protective factors.

The evidence base for PC+ is strong. Studies have consistently documented from pre- to post-program participation an increase in warm, responsive and steady routines and interactions in participating families. Research has also consistently found that program children enter school with the requisite social-emotional skills to be successful in a classroom environment. Child participants out-perform at-risk control or comparison groups on various cognitive measures and close the achievement gap with middle-class children. Randomized controlled trials have also demonstrated cognitive benefits for toddlers immediately after program participation.

The Family Health Centers at NYU Langone leads this program, supporting staffing, resource development, design and implementation. Additional partners, such as IncludeNYC, provide parent workshops on critical early childhood topics, such as understanding children with different abilities and guided play; partners such as Bank Street College of Education provide staff development opportunities on topics including supporting language development for emerging bilinguals.

Families are referred to an array of organizations, agencies, and providers to access needed services. For example, through a medical-legal partnership between Family Health Centers at NYU Langone and Her Justice, women in the program have access to free legal services related to custody, divorce, domestic violence, and immigration. Partners, such as the Sunset Park Early Learning Network, also support the expansion of quality early childhood services throughout the Sunset Park community.

Here's what participants said about ParentChild+ in 2018:

- For me the program is very good as it helps us parents to spend time with our children.
- This is a very good program. I am learning how to be calm and patient when my child gets upset.
- The program has helped me understand my children. I am learning to be patient and I am learning to encourage my children to read.

Progress and impact

ParentChild+ joined the Community Service Plan in September 2017. In the 2017-2018 program year, the program served 52 families with the following activities:

- 2,443 home visits were completed;
- 618 developmentally-appropriate books were provided to families;
- 567 developmentally-appropriate educational toys were provided to families;
- 7 family-learning trips were offered;
- 2 family celebration events were held; and
- 22 parent workshops were offered.

From the beginning of the 2017-2018 program year to the end of the 4th quarter, the program operated at 100% capacity, retaining all families. The 2018-2019 program is also fully enrolled. We attribute this strong performance to the program's leadership team and its commitment to supervision and professional development, the program's fidelity to the evidence-based model, and a focus on culturally representative program staff.



The program uses two validated tools – Parent and Child Together (PACT) and Child Behavior Traits (CBT) – to assess the frequency with which parents and children demonstrate specific desired behaviors as observed by staff during the visits. These behaviors are related to the program's three overarching outcomes – parent-child interaction, social-emotional development of the child, and pre-literacy skills – all of which are essential components of the child's school readiness. Baseline assessments

are conducted at the beginning of each program cycle and are used to customize the support given to each family. Assessments are re-administered at the end of the program cycle to ensure families have acquired sustainable skills that will impact the entire family and to measure outcome attainment from the beginning of the program.

The 16 families that graduated from the two-year intervention in 2018 showed substantial progress. At the end of the program, 13 of the 16 parents frequently or always demonstrated positive parenting behaviors in home visits, compared to only 4 at the start of the program. Twelve of the 16 participating children frequently or always demonstrated school-readiness skills in home visits at the end of the program, compared to only 1 child at the beginning.

Plans

Over the next three years, ParentChild+ will support 84 Sunset Park families. Through their participation in the program, they will receive 1,932 home visits, 924 educational toys, and 1,008 books. The program plans to retain 90% of enrolled families for the two-year duration. At the end of the two-year intervention, enrolled parents will consistently demonstrate increased knowledge and awareness of child development and increased use of positive parenting techniques, while children will demonstrate improved social and emotional development, indicating increases in school-readiness.

B. Video Interaction Project

The Video Interaction Project (VIP: www.videointeractionproject.org) is an evidence-based parenting program developed by faculty at NYU Langone and NYC H+H/Bellevue that uses videotaping and developmentally-appropriate toys, books and resources to help parents utilize pretend play, shared reading, and daily routines as opportunities for strengthening early development and literacy in their children. VIP sessions take place in pediatric clinics on days of routine well-child visits, and at each session families meet individually with an interventionist for approximately 25 minutes.

Background

Decades of research all point to the same conclusion: Poverty causes significant barriers to a child's scholastic success and reduces opportunities for early learning and educational achievement. These poverty-related gaps (disparities) in achievement originate in infancy and continue into early childhood and grow wider over time in the absence of intervention. Even when academic and behavioral-mediation programs are successful, they nonetheless place great burdens—financial and otherwise—on parents, schools, and society. Approximately 50 percent of disparities in school achievement in children of low-income families can be traced to fewer opportunities for early learning activities with parents, including: reading aloud, play, talking, and teaching. Although a host of programs exist to support early learning through enhanced parenting, few of them have VIP's level of evidence and cost remains a barrier for widespread dissemination. NYU Langone Health pediatricians and psychologists have developed an early-childhood intervention aimed at reducing educational achievement gaps before children reach the classroom in a way that is sustainable, cost-efficient, and scalable. In addition, there has been significant interest in VIP over the past several years by multiple stakeholders in NYC, including the city government, public service agencies, foster care agencies, health care providers and administrators at potential sites.

The Challenge

As more than two in five children in the United States grow up in poverty or in low income families, poverty-related disparities in learning and achievement represent one of the most important problems facing society at this time. While the causes of disparities in learning are complex, it is well established that readiness to learn – demonstrated by capacity to pay attention and control behavior, attainment of early reading and math skills, among other indicators – is already greatly reduced for children growing up in poor or near-poor households

by the time they enter school. The early onset of disparities and high cost of remediation suggest the need for effective programs that can prevent problems with behavior and learning before they emerge. Children's early experiences from birth to five years of age play a critical role in shaping their brain development. Differences in these experiences are an important cause of developmental disparities for children growing up in poverty and near-poverty. In particular, such children have reduced experiences with positive parenting activities such as reading aloud, playing, talking, and teaching. Lack of exposure to these activities may account for half of the disparities present at school entry. As such, promotion of these activities is an important focus for early, preventive intervention.

The Video Interaction Project

VIP's core mechanism for promoting positive parenting activities is to engage and empower parents during pediatric primary care visits by making a video-recording of each parent and child interacting together using a toy or book provided by the program. Immediately after the recording is made, a VIP Facilitator watches the video with the parent to highlight and reinforce interactions that have been shown in scientific studies to advance development. The combination of practice during the interaction and self-reflection following the interaction empowers parents to consider and to value their role in fostering their child's development. It also provides parents with the confidence and skills to engage in activities that will foster child development in the home.



VIP occupies a very distinct and critically important niche in the context of broad policies to address disparities. Specifically, VIP addresses the following gaps and key needs:

- 1) Addressing parenting challenges and developmental problems prior to their emergence ("primary prevention");
- 2) Engaging all poor and low-income households through pediatric primary care visits; and
- 3) Providing families with the confidence and skill to engage in behaviors supporting child development.

A VIP Facilitator meets with each family for 25-30 minutes in one-on-one sessions at the time of every well-child visit from birth to 5 years. Using the proven effectiveness of video playback, the VIP Facilitator works with the parent to increase confidence and skills in interacting with his/her child. During each session:

- The family is provided with a developmentally-appropriate toy or book to take home, giving the family access to materials that facilitate rich interactions.
- The VIP Facilitator leads a discussion about child development, suggests activities, and promotes goal-setting and planning with the parent.

- After about 5-10 minutes of discussion regarding parent activities and the child's development, the parent is videotaped playing and/or reading with the child and then given a guided review of these interactions.

VIP brings together three separate disciplines – pediatrics, developmental psychology, and early childhood education – and has been refined and tested in the context of two separate randomized controlled trials at NYC Health+Hospitals/Bellevue with a third randomized control trial in progress. As a result, VIP has among the strongest evidence bases



for any primary prevention, health care based program and seeking to address poverty-related disparities in school readiness. Findings to date include large impacts on positive parenting activities (reading aloud, teaching, talking, playing together), reduced harsh parenting, enhanced coping with parenting (reduced parenting stress, depressive symptoms), enhanced parent-child relationships, and enhanced development (across domains, but most strongly for social-emotional development with reductions in hyperactivity and attention problems sustained into school entry).

Progress and impact

The Video Interaction Project (VIP) was added to the Community Service Plan in September 2018. It is being implemented at the Sunset Park Family Health Center following an implementation protocol developed in collaboration with Community Resource Exchange. The protocol includes a 3 year startup period, beginning with development of processes to align with practice flow, and ramping up of families seen. In addition to delivery of 1:1 VIP implementation, the program will develop linkages and synergies based on work performed at other sites, including through the New York City Council City's First Readers program and based on programs currently available at the Sunset Park Family Health Center. These include: Healthy Steps, Reach Out and Read, ParentChild+, and the Brooklyn Public Library, and other programs as appropriate. In the current plan, evaluation will take place utilizing existing surveys and visit documentation tools, and will include documentation of both engagement and pre-/post-measures as appropriate. We will also assess the feasibility of and need for more formal evaluation and/or research plans. During 2018-2019, the program will reach 20-40 families.

Plans

Over the next three years, the Video Interaction Project will continue to refine the program implementation. The program will work with practice leadership, providers and staff to align pathways and processes for referral and implementation within the practice flow, and establish and maintain linkages with the Sunset Park Family Health Center and community programs. The program will deliver one-on-one VIP sessions to 450-650 parent/child dyads during the 2019-2021 Plan.



C. Project SAFE

Project SAFE prevents unintended pregnancy and the spread of STDs and HIV/AIDS through evidence-based interventions within a youth development framework that builds upon the existing strengths of young people. Project SAFE has been providing teen leadership, culturally appropriate sexual health information and services, and HIV peer education programming at the Project Reach Youth (PRY) site in Brooklyn since 1989. The program provides youth ages 13 to 24 with the support and the opportunities to avoid risky behaviors and to develop to their full potential and become agents of change in their communities.

Project SAFE is informed by a youth development approach, focusing on building participants' strengths and assets and increasing their exposure to positive relationships and experiences. This approach is based on the Search Institute's identification of 40 positive supports and strengths that young people need to succeed and research indicating that the greater the number of assets youth possess, the more likely they are to experience positive outcomes and the less likely to engage in risky behavior.

The program model includes evidence-based sexual health workshops, peer-led health education groups and community events, sexual health services designed to meet the unique needs of adolescents, and workshops for youth workers and parents.



Progress and impact

Multi-Session Workshop Series

Project SAFE works with partners to provide pregnancy prevention workshops to youth in underserved communities in Brooklyn. The program utilizes two evidence-based sexual health curricula that have been shown to increase knowledge and eliminate or reduce risky sexual behaviors – [Be Proud! Be Responsible \(BPBR\)](#) and [4Me!](#). Topics covered during the seven-session workshop series include pregnancy and STD/HIV prevention, as well as confidence, pride, and respect-building activities. Since September 2016, Project SAFE has facilitated 89 cycles of BPBR and 4Me!, reaching a total of 2,277 youth in 26 high schools, community-based organizations, and high school equivalency programs. New partnerships developed since September 2016 include Grand Street Settlement, Good Shepherd Services, Wingate Campus (4 schools), Brooklyn College Community Partnership (3 sites), EBC High School, Brooklyn Frontiers High School, Nelson Mandela High School, Benjamin Banneker Academy, and P. S. 371, an alternative high school in Sunset Park. Program evaluations have shown that, as a result of the workshops, most participants know more about how to protect themselves from pregnancy or STIs and are more likely to practice safer sex or abstain from sex (97% and 89% respectively, as reported on a post workshop survey). Eighty-five percent of workshop participants completed at least 75% of workshop sessions.

Peer Education Groups

Youth who complete the workshop series transition into the Project SAFE Teen Health Council, an introductory peer health education group. In the Teen Health Council, peer educators learn the basics of workshop facilitation, community event planning, and outreach strategies, while engaging in activities that focus on community and group connectedness. After completing the semester-long Teen Health Council, teens can then transition into one of the advanced peer education groups. Facilitated by an adult project facilitator and a peer leader, the groups offer a variety of ways for youth to have a positive impact in their community. Since September 2016, Project SAFE has recruited and trained 192 Peers Educators. The current groups include:



- *Theater:* Peer educators create and perform pieces that explore issues of safer sex, gender, culture, identity, and HIV/AIDS prevention using movement, poetry, and drama;
- *Media, Outreach and Branding:* Peer educators use social media, such as Instagram, Snapchat, Facebook, and YouTube, to reach high-risk youth and provide sexual health education;
- *Ambassadors:* Youth are trained to facilitate sexual health workshops for their peers at schools and community events;

- *Social Activism:* Participants select a reproductive justice issue and, with the guidance of a facilitator, initiate a project (such as a workshop or social media campaign) to address the issue.

The goal is for at least 70% of Teen Health Council participants to move to an advanced peer education group. While the overall retention for the 2016-2018 cohorts was below the target (58%), the retention for the 2017-2018 academic year was 70%. Teens participating in peer education groups from 2012-2015 demonstrated statistically significant increases in: frequency of condom use; HIV knowledge; knowledge of HIV status; and knowledge of STD status. In addition, participants demonstrate increases in school connectedness and self- efficacy, which have been shown to be protective factors against HIV infection.

In 2018, the Project SAFE Peer Educators were featured on the New York Times Podcast, *The Daily*, discussing issues of consent.

Community Events and Single-Session Workshops: Throughout the year, peer educators and Project SAFE staff work collaboratively to produce a series of community events to promote teen sexual health. The events typically include performances from the arts-based groups and an open mic session in which guests and community members can perform. Most of the community events also offer on-site HIV testing and promote teen health services available through Project SAFE and other community organizations. The post-event and post-workshop surveys were redesigned and piloted in fall 2017/winter 2018 to better align with program design, context, and goals.

Since September 2016, Project SAFE has hosted or performed at 41 community events, reaching 2,018 youth. The events consistently receive overwhelmingly positive feedback and young people report high likelihood of attending future Project SAFE community events and recommending events to friends (100% of participants who completed surveys). Additionally, 80% of participants who completed a survey indicated that they were likely to utilize a Project SAFE Teen Clinic in the future.

Project SAFE also offers single-session peer-led sexual health workshops. Since September 2016, we have reached 1,180 young people through 39 single-session sexual health workshops. Of workshops facilitated since the roll out of the revised post-workshop survey, 86% of participants who completed a survey left knowing the core HIV concepts from the workshop, 98% of participants who completed a post-workshop survey reported good or excellent HIV knowledge after the workshop (compared to 56% before the workshop) and 85% indicated they would use one of our Teen Health Clinics in the future.

Teen Health Clinic: Project SAFE partnered with the Family Health Centers to establish the Teen Health Clinic, refining systems to be as teen-friendly as possible and providing young people with a health care experience tailored to their needs. The Project SAFE Teen Health Clinic offers youth a non-judgmental, personal approach to sexual health, with a teens-only waiting room and a staff, including Project SAFE staff and peer educators, who are trained to use an empowering, strengths-based approach. The clinic addresses the barriers youth experience in accessing sexual health services such as stigmatization, fear of parental disapproval, and lack of

access to confidential health coverage. The clinic offers a full range of sexual health counseling and clinical services. Since September 2016, 455 teens received STI testing and other services at the Teen Health Clinics in Park Slope and Sunset Park. Over 2,000 teens were screened for pre- and post- HIV exposure prevention needs (PEP and PrEP) at the Teen Health Clinics, workshops, and community events.

Workshops for Youth Workers and Parents:

Talking with youth about sex can be challenging. Project SAFE provides workshops and other support to youth organizations and parents to make these conversations easier. The *Let's Talk about Sex* workshop covers basic principles of Motivational Interviewing, tips for starting the conversation, and making referrals to sexual health services. Since September 2016, seven workshops were provided to 34 youth workers and parents from Brooklyn College, John Jay Campus High School, and Project SAFE.

Here's what teens said about Project SAFE programs in 2018:

- Project SAFE is like a home where I feel like myself. I've learned plenty here about sex education and also about myself. I can come here for help when I most need it.
- The community is very welcoming and it helps me learn a lot/ it also helps me with feeling safe and knowing I have people.
- The program actually made me aware and knowledgeable about HIV and safe sex, plus they do fun activities and there is interaction with other students.

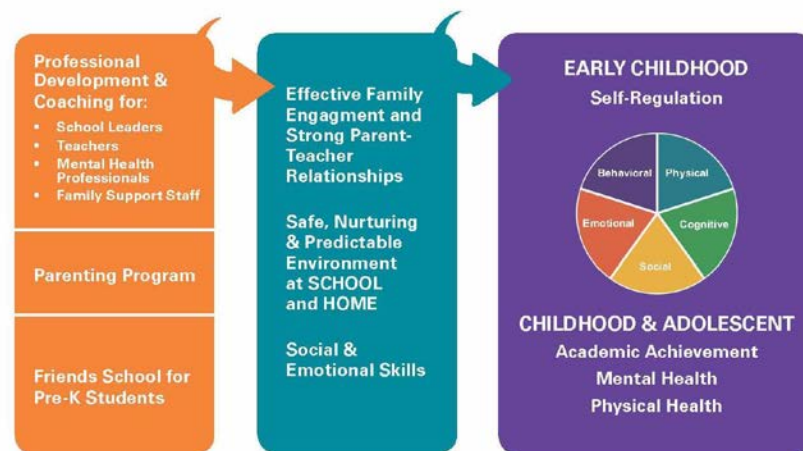
Plans

Over the next three years, Project SAFE will reach over 5,000 teens. Project SAFE plans to work with high schools connected to Family Health Centers at NYU Langone school-based health center sites, reaching an anticipated 3,855 teens through 156 workshop series cycles. The program will use an additional evidence-based intervention [*Making Proud Choices!*\(MPC\)](#), which has been shown to increase the consistency and frequency of condom use 3, 6, and 12 months after the intervention. Peer educators and staff will facilitate 78 single-session workshops, reaching an anticipated 1,562 teen participants. Teens will host or perform at 17 community events over the next three years, reaching approximately 831 of their peers with core pregnancy, STD, and HIV/AIDS prevention and resource messages. One hundred and fifty two new teens will move from the Teen Health Council to advanced peer education groups. To support protective factors against HIV such as educational achievement, Project SAFE will establish biannual college and career panels for peer educators. Panelists will include Project SAFE alumni with varied academic and professional backgrounds. The events will be designed to provide youth with insight into the details of each field and help students to envision their future as college students and professionals. The program will reach 18 youth workers and parents through 125 single-session workshops.

Screenings will remain a core part of the program. Building on efforts to provide comprehensive HIV prevention services, Project SAFE will begin to administer substance abuse screenings. It is anticipated that through Project SAFE workshops, community events, and the Teen Health Clinic: 586 teens will receive HIV screenings; 3,855 teens will receive PrEP and PEP screenings; and 750 teens will receive substance abuse screenings. Teens will continue to be connected to appropriate community resources and services.

D. ParentCorps

Faculty and staff at NYU Langone Health's Center for Early Childhood Health and Development (CEHD) have developed, delivered, evaluated, and continuously improved interventions to meet the needs of NYC pre-kindergarten students and their families for more than two decades. ParentCorps, a family-centered, evidence-based intervention developed by CEHD faculty, aims to help parents and early childhood teachers to develop authentic relationships and to create safe, nurturing and predictable home and classroom environments in support of children's learning, behavior and health. ParentCorps is implemented in partnership with school district and Pre-Kindergarten (Pre-K) program leaders as an enhancement to Pre-K in historically disinvested neighborhoods, centering racial equity and the voices of people of color throughout all aspects of implementation. For families facing a multitude of challenges including poverty, racism, discrimination and immigration-related stressors, ParentCorps has the potential to serve as a trusted and safe place of learning, cultural connection, and community building, providing a foundation to enhance social capital and meaningful relationships among parents and between schools and families. ParentCorps includes three components to help teachers and parents create environments that are safe, predictable, and nurturing for children:



- A 14-week Social-Emotional Development Curriculum implemented by classroom teachers in all pre-K classrooms;
- A 14-week Parenting Program for all families of pre-K students facilitated by school-based mental health professionals; and
- Professional Development for school leaders, pre-K teachers, mental health professionals, and parent support staff, including weekly coaching for pre-K teachers and mental health professionals to support high-quality program implementation.

Two randomized controlled trials found that ParentCorps works as intended to promote self-regulation in early childhood by strengthening adult capacity to support children's skill development. Specifically, ParentCorps impacts important aspects of the home and classroom environments, including increased knowledge and use of effective practices (such as setting clear expectations, positive reinforcement) and more nurturing adult-child interactions. ParentCorps also strengthens family engagement as perceived by both parents and teachers. ParentCorps impacts social-emotional development in Pre-K and prevents the development of mental health problems, including both emotional and behavioral problems, through second grade. ParentCorps leads to improved academic achievement by the end of kindergarten and that impact is sustained through second grade. In addition, for children who enter Pre-K without strong behavior regulation skills, ParentCorps reduces early behavior problems and prevents the development of obesity and unhealthful behaviors through second grade. A

benefit-cost analysis indicates that ParentCorps has the potential to yield cost savings of more than \$2,500 per student. In sum, this robust evidence of long-term impact across parent and child outcomes suggests a promising strategy to promote health and development and reduce racial and income disparities in health and education.

Progress and impact

Through the Community Service Plan, ParentCorps has partnered with the University Settlement Society, a large social service agency with three early childhood sites, and with the Earth School, an elementary school located on the Lower East Side.

Since September 2016, ParentCorps has provided Professional Development to 160 teachers, teaching assistants mental health professionals, social workers and administrators. In addition, site-based mental health professionals have implemented thirty 14-session series of the Program for Parents in English, Spanish, Mandarin and Cantonese, reaching 555 families. ParentCorps has translated and adapted manuals and materials so that they are culturally relevant for the participating families.

All three sites at University Settlement implemented Friends School in Pre-K classrooms, with ongoing support and coaching from the ParentCorps team. Friends School has been implemented in 45 classrooms since 2013, serving 583 students. A total of 38 teachers and mental health professionals received weekly coaching by ParentCorps to ensure high quality implementation and high levels of fidelity.

University Settlement Society

University Settlement is one of New York's most dynamic social service institutions with deep roots on the Lower East Side. Each year University Settlement's diverse programs help over 30,000 low-income and at-risk people build better lives for themselves and their families. With an impressive legacy as the first settlement house in the United States, University Settlement has been an incubator for progressive ideas for over 125 years, offering pioneering programs in early childhood education, literacy, mental health, arts education, and adolescent development that set the standard. From its earliest days, University Settlement has invested in a robust range of early childhood services, including education, mental health care, early intervention, childcare and arts and recreation. Today, University Settlement's early childhood programs directly support nearly 1,600 New York City children each year.



Parents and caregivers who participated in the Parenting Program were asked to complete short feedback forms on their experience and their use of strategies and tools after each session. Ninety-two percent of the parents indicated that their overall experience in the sessions over the 14 weeks was “Very Good” or Excellent”. More than 95% of parents indicated that they felt supported and valued by the group members and that they felt comfortable sharing their concerns. Additionally, more than 95% of parents indicated that the sessions helped

them feel better and more confident about themselves as parents and that the topics helped them reach their goals for their child. Eighty-nine percent of the families across all programs reported trying the strategies in the prior weeks.

ParentCorps has been partnering with the Division of Early Childhood Education in the NYC Department of Education as part of the Pre-K Thrive initiative. Since the launch of Pre-K for All in 2014, New York City has been committed to ensuring high-quality Pre-K programming for all four-year old children and to develop and sustain professional development for Pre-K professionals working with this population. NYC Pre-K Thrive is part of ThriveNYC, a citywide initiative to support the mental health of all New Yorkers. One of these initiatives is to provide a specialized professional learning track, Thrive Pre-K Professional Learning, to Pre-K teaching teams, to promote evidence-based practices for family engagement and social emotional learning. ParentCorps is providing Thrive Professional Learning for 350 Pre-K for All programs (350 leaders and about 3000 teachers) and professional learning to all Early Childhood Education Social Workers, who support all 1850 Pre-K programs.

The materials and lessons learned through implementation as part of the Community Service Plan have enriched the ParentCorps team’s capacity in delivering Professional Learning with teachers, assistants and leaders from district schools and centers. Additionally, the ParentCorps Fun with Feelings cards, which provide a playful way for families to help children learn about feelings and support social emotional skill-building at home, have been translated into all official 10 languages within the NYC Department of Education. This was built off the work in translating and adapting materials for the Community Service Plan. The cards have been distributed to all Pre-K for All programs and families in NYC since spring 2017. Program efforts at this time also include public-private partnerships to scale and evaluate ParentCorps including three randomized controlled trials in nearly 200 Pre-K programs in New York City.

Here’s what parents said about how the ParentCorps programs were helpful to them:

- I think that this program is AWESOME. I think more schools should have it.
- I’m happy. Overall, I think that it’s a great thing for the bigger picture. Better parents, better kids, better society/community.
- It has helped me to apply better parenting, positive strategies and stay consistent with it.
- It has helped me try different strategies to help understand, and discipline my children.
- Made me a better parent.
- Nice to know others have similar issues, bonding with other parents, sharing strategies.
- It is helpful to remind me of the strategies that have worked in the past, but are forgotten. Good to meet and hear the strategies and concerns of other parents, to know we have things in common.
- Very helpful. Loved being able to communicate with my kids and have more understanding.
- I think it is very important because parenting is hard and here I learned a lot about dealing with the negatives and challenges that come with being a mother.



Plans

For this next phase of the CSP, we will continue our long-standing partnership with University Settlement, assisting and supporting high-quality early childhood programs on the Lower East Side and in Brooklyn. In addition, we plan to build on the considerable public and private investments in ParentCorps to develop and provide enhanced evidence-based and culturally relevant digital products to New York City Department of Education Pre-K for All programs within Sunset Park, Brooklyn.

Since 2016, the Department of Education's Division of Early Childhood Education (DECE) has invested in both the scale up of ParentCorps and the development of evidence-based, culturally relevant policies, practices and products. ParentCorps is currently operating in 50 Pre-K for All programs across all five boroughs, with the largest number of programs in Brooklyn. To reach and serve more programs, DECE contracted with CEHD to develop a range of services and products based on ParentCorps, including the Thrive Professional Learning series and the Fun with Feelings Cards.



The NYC DOE, like school districts all over the country, seeks digital solutions to providing greater reach of existing services and products and improving uptake and use. Given these demands from school districts, and as CEHD is preparing to scale ParentCorps in other geographies, we have engaged colleagues from the Department of Population Health's Digital Learning Lab to conduct a comprehensive digital needs assessment for ParentCorps implementation in NYC and across the country. We completed this assessment in December 2018, and we are now working toward building the ParentCorps technology platform and prioritizing products to be developed and activities for the next two years.



As part of the Community Service Plan, we will prioritize the needs of the Sunset Park community as we develop digital solutions to improve ParentCorps and Thrive uptake and use. In Year 1, we will conduct a series of needs assessments across the 31 Pre-K for All programs in Sunset Park, with focused user assessments in 10 pre-K programs (10 leaders, 30 teachers, 30 families). The goal is to understand how the programs and families are engaging with

existing ParentCorps and Thrive services and products, and to determine where there are opportunities to improve uptake and use of services and products through digital solutions. These activities will inform the specific digital products and solutions that CEHD will develop in Year 1, and distribute and assess in Years 2 and 3.

We envision that the users will be primarily pre-K program leaders, administrators, mental health professionals and teachers; we will consider digital solutions for families as a secondary application. Digital solutions may include webinars and other digital professional learning resources for school personnel; facilitated learning communities for school personnel; editable surveys to assess family needs; a library of short videos that could be shared with families; and editable materials for engaging families.

V. Cross-Sector Capacity Building Initiatives

A. Brooklyn Health & Housing Consortium

The Brooklyn Health & Housing Consortium (BKHHC) formed after a year-long assessment of the health and housing needs of the Sunset Park and neighboring areas in Southwest Brooklyn, completed in early 2018. Working closely with colleagues who created the Bronx Health & Housing Consortium, we are following a similar model for establishing a Consortium in Brooklyn.

With an initial focus on Southwest Brooklyn, we invited members of area hospitals and community based organizations to join the BKHHC Steering Committee to set the mission, goals and priorities for the Consortium. The first meeting was held in June 2018, and the Committee has met quarterly since then. The mission of BKHHC is to be a collaborative network of healthcare, housing, and community providers with the shared goal of improving health equity by fostering relationships, developing infrastructure, and building capacity to support people with health and housing needs. Current member organizations of the Steering Committee are: Breaking Ground, CAMBA, Riseboro Community Partnership, Enterprise Community Partners, NYU Langone Health, NYU Brooklyn PPS, the Family Health Centers at NYU Langone, Maimonides Medical Center, New York-Presbyterian/Brooklyn Methodist Hospital, NYC Housing Preservation and Development, Empire BlueCross BlueShield HealthPlus, and the Bronx Health & Housing Consortium.

Working with the Office of Government and Community Affairs at NYULH, we have met with representatives at the Brooklyn Borough President's Office to brief them on the work of the Consortium and have attended Community Board 7 committee meetings related to housing and homelessness.

The goal of the Consortium is to improve outcomes for vulnerable people in Brooklyn with overlapping health and housing needs. BKHHC will achieve this goal in the following ways:

- Expand understanding of the healthcare, housing, and related needs of people in Brooklyn;
- Build relationships with stakeholders serving a shared population;
- Share, develop, and advocate for resources; and
- Create sustainable models for health and housing partnerships.

The priorities areas of the Consortium are to:

- Develop a shared best practices screening tool for homelessness and housing instability

- Convene stakeholders working on this issue (hospitals, DOHMH, the Department of Homeless Services, H+H, housing advocacy groups);
- Agree to standard housing assessment (VA questions, PRAPARE, etc.) that includes attention to eviction prevention;
- Identify when the assessment will be completed (e.g. intake, registration, triage, assessment, discharge) and by whom (e.g. registrar, social worker, case worker, nurse, doctor, discharge planner); and
- Establish documentation process (Z codes, EMR and/or RHIO alerts, CBO case management systems, etc.).
- Increase understanding and coordination across sectors and organizations
 - Trainings; and
 - Events/activities to build relationships (e.g., interagency case conferences, Housing Marketplaces, Hospital Open House, CBO site visits).
- Serve as a convening platform for community level discussions on medical respite
- Keep abreast of other health and housing initiatives to avoid duplication, share learning, promote best practices, and bring successful efforts to scale
- Develop an advocacy platform to expand the quality and availability of services, and the supply and affordability of housing

Progress and impact

The BKHHC has already made significant headway on a number of our priority areas. Over the past year-and-a-half, we have:

- Held two trainings in partnership with the Legal Aid Society: Preventing Evictions (9/26/18; 28 attendees) and Overview of Family Homelessness and Eviction Prevention Supplement (FHEPS; 11/7/18; 27 attendees);
- Organized three case conferences focused on communication and work flow between hospitals and shelters/safe havens/supportive housing organizations on 10/17/18 (21 attendees), 11/28/18 (15 attendees), and 1/16/19 (17 attendees);
- Drafted communication/responsibilities flow chart; participants included: NYULH, Maimonides Medical Center, Kings County Hospital, NYP/Methodist Brooklyn, Breaking Ground, CAMBA, Riseboro, Bronx Health & Housing Consortium; and
- Set priorities for 2019 and beyond.

Evaluations collected at each of our events indicate widespread satisfaction with the trainings, with the great majority of participants rating them as “Excellent” or “Good.” Additional trainings requested include: “Housing resources for undocumented residents,” “Homeless services 101,” “Health and housing issues of formerly incarcerated,” “Rental arrears assistance,” “Disability SSI/SSDI,” and “Dementia care and support.”

In addition, in January 2019, we collaborated with the Bronx Health & Housing Consortium on the Hospital Homeless Count, which is conducted on the same night as the Department of Homeless Services’ Homeless Outreach Population Estimate (HOPE) Count. The Hospital Homeless Count supplements the HOPE Count with a survey of unsheltered homeless people in hospital emergency departments (EDs). The Brooklyn Health & Housing Consortium assisted by establishing contacts in Brooklyn hospital EDs that had not previously taken part in the Hospital Homeless Count. We also conducted outreach to our stakeholders and community partners to

encourage people to sign up to volunteer to conduct the surveys in Brooklyn EDs. A number of members of our Steering Committee also took part.

Plans

As we have continued to expand our network and reach out to new partners, awareness of the Consortium is growing and we have extended our reach beyond Southwest Brooklyn. Over the next three years, we will:

- Work with partners to offer a series of new trainings related to health and housing and make them widely available to interested hospital and CBO staff members in Brooklyn;
- Continue holding case conference meetings to work on the flow chart to improve communication between shelters and hospitals regarding homeless clients' visits to hospitals;
- Use the case conferences to identify common issues and concerns and invite representatives from the Department of Homeless Services to engage in a dialogue about how these issues can be addressed;
- Participate in the annual HOPE Count by working with Brooklyn hospitals to count homeless patients in the emergency room on that night ("Hospital Homeless Count," led by the Bronx Health & Housing Consortium);
- Conduct a medical respite needs assessment among partner hospitals in Brooklyn in order to estimate the number of homeless and housing-insecure patients who could be discharged if medical respite beds were available;
- Convene a group of policymakers and health care and housing/homeless organizations to develop coordinated approaches to screening for housing insecurity and referral; and
- Continue to work with government officials and policymakers to keep them informed about our work and to find areas for collaboration to address housing as a social determinant of health.

B. Community Health Worker Research and Resource Center

With overarching twin goals of improving health for all and reducing health inequities, NYULH – through Community Service Plan projects and other programs – has developed, implemented and evaluated a portfolio of initiatives that employ community health workers (CHWs).^{*} Relying on these frontline health workers who are trusted members of their communities, these programs, whether in clinical or community-based settings, seek to enhance care, link services, improve community health, address social determinants of health, and build community leadership and capacity. Because of their shared life experiences with the communities they serve, CHWs are well-positioned to provide culturally relevant care and health coaching for community members that face significant health disparities and barriers to care.

Our CHW initiatives are located in a range of settings: community- and faith-based organizations, primary care practices, senior centers, barbershops and hair salons, low-income

^{*} As used here, CHWs refer to frontline health workers who are trusted members of their communities with a shared life experience with the patients/clients they serve. Other titles include Lay Health Workers, Peer Navigators/Counselors, Health Coaches/ Educators, Practice Facilitators.

housing. They are culturally tailored to address the needs of diverse populations and they have addressed a wide array of medical and socioeconomic issues: housing insecurity, food insecurity, job readiness, substance/alcohol use disorder, tobacco cessation, hypertension, cardiovascular disease, diabetes, nutrition, cancer, hepatitis B, sleep apnea-related metabolic syndromes, medication adherence, and mental health.



Our CHW programs work across multiple levels of impact, including addressing individual health behaviors, fostering social and interpersonal support, and addressing policy, systems, and organizational levels. Our work in diverse neighborhoods in New York City and our international portfolio have allowed us to develop a deep expertise in the development and evaluation of CHWs programs tailored to the specific needs of immigrant and minority communities, thus offering models of care to reduce health disparities across diverse populations.



Drawing on this deep experience, over the past year, we have established the CHW Research and Resource Center (CHW-RRC) to serve as a resource to community-based organizations, health systems, municipal agencies, and research organizations that are planning, or seeking to strengthen, CHW initiatives. In addition, by engaging in rigorous research

and evaluation we seek to build the knowledge base of this field, identifying and disseminating findings about what models work under what circumstances and for which populations. Our vision is to build a resource that creates and shares cutting edge knowledge and evidence to help inform the design, implementation and evaluation of CHW programs to improve health, reduce health inequities, and recognize and help build community capacity and leadership.

Progress and impact

Beginning in the fall of 2017, a stakeholder group has met on a regular basis to develop a mission and vision for the CHW-RCC and to set priorities. The group includes clinicians, researchers, staff and CHWs from across the NYULH community. In the first year, the focus has been on developing a CHW Learning Community, which has an in-person and online component, to provide opportunities for professional development and social support.



Advised and led by a CHW Learning Committee with a rotating membership of seven CHWs, the CHW Learning Community has hosted events, trainings, and workshops to build a strong community of CHWs across programs. The online component of the Learning Community is designed to allow CHWs to stay connected in between in-person meetings and function as an interactive Facebook-like website where members can contribute content, share (anonymized) stories, request advice, and post events on a calendar. Our plan is for the Learning Community to serve as a pilot and model for other groups of CHWs – to support and extend peer learning, to foster workforce development, and to help develop future leaders in the field of population health.



Over the past year, the Learning Community set priority activities for social support and professional development, including training on specific health topics (diabetes, mental health, intimate partner violence) and inviting speakers to talk about low-income housing and legal aide. The

group is also developing programs to strengthen professional skills related to preparing and giving presentations, professional writing, and train the trainer skills.

Plans

Over the next three years we will continue to grow the Learning Community, documenting and sharing the work as a potential model. We also plan to build out a Repository of CHW materials – the other core priority identified by the stakeholder group. This Repository is designed to support new and existing CHW programs, allowing users to upload and search for documents to help develop, implement and evaluate CHW programs (e.g., literature reviews, CHW job descriptions, program protocols, evaluation tools, etc.) Over the next three years, the CRC-RRC will collect, curate and expand access to tools, guides, and other materials in the following areas: strategic program planning; recruitment and hiring; training and development; and program management/monitoring. The Repository will be available for use within NYULH, by our community partners and by other health systems, municipal agencies, and research organizations that are planning, or seeking to strengthen, CHW initiatives.

Areas of technical assistance

Our work implementing CHW programs is supported by extensive experience in stakeholder-engaged protocol development, which allows us to develop programs that are relevant to the settings in which they will be implemented; data analysis, which allows us to identify need, target resources, and measure impact; community-based participatory research, which allows us to foster and learn from deep community partnerships; and mixed methods evaluation, including the development of innovative study design that can be used in applied practice settings and metrics that integrate physical health, economic stability, and other qualities of daily life to understand the impact of CHW programs in improving health and reducing cost.

In the coming years, we will also explore ways to provide technical assistance for program development and evaluation and plan to convene expert researchers and practitioner from across the country, as well as key international leaders, to discuss developments in the field and to identify and prioritize best practices and key unanswered questions.

C. Brooklyn Data Station

The Brooklyn Data station provides the infrastructure to support our several community health needs assessments, to target resources by identifying areas of need, and to monitor trends. Its focus is primarily in Sunset Park and Red Hook in Brooklyn, but the Data Station has also provided support for our needs assessments in the Lower East Side and Chinatown.

Progress

Over the past year, the Data Station has acquired data from multiple sources through a mix of publically available, specialized data use agreements, and special requests of aggregate summaries. This includes a number of public datasets: US Census Bureau American Community Survey; New York City Health Department Community Health Survey; New York City Department of City Planning property tax parcel records; and New York City Department of Education school-level enrollment and demographic records. These data have been used to describe the demographic, social, economic, housing, education and health in Sunset Park, Red Hook and Manhattan Community District 3. Housing and property data were also used to inform planning of Brooklyn Health and Housing Consortium. See Appendix D.

The Data Station has also helped facilitate and support specialized data use agreements or requests for data from City agencies.

Plans

The vision for the Data Station is that it will provide the infrastructure that supports our efforts to improve population health by turning data into action. When fully operational, the Brooklyn Data Station will include:

- Value added shared data and resource infrastructure, encompassing the spectrum from:
 - Data acquisition
 - Data repository
 - Data analytics
 - Data communication
- Governance structure for data access and use
- Knowledge networks (technical advisors; peer-to-peer resources)
- Translation and dissemination (communicating data findings to various audiences for action)

D. Red Hook Community Health Network

During 2017-2018, The Alex House Project, Family Health Centers at NYU Langone, Good Shepherd Services, NYU Langone Department of Population Health, Red Hook Community Justice Center, and the Red Hook Initiative designed and conducted a Community Health Needs and Assets Assessment (CHNAA). Over 20 Red Hook organizations and more than 600 people who live or work in Red Hook participated and helped identify opportunities to connect the community's strengths and needs to improve the health and wellbeing of Red Hook residents.

Progress and Impact

The Red Hook Community Health Needs and Assets Assessment was completed in fall 2018. The CHNAA team responded to needs as they arose throughout the process.

An existing education and home assessment program for people who have asthma and are on Medicaid was expanded to Red Hook. Materials about quitting smoking and lead exposure were also distributed to residents through CHNAA team organizations. During 2018-2019 we are



Welcome to Red Hook mural by Groundswell located at the corner of Hamilton Avenue and West 9th Street.

finalizing the structure for the Red Hook Community Health Network, including hiring a coordinator.

Plans

In year one of the CSP, the Network will plan and implement a collaborative initiative to address the needs identified in the CHNAA and to connect and strengthen community assets.

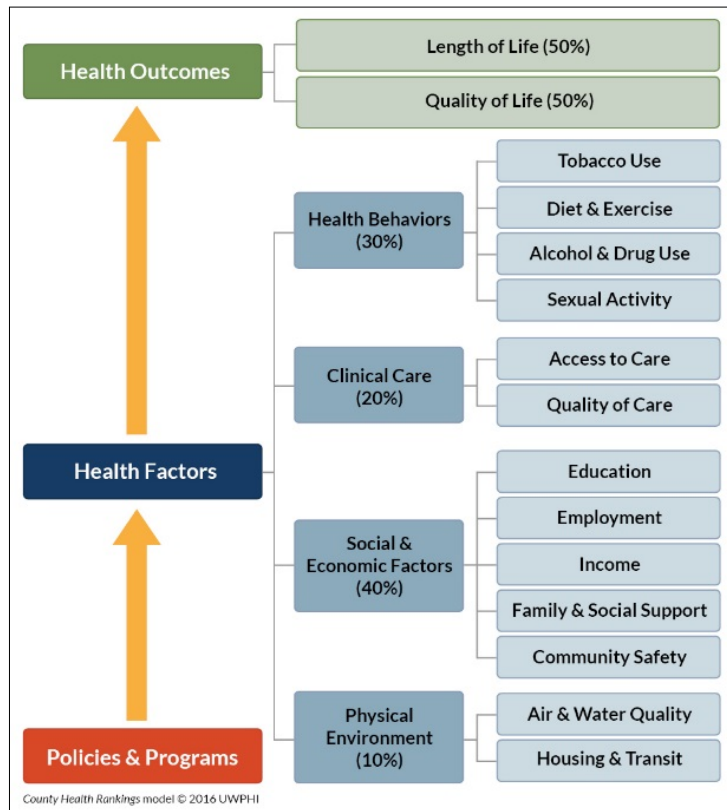
E. Addressing social determinants of health

County Health Rankings estimates that social and economic factors, such as education, employment, income, family and social support, and community safety, account for 40% of health outcomes, defined as the length and quality of life.

Two promising strategies to address the interwoven social, economic, and environmental factors that impact health and wellbeing are widespread screening in primary care settings, and “warm” connections to services.

For over three decades, Family Health Centers at NYU Langone have played an important role in Brooklyn by helping connect patients and community members to services provided by both the FHCs and its partners to address social determinants of health, including food insecurity, education, housing and environment, and economic stability.

The FHCs have piloted several efforts to integrate social determinant screening, referral and follow-up across FHC sites and a consortium of community agencies. Our experience aligns with that of other organizations implementing similar processes:



- Conducting broad-reaching screenings at a person’s point of entry (be it in primary care or community-based settings) can help support the whole person and family;
- Many community members have more than one need;

- People need assistance with navigating available community services both to prevent and to address crises;
- People are more likely to connect to services through timely, warm handoffs from a trusted staff member; and
- Both screening processes and services need to be culturally- and linguistically-appropriate.

Plans

Over the next year, we will continue to build the FHCs' capacity to integrate SDOH screening into the fabric of service delivery through information technology, workflow processes, and staff development. We will also investigate the viability of modifying the existing medical-legal partnership design to provide more culturally- and linguistically-tailored services for a larger suite of legal needs. Assuming feasibility, years two and three of the CSP will be dedicated to finalizing the initiative designs (including documenting the evidence base and anticipated impact and performance measures) and implementation.

F. Incubation fund

To foster new partnerships between NYULH and community based organizations and to provide an avenue to elicit input and new ideas, we are creating an incubation fund. A subcommittee of the Coordinating Council will develop an application and review process that encourages collaborative efforts to develop and implement evidence-based programs to address the priorities identified in our CHNA: [Preventing Chronic Diseases](#) and [Promoting Healthy Women, Infants and Children](#).

Apart from the programs outlined above, which are supported directly by NYULH as part of the Community Service Plan, NYULH has numerous community programs that address unmet community need. See *NYU Langone Health in the Community: 2017-2018*.

VI. Dissemination

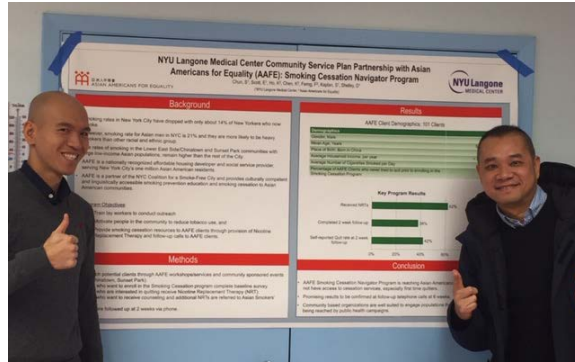
The Community Health Needs Assessment and Community Service Plan, together with our Progress Reports, are conspicuously posted on the NYULH internal and external websites with instructions for downloading and in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report. (<http://www.nyulangone.org/our-story/community-health-needs-assessment-service-plan>). An individual seeking access to these materials is not required to create an account or provide any personally identifiable information.

Hard copies of the Community Health Needs Assessment, Community Service Plan and Progress Reports are available without charge to anyone upon request and are regularly distributed to Community Board members, policymakers, local health centers, community-based organizations, community members, and other interested stakeholders. Through our outreach and engagement activities, we continually seek to keep the community informed about our activities and to get feedback and input. This year, we distributed the Red Hook Needs and Assets Assessment to over 50 people and organizations, including community residents,

policymakers, partners, community groups and colleagues. Additional data and materials are also publicly posted for broad public use (<https://redhookchnaa.wordpress.com>). Similarly, we shared the Southwest Brooklyn Health and Housing Needs Assessment with a large group of stakeholders and others who are interested in developing health and housing related initiatives.

The Executive Summary of our Community Health Needs Assessment and Community Service Plan (available here) shares our analysis and conclusions in a more accessible format for a broader constituency. This document, which is written at an 8th grade literacy level, has been translated into Arabic, Chinese, and Spanish.

In addition, information about Community Service Plan projects has been presented at conferences and in presentations to Primary Care Residents, medical students and undergraduate students, often in collaboration with community partners. We plan to conduct similar internal and external presentations for the 2019-2021 CHNA-CSP.



VII. Community Engagement

We have continued to engage our partners and the broader community through a variety of mechanisms with the objective of creating an infrastructure for the ongoing exchange of information and ideas and a platform for continued cross-sector work at the neighborhood level to address high priority public health issues. We embrace collaboration as the foundation of successful service development and implementation, and actively seek community involvement as part of our program management philosophy. These relationships have provided ongoing opportunities for interaction, including the joint development of programming.

The Community Service Plan Coordinating Council, composed of NYU Langone Health faculty and staff from across the institution, leadership and staff of our community partners, and other interested partners and policymakers, continues to meet every three months – now alternating



between the Manhattan and Brooklyn campuses of NYU Langone Health. The Council coordinates Community Service Plan projects, ensuring that they are meeting milestones, maximizing their impact, and fostering collaboration across institutions and sectors. We continue to find opportunities to learn and to work across projects and with colleagues throughout the institution and in the community. We also use this forum to distribute information about the NYULH Financial Assistance Policy.

Within the past year, a Network group has formed that includes faculty and staff (from within NYU Langone Health and from community partners), to explore cross-cutting topics, thus far

including: the use of photovoice, how to present quantitative and qualitative data to community members, survey development, recruitment techniques.

We also periodically invite outside speakers to the meetings of the Coordinating Council. Over the past several years, topics have included: reverse migration separation, affordable housing, *Overcoming Challenges to Mental Health Services for Asian New Yorkers*, precision medicine and social determinants of health, cancer screening outreach, and proposed changes to the Public Charge rule.

Members of the Coordinating Council also attend presentations of interest at the NYULH. Over a dozen leaders and staff from our community partners regularly attend the Department of Population Health's annual **Health and...** conference, which brings together leading investigators, policymakers, practitioners, and community leaders to better leverage the intersection between **Health and...** its many determinants.

Program and administrative staff participate in a broad range of place-based and issue-based networks to stay abreast of emerging needs and promising practices. We continue to meet with advocates, service providers, and community groups, including committees of Manhattan Community Boards 3 and 6, and Brooklyn Community Board 7 to provide regular updates and opportunities for input. See Appendix B for the list of these networks and agencies.

Finally, the joining of the Manhattan CSP with the CSP and other community-based programs in Sunset Park and now Red Hook continues to enrich the Community Service Plan across the institution. We have now integrated our efforts and deployed our collective resources and expertise to strengthen our programs.

VIII. Anticipated Impact and Performance Measures

The Coordinating Council will continue to oversee program implementation, work collaboratively to find points of synergy across programs and neighborhoods, and assess progress and make mid-course corrections. In addition, each program collects data about levels of participation, participant satisfaction, and impact on health and well-being. This is done through attendance records, surveys, and other forms of data collection. Attached as Appendix F is a table summarizing preliminary goals and performance measures, together with sources of data to be used to measure outcomes.

Appendices

- A. Data Sources and References Consulted
- B. Input from Persons Who Represent the Broad Interests of the Community
- C. Red Hook Needs and Assets Assessment
- D. The Southwest Brooklyn Health and Housing Consortium: Needs Assessment and Priorities in Sunset Park
- E. Evidence Base for Programs
- F. Anticipated Impact and Performance Measures

Appendix A

Data Sources and References Consulted

I. Secondary Data

500 Cities Project Data – Centers for Disease Control and Prevention

Health behaviors and health outcomes by census tract. Data obtained from:

- [NYU Langone Health – City Health Dashboard](#) (2015, two year modeled estimates)

American Community Survey - US Census Bureau.

Demographic, housing, health insurance, and socioeconomic factors by Public Use Microdata Areas (Community District approximations) and census tracts. Data obtained from:

- [US Census Bureau-- American Fact Finder](#) (2011-2015; 2013-2017)
- [NYC Department of City Planning – Population Fact Finder](#) (2006-2010; 2012-2016)

Community Health Survey – NYC Department of Health and Mental Hygiene

Health behaviors, health outcomes and access to care by race/ethnicity, neighborhood poverty and housing type. Data obtained from:

- [NYC Health Department – EpiQuery](#) (2002-2017)

Housing and Vacancy Survey – NYC Department of Housing Preservation and Development

Housing conditions such as presence of mice, rats or roaches; use of supplemental heat. Data obtained from:

- [NYC Health Department – Environment and Health Data Portal](#) (2014)

NYC Public Housing Residents – NYC Housing Authority

Number of residents living in public housing by neighborhood. Data obtained from:

- [NYC Health Department – Neighborhood Health Atlas](#) (2016)

Primary Land Use Tax Lot Output (PLUTO™) – New York City Department of City Planning

Residential housing units and tax parcel ownership. Data obtained from:

- [NYC Department of City Planning – PLUTO 17v1.1](#) (Jan 2018)

Rental Subsidies -- NYU Furman Center

Housing choice vouchers. Data obtained from:

- [NYU Furman Center – CoreData.nyc](#) (2009-2016)

Teen Births Vital Statistics – NYC Department of Health and Mental Hygiene

Teen birth rates by Community District. Data obtained from:

- [NYC Health Department – EpiQuery](#) (2014-2016)

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Appendix B

Input from Persons Who Represent the Broad Interests of the Community

Meetings with public health experts:

Agency	Attendees	Dates
Airnyc	<ul style="list-style-type: none"> ▪ Shoshanah Brown, Executive Director ▪ Enrico Cullen, Chief Strategy Officer 	June 2018
Asian Health & Social Service Coalition	<ul style="list-style-type: none"> ▪ Access Nursing Services ▪ Alzheimer's Association NYC Chapter ▪ Americare ▪ Asian American Community Consultation Assoc. ▪ Beth Israel Medical Center ▪ Cabrini Center for Nursing And Rehabilitation/td> ▪ Charles B. Wang Community Health Center ▪ Chinese- American Planning Council, Inc. ▪ Comprehensive Care Management Corp. ▪ FEGS ▪ Hamilton-Madison House, Inc. ▪ Heart to Heart Home Care ▪ Henry Street Settlement ▪ Isabella Home Care ▪ Lantern (Lupus Asian Network) Hospital for Special ▪ Magellan Health Services ▪ Manhattan Legal Services ▪ Mental Health Association of NYC/ Asian LifeNet ▪ New York Asian Women's Center ▪ New York Downtown Hospital ▪ NY Organ Donor Network ▪ NYS OMH - Creedmoor ▪ NYS - South Beach Psychiatric Center ▪ NYS EPIC Program (Magellan Health Services) ▪ University Settlement Society Of NY ▪ VNSNY 	Multiple meetings and communication
Asian Smokers Quitline (ASQ)	<ul style="list-style-type: none"> ▪ Shu-Hong Zhu, Principal Investigator ▪ Caroline Chen, Project Manager 	Multiple meetings and communication
Bronx Health and Housing Consortium	<ul style="list-style-type: none"> ▪ Bonnie Mohan, Executive Director ▪ Henie Lustgarten, Board President ▪ 	Multiple meetings and communication from 2017 to present

Agency	Attendees	Dates
Charles B. Wang Community Health Center	<ul style="list-style-type: none"> ▪ Regina Lee, Chief Development Officer ▪ Loretta Au, Chief of Pediatrics ▪ Perry Pong, Chief Medical Officer ▪ Maggie Wong, Coordinator of Marketing Programs ▪ Jin Lu, Nurse Practitioner ▪ Rachelle Ocampo, Associate Director of Health Education ▪ Michelle Chen, Health Educator ▪ Lucas Lao, Health Coach 	Multiple meetings and communication
Gouverneur Health	<ul style="list-style-type: none"> ▪ Mary McCord, Director of Pediatrics ▪ Peter Davidson, Director of Medicine ▪ Karyn Singer, ACO Lead Physician ▪ Primary Care Residents ▪ Public Health Advocates ▪ Migdalia Hernandez, Health Home Referral Coordinator ▪ Rafael Dominguez, Senior Director, Marketing & Engagement 	Multiple meetings and communication
Greater New York Hospitals Association	<ul style="list-style-type: none"> ▪ Lloyd Bishop, Senior Vice President, Community Health Initiatives and Government Affairs ▪ Staff from Community Affairs/Community Health ▪ Orville Francis, AVP for Finance 	Multiple meetings and communication including large meeting with leadership on June 18, 2018
Healthfirst/DOHMH Pediatric Bundle	<ul style="list-style-type: none"> ▪ Nora Chaves - Healthfirst ▪ Abby Velikov – NYC DOHMH 	Multiple meetings and communication
HIV Health & Human Services Planning Council of NYC	<ul style="list-style-type: none"> ▪ Multiple persons living with HIV/AIDS, service providers, and governmental representatives 	Multiple meetings
Maimonides Medical Center	<ul style="list-style-type: none"> ▪ Sara Kaplan-Levenson, Executive Director, Brooklyn Health Home ▪ Shari Suchoff, Vice President, Population Health Policy and Strategy ▪ Josh Schiller, Attending Physician, ED ▪ Jason Staum, Social Worker, ED 	Multiple meetings and communication from April 2017 to present
New York City Department of Education 0-3 Advisory Committee	<ul style="list-style-type: none"> ▪ Jessica Bialeci – Director of Policy – Division of Early Childhood Education ▪ Josh Wallack – Deputy Chancellor for Early Childhood Education 	Monthly meetings January 2018 to present

Agency	Attendees	Dates
NYCDOHMH Bureau of the Primary Care information Project	<ul style="list-style-type: none"> ▪ Sarah Shih, Assistant Commissioner Bureau of the PCIP ▪ Hang Pham Singer, Sr Director of Quality Improvement 	Multiple meetings
New York City Department of Health and Mental Hygiene	<ul style="list-style-type: none"> ▪ Shannon Farley, Bureau of Chronic Disease Prevention and Tobacco Control ▪ Pauline Ferrante, Community Liaison ▪ Victoria Grimshaw, Policy Analyst/Community Benefits Coordinator ▪ Jacqueline Kennedy, Partnerships for a Healthier NY ▪ Natalia Linos, Science Advisor ▪ Javier Lopez, Assistant Commissioner, Center for Health Equity ▪ Sarah Perl, Senior Advisor/Writer to the Commissioner ▪ Rishi Sood, Deputy Director of Policy, Bureau of Primary Care Access and Planning ▪ Ana Gallego, Director of Policy and Health Systems Analysis, Office of the First Deputy Commissioner ▪ Andriana Azarias, Senior Advisor, Special Projects ▪ Patrick Germain, Executive Director of Policy, Planning, and Strategic Data Use ▪ Xusana Davis, Director, Health & Housing Strategic Initiatives 	Multiple meetings and communication
New York City Department of Health and Mental Hygiene – Brooklyn Community Action Team	<ul style="list-style-type: none"> ▪ Molly Berman, Brooklyn Community Engagement Coordinator ▪ Staff representatives from: <ul style="list-style-type: none"> ▪ El Puente ▪ Peer Health Exchange ▪ CAMBA ▪ HEAT ▪ THEO ▪ North Brooklyn Prevention Coalition ▪ New York City Teen Connection ▪ Grand Street Settlement ▪ Bedford YMCA ▪ Bedford Stuyvesant Community Connections 	Monthly meetings
New York City Department of Health and Mental Hygiene –	<ul style="list-style-type: none"> ▪ Patrick Pagen <i>New York Knows</i> Project Officer ▪ Brooklyn Knows partners 	Monthly meetings

Agency	Attendees	Dates
Brooklyn Knows Steering Committee		
New York City Department of Health and Mental Hygiene – Brooklyn Knows Youth Subcommittee “Brooklyn United”	<ul style="list-style-type: none"> ▪ Patrick Pagen <i>New York Knows</i> Project Officer ▪ Youth and staff representatives from Community Healthcare Network, SUNY Downstate, Diaspora, Ali Forney 	Monthly meetings until fall 2017
New York City Department of Health and Mental Hygiene, Early Childhood Health & Development Unit - Division of Family & Child Health	<ul style="list-style-type: none"> ▪ Abigail M. (Jewkes) Velikov, PhD - Senior Director, Early Childhood Health & Development Unit; Division of Family & Child Health 	Multiple communications
New York City Department of Health and Mental Hygiene, Office of Faith-Based Initiatives	<ul style="list-style-type: none"> ▪ Borough of Brooklyn Interfaith Advisory Group High Blood Pressure Task Force, multiple organizations 	Multiple meetings and communication
New York City Department of Health and Mental Hygiene, Take Care New York (TCNY) Neighborhood Health Initiative Advisory Committee	<ul style="list-style-type: none"> ▪ New York City Department of Health and Mental Hygiene ▪ Jewish Community Center of Greater Coney Island ▪ Family Health Centers at NYU Langone ▪ Northwest Bronx Community & Clergy Coalition ▪ Project Hospitality ▪ Public Health Solutions ▪ Rockaway Waterfront Alliance ▪ Staten Island Partnership for Community Wellness ▪ Washington Heights CORNER Project 	Multiple meetings and communication
New York State Department of Health	<ul style="list-style-type: none"> ▪ Sylvia Pirani, MPH, Director Office of Public Health Practice 	Multiple meetings and communication

Agency	Attendees	Dates
New York State Medicaid Redesign – First 1,000 Days on Medicaid (New York State Department of Health, United Hospital Fund)	<ul style="list-style-type: none"> ▪ Suzanne Brundage, Director – Children’s Health Initiative of United Hospital Fund 	Multiple meetings and communication
NYS Office of Mental Health	<ul style="list-style-type: none"> ▪ Donna Bradbury, Associate Commissioner, Division of Integrated Community Services for Child and Families ▪ Presentation to Division (30 stakeholders) ▪ Presentation at all day conference: Innovative Practices in Prevention Science (policy makers, educations, NYS based government) 	<p>Multiple meetings and 2013 to present</p> <p>Two meetings on 9/2018 and 1/2019 with stakeholders in Albany</p> <p>Presentation to Division on 5/4/2016</p> <p>Conference presentation in Albany on 9/14/18</p>
NY Links	<ul style="list-style-type: none"> ▪ Multiple organizations associated with linkages to and retention in care and supports for Persons living with HIV/AIDS (PLWHA) in New York State 	Multiple meetings
<p>NYC Department of Education</p> <ul style="list-style-type: none"> ▪ Office of Family and Community Engagement, Division of Early Childhood Education (DECE) ▪ Data & Analytics ▪ Research & Policy Support Group (RPSG) 	<ul style="list-style-type: none"> ▪ Joshua Wallack, Deputy Chancellor, Early Education and Student Enrollment ▪ Jill Resnick, Executive Director, Family and Community Engagement, DECE ▪ Alyse Erman, Thrive Director, DECE ▪ Adrienne Dominguez, Senior Executive Director, Data & Analytics ▪ Jeff Kitrosser, Family Engagement, DECE ▪ Kate Rockey, Research Manager, RPSG ▪ Matt Snyder, Director of Team Organization and Special Projects, DECE 	Multiple meetings and communication
NYC Health + Hospitals	<ul style="list-style-type: none"> ▪ Kalpana Bhandarkar, Lead, Social Determinants ▪ Majorie Momplaisir-Ellis, Senior Director, DSRIP, OneCity Health ▪ Kacia Phillips, Social Worker, Kings County Hospital Center ▪ Rasaan Sanni, Social Worker, Kings County Hospital Center ▪ Nichola Davis, Assit VP Chronic Disease 	Multiple meetings from fall 2018 to present

Agency	Attendees	Dates
New York Presbyterian/Brooklyn Methodist Hospital	<ul style="list-style-type: none"> ▪ Nava Katz-Birnberg, Asst. Vice President, Process, Integration, DSRIP ▪ Wendy Ann Plaza, Social Worker 	Regular meetings from October 2018 to present
Providers of Health Care for the Homeless in New York City	<ul style="list-style-type: none"> ▪ Brightpoint Health ▪ Callen-Lorde Health Center ▪ Care for Homeless ▪ Covenant House ▪ Harlem United ▪ Housing Works ▪ ICL Health Care Choices ▪ Project Renewal ▪ New York Children's Health Project, a Program of the Children's Hospital at Montefiore & Children's Health Fund ▪ The Floating Hospital ▪ William F. Ryan Community Health Center 	Multiple meetings
United Hospital Fund	<ul style="list-style-type: none"> ▪ Gregory Burke, Director, Innovation Strategies ▪ Kristina Ramos-Callan, Program Manager, Program Initiatives ▪ Chad Shearer, Vice President for Policy; Director, Medicaid Institute 	Multiple meetings and communication

Meetings with community groups and community leaders :

Organizations	Attendees	Dates
ArchCare	<ul style="list-style-type: none"> ▪ Mashi Blech, Director, TimeBank ▪ Omayra Torres, Supervisor 	Multiple meetings and communication from January 2013 to present
Asian Americans for Equality	<ul style="list-style-type: none"> ▪ Chris Kui, Executive Director (former) ▪ Flora Ferng, Director of Programs ▪ Ken Ho, Program Coordinator ▪ Kenny Chen, Staff ▪ Ivy Au, Staff 	Multiple meetings and communication from September 2013 to present
Breaking Ground	<ul style="list-style-type: none"> ▪ Casey Burke, Program Director ▪ Ara Mendoza, Program Coordinator ▪ Eric Londregan, Clinical Coordinator 	Multiple meetings and communication from April 2017 to present
Brooklyn Borough President's Office	<ul style="list-style-type: none"> ▪ Italia Granshaw, Deputy Director of Policy and Planning ▪ Anthony Drummond, Policy Analyst 	Meeting on August 2018

Organizations	Attendees	Dates
Brooklyn College Community Partnership	<ul style="list-style-type: none"> ▪ Jeremy Goren, Program Manager 	Multiple meetings and communication
Brooklyn Family Justice Center	<ul style="list-style-type: none"> ▪ Center leadership and direct service staff 	Multiple meetings and communication
Brooklyn Pride	<ul style="list-style-type: none"> ▪ Leadership and staff 	Multiple meetings and communication
Brooklyn Public Library - Common Sense Panel on Media and Young Children	<ul style="list-style-type: none"> ▪ Rachel Payne – Brooklyn Public Library 	January 2018
CAMBA, Inc.	<ul style="list-style-type: none"> ▪ Joanne Oplustil, Executive Director ▪ Valerie Barton-Richardson, Executive Vice President ▪ Michael Erhard, Senior Vice President for Health and Housing ▪ Micheal Maffai, Senior Program Manager ▪ Carol Rubenstein, Vice President, Single Adult Shelter Service 	Multiple meetings and communication
Caribbean Women’s Health Association	<ul style="list-style-type: none"> ▪ Cheryl Hall, Executive Director 	Multiple meetings and communication
Center for Family Life, part of SCO Family of Services	<ul style="list-style-type: none"> ▪ Julia Jean-Francois, Co-Director ▪ Julie Brockway, Co-Director ▪ Helene Onserud, Program Director, PS 503/506 	Multiple meetings and communication
Chinatown Partnership	<ul style="list-style-type: none"> ▪ Wellington Chen, Executive Director 	Multiple meetings and communication from September 2013 to present
Chinatown YMCA Cornerstone @ Two Bridges Community Center	<ul style="list-style-type: none"> ▪ Chi Yung, Center Director (former) ▪ Kingsley Bofo, Associate Director (former) 	Multiple meetings and communication
Chinese American Medical Society (CAMS)	<ul style="list-style-type: none"> ▪ Jamie Love, Administrator 	Multiple meetings from September 2015; presentation at Annual Scientific Conference November 2015
Coalition of Asian American Independent Practice Association (CAIPA)	<ul style="list-style-type: none"> ▪ Peggy Sheng, Chief Operations Officer 	Multiple meetings and communication from January 2013 to present
Community Board 3 (Manhattan)	<ul style="list-style-type: none"> ▪ Susan Stetzer, District Manager ▪ Presentations to Human Services, Health, Disability and Seniors/Youth and Education Committee 	Multiple meetings and communication from September 2013 to present

Organizations	Attendees	Dates
Community Board 6 (Manhattan)	<ul style="list-style-type: none"> ▪ Health, Senior and Disability Issues Committee 	Annual meetings
Community Board 7 (Brooklyn)	<ul style="list-style-type: none"> ▪ Jeremy Laufer, District Manager ▪ Cesar Zuniga, Community Board Chair ▪ Multiple community residents, businesses and organizations 	Multiple meetings and communication
Delancey Street Associates/Essex Crossing	<ul style="list-style-type: none"> ▪ Katie Archer, Director of Community Relations 	May 2019
Diaspora Community Services	<ul style="list-style-type: none"> ▪ Carine Jocelyn, Chief Executive Officer 	Multiple meetings and communication
Earth School	<ul style="list-style-type: none"> ▪ Abbe Futterman, Principal ▪ Shirley Suarez, mental health professional ▪ Jocelyn Walsh, Parent Coordinator 	Monthly Meetings from September 2015 to March 2016
Empire BlueCross BlueShield HealthPlus	<ul style="list-style-type: none"> ▪ Osiris Marte, Health Promotion Manager ▪ Elizabeth Oudens, Chief Clinical Officer, Clinical Management ▪ Nandita Bali, Strategy and Program Dev. Director 	Multiple meetings and communication
Enterprise Community Partners, Inc.	<ul style="list-style-type: none"> ▪ Elizabeth Zeldin, Director 	Regular meetings from April 2017
Fifth Avenue Committee	<ul style="list-style-type: none"> ▪ Michelle De La Uz, Executive Director ▪ Jay Marcus, Director of Housing & Community Facility Development ▪ Aaron Shiffman, Executive Director, Brooklyn Workforce Innovations ▪ Marcela Mitaynes, Tenant Organizing & Advocacy Program Coordinator, Neighbors Helping Neighbors ▪ Aura Mejia, Neighbors Helping Neighbors 	Multiple meetings and communication
Good Shepherd Services	<ul style="list-style-type: none"> ▪ Kathy Gordon, Associate Executive Director ▪ Rachel Forsyth, Senior Director of Partnership Schools ▪ Shalini Schaeffer, Program Director 	Multiple meetings and communication
Grand Street Guild Resident Association	<ul style="list-style-type: none"> ▪ Daisy Paez, President (former) ▪ Sandra Strother, President (current) ▪ Members and residents 	Multiple meetings and communication from September 2015 to present

Organizations	Attendees	Dates
Grand Street Settlement	<ul style="list-style-type: none"> ▪ Willing Irene Chin-Ma, Associate Executive Director ▪ Leslie Capello, Early Head Start Director 	Multiple meetings and communication from September 2014 to present
Hamilton-Madison House	<ul style="list-style-type: none"> ▪ Joanne Hsu, Supervisor, Caregiver Services Program 	Meeting in 2018
Healthy Families New York Brooklyn Advisory Meetings	<ul style="list-style-type: none"> ▪ Brooklyn Perinatal Network ▪ Bushwick BrightStart Healthy Families at Public health Solutions ▪ Healthy Families Brookdale ▪ Healthy Families Successful Start at Bedford-Stuyvesant Family Medical Health Center ▪ NYCDOHMH Healthy Homes Program ▪ Safe Horizon Inc. ▪ Womankind 	Quarterly meetings
Healthy Village at Claremont - Pediatric Bundle Initiative	<ul style="list-style-type: none"> ▪ Claremont Neighborhood Center ▪ Healthfirst ▪ NYC DOHMH 	Multiple meetings and communication
Henry Street Settlement	<ul style="list-style-type: none"> ▪ Diane Rubin, Chief Program Officer (former) ▪ Ashley Young, Program Director of Henry Street Settlement's Neighborhood Resource Center ▪ Kristin Hertel, Deputy Program Officer of Health and Wellness 	Multiple meetings and communication
HER Justice	<ul style="list-style-type: none"> ▪ Amy Barasch, Executive Director ▪ Hamra Ahmad, Director of Legal Services 	Multiple meetings and communication
Hester Street Collaborative	<ul style="list-style-type: none"> ▪ Betsy MacLean, Executive Director ▪ Nisha Baliga, Director, Participatory Planning 	Multiple meetings and communication
Legal Aid Society	<ul style="list-style-type: none"> ▪ Sunny Noh, Supervising Attorney, Tenant Rights Coalition ▪ Caryn Schreiber, Staff Attorney, Brooklyn Neighborhood Office, Tenant Rights Coalition ▪ Meghan Walsh, Staff Attorney, Brooklyn Neighborhood Office, Tenant Rights Coalition 	Multiple meetings and communication from August 2018 to present
Local Initiatives Support Corporation (LISC) New York City	<ul style="list-style-type: none"> ▪ Emily Blank, Senior Community Development Officer 	Multiple meetings and communication

Organizations	Attendees	Dates
Council Member Carlos Menchaca's office	<ul style="list-style-type: none"> ▪ Ivan Valladares, Constituent Liaison 	Multiple meetings and communication
Mayor's Committee for Community Schools	<ul style="list-style-type: none"> ▪ Multiple organizations 	Multiple meetings and communication
Mixteca Community Organization	<ul style="list-style-type: none"> ▪ Karla Alvarez, Executive Director 	Multiple meetings and communication
NYC City Council Early Literacy Initiative (City's First Readers) (initiative of 11 early-literacy focused organizations across NYC; funded by NYC City Council)	<ul style="list-style-type: none"> ▪ Stephen Levin – NYC City Council – District 33 ▪ Antonio Reynoso – NYC City Council – District 34 ▪ Brooklyn Public Library ▪ Committee for Hispanic Children and Families ▪ JCCA ▪ Jumpstart Literacy, Inc ▪ Parent Child Home Program ▪ Queens Library ▪ Reach Out and Read of Greater New York ▪ United Way 	Multiple meetings and communication
New York City Housing Authority	<ul style="list-style-type: none"> ▪ Andrea Mata, Senior Manager for Community Initiatives ▪ Kim Truong, Community Coordinator 	Multiple meetings and communication
NYC Department of Housing, Preservation and Development	<ul style="list-style-type: none"> ▪ Vicki Been, Commissioner (former) ▪ Elyzabeth Gaumer, Housing Policy Research ▪ Elizabeth Greenstein, Director of External Affairs ▪ Jessica Katz, Assistant Commissioner, Special Needs Housing ▪ Ahuva Jacobowitz, Director, Division of Research & Evaluation ▪ Jessica Gomez, Program Director of Preservation Initiatives ▪ Jenny Weyel, Director of Neighborhood Stabilization 	Multiple meetings and communication
NYC Smoke Free	<ul style="list-style-type: none"> ▪ Deidre Sully, Director ▪ Ayodele Alli, Engagement Coordinator 	
New York Immigration Coalition	<ul style="list-style-type: none"> ▪ Claudia Calhoon, Director of Health Advocacy ▪ Max Hadler, Health Advocacy Specialist 	Multiple meetings and communication

Organizations	Attendees	Dates
NYU LH Latino Community Meeting	<ul style="list-style-type: none"> ▪ Brooklyn Public Library ▪ Center for Family Life ▪ Mixteca ▪ Salvation Army ▪ Samaritan Village The Healing Center New York 	Multiple meetings and communication
NYULH – Brooklyn Arab Community Advisory Council	<p>Board members, executive leadership, and staff from:</p> <ul style="list-style-type: none"> ▪ Arab American Association of NY ▪ Arab American Cancer Education & Referral Program (AMBER) ▪ Arab American Family Support Center ▪ Arab American Federation ▪ Arab Muslim American Federation ▪ Beit Al Maqdis Islamic Center ▪ Egyptian American Alliance ▪ Empire Blue Cross Blue Shield ▪ Islamic Society of Bay Ridge ▪ MAS Youth Center ▪ Memorial Sloan Kettering ▪ Moroccan American House Association ▪ National Arab American Medical Association ▪ Network of Arab-American Professionals of NY ▪ New Life Day Care ▪ Salaam Club ▪ Salam Arabic Lutheran Church ▪ Yemen American Association of Greater NY ▪ Yemeni Merchants Association 	Multiple meetings and communication
NYULH – Brooklyn Chinese Community Advisory Council	<p>Board members, executive leadership, and staff from:</p> <ul style="list-style-type: none"> ▪ Asian Community United Society ▪ Asian Health and Social Service Council ▪ Brooklyn Chinese-American Association ▪ Chinese American Independent Practice Association ▪ Chinese-American Planning Council ▪ Chinese Promise Baptist Church ▪ Chinese American Social Services Center ▪ CaringKind 	Multiple meetings and communication

Organizations	Attendees	Dates
	<ul style="list-style-type: none"> ▪ Health First ▪ Homecrest Community Services ▪ ElderServe Health Inc. ▪ Mannings 8th Ave Pharmacy, ▪ Visiting Nurse Service of New York 	
Opportunities for a Better Tomorrow	<ul style="list-style-type: none"> ▪ Lilita Polo-McKenna, Chief Executive Officer 	Multiple meetings and communication
Reach Out and Read of Greater New York – External Advisory Board	<ul style="list-style-type: none"> ▪ Leora Molgilner, Medical Director ▪ Laurie Williams, Director 	Multiple meetings and communication
Red Hook Community Justice Center	<ul style="list-style-type: none"> ▪ Ross Joy, Manager, Housing Resource Center ▪ Viviana Gordon, Deputy Director 	Multiple meetings and communication
Red Hook Initiative	<ul style="list-style-type: none"> ▪ Jill Eisenhard, Executive Director ▪ Catherine McBride, Director of Community Building ▪ Vanessa Nisperos, Director of Professional Development 	Multiple meetings and communications
RiseBoro Community Partnership	<ul style="list-style-type: none"> ▪ Chris Leto, Director of Outreach and Special Projects ▪ Hector Alicia, Community Engagement Specialist, Asthma Educator 	Multiple meetings and communication
Southwest Brooklyn Industrial Development Corporation	<ul style="list-style-type: none"> ▪ Ben Margolis, Executive Director ▪ Justin Collins, Director of Workforce Development 	Multiple meetings and communication
SUNY Downstate THEO Program BATES Planning Committee	<ul style="list-style-type: none"> ▪ Marian Searchwell, CAPP Coordinator ▪ Youth and staff representatives from CAMBA, HEAT, Project Ally 	Bi-monthly meetings
Sunset Park Early Learning Network	<ul style="list-style-type: none"> ▪ Multiple Sunset Park early childhood centers, family daycares, and home visiting programs 	Multiple meetings and communication
Sunset Park Shape Up NY Advisory Board	<ul style="list-style-type: none"> ▪ Community members ▪ Blue Cross/ Blue Shield ▪ Sunset Park Neighborhood Center ▪ The Healing Center ▪ United Senior Center 	Multiple meetings and communication
Sunset Park Roundtable	<ul style="list-style-type: none"> ▪ Academy of Medical and Public Health Services ▪ Atlas:DIY ▪ Center for Family Life ▪ Family Health Centers at NYU Langone ▪ Mayor’s Office of Immigrant Affairs 	Multiple meetings and communication

Organizations	Attendees	Dates
	<ul style="list-style-type: none"> ▪ Safe Horizons ▪ Theater of The Oppressed ▪ Turning Point ▪ UPROSE 	
The Alex House Project	<ul style="list-style-type: none"> ▪ Samora Coles, Founder and Executive Director 	Multiple meetings and communication
The Door	<ul style="list-style-type: none"> ▪ Various staff 	Multiple meetings and communication
Two Bridges Neighborhood Council	<ul style="list-style-type: none"> ▪ Francine Jean, Health & Wellness Program Manager 	Multiple meetings and communication
Two Bridges NYCHA Resident Association	<ul style="list-style-type: none"> ▪ Kenneth McIntosh, President ▪ Members and residents 	Multiple meetings and communication from September 2015 to present
University Settlement	<ul style="list-style-type: none"> ▪ Bonnie Cohen, Director of Family and Clinical Services ▪ Early childhood staff ▪ Mary Adams Managing Director of Mental Health Programs 	Multiple meetings and communication from September 2013 to present
Congresswoman Nydia Velázquez's Office	<ul style="list-style-type: none"> ▪ Melissa del Valle Ortiz, Community & Housing Coordinator 	Multiple meetings and communication
Wavecrest Management Grand Street Guild	<ul style="list-style-type: none"> ▪ Leadership team and building board and management 	Multiple meetings and communication from September 2015 to present
Zone 126	<ul style="list-style-type: none"> ▪ Anju Rupchandani, Director of Collective Impact ▪ School leaders and administrators 	Quarterly meetings 2015-2016

Other health organization partners:

AIDS Service Center NYC	Hamilton Park Nursing & Rehabilitation Center
Arthur Ashe Institute	Hatzolah of Boro Park
Be Well Primary Health Care Center	L'Refuah Health and Rehabilitation Center / Ezra Medical Center
Boropark Care Center for Rehabilitation and Health Care	Maimonides Medical Center
Bowery Residents Committee	Memorial Sloan-Kettering Center for Immigrant Health
Bridge Back to Life Center	Menorah MercyFirst
Brooklyn AIDS Task Force	Metropolitan Jewish Health System (Hospice)
Buena Vida Nursing Home & Rehabilitation Center	New Dimensions
Callen Lorde	Norwegian Christian Home and Health Center
Care for the Homeless	ODA Primary Health Care Network

Cerebral Palsy Association of NYS	Park Slope Center for Mental Health
Charles B. Wang Health Center	Pharmacy on Fifth
Coalition of Asian American IPAs	Premium Health Inc.
Cobble Hill Health Center	Ridgewood Bushwick Senior Citizens Council
Crown Nursing & Rehabilitation Center	Sephardic Nursing & Rehabilitation
Duane Reade Pharmacy	South Beach Psychiatric Services
Ezra Medical Center	SUNY Downstate Medical Center
Gay Men's Health Crisis (GMHC), Inc.	Visiting Nurse Service of NY
Guild for Exceptional Children	White Glove Community Care

Faith-Based Partners:

Bay Ridge Christian/ Sunset Park Community Church	Our Lady of Solace Church
Beit Al Maqdis	Sacred Heart – Saint Stephen Church
CHIPS	Salam Arabic Lutheran Church
Holy Spirit Church	Salvation Army, Sunset Park
Masjid Al Rahman	St. Agatha Church
Mogjid el Roham	St. Michael's Church
Muslim Community Center	St. Rose of Lima Church
Our Lady of Perpetual Help Church	Visitation of the Blessed Virgin Mary Church
Our Lady of Refuge Church	

School Partners:

PS 1	PS 169	MS 88
PS 2	PS 172	MS 136
PS 10	PS 179	MS 313
PS 12/ MS 484	PS 188	Abraham Lincoln High School
PS 15	PS 196	Boys & Girls High School
PS 18	PS 217	EBC High School for Public Service
PS 24	PS 282	Erasmus Academies
PS 28	PS 288	Frank J. Macchiarola Education Complex
PS 31	PS 307	High School of Telecommunication Arts and Technology
PS 38	PS 329	John Jay Educational Campus
PS 50	PS 335	Juan Morel Campos
PS 59	PS 352/ 375	South Brooklyn Community High School
PS 90	PS 369	South Shore Educational Complex
PS 92	PS 371	Sunset Park High School
PS 94	PS 503	Wingate Educational Campus
PS 96	PS 506	School District 15
PS 124	PS 971	School District 20
PS 153	IS 62	
PS 164	JHS 220	

Shelter Partners:

CAMBA
Bowery Residents Committee
Volunteers of America
HELP USA
Grand Central Neighborhood Social Services
Project Hospitality
Project Find
NYC Department of Homeless Services



RED HOOK COMMUNITY HEALTH

OCTOBER 2018

1

A Red Hook Community Health Needs and Assets Assessment (CHNAA) was conducted with support from the NYU Langone Health Community Service Plan. The assessment was planned by a team of six organizations: The Alex House Project, Family Health Centers at NYU Langone, Good Shepherd Services, NYU Langone Health Department of Population Health, Red Hook Community Justice Center, and the Red Hook Initiative.

More than 20 Red Hook organizations and more than 600 people who live or work in Red Hook participated in this collaborative, community-based project to get more information about:

- > Important health issues for the Red Hook community
- > Strengths and existing programs in Red Hook
- > Needed programs and services in Red Hook
- > Opportunities to connect the community's strengths and needs to improve the health and wellbeing of Red Hook residents

During the assessment process, the CHNAA team:

- > Looked at data from hospitals, the New York City Department of Health and Mental Hygiene, Red Hook organizations, and other agencies, and identified missing data needing further exploration
- > Collected additional information from people who live and work in Red Hook through dot voting, surveying, and small-group conversations
- > Identified strengths and existing programs and resources
- > Identified potential future actions to address top health concerns

THE RED HOOK COMMUNITY

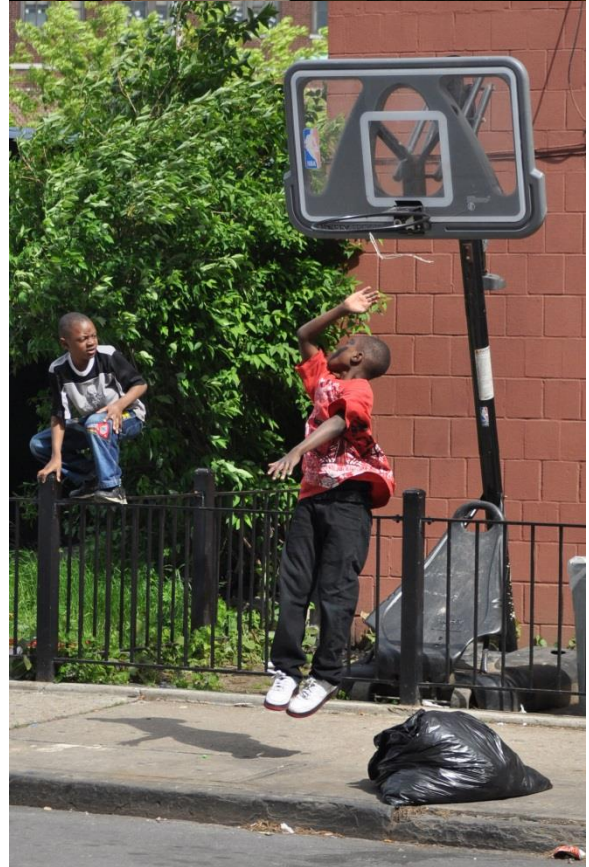
Red Hook residents are engaged. Approximately 1 out of every 5 survey and small group conversation participants provided contact information to stay informed about findings and next steps in the process.

Red Hook has a connected network of community-based organizations. 39% of community members rated community-based organizations as a top strength in Red Hook.⁹ Red Hook is home to a dedicated network of non-profits, arts and cultural organizations, religious institutions, and resident-led community building activities. This strong network is evident in the more than 20 organizations that helped recruit over 600 community members to participate in this assessment.

Residents value the community's affordable housing, parks, community gatherings, schools, and public transportation. 37% of community members rated affordable housing and parks and resources for physical activity as top strengths. 23% of community members rated community gatherings, good schools and good public transportation as strengths.

Poverty, high unemployment and low educational attainment are challenges in the community. 44% of children under the age of 18 in Red Hook live in poverty.³ Unemployment is extreme. 19% of residents 16 and older are unemployed, compared to 9% of residents citywide.³ 35% of adults have not completed high school.³

There are widespread outdoor and indoor environmental problems. Red Hook was greatly impacted by Superstorm Sandy and recovery efforts continue. Most of the Red Hook Ballfields were closed in 2012 and again in 2015 because of lead soil contamination. They have remained closed and efforts are underway to fix the problem. Many Red Hook residents are also impacted by poor housing conditions that affect the entire NYCHA system, such as heat and hot water outages, mold, and risk for lead exposure.¹⁰



11, 12, 13

TOP HEALTH CONCERNS

The Red Hook residents who participated in our survey reported worse overall health than NYC residents as a whole. 36% of Red Hook residents rated their health as fair or poor compared to 22% NYC wide.¹⁴

Most of Red Hook community members' top health concerns align with the health needs and risks the CHNAA team identified through hospital, NYC Department of Health and Mental Hygiene, and other data.



ASTHMA

- > 45% of survey participants rated asthma as one of the most important health issues in Red Hook. Residents made the connection between housing conditions and asthma in the small group conversations. They identified the impact that inconsistent heating and cooling, mold, and cockroaches and rats can have on people with asthma.
- > Asthma diagnoses among children on Medicaid and preventable asthma hospitalizations for adults are slightly higher in Red Hook and surrounding neighborhoods than in NYC as a whole.^{15,16}
- > 23% of residents of the Red Hook Houses surveyed by Red Hook Initiative in 2016 had at least one family member with asthma, and 40% of those surveyed had mold in their apartments.¹⁷ Mold and other housing conditions can make asthma worse.



STRESS + ANXIETY + DEPRESSION

- > 35% of survey participants rated stress, anxiety and depression as one of the most important health issues in Red Hook. Needed home repairs, rent increases, housing insecurity, safety concerns, and over-policing were cited as causes of stress, anxiety, and depression.
- > Frequent mental distress is higher among Red Hook residents than NYC residents as a whole. Approximately 1 in 5 adults who live in the Red Hook Houses reported frequent mental distress.¹⁸



DIABETES

- > 31% of survey participants rated diabetes as one of the most important health issues in Red Hook. Diabetes was a major topic of discussion in the Spanish-speaking small group conversation.
- > Approximately 18% of adults who live in the Red Hook Houses reported having diabetes compared to 11% of adults in NYC as a whole.¹⁸
- > 19% of adults with diabetes who live in the Red Hook area have poorly controlled diabetes.¹⁹



SMOKING

- > 31% of survey participants rated smoking as one of the most important health issues in Red Hook.
- > The smoking ban in NYC public housing came up in a few of the small group conversations and the CHNAA team's day-to-day work with community residents. 1 in 5 adults who live in NYC public housing smoke.²⁰

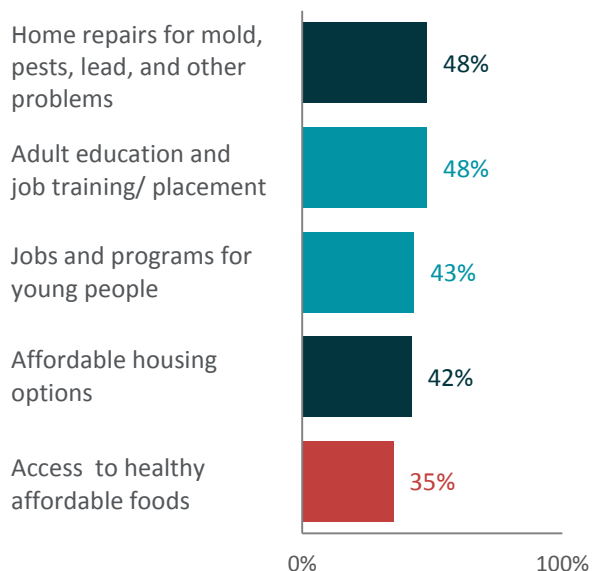


SUBSTANCE USE (INCLUDING ALCOHOL)

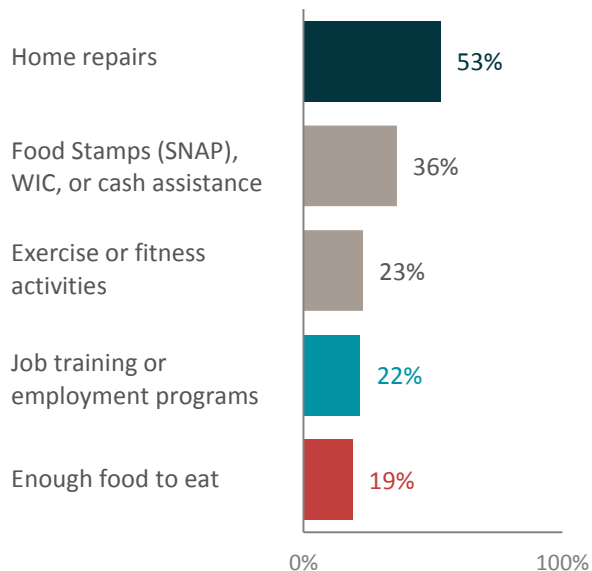
- > 29% of survey participants rated substance use (including alcohol) as one of the most important health issues in Red Hook. The connection between mental health and substance use came up in some of the small-group conversations and the CHNAA team's day-to-day work.
- > Alcohol-related hospitalizations are higher in the Red Hook area than the citywide rate.²¹ There are also more alcohol retailers in the area compared to the citywide rate.²²

NEEDED SERVICES

Participants rated programs and services related to **housing**, **education + training**, and **food access** as most needed to improve the health and wellbeing of Red Hook residents.



Residents needed but had trouble accessing similar programs and services in the past 12 months.



HEALTH

Residents reported needing more (or better connections to) preventive and health management services in the community. In

several of the small group discussions, residents said that they wanted more medical services and options to choose from in Red Hook. One group suggested that services could be offered in community locations where residents regularly go and not just in medical offices and clinics.

Discussions also revealed the need for better awareness of and connection to existing resources in the community.

HOUSING

Residents reported that the current NYCHA repairs system takes a long time and often requires multiple steps. A few participants spoke

about making repairs themselves, or getting needed repairs by advocating for themselves and with support from the Red Hook Community Justice Center.

Housing conditions have an effect on health.

Community residents identified home repairs as the #1 needed service to improve health in Red Hook. In the small group conversations, community members shared their experiences with poor housing conditions and the impact they have on their families' health, especially asthma and stress.

EDUCATION + TRAINING

More information is needed about how residents access existing education and training programs.

Many Red Hook residents rated education and training programs as top needed services to improve health and wellbeing, yet 1 in 5 residents reported having trouble accessing job training or employment programs in the past year. This topic needs further investigation.

NEEDED SERVICES

FOOD ACCESS

Healthy food options seem limited and too expensive to many Red Hook residents. 58% of survey respondents reported not having places in the neighborhood to buy affordable fresh fruits and vegetables. Residents spoke about available options (such as C-Town, Fairway, and the Red Hook Community and Red Hook Houses Farms) but reported challenges such as cost, limited healthy and quality options, and inconvenient locations. Several small group conversation participants wanted more information about the safety of the soil at the Red Hook Farms because of the lead soil contamination at the NYC Department of Parks and Recreation Ballfields. (The soil is regularly tested and is safe for growing food).²³ Some residents also talked about challenges with food stamps (SNAP). Some said that they do not cover enough expenses. Other participants said they make too much money to qualify for food stamp benefits but still struggle to have enough money to put food on the table.

OTHER NEEDS

Residents reported that more services are needed in Spanish and Chinese. The Spanish- and Cantonese-speaking small group participants expressed a need for more community services in their languages. Members of the Cantonese-speaking group reported that they are sometimes required to complete and sign forms in English that they do not understand.

Residents have multiple, related needs and need help accessing a variety of programs and services. Residents reported needing access to a variety of services that focus on social needs, such as home repairs and workforce development, in the survey and in the small group conversations.

During the discussions other issues were raised that need more examination, such as:

SAFETY + POLICING. The Cantonese-speaking small group reported safety and violence as a major concern. They reported being afraid to answer their doors or go out early in the morning or late at night. The young parent small group reported police interactions as the primary contributor to stress, anxiety, and depression.

DISPLACEMENT + GENTRIFICATION. Displacement and gentrification came up at various points in the assessment. One of the small groups said the issues with NYCHA home repairs and the smoking ban seemed intentional to push out longtime NYCHA residents.

Did you know that housing problems can affect your health?

Poor housing conditions	...can lead to...	health problems
<ul style="list-style-type: none"> • Mold • Pests • Poor ventilation 	➔	<ul style="list-style-type: none"> • Asthma and other respiratory issues
<ul style="list-style-type: none"> • Lead paint 	➔	<ul style="list-style-type: none"> • Harm to children's brain development
<p>Other structural problems like:</p> <ul style="list-style-type: none"> • Uneven or slippery flooring • Unprotected windows • Lack of grip bars for the elderly • Poor lighting • Exposed heating systems 	➔	<ul style="list-style-type: none"> • Falls and injuries • Burns
<ul style="list-style-type: none"> • Rent burden (spending more than 30% of income on rent) • Overcrowding 	➔	<ul style="list-style-type: none"> • Depression, anxiety, and stress • Unable to afford medication and health care • Unable to afford healthy foods
<ul style="list-style-type: none"> • Being homeless • Not having a stable and secure place to live 	➔	<ul style="list-style-type: none"> • Illness, depression, anxiety and stress • Behavioral and developmental issues for children

Handout used in the small group conversations

CONNECTING STRENGTHS + NEEDS

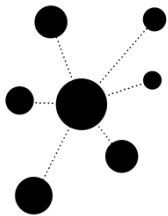
STRATEGIES

The following ideas build on community strengths, incorporate feedback from community members, and expand on successful practices already being used in Red Hook.



Peer-to-peer programs

Residents talked about the importance of trust and working with someone they can relate to. They thought that peer-to-peer programs were an appealing model to help with different health issues. These types of programs have been successful in Red Hook and other communities. Teen health and parenting programs are examples of programs in Red Hook that use this model. Potential services the peer workers can help with include health education, assistance accessing services, and organizing and advocacy. Peer-to-peer programs also provide an opportunity for training and job placement for Red Hook residents.



Holistic strategies that meet community members at the point of their most pressing need

Residents often have multiple, related needs. An approach that addresses a number of related issues at the same time would be more effective than strategies that address individual issues. Connections to Care is an example of a program in Red Hook that uses a holistic approach. It helps non-medical staff identify mental health and related needs, and connect community members to services.

Training and culturally-appropriate resources are needed for holistic strategies to be successful.



Advocacy and organizing

Many Red Hook residents experience systemic inequalities based on race and class, such as health disparities and inadequate funding of public housing. Continuing to build community capacity to advocate and organize can help address these and other longstanding challenges and create long-term change.

CONNECTING STRENGTHS + NEEDS

TAKING ACTION

The CHNAA team is exploring opportunities to implement these strategies to address the community's top health needs. The team also responded to needs as they came up during this year-long process. An existing education and home assessment program for people who have asthma and are on Medicaid was expanded to Red Hook. Materials about quitting smoking and lead exposure were also distributed to residents through CHNAA team organizations.

The CHNAA team is planning to use the results of this assessment to expand additional Red Hook programs and services through the NYU Langone Health Community Service Plan. This plan includes programs that focus on top community health needs in southwest and central Brooklyn (including Red Hook) and the Lower East Side and Chinatown in Manhattan. Updates will be posted on the [Red Hook HUB](http://www.redhookhub.org/) (<http://www.redhookhub.org/>) and the NYU Langone Health [Community Service Plan website](https://nyulangone.org/our-story/community-health-needs-assessment-service-plan) (<https://nyulangone.org/our-story/community-health-needs-assessment-service-plan>).

We hope community organizations and residents will use this information for program planning, advocacy, additional information gathering and more. Tools and more detailed data are available at <https://redhookchnaa.wordpress.com/>, including full survey results categorized by age and housing situation, community data from other sources, and additional information.



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DATA SOURCES

Data review: The CHNAA team looked at community data from different agencies and organizations and identified missing data needing further exploration. An existing list of Red Hook programs and services was updated based on planning partner knowledge and information available on [HITE Site](https://www.hitesite.org/) (<https://www.hitesite.org/>) and the NYC Department of City Planning [Capital Planning Platform](https://capitalplanning.nyc.gov/facilities) (<https://capitalplanning.nyc.gov/facilities>). The CHNAA team focused on programs and services that address the top health concerns and needed services identified in the survey results. There may be programs and services missing from the inventory. The goal was to get a general sense of existing services and gaps to help inform next steps.

Dot Voting: Approximately 187 Red Hook community members participated in dot voting during seven events at CHNAA team organizations. Most participants were young adults. 12 health issues and an "other" category were written on large posters. Participants were given three stickers to vote for the most important health issue(s) affecting the Red Hook community. Participants could place all three stickers under one issue, or place them under different issues.

Survey: 594 people who live or work in Red Hook completed surveys (paper or online). Over 20 organizations in Red Hook helped with distribution. Surveys were completed in English (84%), Spanish (15%), and Chinese (1%).

Small Group Conversations: Approximately 57 community members participated in five small group conversations hosted by CHNAA team organizations. Three groups were conducted in English, one in Cantonese, and one in Spanish. The survey results and the connection between housing and health were discussed. Participants were recruited by word of mouth through staff and residents. Survey participants who provided their email addresses were also invited to participate.

Materials and additional data are available at <https://redhookchnaa.wordpress.com/>

DATA SOURCES

- ¹ *Welcome to Red Hook* mural by Groundswell located at the corner of Hamilton Avenue and West 9th Street.
- ² Total Red Hook population Census Tracts 53, 59, and 85 combined: U.S. Census Bureau, American Community Survey (ACS) 2012-2016, retrieved from [New York City Population FactFinder](#). Red Hook Houses East and Red Hook Houses West total residents: “MyNYCHA Developments Development Data,” New York City Housing Authority, accessed September 14, 2018.
- ³ Red Hook Asian population is an estimate. U.S. Census Bureau, American Community Survey (ACS) 2012-2016, retrieved from [New York City Population FactFinder](#). Census Tracts 53, 59, and 85 combined.
- ⁴ U.S. Census Bureau, American Community Survey (ACS) 2006-2010 and 2012-2016, retrieved from [New York City Population FactFinder](#).
- ⁵ Map created in “[DATA2GO.NYC](#),” Measure of America of the Social Science Research Council.
- ⁶ *Red Hook Houses* by Ross Joy is licensed under [CC0 1.0 Universal](#).
- ⁷ *MG 2733* by Sunghwan Yoon is licensed under [CC BY-SA 2.0](#).
- ⁸ *185 Van Dyke Street Red Hook 2d* by Rhododendrites is licensed under [CC BY-SA 4.0](#).
- ⁹ While we reached over 600 people who live or work in Red Hook, findings from this Community Health Needs and Assets Assessment may not represent the entire Red Hook community.
- ¹⁰ See, for example: U.S. Attorney’s Office Southern District of New York “[Settlement with NYCHA and NYC](#),” June 11, 2018; New York State Department of Health, “[Assessment of New York City Housing Authority \(NYCHA\) Properties](#),” March 2018; and New York City Department of Investigation, “[Investigation into False Certification of NYCHA Lead Paint Inspections](#),” November 2017.
- ¹¹ *MG 2900* by Sunghwan Yoon is licensed under [CC BY-SA 2.0](#).
- ¹² *Dunk* by Ludovic Bertron is licensed under [CC BY 2.0](#).
- ¹³ *NYC – Brooklyn – Red Hook: Red Hook Food Vendors* by Wally Gobetz is licensed under [CC BY-NC-ND 2.0](#).
- ¹⁴ New York City Department of Health and Mental Hygiene, [New York City Community Health Survey](#), 2016.
- ¹⁵ Data is from the Carroll Gardens – Columbia Street – Red Hook Neighborhood Tabulation Area. New York State Medicaid Enterprise System, 2015, retrieved from New York City Department of Health and Mental Hygiene, [New York City Neighborhood Atlas](#).
- ¹⁶ Data is from the Carroll Gardens – Columbia Street – Red Hook Neighborhood Tabulation Area. Statewide Planning and Research Cooperative System (SPARCS) Inpatient Hospitalizations, 2012-2014, retrieved from New York City Department of Health and Mental Hygiene, [New York City Neighborhood Atlas](#).
- ¹⁷ Findings may not represent all Red Hook Houses residents. Red Hook Initiative, “[The Impact of Mold on Red Hook NYCHA Tenants](#),” October 2016.
- ¹⁸ Data are estimates. Red Hook is defined as Census Tracts 53, 59, and 85. Census Tract 85 data was used as an approximation for Red Hook Houses residents. 500 Cities Project Data, Centers for Disease Control and Prevention, 2015 2 Year Modeled Estimates, retrieved from [City Health Dashboard](#).
- ¹⁹ Data is from the Carroll Gardens – Columbia Street – Red Hook Neighborhood Tabulation Area. New York City A1C Registry, 2014, retrieved from New York City Department of Health and Mental Hygiene, [New York City Neighborhood Atlas](#).
- ²⁰ New York City Department of Health and Mental Hygiene, [New York City Community Health Survey](#), 2015.
- ²¹ There were 997 alcohol hospitalizations per 100,000 people 15-84 years old in the Carroll Gardens – Columbia Street – Red Hook Neighborhood Tabulation Area compared to 955 alcohol hospitalizations per 100,000 people in NYC as a whole. Statewide Planning and Research Cooperative System (SPARCS) Inpatient Hospitalizations, 2014, retrieved from New York City Department of Health and Mental Hygiene, [New York City Neighborhood Atlas](#).
- ²² There are 47 alcohol retailers per 10,000 people in the Carroll Gardens – Columbia Street – Red Hook Neighborhood Tabulation Area compared to 26 alcohol retailers per 10,000 people in NYC as a whole. NY State Liquor Authority, Active License Data - Open NY, November 8, 2016, retrieved from New York City Department of Health and Mental Hygiene, [New York City Neighborhood Atlas](#).
- ²³ “[Frequently Asked Questions](#),” Added Value Farms, accessed September 6, 2018.
- ²⁴ *MG 2740* by Sunghwan Yoon is licensed under [CC BY-SA 2.0](#).

Many thanks to all of the community residents and organizations that helped make this assessment possible.

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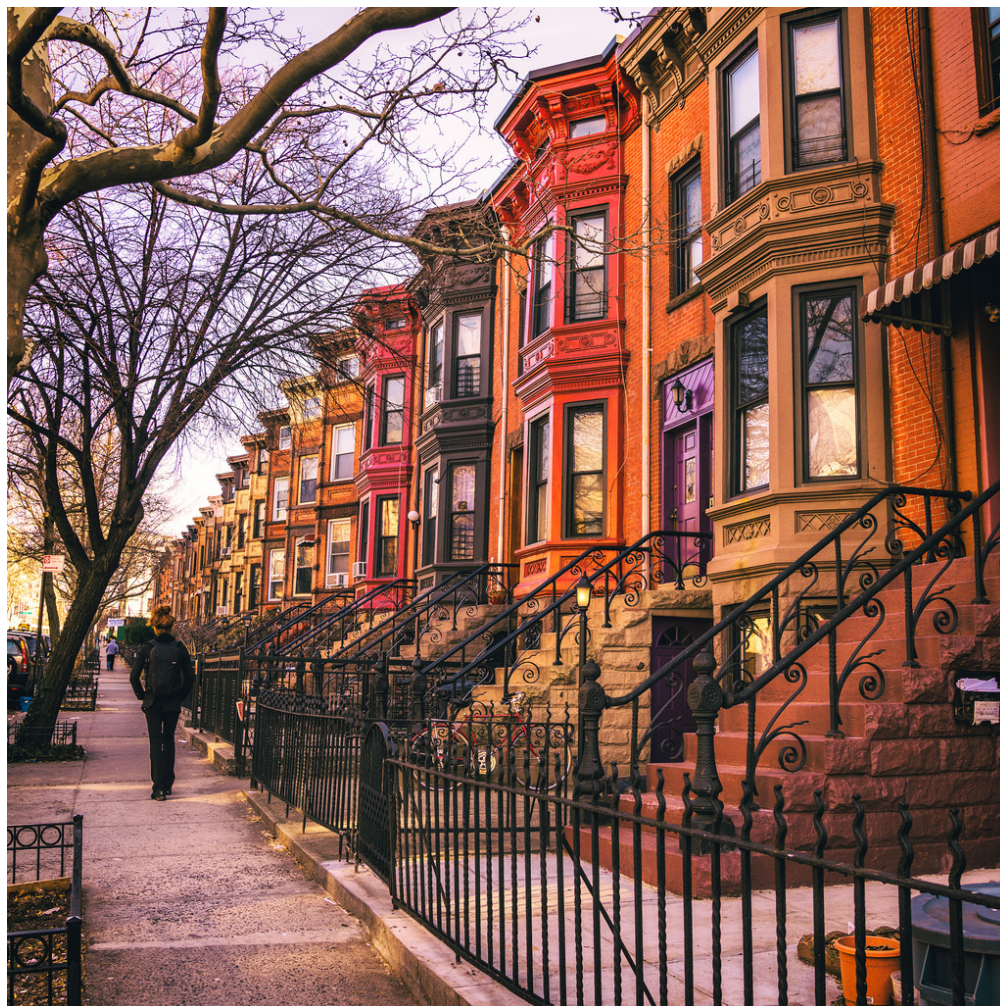
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The Southwest Brooklyn Health and Housing Consortium

Needs Assessment and Priorities in Sunset Park



SUPPORTED BY THE NYU LANGONE HEALTH COMMUNITY SERVICE PLAN

Consultants: Henie Lustgarten and Bonnie Mohan, The Bronx Health and Housing Consortium

EXECUTIVE SUMMARY

In the spring of 2017, leadership from the NYU Langone Health Community Service Plan and NYU Langone Health Brooklyn began to explore the interaction between housing insecurity and health status and care in Brooklyn communities served by NYU Langone Health (NYULH). Henie Lustgarten and Bonnie Mohan, two founders of The Bronx Health & Housing Consortium, were hired as consultants to assist with a needs assessment and environmental scan of housing in Southwest Brooklyn. A leadership group was formed to guide this work and to develop recommendations based upon the findings. The group included colleagues from the Department of Population Health and of Emergency Medicine at NYU School of Medicine, the Family Health Centers at NYU Langone, the Brooklyn Health Home, Enterprise Community Partners, CAMBA, and Local Initiatives Support Corporation (LISC). Additional community-based organizations (CBOs) provided input and insights at meetings of the Community Advisory Group for the NYU Langone Brooklyn Performing Provider System (PPS) Delivery System Reform Incentive Payment (DSRIP). (A list of participants is attached as Appendix A.)

The composition of the leadership group reflects a recognition that partnerships with health, social service and housing providers will be essential to any housing and health initiative. The goals of the group were to:

1. Understand the intersection of health and housing needs of people in Southwest Brooklyn;
2. Build relationships with stakeholders serving a shared population; and
3. Share, develop, and advocate for resources.

The result of this work is the creation of **The Southwest Brooklyn Health & Housing Consortium**. This report summarizes the findings of the needs assessment and outlines short- and longer-term responses to the needs identified. Part I provides a brief overview of the intersection of health and housing and describes relevant experience and expertise at NYU Langone Health. Part II describes the methodology and key findings from the analysis of primary and secondary data. Part III discusses opportunities, challenges and current programs, and outlines a plan, building on existing efforts and developing new systems and programs, to:

Provide systematic ways to share information, and develop pathways within and across the health and housing sectors, including:

- Building a network across sectors to better understand the health/housing issues of patients/clients and to share information and resources, leveraging the existing PPS partnerships and structures. This will be done through:
 - Open houses, field trips and marketplace events so that health care, housing and CBO staff can learn about existing resources, understand how to navigate the health care and housing systems, and develop personal relationships and contacts to facilitate referrals and sharing of information;

- Case conferences to chart the path of selected patients/clients through clinical and community services to understand gaps and barriers and to optimize pathways;
- A working conference on Health and Housing to explore intake processes, coding, and best practices for screening; and
- Developing and implementing processes for sharing client/patient information and improving communication among different stakeholders, taking into account the need for privacy and confidentiality.
- Building capacity and infrastructure of health systems and CBOs to identify and address health/housing issues through:
 - DSRIP workforce development programs;
 - Accessing New York State capacity-building resources to support CBOs in strengthening their data infrastructure and enhancing their ability to partner with health and housing systems; and
 - Enhancing client/patient access to legal services, particularly around housing issues.
- Exploring ways to build capacity for medical respite services for people who are homeless or unstably housed and have time-limited medical needs, and stabilization for people with substance use disorders.

Track and coordinate with other health and housing efforts and expand the partnership to include:

- Managed care organizations;
- City and State officials;
- Policymakers; and
- Leaders of related efforts.

Create and prioritize longer term strategies, which might include:

- Establishing a respite program for homeless or unstably housed patients;
- Establishing a stabilization center for people with substance use disorders;
- Developing a policy agenda and working with community leaders, policymakers, and elected officials to educate them about the deleterious health effects of the housing crisis and health-related housing needs in the community; and
- Developing infrastructure to measure need and impact including health outcomes, financial impact, and patient and staff satisfaction.

ACKNOWLEDGEMENTS

We would like to thank **Henie Lustgarten** and **Bonnie Mohan**, two founders of The Bronx Health & Housing Consortium, who assisted us with the needs assessment and environmental scan of housing in Southwest Brooklyn and provided invaluable guidance throughout this process. We also thank the following organizations and NYU Langone staff in Brooklyn for giving their time and sharing their experiences, which were invaluable to conducting this needs assessment:

Arab-American Family Support Center

Brooklyn Health Home

CAMBA

Caribbean Women’s Health Association

Center for Urban Community Services

Chinese-American Planning Council

Mixteca Organization Inc.

NYU Langone Brooklyn PPS CBO partners

NYU Langone Hospital – Brooklyn

Social Worker, Psychiatric Emergency Department

Director, Patient Navigation Center

Chief of Service, Emergency Department

Director of Social Work

NYU Langone Health

Behavioral Health Services, Family Health Centers at NYU Langone - Sunset Terrace

Executive Director, Family Health Centers at NYU Langone/Vice President for Community Health

Chief Medical Officer, Family Health Centers at NYU Langone/Medical Director, NYU Langone

Brooklyn PPS

DSRIP Director, NYU Langone Brooklyn PPS

Community Medicine Medical Director, Behavioral Health

Director of Adolescent Health Services and Coordinator of Social Work Services, Project Reach Youth

RiseBoro Community Partnership

Thank you to James David, Sue Kaplan and Jennifer Norton for their help in preparing this report, as well as Kelly Doran, Anne Meara and Kathleen Hopkins for invaluable input and comments. Analysis of secondary demographic and housing data was provided by Jennifer Norton.

I. OVERVIEW OF HOUSING AND HEALTH

In recent years, numerous reports and papers have been written about the intersection of housing and health.¹ A recent report by the American Hospital Association entitled *Housing and the Role of Hospitals*, succinctly summarizes the association between housing instability and poor health and increased health care utilization:

Housing Issue	Examples	Related Health Conditions
Homelessness	<ul style="list-style-type: none"> • Total lack of shelter • Residence in transitional or emergency shelters 	<ul style="list-style-type: none"> • Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis) • Mental health issues, including depression and elevated stress • Developmental delays in children
Lack of affordable housing	<ul style="list-style-type: none"> • Severe rent burden • Overcrowding • Eviction or foreclosure • Frequent moves 	<ul style="list-style-type: none"> • Stress, depression and anxiety disorders • Poor self-reported health • Delayed or diminished access to medications and medical care
Poor housing conditions	<ul style="list-style-type: none"> • Structural issues • Allergens like mold, asbestos or pests • Chemical exposures • Leaks or problems with insulation, heating and cooling 	<ul style="list-style-type: none"> • Asthma or other respiratory issues • Allergic reactions • Lead poisoning, harm to brain development • Other chemical or carcinogenic exposures • Falls and other injuries due to structural issues

Health Research & Educational Trust. (2017). *Social Determinants of Health Series: Housing and the Role of Hospitals*. Chicago: Health Research & Educational Trust.

As one of the nation’s premier academic medical centers, NYU Langone Health’s “trifold mission to serve, teach, and discover is achieved daily through an integrated academic culture devoted to excellence in patient care, education, and research.” In carrying out this mission, NYULH frequently partners across sectors with experts and organizations that address the social determinants of health, including housing experts and providers. For example, through grant-funded research (most recently with the support of the Robin Hood Foundation) and through the network of community-based services

¹ Enterprise Community Partners, Inc., Center for Outcomes Research and Education (CORE). (2016). *Health in Housing: Exploring the Intersection between Housing and Health Care*. Columbia, MD: Enterprise Community Partners, Inc.
 Health Research & Educational Trust. (2017). *Social Determinants of Health Series: Housing and the Role of Hospitals*. Chicago: Health Research & Educational Trust.
 Mercy Housing, the Low Income Investment Fund for the California Endowment, The Kresge Foundation. (2017). *Innovative Models in Health and Housing*. San Francisco: The Low Income Investment Fund.
 Scally, C. P., Waxman, E., Gourevitch, R., & Adeeyo, S. (2017). *Emerging Strategies for Integrating Health and Housing: Innovations to Sustain, Expand, and Replicate*. Washington, DC: Urban Institute.
 Spillman, B. C., Leopold, J., Allen, E. H., & Blumenthal, P. (2016). *Developing Housing and Health Collaborations: Opportunities and Challenges*. Washington, DC: Urban Institute.

provided by NYU Langone Brooklyn, NYU Langone Health has considerable expertise in homelessness and in housing-based interventions to address health and the social determinants of health. Much of this work has been done in partnership with City agencies and with social service providers and housing providers. NYULH also collaborates with NYU's Furman Center, the premier source of data and research on housing, neighborhoods, and urban policy in New York City.

II. NEEDS ASSESSMENT

Methodology

Our methodology for understanding health-related housing needs in Southwest Brooklyn included analysis of secondary data and the collection and analysis of primary data. Secondary data from population-based surveys, reports, and administrative data were used to describe the current snapshot of housing and demographics in Sunset Park, the main catchment area of NYU Langone Brooklyn (see Appendix B for data sources and indicator descriptions). The majority of data sources define Sunset Park according to the United States Census Bureau Public Use Microdata Area (PUMA), which includes Windsor Terrace and approximates the Sunset Park Community District (BK07). These population-based data help to characterize the overarching housing landscape in Sunset Park, and provide context for the themes raised during focus group discussions.

Population-based surveillance surveys and reports

- US Census Bureau American Community Survey, 2011-2015
- State of NYC's Housing and Neighborhoods in 2016, NYU Furman Center
- NYC Housing and Vacancy Survey, 2014
- NYC Community Health Profiles, 2015
- Brooklyn Community Needs Assessment, 2014
- Children's HealthWatch, Boston

Targeted studies and surveys

- NYU Langone-Brooklyn ED Study, 2017
- Hospital Homeless Count, The Bronx Health & Housing Consortium, 2017

Primary data collection consisted of key informant interviews and focus groups. In late June 2017, consultants Bonnie Mohan and Henie Lustgarten first met with the community-based organizations (CBO) that are partners in the NYU Langone Brooklyn PPS to introduce the project and to hear their perspectives. Following this introduction, from July to September they held 11 focus groups (lasting from 60 to 90 minutes) with a mix of supervisory and direct care staff. They also conducted seven interviews with key informants from the NYU Langone Hospital - Brooklyn and from the Family Health Centers.

Preliminary findings were presented at a large meeting on October 2, 2017 to a group that included representatives from NYU Langone Health, the Brooklyn Health Home, CAMBA, Enterprise Community Partners, LISC, and the Robin Hood Foundation. Insights from that discussion are included in this summary as well.

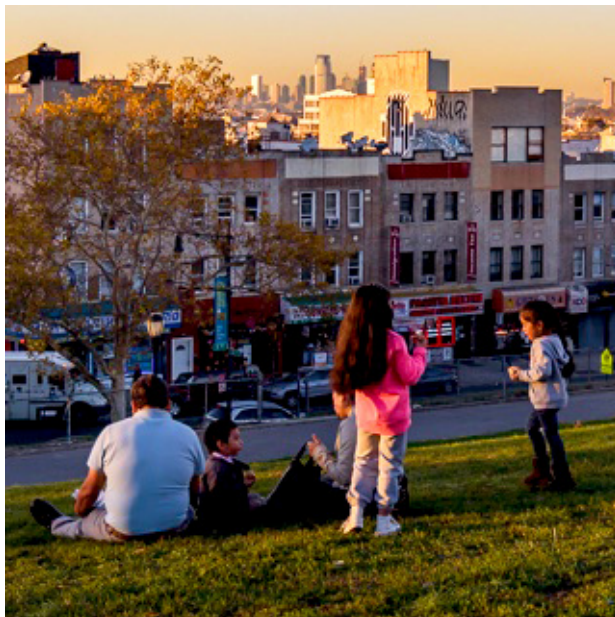
Secondary Data Analysis

Demographic in Sunset Park

Sunset Park has historically been a first destination for immigrants. About half of Sunset Park residents were born outside the United States. About three out of four Sunset Park residents speak a language other than English at home, and about one-half speak English very well. Sunset Park is a diverse community with Chinese, Mexican, and Puerto Rican people comprising more than one-half of the population.



Poverty is high in Sunset Park, with more than one out of four residents living in households with incomes below the Federal Poverty Level. Unemployment is lower in Sunset Park than Brooklyn overall, however, more than one out of four working age adults lack health insurance. About three out of four children under age 18 years and one out of three adults 18 to 64 years are covered by Medicaid.



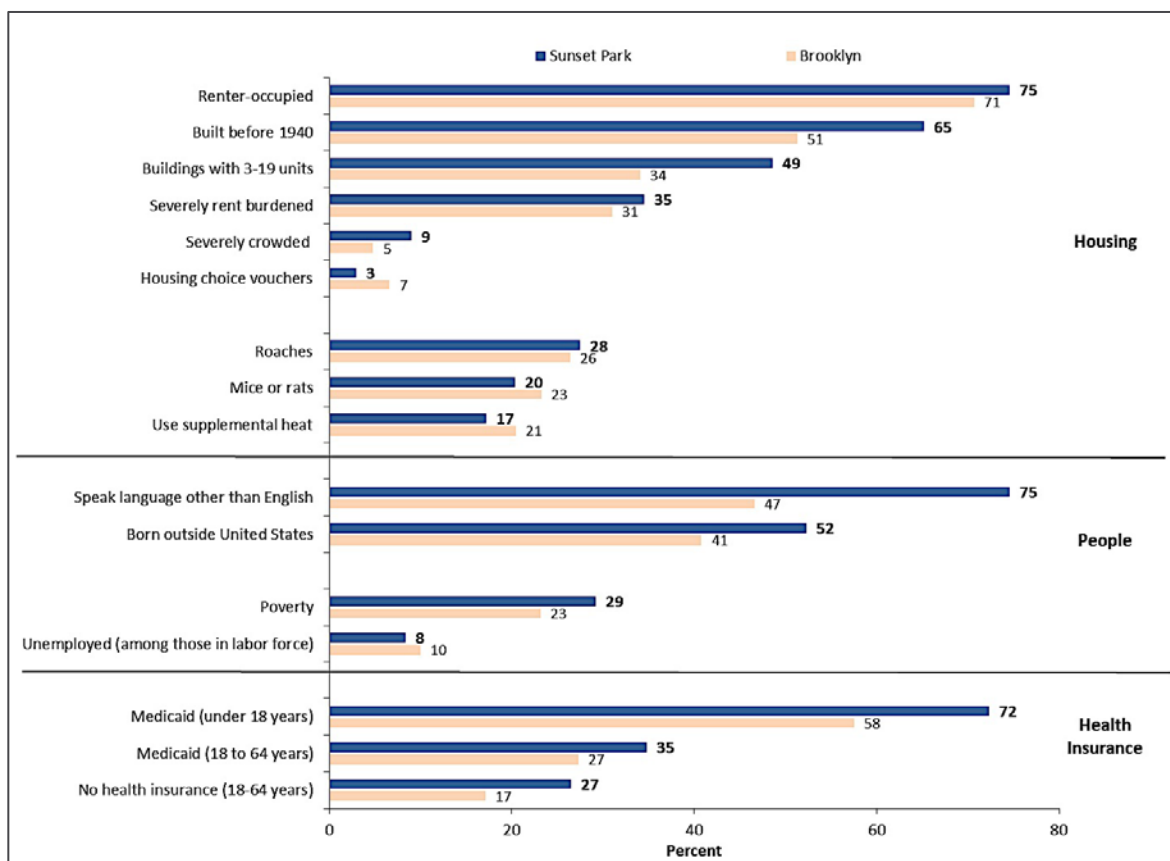
Housing in Sunset Park

Small residential buildings, generally two to three floors with basements, dominate the housing landscape in Sunset Park. Most housing units are renter-occupied. There are no public housing units in the neighborhood, and the use of federally subsidized housing choice vouchers is low in Sunset Park. Properties tend to be owned by individuals or entities that own a single property in Sunset Park. Sunset Park has the second oldest housing stock in New York City, with nearly two out of three housing units built before 1940.

More than one out of three renter households are severely rent burdened, meaning that gross rent is

more than one half of household income, despite about one out of two rental units being rent-controlled or rent-stabilized. In 2016, the median asking rent was \$2,100 per month, yet the median annual household income amounted to \$3,256 per month for renter-occupied households. An average household in Sunset Park has 3.25 people, compared with 2.74 in Brooklyn overall. Sunset Park ranks third highest in severely crowded households among New York City neighborhoods, with nearly one out of ten renter households having more than 1.5 people per room.

More than one out of four households see roaches on a typical day and one out of five households have seen mice or rats in their building. Due to inadequate heating, about one out of six households has used a supplemental source of heat in the winter such as a kitchen stove, fireplace or portable heater.



US Census Bureau, American Community Survey, 2011-2015. New York City Housing and Vacancy Survey, 2014

NYU Langone Hospital-Brooklyn Emergency Department Survey

From November 2016 – July 2017, NYU Langone Hospital – Brooklyn conducted a convenience sample survey of Emergency Department (ED) patients carried out by volunteer research assistants in order to get a preliminary sense of the social needs of these patients. The survey results found that the ED population struggled with a variety of health-related social needs, including housing, though frank homelessness was less common than we see in some other NYC hospitals. Still, the survey identified a

fair number of people who are living doubled up, are unstably housed in various ways, and who have other markers of high financial need.

2017 Hospital Homeless Count

NYU Langone Hospital – Brooklyn also participated in a Hospital Homeless Count in 2017, organized

by The Bronx Health & Housing Consortium. Every January, the NYC Department of Homeless Services (DHS) conducts its annual Homeless Outreach Population Estimate (HOPE) Count. This event, which takes place in the middle of the night during the winter, consists of an outdoor street count throughout the five boroughs and MTA system to identify homeless individuals.

Understanding that homeless and unstably housed populations are a significant driver of hospital-based health care utilization, for the past three years, The Bronx Health & Housing Consortium has done its own count of homeless people in hospital emergency departments on the night of the annual DHS HOPE Count. On the night of February 6th, 2017, volunteers visited 14 hospitals on 17 sites in the Bronx, Manhattan, Queens, and Brooklyn and found a total of 131 people who identified as homeless. The number of people found varied by hospital, with a low of two people and a high of 24. At NYU Langone Hospital – Brooklyn, volunteers found four homeless people (three street homeless and one newly homeless) in the emergency department during the hours of the count.

Primary Data Collection and Analysis:

Report from Consultants Henie Lustgarten and Bonnie Mohan

In all focus groups and interviews with health care providers and CBO staff, we asked about the health and housing needs of the people served: how these needs are identified, what services the organization provides to meet those needs, where they make referrals for services they do not provide, and what gaps they have identified in the availability of resources and in their partnerships with other organizations and health systems. Findings from these conversations are summarized below. Please note that although we held 11 focus groups and seven key informant interviews, the findings presented here are not comprehensive and reflect only the views of the people with whom we spoke.

Furthermore, because many system changes are currently underway, including the implementation of a new electronic medical record system, interviewee knowledge about resources may not be fully up to date. Finally, although many important issues and challenges were raised during the course of the focus groups and interviews, this report focuses specifically on issues germane to the nexus of health and housing.

NYU Langone Hospital – Brooklyn ED Survey (n=530)

Housing

- 82% were in own apartment, 7% in someone else’s apartment previous night.
- 8% not living in stable housing in past 2 months, 9% concerned about stable housing in next 2 months
- 11% owe rent arrears (back rent payments)
- 4% have been homeless or doubled up in past 12 months, 11% in lifetime

Employment and Income

- 25% unemployed or unable to work
- 21% had not met essential expenses in last 12 months.
- 21% had experienced food insecurity

Identifying the Population

From our discussions with staff at NYU Langone Hospital - Brooklyn, there was a general recognition that housing is an important issue. Unstably housed patients are identified through staff relationships with patients that have developed over time (especially in the ED), formal and informal assessments, and by patients raising housing issues, for example during the discharge process or during psychotherapy sessions.

Across NYU Langone Health - Brooklyn, staff currently utilize a variety of methods and informal systems to assess for housing status, with limited ability to share across systems. Assessments usually include where people live, with whom, and housing problems. Details that may affect housing options, such as whether one's name is on the lease, are not usually collected or noted. The community Ambulatory Behavioral Health Services group routinely asks more detailed housing questions as do some of the Health Home staff. There are various assessment points, but pathways for routine sharing of information may not be clear. For example, the Behavioral Health Service staff may know the patient is living in a very overcrowded setting but it is unclear if that information is reflected in the medical records. As noted, with the implementation of a new electronic health record system, this area is in flux and clearly warrants further investigation since the gathering and sharing of information on patients' housing is a critically important element in addressing the need and creating effective discharge plans.

In speaking with CBO staff, we found that there are no standard assessment tools, even within an agency. Assessment processes vary program to program and often depend on the funder's requirements. Most assessments do not collect detailed information about the health of their clients and many CBO staff do not have access to data systems to keep these records. They generally capture more information about their clients' housing situation, primarily where the person was currently living. Typically, the level of detail about health and housing issues depended on what services the CBO provides in those areas and the extent of their referral networks. Among the CBOs, supportive housing providers and those engaged with Health Homes and/or DSRIP tended to have the most comprehensive assessments.

Housing and Health Issues

We found a strong consensus among health care providers and CBO staff that housing is a key social determinant of health, that people need assistance to obtain and stay in decent housing, and that many organizations need help to understand housing options. Although street homelessness may not be as visible in Sunset Park as in some other poor communities in NYC, those who are street homeless and unstably housed account for a disproportionate amount of health care utilization and staff time. Hospital staff estimated that there are about 40 people per month who require varying levels of housing support. About 12 of these 40 present in the ED and the others are inpatients. We also heard that patients' lack of safe or appropriate housing can create barriers to safe discharge. Informants identified several factors that contribute to housing instability:

- Affordability. The average one bedroom apartment in Sunset Park is about \$2,100/month in rent. Since the median monthly income for renter-occupied households is \$3,256 in Sunset Park, this means rents are often unaffordable. About 29% of Sunset Park residents live below the poverty level, which contributes to housing insecurity. According to the Health Home staff, a sub-tenancy (i.e., rental of a room in someone else's apartment), often illegal, is about \$700/month. For those who cannot work, the Health Home staff noted that monthly Public Assistance payments of \$882 and SSI payments of \$700 are inadequate to obtain and maintain housing.
- Suitability. In areas with low-rise housing such as Sunset Park, landlords sometimes respond by creating additional housing units in basements and similar parts of buildings that are not zoned for separate living quarters. As a result, these units may not meet building code requirements. When City officials find these units, residents are often forced to leave unless the landlord can renovate the unit to meet building codes. This underscores something we've heard: poor housing can readily become no housing.

From interviews, we learned that residents, particularly those with behavioral health problems or immigrants who are undocumented, may be reluctant to complain because they have fewer options or are fearful of repercussions. We heard of several such examples including people living in basements or hallways. For example, we learned about one man with behavioral health diagnoses who is living in a hallway and gives his SSI check to his landlord. He receives no services and since he is not officially homeless, he does not meet requirements for supportive housing that might be otherwise be available to him. Other examples of unreported problems include pests and mold, which also are directly related to health.

Immigrant communities, where households are frequently forced to double up due to financial constraints, often experience overcrowded conditions. Our respondents described how overcrowding can lead to lack of privacy and anxiety, aggressive behavior, and children exposed to unsuitable behaviors that affect their wellbeing. Access to suitable housing is also affected by community residents' ability to access benefits that may help them find and afford housing. CBOs serving immigrants told us that their clients are often uncomfortable sharing information with governmental agencies, thus preventing them from accessing benefits and income that could improve their housing and health.

- Gentrification. Many staff of the CBOs and Health Homes we interviewed talked about the pressures of gentrification on housing market prices. Staff noted that landlords may seek to push current tenants out by neglecting needed repairs, pests, and in some cases keeping heat at the minimum temperature legally required, all of which can negatively impact people's health. Staff also noted that although landlords are legally obligated to accept vouchers like LINC, a rental assistance program to help families and singles living in shelters to move into community apartments, they often do not comply. In addition, current tenants who require modifications to their units (for example aging tenants who require ramps or supporting hardware) find landlords reluctant to

provide them. Overall, there was a strong consensus among all interviewees that the shortage of affordable housing in the area is becoming a crisis for the existing population.

- Effects of substance use and mental health on housing instability. CBO and NYULH staff confirmed the strong link between housing insecurity and mental health and/or substance use disorder. Several observed that depression can affect people's ability to work, which can lead to nonpayment of rent, then eviction. These staff reported that people with substance use disorders have particular difficulty finding and keeping housing.
- Respite. Many key informants identified the need for a type of respite service, where people with health problems and no or poor housing can live temporarily while receiving intensive care management, medications management, and other services, so that they can be stabilized and then move safely into to housing or to the shelter system.
- Shelter system. Hospital and CBO staff reported that homeless people are sometimes fearful of and reluctant to enter the shelter system with the result that they can end up living in conditions that exacerbate their health problems. The gentleman living in a hallway, discussed above, had originally been in a shelter, but refused to return. We also heard about people who have entered the shelter system and have been placed in locations far from their health care providers and communities, with poorer health care status as a result. Informants reported that available shelter beds and housing units are often found in Staten Island and the Rockaways, far from residents' communities and health care providers. In neighborhoods like Sunset Park where people have strong community ties, being separated from those communities can be disruptive to their care and wellbeing.

From our interviewees, we learned that shelters are under pressure to make housing placements, and are not always able to make the most appropriate placements that meet people's needs. When this is not successful, people often cycle back to the providers, CBOs and communities where they feel comfortable and supported, but where their housing situation may be worse. As an example, we were told about one man who has HIV/AIDS who has been moved to various shelters, further from his primary clinical providers, thereby making continuity of care all the more challenging. There are currently inadequate communication systems between the shelter system and clinicians, which is very frustrating to the NYU Langone clinical staff and to patients alike. Finally, some health providers believe that shelters are not preparing long-term residents for living independently.

- Language and cultural barriers. Because Southwest Brooklyn has a largely foreign-born population, language and cultural barriers that impact people's health care and housing were raised.² We heard

² It is worth noting that immigration and legal issues were frequently raised as impacting people's health as well as their housing. Interviewees observed an increase in depression and anxiety among immigrant communities since the 2016 election and very little emotional support for affected families. As a result, the fear an increase in alcohol and substance use. Informants noted the strain and isolation experienced by immigrants who come to this country alone to work and send money back home. Single men in particular are often living in shared spaces with little privacy. Without a comfortable home in which to relax after working all day and no support network, CBO staff reflected that many of these men go out to drink in their free time.

several stories of how the healthcare and shelter systems can find it difficult to accommodate immigrants' language and cultural or religious practices. Lack of adequate translation came up repeatedly, particularly for Arab and Chinese American communities. Improved language access and cultural competence for housing, social service and health care providers was a high priority for many interviewees.

- Accessing housing. Many housing applications, like Housing Connect, are online but CBO staff told us that many people do not have computers or Internet access. Additional fees can be prohibitive for people who are very poor. In addition, we were reminded by several CBO staff members that many immigrants, even those with legal status, do not think they are eligible for or are hesitant to apply for certain housing subsidies or income assistance that would help acquire housing.
- Housing referrals. The universe of housing is broad and complex. There are dozens of housing programs each with specific eligibility criteria, application processes, and levels of services provided. Most CBOs we met with do not provide housing assistance directly. Staff typically refer to other organizations but have few or no direct housing provider contacts, and they are uncertain about how to obtain housing support for their clients. The expertise required to determine housing eligibility and to complete the referral/application process is not easily found within the health care system or the local CBOs.

As previously noted, NYULH staff in various parts of the organization, including the Health Home, EDs, and community clinics, currently are using different assessments, usually informal, to determine whether a patient has a housing issue that may impact his or her health and/or the care plan. Similarly, there are currently no clear protocols within NYULH as to how to address housing needs; referral processes within and outside the organization are not codified or part of staff training. Some staff work with patients over a short period of time, others longer. Since many housing interventions require long periods of time to complete forms with documentation, allow for processing and interviews, etc. it is critical to agree to a pathway of information, interventions and responsibility if housing issues are to be addressed.

Overall, we identified a major need to support staff in understanding current housing resources and options available and in learning how to access this support. And there was a strong recognition of the need to work towards improving and expanding those resources.

Organizational Issues for CBOs

CBO staff with whom we spoke were interested in learning more about their clients' health and housing challenges and many were keen to have a deeper engagement with the health care delivery system. Often, staff do not know whom to contact at the hospital about their clients' care and there is no clear protocol to follow. When they are able to make this connection, it is because of the organization's relationship with a specific health care provider. Several staff members suggested that their organizations could help improve the health and housing stability of their clients, even when they do not

provide direct housing services. They noted that the relationships and trust they have built could be used to engage clients and connect them to services, including health care and housing.

Although there are no supportive housing providers located in Sunset Park, two supportive housing providers, Center for Urban Community Services (CUCS) and CAMBA, have units in Brooklyn that serve people with complex medical and behavioral health needs. As a result, they know their tenants' medication history, patterns of behavior and baseline mental status, specialty and primary care providers, and family members. Supportive housing social workers are often the people making the EMS call when a tenant needs to go to the hospital. Supportive housing providers we interviewed expressed their desire to be a resource for medical care providers generally to ensure care coordination and continuity of care based on their own positive experience linking people's housing and medical support systems. Staff are often able to notice when someone is decompensating and, when working closely with the hospital, could potentially prevent a crisis. They noted that it is important for them to know when their clients have been admitted and to receive discharge summaries so they can support clients with any new medications and required follow-up. Receiving discharge plans from hospitals has become more challenging since hospitals have moved from paper to online portals, which creates access barriers.

Other housing providers are seeking ways to support the health needs of their tenants. We have learned that Enterprise Community Partners, which works with affordable housing providers, also is engaging landlords to help their tenants with health issues to have improved access to services.

Issues of health insurance and payment for health care came up repeatedly in discussion with CBO staff. Some CBO staff seem to believe that clients who are uninsured and/or undocumented can only be referred to public hospitals like Kings County. CBO staff also reported that people sometimes avoid seeking treatment because they are afraid of the cost. One CBO's staff member mentioned that they often have clients come to their offices when they are sick before going to the hospital because they are concerned about cost. Most CBO staff do not understand hospital billing systems so struggle to advise clients.

Finally, most CBO staff indicated that they are not aware of the full scope of resources available to their clients and how to access them. Most have informal systems and contact networks, mainly based on individual staff's personal knowledge. When they do make a referral, they often do not hear anything back from the other agency about whether the person went to the appointment and what the outcome was. Most rely on the client to report back, which does not always happen. Many CBO staff members report feeling stressed and overburdened as their clients try to understand and navigate in the current political environment.

III. ADDRESSING THE NEED

Challenges

The key challenges that were raised through the Needs Assessment were the lack of cross organizational assessments to identify the population with both health and housing needs, the need to communicate internally and across organizations about making effective referrals, and the inability to share relevant information at critical points such as discharge planning. The technology to share and inform care planning exists, but requires many systems to be effectively used and processes to be established for sharing information.

Opportunities

One of the major opportunities we identified was a widespread acknowledgement of and consensus on the issues and challenges. From staff at small CBOs to personnel throughout the health care system, there was recognition that health and housing are intertwined and agreement on the challenges that exist. Similarly, all of the people with whom we spoke expressed a desire to work more closely with other groups and to strengthen partnerships.

There already exists a strong network of CBOs engaged with their communities and where there are gaps in this network, there is hunger for information about other organizations and resources. There is therefore an opportunity to weave together the different systems so that housing information can be used to inform health diagnoses/treatment and health information to inform housing needs.

Current but Disparate Efforts

Through the course of our discussions, we learned of other relevant efforts to address health and housing. We describe some of these efforts below so that we all can learn and benefit from the important work already underway. NYU Langone Health is conducting a number of initiatives that could support the work of the Consortium:

- The NYU Langone-Brooklyn psychiatric ED is conducting multi-agency case conferences, which are bringing together various organizations to work together to support homeless people who are often high utilizers.
- Healthify, a community resource search tool currently being piloted by DSRIP partners in the NYU Langone Brooklyn PPS, could be used as a central repository for information about community based organizations that could be systematized and operationalized throughout the health system.
- The ED includes Community Health Workers (CHWs) in its workflow to target high risk patients (via EPIC alert) at NYU Langone – Brooklyn.

- NYU Langone Hospital – Brooklyn has launched a Patient Navigation Center (PNC). Within the PNC, CHWs target high-risk patients (via EPIC alert) with a screening of social determinants of health (SDH) to connect the patient to services, including a housing specialist when applicable.
- A protocol for coding patients who are homeless is being standardized throughout the system, which allows for more accurate reporting and targeting of services

This Needs Assessment was supported by NYU Langone Health’s Community Service Plan and has therefore focused initially on the NYU Langone Brooklyn catchment area. But there are important opportunities for synergy with other health care providers and in a broader geographic area. The Brooklyn Health Home has been a leader in developing community partnerships and has been involved in the wider discussions about understanding and serving this part of Brooklyn. Maimonides Medical Center has also been involved with housing organizations in a contiguous area and its PPS has partnered with housing organizations as well, several of which overlap the NYU partnerships. The Brooklyn Health Home has adopted a screening tool for housing issues and they are working to develop effective interventions. Maimonides has also undertaken several research projects that focus on social determinants and are committed to support people with housing as well as health needs.

On the housing side, in an effort to improve communication with nearby hospitals, one supportive housing provider we interviewed has assigned a social worker to serve as the agency liaison to hospitals where their tenants frequently receive care. This could also serve as a resource to those hospitals, allowing them to be in contact with the supportive housing provider when a resident comes to the ED, is admitted or discharged. Although there are few supportive housing buildings in Sunset Park, the model of designating dedicated liaisons is useful and may be replicated with other landlord groups, such as those providing affordable housing.

Recognizing that homeless clients represent some of the highest utilizers of health care services with some of the poorest health outcomes, the Department of Homeless Services (DHS) is beginning to explore initiatives around improving coordination between the homeless service and health care delivery systems, including pending connectivity between DHS and the Healthix Regional Health Information Exchange (RHIO). Another recent initiative seeks to identify best practices for hospitals to identify homeless patients and increase coordination between hospitals and homeless outreach teams citywide.

Next Steps: The Southwest Brooklyn Health & Housing Consortium

The formation of The Southwest Brooklyn Health & Housing Consortium reflects a shared understanding of the intersection of health and housing and the power of cross-sector collaboration to address these issues. The Consortium will build on and enhance existing efforts and develop systems and programs to address the needs identified. The Consortium will also continue to inventory other, related efforts so that we kind find opportunities for synergy. With the support of the NYULH Community Service Plan, we

have focused our initial assessment on the NYU Langone Brooklyn catchment area. Nevertheless, the partnerships and opportunities extend to other parts of Brooklyn as well.

The Consortium will:

Provide systematic ways to share information, and develop pathways within and across the health and housing sectors, including:

- Building a network across sectors to better understand the health/housing issues of patients/clients and to share information and resources, leveraging the existing PPS partnerships and structures. This will be done through:
 - Open houses, field trips and marketplace events so that health care, housing and CBO staff can learn about existing resources, understand how to navigate the health care and housing systems, and develop personal relationships and contacts to facilitate referrals and sharing of information;
 - Case conferences to chart the path of selected patients/clients through clinical and community services to understand gaps and barriers and to optimize pathways;
 - A working conference on Health and Housing to explore intake processes, coding, and best practices for screening; and
 - Developing and implementing processes for sharing client/patient information and improving communication among different stakeholders, taking into account the need for privacy and confidentiality.
- Building capacity and infrastructure of health systems and CBOs to identify and address health/housing issues through:
 - DSRIP workforce development programs;
 - Accessing New York State capacity-building resources to support CBOs in strengthening their data infrastructure and enhancing their ability to partner with health and housing systems; and
 - Enhancing client/patient access to legal services, particularly around housing issues.
- Exploring ways to build capacity for medical respite services for people who are homeless or unstably housed and have time-limited medical needs, and stabilization for people with substance use disorders.

Track and coordinate with other health and housing efforts and expand the partnership to include:

- Managed care organizations;
- City and State officials;
- Policymakers; and
- Leaders of related efforts.

Create and prioritize longer-term strategies, which might include:

- Establishing a respite program for homeless or unstably housed patients;
- Establishing a stabilization center for people with substance use disorders;
- Developing a policy agenda and working with community leaders, policymakers, and elected officials to educate them about the deleterious health effects of the housing crisis and health-related housing needs in the community; and
- Developing infrastructure to measure need and impact including health outcomes, financial impact, and patient and staff satisfaction.

APPENDIX A: NYU Langone Brooklyn PPS Community Advisory Group

- Arab American Family Support Center
- Arab American Association of New York
- ArchCare
- Arthur Ashe Institute for Urban Health
- Brooklyn Chinese-American Association
- CAMBA
- Caribbean Women's Health Association
- Chinese-American Planning Council
- Diaspora Community Services
- Fifth Avenue Committee
- Mixteca Organization Inc.
- RiseBoro Community Partnership (formerly Ridgewood Bushwick Senior Citizens Council)
- SCO, Center for Family Life
- Turning Point Brooklyn

APPENDIX B: Data Sources and Indicator Descriptions

Topic	Indicator Description	Indicator Definition	Primary Data Source	Obtained From
Housing	Renter-occupied	Percent of occupied housing units that are rented	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table B25003
Housing	Built before 1940	Percent of housing units in structures built before 1940	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table B25034
Housing	Buildings with 3-19 units	Percent of housing units in buildings with 3 to 19 units	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table B25024
Housing	Rent-controlled or stabilized	Percent of rental units rent-controlled or rent-stabilized		Office of the New York State Comptroller. An Economic Snapshot of the Greater Sunset Park Area. Sept 2016
Housing	Severely rent burdened	Percent of renter occupied housing units whose gross rent equaled at least 50 percent of income	US Census Bureau, American Community Survey, 2011-2015	NYU Furman Center, Neighborhood Data Profiles
Housing	Severely crowded	Percent of renter occupied housing units in which there are more than 1.5 household members for each room, excluding bathrooms, in the unit	US Census Bureau, American Community Survey, 2011-2015	NYU Furman Center, Neighborhood Data Profiles
Housing	Housing choice vouchers	Percent of occupied, privately owned rental units whose occupants use a housing choice voucher from the US Department of Housing and Urban Development	Computed measure from multiple sources including Picture of Subsidized Households, American Community Survey, New York City Housing Authority and NYU Furman Center	NYU Furman Center, Neighborhood Data Profiles
Housing	Average household size	Average number of people living in occupied housing units	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table B25010
Housing	Median asking rent	Median rent that landlords advertise for housing units available for rent	StreetEasy, NYU Furman Center, 2016	NYU Furman Center, Neighborhood Data Profiles
Housing	Median household income	Median annual household income, by tenure	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table B25119
Housing	Public housing	Percent of rental units classified as public housing	NYU Furman Center, 2016	NYU Furman Center, Neighborhood Data Profiles
Housing	Roaches	Percent of households that report seeing at least one cockroach on a typical day during the past month	NYC Housing and Vacancy Survey, 2014	NYC Dept of Health and Mental Hygiene (DOHMH), Environment and Health Data Portal
Housing	Mice and rats	Percent of households that report mice or rats in their building in the past 90 days	NYC Housing and Vacancy Survey, 2014	NYC DOHMH, Environment and Health Data Portal

Housing	Use supplemental heat	Percent of households that used an additional source of heat because regular heating source did not provide enough heat	NYC Housing and Vacancy Survey, 2014	NYC DOHMH, Environment and Health Data Portal
Housing	Number of floors per building	Number of floors, starting from ground level, in the primary building in tax lot. Among tax lots that have residential units.	NYC Department of City Planning, PLUTO 16v2, September 2016	NYC Dept of City Planning. Analysis based on tax parcels located in Sunset Park Neighborhood Tabulation Area, conducted by NYU School of Medicine, Dept of Population Health
Housing	Type of basement	Type of basement. Among tax lots that have residential units.	NYC Department of City Planning, PLUTO 16v2, September 2016	NYC Dept of City Planning. Analysis based on tax parcels located in Sunset Park Neighborhood Tabulation Area, conducted by NYU School of Medicine, Dept of Population Health
Housing	Owner	Name of owner of tax lot. Among lots that have residential units.	NYC Department of City Planning, PLUTO 16v2, September 2016	NYC Dept of City Planning. Analysis based on tax parcels located in Sunset Park Neighborhood Tabulation Area, conducted by NYU School of Medicine, Dept of Population Health
People	Speak language other than English	Percent of population ages 5 years and older who speak a language other than English at home	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table S1601
People	Born outside United States	Percent of population born outside the fifty United States and District of Columbia	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table DP02
People	Poverty	Percent of individuals living in households with incomes below the Federal Poverty Level (among those for whom poverty status is determined)	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table S1701
People	Unemployed	Percent of population ages 16 years in labor force who are unemployed	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table B23025
Health Insurance	Medicaid (under 18 years)	Percent of population younger than 18 years covered by Medicaid (includes any Medicaid coverage)	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table S2704
Health Insurance	Medicaid (18 to 64 years)	Percent of population ages 18 to 64 years covered by Medicaid (includes any Medicaid coverage)	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table S2704
Health Insurance	No health insurance (18 to 64 years)	Percent of population ages 18 to 64 years with no health insurance	US Census Bureau, American Community Survey, 2011-2015	US Census Bureau, American Fact Finder, Table S2701

Appendix E

Evidence for Community Service Plan Projects

Intervention	Evidence	Citations
Preventing Chronic Disease		
Tobacco Free Community	<ul style="list-style-type: none"> ▪ Quitline interventions, particularly proactive quitlines (i.e. those that offer follow-up counseling calls) have been shown to be effective. For example, telephone counseling found to be effective for Chinese-, Korean-, and Vietnamese-speaking smokers measuring 6-month prolonged abstinence rates. ▪ Patient navigation programs have been shown to be effective. Patient navigator model has been well studied and implemented by the American Cancer Society. For example, an intervention delivered by peer health advocates was able to increase utilization of treatment programs and smoking abstinence among public housing residents. ▪ Financial incentives have been shown to support smoking cessation interventions. Participants who received incentives were more likely to call the Quitline and complete counseling sessions. Incentive receipt was positively associated with self-reported quit attempts, self-reported quits, or passing cotinine tests of smoking cessation in most programs 	<ul style="list-style-type: none"> ▪ Kuiper N, Zhang L, Lee J, et al. A national Asian-language smokers' quitline — United States, 2012-2014. <i>Prev Chronic Dis.</i> 2015;12:E99. ▪ Zhu SH, Wong S, Stevens C, Nakashima D, Gamst A. Use of a smokers' quitline by Asian language speakers: results from 15 years of operation in California. <i>American Journal of Public Health.</i> 2010;100(5):846-852. ▪ Fiore, M. Treating tobacco use and dependence: 2008 update: Clinical practice guideline. DIANE Publishing, 2008. ▪ Esparza, A. Patient Navigation and the American Cancer Society. <i>Seminars in Oncology Nursing.</i> May 2013;29(2):91-96 ▪ Your online guide of what works to promote healthy communities. The Guide to Community Preventive Services (The Community Guide). http://www.thecommunityguide.org/tobacco/RRquitlines.html. Published December 1, 2016. Accessed March 12, 2019. ▪ Brooks DR, Burtner JL, Borrelli B, et al. 2017. Twelve-Month Outcomes of a Group-Randomized Community Health Advocate-Led Smoking Cessation Intervention in Public Housing. <i>Nicotine & Tobacco Research.</i> DOI: 10.1093/ntr/ntx193. ▪ Halpern SD, French B, Small DS, et al. Randomized trial of four financial-incentive programs for smoking cessation. <i>The New England Journal of Medicine.</i> 2015;372(22):2108-2117. ▪ Witman A, Acquah J, Alva M, Hoerger T, Romaine M. Medicaid incentives for preventing chronic disease: Effects of financial incentives for smoking cessation. <i>Health Services Research.</i> 2018;53(6):5016-5034.
Health+Housing Project	<ul style="list-style-type: none"> ▪ Community Health Worker interventions have been shown to be effective in addressing social determinants of health and in affecting downstream health care utilization and health outcomes. 	<ul style="list-style-type: none"> ▪ Viswanathan M, Kraschnewski JL, Nishikawa B, et al. Outcomes and costs of Community Health Worker interventions: a systematic review. <i>Medical Care.</i> 2010;48(9):792-808. ▪ Brooks DR, Burtner JL, Borrelli B, et al. Twelve-Month Outcomes of a Group-Randomized Community Health Advocate-Led Smoking Cessation Intervention in Public Housing. <i>Nicotine Tob Res.</i> 2018; 20(12):1434-1441.

Intervention	Evidence	Citations
		<ul style="list-style-type: none"> • Gibbons MC , Tyus NC. Systematic review of U.S.-based randomized controlled trials using Community Health Workers. <i>Progress in Community Health Partnerships</i>. 2007;1(4):371-81. • Gutierrez Kapheim M, Ramsay J, Schwindt T, Hunt BR, Margellos-Anast H. Utilizing the Community Health Worker Model to communicate strategies for asthma self-management and self-advocacy among public housing residents. <i>Journal of Communication in Healthcare</i>. 2015;8(2): 95-105. • Islam NS, Wyatt LC, Taher MD, et al. A Culturally Tailored Community Health Worker Intervention Leads to Improvement in Patient-Centered Outcomes for Immigrant Patients with Type 2 Diabetes. <i>Clin Diabetes</i>. 2018;36(2):100-111. • Kangovi S, Mitra N, Norton L, et al. Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial. <i>JAMA Intern Med</i>. 2018;178(12):1635-1643. • Kim K, Choi JS, Choi E, et al. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. <i>Am J Public Health</i>. 2016;106(4): e3-e28. • Lopez PM, Islam N, Feinberg A, et al. A Place-Based Community Health Worker Program: Feasibility and Early Outcomes, New York City, 2015. <i>Am J Prev Med</i>. 2017;52(3S3): S284-S289. • Levy JI, Brugge D, Peters JL, Clougherty JE, Saddler SS. A community-based participatory research study of multifaceted in-home environmental interventions for pediatric asthmatics in public housing. <i>Soc Sci Med</i>. 2016;63(8):2191-2203.
<p>Healthy Habits Program/ Programa de hábitos saludables</p>	<p>The design of this multi-component program is informed by:</p> <ul style="list-style-type: none"> • The recommended components of effective child and adolescent obesity interventions, as identified by the US Preventive Services Task Force’s (USPSTF) systematic reviews of controlled clinical trials and randomized control trials: <ul style="list-style-type: none"> ○ 26 hours or more of lifestyle-based, behavioral intervention to result in improvements in weight status for up to 12 months; ○ takes place outside of the primary care setting; 	<ul style="list-style-type: none"> • O’Connor EA, Evans CV, Burda BU, Walsh ES, Eder M, Lozano P. Screening for Obesity and Intervention for Weight Management in Children and Adolescents: Evidence Report and Systematic Review for the US Preventive Services Task Force. <i>JAMA</i>. 2017;317(23):2427–2444. doi:10.1001/jama.2017.0332 • US Preventive Services Task Force. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. <i>Pediatrics</i>. 2010; 125(2):361-7. • Rodearmel SJ, Wyatt HR, Barry MJ, et al. A Family-Based Approach to Preventing Excessive Weight Gain. <i>Obesity</i>.2006;14: 1392-1401. doi:10.1038/oby.2006.158

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> ○ targets both the child and parent; ○ provides didactic information; ○ engages parents and children in goal setting and encourages self-monitoring of goals and problem-solving; ○ provides children and parents with strategies and opportunities to practice stimulus control (such as limiting screen time); and, ○ includes supervised physical activity sessions; ▪ Research highlighting the impact of: <ul style="list-style-type: none"> ○ combining behavioral skills (such as self-regulation) and social facilitation (such as self-perception and social support) to sustain weight loss ○ aligning interventions with families' cultural practices to increase initiation of healthy behaviors at home, including family meal preparation ▪ Research-validated or evidence-based programs and curricula: 5-2-1-0; Media Smart Youth; We Can! Energize Our Families; Nutrition to Grow On; and Eat Healthy, Be Active. 	<ul style="list-style-type: none"> ▪ Wilfley DE, Stein RI, Saelens BE, et al. Efficacy of Maintenance Treatment Approaches for Childhood Overweight: A Randomized Controlled Trial. <i>JAMA</i>. 2007;298(14):1661–1673. doi:10.1001/jama.298.14.1661 ▪ Miller E, Goldsworthy N, Wojtowicz A, Edens N. Family Nutrition Education Improves Healthy Eating and Preferences, but Children and Adults Differ in Behavioral Changes. <i>Journal of Nutrition Education and Behavior</i>. 2018;50(7):S61. ▪ Jarpe-Ratner E, Folkens S, Sharma S, Daro D, Edens NK. An Experiential Cooking and Nutrition Education Program Increases Cooking Self-Efficacy and Vegetable Consumption in Children in Grades 3–8. <i>Journal of Nutrition Education and Behavior</i>. 2016;48(10):697-705.
Greenlight	<ul style="list-style-type: none"> ▪ As part of the NIH-funded multi-site cluster randomized study, children who received Greenlight had a lower BMI z-score at 6, 12, and 18 months of age. ▪ There were also reductions in obesogenic behaviors, including less juice consumption by children, among families who received Greenlight. ▪ The Greenlight intervention incorporates evidence-based messages related to child obesity based on comprehensive review of evidence. 	<ul style="list-style-type: none"> ▪ Sanders LM, Perrin EM, Yin HS, Bronaugh A, Rothman RL, Greenlight Study Team. "Greenlight study": a controlled trial of low-literacy, early childhood obesity prevention. <i>Pediatrics</i>. 2014;133(6):e1724-1737. PMID: PMC4035594. ▪ Sanders LM, Perrin EM, Yin HS, et al. Results from a cluster randomized, controlled trial of a low-literacy, early childhood obesity prevention intervention. Manuscript in preparation. ▪ Ciampa PJ, Kumar D, Barkin SL, et al. Interventions aimed at decreasing obesity in children younger than 2 years: a systematic review. <i>Arch Pediatr Adolesc Med</i>. 2010;164(12):1098-104. PMID: PMC3369272.
REACH FAR	<ul style="list-style-type: none"> ▪ Culturally tailored community health worker programs have been shown to be effective in reaching and engaging populations that experience health disparities. ▪ Faith-based outreach programs have been shown to be effective in 	<ul style="list-style-type: none"> ▪ Islam NS, Wyatt LC, Taher M, et al. A culturally tailored community health worker intervention leads to improvement in patient-centered outcomes for immigrant patients with type 2 diabetes. <i>Clinical Diabetes</i>. 2018:cd170068. ▪ Islam NS, Zanolwiak JM, Wyatt LC, et al. Diabetes prevention in the New York City Sikh Asian Indian community: a pilot study. <i>International journal of</i>

Intervention	Evidence	Citations
	<p>engaging populations and fostering behavior change.</p> <ul style="list-style-type: none"> • Cultural adaptation has been shown to be essential in reaching immigrant and minority populations. 	<p><i>environmental research and public health</i>. 2014;11(5):5462-5486.</p> <ul style="list-style-type: none"> • Ursua RA, Aguilar DE, Wyatt LC, et al. A community health worker intervention to improve blood pressure among Filipino Americans with hypertension: A randomized controlled trial. <i>Preventive Medicine Reports</i>. 2018;11:42-48. • Kwon S, Patel S, Choy C, et al. Implementing health promotion activities using community-engaged approaches in Asian American faith-based organizations in New York City and New Jersey. <i>Translational behavioral medicine</i>. 2017;7(3):444-466. • Berra K, Franklin B, Jennings C. Community-based healthy living interventions. <i>Progress in cardiovascular diseases</i>. 2017;59(5):430-439. • Walton JW, Snead CA, Collinsworth AW, Schmidt KL. Reducing diabetes disparities through the implementation of a community health worker–led diabetes self-management education program. <i>Family & community health</i>. 2012;35(2):161-171. <p>Hammoud MM, White CB, Feters MD. Opening cultural doors: Providing culturally sensitive healthcare to Arab American and American Muslim patients. <i>American journal of obstetrics and gynecology</i>. 2005;193(4):1307-1311.</p>
Promoting Healthy Women, Infants and Children		
ParentChild+	<ul style="list-style-type: none"> • ParentChild+ (PC+) is a national model that has been shown to reduce the achievement gap between low-and middle-income children. PC+ is a cost-effective approach that impacts school readiness, long-term school success, and strengths-based parenting, as demonstrated in many studies, including matched comparison group and randomized control group studies. The model is replicated with high-fidelity in Sunset Park. • Compared to control groups, PC+ child graduates have: <ul style="list-style-type: none"> ○ stronger social emotional and language skills(core school readiness indicators); ○ higher levels of English proficiency in kindergarten; 	<ul style="list-style-type: none"> • ORS Impact (2015), Long-Term Academic Outcomes of Participation in the Parent-Child Home Program (PCHP) in King County, WA. Seattle, WA. • Astuto J. Playful learning, school readiness, and urban children: Results from two rcts. PCHP Annual Meeting. Uniondale, NY. May 2014. New York University • Lazar I, Darlington R. Lasting effects of early education: A report from the Consortium of Longitudinal Studies. <i>Monographs of the Society for Research in Child Development</i>. 1982;47(195). • Levenstein P, Levenstein S, Shiminski JA, Stolzberg JE. Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the Mother-Child Home Program. <i>Journal of Applied Developmental Psychology</i>. 1998;19:267-285. • Madden J, O’Hara JM, Levenstein P. Home again. <i>Child Development</i>. 1984;55:636-647.

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> ○ higher third-grade reading and math scores; ○ a significant reduction in need for special education by third grade; and ○ higher high school graduation rates. ▪ Compared to control groups, PC+ parent graduates have: <ul style="list-style-type: none"> ○ higher pro-social competence (such as fewer problem behaviors); and, ○ sustained higher-frequency and quality interactions two years after the program that correlates with children’s first grade cognitive and emotional skills. 	<ul style="list-style-type: none"> ▪ Rafoth M, Knickelbein B. Cohort One Final Report: Assessment Summary for the <i>Parent Child Home Program</i>. An evaluation of the Armstrong Indiana County Intermediate Unit PCHP program, Center for Educational and Program Evaluation located at Indiana University of Pennsylvania. 2005. ▪ Kamerman SB, Kahn, AJ. <i>Starting Right, New York</i>. Oxford University Press; 1995.
Video Interaction Project	<p>Two randomized control trials have demonstrated VIP’s impacts including:</p> <ul style="list-style-type: none"> ▪ Large impacts on positive parenting activities <ul style="list-style-type: none"> ○ reading aloud ○ teaching ○ talking & back-and-forth conversation ○ playing together ▪ Reduced harsh discipline ▪ Enhanced coping with parenting <ul style="list-style-type: none"> ○ reduced parenting stress ○ fewer depressive symptoms ▪ Enhanced parent-child relationships ▪ Enhanced child development across domains <ul style="list-style-type: none"> ○ most strongly for social-emotional development ○ reductions in hyperactivity and attention problems sustained into school entry ○ Impacts on child development occur through impacts on both parent coping with psychosocial stressors and positive parenting activities ▪ Impacts on positive parenting and child social-emotional development sustained 1.5 years after program completion ▪ Potential for further increasing impacts through linkages with community-based services, such as libraries 	<ul style="list-style-type: none"> ▪ Cates CB, Weisleder A, Johnson SB, et al. Enhancing parent talk, reading, and play in primary care: sustained impacts of the Video Interaction Project. <i>The Journal of pediatrics</i>.2018. ▪ Canfield C, Weisleder A, Cates CB, et al. Primary care parenting intervention effects on use of corporal punishment among low-income parents of toddlers. <i>Journal of Developmental and Behavioral Pediatrics</i>. 2015;36(8):586-593. ▪ Berkule SB, Cates CB, Dreyer BP, et al. Reducing Maternal Depressive Symptoms Through Promotion of Parenting in Pediatric Primary Care. <i>Clinical Pediatrics</i>. 2014; 460-469. PMID: 24707022. ▪ Cates CB, Weisleder A, Johnson SB, Seery, et al. Enhancing parent talk, reading, and play in primary care: sustained impacts of the Video Interaction Project. <i>The Journal of pediatrics</i>.2018. ▪ Mendelsohn A, Cates CB, Weisleder A, et al. Reading aloud, play, and social-emotional development. <i>Pediatrics</i>. 2018. ▪ Weisleder A, Cates CB, Dreyer B, et al. Promotion of positive parenting and prevention of socioemotional disparities. <i>Pediatrics</i>. 2016;137(2). ▪ Canfield CF, Seery A, Weisleder A, et al. Encouraging parent–child book sharing: Potential additive benefits of literacy promotion in health care and the community. <i>Early Childhood Research Quarterly</i>. 2018.

Intervention	Evidence	Citations
Project SAFE	<ul style="list-style-type: none"> • The program uses three evidence-based sexual health curricula in the multi-session workshop series that have been shown to increase knowledge and eliminate or reduce risky sexual behaviors: Be Proud! Be Responsible (BPBR), Teen Health Project, and Making Proud Choices! (MPC). • Teens participating in Project SAFE peer education groups from 2012-2015 were part of the Complementary Strengths Research Project conducted by Cornell University and demonstrated statistically significant increases in: frequency of condom use; HIV knowledge; knowledge of HIV status; and knowledge of STD status. In addition, participants demonstrated increases in school connectedness and self- efficacy, which have been shown to be protective factors against HIV infection. 	<ul style="list-style-type: none"> • Jemmott JB III, Jemmott LS, Fong, GT. Reductions in HIV risk-associated sexual behaviors among Black male adolescents: Effects of an AIDS prevention intervention. <i>American Journal of Public Health</i>. 1992;82(3):372–377. • Jemmott JB III, Jemmott LS, Fong GT, McCaffree K. Reducing HIV risk-associated sexual behavior among African American adolescents: Testing the generality of intervention effects. <i>American Journal of Community Psychology</i>.1999;27(2):161-87. • Sikkema KJ, Anderson ES, Kelly JA, et al. Outcomes of a randomized, controlled community-level HIV prevention intervention for adolescents in low-income housing developments. <i>AIDS</i>.2005;19(14):1509-1516. • Jemmott JB III, Jemmott LS, Fong, GT. Abstinence and safer sex HIV risk-reduction interventions for African American adolescents: A randomized controlled trial. <i>JAMA</i>.1998;279 (19):1529-1536.
ParentCorps	<ul style="list-style-type: none"> • Two randomized controlled trials found that ParentCorps works as intended to promote self-regulation in early childhood by strengthening adult capacity to support children’s skill development. • Specifically, ParentCorps impacts important aspects of the home and classroom environments, including increased knowledge and use of effective practices (such as setting clear expectations, positive reinforcement) and more nurturing adult-child interactions. • ParentCorps also strengthens family engagement as perceived by both parents and teachers. • ParentCorps impacts social-emotional development in Pre-K and prevents the development of mental health problems, including both emotional and behavioral problems, through second grade. • ParentCorps leads to improved academic achievement by the end of kindergarten and that impact is sustained through second grade. 	<ul style="list-style-type: none"> • Brotman LM, Calzada E, Kingston S, et al. Promoting effective parenting practices and preventing child behavior problems in school among ethnically diverse families from underserved, urban communities. <i>Child Development</i>. 2011;82(1):258-276. PMID: 1291441. • Brotman LM, Dawson-McClure S, Huang KY, et al. Early childhood family intervention and long-term obesity prevention among high-risk minority youth. <i>Pediatrics</i>.2012; 129:621-628. PMCID: PMC3289522 • Brotman LM, Dawson-McClure S, Calzada EJ, et al. randomized controlled trial of <i>ParentCorps</i>: Impact on kindergarten academic achievement. <i>Pediatrics</i>. 2013;131: e1521-1529. PMCID: PMC39641414 • Brotman LM. A population-level approach to promoting healthy development and school success in low-income, urban neighborhoods: Impact on parenting and child conduct problems. <i>Prevention Science</i>.2015;16(2):279-290. PMCID: PMC4156570. • Brotman LM, Dawson-McClure S, Kamboukos D, et al. Effects of ParentCorps in prekindergarten on child mental health and academic performance: Follow-up of a randomized

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> • For children who enter Pre-K without strong behavior regulation skills, ParentCorps reduces early behavior problems and prevents the development of obesity and unhealthful behaviors through second grade. • A benefit-cost analysis indicates that ParentCorps has the potential to yield cost savings of more than \$2,500 per student. 	<ul style="list-style-type: none"> controlled clinical trial through 8 years of age. <i>JAMA Pediatrics</i>. 2016;170(12):1149-1155. PMID: PMC5642293. • Dawson-McClure S, Calzada E, Huang KY, et al. A population-level approach to promoting healthy development and school success in low-income, urban neighborhoods: Impact on parenting and child conduct problems. <i>Prevention Science</i>. 2015;16(2):279-290. PMID: PMC4156570. • Hajizadeh N, Stevens ER, Applegate M, et al. Potential return on investment of a family-centered early childhood intervention: A cost-effectiveness analysis. <i>BMC: Public Health</i>. 2017;17(1):796. PMID: 29017527. PMC: 5635549.
Cross Sector Capacity Building Initiatives		
Brooklyn Health and Housing Consortium	<p>A growing body of evidence links poor quality housing and instability to poor health outcomes.</p> <ul style="list-style-type: none"> • Homelessness has been shown to result in: <ul style="list-style-type: none"> ○ Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis) ○ Mental health issues, including depression and elevated stress ○ Developmental delays in children • Lack of affordable housing and resulting in overcrowding, rent burden, eviction has been linked to: <ul style="list-style-type: none"> ○ Stress, depression and anxiety disorders ○ Poor self-reported health ○ Delayed or diminished access to medications and medical care • Poor housing conditions have been shown to increase risk for: <ul style="list-style-type: none"> ○ Asthma or other respiratory issues ○ Allergic reactions ○ Lead poisoning, harm to brain development ○ Other chemical or carcinogenic exposures ○ Falls and other injuries due to structural issues 	<ul style="list-style-type: none"> • Enterprise Community Partners, Inc., Center for Outcomes Research and Education (CORE). (2016). <i>Health in Housing: Exploring the Intersection between Housing and Health Care</i>. Columbia, MD: Enterprise Community Partners, Inc. • The Bronx Health & Housing Consortium. The Bronx Health & Housing Consortium. http://www.bxconsortium.org/. • Health Research & Educational Trust. (2017). <i>Social Determinants of Health Series: Housing and the Role of Hospitals</i>. Chicago: Health Research & Educational Trust. • Coley RL, Leventhal T, Lynch AD, Kull M. Relations between housing characteristics and the well-being of low-income children and adolescents. <i>Developmental Psychology</i>. 2013;49(9):1775-1789. doi:10.1037/a0031033 • Butler S, Cabello M. Housing as a hub for health, community services, and upward mobility. Washington, D.C. <i>Economic Studies at Brookings</i>. 2018 • Robert Wood Johnson Foundation. Improving the health of all Americans through safe and healthy housing. Retrieved from Commission to Build a Healthier America. 2016. http://www.commissiononhealth.org/ • Sharp M, Myers N. Stable Housing, Stable Health: Addressing Housing Insecurity through Medicaid Value-Based Payment. <i>HealthWatch, United Hospital Fund</i>. July 2018;1-9.

Intervention	Evidence	Citations
	Evidence that health systems can impact health outcomes by partnering with housing organizations.	<ul style="list-style-type: none"> • Taylor L. Housing and Health: An Overview of the Literature. <i>Health Affairs Policy Brief</i>. June 7, 2018. • Urban Institute. Emerging Strategies for Integrating Health and Housing: Innovations to Sustain, Expand, and Replication. July 2017;1-30.
CHW Research and Resource Center	<i>In development</i>	
Red Hook Community Health Network	<i>In development</i>	
Addressing Social Determinants of Health	<i>In development</i>	

Appendix F

Anticipated Impact and Performance Measures

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Preventing Chronic Disease Program: Tobacco Free Community Reach: Over 2000 community residents in the Lower East Side/Chinatown and Sunset Park						
Smoker Navigator Program	<ul style="list-style-type: none"> ▪ Enroll 85 smokers (including at least 10 NYCHA residents) ▪ Dispense nicotine replacement therapy patches/gums to at least 50 smokers ▪ Complete 35 two-week follow-up interviews ▪ Complete 35 referrals to Asian Smokers Quitline (for smokers who speak Chinese) or New York State Smokers' Quitline (for smokers who speak English) ▪ Refer 5 smokers to Smokefree Text Messaging Programs 	<ul style="list-style-type: none"> ▪ Enroll 85 smokers (including at least 10 NYCHA residents) ▪ Dispense nicotine replacement therapy patches/gums to at least 50 smokers ▪ Complete 35 two-week follow-up interviews ▪ Complete 35 referrals to Asian Smokers Quitline (for smokers who speak Chinese) or New York State Smokers' Quitline (for smokers who speak English) ▪ Refer 5 smokers to Smokefree Text Messaging Programs 	<ul style="list-style-type: none"> ▪ Enroll 85 smokers (including at least 10 NYCHA residents) ▪ Dispense nicotine replacement therapy patches/gums to at least 50 smokers ▪ Complete 35 two-week follow-up interviews ▪ Complete 35 referrals to Asian Smokers Quitline (for smokers who speak Chinese) or New York State Smokers' Quitline (for smokers who speak English) ▪ Refer 5 smokers to Smokefree Text Messaging Programs 	<ul style="list-style-type: none"> ▪ Increased self-reported use of smoking cessation treatment services and medications ▪ Increased quit attempts and quit rates among those interacting with navigators and coaches ▪ Increased satisfaction with the Smoker Navigator Program 	<ul style="list-style-type: none"> ▪ Increased smoking cessation rate among Chinese Americans and NYCHA residents ▪ Increased utilization of existing smoking cessation treatment resources 	<ul style="list-style-type: none"> ▪ AAFE tracking document for enrollment in Navigator Program ▪ Survey data collected by CSP and AAFE
Community outreach activities to increase access to smoking cessation resources	<ul style="list-style-type: none"> ▪ Reach out to 1500 people ▪ Collaborate with 7 community-based organizations (including at least 3 that work with NCHYA developments) to increase the reach of Smoker Navigator Program and educational outreach activities 	<ul style="list-style-type: none"> ▪ Reach out to 1500 people ▪ Collaborate with 7 community-based organizations (including at least 3 that work with NCHYA developments) to increase the reach of Smoker Navigator Program and educational outreach activities 	<ul style="list-style-type: none"> ▪ Reach out to 1500 people ▪ Collaborate with 7 community-based organizations (including at least 3 that work with NCHYA developments) to increase the reach of Smoker Navigator Program and educational outreach activities 	<ul style="list-style-type: none"> ▪ Increased awareness about the Smoker Navigator Program ▪ Increased knowledge about the harms of secondhand smoke exposure and existing smoking cessation treatment resources ▪ Increase use of Navigator Program 	<ul style="list-style-type: none"> ▪ Increased public support for smoke-free housing 	<ul style="list-style-type: none"> ▪ Community outreach tracking document (AAFE completes)

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	<ul style="list-style-type: none"> Deliver 3 workshops to senior centers Deliver 3 workshops at AAFE tenant meetings 	<ul style="list-style-type: none"> Deliver 3 workshops to senior centers Deliver 3 workshops at AAFE tenant meetings 	<ul style="list-style-type: none"> Deliver 3 workshops to senior centers Deliver 3 workshops at AAFE tenant meetings 			
Asian American Tobacco Free Community Initiative (AATFCI)	<ul style="list-style-type: none"> Organize 4 AATFCI meetings with partners (on a quarterly basis) Identify and invite 2 new organizations who work with immigrant populations experiencing high smoking rates to join AATFCI Identify and engage 5 community partners to join the efforts of applying for tobacco control funding from New York City Council Host 2 large group meetings with New York City Council budget initiative partners to plan for unified budget ask Host at least 5 meetings with individual AATFCI partners that work on New York City Council budget initiative Participate with AATFCI partners in 3 meetings with New York City Council members 	<ul style="list-style-type: none"> Organize 4 AATFCI meetings with partners (on a quarterly basis) Identify and invite 1 new organizations who work with immigrant populations experiencing high smoking rates to join AATFCI Identify and engage 5 community partners to join the efforts of applying for tobacco control funding from New York City Council Host 2 large group meetings with New York City Council budget initiative partners to plan for unified budget ask Host at least 5 meetings with individual AATFCI partners that work on New York City Council budget initiative Participate with AATFCI partners in 3 meetings with New York City Council members 	<ul style="list-style-type: none"> Organize 4 AATFCI meetings with partners (on a quarterly basis) Identify and invite 1 new organizations who work with immigrant populations experiencing high smoking rates to join AATFCI Identify and engage 5 community partners to join the efforts of applying for tobacco control funding from New York City Council Host 2 large group meetings with New York City Council budget initiative partners to plan for unified budget ask Host at least 5 meetings with individual AATFCI partners that work on New York City Council budget initiative Participate with AATFCI partners in 3 meetings with New York City Council members 	<ul style="list-style-type: none"> Increased access to linguistically- and culturally-competent tobacco use cessation and prevention services. Increased applications for community-based tobacco control funding from New York City Council Increased number of members and diversity of membership of AATFCI Reduce tobacco use disparities experienced by immigrant populations 	<ul style="list-style-type: none"> Reduce tobacco use disparities experienced by immigrant populations 	<ul style="list-style-type: none"> AATFCI program documentation (meeting minutes, tracking system)
Education on e-cigarette use among youth	<ul style="list-style-type: none"> Develop an interactive educational toolkit Deliver 6 workshops 	<ul style="list-style-type: none"> Refine the toolkit Deliver 6 workshops in high schools 	<ul style="list-style-type: none"> Refine the toolkit Deliver 6 workshops in high schools 	<ul style="list-style-type: none"> Increased knowledge about the harms of e-cigarette use 	<ul style="list-style-type: none"> Reduced e-cigarette initiation rate among youth 	<ul style="list-style-type: none"> Program assessment tools NY State Youth Tobacco survey

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	<ul style="list-style-type: none"> The workshops reach out to 120 adolescents and teens in total 	<ul style="list-style-type: none"> The workshops reach out to 120 adolescents and teens in total 	<ul style="list-style-type: none"> The workshops reach out to 120 adolescents and teens in total 	<ul style="list-style-type: none"> Decreased susceptibility to initiating e-cigarette use 		
WeChat Quit Coach Pilot Program	<ul style="list-style-type: none"> Develop a program protocol Develop a message and question library Enroll 20 smokers to the Program 	<ul style="list-style-type: none"> Refine the program protocol Refine the message and question library Enroll 30 smokers to the Program 	<ul style="list-style-type: none"> Refine the program protocol Refine the message and question library Enroll 30 smokers to the Program 	<ul style="list-style-type: none"> Increased knowledge about the feasibility of using social media platform in smoking cessation interventions 	<ul style="list-style-type: none"> Improve engagement and effectiveness of smoking cessation interventions targeting Chinese immigrant smokers Reduce tobacco use disparities experienced by immigrant populations 	<ul style="list-style-type: none"> Program assessment tools
Prevention Agenda Priority: Preventing Chronic Disease Program: Health + Housing Project Reach: 150-200 individuals/families						
Develop and implement a community health worker (CHW) pilot program in two low-income apartment buildings in CD 3 and explore expansion to other locations in Brooklyn	<u>Assess program effectiveness</u> <ul style="list-style-type: none"> Pre-post analysis comparing outcomes within intervention buildings before and after intervention period Analysis of SPARCS and Medicaid claims data comparing outcomes for intervention buildings with those of a matched control group Assess cost-effectiveness and ROI Work with insurers and City and State initiatives (e.g., Medicaid Redesign Teams) to develop 	<ul style="list-style-type: none"> Analysis of SPARCS and Medicaid claims data comparing outcomes for intervention buildings with those of a matched control group Publication of results 		<ul style="list-style-type: none"> Lifestyle changes (diet/exercise) Increased use of tobacco cessation resources Resolution of apartment/ structural issues Improved coordination of health care and social services Resident satisfaction with and acceptance of CHW program Increased resident engagement in improving health status and overall well being Improved management of chronic illnesses 	<ul style="list-style-type: none"> Reduced utilization of emergency departments Reduced inpatient hospital stays Improved self-reported health status Improved management of chronic illnesses Improved healthful behaviors Increased self-efficacy Decrease in smoking prevalence Reduced costs 	<ul style="list-style-type: none"> SPARCS/ Medicaid claims data Focus groups Baseline and follow-up surveys of adult residents CHW intake and encounter data Qualitative interviews with building residents and key stakeholders to assess impact of program, participant satisfaction, and community activation

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	sustainability strategy			<ul style="list-style-type: none"> Reduced utilization of emergency departments Reduced inpatient hospital stays 		
Prevention Agenda Priority: Preventing Chronic Disease Program: Healthy Habits/Programa de Hábitos Saludables Reach: 150 families						
Implement Healthy Habits/ Programa de Hábitos Saludables, a Pediatric Obesity Intervention	<ul style="list-style-type: none"> Conduct a total of 5 cycles in 2 sites Reach 50 children and families Retain ≥ 60% of enrolled families for 9 or more sessions 	<ul style="list-style-type: none"> Conduct a total of 5 cycles in 2 sites Reach 50 children and families Retain ≥ 65% of enrolled families for 9 or more sessions 	<ul style="list-style-type: none"> Conduct a total of 5 cycles in 2 sites Reach 50 children and families Retain ≥ 65% of enrolled families for 9 or more sessions 	<ul style="list-style-type: none"> Increased knowledge and awareness of nutrition, physical activity, and other healthy lifestyle concepts Improved compliance with 5-2-1-0 daily guidelines – increased fruit and vegetable consumption (to 5 or more); decreased screen time (to 2 hours or less of recreational screen time); increased activity (to 1 or more hours per day); decreased sugar sweetened beverage consumption (to 0 sugar sweetened beverages, and more water). Stabilize or reduce BMI scores 	<ul style="list-style-type: none"> Sustained change in behaviors and attitudes towards healthy living in both children and parents Reduce the percentage of children and adolescents who are obese 	<ul style="list-style-type: none"> Attendance data Height/ weight measurement (before and at the end of each cycle, and 1-year follow up) Healthy behaviors and depression screening survey administered to children (before and at the end of each cycle, and 1-year follow up) Satisfaction survey

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Preventing Chronic Disease Program: Greenlight Reach: over 2,000 children and parents/families						
<p>Continue to implement Greenlight health literacy/ parent engagement program in pediatric clinic at Charles B. Wang Community Health Center [component of program delivered by physician / provider during well-child visits]</p>	<ul style="list-style-type: none"> ▪ Provide Greenlight materials to eligible CBWCHC families at well-child visits (2, 4, 6, 9, 12, 15-18m check-ups) <ul style="list-style-type: none"> ○ Core booklets ○ Supp. booklets ○ Tangible tools (e.g. portion size snack cups) ▪ Complete assessments for 24 month visits and continue assessments for 36 month visits for families participating in evaluation ▪ Conduct training with 20 current providers (physicians, nursing staff, nutritionists, health educators) on Greenlight program / health literacy (HL)-informed counseling ▪ Maintain program reach of at least 80% of 0-2 year old children, representing at least 500 participants ▪ 1500 booklets distributed 	<ul style="list-style-type: none"> ▪ Provide Greenlight materials to eligible CBWCHC families at well-child visits <ul style="list-style-type: none"> ○ Core booklets ○ Supp booklets ○ Tangible tools (e.g. portion size snack cups) ▪ Complete assessments for 36 month visits for cohort of families participating in program evaluation ▪ Conduct training with 20 current and new providers on Greenlight program / HL- informed counseling ▪ Maintain program reach of at least 80% of 0-2 year old children, representing at least 500 participants ▪ 1500 booklets distributed 	<ul style="list-style-type: none"> ▪ Provide Greenlight materials to eligible CBWCHC families at well-child visits <ul style="list-style-type: none"> ○ Core booklets ○ Supp. booklets ○ Tangible tools (e.g. portion size snack cups) ▪ Conduct training with 20 current and new providers on Greenlight program / HL- informed counseling ▪ Maintain program reach of at least 80% of 0-2 year old children, representing at least 500 participants ▪ 1500 booklets distributed 	<ul style="list-style-type: none"> ▪ Improved parent/family knowledge, attitudes, and practices related to their child’s diet and physical activity ▪ Increased parent confidence/ empowerment ▪ Increased staff knowledge and awareness Improved provider engagement and satisfaction ▪ Greater provider use of recommended health communication strategies 	<ul style="list-style-type: none"> ▪ Healthier eating behaviors / practices for children/ families ▪ Increased physical activity / decreased sedentary time for children ▪ Reduced screen time ▪ Exploratory goal: 20% relative reduction in rate of obesity from 25% to 20% among 3-5 year olds 	<p><i>At CBWCHC:</i></p> <ul style="list-style-type: none"> ▪ Program data, including surveys of: <ul style="list-style-type: none"> ▪ 300 parent/ child dyads (baseline assessment for use in analyses of change of health and wellness outcomes, including 75 at each of 4 time points – 6 mos, 12 mos, 24 mos and 36 mos (data previously collected will serve as baseline data); ▪ 200 parent/ child dyads followed to perform exploratory assessment of intervention impacts (in progress); ▪ 10-15 providers (physicians, nurses, nutritionists, health educators) assessed via pre- and post- surveys (in progress)

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Implement Greenlight waiting room program at Charles B. Wang Community Health Center [component delivered by health educator in waiting room]	<ul style="list-style-type: none"> ▪ Maintain Greenlight waiting room program delivery to 50% of eligible children <ul style="list-style-type: none"> ○ 300 families reached ▪ Peer training of new staff ▪ Explore ability to track diet, physical activity, screen time via health educators (to allow for more tailored delivery of intervention content and for program evaluation purposes) 	<ul style="list-style-type: none"> ▪ Maintain Greenlight waiting room program delivery to 50% of eligible children <ul style="list-style-type: none"> ○ 300 families reached ▪ Peer training of new staff ▪ Explore feasibility of development of EHR data collection for HE sessions on child diet, physical activity, screen time 	<ul style="list-style-type: none"> ▪ Maintain Greenlight waiting room program delivery to 50% of eligible children <ul style="list-style-type: none"> ○ 300 families reached ▪ Peer training of new staff ▪ If feasible, health educators to collect limited standardized information in waiting area using EHR form to assess child diet physical activity and screen time use during HE sessions 			<ul style="list-style-type: none"> ▪ EHR data to track Greenlight program process measures (e.g. provider/health educator counseling, booklet /tangible tool distribution; child height/ weight data <p><i>At NYU Brooklyn 7th Avenue Clinic:</i></p> <p>Continue to collect program data, including surveys of:</p> <ul style="list-style-type: none"> ▪ 300 parent/ child dyads (baseline assessment for use in analyses of change of health and wellness outcomes, including 75 at each of 4 time points – 6 mos, 12 mos, 24 mos and 36 mos; ▪ 200 parent/ child dyads followed to assess intervention impacts; ▪ 5-10 providers (physicians, nurses, nutritionists, health educators) assessed via pre- and post- surveys
New initiative to enhance reach of Greenlight through technology enhancements at Charles B. Wang Community Health Center	<ul style="list-style-type: none"> ▪ Adaptation of Greenlight into an online Chinese language web resource, with Greenlight booklets available as digital flipbooks in English and Chinese ▪ Explore how web-tools can be used as part of Greenlight waiting room program to increase accessibility and allow for more tailored content ▪ Explore how social media platforms can be used to promote Greenlight / make 	<ul style="list-style-type: none"> ▪ Digital Greenlight flipbooks available on line for staff to send to parents and for parents to email share with family members ▪ Greenlight web tools to be introduced to parents as part of waiting room program ▪ Use of Greenlight booklets tracked via web tools ▪ Promote Greenlight materials to families at CBWCHC via social media networks ▪ Further refine and adapt Greenlight 	<ul style="list-style-type: none"> ▪ Digital Greenlight flipbooks available on line for staff to send to parents and for parents to email share with family members ▪ Greenlight web tools to be introduced to parents as part of waiting room program ▪ Use of Greenlight booklets tracked via web tools ▪ Continue to promote Greenlight materials to families at CBWCHC via social media networks 			

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	Greenlight more accessible to families served at CBWCHC	web app to optimize utilization	<ul style="list-style-type: none"> Further refine and adapt Greenlight web app to optimize utilization 			
Continue to implement Greenlight program at additional CBWCHC practices	<ul style="list-style-type: none"> Continue to make Greenlight materials available to CBWCHC Flushing sites 	<ul style="list-style-type: none"> Continue to make Greenlight materials available to CBWCHC Flushing site 	<ul style="list-style-type: none"> Continue to make Greenlight materials available to CBWCHC Flushing site 			
Continue to implement Greenlight program at NYU Family Health Center (FHC) - 7 th Avenue Site	<ul style="list-style-type: none"> Provide Greenlight intervention to eligible families at the NYU FHC Brooklyn 7th Avenue site at well child visits (2, 4, 6, 9, 12, 15-18 month check-ups), including core and supplement booklets as well as tangible tools, and waiting room education component Continue to enroll cohort of families as part of program evaluation (total of 200 families) Conduct training with 10 current providers (physicians, nursing 	<ul style="list-style-type: none"> Provide Greenlight intervention to eligible families at the NYU FHC Brooklyn 7th Avenue site at well child visits, including core and supplement booklets as well as tangible tools, and waiting room education component Continue to conduct assessments for cohort of families as part of program evaluation Conduct training with 10 current providers on Greenlight program 	<ul style="list-style-type: none"> Provide Greenlight intervention to eligible families at the NYU FHC Brooklyn 7th Avenue site at well child visits, including core and supplement booklets as well as tangible tools, and waiting room education component Continue to conduct assessments for cohort of families as part of program evaluation Conduct training with 10 current providers on Greenlight program 			

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	staff, nutritionist, health educators) on Greenlight program /health literacy-informed counseling <ul style="list-style-type: none"> Maintain program reach of at least 80% of 0-2 year old children, representing ~100 patients and their families 300 booklets distributed 	/health literacy-informed counseling <ul style="list-style-type: none"> Maintain program reach of at least 80% of 0-2 year old children, representing ~100 patients and their families 300 booklets distributed 	/health literacy-informed counseling <ul style="list-style-type: none"> Maintain program reach of at least 80% of 0-2 year old children, representing ~100 patients and their families 300 booklets distributed 			
Implement Greenlight at new practices	<ul style="list-style-type: none"> Explore implementation of Greenlight at other NYU Family Health Centers (FHC) sites, including implementation of the waiting room program 	<ul style="list-style-type: none"> Implement Greenlight at the NYU Family Health Centers (FHC) Sunset Park, including implementation of the waiting room program 150 families / patients reached at NYU FHC Sunset Park site 	<ul style="list-style-type: none"> Implement Greenlight at the NYU Family Health Centers (FHC) Sunset Park, including implementation of the waiting room program 300 families / patients reached at NYU FHC Sunset Park site 			
Prevention Agenda Priority: Preventing Chronic Disease Program: REACH FAR Brooklyn: Preventing Chronic Disease through Engagement with Community and Faith-Based Organizations in Brooklyn Reach: over 3,500 community residents						
Implement nutritional policy in faith-based settings (FBO)	<ul style="list-style-type: none"> Identify champion or health committee at Brooklyn Islamic Center and Darul Jannah Jame Masjid Engage with FBO leadership and host implementation planning meetings 	<ul style="list-style-type: none"> Identify champion or health committee at 2 additional mosques in Brooklyn: Al-Aman Masjid and Baitul Jannah Masjid Engage with FBO leadership and host 	<ul style="list-style-type: none"> Conduct quarterly monitoring of nutritional policy change at Brooklyn Islamic Center and Darul Jannah Jame Masjid and 2 additional mosques in Brooklyn Al-Aman 	<ul style="list-style-type: none"> Increased percentage of people reporting healthy change in diet in the past 3 months 	<ul style="list-style-type: none"> Increased frequency of those reporting having tried healthy options at communal meals 	<ul style="list-style-type: none"> Baseline and follow-up nutritional survey

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	<ul style="list-style-type: none"> Conduct baseline nutrition survey with 150 congregants Conduct baseline organizational assessment Implement nutritional change reaching all congregants 	<ul style="list-style-type: none"> implementation planning meetings Conduct baseline nutrition survey with 150 congregants Conduct baseline organizational assessment Implement nutritional change reaching all congregants Conduct quarterly monitoring of nutritional policy change at Assafa and Madina 	Masjid and Baitul Jannah Masjid			
Implement blood pressure screening program in FBO setting	<ul style="list-style-type: none"> Identify champion or health committee at Brooklyn Islamic Center and Darul Jannah Jame Masjid Train 5 volunteers at FBO site on Keep on Track (KOT) manual Implementation planning – training of key personnel, development of implementation protocol Launch KOT program, enrolling 75 congregants at each site Conduct monthly blood pressure screening with 50 congregants at each site 	<ul style="list-style-type: none"> Identify champion or health committee at 2 additional mosques in Brooklyn: Al-Aman Masjid and Baitul Jannah Masjid Train 5 volunteers at FBO site on KOT manual Implementation planning – training of key personnel, development of implementation protocol Launch KOT program, enrolling 75 congregants at each site Conduct monthly blood pressure screening with 50 congregants at each site (4 sites total) 	<ul style="list-style-type: none"> Conduct monthly blood pressure screening with 50 congregants at each site (4 sites total) 	<ul style="list-style-type: none"> Increased prevalence of self-reported blood pressure screening 	<ul style="list-style-type: none"> Increased percentage of controlled hypertension (systolic BP<140, diastolic BP<90) among those with hypertension 	<ul style="list-style-type: none"> Baseline and follow-up survey among participants enrolled in the program Participant tracking cards

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Community-Clinical Linkage for Diabetes	<ul style="list-style-type: none"> Conduct baseline assessment of availability existing diabetes management and prevention resources Refer 50 congregants from FBO and CBOs to DREAM education programs Conduct 4 community-wide activities supporting diabetes management and prevention activities Implement referral mechanisms from FBO/CBOs to existing community-based prevention and management classes 	<ul style="list-style-type: none"> Provide DOHMH-facilitated technical assistance and resources to 1 CBO/FBO to establish new culturally tailored programs Implement 1 new diabetes management or prevention program at CBO or FBO enrolling 50 people 	<ul style="list-style-type: none"> Dissemination of information about community-based diabetes prevention and management programs 	<ul style="list-style-type: none"> Increased knowledge of diabetes management and prevention skills Increased number of referral to DREAM Education program 	<ul style="list-style-type: none"> Increased percentage of people reporting lower blood sugar level or hemoglobin A1c Increased capacity in FBO or CBO to provide diabetes management or prevention support to the congregants 	<ul style="list-style-type: none"> Pre and post-test among the participants attending educational programs
Arab American Needs Assessment	<ul style="list-style-type: none"> In collaboration with the NYULH Brooklyn Arab American Advisory Council (19 community-based organizations), conduct needs assessment of the Arab American community in southwest Brooklyn Develop and implement community survey Conduct 2 focus groups and 5 key informant interviews 	<ul style="list-style-type: none"> Complete data analysis and develop and share report Disseminate report and begin development of culturally tailored strategies and programs 	<ul style="list-style-type: none"> TBD 			

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Promoting Healthy Women, Infants and Children Program: ParentChild+ Reach: 180 families						
Implement ParentChild+, an early literacy, school-readiness and parenting home-visiting program	<ul style="list-style-type: none"> Provide home visiting services for 52 families Conduct a total of 1,196 home visits Retain 90% of enrolled families for duration of program year Distribute 572 educational toys and 624 books to participating families 	<ul style="list-style-type: none"> Provide home visiting services for 52 families Conduct a total of 1,196 home visits Retain 90% of enrolled families for duration of program year Distribute 572 educational toys and 624 books to participating families 	<ul style="list-style-type: none"> Provide home visiting services for 52 families Conduct a total of 1,196 home visits Retain 90% of enrolled families for duration of program year Distribute 572 educational toys and 624 books to participating families 	<ul style="list-style-type: none"> Parents: Increased knowledge and awareness of child development Parents: Increased use of positive parenting techniques Children: Improved social and emotional development as well as early literacy skills essential for school readiness 	<ul style="list-style-type: none"> Children will outperform the statewide average on their third grade state math achievement test Children will graduate from high school at the same rate as their middle class peers, eliminating disparities in education attainment based on income 	<ul style="list-style-type: none"> Attendance data Documentation of the number of sessions and distribution of curricular materials to families Parent and Child Together (PACT) assessment administered to parents at beginning and end of each program year Child Behavior Traits (CBT) assessment administered to children at beginning and end of each program year

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Promoting Healthy Women, Infants and Children Program: Video Interaction Project Reach: 450 – 650 parent/child dyads						
One-on-one sessions with VIP Coach	<u>Implementation</u> <ul style="list-style-type: none"> Work with practice leadership, providers and staff to refine pathways and processes for referral and implementation within current practice flow <u>Participants</u> <ul style="list-style-type: none"> Deliver one-on-one VIP sessions to 100 families 	<u>Implementation</u> <ul style="list-style-type: none"> Work with practice leadership, providers and staff to continue to optimize pathways and processes for referral and implementation within current practice flow <u>Participants</u> <ul style="list-style-type: none"> Deliver one-on-one VIP sessions to 150 families 	<u>Implementation</u> <ul style="list-style-type: none"> Continue to work with practice leadership, providers and staff for ongoing optimization pathways and processes for referral and implementation within current practice flow <u>Participants</u> <ul style="list-style-type: none"> Deliver one-on-one VIP sessions to 200-400 families 	Positive parenting activities (reading aloud, playing together, etc.) Learning materials in the home (toys and books) that support positive parenting activities Enhanced parent capacity for coping with stressors (e.g., reduced parenting stress)	Positive parenting activities (reading aloud, playing together, etc.) Learning materials in the home (toys and books) that support positive parenting activities Enhanced parent capacity for coping with stressors (e.g., reduced parenting stress) Child school readiness (could be from social-emotional or other domains)	<ul style="list-style-type: none"> Attendance Visit documentation notes Pre-post parent surveys VIP provider surveys
Linkages with FHC programs, (including programs through New York City Council City's First Readers initiative, CFR)	<u>Implementation</u> <ul style="list-style-type: none"> Refine linkages between CFR and VIP programs Refine linkages between Healthy Steps and VIP programs 	<u>Implementation</u> <ul style="list-style-type: none"> Continue to refine linkages between CFR and VIP programs Continue to refine linkages between Healthy Steps and VIP programs 	<u>Implementation</u> <ul style="list-style-type: none"> Maintain linkages between CFR and VIP programs Maintain linkages between Healthy Steps and VIP programs 	<ul style="list-style-type: none"> In addition to above, receipt of mental health support through Healthy Steps for families in need of services 	<ul style="list-style-type: none"> In addition to above, receipt of mental health support through Healthy Steps for families in need of services 	<ul style="list-style-type: none"> Attendance Referral documentation within visit notes Pre-post parent surveys
Linkages with community programs (through New York City Council City's First Readers initiative, CFR)	<u>Implementation</u> Brooklyn Public Library (BPL): <ul style="list-style-type: none"> Pilot and refine processes for providing families with 	<u>Implementation</u> <ul style="list-style-type: none"> BPL: continue to refine processes for linkages PC+: refine processes for linkages 	<u>Implementation</u> <ul style="list-style-type: none"> BPL: maintain processes for linkages PC+: maintain processes for linkages 	<ul style="list-style-type: none"> As above for VIP delivery 	<ul style="list-style-type: none"> As above for VIP delivery 	<ul style="list-style-type: none"> Documentation of library card provision and resource provision within visit notes

Prevention Agenda Priority: Promoting Healthy Women, Infants and Children

Program: Video Interaction Project

Reach: 450 – 650 parent/child dyads

	<p>Brooklyn Public Library library cards</p> <ul style="list-style-type: none">▪ Pilot and refine processes for providing information about BPL family programs▪ PC+: Work with PC+ to understand opportunities/capacity for linkages▪ Pilot and refine processes for linkages <p><u>Participants</u> Brooklyn Public Library: provide library cards and/or information about local library resources for 50 families</p>	<p><u>Participants</u> Brooklyn Public Library: provide library cards and/or information about local library resources for 100 families</p>	<p><u>Participants</u> Brooklyn Public Library: provide library cards and/or information about local library resources for 150 families</p>			<ul style="list-style-type: none">▪ Pre-post parent surveys
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Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Promoting Healthy Women, Infants and Children Program: Project SAFE Reach: over 5,000 teens						
Multi-Session Workshop Series	<ul style="list-style-type: none"> Conduct a total of 46 cycles of Be Proud! Be Responsible (BPBR) and Making Proud Choices! (MPC) Curricula administered with high fidelity Reach 1155 teens 308 teens referred to social and health services Expand to 2 new sites 75% of workshop participants will complete 75% of workshops 	<ul style="list-style-type: none"> Conduct a total of 50 cycles of BPBR and MPC Curricula administered with high fidelity Reach 1300 teens 350 teens referred to social and health services Expand to 2 new sites 75% of workshop participants will complete 75% of workshops 	<ul style="list-style-type: none"> Conduct a total of 60 cycles of BPBR and MPC Curricula administered with high fidelity Reach 1400 teens 375 teens referred to social and health services Expand to 2 new sites 75% of workshop participants will complete 75% of workshops 	<ul style="list-style-type: none"> Increased knowledge and awareness of STD, HIV, and pregnancy prevention Increased knowledge of resources Improved behavior change - intent to use and actual use of skills, practices, and resources 	<ul style="list-style-type: none"> Reduced teen pregnancy Reduced disparities in teen pregnancy rate for Hispanic and African American teens in relation to white teens Reduced teen birth rate Reduced disparities in teen birth rate for Hispanic and African American teens in relation to white teens Reduced disparities in teen birth rate for teens with Medicaid in relation to teens not on Medicaid Reduce STI and HIV rates among male and female adolescents and young adults 	<ul style="list-style-type: none"> Pre/post survey Referral sheets, including documentation confirming first visit Implementation data
Single-Session Workshops	<ul style="list-style-type: none"> Peer Educators and staff facilitate 23 single-session workshops Reach 462 teen participants 	<ul style="list-style-type: none"> Peer Educators and staff facilitate 25 single-session workshops Reach 500 teen participants 	<ul style="list-style-type: none"> Peer Educators and staff facilitate 30 single-session workshops Reach 600 teen participants 	<ul style="list-style-type: none"> Increased knowledge and awareness of STD, HIV, and pregnancy prevention Increased knowledge of prevention and intervention resources 	<ul style="list-style-type: none"> Reduced disparities in teen birth rate for teens with Medicaid in relation to teens not on Medicaid Reduce STI and HIV rates among male and female adolescents and young adults 	<ul style="list-style-type: none"> Post workshop survey Implementation data

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Promoting Healthy Women, Infants and Children Program: Project SAFE Reach: over 5,000 teens						
Peer Education Groups	<ul style="list-style-type: none"> Recruit and train 46 teens 42 teens serve as Peer Leaders Retain ≥ 70% of enrolled teens 	<ul style="list-style-type: none"> Recruit and train 60 teens 55 teens serve as Peer Leaders Retain ≥ 70% of enrolled teens 	<ul style="list-style-type: none"> Recruit and train 60 teens 55 teens serve as Peer Leaders Retain ≥ 70% of enrolled teens 	<ul style="list-style-type: none"> Increased knowledge and skills – facilitation, community event planning/outreach Increased knowledge and awareness of STD, HIV, and pregnancy prevention Increased knowledge of resources Increased number of sexually active youth who consistently use condoms Enhanced social skills of youth that can be utilized in peer to peer interaction to diminish the risk of HIV infection. Increased number of sexually active youth using contraception to prevent unintended pregnancy 		<ul style="list-style-type: none"> Complementary Strengths Survey – baseline assessment, re-administered every six months of participation in the program Implementation data

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Promoting Healthy Women, Infants and Children Program: Project SAFE Reach: over 5,000 teens						
Community Events	<ul style="list-style-type: none"> Host or perform at 5 community events Reach 231 youth (50% unduplicated) 50 youth receive HIV screening at Project Reach Youth (PRY) hosted events Additional 116 tested at cohosted events 	<ul style="list-style-type: none"> Host or perform at 6 community events Reach 300 youth (50% unduplicated) 60 youth receive HIV screening at PRY hosted events Additional 150 tested at cohosted events 	<ul style="list-style-type: none"> Host or perform at 6 community events Reach 300 youth (50% unduplicated) 60 youth receive HIV screening at PRY hosted events Additional 150 tested at cohosted events 	<ul style="list-style-type: none"> Increased knowledge and awareness of STI, HIV, and pregnancy prevention Increased knowledge of prevention and intervention resources 		<ul style="list-style-type: none"> Post-event survey Screening records
Teen Health Clinic	<ul style="list-style-type: none"> 350 teens receive screenings and other services at the Teen Health Clinic and School Based Health Centers (SBHCs) PrEP and PEP services expanded – 1155 teens receive screenings 150 youth receive substance abuse screening 	<ul style="list-style-type: none"> 350 teens receive screenings and other services at the Teen Health Clinic and SBHCs services expanded – 1300 teens receive screenings and connection to services services expanded – 250 youth receive substance abuse screening 	<ul style="list-style-type: none"> 350 teens receive screenings and other services at the Teen Health Clinic and SBHCs services expanded – 1400 teens receive screenings and connection to services services expanded – 350 youth receive substance abuse screening 	<ul style="list-style-type: none"> Increased knowledge of HIV and STI status Increased knowledge of contraceptive options Increased knowledge of substance abuse treatment and support resources 		<ul style="list-style-type: none"> Appointment records CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screening tool for adolescent
Staff and Parent Workshops	<ul style="list-style-type: none"> Staff facilitate 4 single-session workshops for staff and parents Reach 35 adult participants 	<ul style="list-style-type: none"> Staff facilitate 6 single-session workshops for staff and parents Reach 40 adult participants 	<ul style="list-style-type: none"> Staff facilitate 8 single-session workshops for staff and parents Reach 50 adult participants 	<ul style="list-style-type: none"> Increased knowledge of best practices for communication with teens about sexual health Increased knowledge of health resources for teens 		<ul style="list-style-type: none"> Post workshop survey Implementation data

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Promoting Healthy Women, Infants and Children/Preventing Chronic Disease Program: ParentCorps Reach: 1,700 annually						
Develop and provide enhanced evidence-based and culturally relevant products to children and families enrolled in DOE Pre-K programs within Sunset Park, Brooklyn	<ul style="list-style-type: none"> ▪ Needs Assessment <ul style="list-style-type: none"> ▪ 30 families ▪ 30 teachers ▪ 10 leaders ▪ Develop portfolio of evidence-based and culturally relevant products in partnership with leaders, teachers and parents (Webinars for educators and families, tools, materials and products for classrooms/teachers and for families) 	<ul style="list-style-type: none"> ▪ Distribute portfolio of products <ul style="list-style-type: none"> ▪ 31 Pre-K programs serving ~1,700 children and families 	<ul style="list-style-type: none"> ▪ Distribute portfolio of products <ul style="list-style-type: none"> ▪ 31 Pre-K programs serving ~1,700 children and families 	<u>Pre-K Program</u> <ul style="list-style-type: none"> ▪ Increased use of evidence-based and culturally relevant policies and practices in support of Family Engagement and Social Emotional Development ▪ Positive reputation among families regarding culturally relevant policies and practices 	<u>Pre-K Program</u> <ul style="list-style-type: none"> ▪ Intermediate plus ▪ Welcoming hub of evidence-based and culturally relevant services and offerings for families in support of family health and wellness outcomes 	<ul style="list-style-type: none"> ▪ Focus Groups ▪ Parent and Teacher surveys ▪ Leader Reports ▪ Observations ▪ DOE administrative data
		<ul style="list-style-type: none"> ▪ Obtain feedback and refine accordingly <ul style="list-style-type: none"> ▪ 30 families ▪ 30 teachers ▪ 10 leaders 	<u>Families</u> <ul style="list-style-type: none"> ▪ Families engaged in school community and perceive school as a welcoming and supportive place ▪ Parents feel valued and empowered to support and advocate for their children ▪ Children build foundational skills for learning and healthful development 	<u>Families</u> <ul style="list-style-type: none"> ▪ Families have access to a range of services, programs and opportunities for building social capital and health promotion ▪ Children engage in healthful behaviors, are confident problem-solvers and see themselves as important members of the school community 		

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Cross Sector Capacity Building Program: Brooklyn Health & Housing Consortium						
<p>The Brooklyn Health & Housing Consortium (BKHHC) is a collaborative network of healthcare, housing, and community providers with the shared goal of improving health equity by fostering relationships, developing infrastructure, and building capacity to support people with health and housing needs, with an initial focus on Southwest Brooklyn.</p>	<p><u>Program planning and needs assessment</u></p> <ul style="list-style-type: none"> ▪ Hold Steering Committee meetings 4-6 times a year ▪ Monitor goals and priorities of the Consortium ▪ Implement medical respite needs assessment in Brooklyn hospitals ▪ Work with Bronx Health & Housing Consortium for guidance on BKHHC activities and strategic development <p><u>Program development and implementation</u></p> <ul style="list-style-type: none"> ▪ Organize trainings and events of interest to Consortium members ▪ Evaluate trainings ▪ Convene interagency case conferences around shelter-hospital communication to develop work flow document to use for training 	<p><u>Continue program implementation and tracking</u></p> <ul style="list-style-type: none"> ▪ Track: <ul style="list-style-type: none"> ○ # steering committee meetings ○ # trainings and attendance ○ # case conferences and attendance ○ # and type of training materials produced ○ # hospitals and organizations involved in BKHHC events ○ # surveys collected for medical respite needs assessment ○ # local politicians met with ○ # city agencies collaborate with <p><u>Assess program implementation</u></p> <ul style="list-style-type: none"> ▪ Analyze training evaluations ▪ Analyze medical respite assessment surveys ▪ Debrief with steering committee about 	<p><u>Continue program implementation and partnership development and assess program effectiveness</u></p> <ul style="list-style-type: none"> ▪ Work with hospitals and MCOs on the importance of medical respite ▪ Collaborate with city hospitals, agencies and CBOs on importance of standardized city-wide housing insecurity screening 	<p>Have systems in place to:</p> <ul style="list-style-type: none"> ▪ Ensure effective and timely communication between homeless shelters/supportive housing and hospitals ▪ Establish medical respite beds in Brooklyn ▪ Conduct housing insecurity screen with all incoming hospital patients in NYC ▪ Communicate between different city, borough and local stakeholders on issues pertaining to health and housing 	<ul style="list-style-type: none"> ▪ Reduced inpatient hospital stays due to lack of appropriate housing for discharge ▪ Fewer inappropriate hospital discharges of homeless patients ▪ Increased resources for housing insecure residents ▪ Standardized housing insecurity screener used at all NYC hospitals with appropriate referral process in place 	<ul style="list-style-type: none"> ▪ Hospital discharge data ▪ Medical respite needs assessment ▪ Training evaluations ▪ Meeting minutes ▪ EMR data on housing screening

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	<ul style="list-style-type: none"> ▪ Participate in annual HOPE Count by assisting with count of homeless in Brooklyn EDs ▪ Develop and implement medical respite assessment survey in Brooklyn hospitals ▪ Convene partners working on housing insecurity screen for hospitals ▪ Outreach to potential hospitals and CBOs to join Consortium ▪ Convene borough wide stakeholder meeting ▪ Develop advocacy platform and collaborate with city agencies and local politicians 	<p>progress and priorities</p> <ul style="list-style-type: none"> ▪ Continue collaboration with Bronx Health & Housing Consortium 				