SUMMARY

Following a community health needs assessment that analyzed the needs and assets of the Community Districts in lower Manhattan (south of 59th Street), the NYU Langone Medical Center selected Manhattan Community District 3 (CD 3) – the Lower East Side and Chinatown – as the core focus of its Community Service Plan. This community, with its areas of concentrated poverty and high percentage of Latino and Asian residents – groups that experience disparities in many health outcomes – was identified as having the greatest potential for health improvement through Community Service Plan partnerships.

In the fall of 2013, the Medical Center launched its new Community Service Plan, which takes a family-centered, multi-sector approach to reducing risk factors for obesity, cardiovascular disease and cancer in CD 3. These priorities align with the New York State Prevention Agenda and New York City public health priorities; reflect the key causes of premature mortality across the City, State and country; and are key concerns in CD 3.

Over the course of our first two years we have:

- Adapted and implemented three evidence-based programs and launched one new pilot initiative;
- Developed strong and collaborative partnerships with a wide range of community organizations and government agencies; and
- Brought attention and resources to meet the needs of this community.

And we have built a platform – a structure and set of relationships – to support health promotion and disease prevention at the neighborhood level with a focus on issues of high priority to the public’s health.

MISSION STATEMENT

NYU Langone Medical Center, a world-class, patient-centered, integrated, academic medical center, is one of the nation’s premier centers for excellence in clinical care, biomedical research and medical education. Located in the heart of Manhattan, NYU Langone is composed of three hospitals (the “Hospitals Center”) – Tisch Hospital, its flagship acute care facility; the Rusk Institute of Rehabilitation Medicine, the world’s first university-affiliated facility devoted entirely to rehabilitation medicine; and the Hospital for Joint Diseases, one of only five hospitals in the nation dedicated to orthopaedics and rheumatology – plus the NYU School of Medicine, which since 1841 has trained thousands of physicians and scientists who have helped to shape the course of medical history. With the recent merger of NYU Langone and NYU Lutheran, the expanded healthcare delivery system will provide better care to more New Yorkers in more locations than ever before. The Medical Center’s tri-fold mission to serve, teach and discover is achieved 365 days a year through the seamless integration of a culture devoted to excellence in patient care, education and research. For information about the Medical Center’s financial assistance program go to: http://www.nyulangone.org/files/72504-financialassistpamp-TH-EngR.PDF

Through impact-oriented research and front-line partnerships, the Department of Population Health at NYU Langone Medical Center is bridging the worlds of medical care and public health to improve peoples’ lives and the health of populations in New York City and around the globe. As part of carrying out this mission, the Department has helped shape NYU Hospitals Center’s Community Health Needs Assessment and Community Service Plan.
Our programs span multiple sectors:

- **Community-based early childhood education settings and schools** – ParentCorps, an evidence-based family-centered early childhood intervention to improve child health, behavior and learning, is being implemented in partnership with University Settlement Society of New York and with the Earth School, a public elementary school in CD 3;

- **Primary care** – Greenlight, a program to improve health literacy and foster healthful behavior that is being tested in a national randomized control trial, 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;

- **Community** – a community navigator program to facilitate access to smoking cessation treatment and reduce children’s exposure to secondhand smoke is being adapted and implemented in partnership with Asian Americans for Equality;

- **Housing** – a Community Health Worker program to address social, environmental, behavioral, and structural determinants of health is being implemented 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, the NYC Department of Housing Preservation and Development, Hester Street Collaborative, the Chinatown Y, and with support from the Robin Hood Foundation.

**PROGRESS**

**In early childhood education settings and schools:**

Developed by NYU Langone Medical Center’s Center for Early Childhood Health and Development, ParentCorps is a family-centered, school-based intervention that aims to help parents and teachers create safe, nurturing and predictable environments for young children. It is delivered as an enhancement to Pre-Kindergarten (Pre-K) programs serving large numbers of low-income families. The program includes professional development for teachers and a 14-session program implemented by mental health professionals and teachers and offered to all families of children enrolled in Pre-K. Two cluster randomized trials of ParentCorps found impact on early childhood health and development.

Through the Community Service Plan, ParentCorps has partnered with University Settlement Society, a large social service agency; and with the Earth School, an elementary school located on East 6th Street.
In partnership with University Settlement Society, in the first two years of the Community Service Plan, ParentCorps provided professional development to 56 University Settlement staff, including a four-day series called ParentCorps FUNdamentals. In addition, 21 teachers, teaching assistants and school aides received training and coaching on implementation of the ParentCorps Program for Students (“Friends School”) in Pre-K classrooms, and six social workers, family service workers and school aides received training and coaching on the ParentCorps Parenting Program.

Building on this foundation, in 2014-2015, all Pre-K classrooms implemented the Friends School curriculum, providing the 14 session intervention to 147 children. In addition, University Settlement mental health professionals and staff implemented six 14-session series of the Parenting Programs reaching 116 families. The Parenting Program series were implemented in English, Mandarin, and Cantonese. Teachers and mental health professionals received weekly coaching by ParentCorps throughout the year to support them in following the program model.

Parents and caregivers were asked to complete brief questionnaires after each session. More than 90% reported that they felt welcomed and respected, supported and valued by program facilitators. Nearly all parents stated that they were able to understand the material presented and were ready to try the strategies at home. Importantly, the vast majority of parents indicated that they felt more confident in their ability to support their children’s development.

Beginning in 2013, mental health professionals and other staff from the Earth School (PS 364) received professional development so that they could offer the Parenting Program to families of Pre-K students. During the 2014-15 school year, the Earth School successfully implemented a 14-session cycle of the Parenting Program to 21 families.

In 1992, teachers in Manhattan’s East Village founded the Earth School to create a peaceful, nurturing place to stimulate learning in all realms of child development intellectual, social, emotional and physical. Today it is a thriving community of over 300 children in pre-kindergarten through grade 5 with a teaching staff dedicated to the founding values of hands-on exploration, an arts-rich curriculum, responsible stewardship of the Earth’s resources, harmonious resolution of conflict, and parent-teacher partnership.
Leaders and staff from University Settlement and the Earth School are committed to providing evidence-based ParentCorps programs to the children and families served throughout their early education programs. By providing ParentCorps as an enhancement to high-quality early childhood education, children are much more likely to develop the foundational self-regulation and social-emotional skills necessary for school success and healthy development.

**Here’s what parents said about ParentCorps programs:**

- “Today’s group was very enlightening and helpful. The support offered was amazing. The concerns expressed by other parents were similar to my concerns.”
- “As a grandparent, I was happy that I was able to be here for my daughter. Being a support system, I learn a lot from other parents.”
- “I was able to express my views on discipline and learn new strategies.”
- “I am confident that I can hear about some great parenting techniques to teach my child.”
- “From all the parents I learned that children have different responses to different strategies. I will try to find one that fits mine.”

**PROGRESS**

*In the primary care setting:*

Taking advantage of the frequency of primary care pediatric visits in the early years of life, the Department of Pediatrics at NYU Langone Medical Center, in partnership with the Charles B. Wang Community Health Center (CBWCHC), has adapted 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 how to communicate with families using toolkits that contain culturally-tailored educational materials for people with low 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. Minority, immigrant families are at increased risk. Low health literacy and...
Numeracy is associated with lower rates of breastfeeding, difficulty understanding food labels and portion sizes, and higher rates of obesity.

Early intervention for Chinese American immigrants is critically important in preventing obesity and its health consequences later in life. A study several years ago by CBWCHC found that 24.6% of the children in the pediatric practice (drawn largely from the Chinatown area) were overweight or obese. Among U.S. born boys ages 6-12, the combined prevalence of overweight and obesity was 40%. This problem is magnified by the fact that Asian populations appear to be more vulnerable to the onset of Type II diabetes at lower weights.

In adapting the Greenlight program for Chinese American immigrant families, the team strove to go beyond translating language and changing ethnicity in photographs. As one community member observed, “Translation is necessary, complicated and insufficient.” Greenlight’s materials reflect deeper cultural values, norms and lifestyle differences. (For specific examples, view the Greenlight team’s poster, which they recently presented at National Association of Community Health Centers annual conference, where it won 2nd prize: http://bit.ly/24wXUci)

The process has been complex, including outreach to over 160 parents, three focus groups with parents (two in Mandarin and one in Cantonese), and two focus groups with 17 providers/health educators. In addition, providers (physicians, nurses, nutritionists) and health educators have provided 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.

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 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.
Over the past year, we have rolled out a full set of materials (core and supplemental booklets and tools all translated into Traditional and Simplified Chinese), trained providers, and enrolled families into the Greenlight program.

To date, we have trained 15 providers (4 health educators, 11 pediatricians, 2 nurses, 2 nutritionists); completed baseline surveys of 280 parent/child-dyads to assess baseline behaviors, attitudes, and practices, and child weight; and recruited 62 parent/child-dyads who will be followed as they receive the program from 2 months through 2 years of age. An additional 81 parents have received the waiting room program as part the piloting and development stage of the program.

For many immigrant groups, each subsequent generation is at increased risk for obesity and for the development of diabetes. By engaging families in the pediatric setting, Greenlight can prevent this health trajectory for the Chinese American population, which is one of the fastest growing immigrant groups in NYC.

**PROGRESS**

**In the community:**

Although New York City has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 13.9% in 2014, the rates of reduction across populations have been uneven and income-related and racial and ethnic disparities persist. Of particular concern is the smoking rate among Asian American men in NYC (21.3% in 2014) – the only group that has a higher rate of smoking now than it did in 2002.

*Source: New York City Department of Health and Mental Hygiene, Community Health Survey 2002-20014. Available at: https://a816-healthpsi.nyc.gov/epiquery/

A recent study underscores the urgent need to address smoking in NYC housing. 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. This is of great concern in CD 3 where housing is overcrowded and where, according to data from the NYC Department of Health and Mental Hygiene, adults are significantly less likely to have adopted a smoke-free home policy than adults in other neighborhoods. Thus, the rates of exposure to secondhand smoke (SHS) among families living in CD 3 are likely to be dangerously high, placing many children at risk of SHS-related health consequences.

In partnership with Asian Americans for Equality (AAFE), experts from the Section on Tobacco, Alcohol, and Drug Use in NYULMC’s Department of Population Health are implementing a community navigator model, which mirrors the patient navigator model that has been well studied and implemented by the American Cancer Society.

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.

This model provides lay workers or resident/community volunteers the skills to educate and motivate people in the community to address modifiable health risks like tobacco use and link community members to evidence based smoking cessation resources. Despite the availability of safe and effective treatment for tobacco dependence, only a small proportion of smokers who try to quit each year use cessation therapies. This is particularly true among low-income adults and for non-English language speakers, contributing to growing disparities in smoking prevalence. The CSP navigator program is designed to address this gap.
In our first year of the CSP, NYULMC experts on tobacco cessation provided comprehensive training to 14 staff from community based organizations and separately trained 11 members of the AAFE staff. Our approach is comprehensive, raising awareness about the often hidden threat of SHS in multiunit housing and ensuring that smokers have access to evidence-based treatment.

Training focused on the use of Motivational Interviewing techniques to: (a) assess readiness to change smoking behavior; (b) employ strategies to increase motivation; (c) inform smokers about free evidence based smoking cessation resources; and (d) for those ready to quit, link smokers to services including arranging doctor appointments and connecting smokers to the New York State or Asian Smokers Quitline. The program was extremely well-received, with all participants reporting significant increases in knowledge and confidence. Subsequently, many of our partners and other community groups and agencies have requested training for their staff. This year, we continued to provide tobacco cessation trainings to our community partners, including two separate trainings with 3 staff members from AAFE and 9 health educators from CBWCHC.

Since the inception of the CSP, building on AAFE’s existing programs and relationships in the community, we have reached over 970 smokers, many of whom had never previously tried to quit or cut down. Of the 158 who received counseling, 131 (83%) were given nicotine replacement therapy. Of the 114 smokers who were followed-up at two weeks, 96 (84%) report cutting back on smoking and 25 (22%) quit altogether. We are also tracking calls to the Asian Smokers Quitline, which have tripled since implementation of outreach with 45 calls.

In addition, AAFE now screens for tobacco use on all of its intake forms (for housing, insurance, small business development) and provides information about smoking cessation at community meetings on a wide array of topics. This kind of institutional change in practice is an important element of community capacity building and a way to ensure sustainability.

Growing out of this partnership, the Charles B. Wang Community Health Center was awarded a grant from the RCHN Community Health Foundation to address the high rates of smoking among Chinese American men. Activities include:
- Developing a bi-lingual smoking cessation coaching program;
- Providing smoking cessation counseling and personalized follow-up to support changes in smoking behaviors;
• Developing communication strategies to deliver key anti-smoking messages through print, broadcast and digital media platforms (first press conference for Chinese language media held on November 18, 2015);
• Training and encouraging private practice physicians to adopt tobacco screening, counseling, and referral protocols; and
• Establishing multi-sector partnerships to deliver key messages and services.

PROGRESS

Housing:

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. To address these needs, this year we launched a pilot Community Health Worker (CHW) program in two low-income buildings located on the Lower East Side in partnership with Henry Street Settlement, the NYU Furman Center for Real Estate and Urban Policy, the New York City Housing Authority, the NYC Department of Housing Preservation and Development, Hester Street Collaborative, the Chinatown Y, and with support from the Robin Hood Foundation.

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

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. Through these programs, seniors received nutrition, case management and other vital services; youth received educational, recreational and employment services; members of our community received primary and mental health care, free legal and financial counseling and help accessing benefits including low-cost health insurance; homeless individuals and families received shelter and supportive services; the unemployed or underemployed were connected to jobs, and thousands of individuals of all ages were provided access to the arts, including dance, music, theater and visual arts.

Thus far, we have held two workshops to understand more about residents’ needs and priorities; community surveyors currently are surveying residents to inform the intervention and to provide baseline information for the evaluation (over 300 surveys completed to date) and we have hired and trained bilingual CHWs (Chinese/English and Spanish/English).
PROGRESS

Dissemination:

The Community Health Needs Assessment/Community Service Plan, together with this Progress Report, are conspicuously posted on the Medical Center’s internal and external (http://www.nyulangone.org/our-story/community-health-needs-assessment-service-plan) 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. 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 Report are available without charge to anyone upon request and are regularly distributed at meetings with members of Community Boards 3 and 6, with policymakers, and community members. Through the outreach and engagement activities described below, we continually seek to keep the community informed about our activities and to get feedback and input. This year we also sent out an electronic newsletter to nearly 400 people, including policymakers, partners, community groups and colleagues (see: http://eepurl.com/bDaEgy).

PROGRESS

Community engagement:

The overarching goal of the Community Service Plan is to help improve the health of the population of CD 3. 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.

Early in the first year of the CSP, we created a Coordinating Council composed of NYU Langone Medical Center faculty and staff, and leadership and staff of our community partners. The Coordinating Council has met every three months since September 2013 to coordinate the various projects and ensure that they are meeting milestones, maximizing their impact, and fostering cross sector collaboration. As we have identified shared challenges and opportunities, we have invited expert consultants – from across New York University as well as other institutions – to discuss issues of behavior change, cross cultural communication, community-based participatory approaches to program development and evaluation, and motivational interviewing.

In addition to its regular meetings, in the first year, the Coordinating Council also sponsored a community forum on the changing demographics of CD 3, presented by Joseph Salvo, PhD, and Peter Lobo, PhD, Director and Deputy Director respectively of the Demography Division of the NYC Office of City Planning. This event was attended by over 50 people, including staff and leadership from all of our partner organizations, the District Manager and staff of Community Board 3, and central medical center administrators. We also periodically invite members of the Coordinating Council to attend presentations of interest at the Medical Center and have plans in the coming year to host other community events.
Over the course of our first two years, our relationships with our partners, as well as with other groups in the community, have grown. For example, the Charles B. Wang Community Health Center has repeatedly welcomed a group of medical students, and is working with other NYULMC faculty on a variety of initiatives. We partnered with Asian Americans for Equality and CBWCHC to develop a grant proposal to support and expand their tobacco-related work. And we work with other organizations, including the Two Bridges Neighborhood Council, in their efforts to increase access to healthy food and to support physical activity on the Lower East Side. (See: http://www.twobridges.org/press-publications/what-s-new/213-two-bridges-neighborhood-council-receives-healthy-neighborhoods-funds-grant-from-the-new-york-state-foundation)

Finally, we continue to meet with advocates, service providers, and community groups, including committees of Community Board 3 as well as Community Board 6 (the Board that covers the area in which the Medical Center is geographically based) to provide regular updates and opportunities for input.