NYU Hospitals Center

Community Health Needs Assessment and Community Service Plan

September 1, 2013 – August 31, 2016

Copies of this document can be downloaded from the NYU Langone Medical Center website at: http://www.med.nyu.edu/about-us/who-we-are/community-needs-assessment-service-plan

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SUMMARY

Aligning with New York State and New York City public health priorities, and building on the scientific and clinical capacities of NYU Langone Medical Center, the Hospitals Center’s three year Community Service Plan takes a family-centered, multi-sector approach to reducing risk factors for obesity, cardiovascular disease and cancer in the Lower East Side and Chinatown. Through its Community Service Plan, the Hospitals Center brings to bear a wide range of expertise: in obesity prevention, health literacy, parenting, family engagement, smoking cessation, prevention science, implementation science, community-based participatory research, and population health.

Children and families are at the center of our Community Service Plan, which engages community-based and government partners across four sectors:

- Childcare programs and schools
- Housing developments
- Primary care settings
- Local businesses

The partnerships at the core of our Plan will provide an agile yet enduring framework for cross-sectoral initiatives measurably to improve health in our neighboring communities.

COMMUNITY HEALTH NEEDS ASSESSMENT

I. Hospitals Center Mission Statement

NYU Langone Medical Center—a world-class, patient-centered, integrated, academic medical center—is one of the nation’s premier destinations for excellence in patient care, biomedical research, and medical education. Located in the heart of Manhattan, NYU Langone is composed of Tisch Hospital, its flagship acute care facility; the Hospital for Joint Diseases, a dedicated inpatient orthopaedic hospital; Hassenfeld Pediatric Center, a comprehensive pediatric hospital supporting a full array of children’s health services; and Rusk Rehabilitation, the #1 rehab program in New York since U.S. News & World Report began its hospital rankings in 1989 (the “Hospitals Center”). It also includes a growing ambulatory care network with locations throughout Manhattan, the outer boroughs, and the tri-state area, bringing services directly to where its patients live and work. An integral part of NYU Langone, NYU School of Medicine has trained thousands of physicians and scientists who have helped to shape the course of medical history and enrich the lives of countless people since 1841. NYU Langone's tri-fold mission to serve, teach, and discover is achieved 365 days a year.
The commitment of NYU Langone to the health of the community was recently strengthened with the launch of a new Department of Population Health in the spring of 2012, with the mission of advancing the health of populations by discovering new knowledge that informs policy and practice, educating tomorrow’s leaders, and serving local, national and global communities. As part of carrying out this mission, the Department has been asked to help shape NYU Hospitals Center’s Community Health Needs Assessment and Community Service Plan, described below.

In addition to providing the highest quality care to the patients of the Hospitals Center, the Hospitals Center seeks to bring its scientific and clinical capacities to bear to support the health of broader populations in the community, fostering healthy behavior change and reducing risk factors for disease. 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.

II. Definition and Brief Description of Community Served

As a major academic medical center, NYU Hospitals Center serves a broad community of diverse populations with a wide range of health care needs. Its primary service area includes zip codes in Manhattan, Brooklyn and Queens; its secondary service area extends into Staten Island, Long Island, Westchester, and New Jersey. The Hospitals Center’s 2012 discharge data depicts a broad geographic area from which the hospitals draw patients: no single zip code accounts for more than 4% of discharges.

Reflecting this broad catchment area, we have analyzed citywide data on health needs as part of the Community Health Needs Assessment. In addition, as part of this assessment, we have undertaken a more in-depth analysis of the needs and assets of the Community Districts in lower Manhattan (south of 59th Street). In doing so, Community District 3 in Manhattan (CD3), which includes the Lower East Side...
and Chinatown, stood out as having the greatest potential for health improvement through Community Service Plan-related partnerships. (A list of data sources accessed is set forth in Appendix A.)

Although lower Manhattan as a whole has relatively low poverty rates, CD3 has a poverty rate of 31.4% for families with children under 18, compared with 21% for Manhattan as a whole. 51% of the population residing in CD3 receives income support. Within CD3, there are areas of concentrated poverty. The wealthiest census tract has a median family income of $171,458, compared with the poorest census tract, which has a median family income of $20,271.

Of the 163,000 residents in CD3, 34% are Asian and 25% are Latino. Census tracts in which Latinos and Asians live are more likely to be poor and to have residents with limited English proficiency.
In light of the density of concentrated poverty in CD3 as well as its high percentage of Latinos and Asians – groups that experience disparities in many health outcomes – we selected this geographic area as a core focus of the Hospitals Center’s Community Service Plan since it is as the closest area of greatest need.

III. Public Participation

In assessing community need and setting priorities, we consulted on multiple occasions with numerous public health experts in the City and State Health Departments, the State Office of Mental Health, the City Department of Education, and other agencies and organizations with expertise on the needs of low-income populations and children. We also met with many community leaders and community-based organizations to understand their perspectives on community needs and assets, and to begin to develop partnerships to address the issues identified. A list of people and organizations consulted to date is attached as Appendix B. Because the development and implementation of the Community Service Plan is an iterative process, ongoing outreach and evolution of related partnerships will continue over the next three years.

In addition, public notification about the assessment and plan development was provided through meetings with the Human Services, Health, Disability, & Seniors/Youth & Education Committee of Community Board 3 and with the Health, Seniors & Disabilities Subcommittee of Community Board 6, which covers the area in which the Hospitals Center is located.
Through these meetings and interviews, as well as through an extensive review of secondary sources of data (see Appendix A for list of data analyzed), we have compiled a profile of the health needs and strengths of CD3. This analysis has, in turn, informed the priorities and partnerships that comprise our Community Service Plan.

IV. Assessment and Selection of Public Health Priorities

As described below, our Community Service Plan takes a multi-sector, family-centered approach to reducing risk factors for obesity, cardiovascular disease and cancer. These priorities are aligned with New York State’s Prevention Agenda 2013-2017 and New York City’s public health priorities and plans for the next generation of Take Care New York 2016. The Prevention Agenda 2013-2017 identifies reducing obesity and tobacco use as the first two priorities under the Preventing Chronic Disease Action Plan. The State’s plan notes that these priorities were selected because “they are the leading causes of preventable death” and because they “disproportionately impact low-income and minority communities.” Similarly, the NYC Department of Health and Mental Hygiene (DOHMH) has identified being “tobacco free” and “healthy eating” and “active living” as the top three priorities in the proposed Take Care New York 2016.

As described below, preventing obesity and reducing tobacco use are also key concerns in CD3, and the evidence-based programs we are adapting and implementing to address these issues allow us to bring to bear the substantial scientific and clinical expertise of the Hospitals Center in obesity prevention, health literacy, parenting, family engagement, smoking cessation, prevention science, implementation science, community-based participatory research, and population health.

A. Priority Area: preventing obesity

Although a recent study found an encouraging decrease in the prevalence of obesity among elementary school children in NYC, obesity continues to be epidemic: more than half of adult New Yorkers are overweight (34%) or obese (22%). Obesity begins early in life. Two out of every five NYC elementary school children are overweight or obese, putting these children at immediate 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.

The link between tobacco use and cancer is widely recognized, but there is less public awareness of the link between obesity and cancer. According to the National Cancer Institute, obesity is associated with increased risks of cancers of the esophagus, breast, endometrium (the lining of the uterus), colon and rectum, kidney, pancreas, thyroid, and gallbladder. One study estimated that in 2007 in the U.S., about 4% of new cases of cancer in men and 7% in women were due to obesity. The percentage of cases attributed to obesity varied widely for different cancer types but was as high as 40% for some cancers.
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: the adult obesity rate is 18% among Whites, 27% among Latinos, and 34% among Blacks. And the lowest income New Yorkers have a rate of obesity almost twice that of the highest earners. Obesity rates among NYC’s children vary dramatically. For example, the obesity rate among Latino children in the City’s public schools is 53% higher than that of White children.

Understanding the extent of this and other health problems in Community District 3 is a challenge. CD3 is a very diverse community, economically and in terms of race and ethnicity. One census tract with a median family income of $25,700 abuts another with an income of $115,495 – a nearly five-fold difference. The census tracts in which Latinos and Asians live are more likely to be poor and to have residents with limited English proficiency. Other census tracts are largely White, middle or upper-middle class and English-speaking. As a result, the City’s health data for the neighborhood, which is defined to include Union Square, mask large pockets of need associated with poverty and with racial and ethnic disparities in health.

Despite these limitations, all available data and input from community leaders – including parent groups, health care providers, early childhood experts, teachers, and health advocates – indicate that childhood obesity is a significant problem in Community District 3 and that promoting healthy eating and physical activity are high priorities. For example, a study by researchers at the Charles B. Wang Community Health Center 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%. Given emerging evidence that Asian populations are more vulnerable to insulin resistance at lower weights, as well as the large and vulnerable Latino population in this community, it is not surprising that the rates of diabetes in CD3 are among the highest in Manhattan. Noting that the “crisis” of obesity and overweight is fueled by neighborhood poverty, the Community Board, in its District Needs Statement for Fiscal Year 2013, calls for a “comprehensive approach” to address this problem by “engaging families, the school district, as well as health care centers in the community.”

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 (e.g., eating habits, 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.
Parents can therefore play a critical role in the prevention of obesity among young children. However, there are substantial challenges to engaging low-income families, who are 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. Successful efforts to engage parents and other key family members in obesity prevention will need to address these challenges.

Another critical moment for intervention is at the time of adolescence when children develop better abstract reasoning ability, are better able to consider the consequences of their actions, and have more control over what they eat and how they spend their time. Overweight adolescents with metabolic syndrome have a sevenfold greater risk for developing diabetes and twice the risk for developing cardiovascular disease. The cluster of metabolic syndrome risk factors is generally silent and remains undetected until medical testing or presentation of overt disease. Adolescents are low users of preventive health care services and are unlikely to come to medical attention until symptomatic, by which time their health problems are more difficult to reverse.

As described below, we are proposing to take advantage of significant synergies across the Hospitals Center – within the Departments of Population Health, Psychiatry, Pediatrics, and the Cancer Institute – as we work with community partners to address these challenges and reduce early childhood obesity. The Hospitals Center brings scientific and clinical capacities to support obesity prevention, health literacy, parenting, family engagement, prevention science, implementation science, and population health. Our community partners, including the University Settlement House, the Charles B. Wang Community Health Center, and the New York City Department of Education and Department of Health and Mental Hygiene, bring tremendous expertise in education, childcare and delivery of health care services, together with on-the-ground experience linking families to needed services. Building on innovative evidence-based models, we are proposing a community-centered approach that emphasizes child wellness through improved nutrition and physical activity, and family engagement.

**B. Priority Area: 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 440,000 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, 25,500 people die each year from a smoking-related disease and 3,040 non-smokers die each year from exposure to others’ smoking. 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.

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 a new emphasis on developing strategies to reduce the toll of secondhand smoke exposure, particularly among children. 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. Living in multiunit 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 14.8% in 2011. But the rates of reduction across populations have been uneven and income-related and racial and ethnic disparities persist. In 2011, the smoking prevalence of adults overall in NYC was 14.8% compared to 18.4% among low-income adults. Of particular concern is the smoking rate among Asian men in NYC (22.6%), which, by contrast with most other groups and despite targeted DOHMH efforts, has remained steady since 2002.

Not surprisingly, given these demographic trends, the challenge in CD3, with its pockets of poverty and large Asian population, remains higher than in much of the rest of Manhattan. In response, Community Board 3 has identified “expanded and enhanced outreach to help residents stop smoking” as a key health priority. Indeed, several years ago, the Community Board passed a resolution supporting measures to limit tobacco marketing to youth by restricting sales in pharmacies, decreasing the visibility of tobacco marketing in stores, and limiting the sale of tobacco products near schools.

Although many community leaders in CD3 recognize smoking cessation as a public health priority, many also noted that it may not be high on the list of concerns for community residents, particularly for those who are struggling with other stressors and pressing immediate needs. Yet, as noted above, with the price of cigarettes over $11 a pack, the direct economic impact of continued smoking among low-income groups is significant. In addition, according to data from the New York City DOHMH, adults in lower Manhattan are significantly less likely to have adopted a smoke-free home policy than adults in other neighborhoods (33% of homes in Lower Manhattan do not have a smoke-free policy compared to 16% in Upper West Side). Of particular relevance, given
the large Asian American population in this neighborhood, Asian American non-smokers are less likely to prohibit smoking in the home than are other non-smokers. Thus, the rates of exposure to secondhand smoke among many families and children living in CD3 are likely to be dangerously high.

As described below, in partnership with housing experts, schools, health care settings and the New York City DOHMH Bureau of Chronic Disease, NYULMC experts in tobacco control will develop and implement programs to reduce exposure to secondhand smoke in public and private housing units in lower Manhattan and increase access to evidence-based smoking cessation treatment.

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 initiative identifies ten key priority areas for the City; our Plan focuses primarily on the top three: tobacco-free living, healthy eating and active living.

Selecting priority areas for the Hospitals Center’s Community Service Plan and using resources efficiently and effectively necessarily means concentrating on some specific challenges and affording less attention to others. For example, in meetings with members of the Community Board and in the Community Board’s District Needs Statement, the need for substance abuse treatment and for mental health services, particularly for children and adolescents and for Latino and Chinese populations, were identified as pressing concerns. Other key informants noted the aging of the population in CD3 and the need to reach isolated elderly residents.

Many important community organizations and health care providers are addressing these and other issues. As described below, through continued outreach and by developing an Advisory Committee, we will coordinate our efforts with those of other groups and initiatives so they and we continue to have a comprehensive and up-to-date understanding of community needs and resources.

D. Information gaps that limit the Hospitals Center’s ability to assess the community’s 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 of CD3 – economically and in terms of race and ethnicity – necessitates a more granular, on-the-ground approach to understanding community needs and assets. Our engagement with community partners and meetings with community residents and organizations has greatly enhanced our understanding of the community’s needs and priorities. As described below, this process will continue as the partnership develops over the life of the Plan.
E. Existing facilities and resources

To develop an inventory of community 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 CD3. These provided a useful and comprehensive guide and checklist. In addition, we gained a deeper understanding of community assets from interviews and meetings with community leaders.

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 organizations, including University Settlement House, 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. Many smaller grassroots groups continue to serve this neighborhood and will be invaluable partners in any 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.

CD3 also has many valued health care providers, including the William F. Ryan-NENA Community Health Center, the Betances Health Center, and the Gouverneur Diagnostic and Treatment Center, among others. In addition to the Charles B. Wang Community Health Center, which is a partner in the Community Service Plan, there are others with whom we have met (see Appendix B) and others with whom we plan to meet as we evolve and coordinate our efforts.

**COMMUNITY SERVICE PLAN/IMPLEMENTATION STRATEGY**

**V. Three Year Plan of Action**

The Hospitals Center’s three year Community Service Plan takes a family-centered, multi-sector approach to reducing risk factors for obesity, cardiovascular disease and cancer in the Lower East Side and Chinatown. Children and families are at the center of our Plan, which engages community-based and government partners across four sectors:

- Childcare programs and schools
- Housing developments
- Primary care settings
- Local businesses

Over the course of implementing the Plan, through the Coordinating Council and Advisory Committee described below, we will continue to build bridges and develop relationships across the sectors.
The graphic below outlines the partnership, programmatic elements of the Plan, and expected outcomes. These are described in detail in the sections that follow.

**Sector 1: Childcare settings and schools** – implementing an evidence-based professional development and parenting program to lower rates of obesity and improve mental health; and screening, educating, and referring overweight youth at risk for diabetes and cardiovascular disease

**ParentCorps**

ParentCorps is a population-level approach to buffering the adverse effects of poverty and related stressors on early child development by engaging and supporting both parents and teachers at children’s transition to school. The goal is to promote child self-regulation (including emotion regulation, coping skills, and problem-solving) by increasing positive behavior support (e.g., nurturing parent-child interactions, reinforcement for competencies, proactive strategies), effective behavior management (e.g., limit setting, consistent consequences for misbehavior), and parent involvement in education in home and early childhood education settings.

ParentCorps is implemented in early childhood education or childcare settings and includes: (1) professional development for teachers and other caregivers (including an innovative e-learning and social networking program); and (2) a 14-session weekly group educational series for parents and children.
Two federally-funded, randomized controlled trials with more than 1,200 poor, minority NYC children have found that ParentCorps results in more supportive and nurturing home and early childhood classroom environments, higher kindergarten achievement test scores (reading, writing and math) and, among the highest-risk children, lower rates of obesity and mental health problems.

In 2012, the evidence in support of ParentCorps and our capacity for high-quality implementation and dissemination was reviewed by the Substance Abuse and Mental Health Services Administration (SAMHSA). ParentCorps is now included in the SAMHSA National Registry of Evidence-based Programs and Practices; it is the only early childhood program developed specifically for poor, minority children.

For the past 15 years, we have partnered with New York City and New York State policy makers, community stakeholders, and child advocates across child education, health, and childcare settings. Key partners include the NYC Department of Education Office of Early Childhood Education, the New York State Early Childhood Advisory Council, the New York State Office of Mental Health, Harlem Children’s Zone, University Settlement House, and the Child Center of New York.

We have provided professional development and consultation to teachers in pre-kindergarten, kindergarten and first grade across 18 schools in Brooklyn and the Lower East Side, and four community-based organizations with early childhood programming in Queens, Brooklyn and Manhattan. ParentCorps after-school family groups have been delivered to more than 1000 families.

For the past four years, we have provided professional development and consultation to all of the New York City Early Childhood Social Workers (approximately 80) working with the 559 pre-kindergarten programs throughout all five boroughs, serving more than 23,000 pre-kindergarten students each year.

ParentCorps Academy (PCA) will support partner organizations and elementary schools with Universal Pre-Kindergarten Programs in CD3 in the following ways:

1. **Readiness for ParentCorps:** PCA will help schools and partner organizations make decisions about program adoption and, through readiness assessment and alignment of philosophy, policy and practice, prepare for implementation and plan for sustainability of ParentCorps.
2. **Professional Development and Consultation**: PCA will prepare mental health professionals (typically social workers with early childhood and family engagement experience), their supervisors, teachers and school leadership teams to implement ParentCorps. Professional development and consultation uses a competency model of instruction and interactive and experiential learning that builds on the professional education and the experience of the participants. PCA faculty will provide ongoing consultation on professional practice issues (mental health or education) as they relate to the ParentCorps model and in the context of school or partner organization policies, programs and practices.

3. **Marketing and Communications**: PCA will provide an array of materials for implementing schools and partner agencies to use to increase family engagement and program awareness among a broad range of stakeholders, including messaging for parents and educators about early child development and learning.

   Within Community District 3, we will market the program to local school networks and community-based agencies with early childhood education and childcare programming (Universal Pre-Kindergarten, Head start, daycare). This communication strategy will include presentation of the value of the program aligned with partner goals, research evidence, and strategies for covering costs with existing funds (e.g., strategies for schools to use Title I money for family engagement or State Department of Education Pre-Kindergarten funds, Head Start quality indicators).

4. **High-Quality Implementation**: Replication of the ParentCorps impact relies on high quality program implementation, including achieving high levels of family engagement, especially of the highest-need families. High quality implementation also involves high levels of teacher engagement and achieving specific benchmarks of quality in early childhood classrooms.

   The ParentCorps Quality Implementation Data-Driven Decision Support System (QIDDSS) will provide the mechanism for monitoring implementation fidelity at the school/program level and identifying the need for technical assistance or additional implementation supports. Performance data are also provided to the partner organization so that they can make informed decisions about programming and future investments.

5. **Community-Level Innovations**: QIDDSS allows for integration of data across schools and organizations, thereby supporting strategic planning and business operations and facilitating networking opportunities and innovation across partner organizations. QIDDSS also allows us to identify the need for improvements and augmentations to support program implementation in new settings and with new populations.

Building on the work of the previous Community Service Plan, we will continue to support and expand services within University Settlement and their early childhood programs, and in PS 188 and 4 other public schools with Universal Pre-Kindergarten programs within CD3.
University Settlement House

University Settlement offers a range of programs that address challenges and needs of diverse children, their parents and caregivers, including high-quality early childhood programs for low-income families. For working parents, this solves an urgent childcare problem while providing their children with cutting edge literacy and math curriculums, small classes and multi-lingual teachers. For children who don't speak English at home, their classroom experience is a bridge to English language skills critical for success in elementary school.

In 2012, we provided ParentCorps training for 58 early childhood staff at University Settlement. Following our timeline for ParentCorps implementation, in 2013-2014 we will consult with the early childhood leadership team at University Settlement on philosophies, policies and practices in early childhood and provide training for 30 additional staff, including 5 Early Childhood Mental Health Professionals. In collaboration with University Settlement early childhood leadership, we will implement a classroom-based program as part of the curriculum one morning a week and provide parallel parenting groups. Through this part of the program, we will serve approximately 225 students from 19 early childhood classrooms, 11 in their Brooklyn location and 8 in the Lower East Side. Additionally, 100 parents are expected to participate in the ParentCorps parent groups across the University Settlement programs (Early Learn Sites, Butterflies Program, and Project Hope). These activities will continue in 2014-2015 and 2015-2016, serving a total of 225 students per year and 100 parents per year. Over a three-year period, 675 students and 300 families will be served across 19 classrooms in two sites of University Settlement.

Elementary Schools with Pre-Kindergarten Programs

There are 12 elementary schools with pre-kindergarten programs in Community District 3. We will continue to provide professional development and support for the 3 Department of Education Early Childhood Social Workers who serve these schools. We will also provide comprehensive services to PS 188, where we have already begun our partnership, and four additional schools following the ParentCorps implementation model.
In 2013-2014, implementation of ParentCorps will begin in PS 188 and ParentCorps Academy (PCA) will conduct readiness assessments in 4 additional schools, which will then implement the program in the subsequent years of the Community Service Plan.

PS 188
PS 188/The Island School, a pre-kindergarten through 8th grade school located on the Lower East Side of Manhattan near several large public housing developments, serves over 400 children from the predominantly Hispanic community surrounding the school. Believing in the “full service community school model,” the school has developed an extensive network of collaborators enabling it to provide a wide range of services to children and families. For example, the Ryan-NENA Health Center provides an on-site medical clinic staffed by nurse practitioners; the Jewish Board provides on-site mental health screening and individual, small group, and family therapy; and the NYC Department of Health and Mental Hygiene provides on-site dental screenings. For the past several years, the school has partnered with ParentCorps to engage families and provide support to teachers and early childhood staff in the pre-kindergarten program.

In PS 188 and the 4 new schools, PCA will provide professional development and technical assistance regarding family engagement and healthy development to 18 pre-kindergarten teachers and nine kindergarten teachers. PCA will also provide training and support on the classroom-based program and parallel parenting groups will be conducted by the early childhood social workers in all five schools. Through these programs, a total of 830 pre-kindergarten and kindergarten students and 385 parents will be served over the three-year period.

The BODY Project

The Banishing Obesity and Diabetes in Youth (BODY) Project is a school-based longitudinal intervention in its sixth year of operation. Supported by the Community Service Plan for four years, the BODY Project medically screens overweight and obese high school students, provides personalized medical feedback, and connects students and their families to appropriate healthcare providers in their community. The American Academy of Pediatrics and the American Diabetes Association have advocated medical screening for obese and overweight children, particularly those who belong to minority groups or have a family history of diabetes. However, these recommendations have not been implemented in a widespread fashion. By partnering with NYC public high schools that serve a high percentage of culturally and ethnically diverse students who qualify for free lunch, the BODY Project aims to reach and serve a population of adolescents carrying excess weight that to date has been poorly served. By bringing screening to the school setting, the BODY Project seeks to make this service convenient and accessible so that young people are more likely to avail themselves of it than if they had to travel elsewhere to do so.

The mission of the BODY Project is to halt the progression of obesity-related disease among adolescents by providing students and their families with personally relevant health information that will incentivize them to institute lifestyle changes, lose weight, and improve their health. Because of the longitudinal nature of the project, students have the opportunity to participate in multiple academic years, allowing for longitudinal comparison of body mass index (BMI), medical lab results, and responses to survey questions, yielding data that can be used in evaluating program impact. The BODY
Project, which is housed in the Department of Psychiatry, is carried out in partnership with the NYC Department of Education, NYC DOHMH, and the Nathan Kline Institute. The BODY Project’s approach is to emphasize health rather than size. By providing adolescents with their medical “numbers,” together with recommendations to improve them as indicated, the goal is to foster weight loss and healthier lifestyle.

To date, the BODY Project has partnered with 8 high schools located in Manhattan and Brooklyn, collecting over 13,500 heights and weights with which to calculate each student’s BMI. Of participating students, 32.3% met criteria for overweight or obesity. All students with a BMI in the overweight or obese range are invited to participate in the feedback component of the project. Parental consents are obtained for assenting students under age 18, opening the door to conducting fuller medical screening for metabolic syndrome and educating students and their parents/caregivers about associated risk factors.

The BODY Project has been very well received by student participants and their families, as well as by school administrators, school health center staff, and physical/health education instructors. To date, approximately 4,137 medical screens have been completed and each student and his/her family have received a report of the student’s results in a straightforward and easy-to-understand personalized report written in both English and Spanish. (Evaluations are provided by the BODY Project team at no cost to students, their families, the school, or the school-based health center.) Only about 23% of the overweight and obese students screened have no medical abnormalities. Importantly, approximately 30% of these students have one metabolic syndrome risk factor, 25% have two risk factors, and 22% have three or more risk factors, thus meeting criteria for a diagnosis of metabolic syndrome. In addition, BODY Project staff uncovered five cases of type 2 diabetes in students who, because of the insidiousness of the symptoms, were unaware that they had a serious condition.

BODY Project staff members follow up with students whose results fall outside of the healthy range and contact their parent/guardian to review the child’s medical report as well as to offer referrals to either the school-based health center (if there is one at the school) or to health care providers in their neighborhood. Through the personalized report and follow-up referrals, students and their families are educated on the health risks associated with obesity and are provided with recommendations based on their individual results in an attempt to halt the progression to type 2 diabetes and/or early cardiovascular disease. In addition, during year 6, a pilot project was launched, BODY Project Plus, in which participants were invited to educational sessions with NYU medical students. These sessions began in a large group setting with a presentation that provided an overview of the national obesity epidemic and its health consequences. Medical students then met with the participating high school students in small groups to discuss the specific components of the BODY health report. Finally, the high school students participated in a “reflective assignment” that involved assessing their own lifestyle, identifying changes that might make for a healthier lifestyle, and considering how the information provided in the educational session could be personally applicable. Handouts were provided that outlined tips for healthy living and students had the
opportunity to speak with the medical students individually about their personalized report.

As part of the current Community Service Plan, the BODY Project will continue its partnership with schools in lower Manhattan. Current BODY Project staffing includes Spanish speakers and all reports and other materials have been translated into Spanish. Two to three hundred medical screenings will be provided for students and individualized health referrals will be made for youth with high risk factors. The success of the referral process will be ascertained through surveys of the families of participating students, and evaluation of overall program impact on health outcomes will determine its future configuration within the Community Service Plan.

**Sector 2: Primary care – adapting and implementing an evidence-based program to improve health literacy and foster family engagement to lower rates of childhood obesity in the Chinese American community**

Pediatric primary health care may represent the only truly universal, population-level platform for engagement of difficult to reach, low-income families prior to school entry. Pediatric primary care’s potential effectiveness as a point of intervention is the result of many factors, including: (1) multiple visits beginning in infancy that are attended by nearly all families in order to meet school vaccination and screening requirements; (2) existing relationships between pediatric practices and families that have recently been strengthened through “family-centered medical home” models; and (3) existing infrastructure that can be used as a low-cost platform.

Using the infrastructure of the primary care pediatric visit, the NYU Langone Medical Center Department of Pediatrics will partner with the Charles B. Wang Community Health Center to create an innovative model, adapting for use in the Chinese community an evidence-based health literacy informed program, GREENLIGHT, designed to foster family engagement in the prevention of early childhood obesity.

GREENLIGHT is an innovative, evidence-based program that uses health literacy principles to address obesity. Approximately 90 million Americans have basic or below basic literacy skills, and 110 million have basic or below basic quantitative (numeracy) skills; minority, immigrant families are at particular risk. Low literacy/numeracy skills are independently associated with poor understanding of health information, poor health behaviors, and worse clinical outcomes. In the context

**The Charles B. Wang Community Health Center**
For more than 40 years, the Charles B. Wang Community Health Center 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. The Pediatric Clinic at the CBWCHC Chinatown site serves close to 8,500 patients, through over 30,000 visits annually to their primary care and subspecialty clinics.

In addition to providing comprehensive primary care, the Center promotes the overall health of the community through innovative health education and disease prevention programs. The Center partners with many health care providers, government agencies, managed care plans, schools, churches, businesses, media, and community-based organizations to assess community needs and develop effective interventions. In recent years, the Center has been very active in the areas of obesity prevention, cancer screening, hepatitis B, and chronic diseases management.
of obesity, low health literacy/numeracy is associated with lower rates of breastfeeding, difficulty understanding food labels and portion sizes, and higher BMI. Over the past decade, there has been increased focus on incorporating evidence-based health literacy strategies into interventions to promote patient engagement in disease management, particularly for adults, but there has been limited work targeting pediatrics and childhood obesity.

The GREENLIGHT program provides training in communication skills to pediatricians and facilitates the use of GREENLIGHT toolkits (low-literacy, culturally-tailored educational materials) during well-child visits. Preliminary results from a federally funded randomized control trial with 865 English- and Spanish-speaking families show better self-reported diet and physical activity-related infant care behaviors among intervention families, including more breastfeeding and decreased TV watching.

As part of the Community Service Plan, we will adapt this program for the Chinese American population served by the Charles B. Wang Community Health Center (CBWCHC), in which nearly 1 in 4 preschool children are overweight or obese. To facilitate implementation in this practice setting, the program will be extended beyond the visit with the clinician to include a unique waiting room parent engagement program modeled after the Health Education and Literacy for Parents (HELP) project, which was developed by Medical Center faculty and has been used within the Bellevue Hospital’s Pediatric outpatient clinic for over 10 years. By training staff and volunteers, this program makes productive use of waiting time to build parent confidence and knowledge, using an interactive, informal and flexible approach based on a parent-directed, layered curriculum.

In the first year of the Community Service Plan, we will adapt the GREENLIGHT program for use at CBWCHC. This will entail:

- Translating (into Simplified and Traditional Chinese) and culturally adapting existing GREENLIGHT materials (targeting 0-2 year olds) for the Chinese population served by CBWCHC;
- Developing a plan for adapting GREENLIGHT materials for 2-5 year olds in order to extend this intervention into the preschool period;
- Developing a plan to train medical providers (nurses, physicians, nutritionists) in low literacy communication strategies using GREENLIGHT;
- Developing a plan to expand the delivery of GREENLIGHT curriculum through a waiting room component involving health educators and specially trained volunteers (including trained parent health educators), modeled after Bellevue’s HELP program.

During the first year of the Plan, focus groups and interviews will be used to explore parent/caregiver knowledge, attitudes, and practices related to child nutrition/physical activity, as well as satisfaction with provider counseling practices, to inform the
development of GREENLIGHT materials. Focus groups and interviews will also be conducted with healthcare providers to explore their attitudes, knowledge, and practices related to child diet/physical activity counseling, and to obtain feedback about GREENLIGHT. During this development and testing phase, we will measure the number of parents/caregivers and providers assessed, the number of GREENLIGHT materials adapted/created, and satisfaction with the process of developing the provider training and waiting room implementation programs.

During years two and three of the Plan, we will implement and examine the impact of the newly developed GREENLIGHT program on parent/family knowledge, attitudes, and practices related to their child’s diet and physical activity. We will also begin to explore strategies for expanding the program through:

- Adaptation of GREENLIGHT to other settings, such as daycare centers and schools, including other partners in the Community Service Plan;
- Expansion of the scope of GREENLIGHT to include older children; and
- Dissemination of the culturally adapted and translated GREENLIGHT materials to other health facilities in CD3 and the rest of NYC and across the country by making materials available for providers on-line, and leveraging existing relationships with groups like the Community Health Care Association of New York, the American Academy of Pediatrics and the Academic Pediatric Association.

Over the course of the three years of the Community Service Plan, we expect GREENLIGHT to reach over 1500 children and families.

**Sector 3: Housing** – developing and implementing a community navigator program to facilitate access to smoking cessation treatment, build support for smoke-free housing, and reduce children’s exposure to secondhand smoke

In partnership with housing experts at Asian Americans for Equality (AAFE), schools, health care providers, the New York City DOHMH Bureau of Chronic Disease, and the New York City Housing Authority (NYCHA), experts in tobacco control in the NYU Langone Medical Center Manhattan Tobacco Cessation Center will: (1) develop and implement programs to reduce exposure to secondhand smoke (SHS) in public and private housing units in lower Manhattan; and (2) increase access to evidence-based smoking cessation treatment.

These two primary goals are informed by the strong scientific evidence of the dangers of exposure to SHS, particularly among children, and the disproportionately high rates of exposure to this significant health risk in CD3 compared with other NYC communities. We therefore are taking a comprehensive approach – one that includes raising awareness about the often hidden threat of SHS in multiunit housing and ensuring that smokers have access to evidence-based treatment.
According to the Public Health Services Guidelines for Treatment Tobacco Use and Dependence, evidence-based treatment for smoking cessation includes access to counseling and pharmacotherapy. We are fortunate in NYC to have population level programs (e.g., the NY State telephone Quitline and free nicotine replacement therapy) that offer these options. However, there is evidence that smokers living in low-income communities are often not aware of these resources. Additionally, the NYC DOHMH has started an aggressive program to assist tenants in creating smoke-free environments and with this initiative they have developed a range of educational materials and practical information about strategies to implement this policy.

In partnership with AAFE, NYCHA, and other community groups, we propose to leverage existing partnerships and resources at the NY State Department of Health and the New York City Department of Health and Mental Hygiene, and expand our relationships with local community organizations to create a comprehensive program that will promote smoke-free homes and facilitate smoking cessation in CD3. Our hope is that this project will serve as a model for academic/community partnerships to advance this critical public health agenda.

Our initiative will use a community service navigator model, which mirrors the patient navigator model that has been well studied and implemented by the American Cancer Society. This model provides lay workers or resident/community volunteers the skills to educate and motivate people in the community to address modifiable health risks and link community members to evidence based resources. Navigators fill important gaps in knowledge and access to health information, policies and programs that can improve population health.

Our partnering organizations will help us identify and supervise appropriate individuals to serve as navigators. The Medical Center Manhattan Tobacco Cessation Center, in collaboration with the NYC DOHMH and AAFE, will provide training that is based on existing curriculum and will offer ongoing supervision to continue to build navigators’ skills. The components of the navigator model will include:

**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 affiliate organizations, the AAFE Community Development Fund and Renaissance Economic Development Corporation, provide homeownership counseling and small business training, respectively.

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 has provided culturally competent and linguistically accessible smoking prevention education and smoking cessation to Asian American communities, and has led grassroots advocacy campaigns to build support for key initiatives such as smoke-free outdoor air and smoke-free housing. AAFE sees tobacco control as a social justice issue, which affects not only the health of individuals who use tobacco but also the health and economics of their families and community members.
• Establishing a rapport with the target community through workshops and other strategies determined in collaboration with partnering organizations;

• Disseminating information about SHS, particularly as it relates to multiunit housing and dangers to children’s health;

• Developing and leading workshops or forums specifically targeted to families with children that address a range of preventive measures that parents can take to promote their child’s health including creating smoke-free home policies;

• Meeting with smokers individually or in groups and applying Motivational Interviewing (MI) techniques, to help smokers:
  o Identify and act upon ambivalence regarding smoking cessation;
  o Learn about free resources (e.g., Medicaid covers cessation medication with a prescription, the Quitline will mail a 2 week starter kit of medication); and
  o For those ready to quit, facilitate counseling and a prescription for cessation medication as needed, including arranging MD appointments and linking patients to the Quitline.

Throughout the Plan, we will monitor processes and outcomes using tracking forms for the navigators to document activities (number of workshops, contacts, counseling sessions, referrals to Quitline), pre- and post-surveys of program participants (self-reported smoking rates, medication use, home policies on SHS), and data on rates of use of the Quitline. We also plan to conduct pre- and post-program tests of the presence of SHS in public spaces using TSI SidePak Personal Aerosol Monitors. The primary outcome of this initiative will be a tested navigator model that we and our partners can disseminate more widely throughout CD3 and potentially to other communities.

In addition, we will work with the NYC DOHMH Community Transformation Tobacco Free Living Initiative (funded through the Prevention and Public Health Fund of the Affordable Care Act), and its partner organizations, including the LGBT Community Center and the Manhattan Smoke-Free Partnership, which is launching a smoke-free housing technical assistance, community organizing and advocacy program in lower Manhattan, with the goal of creating two to three smoke-free buildings over the course of the Plan.
Sector 4: Local Businesses – developing and implementing health promotion guidelines for partners and local businesses

We also plan to engage the broader community, including local businesses, in efforts to improve the health environment in this community. For example, a recent analysis conducted by the New York State Department of Health found that tobacco retailers tend to be more densely distributed in high minority or low-income neighborhoods and 75% of the almost 10,000 licensed tobacco retailers in the State are within 1000 feet of a school perimeter – an issue raised by the Community Board of CD3. Of particular concern is the marketing and sales of alternative products (electronic cigarettes, smokeless tobacco) and little cigars, which are not subject to the State and City cigarette tax, making them less expensive and thus more attractive to adolescents. We will explore working with community partners and with the City Department of Health and Mental Hygiene to monitor tobacco availability and marketing in this community in order to understand the extent of the problem and to develop strategies to decrease exposure for children.

Finally, all of the partners in the Community Service Plan will be asked to develop worksite wellness policies, including policies on vending machines, event sponsorship, and food served at fundraising and other events.

Cross Sector Approaches: fostering cross-sector collaboration and synergy

Although each initiative described above will have its own structure, partners, processes and outcomes, over the course of the Community Service Plan, we will seek opportunities for cross sector-collaboration and synergy. For example, the secondhand smoke initiative, which is located primarily in housing developments, will also work with the ParentCorps program and the Charles B. Wang Community Health Center to train staff, conduct workshops and forums, and disseminate information to increase cessation among parents who smoke and reduce exposure of children to SHS. Similarly, the health literacy and parent engagement project in the Charles B. Wang Community Health Center may eventually be

Other relevant NYULMC programs
Apart from the programs outlined above, which are supported directly by the Hospitals Center as part of the Community Service Plan, the Medical Center has numerous community-based programs that address the problem of obesity and other risk factors for cardiovascular disease and cancer. For example:

- The Cancer Institute is partnering with community-based organizations across the City to offer educational programs and workshops, and is enhancing its language capacity and cultural competence to increase access for underserved populations. As part of this initiative, the Institute is partnering with various community groups to host a viewing of the HBO documentary *Weight of the Nation*, to be followed by an interactive discussion with a Medical Center researcher or clinician, who will provide community members with information on the connections between obesity and cancer, and what steps individuals and communities can take to reduce the risk factors for obesity.
- The Center for Corporate Wellness runs screenings, health fairs, and workshops on cardiovascular health, workplace wellness, and smoking cessation at worksites across the City, reaching nearly 18,000 people in the first part of FY 2013.
- The Center for Healthful Behavior Change has launched blood pressure screening and other interventions in 69 faith-based organizations and 63 barbershops, as well as 64 other community based organizations and events, reaching over 6,165 African American men age 50 or older, who are particularly vulnerable to hypertension. The Center has also provided screening and education in 3 naturally occurring retirement communities (NORCs).
adapted for other settings, including daycare centers and schools. Finally, the knowledge and expertise on parent engagement developed by the ParentCorps program will help shape our approach in other settings, while the geographic breadth of that program, as well as its policy orientation, will help extend its reach beyond our current partners.

**Anticipated Impact and Performance Measures**

The Coordinating Council, composed of the community partners and Hospitals Center program leaders who are participating in the Plan, will collaboratively develop performance measures and monitor program implementation to assess progress and make mid-course corrections. Attached as Appendix C is a table summarizing preliminary goals and performance measures, together with sources of data to be used to measure outcomes.

**VI. Dissemination Plan**

The Community Health Needs Assessment and Community Service Plan will be conspicuously posted on the Hospitals Center’s internal and external (http://www.med.nyu.edu) 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 the Community Health Needs Assessment and Plan will not be required to create an account or provide any personally identifiable information. This document will remain available on the websites until two subsequent reports have been posted.

Hard copies of the Community Health Needs Assessment and Community Service Plan will be available without charge to anyone upon request and will be disseminated to the membership of Community Boards 3 and 6 and to the offices of the relevant City Council members. Additionally, hard copies will be made available to patients accessing care at the Hospitals Center in all locations, including NYU-Hospital for Joint Diseases, Tisch Hospital, Rusk Institute of Rehabilitation Medicine, and the NYU Cancer Institute.

**VII. Maintaining Engagement with Partners, Tracking Progress, and Making Mid-Course Corrections**

An overarching goal of the Community Service Plan is to strengthen collaborations among the Hospitals Center, the City DOHMH, and community partners in CD3. We will continue 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 will provide regular updates and opportunities for input through Community Board 3, primarily through the Human Services, Health, Disability and Seniors/Youth and Education Committee and, as appropriate, to the full Board. We will also report on progress to Community Board 6, the Board that covers the area in which the
Hospitals Center is located. CB6 has worked closely with the Hospitals Center on previous Community Service Plans as well as many other community issues.

- We will create a Coordinating Council composed of the community partners and Hospitals Center program leaders who are participating in the current plan. This will be the mechanism for coordinating the various projects and ensuring that they are meeting milestones, maximizing their impact, and working across institutions and sectors. This group will meet quarterly to hear quantitative progress reports, as well as qualitative assessments of implementation challenges and lessons learned. Early in year one, the Coordinating Council will develop a set of “Rules of Engagement” that will govern our work together to ensure full participation and transparency.

- Finally, we will convene an Advisory Committee that will meet at least annually. This group, with wider membership from the community and from across the University, will serve to link the Community Service Plan to other resources and expertise – within the Hospitals Center, at the University, and from the community.
Appendix A

Data Sources Consulted


New York City Department of City Planning. Selected Facilities and Program Sites in New York City [Database] Released 2009


### Appendix B

**Input from Persons Who Represent the Broad Interests of the Community**

*Meetings with public health experts*

<table>
<thead>
<tr>
<th>Agency</th>
<th>Attendees</th>
<th>Dates</th>
</tr>
</thead>
</table>
| **NY State Department of Health**          | ▪ Sylvia Pirani, MPH, Director Office of Public Health Practice  
▪ Priti Irani, MS, Research Scientist, Office of Public Health Practice  
▪ Karen Lipson, Director, Division of Policy of the Office of Health Systems Management | Multiple meetings with DOH staff from 5/2012 to the present |
| **New York City Department of Health and Mental Hygiene** | ▪ Susan Kansagra, Assistant Commissioner, Chronic Disease Prevention and Tobacco Control  
▪ Mindy Bockstein, Assistant Commissioner for Policy Development, DOHMH  
▪ Christina Chang, Deputy Commissioner, Division of Policy and External Affairs  
▪ Mindy Bockstein, Assistant Commissioner, Bureau of Policy Development | 1/17/13 and 2/8/13 |
| **GNYHA presentations by:**                | ▪ Mindy Bockstein on Take Care NY  
▪ Wendy McKelvey, Director of Environmental Health Surveillance, Bureau of Environmental Surveillance and Policy  
▪ Carolyn Olson, Director, Community Epidemiology Unit, Bureau of Epidemiology  
▪ Thomas Cannell, Director, Community Projects, Bureau of Health Planning | 2/20/13 and 2/20/13 |
| **NYS Office of Mental Health**            | ▪ Mary McHugh, Director, Strategic Clinical Solutions  
▪ Susan Thaler, Director, Children’s Services  
▪ Catherine Vourkas, NYC Field Office | Multiple meetings in 2012 to present |
| **NYS Early Childhood Advisory Council**   | ▪ Sherry Cleary, Co-Chair of the NYS Early Childhood Advisory Council  
▪ Bob Frawley, Co-Chair of the NYS Early Childhood Advisory Council  
▪ Dina Lieser, Co-Chair of the Promoting Healthy Development Workgroup  
▪ Rachel de Long, NYS Department of Health - Bureau of Maternal & Child Health  
▪ Donna Noyes, NYS Department of Health - Early Intervention Program | Multiple meetings in 2012 to present |
Meetings with community groups and community leaders

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Attendees</th>
<th>Dates</th>
</tr>
</thead>
</table>
| **University Settlement**                         | - Michael Zisser, Chief Executive Officer  
- Bonnie Cohen, Director of Family and Clinical Services  
- Early childhood staff                                 | 1/7/13  
2/11/13 and multiple meetings in 2012 to present |
| **Cooper Square Committee**, a membership organization that works with area residents “to preserve and develop affordable, environmentally healthy housing and community/cultural spaces on the Lower East Side” | - Chairperson and President of the Board                                                           | 2/1/13 |
| **Charles B. Wang Community Health Center**       | - Shao-Chee Sim, Chief Strategy Officer  
- Perry Pong, Chief Medical Officer  
- Regina Lee, Chief Development Officer  
- Loretta Au, Chief of Pediatrics                  | Multiple meetings from 1/4/13 to present                                                                 |
| **Asian Americans for Equality**                  | - Douglas Nam Le, Director of Community Building and Organizing                                | Multiple meetings from 3/12/13 to present                                                                                 |
| **Community Board 3**                             | - Susan Stetzer, District Manager  
- Susan Scheer, Chair, Human Services, Health, Disability and Seniors/Youth and Education Committee  
- Gigi Li, Chair of Community Board  
- Presentation to Human Services, Health, Disability and Seniors/Youth and Education Committee | 4/11/13  
3/19/13  
4/19/13  
5/2/2013 |
| Community Board 6 | • Meetings with Community Board and with Health, Senior and Disability Issues Committee  
• Presentation to Health, Senior and Disability Issues Committee | Multiple meetings in 2012 to present 3/18/13 |
| Educational Alliance, a community-based organization that serves 50,000 New Yorkers annually through 39 programs, including preschools, camps, after school programs, senior centers, health and wellness programs, arts and culture classes and addiction recovery programs | • Joanna Samuels, Executive Director of the Manny Cantor Center | 3/1/13 |
| NYC Department of Small Business Services | • Commissioner Robert Walsh  
• James Mettham, Assistant Commissioner, Neighborhood Development Division | 3/4/13 |
| Ryan/NENA Health Center, a community health center located on the Lower East Side that “supports culturally diverse communities most in need of medical assistance” | • Kathy Gruber, Executive Director | 4/19/13 |
| Office of Councilmember Rosie Mendez | • Michèle Burger, Director of Constituent Services | 3/13/13 |
| Coalition for Asian American Children and Families, “the nation's only pan-Asian children's advocacy organization, aims to improve the health and well-being of Asian Pacific American children and families in New York City” | • Wayne Ho, Executive Director | 4/22/13 |
### Appendix C

#### Anticipated Impact and Performance Measures

<table>
<thead>
<tr>
<th>Sector/Program</th>
<th>Number of People Participating/Exposed (Process outcome targets)</th>
<th>Health and Wellness Outcomes (Targets)</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td><strong>Schools and Early Childhood Programs: reaching over 1,900 children and 685 parents/families</strong></td>
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<td></td>
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<tr>
<td>Adapt and implement ParentCorps in 2 sites of University Settlement House early childhood programs</td>
<td>ParentCorps Family Program</td>
<td>225 students served</td>
<td>100 parents served</td>
</tr>
<tr>
<td></td>
<td>Professional Development for Early Childhood staff</td>
<td>19 classrooms participating</td>
<td>25 staff members trained and coached</td>
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<tr>
<td></td>
<td>ParentCorps Family Program</td>
<td>225 additional students served</td>
<td>100 additional parents served</td>
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<tr>
<td></td>
<td>Professional Development for Early Childhood staff</td>
<td>19 classrooms participating</td>
<td>30 staff members coached</td>
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<tr>
<td></td>
<td>ParentCorps Family Program</td>
<td>225 additional students served</td>
<td>100 additional parents served</td>
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<tr>
<td></td>
<td>Professional Development for Early Childhood staff</td>
<td>30 staff members coached</td>
<td>19 classrooms participating</td>
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<tr>
<td></td>
<td>School/Agency</td>
<td>Organizational change in support of policies and practices for Pre-K and K students and parents</td>
<td>Increased parent/family engagement</td>
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<tr>
<td></td>
<td>Classroom (Professional Development)</td>
<td>Attendance</td>
<td>Satisfaction</td>
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<td></td>
<td>Home (Family Program)</td>
<td>Attendance by parents</td>
<td>Parent satisfaction</td>
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<tr>
<td></td>
<td>ParentCorps Family Program</td>
<td>225 additional students served</td>
<td>100 additional parents served</td>
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<tr>
<td></td>
<td>Professional Development for Early Childhood staff</td>
<td>30 staff members coached</td>
<td>19 classrooms participating</td>
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<tr>
<td></td>
<td>ParentCorps fully implemented in 5 schools</td>
<td>1 school (PS 188)</td>
<td>4 additional schools</td>
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<tr>
<td></td>
<td>ParentCorps fully implemented in 5 same schools</td>
<td>5 same schools</td>
<td>9 Pre-K &amp; 9 K classrooms</td>
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<td></td>
<td>ParentCorps fully implemented in 5 schools</td>
<td>1 school (PS 188)</td>
<td>4 additional schools</td>
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<td>ParentCorps fully implemented in 5 same schools</td>
<td>5 same schools</td>
<td>9 Pre-K &amp; 9 K classrooms</td>
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<td></td>
<td>ParentCorps fully implemented in 1 school</td>
<td>1 school (PS 188)</td>
<td>2 Pre-K &amp; 1 K classrooms</td>
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<td></td>
<td>ParentCorps fully implemented in 1 school</td>
<td>1 school (PS 188)</td>
<td>2 Pre-K &amp; 1 K classrooms</td>
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<tr>
<td></td>
<td>ParentCorps for Pre-K and K teachers, students and families</td>
<td>Implement ParentCorps in 11 schools with Universal Pre-K programs in Community District 3; ParentCorps for Pre-K and K teachers, students and families</td>
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<td>ParentCorps fully implemented in 1 school</td>
<td>1 school (PS 188)</td>
<td>2 Pre-K &amp; 1 K classrooms</td>
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<td>Year 1</td>
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<td>Year 3</td>
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<tr>
<td>Professional Development for Early Childhood staff</td>
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<tr>
<td>• 4 Pre-K &amp; 1 K teachers trained and coached</td>
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<tr>
<td>• 3 Early Childhood Social Workers trained and coached</td>
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<td>Professional Development for Early Childhood staff</td>
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<td>• 18 Pre-K &amp; 9 K teachers trained and coached</td>
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<td>• 3 Early Childhood Social Workers re-trained and coached</td>
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<td>Professional Development for Early Childhood staff</td>
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<tr>
<td>Mental health professionals</td>
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<tr>
<td>• Staff self-evaluation on implementation</td>
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<td>Classroom &amp; Home</td>
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<tr>
<td>• Enhanced nurturing relationships</td>
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<tr>
<td>• Improved behavior management</td>
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<td>• Increased parent involvement in education</td>
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<td>• Increased support of health-related behaviors for teachers and parents</td>
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<tr>
<td>• Healthier eating for children and families</td>
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<tr>
<td>• Increased physical activity for children</td>
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<tr>
<td>• Decreased sedentary time for children</td>
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[total over 3 years = 830 students and 385 parents]
<table>
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</table>
| Implement the BODY Project at 1-2 high school sites in lower Manhattan [~400 medical screens provided] | The BODY Project implemented in 1-2 schools in lower Manhattan  
- Continue partnerships with 1-2 high schools  
- Medical screens and evaluation for students  
- Follow-up medical screening of students to track health status and progress  
- Health status reports sent home to students and their families  
- Provide individual health referrals and resources to parents of students identified as having high risk factors | To be determined based on evaluation of Year 1 impact.  
To be determined based on evaluation of Year 1 impact. | • Height and weight data from Fitnessgram  
• Medical screening lab results  
• Survey assessing quality of life, eating behaviors, physical activity habits, leisure activities, and sleep quality  
• Telephone interviews with high risk students and their parent/guardian |
| Primary Care: reaching over 1,500 children and parents/families | Translate, adapt and implement GREENLIGHT health  
- 6 Core booklets translated/ adapted  
- 6 Supp. booklets  
- Refine curriculum and materials  
- 3-4 new Core  
- Booster training of existing providers, nurses | Improved parent/family knowledge, attitudes,  
Healthier eating behaviors/ | Program data, including surveys of: |

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| literacy/ parent engagement program in pediatric practice at Charles B. Wang Community Health Center | * Translated / adapted Conduct age/material-specific focus groups  
  * 5 focus groups, involving 40 parents (2-6 mos, 9-18 mos, 2-3 year olds, 4-5 year olds, supplemental materials)  
  * 3 provider focus groups, involving 10-15 providers (physicians, nurses, nutritionists, health educators)  
  * Pilot testing of materials with 25 families  
  * Adapt present curriculum for training providers on HL counseling  
  * Pilot test with 1-2 representative providers from each group that will use materials (physicians, nurses, nutritionists, health educators) | * Booklets developed  
  * 10 providers trained  
  * 2 nutritionists trained  
  * Program reaches 25% of 0-2 year olds children, representing 250 participants  
  * Identification and addressing of barriers to distribution of materials | * Practices for children/families  
  * Increased physical activity / increased sedentary time for children  
  * Reduced media exposure  
  * Exploratory goal: 20% relative reduction in rate of obesity from ~25% to ~20% among 3-5 year olds | * 200 parent/child dyads year 1 (baseline assessment for use in analyses of change of health and wellness outcomes, including 50 at each of 4 time points – 3 mos, 9 mos, 18-24 mos and 3-5 years);  
  * 200 parent/child dyads year 3 to perform exploratory assessment of intervention impacts;  
  * 10-15 providers (physicians, nurses, nutritionists, health educators) assessed pre and post implementation, possibly through focus groups |
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<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
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<tr>
<td><strong>Adapt and implement waiting room program</strong></td>
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<tr>
<td>• Adapt and implement waiting room program to address healthy eating and exercise</td>
<td>5 parent health educators and volunteers trained</td>
<td>5 parent health educators and volunteers trained</td>
<td>5 parent health educators and volunteers trained</td>
</tr>
<tr>
<td>• 2 parent health educators and volunteers consulted</td>
<td>200 children/families reached</td>
<td>1000 children/families reached</td>
<td></td>
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<tr>
<td>• 50 children/families consulted</td>
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<tr>
<td><strong>Expand program to other practices</strong></td>
<td></td>
<td></td>
<td>Identification of and meetings with 5 Chinatown and Chinese serving pediatric practices</td>
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<tr>
<td><strong>Housing: reaching over 2,000 community residents</strong></td>
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<tr>
<td><strong>Train local health navigators in facilitating smoking cessation and access to other resources</strong></td>
<td>Develop and refine curriculum</td>
<td>2 additional navigators trained</td>
<td>2 new navigators trained</td>
</tr>
<tr>
<td>• 2 navigators trained</td>
<td>2 navigators retrained</td>
<td>4 navigators retrained</td>
<td>Retention</td>
</tr>
<tr>
<td><strong>Provide outreach and assistance to smokers via health navigators</strong></td>
<td>50 smokers contacted</td>
<td>75 smokers contacted</td>
<td>100 smokers contacted</td>
</tr>
<tr>
<td>• 30 counseled</td>
<td>50 counseled</td>
<td>75 counseled</td>
<td>Smoking rates in past 7 days</td>
</tr>
<tr>
<td>• 10 provided faxed referrals to Quitline</td>
<td>20 provided faxed referrals to Quitline</td>
<td>50 provided faxed referrals to Quitline</td>
<td>Smoking rates in past 7 days</td>
</tr>
<tr>
<td><strong>Provide community outreach to raise awareness and</strong></td>
<td>3 workshops</td>
<td>3 workshops</td>
<td>3 workshops</td>
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<tr>
<td><strong>Develop housing-based organizing</strong></td>
<td>Community meetings</td>
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<tr>
<td>knowledge about smoke-free housing initiative and increase knowledge about smoking cessation resources</td>
<td>- strategy: Select buildings for smoke-free initiatives and develop strategies</td>
<td>- Increased knowledge</td>
<td>Personal Aerosol Monitors (exploratory)</td>
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<tr>
<td></td>
<td>- Work with 2 or 3 buildings to develop and implement smoke-free policies</td>
<td>- Changes in attitudes toward smoke-free housing</td>
<td>- Changes in smoking policies in 2-3 buildings</td>
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<tr>
<td></td>
<td>- Continue to work with 2 or 3 buildings to implement and monitor smoke-free policies</td>
<td>- Decreased levels of CO (exploratory)</td>
<td></td>
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<tr>
<td>Business</td>
<td></td>
<td>- Increased knowledge</td>
<td></td>
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<tr>
<td>Worksite wellness: Agreements from all partners to implement wellness standards</td>
<td>- Wellness policies defined</td>
<td>- Improved health-related policies and practices in participating schools, childcare settings, apt buildings, primary care practices, CBOs, and businesses</td>
<td>Site visits/key informant interviews</td>
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<td></td>
<td>- All partners sign agreements</td>
<td>- New partners sign agreements</td>
<td>- Exploratory: annual risk assessments/compliance surveys</td>
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<td></td>
<td></td>
<td>- Recruit other local businesses</td>
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<tr>
<td></td>
<td></td>
<td>- Develop employee risk assessment (exploratory) and/or compliance surveys</td>
<td></td>
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<tr>
<td>Cross Sector</td>
<td></td>
<td>- Continue employee risk assessment and/or compliance surveys</td>
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<tr>
<td>Develop and implement cross sector projects to create synergy among partners</td>
<td>- Form Coordinating Council to oversee CSP implementation and identify areas for synergy and collaboration</td>
<td>- Develop and implement 2 additional cross sector initiatives</td>
<td>Program data</td>
</tr>
<tr>
<td></td>
<td>- Develop and implement 2 cross sector initiatives</td>
<td>- Coordinating Council finds and develops opportunities to extend and expand program reach across multiple sectors</td>
<td>Interviews with CSP participants</td>
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<td></td>
<td></td>
<td>- Continue to work with 2 or 3 buildings to implement and monitor smoke-free policies</td>
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