NYU Langone Hospitals
Community Health Needs and Assets Assessment and Community Service Plan
2025-2027

Adopted June 2025
NYU Langone Hospitals Board of Trustees
Audit and Compliance Committee

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

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

We welcome your questions and comments.
Please feel free to contact:

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Counties included: communities in Kings County, New York County, Nassau and Suffolk Counties

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Mission

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

- Tisch Hospital, an acute-care hospital located in Manhattan
- Kimmel Pavilion, a state-of-the-art, digitally integrated healthcare facility in Manhattan
- NYU Langone Orthopedic Hospital, an orthopedic, neurologic and rheumatologic specialty hospital in Manhattan
- Hassenfeld Children's Hospital at NYU Langone, which provides pediatric inpatient care, outpatient care, procedural and surgical services, the KiDS Emergency Department and multiple ambulatory services
- NYU Langone Hospital–Brooklyn, a full-service teaching hospital and Level I Trauma Center located in Sunset Park, Brooklyn
- NYU Langone Hospital – Long Island, which provides inpatient and outpatient medical care throughout Long Island
- NYU Langone Hospital – Suffolk (formerly Long Island Community Hospital at NYU Langone Health), which provides medical care to residents of eastern Long Island

Ambulatory facilities number over forty, and include the Perlmutter Cancer Center, a National Cancer Institute-designated cancer center; the NYU Langone Ambulatory Care Services; and NYU Langone Health – Cobble Hill, a free-standing Emergency Department in Cobble Hill.

In addition, the Family Health Centers at NYU Langone, which is co-operated with NYULH, is a Federally Qualified Health Center network, which includes nine primary care health centers in Brooklyn and over 60 school- and shelter-based extension clinics.

NYULH is the principal teaching hospital for NYUGSoM, which has trained thousands of physicians and scientists since its founding in 1841, and NYUGLISoM, which opened in 2019 and is dedicated to educating exemplary physicians and academic leaders in primary care; both NYUGSoM and NYUGLISoM offer full-tuition scholarships. In addition, NYUGSoM, through its faculty group practice, delivers patient care at over 320 practice sites and has

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

affiliations with the Manhattan campus of the Veterans Affairs New York Harbor Health Care System and with NYC Health + Hospitals, which includes facilities at Bellevue and Gouverneur in Manhattan and Woodhull in Brooklyn.

Overview*

Over the course of implementing our Community Service Plan, we continually assess community health needs, assets and priorities. As described below, we use multiple sources of primary and secondary data and have multiple ways of obtaining community input – through our programs, partnerships, advisory structures and bi-directional feedback mechanisms. This Community Health Needs and Assets Assessment (CHNAA) process, and our findings, are outlined in the first half of this report. Section I.C. provides community-specific profiles on the needs, assets and demographics for Sunset Park and Red Hook in Brooklyn; the Lower East Side and Chinatown in Manhattan; and the Village of Hempstead in Nassau County, Long Island. We have also begun to extend our analysis into new areas on Long Island: Uniondale and Roosevelt in Nassau County, and the Tri-Hamlet area of Shirley, Mastic, and Mastic Beach, which account for largest number of discharges of the new NYU Langone Hospital—Suffolk.

These geographic summaries are followed by a discussion of topics that have emerged as key community priorities: digital access, health and housing, healthy eating and food security, tobacco prevention and cessation, maternal and child health and children's social and emotional development, and weather and health effects.

Growing out of the Community Health Needs and Assets Assessment and aligning with the New York State Prevention Agenda and New York City and Long Island public health priorities, the NYU Langone Hospitals' three-year implementation plan (the Community Service Plan, "CSP") focuses on **Economic Stability** by addressing food security and healthy food availability and the need for stable and safe housing; **Social and Community Context** by promoting healthy eating, providing health coaching, and decreasing tobacco use and exposure to secondhand smoke; **Neighborhood and Built Environment** by supporting local health networks and enhancing the capacity of community health workers; **Health Care Access and Quality** through parenting programs, programs to support mobility and reduce the risk of falls for elderly populations, and by connecting families to needed resources (including virtual care and digital literacy); and **Education Access and Quality** through early childhood programs that engage parents, caregivers and educators, and peer education and youth development programs.

Our Community Service Plan programs span multiple sectors: early childhood settings and schools, primary care, housing, and community settings, such as faith-based organizations and social service providers.

See Appendix A for a snapshot of the Community Service Plan reach and impact September 2023 – August 2024.

* In the fiscal year ending August 2024, NYU Langone Health's net community benefit amounted to $1,797,559,339, with $38,146,560 allocated to community health improvement services and community benefit operations. An additional $1,066,868 was expended on community building activities; shortfall on Medicare services amounted to $560,505,759.

Drawing on its expertise in developing and implementing effective approaches to health promotion at the community level, the Department of Population Health (DPH) has served as the architect for the CHNAA and Plan since 2013.

Department of Population Health approach to advancing population health and health equity

Since 2016, DPH and the Family Health Centers at NYU Langone have worked together to develop a CSP designed to create synergies across programs and to take advantage of the combined expertise of our larger institution, the strong foundation of work under both of our previous Plans, and the strengths of our community partnerships.

Beginning in 2022, the CHNAA and CSP expanded to include NYU Langone Hospital – Long Island, focused initially on building community partnership and developing programs to meet the needs of the Hempstead community. Following NYULH growth on Long Island, this CHNAA extends to several other communities as well. See Section I. C.

Through its Community Service Plan, NYULH brings to bear a wide range of expertise: in healthy eating and obesity prevention, health literacy, parenting, family and community engagement, smoking cessation, prevention science, and population health. The programs and priorities remain consistent with NYULH prior years' Community Service Plans, but under the current CSP, existing programs have been extended and new initiatives added. The CSP's geographic scope includes the Lower East Side and Chinatown in Manhattan; Sunset Park and Red Hook in Brooklyn; and a growing number of communities on Long Island. We also have several programs that now reach across the City and State.

The Family Health Centers at NYU Langone (FHC) is a federally qualified health center network with a longstanding history of serving underserved and immigrant communities of Brooklyn and throughout New York City. The FHC provides high-quality primary and preventive outpatient care to adults and children regardless of their ability to pay or health insurance status. With over 110,000 patients, the FHC network handles over 600,000 medical, dental, and behavioral health visits each year. The mission of FHC is to improve the overall health of the communities we serve by delivering high quality, culturally competent health and human services in community-based settings. FHC is nationally recognized for innovative, affordable, high-quality care and is one of the largest employers within the communities they serve. FHC established the nation's largest dental residency program, the largest school health program in New York, a community medicine program serving more than 7,000 homeless New Yorkers, and one of the first health-focused AmeriCorps programs. In fiscal year 2024 alone, FHC provided over 40,000 individuals with direct assistance to obtain public benefits, adult literacy classes, legal services, health referrals, and emergency food.

Priority Areas of Focus*

Economic Stability

- The Healthy Food Initiative addresses food security and healthy food availability in Sunset Park, Brooklyn and surrounding communities through evidence-informed interventions focused on emergency food access, screening and case management, community education, and a community-wide coalition of food systems stakeholders.

- The Health and Housing Consortium is a collaborative network of health care, housing, homeless and social services organizations, and government partners with the shared goal of improving health equity and housing stability by fostering cross-sector relationships, informing policy, and building capacity of frontline workers to support New Yorkers with unmet health and housing needs.

- The Health by Housing (HxH) Lab conducts research to build the evidence base for initiatives, programs, and policies at the intersection of health and housing; informs policy and programs related to health and housing through evidence-based advising and research dissemination; and provides education to expand the reach of practice-relevant evidence on health and housing.

Social and Community Context

- Greenlight, an early childhood obesity prevention program to improve health literacy and foster healthful diet- and activity-related behavior, has been adapted and implemented in partnership with the Charles B. Wang Community Health Center and the Family Health Centers at NYU Langone in Sunset Park. It has also been extended to the NYULH pediatric practice in Hempstead, Long Island.

- The Tobacco Free Community collaborates and supports community partners to identify needs, share resources, and build capacity to address smoking disparities, particularly the high rate of smoking in the Asian and immigrant communities. The initiative co-leads a citywide partnership, aiming to facilitate access to tobacco treatment resources, adapt the WeChat Quit Coach intervention, and engage community partners to educate youth about e-cigarettes. Our partners include community organizations, federally qualified health centers, academic institutions, healthcare professional organizations, and government agencies.

- REACH FAR: Community Health for Asian and Arab Americans, an evidence-based program designed to prevent cardiovascular disease by increasing access to healthy foods and providing culturally tailored health coaching and messages, is being implemented in mosques, other faith-based organizations, and community-based organizations on the Lower East Side, Manhattan, Sunset Park and Kensington, Brooklyn, and Long Island.

* NYU Langone's programs do not include preferences, quota, or other set asides or otherwise exclude anyone based on race, sex, or other protected categories.

Neighborhood and Built Environment

- The Red Hook Community Health Network is a network of community-based organizations, residents, and health partners working to improve the health of Red Hook residents by expanding access to health and social services, supporting a community health worker program, and organizing to address root causes of poor health in the community.

- The Community Health Worker Research and Resource Center (CHW-RRC) expands access to training and up-to-date information on health topics and community resources for CHWs across NYC and nationally. It provides social and professional development opportunities for CHWs within the NYULH system; offers technical support and convening opportunities to community-based organizations, health systems, and government partners; and engages in advocacy and research to promote sustainable funding and overall support for the CHW workforce.

- Falls prevention and exercise programs for the elderly are being implemented on the Long Island campus:

    - Tai Chi for Arthritis for Falls Prevention and A Matter of Balance, two evidence-based fall prevention programs, are being implemented at the NYU Long Island Hospital Welcome Center, area libraries, faith-based organizations and other community settings.

    - The Otago Exercise workshop, an evidence-based program, launched at NYU Langone Long Island's Welcome Center and is aimed at helping older adults prevent falls through exercises, home safety tips, and strategies for safer mobility and medication management.

    - Chair Yoga for Wellness is an evidence-informed gentle form of yoga practiced while seated or using a chair for support, designed to improve flexibility, strength, and relaxation for individuals with limited mobility or those seeking a low-impact exercise option, which is being implemented at the Welcome Center.

Health Care Access and Quality

- PlayReadVIP (formerly Video Interaction Project or VIP), an evidence-based parenting program that uses videotaping and developmentally appropriate toys, books and resources to help parents strengthen early development and literacy in their children, will continue to serve Sunset Park and extend its reach to additional locations.

- ParentChild+ (PC+), a national, evidence-based early literacy, parenting and school-readiness program, serves low-income immigrant families in Sunset Park. The program provides intensive home visiting to families with children 16 months -- four years old who are challenged by poverty, low levels of education, language and literacy barriers and other obstacles.

- Enhanced Family Support Services are being provided at the NYU Langone – Long Island Pediatric Practice in Hempstead where a Family Support Counselor screens patients and their families for socials needs, connects them to a network of local services, and follows up to ensure that care is received. The Practice also implements Reach Out and Read, an evidence-based early literacy program, and connects families to the Cribs for Kids Program, a partnership between the NYU

Langone – Long Island Hospital Wellness Center and The Nassau County Department of Health. Its goal is to prevent infant sleep-related deaths by educating parents and caregivers on the importance of practicing safe sleep for their babies and by providing portable cribs to families who, otherwise, cannot afford a safe place for their babies to sleep.

- The Center for Community-Oriented Virtual Primary Care and Technology (CARE Tech), led by a consortium including the Family Health Centers at NYU Langone, the Department of Population Health at NYU Grossman School of Medicine, and MCIT Department of Health Informatics at NYU Langone Health, as well as community, school, and faith-based partners, aims to increase access to virtual health care, by improving digital health literacy and reaching patients in the communities where they live and work.

Education Access and Quality

- ParentCorps is an evidence-based family-centered early childhood intervention that aims to improve child health, behavior, and learning. Since 2019, ParentCorps has applied an intentional place-based, community-engaged strategy to offer ParentCorps in Sunset Park - for young children and the adults who matter most in their lives - parents, caregivers, teachers, school leaders and staff.

- Project SAFE, a peer education program employing an evidence-based youth development approach to prevent teen pregnancy and HIV/AIDS, will continue being implemented in Sunset Park and other Brooklyn communities.

Measure and Enhance Health Equity and Support Local Collaboration-Building

- The Brooklyn Data Station supports partnerships and fosters collaborations that aim to improve population health in Sunset Park, Red Hook and other parts of Brooklyn. The Data Station also supports the CHNAAs across all of the geographic areas that comprise our CSP, providing a range of data services, supporting a knowledge network and a forum to translate findings into action to improve health.

- The Communications Network is a peer knowledge network that enhances community engagement through innovative and adaptable communication strategies.

Alignment with New York City Department of Health and Mental Hygiene HealthyNYC Priority Strategies

All of the NYULH Community Service Plan priority programs align with the NYC DOHMH priority strategies. To prevent and manage cardiometabolic disease and to decrease mortality for screenable cancer prevention, HealthyNYC calls for improved access to food (including enrollment in benefit programs), housing, health care, and financial and social supports, as well as investments in community capacity and efforts to reduce tobacco consumption and increase access to fitness programs and blood pressure monitoring. Several of the HealthyNYC priority areas also note the important role that

community health workers can play in providing access to health and social services and in building community capacity. These strategies are reflected in the portfolio of CSP projects.

I. Community Health Needs / Assets Assessment

A. Definition and Brief Description of Communities Served

As a major academic medical center, NYU Langone Health serves a broad community with a wide range of healthcare needs. Its primary service area includes Manhattan, Brooklyn, Long Island and Queens, and the secondary service area extends into Staten Island, Westchester, and New Jersey.

To begin to understand the needs of our primary service areas, we reviewed publicly available data reports and summaries, such as the Community Health Profiles from the New York City Department of Health and Mental Hygiene and the Prevention Agenda Dashboard from the New York State Department of Health. Additional secondary data sources were reviewed and analyzed, as detailed in Appendix B. Based on that review (described for each community below) and in light of our commitment to continuing our CSP partnerships and work, the 2025-2027 Community Service Plan continues to focus on the communities served through the previous plan: the Lower East Side and Chinatown in Manhattan, and Sunset Park and Red Hook in Brooklyn, and the Village of Hempstead in Nassau County. We are beginning to expand our scope to two additional communities served by NYU Langone Hospital—Long Island, Uniondale and Roosevelt. Recently, with the merger with Long Island Community Hospital (now NYU Langone Hospital – Suffolk) we have reviewed secondary data for the Tri-Hamlet area of Shirley, Mastic, and Mastic Beach, which account for the largest number of discharges.

These communities were selected based on the need for services as evidenced by social determinants of health, health vulnerabilities, risk factors, and utilization data. Although these communities are not geographically contiguous, they share important similarities, including an infrastructure of strong community-based organizations.

B. Public Participation

Public participation in assessing community needs and assets and setting priorities has been a continuous process over the past twelve years. We have engaged a range of stakeholders – with a particular focus on medically underserved residents – to assess community needs; set priorities; develop, design, and implement programs; and share and celebrate progress and results. We employ diverse, often multi-pronged strategies and rely on our extensive network of community partners and advisory boards and committees to provide ongoing outreach and program development. (A description of how each program engages with community members can be found in Section IV.)

We also rely on and value the insights of program staff, particularly Community Health Workers who often come from the communities they serve. Through the CSP Community Health Worker Research and Resource Center (see Section II. C. 2., we learn about challenges and community assets among the diverse populations they serve.

The Family Health Centers at NYU Langone advisory structure includes the Sunset Park Health Council as the community governing board; culturally specific advisory groups; and program-specific councils, including the Teen Health Council. The NYULH Community Service Plan Coordinating Council, which brings together NYU Langone faculty and staff, community partners, and policymakers, meets quarterly to oversee program implementation, share findings, provide insight into community need, and identify priorities. It also provides a forum for sharing information and resources on pressing public health needs. For example, at a quarterly meeting in 2024, the Coordinating Council hosted a training session on the use of Narcan, and kits were distributed to all attendees and made available for wider distribution to partner organizations.

Collection, analysis, presentation and discussion of data

→ To support our CHNAA, we bring the analytic capacity of the Department of Population Health (through the CSP Brooklyn Data Station described in Section II.F.1.) and the significant analytic expertise of the FHCs, to obtain and analyze existing databases, as well as any data that have been collected by community partners (see Appendix B).

→ We use – and strengthen – our existing relationships with partners to engage in a review of data, to identify unanswered questions, and to obtain input through a variety of methods, including surveys, group discussions, and focus groups. Data are always made available to community partners for their own use.

→ We continually use data that are collected through existing projects, and the experience of our partners in providing services, to shed light on unmet need, to strengthen programs, and organically to develop new priorities and initiatives.

→ As issues arise, we work with our partners to collect additional data on needs and assets. For example, over the past few years, we have worked with community-based organizations serving the Arab American communities in southwest Brooklyn. Those findings are presented in Section I.C.1.

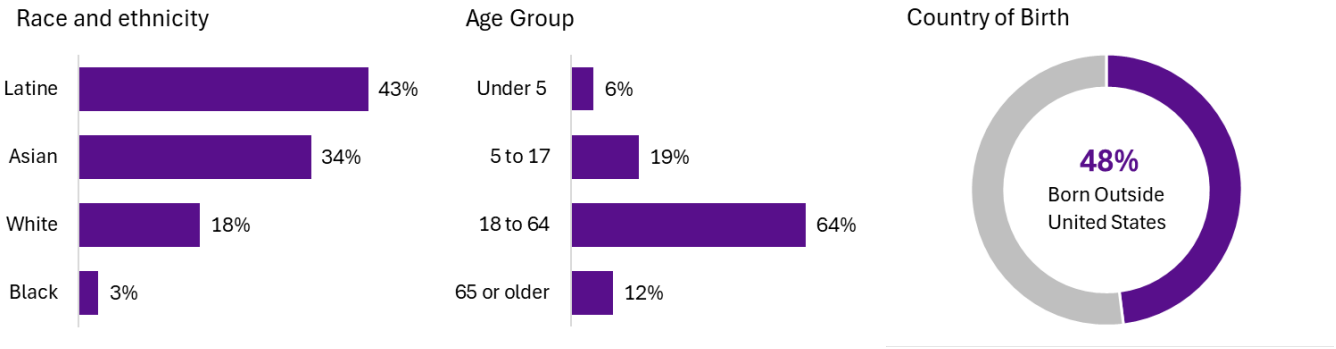
C. Community Profiles

1. Sunset Park Needs and Assets

Sunset Park residents make up the highest percentage of individuals who use NYU Langone Hospital – Brooklyn and Family Health Centers at NYU Langone. The neighborhood is a mixed residential, industrial, and commercial community in Southwest Brooklyn, adjoining the waterfront. Sunset Park can be described as encompassing three geographic areas: Sunset Park West, Sunset Park Central, and Sunset Park East/ Borough Park West.

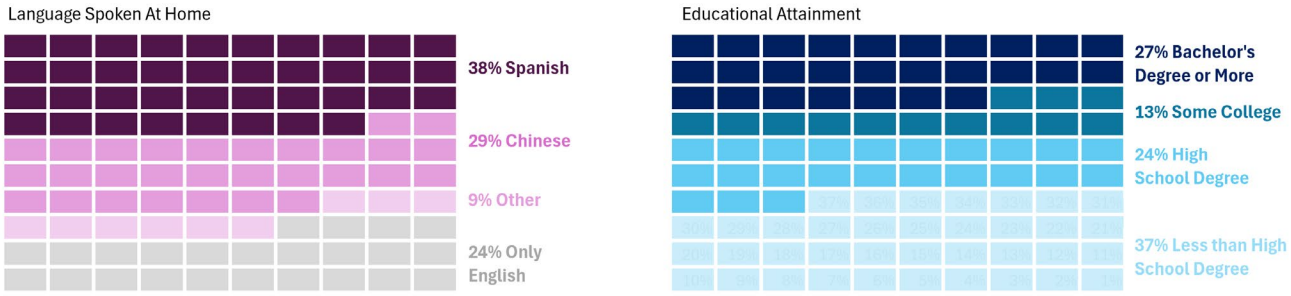
POPULATION

According to the most recent Census 2020 population counts, Sunset Park is home to about 146,000 people. Sunset Park is a diverse, family-friendly, immigrant neighborhood. The majority of Sunset Park residents identify as Latine (43%) or Asian (34%). The Latine population is diverse with highest percentages of origins reported as Mexican (43%), Puerto Rican (18%), and Dominican (14%). Among the Asian population the vast majority are of Chinese origin (90%). The population of Sunset Park is younger than New York City overall, with about 25% under age 18 years. Since the early 20th century Sunset Park has been a first destination for immigrants. In recent years, Sunset Park has seen an influx of migrant shelters and asylum seekers. About 48% of the population were born outside the United States.



LANGUAGE AND EDUCATION

With a network of community- and faith-based organizations and local industries that provide entry-level service and factory jobs, the neighborhood has supported and provided a strong foothold for many new immigrants. Access to and awareness of culturally-appropriate and linguistically accessible health and social services in the community are consistently identified as top needs and priorities by community members and partners. Many Sunset Park residents are best served in a language other than English; 76% of residents ages 5 years and older speak a primary language other than English at home, with Spanish (38%) and Mandarin, Cantonese or other Chinese dialect (29%) being most common. Fifty-three percent of residents ages 5 years and older have limited English proficiency. About 37% of adults ages 25 years or older have less than a high school diploma, including 21% who have less than a 9th grade education. The lower level of educational attainment is in part a reflection of limited educational opportunities outside the United States. Education is highly valued by families in the community and graduation rates of students who attended public high school in Sunset Park are consistently at or above the citywide rate.

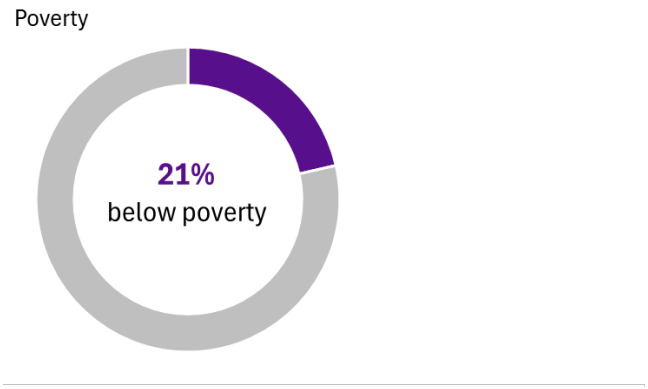


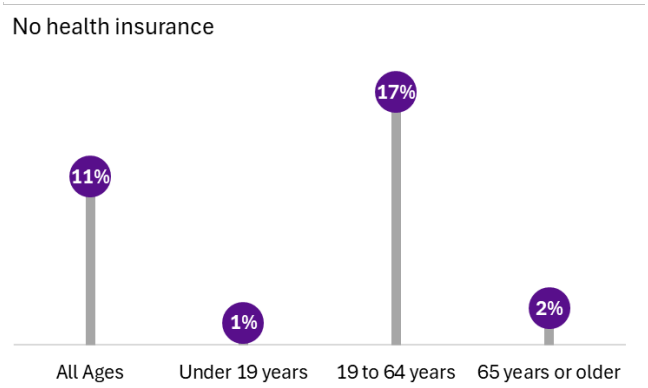
EMPLOYMENT, INCOME, AND HEALTH INSURANCE

Sunset Park is a working-class neighborhood. Unemployment rates are similar to New York City (7%), and job losses due to the pandemic have largely been regained. However, about 20% of employed Sunset Park residents work in the arts, entertainment, recreation, accommodation and food services industry, where wages, benefits, and job security tend to be lower than other industries. The median earnings for Sunset Park workers is $32,544, about $15,000 less than the citywide average.

Median household income is also lower in Sunset Park than New York City ($65,776 vs. $76,607). Sunset Park grapples with high poverty rates: 21% of individuals and 28% of children under the age of 18 years live below the poverty level.

Sunset Park residents are more likely to lack health insurance than residents citywide (11% vs 7%) and more likely to have public insurance (e.g., Medicaid, Medicare) than residents citywide (57% vs. 44%). However, rates vary by age. While nearly all children and older adults in Sunset Park have health insurance, 17% of adults ages 19-64 lack health insurance. Even among employed Sunset Park adults ages 19 to 64 years, 17% lack health insurance–- nearly twice as high as New York City (9%).





HOUSING

Affordable housing is consistently listed as a pressing need by the Sunset Park Community Board, community partners, and residents. Most housing is renter-occupied (75%). There are no public housing units in Sunset Park and limited subsidized units. According to the NYU Furman Center, 90% of new housing units between 2010-2020 in the neighborhood were market rate units. Recent projects by the neighborhood's Fifth Avenue Committee have been held up as a model for affordable housing opportunities for residents, but more affordable housing options are needed to ensure families can continue to live in the neighborhood. About 28% of renter-occupied households are severely rent-burdened--meaning they pay more than one-half of their income on rent. At 22%, Sunset Park also has one of the highest rates of overcrowding.

Section I.D.2. has more information about housing.

ASSETS AND OPPORTUNITES TO ADDRESS NEEDS

Sunset Park has a strong network of trusted culturally-specific community-based organizations many of which have served the community for several generations. In conversations with these longstanding partners, the need to address these social determinants of health – through culturally appropriate outreach and engagement – was repeatedly identified as a key priority. Economic pressures, fear in the

face of anti-immigrant sentiment, language barriers and competing priorities were all identified as barriers to well-being, health and health care access. Working with and relying on these trusted partners is a central to all of our work in the community.

One of the valuable assets of Sunset Park is its network of culturally-specific community-based organizations that serve immigrant residents. For example, Mixteca was established in 2000 by a group of concerned community members to address critical needs in health, education, social and legal issues facing the burgeoning Mexican and Latin American immigrant community in Brooklyn. In June 2024, Mixteca was recognized as a "health hero" and awarded the Joan H. Tisch Community Health Prize.

NEEDS AND PRIORITIES OF THE ARAB AMERICAN COMMUNITY IN SOUTHWEST BROOKLYN

Data specific to the Arab American community are difficult to find as detailed ethnic and cultural heritage are not often collected on population-based surveys or administrative records. In response to a request from Arab American community partners, as part of the 2022-2024 CHNAA, NYULH worked with community based organizations to develop and field a survey to describe the health needs, priorities, and barriers to health care specific to the Arab American community in Brooklyn.

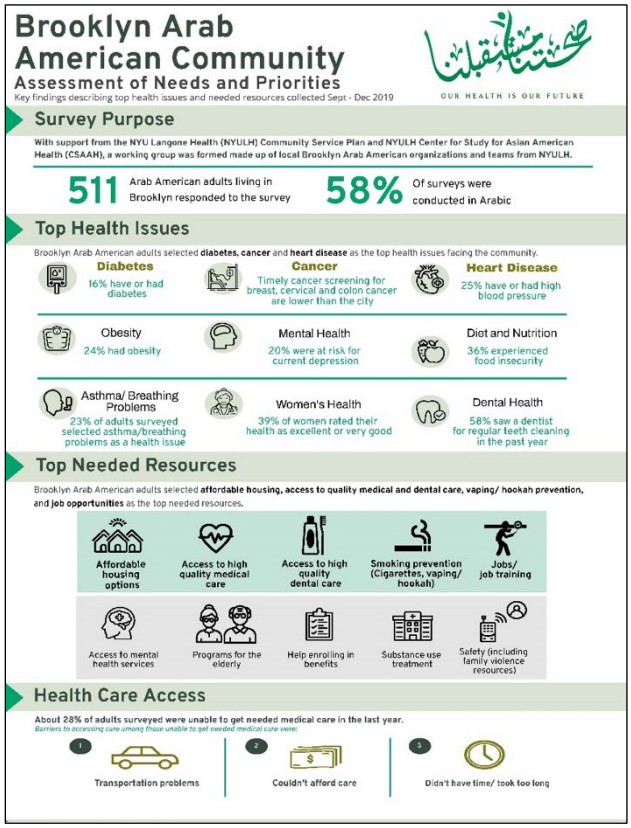
The anonymous survey was administered by interviewers who were trained community members from community organizations in the participants' preferred language (Arabic or English). Responses were collected on paper and entered into an electronic database by trained community organization and health organization staff fluent in both Arabic and English.

As reported in the NYULH 2022-2024 CHNAA, a total of 511 Arab American adults living in Brooklyn responded to the survey. Findings were shared and discussed at community meetings.

Survey Working Group Members:

- Arab American Association of New York
- Arab American Family Support Center
- Moroccan American House Association
- Arab Health Initiative of Memorial Sloan Kettering Cancer Center
- Family Health Centers at NYU Langone
- NYULH Center for the Study of Asian American Health
- NYU Langone Hospital – Brooklyn
- NYULH Brooklyn Data Station

2. In 2023, a working group was formed to develop a one-page (two-sided) summary of the findings, including a guide for resources (on the flip side) for distribution in the community. Partners requested a total of 1,500 copies in English and 3,300 copies in Arabic. These have been distributed at community events, programs and in waiting rooms. In addition, a publication was co-developed by the coalition and accepted for publication.



3. Red Hook Needs and Assets

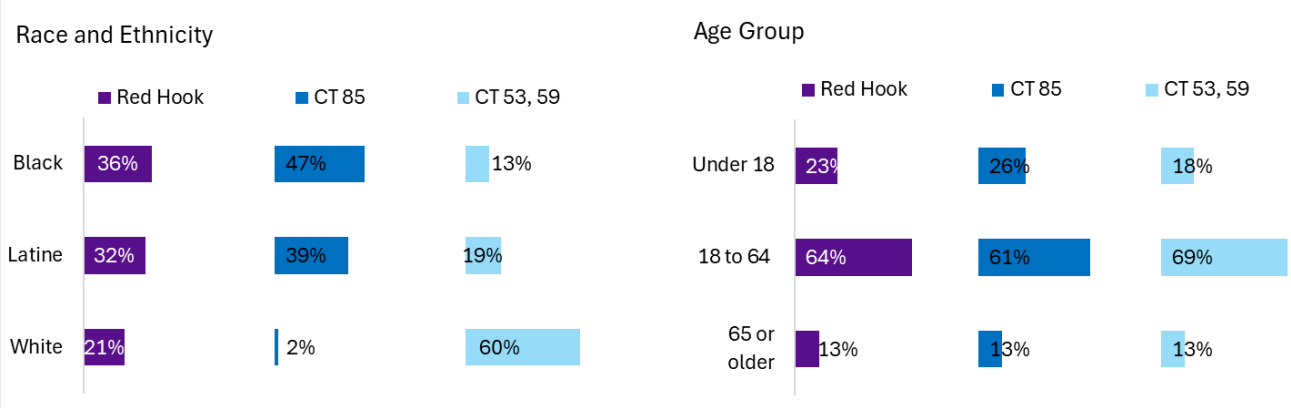
Red Hook is a resilient, diverse, and lively waterfront community in Brooklyn, New York. It is home to the NYC Housing Authority (NYCHA) Red Hook Houses, New York's second largest public housing complex. Red Hook is geographically isolated and lacks a subway station. Travel to transit and other resources is divided by the Brooklyn Queens Expressway which cuts the neighborhood off from the rest of Brooklyn. This very isolation leads to social cohesion, neighborhood pride, and close-knit relationships.

Red Hook experiences numerous climate and environmental issues which further affect the quality of life and health of community residents. These include: a mega construction project within public housing, multiple EPA Superfund clean-up projects, the expansion of last mile warehouses such as Amazon and UPS (leading to a surge in truck and vehicle traffic), and prevalence of lead both in the soil and inside of homes within Red Hook Houses.

POPULATION

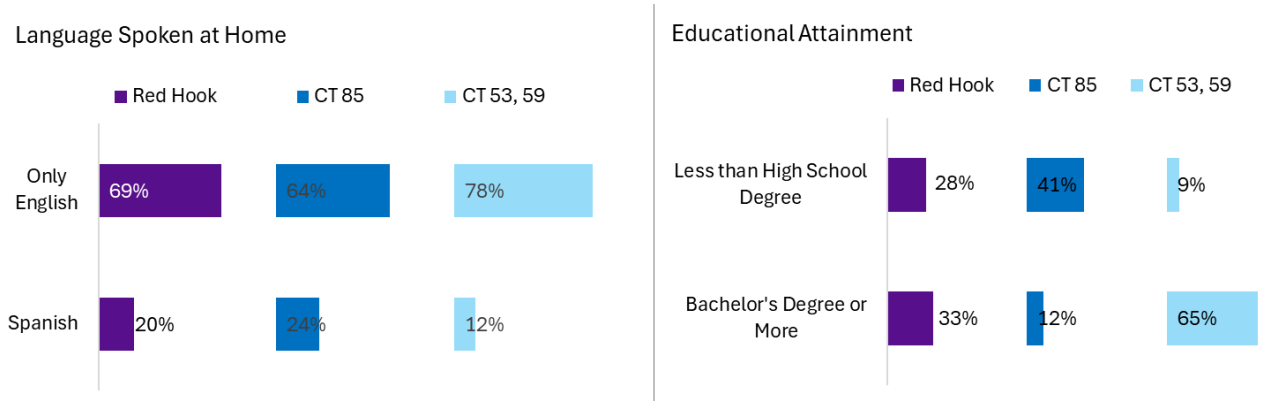
According to the most recent Census 2020 population counts, Red Hook is home to about 11,000 people, the majority of whom live in public housing. Red Hook is generally described as comprising five

Brooklyn census tracts (CT): 53.01, 53.02, 53.03, 59, 85. Census tract 85 is often used as a proxy to describe public housing residents. Red Hook is diverse: 36% of Red Hook residents are Black, 32% are Latine, and 21% are White. The Latine population is mostly of Puerto Rican origin (52%). Census tract 85 is home to a greater percentage of Black (47%) and Latine residents (39%) while other census tracts are home to a greater percentage of White residents (60%). The population in census tract 85 is younger than surrounding census tracts in Red Hook, with 26% of the population under ages 18 years. Overall, about 22% of Red Hook residents were born outside the United States.



LANGUAGE AND EDUCATION

Most Red Hook residents (69%) speak only English at home and about 20% speak Spanish. Low educational attainment is a challenge in the community, particularly for residents in census tract 85 where 41% of adults ages 25 years or older have not completed high school.

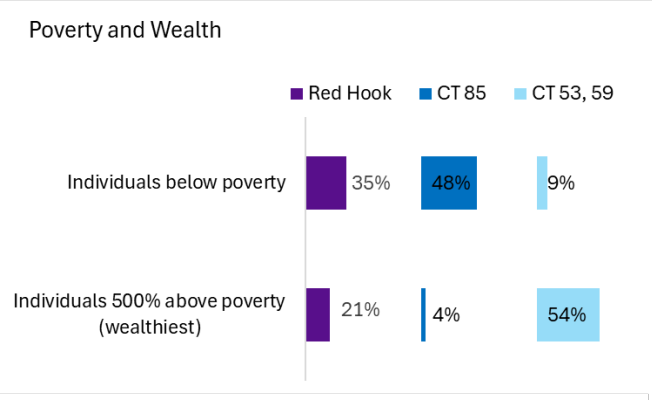


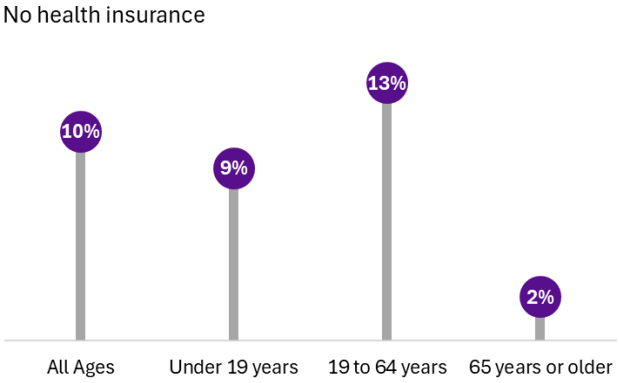
EMPLOYMENT, INCOME, AND HEALTH INSURANCE

Like many NYC neighborhoods, Red Hook is experiencing gentrification. In the areas surrounding the Red Hook Houses, the percentage of the wealthiest residents (incomes at least five times higher than poverty level) doubled, from 24% in 2006-2010 to 54% in 2018-2022. Yet, Red Hook still grapples with poverty and unemployment. While the poverty rate for Red Hook overall is 35%, the rate is five times higher in the census tract (85) containing Red Hook Houses compared with the surrounding census tracts (48% vs 9%). Thirty-eight percent of children under the age of 18 in Red Hook live in poverty. The unemployment rate is higher in Red Hook than citywide (13% of residents 16 and older were unemployed, compared with 8% of residents citywide). About 25% of workers were employed in educational, health care or social assistance industry and about 11% of workers were employed in retail

trade. The median earnings for Red Hook workers is $43,965, about $4,000 less than the citywide average.

Red Hook residents are more likely to lack health insurance than residents citywide (10% vs 7%) and are more likely to have public insurance (e.g., Medicaid, Medicare) than residents citywide (53% vs. 44%). However, rates vary by age. While nearly all older adults in Red Hook have health insurance, 9% of children under age 19 years and 13% of adults ages 19-64 lack health insurance. In June 2023, the Family Health Centers at NYU Langone opened a primary care location in Red Hook, helping to provide a vital resource to residents, particularly those who do not have health insurance or have public health insurance.





HOUSING

Public housing plays a vital role in providing affordable housing options in Red Hook. A lower percentage of renter-occupied households in Red Hook are severely-rent burdened—meaning they spend one-half of income on rent—than NYC overall (18% vs. 28%). However, the quality of housing has been a top concern for residents as years of disinvestment in public housing has led to maintenance issues. Poor housing conditions adversely impact health outcomes in the neighborhood.

Section I.D.2. has more information about housing.

COMMUNITY STRENGTHS AND NEEDS

In the summer of 2024, when asked by the Red Hook Community Health Network (see Section II.C.1.) about the strengths of Red Hook, residents overwhelmingly noted the "unity" and "resiliency" of the neighborhood and the ways in which residents "come together". Respondents also spoke in favor of having access to quality schools, parks, and farms in the neighborhood.

When reflecting on the health needs of the neighborhood, residents noted the following:

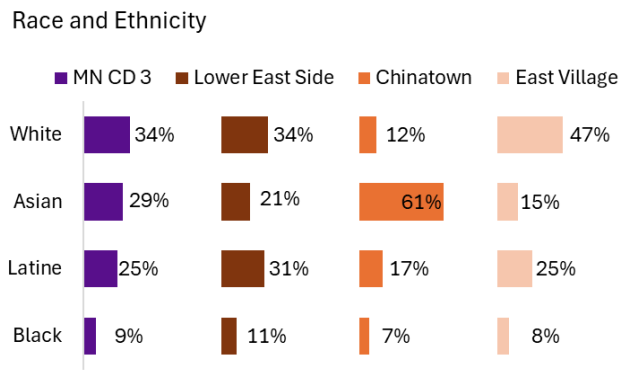
- Additional healthcare services, including more doctors of color and youth-friendly reproductive services.
- Mental health services, including acupuncture.
- Physical therapy offices and clinics.
- Greater health insurance options.
- More space for physical activities and calisthenic workouts.
- Healthier food options and better restaurants.
- Cleaner physical environment.
- Resources for individuals with asthma and for those who smoke.
- Additional laundromat services.

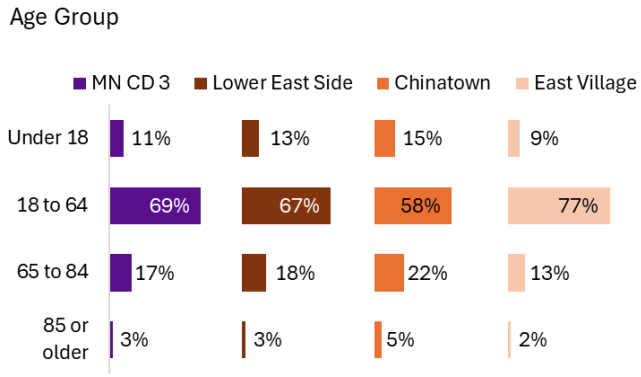
4. Lower East Side and Chinatown Needs and Assets

To increase our impact and create opportunities for synergy across programs, starting with the 2013-2016 CHNAA, NYULH focused on the area closest to the Manhattan campus with the greatest need: the Lower East Side and Chinatown. Located along the eastern shore of lower Manhattan, the Lower East Side/Chinatown Community District (Manhattan Community District 3), which includes neighboring East Village, is one of the earliest areas settled in New York City and was a historic stop for immigrants in the 19th and early 20th century. The neighborhood's rich character is rooted in that history and evident in the range of cultures, languages, and incomes today.

POPULATION

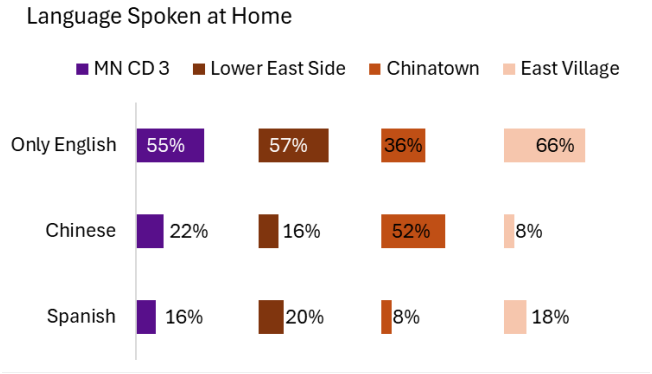
According to the most recent Census 2020 population counts, Manhattan Community District 3 (MN CD 3) is home to 163,000 residents. The population is diverse: 34% are White, 29% are Asian, 25% are Latine, and 9% are Black. The majority of Latine residents are of Puerto Rican origin (57%). The majority of Asian residents are of Chinese origin (86%). Overall, about 32% of residents in the Community District were born outside the United States, with immigrant populations comprising a large percentage (49%) of residents within the Chinatown neighborhood. The population of the Community District is older than New York City overall with 20% of residents ages 65 years or older. The percent of older adults is even higher within the Chinatown neighborhood, with 27% of adults ages 65 years or older, including 5% ages 85 years or older. In its most recent Needs Statement, the Community Board highlighted the need for maintaining and expanding senior services, noting concerns about social isolation, depression, food access and the need for culturally and linguistically appropriate informaton and access health and social services.

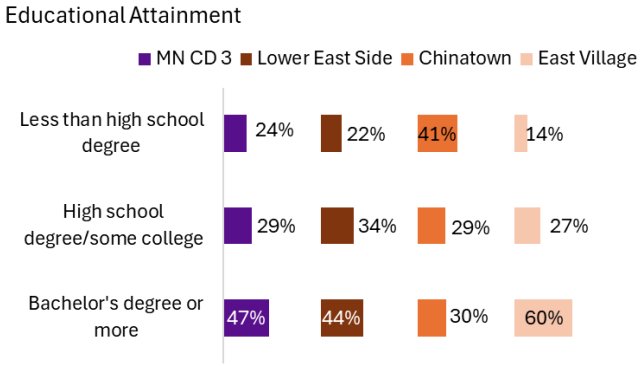




LANGUAGE AND EDUCATION

Nearly one-half of MN CD 3 residents ages 5 years and older speak a language other than English at home (45%), with Chinese dialects (22%) and Spanish (16%) most common. Overall, about one-quarter of residents (24%) speak English less than very well. Among Chinese speakers, about three-quarters (76%) speak English less than very well, underscoring the need for culturally and linguistically appropriate services. Overall, about one-quarter of MN CD 3 residents ages 25 years or older do not have a high school degree (24%) and about one-half (47%) have a bachelor's degree or more.





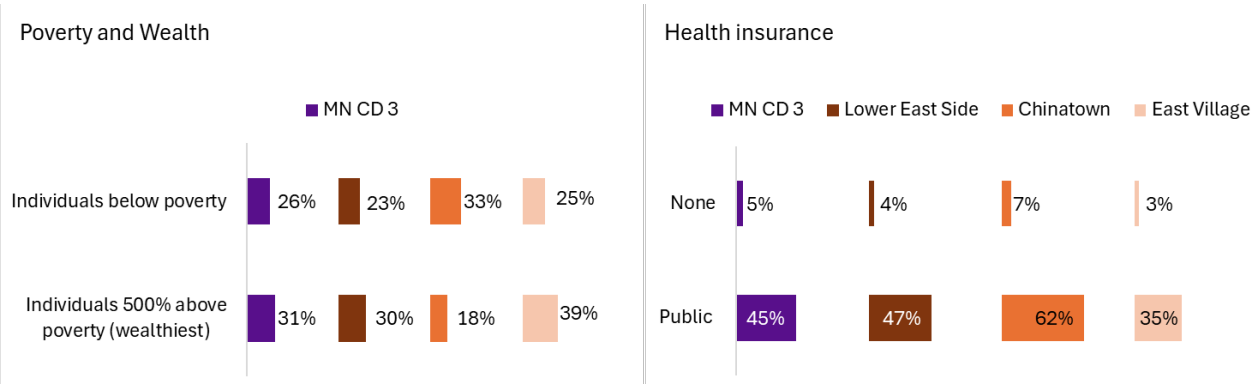
EMPLOYMENT, INCOME, AND HEALTH INSURANCE

Income inequality impacts Community District 3 at multiple geographic scales. Within Manhattan, Community District 3 has the second highest poverty rate (26%) of all twelve Manhattan Community Districts and sits in stark contrast to surrounding neighborhoods in Lower Manhattan – the Financial District and Greenwich Village/SoHo – which rank among the neighborhoods with the lowest poverty rates in all of New York City (6% and 8% respectively). Within the Community District, rates of poverty and wealth differ across and within neighborhoods where wealthier residents have moved into new housing developments adjacent to older housing stock home to residents with lower incomes. Across all neighborhoods in MN CD 3, poverty rates are highest for children (42%) and older adults (33%).

The unemployment rate in MN CD 3 (7%) is similar to New York City overall (8%), however, unemployment rates are higher in the Chinatown neighborhood (12%). At $56,635, the median earnings for workers in Community District 3 is about $8800 higher than the citywide average. However, the median household income ($54,473) is lower than citywide average—in part because many households in Community District 3 are classified as single occupant (householder lives alone). As noted

in the most recent Community Board Needs Statement, household income has not kept pace with rising rents.

The percent of residents in MN CD 3 who lack health insurance is slightly lower than citywide average (5% vs. 7%), and rates of public health insurance coverage (e.g., Medicaid, Medicare) are similar to the City (45% vs. 44%). Within the Chinatown neighborhood, 62% of residents have public insurance and 7% do not have health insurance.



HOUSING

Affordable housing and homelessness are two of the three most pressing issues identified by the Community Board in their most recent Needs Statement. The third issue, senior services, also describes the need to help older residents age in place. While MN CD 3 is home to multiple public housing developments, which together account for more than one-quarter of all public housing units in Manhattan, on-going gentrification has contributed to rising cost of housing. While every neighborhood within MN CD 3 is impacted by housing affordability crisis, the Chinatown neighborhood has a higher percentage of renter-occupied housing classified as severely rent-burdened—meaning households spend one-half of income on rent—compared with citywide average (31% vs. 28%). While development of additional housing units is needed in the neighborhood, a report by the NYU Center for the Study of Asian American Health (CSAAH) highlighted the impact of housing construction on the health of older adults in Chinatown through increased exposure to particulate matter and noise generated during construction. Furthermore, construction sites alter the built environment, affecting sidewalk access and resulting in increased fears of falling.

See Section I.D.2. for more information on housing.

ASSETS AND OPPORTUNITES TO ADDRESS NEEDS

A number of community-based organizations provide culturally and linguistically appropriate supports and services in the neighborhood. Key community partners include:

Asian Americans for Equality (AAFE): Since its founding in 1974, 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 access, local economic development, community lending, civic participation, healthcare access, immigrant rights, and educational access.

Charles B. Wang Community Health Center (CBWCHC): For more than 50 years, the CBWCHC has been a leader in providing high quality, affordable, and culturally competent primary care and support services to medically underserved Asian Americans and other disadvantaged populations in the New York metropolitan area. In addition to providing comprehensive primary care, CBWCHC promotes the overall health of the community through innovative health education and disease prevention programs.

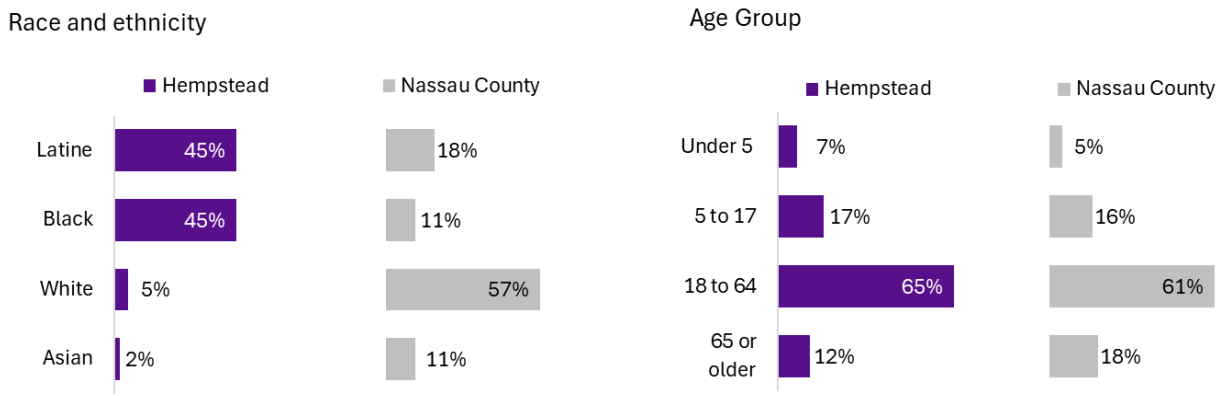
Chinese-American Planning Council (CPC): CPC's mission is to promote the social and economic empowerment of Chinese American, immigrant, and low-income communities. Founded in 1965, CPC is a social services organization that creates positive social change, empowering Asian American, immigrant, and low-income communities in New York City by ensuring equitable access to the resources and opportunities needed to thrive. CPC is the nation's largest Asian American social services organization and a vital resource to more than 60,000 individuals and families striving to achieve their education, family, community, and career goals. CPC welcomes community members at every stage of life to over 50 high-quality programs at 35 sites in Manhattan, Brooklyn (where we partner in our work in Sunset Park), and Queens.

5. Hempstead Needs and Assets

Following the merger of NYU Langone Health and Winthrop Hospital (now NYU Langone Hospital—Long Island), we launched an in-depth, community engaged needs and assets assessment initially focused on the Village of Hempstead, which accounts for the greatest number of discharges at NYU Langone Hospital—Long Island. Located in Nassau County, the Village of Hempstead is a family-friendly, diverse community whose residents look out for one another. Hempstead has long been a commercial, civic and transportation hub which has experienced years of dis-investment and loss of businesses but in recent years has seen efforts to revitalize the community.

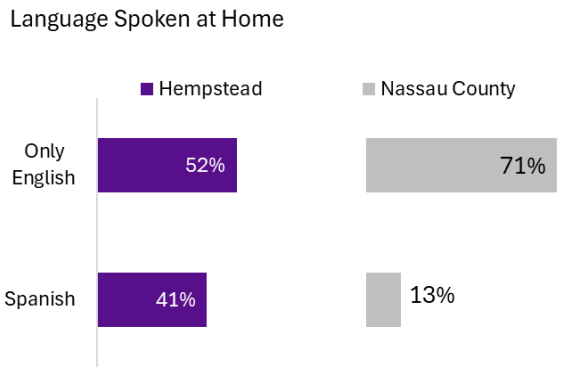
POPULATION

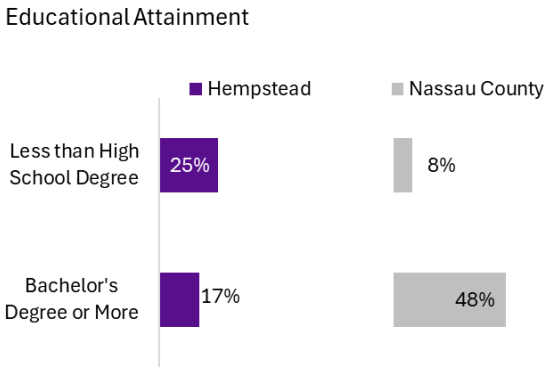
According to the most recent Census 2020 population counts, the Village of Hempstead is home to 59,000 residents, making it the most populous village in New York State. The majority of Hempstead residents identify as Latine (45%) or Black (45%). Most Latine residents are of Salvadoran origin (47%). The population of Hempstead is younger than Nassau County overall, with about 23% aged under 18 years. More than one-third of residents (38%) were born outside the United States.



LANGUAGE AND EDUCATION

Nearly one-half of Hempstead residents speak a language other than English at home, with Spanish being the most common (41%). Among Spanish speakers, 61% speak English less than very well. The lack of bi-lingual services and information has been noted as a barrier to accessing care and other needs. About one-quarter (25%) of Hempstead residents ages 25 years or older do not have a high school degree and 17% have a bachelor's degree or higher. While public high school graduation rates have increased in recent years, rates are still lower in Hempstead than in Nassau County (82% vs. 94%). Rates of chronic absenteeism (missing at least ten percent of school days) have dropped somewhat since the return to full-time in-person instruction but remained high during the 2022-2023 school year for students attending Hempstead public elementary and middle school (46%) and high school (63%).



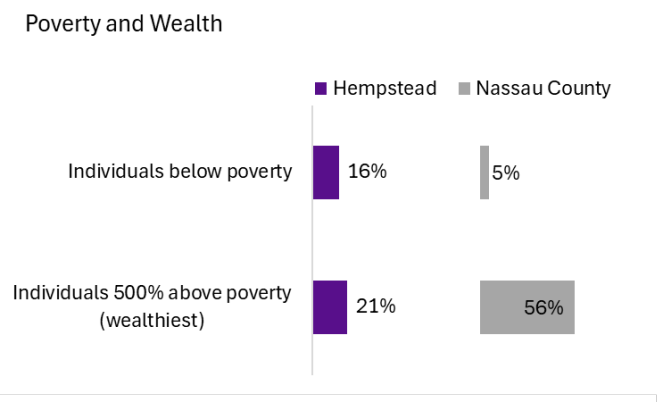


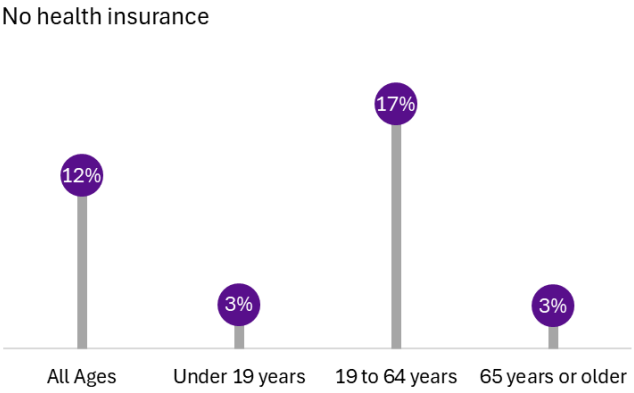
EMPLOYMENT, INCOME, AND HEALTH INSURANCE

Many Hempstead residents note that financial insecurity is a struggle in the community. Median household income in Hempstead is $80,350-almost half the amount of the median for Nassau County ($137,740). The poverty rate is three times higher in Hempstead than in Nassau County (16% vs. 5%). Poverty is particularly acute among children—24% of children younger than 18 years in Hempstead live below the poverty level.

Unemployment is slightly higher in Hempstead (8%) than Nassau County (5%) and average earnings for workers is lower in Hempstead ($36,850) than Nassau County ($59,763). Limited employment opportunities in low-wage occupations often result in residents working multiple jobs to support themselves and their families.

Overall, residents in Hempstead are more likely to lack health insurance than residents in Nassau County (12% vs. 4%). While most children and older adults in Hempstead have health insurance, 17% of Hempstead adults aged 19 to 64 years do not have health insurance—nearly three times the rate of Nassau County (6%). Even among employed adults 19 to 64 years in Hempstead, 18% do not have health insurance. Lack of health insurance has been noted by Hempstead residents as a barrier to receiving care, particularly for preventive health care services.





HOUSING AND TRANSPORTATION

Most housing in Hempstead is renter-occupied (56%). About one-third of renter occupied housing units are severely rent-burdened—meaning households spend more than one-half of their income on rent. About 13% of housing units are classified as crowded (having 1.01 or more occupants per room), including 4% classified as severely crowded (having 1.51 or more occupants per room). There are four public housing developments in Hempstead, including two dedicated to housing older adults. A mixed-use development is under construction and slated to be completed in 2026. This site will include affordable housing units and plans for a new grocery store catering to the Latine population.

Section I.D.2. has more information on housing.

Hempstead is a hub for public transportation, with a terminal for the Long Island Railroad and Nassau County bus service, and has more public transportation options than many other communities on Long Island. However, 21% of households in Hempstead do not have a vehicle available-- three times the rate of Nassau County (7%). Lack of transportation has been noted by residents and community partners as a barrier to getting to medical appointments, school, and for running daily errands.

COMMUNITY STRENGTHS AND NEEDS

The Village of Hempstead is undergoing a revitalization effort with a mix of public and private investment to provide more employment opportunities, housing, and commercial activity. A large network of community-based organizations provide valued support. Since July 2021, regular meetings with community-based organizations have been held to discuss the strengths and needs in Hempstead, with conversations most recently focused around addressing food insecurity needs that were raised in the previous needs assessment process. See Section I.D.3. for a discussion about food security.

At the request of community partners, we summarized the CHNAA findings for Hempstead into a one-page document (with resources on the flip side) in both English and Spanish.

Community Health Needs and Assets Assessment
Village of Hempstead 2021-2022

A Community Health Needs and Assets Assessment (CHNAA) is a way to understand the health of a community by reviewing data and information from community members about their health needs and priorities. NYU Langone Health partnered with Hempstead community-based organizations to learn more about the top needs and assets in Hempstead. We:

- Reviewed public data
- Talked with community members
- Shared results to plan for programs

Top Assets

People
People in Hempstead are an asset. People are friendly, they say hello, they are willing to help. The diversity of the people in the community is valued. People are resilient and supportive of each other. There is a strong focus on family.

Places
Hempstead has many assets, including: convenient location, public library, numerous parks, public transportation options, diverse places of worship, and cultural amenities such as the African American Museum of Nassau County.

Support
There are more than fifty community-based service organizations located in the community when help is needed. In addition, a number of diverse places of worship provide services and support.

Top Needs

Healthcare Access
Community members highlighted a need for improved access to healthcare, including addressing language and transportation barriers; additional sites offering low-cost or sliding scale payment options; and a 24-hour pharmacy.

Environment and Exercise
While there are a number of local parks,community members highlighted the need for expanded park hours, additional structured activities, and improvements to park safety to promote exercise and well-being.

Healthy Food
Community members noted that food prices and lack of access to nutritious foods made it hard to stay healthy.

Community Partners and Resources

Economic Opportunity Commission of Nassau County 516-292-9710
Family & Children's Association 516-486-7200
Harmony Health Care 516-296-3742
Hempstead Community Land Trust 516-224-7701
Hispanic Counseling Center 516-538-2613
Mental Health Association of Nassau County 516-489-2322
RotaCare 516-539-9834
St. George's Episcopal Church 516-483-2771
Salvation Army - Hempstead Citadel Corps 516-485-4900

Thank you to the community members and organizations who shared their thoughts and ideas to help inform this needs and assets assessment. Scan the QR code to access the complete NYU Langone Health Community Service Plan and data report on the Community Health Needs and Assets in the Village of Hempstead.

Evaluación de recursos y necesidades de salud de la comunidad de Hempstead 2021-2022

Una evaluación de recursos y necesidades de salud de la comunidad (CHNAA) es una forma de comprender la salud de una comunidad mediante la revisión de datos e información de sus miembros sobre las necesidades y prioridades de salud. NYU Langone Health se asoció con organizaciones comunitarias de Hempstead para obtener más información sobre las principales necesidades y recursos sociales de Hempstead. Nosotros:

- Revisamos datos públicos
- Hablamos con miembros de la comunidad
- Compartimos resultados para planificar programas

Principales recursos

Ciudadanos
Los ciudadanos de Hempstead son un recurso. Son amables, saludan y están dispuestos a ayudar. Se valora la diversidad de las personas de la comunidad. Las personas son resilientes y se apoyan unas a otras. Hay un fuerte enfoque en la familia.

Lugares
Hempstead tiene muchos recursos, que incluyen: su ubicación conveniente, biblioteca pública, numerosos parques, opciones de transporte público, diversos lugares de culto y servicios culturales como el Museo Afroamericano del Condado de Nassau.

Apoyo
Hay más de cincuenta organizaciones de servicios comunitarios ubicadas en la comunidad cuando se necesita ayuda. Además, hay diversos lugares de culto que brindan servicios y apoyo.

Necesidades principales

Acceso a la atención médica
Los miembros de la comunidad destacaron la necesidad de mejorar el acceso a la atención médica, lo que incluye abordar las barreras del idioma y el transporte; más centros que ofrezcan opciones de pago de escala móvil o de bajo costo; y farmacias abiertas las 24 horas.

Entorno y ejercicio
Si bien hay varios parques locales, los miembros de la comunidad destacaron la necesidad de ampliar el horario de los parques, actividades estructuras adicionales y mejoras en la seguridad de los parques para promover el ejercicio y el bienestar.

Comida sana
Los miembros de la comunidad señalaron que los precios de los alimentos y la falta de acceso a alimentos nutritivos hacian difícil mantenerse saludable.

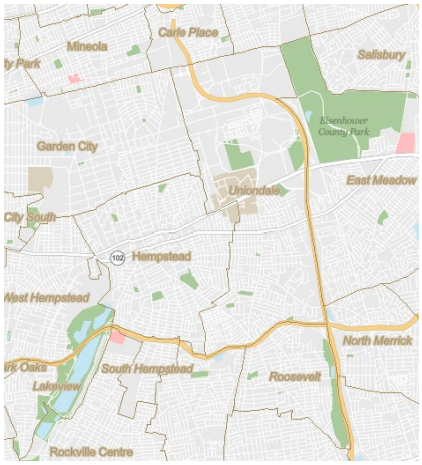
Socios y recursos comunitarios

Economic Opportunity Commission of Nassau County 516-292-9710
Family & Children's Association 516-486-7200
Harmony Health Care 516-296-3742
Hempstead Community Land Trust 516-224-7701
Hispanic Counseling Center 516-538-2613
Mental Health Association of Nassau County 516-489-2322
RotaCare 516-539-9834
Iglesia Episcopal de San Jorge 516-483-2771
Ejército de Salvación - Cuerpo de la ciudadela de Hempstead 516-485-4900

Gracias a los miembros y organizaciones de la comunidad que compartieron sus reflexiones e ideas para ayudar a fundamentar esta evaluación de necesidades y activos. Escanee el código QR para acceder al Plan de servicios comunitarios completo de NYU Langone Health y al informe de datos sobre las Necesidades y activos de salud de la comunidad de Hempstead.

6. Expanding scope in Nassau County: Uniondale and Roosevelt

Two additional communities near NYU Langone Hospital—Long Island have been identified as areas to deepen our community partnerships: Uniondale and Roosevelt. A number of our community partners in Hempstead also serve residents in Uniondale and Roosevelt. As a first step in understanding the needs and assets of these communities, we rely on secondary data. This will be followed by a more comprehensive community-engaged process in the year ahead.



UNIONDALE

Uniondale is an unincorporated hamlet in the Town of Hempstead in Nassau County, east of the villages of Hempstead and Garden City. In 2020, after years of advocacy by the community, the US Census Bureau updated the boundaries of Uniondale to better reflect community definitions. Uniondale is home to Museum Row and the Nassau Coliseum which has been proposed for development of a casino.

According to the most recent 2020 US Census, the population of Uniondale is 32,000. While Uniondale has a similar proportion of residents under the age of 18 years (20%) and aged 65 years or older (17%)

as Nassau County, the percent of residents aged 18 to 24 in Uniondale is 17% compared to 9% in Nassau County, in part due to the presence of Hofstra University which is located in Uniondale and part of neighboring Hempstead.

Most Uniondale residents are Latine (40%) or Black (36%). About one-half (49%) of the Latine population are of Salvadoran origin. More than one-third (36%) of residents were born outside the United States. Nearly one-half (47%) of residents speak a language other than English at home, with Spanish being the most common (38%). About 20% of residents ages 25 years or older do not have a high school degree and 27% have a bachelor's degree or higher. High school graduation rates are lower in Uniondale public schools than Nassau County (83% vs 94%). Rates of chronic absenteeism (missing at least ten percent of school days) have dropped somewhat since the return to full-time in-person instruction but remained high during the 2022-2023 school year for students attending Uniondale public elementary and middle school (30%) and high school (54%).

In Uniondale, about 6% of the civilian workforce is unemployed, similar to Nassau County (5%), however the median earnings for workers in Uniondale is $34,527--about $25,000 less than Nassau County workers. Median household income is lower in Uniondale than Nassau County ($107,885 vs $137,709). The poverty rate in Uniondale is 9% compared to 5% in Nassau County. About 7% of residents do not have health insurance.

While most housing in Uniondale is owner-occupied (72%), a higher percentage of households in Uniondale are renter-occupied (28%) than in Nassau County (18%). About 42% of renter occupied housing units are severely rent-burdened—meaning households spend more than one-half of their income on rent. About 8% of housing units are classified as crowded (having 1.01 or more occupants per room), including 3% classified as severely crowded (having 1.51 or more occupants per room).

Uniondale has limited public transportation options. There are no Long Island Railroad stations in Uniondale. About 10% of households do not have vehicle access, slightly higher than Nassau County overall (7%).

ROOSEVELT

Roosevelt is an unincorporated hamlet in the Town of Hempstead in Nassau County, south of Uniondale. According to the most recent 2020 US Census, Roosevelt is home to 18,000 people. The population is younger than Nassau County, with 25% of the population under the age of 18 years and 10% aged 65 years or older. Most Roosevelt residents are Black (49%) or Latine (44%). The majority of Latine residents are of Salvadoran origin (54%). About 36% of residents were born outside the United States.

About 42% of the population speaks a language other than English at home, with Spanish being the most common (37%). About 19% of adults aged 25 years or older do not have a high school degree and 24% have a bachelor's degree or more. High school graduation rates are lower in Roosevelt public schools than Nassau County (79% vs 94%). Rates of chronic absenteeism (missing at least ten percent of school days) have dropped somewhat since the return to full-time in-person instruction but remained high during the 2023-2024 school year for students attending Roosevelt public elementary and middle school (29%) and high school (34%).

In Roosevelt, about 5% of the civilian workforce is unemployed, similar to Nassau County (5%). However, the median earnings for workers in Roosevelt is $39,841--about $20,000 less than Nassau County workers. Median household income is lower in Roosevelt than in Nassau County ($128,058 vs

$137,709). The poverty rate in Roosevelt is 8% compared to 5% in Nassau County. About 7% of residents do not have health insurance.

While most housing in Roosevelt is owner-occupied (76%), a higher percentage of households in Roosevelt are renter-occupied (24%) than in Nassau County (18%). Nearly two-thirds (62%) of renter occupied housing units in Roosevelt are severely rent-burdened—meaning households spend more than one-half of their income on rent. Similar to Nassau County, about 3% of housing units in Roosevelt are classified as crowded (having 1.01 or more occupants per room).

Roosevelt has limited public transportation options. There are no Long Island Railroad stations in Roosevelt. About 6% of households do not have vehicle access, similar to Nassau County overall (7%).

Health in Uniondale and Roosevelt

- **Asthma emergency department visit rates among children** ages 0 to 17 years are higher in Uniondale and Roosevelt than Nassau County. Roosevelt (86 per 10,000 children) and Uniondale (68 per 10,000 children) rank in the top five zip codes with the highest rates of childhood asthma emergency department visits in the county.

- **Teen pregnancy rates** are higher in Uniondale and Roosevelt than in Nassau County. Roosevelt (44 per 1,000) and Uniondale (30 per 1,000) rank among the top five zip codes with the highest teen pregnancy rates in Nassau County.

- **Childhood obesity rates** are higher in Uniondale and Roosevelt than in Nassau County. The prevalence of obesity among students attending Uniondale public schools is 30% and 24% among students attending public school in Roosevelt compared with 18% of public school students in Nassau County.

- Uniondale and Roosevelt have higher rates of **cardiometabolic conditions** than Nassau County. The prevalence of **diabetes** among adults is 9% in Nassau County, 13% in Uniondale and 13% in Roosevelt. The prevalence of **high blood pressure** among adults is 25% in Nassau County, 32% in Uniondale and 33% in Roosevelt. The prevalence of **obesity** among adults is 27% in Nassau County, 35% in Uniondale and 36% in Roosevelt.

- **Potentially preventable hospitalization rates**, a marker for hospitalizations that may have been avoided with better primary care access, are higher in Uniondale and Roosevelt than in Nassau County. Roosevelt (231 per 10,000 adults) and Uniondale (159 per 10,000 adults) rank in the top three zip codes with the highest potentially preventable hospitalization rates in Nassau County.

- **Opioid-related death and non-fatal hospitalization rates** are generally higher in Roosevelt (172 per 100,000) and lower in Uniondale (117 per 100,000) than Nassau County (142 per 100,000).

7. Expanding scope in Suffolk County: Shirley, Mastic, and Mastic Beach

In March 2025, the merger between Long Island Community Hospital and NYU Langone Health was formalized. The combined tri-hamlet area of Shirley, Mastic, and Mastic Beach account for the largest number of discharges from the former Long Island Community Hospital. Located a few miles east of the hospital (now called NYU Langone Hospital—Suffolk) in the Town of Brookhaven, these communities on the south shore of eastern Suffolk County are rooted in both colonial era history (the Mastics) and the post-World War II suburban housing boom (Shirley) that transformed Long Island.

While we plan to undertake a more comprehensive community-engaged process to better understand the assets and needs in these communities, we begin this effort with a description of secondary data.

According to the most recent 2020 Census population counts, the population of the combined tri-hamlet area was 56,000 (Shirley: 26,000; Mastic: 15,000; Mastic Beach: 15,000). The population is younger than Suffolk County, with 24% of the population under the age of 18 years and 12% aged 65 years or older. Most residents are White (64%) or Latine (22%), similar to Suffolk County. The majority of Latine residents are of Puerto Rican (38%) or Salvadoran origin (18%). About 11% of residents were born outside the United States.

About 21% of the population speaks a language other than English at home, with Spanish being the most common (15%). About 12% of adults aged 25 years or older do not have a high school degree and 19% have a bachelor's degree or more. High school graduation rates are slightly lower in the school district serving these towns (William Floyd School District) than Suffolk County (87% vs 91%). Rates of chronic absenteeism (missing at least ten percent of school days) for high school students in the district were high in the 2023-2024 school year (44%).

About 7% of the civilian workforce is unemployed, slightly higher than Suffolk County (5%). Median earnings for workers range from about $46,000 in Mastic to about $52,000 in Mastic Beach and Shirley—lower than the median for Suffolk County overall (about $55,000). Median household income is lower in each of the communities than Suffolk County ($122,498), ranging from $96,648 in Mastic to $109,821 in Shirley. The poverty rate in the tri-hamlet area (11%) is nearly double the Suffolk County rate (6%), but varies by community: 8% in Shirley, 12% in Mastic, and 16% in Mastic Beach. About 5% of residents do not have health insurance, similar to Suffolk County (4%).

While most housing in the tri-hamlet area is owner-occupied (86%), a higher percentage of households in Mastic and Mastic Beach are renter-occupied (19%) than in Shirley (9%). Similar to Suffolk County, about 2% of housing units in these communities are classified as crowded (having 1.01 or more occupants per room).

The tri-hamlet area has limited public transportation options. There is one Long Island Railroad station (Mastic-Shirley) and only one Suffolk County Transit bus route. About 5% of households do not have vehicle access, similar to Suffolk County overall (5%).

Health

- **Asthma emergency department visit rates among children** ages 0 to 17 years are higher in the tri-hamlet area than Suffolk County. Mastic (70 per 10,000 children), Mastic Beach (69 per 10,000 children) and Shirely (61 per 10,000 children) rank in the top ten zip codes with the highest rates of childhood asthma emergency department visits in the county.

- **Teen pregnancy rates** in the tri-hamlet area are about two times higher than in Suffolk County. Mastic (33 per 1,000), Mastic Beach (33 per 1,000) and Shirley (25 per 1,000) rank among the zip codes with the highest teen pregnancy rates in Suffolk County.

- **Childhood obesity rates** are higher in the William Floyd school district than in Suffolk County. The prevalence of obesity among elementary school students attending William Floyd public schools is 28%, compared with 22% of public elementary school students in Suffolk County. Among middle and high school students attending William Floyd public schools, 32% have obesity compared with 22% of middle and high school students in Suffolk County.

- The tri-hamlet area has similar rates of **cardiometabolic conditions** as Suffolk County. The prevalence of **diabetes** among adults is 9% in Suffolk County, 9% in Shirley, 10% in Mastic and 10% in Mastic Beach. The prevalence of **high blood pressure** among adults is 28% in Suffolk County, 31% in Shirley, 31% in Mastic, and 32% in Mastic Beach. The prevalence of **obesity** among adults is 30% in Suffolk County, 32% in Shirley, 34% in Mastic, and 34% in Mastic Beach.

- **Potentially preventable hospitalization rates**, a marker for hospitalizations that may have been avoided with better primary care access, are higher in the tri-hamlet area than Suffolk County. Mastic Beach (162 per 10,000 adults), Shirley (138 per 10,000 adults) and Mastic (138 per 10,000 adults) rank in the top ten zip codes with the highest potentially preventable hospitalization rates in Suffolk County.

- While **opioid-related death and non-fatal hospitalization rates** have declined between 2016 and 2022, rates remain higher in the tri-hamlet area than Suffolk County. Mastic Beach (501 per 100,000), Mastic (467 per 100,000) and Shirley (368 per 100,000) rank in the top ten zip codes with the highest opioid-related death and non-fatal hospitalization rates in Suffolk County.

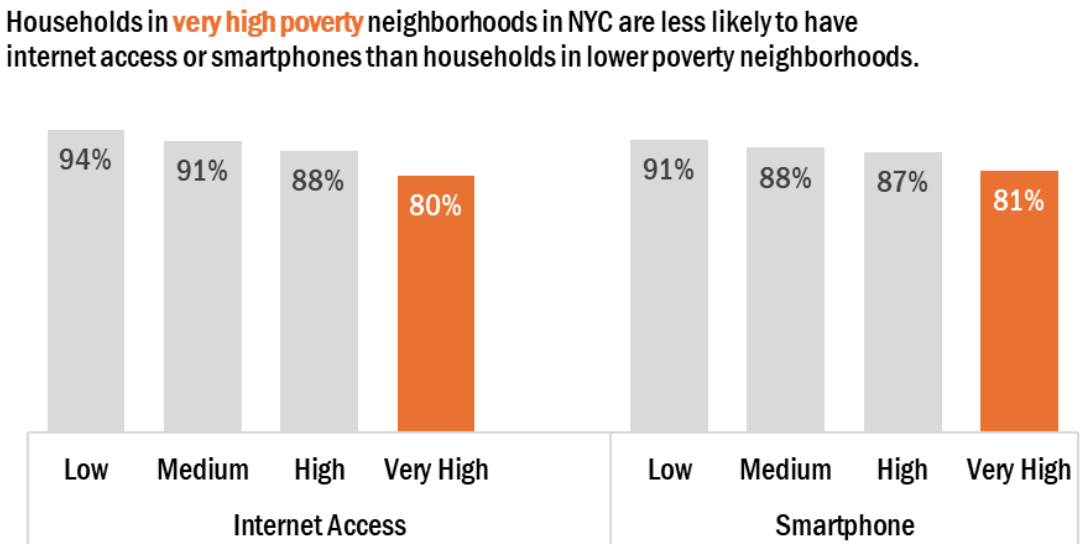
D. Assessment and Selection of Public Health Priorities

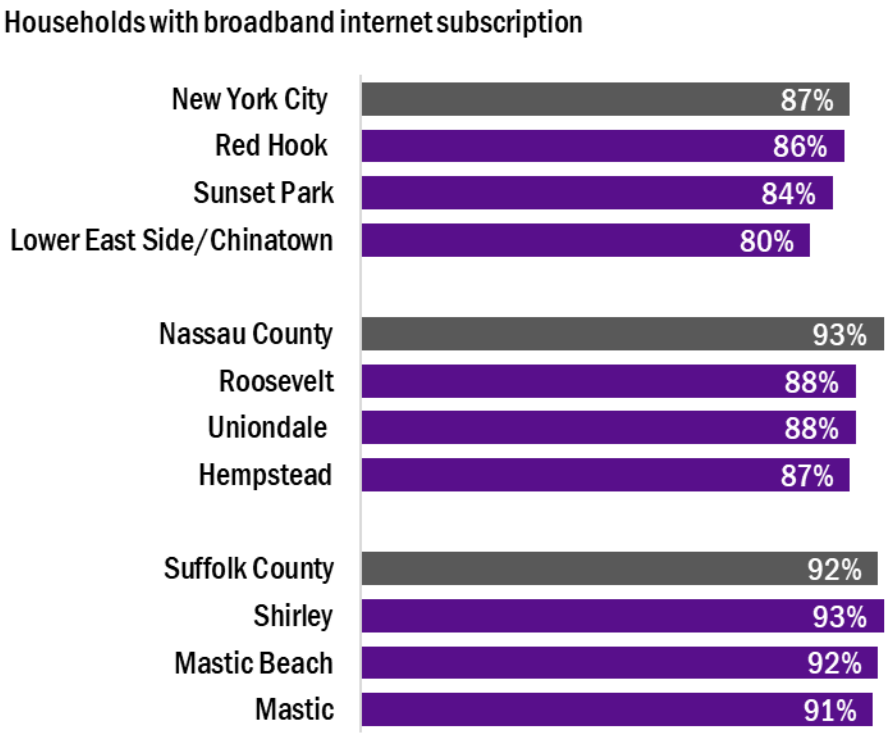
Through the process described in Section I.B., we learn from community members and partners about their concerns and priorities. The issues described below were key priorities identified over the past three years.

1. Needs and Assets: Digital Access

Technology is now an essential tool for accessing health care, education, and social services. Through our previous CHNAA, we saw how the COVID-19 pandemic increased the need for digital access, with the growth of telehealth, remote learning in school, virtual communication of important information, and virtual applications for many benefits. Through our CSP, we helped support the development of the Center for Community-Oriented Virtual Primary Care and Technology (CARE Tech) to increase access to virtual health care for all populations. (See Section II.D.4. for information about this initiative.) Disparities in digital literacy, smartphone and broadband access persist for many living in high-poverty neighborhoods. The need for reliable, quick internet access has been noted by residents and community partners. Even when community members have internet access, many report that the connection speed is too slow to provide meaningful access to many services. Broadband internet service provides a high-speed connection, yet many households in neighborhoods served by the CSP do not have a broadband subscription. Having smartphone access is also not enough to guarantee access to services, as many residents report not having space to download apps or apps are not available in their preferred language.

Internet and smartphone access





Please see Section II.D.4. for a description of the Community-Oriented Virtual Primary Care and Technology program, designed to address these issues.

2. Needs and Assets: Addressing the Intersection of Health and Housing

As highlighted in the NYS Prevention Agenda, access to safe housing is a key determinant of health. The American Hospital Association's *Housing and the Role of Hospitals* report outlines three dimensions of housing instability—homelessness, lack of affordable housing, and poor housing conditions—and their associated health conditions (Table 1). Additionally, people who have difficulty maintaining stable housing are less likely to have regular medical care and are more likely to postpone treatment for health conditions. Tackling issues at the intersection of health and housing has been a long-standing priority in our CSP communities, and strategies to address them require community-engaged research and programming. The following sections describe the housing issues that affect the health and wellbeing of our communities in New York City, including neighborhoods where our CSP projects are focused.

Table 1. Types of Housing Instability and Related Health Conditions

Housing Issue	Examples	Related Health Conditions
Homelessness	• Total lack of shelter • Residence in transitional or emergency shelters	• Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis) • Mental health issues, including depression and elevated stress • Developmental delays in children

Lack of affordable housing	• Severe rent burden • Overcrowding • Eviction or foreclosure • Frequent moves	• Stress, depression and anxiety disorders • Poor self-reported health • Delayed or diminished access to medications and medical care
Poor housing conditions	• Structural issues • Allergens like mold, asbestos or pests • Chemical exposures • Leaks or problems with insulation, heating and cooling	• Asthma or other respiratory issues • Allergic reactions • Lead poisoning, harm to brain development • Other chemical or carcinogenic exposures • Falls and other injuries due to structural issues

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

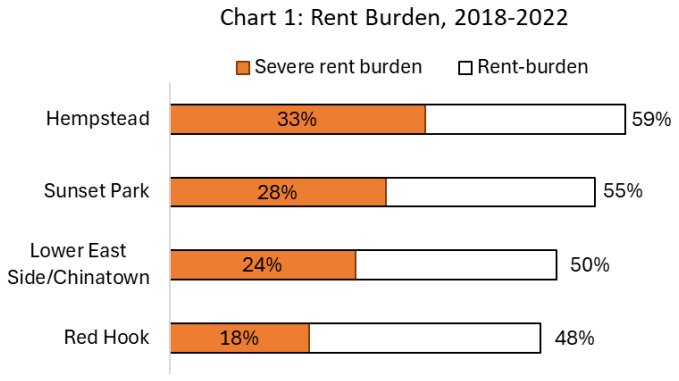
Homelessness

Addressing the homelessness crisis is an urgent need in New York City and of great concern to our CSP community partners, with approximately 146,547 individuals—including 48,304 children—sleeping in a municipal homeless shelter each night in March 2024. Within this population, more than 64,000 individuals have migrated from other countries to New York City since March 2022. Similar to the makeup of our CSP communities, racial and ethnic minority populations make up the majority of people experiencing sheltered homelessness, with 56% individuals identified as Black, 32% Latine, 7% White, 1% Asian American, and 4% other. Additionally, thousands of homeless New Yorkers are unsheltered and sleep on the streets, within public transit systems, and in other public spaces. The New York City Department of Homeless Services (NYC DHS) surveyed and identified 4,140 unsheltered individuals on the night of January 23rd, 2024 as part of its annual point-in-time Homeless Outreach Population Estimate (HOPE), which is likely an underestimation.

Lack of Affordable Housing and Poor Housing Conditions

The lack of affordable housing and the downstream risk of eviction are key drivers of homelessness. According to the 2023 New York City Housing & Vacancy Survey (HVS) Report, the rental vacancy rate fell to one percent, with the vacancy rate of apartments less than $1,650 decreasing to less than one percent.

Based on five-year estimates between 2018-2022, more than one-half of renter households citywide experienced rent burden (spending 30% or more of household income on rent), with 28% experiencing severe rent burden (spending 50% or more of household income on rent). The shares of renter households experiencing rent burden in Hempstead (59%) and Sunset Park (55%) were greater than Nassau County (55%) and New York City (52%) share, respectively.



To navigate severe rent burden, residents often “double up” in overcrowded apartments. In 2023, 9.2% of all rental homes were overcrowded. Sunset Park was identified as the fourth-most overcrowded

neighborhood in New York City, and households headed by someone who was born outside of the US had higher rates of overcrowding than the citywide rate.

Poor housing quality is another consequence of the lack of affordable housing. Indoor environmental complaints in New York City increased drastically in the past decade, with more than 17,000 calls made to 311 reporting the presence of asbestos, poor air quality, sewage issues, and mold in the home in between September 2022 and August 2024. While all tenants regardless of immigration status have a right to habitable housing under New York State and City law, the New York Legal Assistance Group (NYLAG), a partner in the Health and Housing Consortium (see Section II.A.2.), estimates that the prevalence of these hazards is likely much higher due factors such as limited knowledge as well as fears regarding immigration status and potential eviction. A survey conducted the Fifth Avenue Committee, an affordable housing provider and advocacy and social service organization, found high rates of outages in heating and hot water as well as mold and mildew problems in Sunset Park. The Association for Neighborhood and Housing Development also reported over 19% of housing in Sunset Park had severe housing code violation issues in 2018. In our previous CHNAA in Red Hook, residents identified home repairs as the #1 needed service to improve health and reduce stress.

Refer to Section I.C. to learn more about housing in each of our CSP neighborhoods.

Community Feedback on Housing and Health Needs

The Community Service Plan's health and housing initiatives (described in Sections II.A.2. &3.) sought regular guidance from diverse sets of stakeholders that included individuals with lived experience of housing insecurity and homelessness, through ten Health x Housing Lab Advisory Committee meetings and twelve Health & Housing Consortium Program and Policy Committee meetings (Table 2). Through these meetings, as well as through additional engagement with project-specific workgroups and ad-hoc task forces, several themes emerged regarding community needs at the intersection of health and housing.

Table 2. Organizations Represented in CSP Stakeholder Groups, fall 2022-fall 2024

Health x Housing Lab Advisory Committee	***Health & Housing Consortium Program and Policy Committee***
• Breaking Ground*	• Bridging Access to Care
• Citizens' Committee for Children of New York	• BronxWorks
• Human.nyc	• CAMBA
• National Health Care for the Homeless Council	• Concern Housing
• NYC Department of Health and Mental Hygiene*	• Empire BlueCross BlueShield HealthPlus
• NYC Health + Hospitals*	• Greater New York Hospital Association
• NYC Youth Action Board	• Hebrew Home / River Spring
• Volunteers of America	• Legal Aid Society
	• Maimonides Medical Center
	• Montefiore Medical Center
	• Project Renewal
	• RiseBoro Community Partnership
	• Supportive Housing Network of New York
	• The Bridge
	• West Side Federation for Senior and Supportive Housing

**Represented in both the Health x Housing Lab Advisory Committee and Health & Housing Consortium Program and Policy Committee by different individuals. For the full list of organizations represented in stakeholder groups, refer to Appendix C.*

- *Importance of Lived Experience*

CSP community partners deeply value people with lived experience of housing insecurity or homelessness as experts who must play a key role in guiding initiatives at the intersection of health and housing. People with lived experience bring unique perspectives on ways to improve health and housing systems, and their first-hand knowledge enriches community-engaged research, evidence-based interventions and policy-driven practices. In medical education, learning from individuals about the intersection of homelessness and health is crucial to providing high-quality and holistic care to these populations. However, this type of expertise is often overlooked or neglected in academic research settings, policymaking procedures, program development, and in other public forums. Embracing the CSP's community-based participatory action principles, community partners have emphasized the importance of reducing barriers to participation, the need for timely and appropriate compensation to individuals who share their subject matter expertise, and the importance of flexibility and accommodating needs related to transportation and technology. Partnerships with individuals with lived experience of homelessness and housing insecurity must foster a sense of trust to combat potential stigmatization and tokenization as well.

- *Cross-Sector Care Coordination*

Breaking down the silos among healthcare, government, homeless services, and housing services sectors remains a top priority among CSP community partners, as providers continuously navigate limited and disparate resources to care for individuals with complex health and housing needs. Ranging from case managers to program executives, stakeholders wish to build relationships and formalize collaborations with professionals outside of their own sectors to improve outcomes for their shared client and patient populations. Examples include troubleshooting specific client issues through case conferences, embedding care coordinators in emergency room and other hospital settings settings, and streamlining data sharing between sectors.

CSP partners have expressed particular interest in care coordination models related to hospital discharge and connections to proper housing and social services. Community partners have shared longstanding support for medical respite, a program model that fills a care coordination gap for patients experiencing homelessness between the healthcare and homeless services systems, who are too sick to be in a homeless shelter or on the streets, yet not sick enough to require a hospital stay. As community partners consider participation in medical respite programs, they will need to understand program feasibility and expected housing and health-related outcomes. Partners of CSP projects are interested in learning how to leverage opportunities through the New York State Department of Health, which recently released standards for medical respite certification, opened a pilot program, and classified medical respite as a billable service, among other health and housing-related services, under the New York State Medicaid 1115 Waiver.

- *Healthcare and Direct Services Workforce Development*

The direct services providers that are represented by CSP community partners continue to seek cross-sector training opportunities that build their capacity to advocate for their clients and patients (Table 3). The CSP has identified the breadth of training needs to improve provide high-quality care to community members through feedback from (1) its main project advisory groups, (2) event participants, and (3) focus groups in a workforce development needs assessment by the Health & Housing Consortium.

Table 3. Examples of Workforce Training Interests, by Topic			
Housing	**Healthcare**	**Public Benefits**	**Care Management**
• Eviction Prevention • Rental Assistance • Coordinated Assessment and Placement System (CAPS) and Supportive Housing • Healthy Housing	• Medicaid and Medicare Enrollment • Health and Recovery Plans (HARP) • Mental Health Services and Single Point of Access (SPOA) • Harm Reduction	• Social Security Disability Insurance • Naturalization • Voucher Discrimination • Immigration as a Social Determinant of Health	• Motivational Interviewing • Trauma-Informed Care • Cultural Humility • Self-Care Strategies

- *Special Populations and Health Conditions*

While homelessness is in part driven by structural risk factors related to the lack of affordable housing (as described above), research has shown that homelessness can be driven by health-related risk factors such as having an acute health crisis, chronic disease, substance use disorder or a serious mental illness, and not having sufficient funds and resources to maintain healthcare and housing. Conversely, housing insecurity exacerbates these poor health outcomes. The ways in which these conditions intersect with one another are complex, and CSP community partners have prioritized concerns around specific homeless populations or settings, associated health concerns, and potential evidence-based interventions to address them.

5. Housing Policy and Health Advocacy

To address the structural issues that drive poor health and housing instability, CSP partners hope to build their capacity to participate in advocacy work. They expressed the need to support policy campaigns in a timely manner, integrate subject matter expertise from people with lived experience, and amplify advocacy work by partner organizations to colleagues and community members.

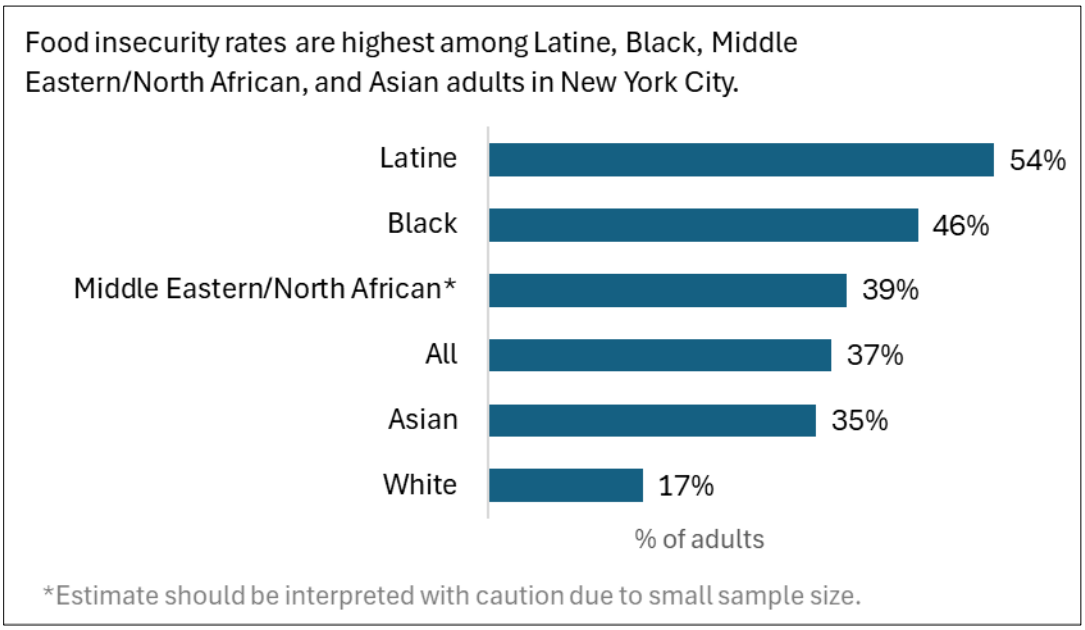
Please see Sections II.A.2. and 3. for descriptions of the Health & Housing Consortium and the Health x Housing Lab.

3. Need and Assets: Healthy Eating and Food Security

Food insecurity — even marginal food insecurity — is detrimental to health and well-being. Food insecurity can lead to poor health status, mental health problems, and poor educational outcomes. It is especially problematic for young children as it can affect development and growth, feeding practices and obesity. Food access barriers are disproportionately experienced by the populations that comprise our Community Service Plan communities: Black, Latine and Asian Americans; older adults; families with children; those living with chronic disease; those with less education; and those living in high poverty neighborhoods. The barriers are often more severe for undocumented residents, who may be ineligible for food benefits.

Since the pandemic, inflation and rising costs have affected household food budgets, with many households forced to purchase less food or purchase less healthy food options. In New York State, food insecurity has risen since the expiration of pandemic-related credits and waivers that helped mitigate the impact of the pandemic on food security. In New York City, 37% of adults experienced food insecurity, with rates highest for Latine adults (54%), Black adults (46%), Middle Eastern/North African adults (39%), and Asian adults (35%) compared with White adults (17%). Among adult New Yorkers

living in households with incomes below 200% of the Federal Poverty Level, 53% experienced food insecurity.



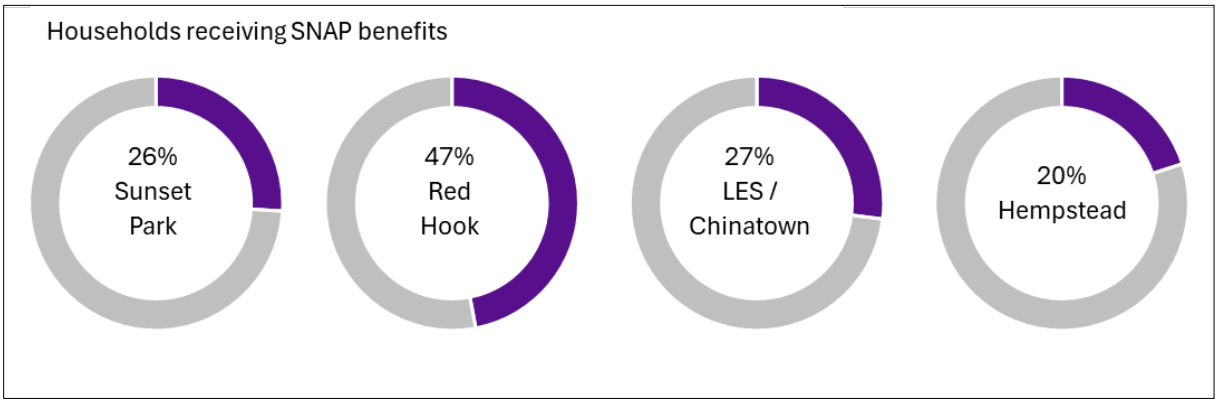
Consistent access to healthy food has been challenging for many residents in our CSP communities. In Sunset Park, 43% of adults experienced food insecurity. In 2018, Sunset Park was identified by the NYC Food Assistance Collaborative as a high priority community due to the large gap between demand and supply of local emergency food resources and the high population of families in poverty. Access to healthy affordable foods was a top need identified by the Red Hook community in our first needs assessment in that community and continues to be a top concern, exacerbated by geographical isolation. In the Lower East Side/Chinatown, 29% of adults experienced food insecurity. The Community District Needs Assessment includes a request for more food delivery vans to serve older adults in the neighborhood who need access to nutritious foods but are unable to shop or cook for themselves. Food insecurity is also a concern in Hempstead. In 2024, a large national grocery chain closed in the community, further limiting residents' access to food. In a conversation with area high school students in summer 2024, many expressed a desire to eat healthier foods but noted there were limited places to purchase healthier choices and many options to purchase fast food in their community. Some noted that family members choose to travel outside of Hempstead, as far as into Queens and the Bronx, to find better quality and better-priced fresh groceries. Similarly, in interviews with the pediatric practice in Hempstead, staff highlighted the lack of healthy food in the neighborhood and the challenges that parents face in cooking healthy and inexpensive meals.

Local screening and on-the-ground accounts suggest even higher rates of food insecurity within our communities. For example, half of all parents with young children screened for social needs in Family Health Centers' pediatric practices in 2021 reported running out of food or worrying about running out of food.

The Family Health Center's emergency food pantry (The Table) served more than 29,000 individuals from close to 10,000 households in fiscal year 2024. The Red Hook Farm – an urban farm in Red Hook Brooklyn, run by Red Hook Initiative – increased the number of food boxes it provides from 100 families

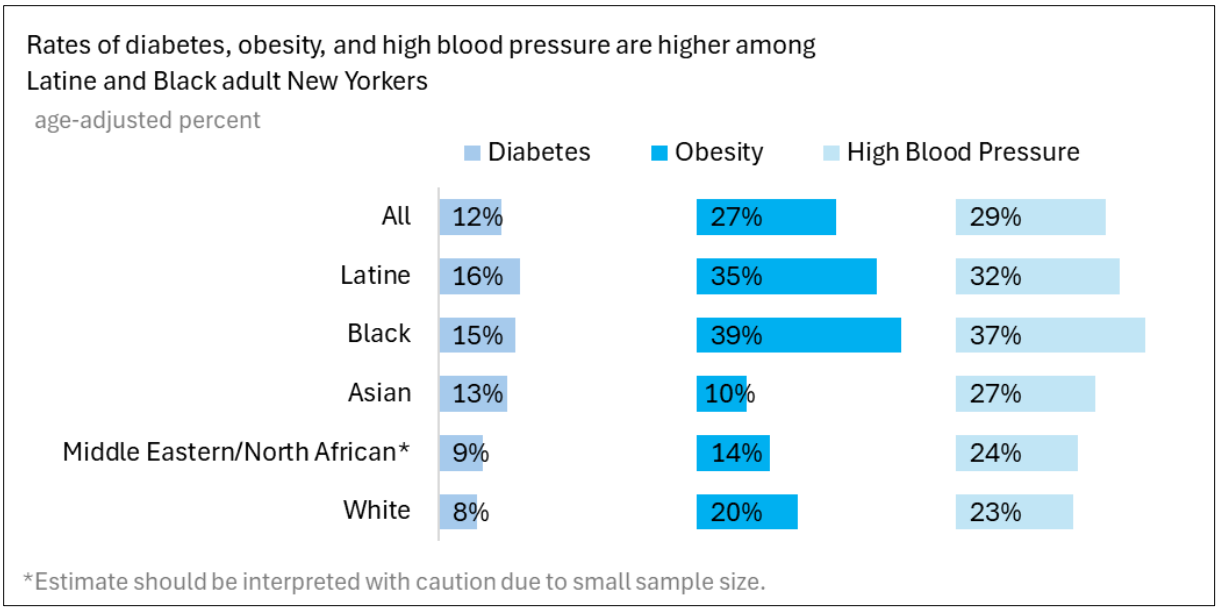
a week, to almost 500 a week. Members of the Sunset Park Community Coalition (see Section II.A.1.), as well as other local food pantries and social service organizations across all our communities, have reported a similar increase in usage, resulting in longer waiting lists. During this time, many organizations were forced to close their offices or changed their service practices and there was no centralized means to stay updated on changes or new benefits and programs that arose in response to COVID-19.

SNAP benefits can help households purchase food, mitigating food insecurity. While many households in neighborhoods served by CSP programs received SNAP benefits, many who are eligible for SNAP benefits do not access them. In addition to providing access to food through food pantries, our programs have focused on connecting people to available benefits.

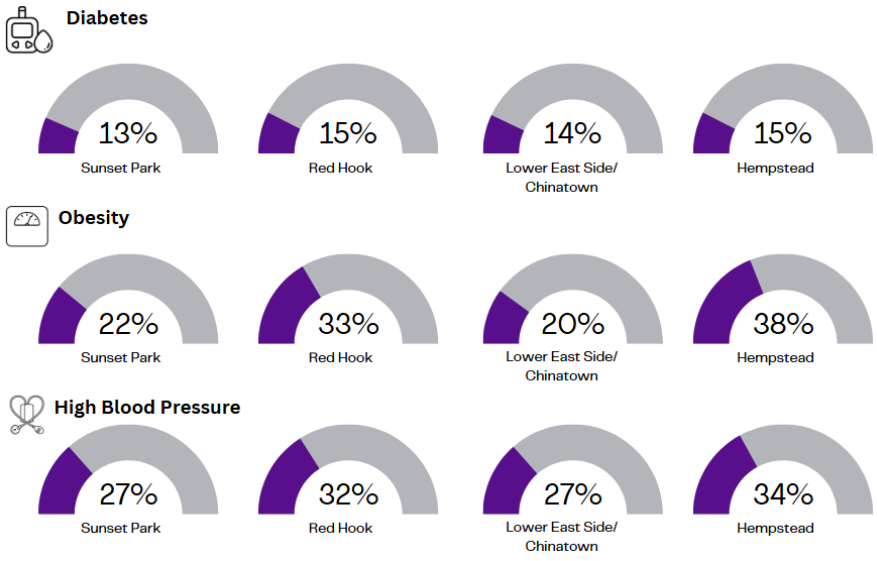


Healthy Eating:
Reducing deaths from cardiometabolic conditions is a priority outlined by the New York City Health Department in its HealthyNYC plan. Cardiometabolic conditions, including heart disease, stroke, high blood pressure, diabetes and kidney disease, are associated with diet and obesity. Obesity continues to be epidemic: more than one-quarter of adult New Yorkers are obese (27%). One out of five NYC public school children in grades K-8 is obese and one out of three Hempstead public school students in grades K-12 is obese. In 2024, four out of ten pediatric patients (ages 3 to 17 years) at the Family Health Centers and five out of ten pediatric patients at the Hempstead pediatric practice were overweight or obese. . Children who are overweight or obese are at risk for hypertension, elevated lipid levels and diabetes – referred to as "adult onset" prior to the obesity epidemic. These risks escalate as obese children become adults, when they also become at risk for heart disease, stroke, arthritis, and cancer.

Rates of diet-related health conditions (diabetes, obesity, and high blood pressure) are higher among Latine and Black adult New Yorkers than White adults. Diabetes rates are also higher among Asian adults than White adults and given evidence that Asian populations are more vulnerable to insulin resistance at lower weights, preventing obesity is a high priority. The American Diabetes Association recommends screening Asian Americans for diabetes at a lower BMI threshold of 23 kg/m2 compared to 25 kg/m2 among the general population.



Poorer 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. Obesity continues to be a concern among community residents and leaders in Chinatown, the Lower East Side and Sunset Park, Hempstead, and was identified as a concern by the Brooklyn Arab American community.



Rates of diet-related health conditions are concerning across all CSP neighborhoods. In all of our communities, residents have expressed concern about diabetes, driven by food insecurity, the need for additional recreational space, and cultural approaches to healthy eating.
Obesity prevention beginning in early childhood is important as a way to affect the health trajectory typically seen for immigrants, where each subsequent generation is at increased risk of obesity and the development of diabetes. There is substantial evidence that the roots of obesity are established in early childhood and that effective obesity prevention efforts need to target families and children early in life. Children already overweight by ages 3 to 7 are at much greater risk of becoming overweight adults.
Many of our Community Service Plan programs directly and indirectly address food insecurity and healthy eating. For example, please see Sections II.A.1., II.B.1. and II.B.3., which describe the Healthy

Food Initiative, the Greenlight Early Childhood Obesity Prevention Program, and REACH FAR Brooklyn: Racial and Ethnic Approaches to Community Health for Asian and Arab Americans in Brooklyn.

4. Needs and Assets: Tobacco Prevention and Cessation

New York City has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 9.0% in 2021-2022. But the rates of reduction across populations have been uneven, with disparities persisting when examining the intersection of race and ethnicity, gender, and birthplace. For example, in 2019-2020, 20% of Asian/Pacific Islander men born outside the United States smoked, virtually unchanged from the citywide rate in 2002 (20%). Smoking prevalence varies by Asian ancestry. In a community survey conducted in 2021-2022 by the NYU Langone Health Perlmutter Cancer Center, 35% of Korean American men surveyed and 15% of Chinese American men surveyed reported current smoking. However, based on citywide data from the NYC Health Department, a small percentage (8%) of Asian New Yorkers who smoke have used nicotine replacement therapy (NRT).

The NYC DOHMH recognizes smoking among Asian American men as a health disparity. As described in Section II.B.2. below, the CSP Tobacco Free Community Initiative has been working in partnership with the DOHMH to understand this disparity and to help develop strategies to address it. One such effort was an observational study of the availability of NRT pharmacies located in Asian American communities in NYC. We also conducted a series of interviews with smokers about their use of and attitudes toward NRT. Those findings are described in Section II.B.2.

Not surprisingly, in Chinatown and the Lower East Side and Sunset Park, communities with large Asian American populations, smoking continues to be a top health concern among our community partners. Similarly, smoking is a concern in Hempstead, Long Island, where rates are higher than in New York City and in Nassau County as a whole: 16% of Hempstead adults smoke, compared with 9% in Nassau County.

NYC adults living in public housing are more likely to smoke than adults living in other types of housing (15% vs 12%). With the implementation of the U.S. Department of Housing and Urban Development's smoke-free public housing policy, there is continued demand for information and access to services to help support public housing residents quit or reduce their dependence on tobacco. Given the large public housing developments in Red Hook and on the Lower East Side, several community partners are interested in enhancing their capacity to meet this need.

The portfolio of CSP projects that address these issues is described in Section II.B.2., below.

5. Needs and Assets: Maternal and Child Health Outcomes and Children's Social-Emotional Development

A fundamental concern for the low-income communities that comprise our Community Service Plan is maternal/child exposure to adversity. In New York State, 13% of children experience two or more adverse childhood events (ACE), defined as traumatic experiences occurring before the age of 18, such as poverty, parental mental illness, parental substance use, neglect or abuse, exposure to domestic violence, and other traumas.

The perinatal period, which spans conception through one year after birth, is a vulnerable time for women. Depression during the perinatal period is a particular concern for both the mother's health and impacts on children's social-emotional development. High stress and low levels of social support are associated with increased risk for depression and anxiety. Results from the 2021 Sunset Park Mental Health Study, a survey of pregnant and parenting women living in or receiving services in Sunset Park, found high rates of anxiety and depression among respondents, particularly among Chinese-speaking pregnant women. However, rates were lower among women who reported receiving needed support. Qualitative interviews with a subset of respondents revealed that women were concerned about their children's health and development and many were interested in classes and information to support their parenting skills. Many women also noted the importance of support, including instrumental support to help with childcare, emotional support from their partners, and informational support to help them with the transition to motherhood and supporting their children's early educational needs.

Preliminary baseline results from the Children, Caregivers, and Community (C3) study, an on-going study in Sunset Park, found that concerns about their child's social-emotional health was a source of stress for one in five mothers surveyed in year 1. In the C3 cross-sectional study, preliminary results indicate that while children ages 4 years and 6 years have mean behavioral health scores on par with national benchmarks, mean scores for school readiness were slightly below national benchmarks

We have also spoken to families and other community stakeholders in Chinatown, the Lower East Side, Sunset Park, Red Hook, and Hempstead about their needs, assets and priorities. In all of these communities, we have heard how the stress resulting from poverty, exacerbated by the COVID-19 pandemic, together with the amplification of anti-immigrant rhetoric and the impact of violence and racism, have combined to heighten concern about maternal/child health and well-being. (See Sections II.D.&E. for a description of CSP programs that respond to these needs.)

The CSP communities are also concerned about high rates of teen pregnancy. While teen birth rates in NYC declined across all poverty levels between 2012 and 2021, the disparity between teens living in low poverty and very high poverty neighborhoods remained unchanged. In 2012 and 2021, the teen birth rate in very high poverty neighborhoods was four times higher than the rate in low poverty neighborhoods. Furthermore, teen birth rates in very high poverty neighborhoods remain high (14.4 per 1,000 compared with 8.9 among NYC teen residents).

While the disparities for Latina and Black teens are narrowing, they are still overrepresented among teen births and remain high compared to non-Latina White teens. In 2021, the teen birth rate for Latinas was 15.9 per 1,000, 3.9 times higher than that of non-Hispanic White teens. Sixty-two percent of all NYC teen births were to Latina teens. The teen birth rate among non-Latina Black teens was 2.5 times higher than White teens (10.3 compared with -4.1 per 1,000). Asian and Pacific Islanders in New York City have the lowest teen birth rate (1.8 per 1,000 compared with the 9.4 citywide rate). Black and Latina teens are also overrepresented in teen pregnancy rates (33.3 and 29.6 per 1,000 respectively, compared with 22.7 citywide).

Teen pregnancy and birth rates are notable in Hempstead and Sunset Park. Hempstead has the highest teen pregnancy rate of all zip codes in Nassau County. The teen pregnancy and teen birth rates are about 5-6 times higher in Hempstead than Nassau County as a whole. In Hempstead, the teen pregnancy rate is 49.9 per 1000 girls ages 15-19 compared with 10.2 in Nassau County, and the teen birthrate is 30.0 compared with 5.0 countywide. In 2017-2020, Sunset Park had the 17th highest teen

birth rate among the 59 community districts in the City, with 13.7 births per 1,000 girls ages 15-19 (compared with 10.0 per 1,000 citywide).

Programs that address these issues are described in Section II.E., below.

6. Weather and Health Effects

In the New York City metro area, residents are at risk of experiencing certain severe weather events, including extreme heat, flooding, and poor air quality. Extreme heat increases incidents of heat-related illnesses and death, particularly for patients with certain health conditions or in certain demographics. Understanding the health effects of extreme heat and air quality events is crucial for developing effective strategies that help our communities achieve better outcomes during these events. This knowledge also allows NYU Langone to improve operational efficiency, resilience to extreme weather events, and capacity planning so that we can respond effectively during these extreme weather events.

Heat Vulnerability for Communities Served by NYU Langone Health

The Heat Health Index (HHI) identifies areas at risk of negative health outcomes from heat. As part of the CHNAA, we analyzed patient data and found that 45,154 patients (22.3%) live in "low heat vulnerable" zip codes, 67,170 (33.1%) live in low-moderate heat vulnerable zip codes, 48,371 patients (23.9%) live in moderately high heat vulnerable zip codes, 39,397 patients (19.4%) live in high heat vulnerable zip codes, and 2,612 patients (1.3%) live in exceptionally high (national top 10%) heat vulnerable zip codes (Figure 1). Heat-vulnerable neighborhoods have a higher percentage of heat- and air-quality-related social and structural vulnerabilities and a higher prevalence of health conditions like heart disease, obesity, diabetes, COPD, asthma, and poor mental health, which are exacerbated by extreme heat and air quality events.

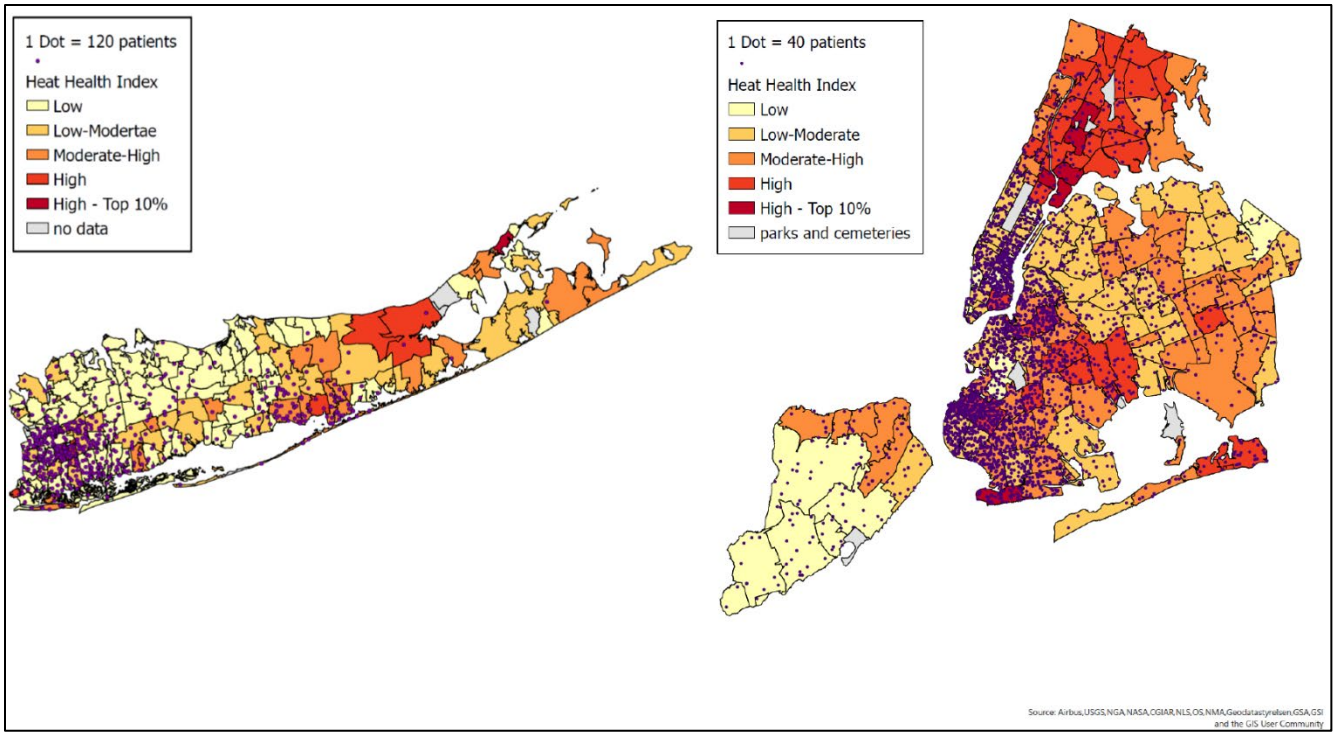


Figure 1: Heat Health Index and NYU patients residential zip code densities in Long Island (left) and New York City (right) metro areas.

In-Person Needs Assessments: Community Engagement Sessions

To understand weather-driven health impacts on our communities, we conducted 3 community engagement sessions. Older adults were prioritized, given their notable heat and air quality-related vulnerabilities. Materials provided were in their native languages: Chinese, English, Russian, and Spanish. The sessions focused on extreme heat and air quality events, aiming to understand the public's concerns and identify opportunities for preventative interventions.

A pre-session survey showed that most respondents recognized the negative health impacts of extreme heat and poor air quality. However, only half knew how to access air quality information or find safe places during poor air quality. Participants expressed interest in public air filter programs and concerns about heat exhaustion and poor air quality. They also recognized the value of public transportation, public pools, and parks for reducing heat exposure. A post-session survey showed that over 70% of respondents were interested in and would trust their primary care doctor to discuss ways to stay safe from heatwaves and air pollution.

Community Session Quote: "When air quality is bad outside, it can affect our health in a lot of different ways. It can make your heart disease worse and can make your lungs worse. It can affect our mental health as well. It can lead to depression."

During the first year of the CSP cycle, we will assess health conditions that increase risk from heat and air quality and focus research on populations who appear to be more sensitive to heat events. We also plan to leverage ongoing research to pilot adaptive interventions for heat and air quality and create

educational materials for patients and staff. We will continue community engagement sessions with a broader demographic and geographic range and develop a more granular post-survey and conduct post-engagement interviews.

See Appendix D for more information about this component of the CHNAA, as well as preliminary plans for addressing the needs identified.

E. Community Needs Not Addressed and Why

Across New York City and Long Island and within our CSP neighborhoods there are many health needs that are beyond the scope of this plan. Indeed, the New York State Department of Health *Prevention Agenda 2025-2030* identifies 24 priorities under five overarching areas.

Many health needs and social risks were highlighted and amplified by the COVID pandemic and exacerbated by hostile rhetoric and policies. Mental health continues to be a pressing concern as people struggle to cope with the economic and social challenges.

People experiencing economic resource strain, food insecurity, and poor home conditions have higher incidence of depression and anxiety. Although our Community Service Plan programs do not directly provide mental health services, they are designed to address those underlying causes and consequences of poor mental health. The CSP includes initiatives that screen residents for these and other needs, and directly provides or connects them to services, including support for accessing health insurance and mental health services.

Selecting priority areas for NYULH's Community Service Plan and using resources efficiently and effectively necessitates concentrating on some specific challenges and affording less attention to others. Many of the needs that are not addressed directly by the CSP are being served by existing NYULH programs, valuable community organizations, and other health care providers in the community. The Community Service Plan coordinates efforts with community organizations so that we continue to have a comprehensive and up-to-date understanding of community needs and resources, enabling us to maximize our collective impact to improve the communities' health.

F. Information Gaps that Limit NYULH's Ability to Assess Communities' Health Needs

The NYC DOHMH provides a wide array of invaluable data about the health of the City and its neighborhoods. But the diversity within Manhattan Community District 3 (the Lower East Side/Chinatown) and Sunset Park and Red Hook – economically and in terms of race and ethnicity – necessitates that we supplement these data with a more granular, on-the-ground approach to understanding community needs and assets. Similarly, data are sparse about the needs and assets of subpopulations. While some county level health data are available, there is limited publicly available data for communities on Long Island. County level data often mask social, economic, and health disparities that communities experience.

To truly understand community needs, assets and priorities, we are in a continual cycle of engagement, assessment, and program development as questions arise and new priorities emerge. Assessment methodologies have included:

- Surveys (see Section I.C.1., which describes the survey of the Arab American community in Brooklyn);
- An innovative Think Tank convening of community experts;
- Secondary data analysis suppplemented by focus groups and community meetings and surveys (see Section I.C.4., which describes the needs and assets assessment in Hempstead, Long Island); and
- Utilization of program data to understand more about community needs and barriers to care.

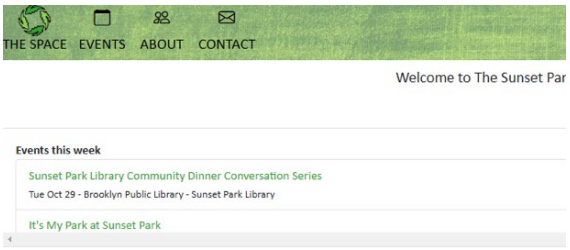
Our engagement with community partners and meetings with community residents and organizations have helped us identify gaps and have deepened our understanding of community needs and priorities.

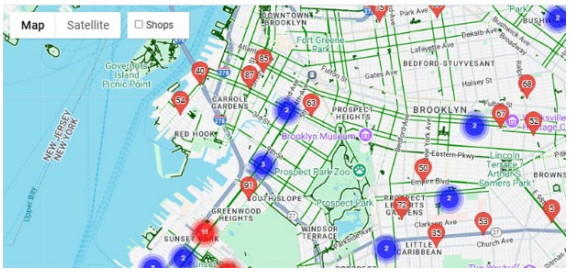
G. Existing Assets, Facilities, and Resources

The City Health Dashboard: a CHNAA Resource
Created by a team at NYU Grossman School of Medicine's Department of Population Health, and with support from the Robert Wood Johnson Foundation, the City Health Dashboard launched in 2018. The Dashboard now offers data on over 40 measures of health and drivers of health for over 970 cities across the U.S. – all cities over population 50,000 plus a growing set of smaller places…
Equipped with the Dashboard's data and action-supporting resources, local leaders have a clearer picture of the challenges facing their communities and how to address them. City leaders and partner organizations have used the Dashboard to target public health investments in high-need neighborhoods, to expand support for city budget allocations for health, and to design evidence-based community health improvement efforts

Reviewing existing assets, facilities and resources is a critical step in our iterative assessment process (which we call a CHNAA – Community Needs **and Assets** Assessment), as well as in our strategy development and implementation processes. We draw from residents, partners, and inventories (such as Greater New York Hospital Association Health Information Tool for Empowerment (HITE) http://www.hitesite.org/, and NYC Facilities Explorer, https://capitalplanning.nyc.gov/facilities) to identify existing resources, gaps in services, and potential partners to advance our goals. Our assessment includes reviewing barriers and facilitators to accessing services, such as language, culture, cost, transportation, and ages served. We also seek to support CHWs throughout the City in their efforts to help connect clients to resources. For example, in the fall of 2024, the CSP Community Health Worker Research and Resource Center held a webinar to demonstrate the Findhelp platform, a tool that connects navigation staff and organizations to a comprehensive directory of resources.

In 2024, supported in part by the CSP, a new resource was launched: The SPACE (Sunset Park Area Assets and Community Events at https://thespacebk.org). The concept for the SPACE came from a community-partnered process and has two primary features. The first is an interactive map highlighting community resources and assets, such as where to find benefits assistance, access to free food, and programs for children and families. The second is a community events calendar featuring recreational activities, cultural events, health pop-ups, educational workshops, and more. The website is available in English, Spanish, and Chinese. This work was completed in part with software developed by NYU Langone Health's Research Software Engineering Core (RRID: SCR_023022).





In each of the CSP communities, there are strong community-based organizations that address a wide range of the social determinants of health. Many of these are partners in our work (see Appendix C) and serve on program advisory committees or our CSP Coordinating Council. In addition, we collaborate with other health care providers: hospitals across New York City participate in convenings and workshops offered by our Health & Housing Consortium; numerous health care providers have attended events and trainings offered by the Community Health Worker Research and Resource Center. Harmony Healthcare is a member of the Hempstead CHNAA planning group. Rockwell Health and Addabbo Family Health Center work with the Red Hook Community Health Network.

We also use the Community Service Plan to leverage other funding. For example, several CSP projects – the Community Health Worker Research and Resource Center, the Health x Housing Lab, Project SAFE, ParentChild+, and the Table food pantry – have been able to obtain grant or public funding to extend their reach. Both the Red Hook Community Health Network and The Table are leveraging the recent 1115 Medicaid Waiver to utilize alternative financing resources to support their CSP work. Other projects – for example ParentCorps, Greenlight, and PlayReadVIP – are able to leverage larger national initiatives or create synergy with local grant-funded programs. Together Growing Strong, a community-driven early childhood initiative in Sunset Park supported by the Bezos Family Foundation, has worked closely with the CSP, resulting in synergies that have strengthened the work and created a more cohesive set of resources for children and families.

An overarching finding of our resource and asset assessment is that essential service providers are universally seeking opportunities for shared information and coordination. Responsive strategies that "treat the whole person" require collaboration. Similarly, residents need support in navigating these resources and systems. Many of our projects are designed to provide this connective tissue, for example, through Community Health Worker strategies, network development, and cross-sector learning and problem solving.

II. Community Service Plan /Implementation Strategy

Building on the clinical and scientific expertise and capabilities of NYU Langone Hospitals and the Family Health Centers at NYU Langone and the expertise and knowledge of our many community partners, NYULH's three-year Community Service Plan takes a multi-sector and holistic approach to improving health in communities in Manhattan, Brooklyn and Long Island. We also have several programs that now reach across the City and State.

New York State Prevention Agenda Priorities

Aligning with New York State Prevention Agenda and New York City and Long Island public health priorities, the Community Service Plan focuses on Economic Stability; Social and Community Context; Neighborhood and Built Environment; Healthcare Access and Quality; and Education Access and Quality. Each of our Community Service Plan programs is supported by a strong evidence base. Please see Appendix E for a description of the evidence for each initiative, together with relevant citations. In addition, as described in Section II.F., several programs support the CHNAA and the CSP initiatives by measuring and enhancing health equity and supporting local collaboration-building.

Promoting Inclusivity and Addressing Health Disparities*

Each of the CSP programs addresses a health disparity: unstable housing and the high risk for food insecurity and obesity among low-income populations; high risks of hypertension and barriers to care for South Asian populations; high rates of smoking among Asian American and immigrant men; high rates of teen pregnancy and risk for sexually transmitted disease among low-income youth; increased risk of maternal depression and child development delays among families who experience the stresses of poverty; and risk of inactivity and falls for the elderly.

Each program strives to implement an agreed upon set of Guiding Principles to Increase Authentic Community Engagement and Improve Health Equity. These principles, together with how they are being implemented, are described in Section IV.

In the sections that follow, we briefly describe our programs, our progress to date, and our goals under the 2025-2027 Plan.

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

A. Promoting Economic Stability: Programs, Progress and Plans

1. Healthy Food Initiative

The Healthy Food Initiative is an evidence-informed intervention that aims to increase food security in Sunset Park, Brooklyn and surrounding communities by distributing emergency food through our food pantry and by assisting community members in accessing benefits and resources to reduce economic strain. In addition to decreasing food insecurity, the initiative also supports the consumption of healthy food by providing information about nutrition and enrolling people in programs that incentivize the purchase of healthy foods, such as New York City's Health Bucks. The initiative includes emergency food assistance, screening for social drivers of health and case management, community education, and a community-wide coalition of food systems stakeholders.

Emergency Food Pantry:

The Family Health Centers at NYU Langone's food pantry program, The Table, is part of a continuum of nutrition-focused FHC services designed to improve long-range health outcomes for Brooklyn residents, including services for obesity prevention and reduction, the mitigation of food insecurity, and nutrition

* NYU Langone's programs do not include preferences, quota, or other set asides or otherwise exclude anyone based on race, sex, or other protected categories.

education to help residents prevent or manage diabetes and other long-term health conditions. Food insecurity, The Table's focus, is detrimental to both mental and physical health and can lead to poor developmental and educational outcomes.

The Table offers emergency food relief on a weekly basis in Sunset Park, Brooklyn, providing access to culturally appropriate shelf-stable staples and fresh fruits and vegetables to anyone who needs food. There are no income eligibility or documentation requirements. The Table is grounded in a *client choice* model, similar to shopping in a grocery store, which enables clients to choose items that are the best fit for their needs and preferences. In contrast to more traditional program models, the client choice model improves diet-quality outcomes and self-sufficiency.

There is promising evidence that food pantries and food banks that use healthy food initiatives to increase fruit and vegetable consumption improve diet quality and increase food security for clients more than traditional food pantries. Strong partnerships enable The Table to provide local, fresh food and are a testament to local businesses' commitment to the community. The Table has collaborated with various small businesses to provide freshly baked bread directly to pantry clients. The Table also has a sustained relationship with Brooklyn Grange, an urban rooftop farm located in Sunset Park that provides hand-picked, locally grown organic produce. The Table and Brooklyn Grange work together to tailor the crops to meet the needs and preferences of the diverse cultural groups served. Through this partnership, Brooklyn Grange provides The Table with a bountiful standing order of culturally specific market crops that are selected based on community feedback.

The program addresses immediate food needs while also connecting clients to services that will reduce food insecurity in the long-term, including SNAP food-stamp benefits, case management, and adult education and workforce development The Table is located in close proximity to the Family Health Centers' Family Support Center to support ease of access to case management and other family services offered at the site.

<u>Screening, Case Management and Nutrition Education</u>:

Staff counselors and AmeriCorps Food Access Navigators (FANs) provide case management services to community members. Counselors and FANs assess the needs and strengths of community residents to collaboratively determine goals and steps needed to achieve those goals. Residents are screened for a range of needs and benefits eligibility and then assisted with accessing food, economic, and other benefits and services to address immediate needs and promote long-term financial stability. Some

services are provided directly (such as SNAP and other benefit application assistance) and others are provided through referrals (such as legal, health, and mental health services). Evidence indicates that SNAP enrollment has a positive impact on long-term outcomes for young children, reduced hospitalization for seniors, and positive academic outcomes for high school students.

Representative of the dominant cultural groups in the community, counselors and FANs are located at the Family Support Center and at community partner sites throughout Sunset Park including primary care centers and community-based organizations. The approach acknowledges and responds to the challenges community members often experience in accessing benefits and resources. Community members may struggle with cultural, language, and literacy barriers as they navigate the complex benefit application process.

Sunset Park Community Coalition:

In partnership with the Chinese American Planning Council and Together Growing Strong (an early childhood grant-funded initiative), FHC launched the Sunset Park Community Coalition in summer 2021, leveraging existing local resources to formalize an integrated system that supports food security. Multi-sector partners include food pantries and soup kitchens, community-based organizations, local businesses in the food supply chain, food recovery organizations, farms, public schools, and citywide organizations focused on hunger prevention. The Coalition is a collaborative and coordinated effort to reduce food insecurity and address the underlying social drivers of health in the community.

Progress and Impact

The Healthy Food Initiative was added to the Community Service Plan in April 2020 to address community needs that intensified during the pandemic. During the current reporting period, 7,483 unduplicated households and 29,932 individuals have received food security services through the Healthy Food Initiative.

Emergency Food Pantry:

Several factors have contributed to a sustained demand for emergency food extending into the post pandemic period. Between pandemic onset and fall 2024, grocery prices increased by 25%, making it even harder for low-income families to afford needed food. Concurrently, there was a significant influx of immigrants and refugees that arrived in NYC in 2022 and 2023 with a related increase in demand for emergency food. The increase in demand coincided with the NYS SNAP policy change in March 2023 in which SNAP recipients stopped receiving the emergency pandemic allotment that had been added to their regular benefit, further exacerbating existing financial strain. According to an analysis of FEEDNYC data, average monthly visits to soup kitchens and food pantries increased by 75% compared to pre-pandemic levels.

During the reporting period, the Table food pantry provided 228,408 pounds of shelf stable food and fresh produce to 7,483 households. In November 2023, another local pantry run by a local faith based organization closed, and the Table food pantry relocated to that location, only half a block from its previous site. This provided additional space and a volunteer base to draw from. The move also provided continuity for existing church pantry clients.

The program also developed new emergency food access models to adapt to community needs, providing food packages to in-need patients being discharged from NYU Langone Hospital – Brooklyn's Emergency Department, partnering with FHC's School Based Health Centers to increase access to emergency food for High School students and conducting special food distributions for families with children under the age of 5. Additionally, the Table expanded its distribution of fresh produce to include four community schools (PS 94, 169, 896, 503/506) and one community-based organization (Mixteca) in Sunset Park. This expansion reduced barriers faced by struggling families in accessing needed food and enabled the FHC and its farm partners to tailor the distribution process and food selection to meet the unique needs of each local community. During the reporting period, there were a total of 48 food distributions at Mixteca, and 33 school-based distributions reaching a total of 990 families.

In addition to increasing the number of distribution sites, the Table was also able to diversify its produce selection through the development of new partnerships with three additional farms (Gentle Times Farms, Catskills Agrarian, and Star Route Farm) affiliated with Choy Commons. The mission of Choy Commons, a minority owned business located in the Hudson Valley, is to collaborate with organizations in NYC that serve the Asian diaspora. The Table also increased its food inventory through strengthened partnerships between the Table and NYU Langone - Brooklyn, which resulted in the launch of an annual canned food drive led by NYU Langone - Brooklyn's Nursing department in 2023 and to seasonal donations of frozen meals from the hospital's Nutrition Department.

FHC worked with the Brooklyn Grange to strengthen the connection between pantry clients and the Grange's rooftop garden through a new Community Cultivation Initiative, which provided pantry clients with a range of onsite opportunities to directly engage with the food being grown there and to give them a greater sense of agency in the food cultivation process. Participants toured the rooftop space, attended nutrition education workshops, and took home a bag of fresh produce. Community cultivation also included the new practice of having Cantonese and Mandarin speaking farmers attend Table food distributions twice a month and offering FHC's FoodCorps AmeriCorps members an opportunity to visit the farm and learn about the crops that are grown there for the Table.

All participants who visited the pantry during this reporting period were invited to participate in a web-based survey via text and 562 responded. Responses indicated that The Table is helping in-need community residents access healthy, community-tailored food. 99% of respondents indicated that most items received were the kind of food their household wanted to eat. The survey also attempted to determine how the Table was improving financial security and related social drivers of health. Responses suggest that the Table is helping alleviate broader financial resource strain:

- Accessing the food pantry in order to be able to use financial resources to meet other needs was the second most cited reason for visiting The Table (41%).
- 53% of respondents reported using the pantry in order to provide healthy food for their household.
- 24% of respondents visited the Table because food was running low.

<u>Screening, Case Management and Nutrition Education</u>:

Recognizing that food insecurity is a symptom of larger household financial instability, the program introduced a new workflow in 2023 in which new clients first meet with a case manager to be assessed for needs and assisted in accessing benefits and concrete resources such as WIC, ESOL classes, health insurance, diapers, and Cash Assistance. This new workflow replaced the previous practice of providing

written resource information and resulted in many more food pantry clients being connected to benefits and programs.

During the reporting period, 4,863 heads of household received case management services. All clients were screened for benefit eligibility and were offered application assistance if eligible:

- 1,855 clients were assisted with 3,295 applications to address financial insecurity. The majority of the applications were for SNAP (1,298), but other applications such as Cash Assistance also improved food security by addressing underlying financial instability.
- 2,071 referrals were made for 1,287 clients. The majority of referrals were for food pantries, housing assistance, and legal services.

FHC successfully expanded the screening and case management capacity in the community by placing AmeriCorps Food Access Navigators at two partner organizations (Chinese American Planning Council and Arab American Association of New York). Additionally, two FANS were placed at the Family Support Center to directly address the needs of community members' food insecurity. Seven new members are scheduled to start service in late fall 2024.

<u>Sunset Park Community Coalition</u>:

Since its launch in June 2021, the Sunset Park Community Coalition met regularly on a bi-monthly schedule. Multi-sector partners included Arab American Association of New York, Center for Family Life, Chinese American Planning Council, Family Health Centers at NYU Langone, Muslims Give Back, Grandma's Love, NYU Grossman School of Medicine, Holding Hands Ministries, Mixteca Organization , P.S. 169, P.S. 94., P.S. 503/506, City Harvest and the Brooklyn Grange. During the reporting period:

- The Coalition leveraged its partnerships to develop two new pantries, which received regular deliveries of fresh produce from the Brooklyn Grange.
- FHC leveraged its work with the Coalition to secure a grant from the New York State Department of Agriculture (New York Food for New York Families), which was used to fund fresh produce deliveries from the Brooklyn Grange and Choy Commons to schools and one community-based organization.
- The Coalition continued its commitment to strengthen local capacity by providing mini-grants to support the development of new pantry locations by Coalition partners as well as strengthen the capacity of existing services.
- FHC submitted a planning grant application (November 2024) to the U.S. Department of Agriculture's Community Food Projects to conduct a robust needs assessment to establish the Coalition's readiness to sustain its food distribution infrastructure and provide nutritious foods culturally tailored for the Sunset Park community. The application aligned with the goals of the National Institute of Food and Agriculture and the Steps for a Hunger-Free Community.

Plans

Over the three years of the 2025-2027 CSP, the Healthy Food Initiative will reach over 52,000 residents experiencing or at-risk of food insecurity. By August 2027, 60% of those served will have improved food or financial security.

The Table will continue to operate weekly, distributing food packages to 1,200 unique families per month at its primary location and to an additional 300 families per week through its satellite locations during the growing season (May through October). The Table will reach 18,000 unique households by 2027. For this next phase of the CSP, we will continue our relationship with The Brooklyn Grange, Choy Commons, and other local businesses to provide fresh, local food at our main center and at satellite pantries at four schools and one community-based organization. The Table will also continue to partner with the Brooklyn Grange to provide community cultivation events at Brooklyn Grange's rooftop garden. The Healthy Food Initiative will serve 9,600 residents through screening and case management provided by Family Support counselors at the Family Support Center, community health workers at FHC clinic sites, and AmeriCorps Food Access Navigators at Sunset Park Community Coalition sites or the Family Support Center. We anticipate that seven FANs will be fully recruited by November 2024 and will serve as a 'connective tissue,' fostering ongoing communication and collaboration among organizations throughout Sunset Park.

In addition, the Healthy Food Initiative will work with colleagues on the Long Island campus to enhance food access in communities of need on Long Island.

2. The Health & Housing Consortium

The Health & Housing Consortium (the Consortium) is a collaborative network of healthcare, housing, homeless and social services organizations, and government partners with the shared goal of improving health equity and housing stability in New York City. The Consortium's core activities foster cross-sector relationships, inform policy, and build the capacity of frontline workers and direct service providers to support people with unmet health and housing needs. The Consortium envisions a world where all people live healthy, fulfilling lives and experience safety and holistic wellbeing in the housing and communities of their choice, with the support they need to thrive.

In 2017, NYULH's collaboration with leaders of the Consortium (then known as the Bronx Health & Housing Consortium) began while conducting a community health and housing needs assessment in Sunset Park and neighboring areas in Southwest Brooklyn. The result of this work was the creation of the Brooklyn Health & Housing Consortium (Brooklyn Consortium) through funding by the Community Service Plan. The work of the Brooklyn Consortium was modeled after the Bronx Consortium and informed by a Steering Committee that included 13 stakeholders across sectors. Through the Steering Committee, the Brooklyn Consortium developed strong partnerships with community-based organizations, housing providers, street outreach, and hospitals throughout Brooklyn.

The Bronx and Brooklyn Consortia worked closely together to identify and address challenges faced by individuals and direct service providers in both boroughs. During the COVID-19 pandemic, as activities transitioned online, the Bronx and Brooklyn Consortia combined efforts to improve access to information for direct service providers across the City through webinars with NYC government agency

representatives and other experts. Following a strategic planning process, the Bronx and Brooklyn Consortia were merged into a single, Citywide Health & Housing Consortium.

Progress and impact

The Health & Housing Consortium has successfully made its transition into a citywide organization. In September 2022, the original Bronx and Brooklyn Consortia steering committees merged into a new Program and Policy Committee that has broader representation of stakeholders across New York City. Members of this Program and Policy Committee represent more than 15 organizations across healthcare, housing services, government agencies and social services. Along with the Consortium's independent board of directors and newly formed Consumer Advisory Committee, the Program and Policy Committee informed the development of more than 60 capacity-building activities and several cross-sector collaborative efforts.

Trainings and Cross-Sector Collaboration Events:

The Consortium provides direct service providers with education and resources to improve the quality of client and patient care, bringing people together across sectors to break down barriers and improve care coordination across housing, homeless and social services, government agencies, and healthcare providers. In partnership with organizations such as the Legal Aid Society, New York Legal Assistance Group's (NYLAG) LegalHealth division, various New York City public agencies, and the US Centers for Medicare and Medicaid Services, the Consortium organized 50 trainings between fall 2022 and fall 2024, with an average of 261 registrants per training and with more than 7,500 registrants for trainings in 2023 alone.

Trainings included:

Housing	CityFHEPs Housing Court Proceedings and Eviction Prevention Shelter Rights	**Healthcare**	Medicaid and Medicare Enrollment Home Care Basics Adult Care Facilities
Public Benefits	Social Security Income and Social Security Disability Insurance (SSI/SSDI) HASA Benefits for People Living with HIV/AIDS	**Legal**	Reporting Voucher Discrimination Naturalization for Low-Income and Disabled Green Card Holders

To provide guidance for navigating care for individual clients, the Consortium hosted three virtual interagency case conferences with diverse stakeholders who offered detailed case studies, identified resources, shared expertise, brainstormed solutions, and built relationships with one another. Case conferences were facilitated by Bridging Access to Care's Director of Supportive Housing and a Social Work Professor at CUNY Staten Island. Case presenters included colleagues from NYC Health + Hospitals' Safety Net Clinics.

Housing marketplaces offered another opportunity for direct services providers to meet with housing providers and learn about their supportive housing vacancies and referral processes. Focusing on understanding the Coordinated Assessment and Placement System (CAPS) and special populations such as veterans and individuals with serious mental illness, the Consortium's two virtual and one in-person housing marketplaces offered a space where providers could network and discuss housing eligibility around specific clients.

Each year, the Consortium hosts a day-long Annual Convening that brings together leaders and providers across sectors to showcase emerging policies and innovations that support people with unmet health and housing needs across the City and State. In 2023, the Consortium hosted its first in-person Convening since the COVID-19 pandemic at NYU Langone Health and gathered 105 professionals representing 52 organizations.

Co-hosted with the Health x Housing Lab at NYU Langone Health, *Flipping the Script* events fill a gap in medical education on housing and homelessness and re-envision how that education is provided. People with lived experience of homelessness teach providers about how homelessness and housing insecurity affect their health and access to care. Please see Section II.A.3. to learn more about *Flipping the Script.*

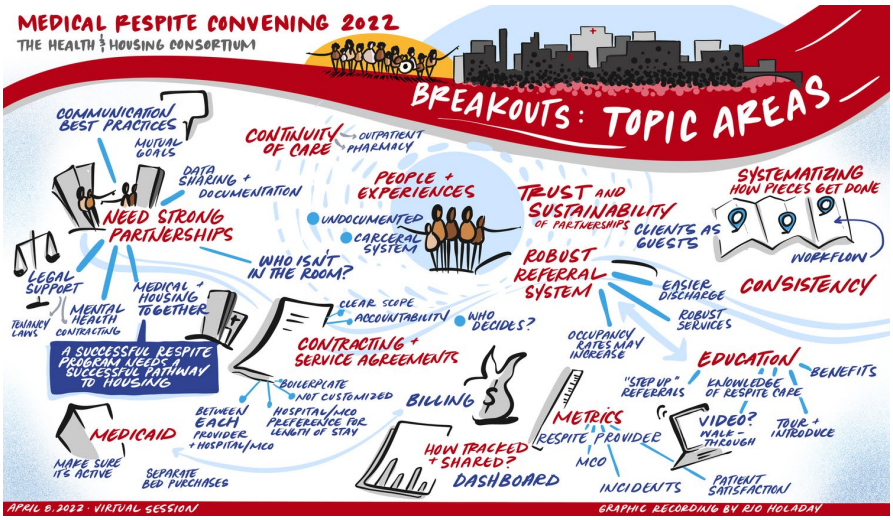
<u>Research and Advocacy</u>:

Throughout the 2022-2024 CSP cycle, the Consortium expanded its capacity to lead and support emerging and promising policies that promote health equity and housing stability.

Through research, education, and advocacy, the Consortium elevated medical respite as a vital service for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury while homeless, but not ill enough to be in a hospital. Due in large part to Consortium advocacy, New York State created a medical respite pilot and regulatory framework to expand the availability of medical

respite. In 2022, the Consortium formed a 13-member Medical Respite Task Force to organize a two-day Medical Respite Convening, which garnered participation from more than 400 individuals across 125 different agencies. The event included a presentation from Emily Engel, Director of the Bureau of Social Care and Community Supports at the Office of Health Insurance Programs, on the upcoming NYS Department of Health medical respite pilot program. There was also a panel discussion with individuals currently involved in medical respite, including providers, hospitals and health plans and two sessions of breakout groups to discuss various aspects of medical respite, from program design and evaluation to funding and legal issues. All of these conversations, and the Task Force that planned the event, included medical respite clients. Following this Convening, the Consortium led efforts to coordinate collective feedback on the proposed medical respite regulations with the Medical Respite Task Force and offered ongoing consultation to NYS DOH as they finalized guidance materials.

The Consortium has also been closely following developments related to the New York State Medicaid 1115 Waiver. Through this waiver, New York State Medicaid will pay for medical respite as part of the bundle of health-related social needs (HRSN) services outlined. The Consortium has been active in convening and educating housing and social service providers about the waiver and is exploring partnerships with the newly awarded Social Care Networks (SCNs) that will lead the coordination of HRSN services. Working with Public Health Solutions, the Consortium will serve as lead advisor on the Medicaid high utilizer population, provide expertise on medical respite, support their efforts to assess the capacity needs of their CBO partners, and provide training and technical assistance to those partners.



The Consortium has also worked at the State and City levels to advocate for and comment on policies of concern to members, including cash assistance, housing budgets, right to shelter, housing access for individuals leaving incarceration, zoning reform, fair pay for human service workers, and mental health crisis response.

Plans

Over the course of the next three years, the Consortium will continue to:

- Offer, with legal partners, a robust training series for front-line workers on eviction prevention, rental arrears, income maximization, and obtaining affordable housing benefits.
- Organize an additional training series focused on social determinants of health.

- Organize an Annual Convening that includes current topics at the intersection of health and housing relevant to health care and housing providers.
- Convene interagency case conferences to improve communication between hospitals and homeless service providers, and with the Department of Homeless Services.
- Pursue new collaborations with other community partners and Community Service Plan projects on relevant projects, events, and research.

In addition, the Consortium will grow by:

- Expanding capacity as a training hub for frontline and direct service workers by launching a new Workforce Development Training Program for health and human services workers. Through a planning grant over the past 18 months, the Consortium researched the training needs of the workforce and designed a program that will include a core curriculum for new staff, peer learning and support cohorts, and a robust catalog of live and recorded trainings.
- Increasing engagement with partners in the boroughs of Manhattan, Queens and Staten Island.
- Launching a cultural awareness training series in late fall 2024/winter 2025, partnering with grassroots organizations serving specific populations.
- Providing consulting and technical assistance to partner organizations' health and housing efforts.
- Creating a NYC Medical Respite Institute (if funding can be obtained), in partnership with the National Institute for Medical Respite Care as a local hub for sharing information and best practices among the variety of stakeholders involved in rolling out medical respite services under NYS's 1115 Medicaid Waiver.

3. Health x Housing Lab

With rapidly growing health system interest in housing and an increasing recognition of the importance of housing for health, the Health x Housing ("health by housing") Lab was created in 2021 with the mission of providing evidence-based guidance for initiatives sitting at the intersection of health and housing. The Lab aims to advance health and health equity by contributing toward a future in which all people have safe, stable, and affordable housing. The Lab focuses on three key activities:

- Informing policy and programs related to health and housing through evidence-based advising and research dissemination.
- Providing education to expand the reach of practice-relevant evidence on health and housing.
- Conducting research to build the evidence base for initiatives, programs, and policies at the intersection of health and housing.

The Lab Advisory Committee:

In addition to committee members with lived experience of homelessness, other committee members are from the following organizations:

- Breaking Ground
- Citizens' Committee for Children of New York
- Human.nyc
- National Health Care for the Homeless Council
- NYC Department of Health and Mental Hygiene*
- NYC Health + Hospitals
- NYC Youth Action Board
- Volunteers of America

Housed in NYU Langone's Department of Population Health, the Health x Housing Lab draws on an understanding of health and health care as well as a commitment to population health policy and practice grounded in research and evidence. The Lab's work is guided by its Advisory Committee, a diverse team of experts that include members with lived experience of homelessness and housing instability as well as representatives from organizations across the health and housing sectors.

Progress and Impact

Providing Education and Informing Policy:

The Health x Housing Lab hosted seven public virtual events to disseminate evidence-based information, amplify the voices of people with lived experience of homelessness and housing insecurity, and educate a wide audience across sectors. Alongside the Community Service Plan's partners at the Health & Housing Consortium, the Lab has hosted three *Flipping the Script* events that feature people with lived experience of homelessness who teach attendees about how homelessness and housing insecurity affect health. Filling a gap in medical education on housing and homelessness, these events teach health care students, trainees, practitioners, care managers, as well as homeless services providers, policymakers, and others about how better healthcare can be provided. A total of 1,724 individuals registered for three *Flipping the Script* events that were focused on homelessness and aging (n=581), homelessness and diabetes management (n=592), and homelessness and the criminal legal system (n=551). These events featured 12 speakers with lived experience of homelessness.

Additionally, the Health x Housing Lab hosted four research seminars on the intersection of health and housing that translated academic research findings for a wide audience and incorporated knowledge from people with lived experience. A total of 1,237 individuals registered for research seminars that were focused on:

- Exploring Peer Partnerships to Improve Health Among People Experiencing Homelessness
- Housing for Health: Data and Program Innovations from NYC Health + Hospitals
- NYC Harm Reduction in Shelters Strategic Plan (2023-2024)
- Homecoming Realities: Understanding Housing Insecurity and Health after Incarceration

The Lab develops research summaries for these events, to further assist in disseminating academic research to a broader audience, including community members, policy makers, people with lived experience of homelessness and housing insecurity, and service providers.

In fall 2023, the Lab launched a quarterly newsletter to disseminate information about our work and events. The recipient list has more than doubled since our first issue to 2,353 subscribers.

In 2023, The Health x Housing Lab launched a Speakers Bureau and Peer Network with an inaugural cohort of ten members who have navigated homelessness or housing insecurity. This group aims to bridge academic and lived expertise to advance research, policy, and education on the intersecting issues of housing insecurity and health. The Speakers Bureau and Peer Network facilitates opportunities for members to serve as a resource for researchers, healthcare providers, journalists and policymakers through public speaking, writing engagements, and consulting. Members have expertise in areas such as mental health crisis response, incarceration, and the impact of homelessness on families, young people and older adults, and the group meets on a bi-weekly basis to participate in peer learning and trainings in effective communication and leadership.

The Lab offers paid summer education programs to foster the career development of future leaders at the intersection of health and housing. Since fall 2022, the Health x Housing Lab Summer Scholar Program has hosted four advanced degree students interested in research and/or medical practice, and the Summer Consultant Program has hosted three professionals with lived experience of homelessness or housing insecurity who have participated in trainings and bidirectional mentorship opportunities. The Lab has also collaborated with its Advisory Committee to formalize processes to participate in advocacy efforts such as sign-on letters and public comments that align with its work and Values Statements in January 2024.

Applied Research:

Financial support from the Community Service Plan allows the Lab to access external funding resources toward conducting and disseminating high-quality, program- and policy-relevant research projects with government and community stakeholders. For example:

- With funding from the U.S. Department of Housing and Urban Development, the Lab has undertaken a community-engaged qualitative study that will examine the housing, health, and social needs of homeless adults aged 55 and over. In partnership with the Corporation for Supportive Housing, Care for the Homeless, and a core group of people with lived experience of homelessness as older adults, the study aims are to 1) examine pathways from shelter to housing for older homeless adults, including identifying housing-specific needs, health and service-related needs, and barriers and facilitators to rapidly exiting homelessness; and 2) build capacity for community-engaged research at the intersection of health and housing that centers the voices of people with lived experience and leverages the collective strengths of academia,

community-based organizations, and people with lived experience to identify, implement, and advocate for solutions to homelessness among older adults.

- The Lab completed an evaluation of a nurse call line pilot program offered at NYC Department of Homeless Services shelters, which offered 24-hour access to a live nurse who provided guidance and care coordination for residents with non-emergency medical conditions, as well as referrals to telehealth, urgent care, and transportation assistance. Through in-depth interviews with shelter residents and staff with experience utilizing the nurse triage line, the study examined perceptions, experiences, and interactions with the program along with barriers and facilitators to implementation.

- In partnership with NYC Health + Hospitals and Test & Trace, the Lab also evaluated a program implemented in response to the COVID-19 pandemic that provided one-time, unconditional cash transfers of $1,000 to low-income New Yorkers who contracted or were exposed to COVID-19. This mixed-methods study examined how program recipients used the cash transfer, their experiences with the program, and self-reported effects of receiving the cash transfer on their health and social needs. The study was funded by the Robin Hood Foundations, and findings were published in the *Journal of Urban Health* in October 2022.

Plans

Over the next three years, the Health x Housing Lab will continue to establish itself as a source of trusted information, educational opportunities, and evidence-based research by:

- Sustaining and expanding the work of the Speakers Bureau and Peer Network and facilitating opportunities for members to engage in writing, speaking and consulting with partners in academia, policy, and media.

- Increasing capacity to study topics at the intersection of health and housing, as well as interventions aimed at improving health and health equity for people experiencing homelessness. Future research may include examining emergency department-based care coordination, medical respite programs, and the impacts of extreme heat on unhoused people.

- Expanding capacity to conduct community-engaged research that builds meaningful partnerships with organizations and individuals in the health and housing sectors.

- Continuing to host bi-annual research seminars and *Flipping the Script* events.

- Providing summaries of important studies related to health and housing in accessible formats (infographics or brief key points, social media, etc.), toward the goal of improving translation of research to practice and policy.

- Publishing and disseminating research findings from current research studies.

B. Social and Community Context: Programs, Progress and Plans

1. Greenlight Early Childhood Obesity Prevention Program

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

The importance of health literacy

Approximately 90 million Americans—or 45 percent of the population—have basic or below basic literacy skills, and 110 million have basic or below basic quantitative skills; individuals with low literacy struggle with understanding and acting on health information, referred to as low health literacy. Nearly 30% of US parents are categorized as having low health literacy. Minority and immigrant families are at increased risk for having low health literacy.

Low health literacy and numeracy is associated with worse health outcomes; with respect to issues related to obesity, low health literacy and numeracy have been associated with lower rates of breastfeeding, difficulty understanding food labels and portion sizes, higher rates of obesogenic behaviors like pressuring feeding, decreased physical activity, and screen time, as well as higher rates of obesity.

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 with newborns, which include booklets containing age-specific recommendations and 'tangible tools' such as portion size snack cups to support evidence-based obesity prevention messages.
- Training of providers in evidence-based health communication strategies (use of plain language, supplementing counseling with written information, along with teach back and goal setting).
- Waiting room program where health educators promote family engagement in care as they introduce and support Greenlight messages.

See Appendix E for evidence of the effectiveness of the Greenlight program resulting from an NIH-funded multi-site cluster randomized study.

The Greenlight intervention incorporates evidence-based messages related to child obesity. These are communicated through "core" booklets that are given out at each well-child visit, which introduce or reinforce three age-appropriate parent behaviors thought to be most strongly associated with preventing obesity during early childhood based on the peer-reviewed literature. These behaviors are highlighted on the cover of each core booklet. Supplemental booklets provide more in-depth guidance on topics known to be important to address in obesity prevention, including breastfeeding, sleep, healthy eating for the whole family, and screen time.

Taking advantage of the frequency of primary care pediatric visits in the early years of life, the NYULH Department of Pediatrics in partnership with the Charles B. Wang Community Health Center (CBWCHC), a federally qualified health center, culturally adapted and implemented Greenlight, an evidence-based program that teaches families about healthy eating and activity in order to prevent early childhood obesity in the Chinese American community. The partnership grew after a needs assessment identified childhood obesity prevention to be a priority issue in the community where approximately 25% of children in low-income Chinese communities are considered to be at risk due to overweight or obesity.

Updated 6-month booklet, showing steps on how to make pureed food and a sample of feeding schedule

The collaboration began with support from the 2014-2016 Community Service Plan, with full implementation at the CBWCHC site in Manhattan's Chinatown in May 2016 and expanded with CSP support to a second CBWCHC site in Flushing, Queens in September 2020, as well as Seventh Avenue Family Health Center at NYU Langone in Brooklyn in October 2020. Each of these sites serve predominantly Chinese American families. The most recent Community Service Plan period was a time of significant additional expansion for Greenlight, with extension of Greenlight to another CBWCHC site in Flushing, Queens in June 2024, as well as expansion to the NYU-affiliated NYC Health+Hospitals (NYC public hospital system) Bellevue Hospital Pediatric clinic in June 2023. The Bellevue site serves predominantly Hispanic / Latine families. In fall 2024, the program expanded to the NYU Langone Hempstead pediatric practice and the Sunset Park Family Health Center at NYU Langone. The NYU Langone Hempstead site as well as the Sunset Park Family Health Center site serve a large population of Hispanic / Latine families.

Updated 15-18 month booklet, showing tips on what and how to feed.

Progress and Impact

The Greenlight intervention has now been incorporated as part of routine well-child visits at the CBWCHC Chinatown and Flushing sites, as well as the Seventh Avenue FHC at NYU Langone in Sunset Park Brooklyn, and NYC H+H / Bellevue Hospital in Manhattan. The program will soon be implemented at NYU Langone Hempstead and Sunset Park FHC at NYU Langone in Sunset Park, Brooklyn. In addition, the Greenlight waiting room program, in which health educators support the provision of evidence-based healthy eating and activity-related practice, is fully implemented at CBWCHC Chinatown.

Implementation at CBWCHC:

The full set of Greenlight materials at CBWCHC (core and supplemental booklets translated into Simplified Chinese), along with tangible tools, have fully been rolled out at CBWCHC's Chinatown site since May 2016, with 14 health care providers, 11 health educators and 4 support staff members trained in the use of the tools. Yearly trainings are offered to clinical team members working directly with families with young children to ensure program updates are communicated across all sites.

From September 2022 through July 2024, the CBWCHC Chinatown site distributed 1900+ booklets and nearly 200 tangible tools. During this period, we reached 720+ unique children and families (~94% of unique eligible patients visiting each year). Of the nearly 2300 well-child visits of children birth -24 months of age that took place after September 2022, nearly 83% of visits included Greenlight intervention with a health educator or with a pediatrician.

Previous assessments have confirmed that participating families and providers are enthusiastic about the program:

- 94% of families said they would recommend the Greenlight program to a friend.
- 74% said they shared the Greenlight booklet with someone else in the home.
- Families have requested sets of Greenlight booklets to take with them when they change clinics, or when they move back to their native country.
- Pediatricians have found that the sample meal plans and schedules in the Greenlight booklets are especially helpful, as these visuals help reinforce appropriate serving sizes and feeding patterns.
- Pediatricians have highlighted how valuable the waiting room health education program has been, as it is often difficult to fully cover key messages about eating/activity within the time constraints of well-child visits.

In September 2020, the Greenlight program was expanded to one of the CBWCHC sites in Flushing, Queens. From September 2022 to July 2024, this CBWCHC Flushing site program distributed 830+ core booklets and reached 355+ children and their families. Of the 1380+ well-child visits of children birth -24 months of age that took place in this cycle, about 69% of visits included Greenlight intervention with pediatrician.

In March 2024, the Greenlight program began with a limited expansion to the second CBWCHC site in Flushing Queens, starting with a few pediatricians. From March 2024 to July 2024, this CBWCHC Flushing site program distributed nearly 200 core booklets and reached 175+ children and their families. Of the 1160+ well-child visits of children birth -24 months of age that took place in this cycle, about 18% of visits included Greenlight intervention with a pediatrician.

Implementation at Seventh Avenue FHC:

The Greenlight program was implemented at Seventh Avenue FHC in October 2020. The clinic is being provided with a full set of materials including core and supplemental booklets (in both English and Simplified Chinese), as well as tangible tools. The Greenlight program is integrated into regular well-child visits and the HealthySteps Specialist's workflow. HealthySteps is a pediatric primary care program focused on promoting the health, wellbeing, and school readiness of young children. During the well-child visit, the HealthySteps Specialist reviews and reinforces the content provided in the Greenlight booklets and answers any questions that families may have. Three pre-implementation training sessions were conducted with staff, which include 5 family practitioners, 1 pediatrician, 1 HealthySteps specialist, and 12 nurses / medical assistants. Yearly trainings are offered to all staff members to ensure program updates are communicated across all sites.

Seventh Avenue Family Health Center at NYU Langone

First opened in 2002, the Seventh Avenue site (formerly known as the Brooklyn Chinese Family Health Center) is part of FHC's network of FQHCs affiliated with NYU Langone Health. It was one of the first medical facilities to open in Sunset Park to serve the needs of medically underserved Asian Americans in the area. The site serves both the medical, rehabilitation, and dental needs of the community, with over 52,000 patient visits per year, including over 14,476 pediatric patient visits. The team of health care providers includes family medicine providers, pediatricians, and an Ob/Gyn. The majority of families seen at the clinic are recent immigrants from Fuzhou, in southern China.

Between September 2022 and August 2024, we distributed 1500+ booklets and 650+ tangible tools. To date, Greenlight has been used as part of ~750 well child visits, reaching about ~250 unique children and families.

Implementation at NYU-affiliated NYC Health+Hospitals/Bellevue:

The Greenlight program was implemented at Bellevue Hospital in June 2023. The clinic is being provided with a full set of materials including core and supplemental booklets (in both English and Spanish). Pre-implementation training sessions have been conducted with staff and trainees, which include 23 attending physicians and ~50 pediatric residents. Yearly trainings are offered to all staff members to ensure program updates are communicated across all sites. Between June 2023 and August 2024, we distributed nearly 5500+ core and 720 supplement booklets.

NYU affiliated NYC H+H / Bellevue

The Bellevue Hospital Center Family Care Clinic (FCC) provides innovative state-of-the-art general pediatric primary care for predominantly poor, underserved and ethnically diverse children from across New York City, with ~35,000 annual outpatient primary care visits. Families come from across the 5 boroughs of NYC. Almost all identify as racial ethnic minorities, with the largest proportion of families Hispanic (~70%). Bellevue Hospital Center is the primary affiliate teaching hospital of NYU School of Medicine. The medical staff of the Bellevue Family Care Clinic consists of faculty of the medical school as well as 50+ pediatric residents. The Bellevue FCC provides comprehensive well-child care, providing physical examinations, immunizations, preventive screening, and anticipatory guidance to children and their families, as well as acute illness care.

Evaluation:

Enrollment of a group of children and caregivers pre- and post-implementation of Greenlight at CBWCHC Chinatown has allowed us to look at the impact of Greenlight (pre: 314 caregiver/child dyads; post: 201 caregiver/child dyads).

- Impacts on behavior include reduced juice/sweet drink intake at 6 and 12 months of age (6 months: 4 vs. 12%, p=0.03; 12 months: 7 vs. 54%, p<0.001), reflecting a 10-fold and 20-fold decreased odds of giving juice at 6 and 12 months, respectively.
- While juice/sugary drink consumption grew significantly at 24- and 36-month time points, there remained a smaller percentage of children who consumed juice/sweet drinks post-implementation at 24 months of age (post vs. pre: 46 vs. 66%; p=0.007), with evidence of continuation of this trend at 36 months (post vs. pre: 61 vs. 73%; p=0.1).
- Children also had a 3-fold increased odds of using cups by 12 months of age, an important step to transitioning from the bottle (post vs. pre: 86 vs. 65%, p=0.01).
- At 12 months of age, there was a 2-fold increased odds of consuming fruits/vegetables 4x or more per day (post vs. pre: 41 vs. 25%, p=0.02), with continued evidence of a trend for higher fruit/vegetable consumption post-implementation at 36 months (post vs. pre: 53 vs. 39%, p=0.06).
- An approximately 2-fold reduction was seen in any consumption of sugary snacks (post vs. pre: 33 vs. 55%, p=0.005) at 12 months.
- There was a greater than 5-fold increased odds of meeting physical activity recommendations in the first year of life.
- No differences were seen in rates of breastfeeding or screen time.

Our evaluation has also allowed us to look at changes in parent self-efficacy/empowerment. Parents were asked about their level of agreement with 4 statements (e.g., "I can do many things to keep my child from being overweight," "I know how to prevent my child from becoming overweight"). Parents of 6- and 12- month old's had an increased odds of choosing "strongly agree" to these statements (3-fold and 10-fold, respectively); differences in self-efficacy were especially strong in parents of 12-month-olds, with evidence of higher self-efficacy post-implementation continuing to be seen through the 24 and 36 month time points.

An abstract based on the evaluation component of the program was accepted for a platform presentation at the Pediatric Academic Societies meeting (considered the premier annual national pediatric research meeting) and was presented at the American Academy of Pediatrics Presidential Plenary; a manuscript describing the findings "Infant Feeding Outcomes from a Culturally-Adapted Early Obesity Prevention Program for Immigrant Chinese American Parents" was published in Academic Pediatrics.

At Seventh Avenue FHC, baseline data on behaviors were obtained on a subset of 68 parent/child pairs. Our pilot data highlight the need to support healthy infant feeding behaviors in this population. Only 14% of mothers were exclusively breastfeeding at 6 months of age; nearly 70% of 6- and 12-month-old infants drink juice; nearly 30% of 12-month-olds did not use a cup; and 40% started solids early, before 6 months.

To further inform implementation at the Seventh Avenue FHC, we conducted 25 semi-structured qualitative interviews with mothers of 1–15-month-old infants. From these interviews we learned that maternal social support networks (both local and transnational) as well as sociocultural beliefs, influenced the development of infant feeding practices and the experience of transnational parenting. In addition, mothers described heightened family hardships due to the COVID-19 pandemic, including financial strain, disruption of plans to send a child back to China for childcare, as well as experiences of racism. Two manuscripts have been published, one in the Journal of Immigrant and Minority Health, "Material Hardship and Stress from COVID-19 in Immigrant Chinese American Families with Infants" and the second "Infant Feeding Practices and Social Support Networks in Immigrant Chinese American Mothers" in Journal of Human Lactation. These findings will inform clinicians, researchers, and program stakeholders that seek to prevent early child obesity in immigrant communities experiencing poverty, particularly in the understudied Chinese American community.

Updated Booklets and Technology:

From 2020-2021, all Greenlight booklets were updated to incorporate the most recent American Academy of Pediatrics recommendations (e.g., related to screen time, juice). Each core and supplement booklet was reviewed and revised for accuracy, clarity, and readability. Updated graphics and images were also included. Two additional core booklet time points, Newborn and 1 month, were added given that important infant feeding practices are established in this period of development.

New Newborn and 1 month core booklet,

A formal adaptation process was used for all booklets to ensure that program materials would resonate with the Chinese American population. For all Chinese translations, a team of 5 bilingual translators underwent 3 rounds of translations before sending materials to be reviewed by providers, health educators, and staff from both CBWCHC and Seventh Ave FHC sites. Suggestions were then incorporated into each booklet before being reviewed a final time for accuracy and flow.

English language versions of the Chinese booklets were created specifically with the Chinese population in mind. Pictures and graphics were updated and reviewed for cultural appropriateness. Special attention was paid to the food photographs included in our updated booklets. All foods were reviewed for cultural relevance and included multiple rounds of feedback from a CBWCHC nutritionist familiar with common Chinese foods.

As of January 2022, all Greenlight core booklets, as well as the Breastfeeding and Formula supplemental booklets, have completed the update process and have been prepared for distribution at all program sites.

The main Greenlight website was launched in July 2018 (https://www.greenlight-program.org/), and houses the Greenlight booklets and additional resources for parents, including an interactive activity that allows parents to identify questions and review answers related to diet- and nutrition-related topics. The updated booklets have been uploaded to the main site, where materials in English, Spanish and Chinese are available for parent and provider use.

Updated Breastfeeding supplement, describing to mothers how to take care of themselves

Creation of Community Advisory Board: As of May 2022, the Greenlight Program established a Community Advisory Board, which we refer to as the Greenlight Program's Parent Advisory Group (PAG), in order to cultivate an environment centered on collaboration and learning among both parents and Greenlight Program staff. Prior to the establishment of the PAG, Greenlight Program staff surveyed parents of CBWCHC pediatric patients to assess their interest in joining the PAG meetings, identify the best times to host meetings, and parents' preferred language for participating in the meetings. CBWCHC and NYULH co-facilitated PAG meetings, aiming to foster an environment that encouraged parent participants to take the initiative in discussions, express their opinions openly, engage without judgment and respect the viewpoints shared. Parent participants received a $50 gift card incentive in recognition of their valuable participation and time.

From September 2022 to July 2024, there were 10 PAG meetings hosted in English and 3 PAG meetings hosted in Mandarin Chinese. Twenty-three parents in total have attended the PAG session: 40% of English PAG participants attended at least 6 out of 10 meetings and 22% of Chinese PAG participants attended at least 2 out of 3 meetings. PAG meetings have helped Greenlight Program staff learn more about some of the challenges parents face in promoting healthy nutrition, activity and other health-related habits for their young children. For example, one theme that emerged in these meetings among less-experienced parents was a sense of being "lost in the sea of information." Parents discussed how much they highly value "practical" advice and clear guidance shared by accredited and licensed professionals. We learned that when parents have the agency to address challenges in parenting, they are very passionate about sharing their experiences and learning from others. Shared wisdom is something universally cherished and embraced by Greenlight PAG participants. We also learned from the PAG about different ways the Greenlight booklet information is used by parents and the challenges they face in actuality following Greenlight recommendations.

The feedback also provided insight into challenges that parents continue to face in feeding and caring for their children. Although parents are aware of the healthy habits they need to develop – the task is not easy. Talking together as a group, parents acknowledge this and feel support that their efforts are worth it as some of the parents of older age kids share their stories and successes as well as best practice/tips. For instance, the Greenlight booklets emphasize the importance of parents encouraging their children to be as active as possible and to limit their screen time. However, some PAG participants expressed that they were not able to cut out screen time completely but were empowered with better approaches to manage a child's screen time with the Greenlight materials messages. Overall, both the

English and Chinese language PAGs offered valuable feedback on the updated revised materials and informed what additional resources were needed in material development. Due to the target age group (0 to 2 yrs) of the Greenlight program, recruitment for new parents to join the English and Chinese PAG began in July 2024 to gain insight of families in their use of revised materials.

Plans

During the next three-year CSP cycle, we anticipate reaching ~2000 children and their families by implementing the Greenlight program across CBWCHC (3 sites: Chinatown, Flushing 37th Ave, Flushing 45th Ave), the Family Health Centers at NYU Langone (2 sites: Seventh Avenue FHC and Sunset Park FHC which serves predominantly Hispanic/Latino and Chinese families), NYU / NYC H+H Bellevue (which serves predominantly Hispanic/Latino families), as well as NYU Langone Long Island - Hempstead (which serves predominantly Hispanic/Latino and African American families), delivering the intervention to underserved, low-income families through health care providers at well-child visits in the primary care setting, and through health educators as part of the associated waiting room program.

At CBWCHC, we anticipate that Greenlight will be used at 1500+ well child visits per year, reaching over 500 families each year, with distribution of at least 1000 booklets and 500 tangible tools each year. This will include continued, routine engagement and training of 25 providers. We anticipate continuing to maintain the Greenlight waiting room program at CBWCHC Chinatown, reaching 250 families per year.

At the NYU-affiliated sites, we anticipate that Greenlight will be used at 4000+ well child visits per year, reaching over 750 families each year, with distribution of at least 5000 booklets and 2500 tangible tools each year. This will include continued, routine engagement and training of at least 25 providers at the NYULH sites (training/informational sessions annually at minimum, and more frequently, if needed). At the NYU Langone Long Island - Hempstead site, a new health educator has been trained, and the Greenlight waiting room program will be launched shortly at that site.

We plan to continually refine translations and update toolkit information with the latest American Academy of Pediatrics recommendations. We also plan to expand the reach of Greenlight through technology enhancements, including exploring how to promote and expand website resources, as well as leveraging social media platforms to make Greenlight messages accessible to more families. The newly updated booklets will be available via the Greenlight website and parent website made available in both Spanish and Chinese.

We will continue our Parent Advisory Group (PAG), to continue to strengthen our partnership and engagement with parents. By working closely with the PAG, we hope to ensure that the intervention is delivered in an effective and culturally appropriate way to the populations we work with; discussions will inform improvements to future intervention implementation activities. We aim to maintain good standing with the current group members while introducing new members to the group. Additionally, we plan to delve deeper into the exploration of Greenlight-related themes of diet and activity related behaviors, as well as, in-depth guidance on topics known to be important to address in obesity prevention, including breastfeeding, sleep, healthy eating for the whole family, and screen time topics that impact our families.

The intermediate goals of our project relate to supporting families in engaging in healthy child eating and physical activity-related behaviors/practices (e.g., less juice/sugary snack/junk food consumption,

increased physical activity, decreased screen time), as well as providing families with tools in the home to support healthy eating/activity-related activities. In addition, we seek to increase provider delivery of evidence-based healthy eating/activity recommendations and provider use of evidence-based health communication strategies. We also seek to increase parents' confidence/empowerment related to the care of their child, with a long-term goal of reducing the rate of overweight/obesity, as well as increasing the capacity of sites to support families in engaging in healthy eating / activity-related behaviors.

Over the upcoming 3 years, we will continue to collect data regarding Greenlight delivery and impact using a variety of strategies. This includes using electronic health record data to track Greenlight program process measures (e.g. provider/health educator counseling, booklet/tangible tool distribution, goal-setting) as well as child height and weight data, gathering information from staff tracking sheets regarding distribution of materials (e.g. booklet, tangible tools), conducting parent and provider surveys, and looking at analytics from the Greenlight website (# downloads / views of program booklets), as well as reviewing suggestions/broader themes gathered from meetings with the PAG.

2. Tobacco Free Community

Progress and Impact

The CSP Tobacco Free Community portfolio is overseen by the Asian and Immigrant Communities Against Smoking (AICAS) Partnership, a collaboration of partners from various sectors working together to identify needs, share resources, and participate in advocacy efforts addressing the high rates of smoking in New York City's Asian and immigrant communities. Partners include Asian Americans for Equality, the Brooklyn Library, the Coalition of Asian-American IPA (CAIPA), the Charles B. Wang Community Health Center (CBWCHC), the Chinese American Medical Society, the Chinese American Planning Council, Immigrant Social Services, Korean Community Services of Metropolitan New York, the NYC Department of Health and Mental Hygiene, NYCHA Smoke-Free, Family Health Centers at NYU Langone, NYU School of Global Public Health, and Public Health Solutions.

The AICAS Partnership, led by the NYULH CSP Tobacco Free Community team and CBWCHC and facilitated by a Partner Support Team, seeks to build the capacity and address the needs of AICAS partners who implement smoking cessation and prevention initiatives among New York's Asian American communities. Its mission is to collaboratively work to eradicate and prevent smoking and vaping among Asians and immigrant communities in New York City. Its vision is to empower and support New Yorkers to create a healthy and smoke-free community for all populations.

Through quarterly meetings, CBWCHC and NYULH have created a platform for sharing tobacco-related information and activities, offering policy updates, and fostering engagement for feedback and decision-making through consensus-building activities.

AICAS ASIAN AND IMMIGRANT COMMUNITIES AGAINST SMOKING	**Our Mission** Collaboratively work to eradicate and prevent smoking and vaping among Asians and immigrant communities in New York City. _____ ***Our Vision*** Empowering and supporting New Yorkers to create an equitable, healthy, and smoke-free community

The AICAS Partnership:

- Oversees outreach programs to help smokers reduce or quit smoking and access care.
- Sets priorities for policy-related initiatives.
- Provides information to partners and responds to requests for community education.
- Facilitates collaboration; and
- Identifies issues that need consideration and exploration, for example, understanding the availability and usage of NRT by Asian American smokers.

Smoker Navigator Program:

Despite the availability of numerous smoking cessation resources, only a small percentage of Chinese American smokers utilize these services, and the smoking rates among Asian American communities, particularly Chinese and Korean male smokers, remain high. According to the 2021 Health of Asian and Pacific Islanders in New York City Report, the smoking rate among Chinese American men stands at 14% and Korean American men at 13%. The high prevalence of smoking among Chinese American men may be attributed to the widespread social acceptance of smoking, lack of awareness and availability of tobacco treatment resources, and environmental and industry factors.

The Smoker Navigator Program, launched in 2014 in partnership with Asian Americans for Equality (AAFE), aims to reduce the disparities in tobacco use among Chinese Americans in the Lower East Side and Chinatown in Manhattan and Sunset Park in Brooklyn. The program serves as a valuable resource for other organizations lacking tobacco treatment services to address tobacco use disparities among Chinese American smokers by offering linguistically and culturally competent tobacco use cessation and prevention services. Community-based navigation has been shown to be an effective intervention for addressing barriers to accessing tobacco cessation treatment services among low-income smokers. The program reaches out to smokers, educating and inspiring them to quit or to reduce the number of cigarettes smoked, and connecting them to evidence-based smoking cessation resources such as the Asian Smoker Quitline.

Participate Testimony:
Mr. Guo visited the AAFE office and requested to be re-enrolled in the program. Mr. Guo found the NRT patches very helpful. He was able to reduce his cigarette consumption to an average of 3 cigarettes per day but would like to continue reducing further. After continuous use of the patch, Mr. Guo was able to reduce to 1 or 2 cigarettes per day, and there were some days when he solely relied on the patch. Mr. Guo acknowledged that abstinence might not be easy and could take a very long time, but he was glad to see improvement.

Since the pandemic, the challenges faced by Asian Americans in New York City have shifted dramatically. Although we have encountered many smokers seeking services, it has become evident that for most, tobacco treatment is not their primary concern. Instead, these community members are grappling with pressing social and economic issues such as securing housing, accessing unemployment benefits, and obtaining social benefits like food stamps. Quitting smoking has understandably become a lower priority compared to these immediate needs. Our goal remains to support these individuals by providing vital services that stabilize their lives, and to serve as a trusted and accessible resource to smokers in their efforts to quit or reduce their tobacco use.

To promote and increase the accessibility of nicotine replacement therapy (NRT) for community members living in Lower Eastside and Chinatown, in 2023 AAFE integrated the Smoker Navigator Program into its Resident Service Program, utilizing various communication channels to reach AAFE's

tenants, including social media, newsletters, and community bulletin boards. Additionally, the program conducts community outreach and education workshops, encouraging resident tenant leaders to advocate for the program and engaging food pantries to promote the services. Interested smokers receive brief cessation counseling and free NRT, as well as referrals to the Asian Smokers Quitline for more intensive counseling.

Between September 2022 and August 2024, AAFE engaged and informed over 4,000 individuals about the Smoker Navigator Program through community outreach efforts. The program provided free smoking counseling to 67 smokers, including 61 smokers who had not participated in a smoking cessation program before. It also provided NRT to 65 smokers and successfully referred 28 smokers to ASQ or NY State Quitline. At the 2-week follow-up survey, 19 smokers reported using NRT to assist them in quitting, 7 smokers reported making a quit attempt, and 3 reported having quit (defined as being abstinent for at least 7 days). In a 6-week follow-up, participants indicated that AAFE counselors were supportive in counseling sessions.

Healthy Lung Partnership:

Given the high rate of smoking among Chinese Americans, lung cancer poses a significant health risk. Although lung cancer is treatable when detected early, according to the 2022 "State of Lung Cancer" report, only 5.8% of eligible Americans have been screened for lung cancer. Moreover, Asian Americans and Pacific Islanders diagnosed with lung cancer are 16% less likely to be diagnosed early and 3% more likely to not receive any treatment compared to the White population. The NYULH Perlmutter Cancer Center's Stamp Out Cancer program has partnered with AAFE to establish the Healthy Lung Partnership to bridge this gap.

The Healthy Lung Partnership is a bi-directional partnership to connect smokers with culturally- and linguistically appropriate resources for smoking cessation and lung cancer screening. The partners have worked together to create culturally tailored and Chinese-language lung cancer screening mixed media materials (e.g., brochures, videos). This initiative has raised awareness about the benefits of lung cancer screening and available smoking cessation resources by creating a referral pathway for community members. During cessation counseling or the lung cancer screening process, community members are asked simple smoking cessation and lung cancer-related questions. A Chinese-speaking Community Health Worker from Stamp Out Cancer Brooklyn assists eligible community members in navigating the process from screening to treatment. AAFE's Navigator shares information about lung cancer screening and forwards the contact information of interested participants or family members to NYU's Lung Cancer Screening program representative. Staff members have been trained on lung cancer screening and tobacco treatment services using educational materials tailored to the community by the Healthy Lung Partnership. The Healthy Lung Partnership is committed to developing an appropriate workflow to increase smokers' access to lung cancer screening in a community setting and promoting linkage to cancer and tobacco cessation services.

NRT Availability and Usage Initiatives:

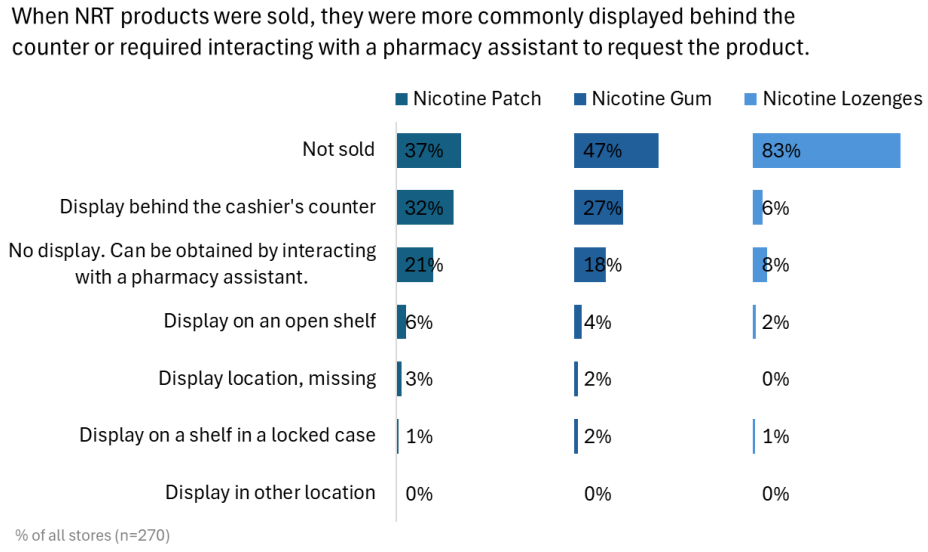
According to data from NYC DOHMH in 2016, only 8.6% of Asian American smokers used Nicotine Replacement Therapy (NRT) to quit smoking. To understand the barriers to NRT utilization, we surveyed Chinese American smokers who participated in the Smoker Navigator Program between September 2020 and December 2023. Of the 50 respondents, most used nicotine patches (86%) or gum (82%). Those who reported not using NRT reported relying solely on willpower to quit.

We also conducted 20 in-depth phone interviews of participants in the Smoker Navigator Program and WeChat Quit Coach pilot project (described below). From these interviews, we learned that most participants had never used NRT before they participated in our tobacco treatment programs; most reported NRT to be helpful and expressed willingness to use NRT in their future quit attempts. Other participants were concerned about the safety of NRT, skeptical about treatment effects, and not ready to quit. The findings suggest that these is a need for culturally adapted Chinese-language interventions to increase awareness about NRT, address misconceptions, and improve accessibility.

The underuse of NRT among Asian American smokers can be attributed to multiple factors, including limited access to NRT products. To understand more about barriers to use, an observational study was conducted to assess the availability of NRT products in pharmacies within NYC Chinese and Korean American communities. This study was led by the CSP Tobacco Free Community staff in collaboration with community partners, including AAFE and Korean Community Services (KCS).

We selected community pharmacies across three NYC neighborhoods with high concentrations of Chinese and Korean Americans: Chinatown and the Lower East Side (Manhattan), Flushing (Queens), and Sunset Park (Brooklyn). Trained research staff visited each pharmacy and filled out an observational assessment form to document the availability of nicotine patches, gum, and lozenges, as well as their placement within the pharmacy stores.

In total, 270 pharmacy stores were surveyed (66 in Manhattan, 140 in Queens, and 64 in Brooklyn). The results revealed that 89 pharmacies (33%) did not offer any NRT products. Among the remaining 181 pharmacies, 171 (94%) stocked nicotine patches, 143 (79%) stocked nicotine gum, and 46 (25%) stocked nicotine lozenges. NRT products were primarily located behind the carriers' counter, with only 16 pharmacies displaying them on open shelves.



Key findings:

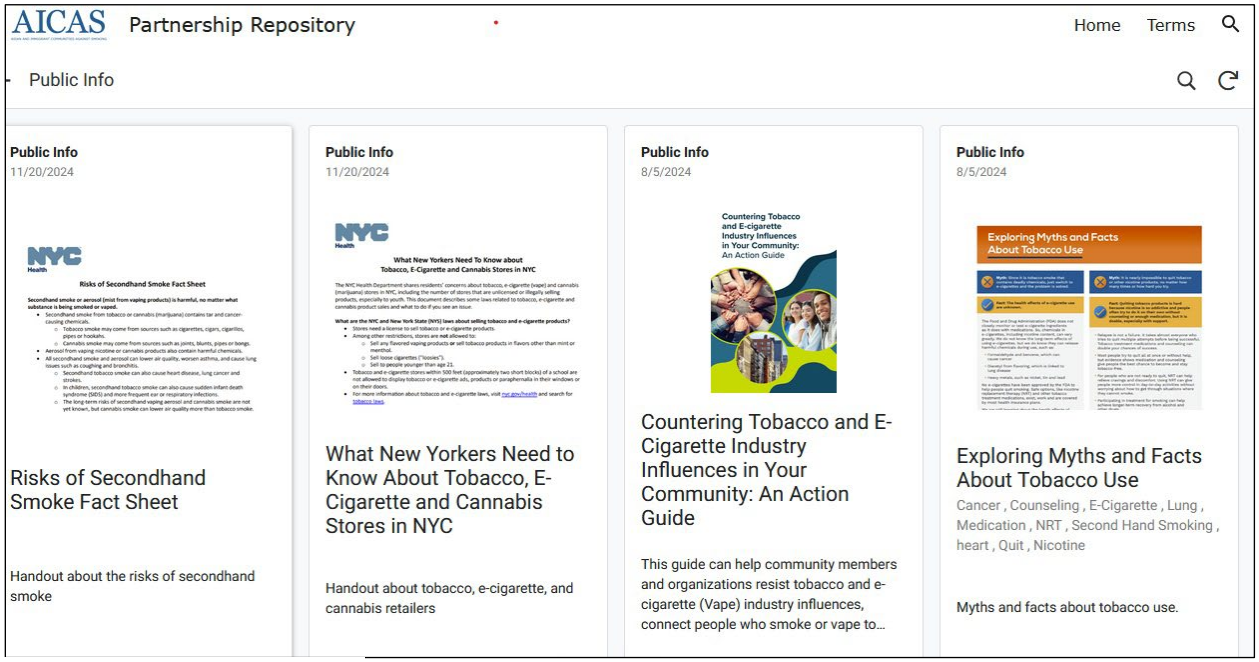
- One-third of the pharmacies in NYC Chinese and Korean American communities do not offer any NRT products.

- Nicotine patches are the most commonly offered form, while lozenges are the least commonly available form.
- NRT products are rarely displayed on open shelves.

As described below, these findings, together with the insights from the interviews, will help inform our strategies for the coming year.

Resource Repository:

In 2023, AICAS launched a Repository to provide smoking cessation and tobacco-related information, resources and tools. The Repository, which has been made available to the public at no cost, provides a wide range of smoking cessation and tobacco-related information, resources and tools to support knowledge and resource sharing for the public, providers, social care organizations.



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E-cigarette Education Efforts:

Behind the Vape: Teen Voice E-cigarette Harm Awareness Competition

One of the priority areas identified by the AICAS partners was to raise awareness about e-cigarette use, particularly among young people. In 2019, around 15% of teenagers in NYC indicated the use of e-cigarettes in the last 30 days, according to the NYC Youth Risk Behavior Survey. The National Youth Risk Behavior Survey found that although cigarette and cigar use among teens decreased from 2015 to 2019, e-cigarette use went up. These trends suggest that public health efforts over the past decade have influenced adolescents' knowledge, attitudes, and behaviors toward smoking. Still, the growing use of e-cigarettes presents a new challenge.

NYULH, the Charles B. Wang Community Health Center's Teen Resource Center (TRC), and the Chinese American Planning Council's (CPC) Community Health Services (CHS) collaboratively organized a *Behind the Vape* competition to raise awareness about the impact of e-cigarettes on young people ages 14-18 in the Chinese American community. The competition consisted of two components. First, the DOHMH Tobacco and Policy Program conducted two workshops to educate participants on the risks associated with e-cigarettes, and to provide guidance about sharing health messages using social media. Following the workshops, a youth-led social media content competition was held to emphasize the harmful effects of e-cigarettes. Using the information and knowledge from the workshops, the young people created 30-second videos highlighting data and the impact of e-cigarettes. A total of 42 young people attended the workshops, and 15 videos were submitted. A review committee of professionals from diverse organizations evaluated the videos and selected the winners. The selected finalists, participants, friends and family, workshop hosts, and panelists were all invited to a hybrid celebration event to view the videos. The winning content was later shared on the winner's personal social media account, the CPC and CBWCHC's Instagram page, and at community meetings.

Brooklyn Public Library Kings Highway Branch

The Kings Highway Library, in partnership with Public Health Solutions' NYC Smoke-Free and the NYULH Tobacco Free Community initiative, hosted a series of events to educate library patrons and the general public in response to concerns regarding vaping inside the library and to raise awareness about the impact of e-cigarettes on young people. This included an interactive "Escape the Vape" workshop which included health educational activities such as "Test Your Knowledge" and a discussion about the influence of marketing tactics used by tobacco companies and their impact on the environment.

Another community event held at the library, titled "Clearing the Air: Uncovering the Truth about Vaping and Tobacco Use in Brooklyn," sought to inform parents and the general public about the prevalence of vaping and tobacco use in the community. The event also presented information about available resources for community members. The panel featured speakers from Parents Against Vaping e-cigarettes (PAVe), NYC Smoke-Free and Tobacco Free, and the NYULH Community Service Plan Tobacco Free Community.

Plans

Over the next three years, we will continue to build the capacity of the AICAS Partnership by engaging other organizations that serve immigrant communities with high smoking prevalence, and working together to inform policy, practice, and research activities. Specifically, the Partnership will focus on:

- Expanding and enhancing CSP tobacco education and treatment initiatives;
- Strengthening the Healthy Lung Partnership;

- Enhancing NRT availability and usage;
- Strengthening and disseminating the Resource Repository;
- Working together to develop other programmatic and policy initiatives.

Expanding and Enhancing CSP Tobacco Education and Treatment Initiatives:

As an enhancement of the Smoker Navigator Program, we will implement the *WeChat Quit Coach* intervention, a culturally and linguistically appropriate social media-based peer-group mobile messaging smoking cessation intervention specifically designed for Chinese-speaking smokers across all levels of readiness to quit.

Despite the notable smoking-related disparities described above, culturally adapted tobacco treatments for Chinese Americans remain scarce and underutilized. The national Asian Smokers' Quitline engages only about 600 Chinese-speaking smokers annually, despite extensive promotion. Three main factors contribute to low use of tobacco treatment among Chinese Americans: 1) current programs target smokers who are ready to quit (planning to quit within a month), yet studies have found that most Chinese American smokers are not ready to quit, due to limited smoking knowledge, attachment to pro-smoking norms, insufficient quitting skills, and lack of social support; 2) programs fail to address barriers to accessing treatment, such as time constraints from long and inflexible working hours, skepticism about treatment effects, and limited awareness of resources; and 3) programs recommend abrupt quitting, which has little appeal to smokers. The reduction-to-quit method, equally effective with more appeal, is often overlooked.

To address the limitations of existing programs, colleagues developed the *WeChat Quit Coach*, a culturally adapted WeChat-based smoking cessation intervention for Chinese immigrant smokers funded by the National Institutes of Health. Unlike many tobacco treatment programs, *WeChat Quit Coach* supports smokers at all levels of readiness to quit, featuring 1) coach-led WeChat peer groups; 2) daily WeChat text messages with interactive questions; 3) chat-based instant messaging support for real-time inquiries; and 4) weekly personalized goals tailored to individual stages and preferences.

Two pilot randomized controlled trials, one in NYC and one nationwide, demonstrated the program's feasibility, acceptability, and promising efficacy in promoting abstinence. At the 6-month follow-up, self-reported abstinence rates were higher in the intervention group than in the control (NYC trial: 25% vs. 5%; national trial: 38% vs. 10%), and biochemically validated abstinence rates were higher in the intervention group than the control group (NYC trial 25% vs. 5%; national trial: 225 vs. 10%). Remarkably, self-reported abstinence rates are comparable to the national Asian Smokers' Quitline (ASQ) (30.7%), despite most of the study participants not being ready to quit at enrollment (NYC trial: 70%; national trial: 62%), unlike the more motivated smokers typically seeking treatment through the ASQ.

The program will recruit a minimum of 30 participants a year over three years. Participants will receive the 8-week *WeChat Quit Coach*, and a 4-week supply of nicotine patches and lozenges by mail upon request. Phone surveys will be conducted at baseline, 8 weeks, and 6 months, with remote biochemical verification at 6 months. To recruit participants, we will employ the following strategies: 1) attend community events in Chinese American communities (e.g., health fairs and immigrant resource fairs) to distribute study flyers; 2) encourage CBOs, including AICAS partners, to post digital flyers and display print flyers in their offices; 3) allow individuals interested in our study to share digital flyers within their social networks with no incentives; and 4) utilize snowball sampling.

Healthy Lung Partnership:

We will continue collaborating with current and potential partners to strengthen and expand the Healthy Lung Partnership. Our focus will be on raising awareness about the benefits of lung cancer screening and promoting resources available for smoking cessation.

NRT Availability and Usage*:*

Based on our findings regarding the availability and use of NRT, we will explore opportunities to work with community partners and pharmacists to educate smokers about the advantages of NRT and enhance its accessibility within the community.

Dissemination of the Resource Repository:

The workgroup will focus on maintaining, expanding, and disseminating the AICAS Resource Repository and improving the design of the AICAS website.

Other Emerging Priorities:

Other projects and programs will emerge depending on the priorities identified by the partners. These will likely include:

- Reducing smoking and treatment access-related disparities.
- Increasing knowledge and awareness of the harmful effects of secondhand smoke exposure and available tobacco treatment resources.
- Increasing awareness of oral and lung cancer screening and connecting smokers to available resources.
- Educating youth about the dangers of tobacco products, including e-cigarettes (vaping).
- Engaging community members and partners in advocacy work related to tobacco issues.
- Providing capacity-building opportunities for community partners to understand the community's needs.

3. REACH FAR: Community Health for Asian and Arab Americans: Preventing Chronic Disease through Engagement with Community and Faith-Based Organizations

Asian Americans experience a large burden from cardiovascular disease (CVD), hypertension and diabetes, with substantial variation in prevalence rates across subgroups, with South Asian populations experiencing higher risk. Certain Asian American subgroups also report poor nutritional practices, further elevating CVD risk. Studies have demonstrated low medication adherence in some Asian American subgroups, a critical component of diabetes and hypertension management.

Each of these risk factors is further exacerbated by barriers to accessing culturally and linguistically appropriate care and tailored health information. Similar risk factors have been documented in Arab

American communities, though there is a paucity of research on this population due to limitations in local and national data collection race and ethnicity categories.

Diabetes and hypertension prevention and self-management programs that enable lifestyle changes and enhance linkage to healthcare have been shown to be an effective method of promoting prevention and control of these chronic conditions. Yet there is a lack of culturally tailored programs to promote diabetes and hypertension prevention and management.

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

Specifically, the program:

- Enhances and promotes systematic and sustainable linkages to culturally and linguistically tailored community- and clinically-based resources to improve diabetes and hypertension prevention and management in South Asian and Arab communities;
- Implements reinforcing and integrated evidence-based approaches to improve access to environments promoting nutrition in South Asian and Arab communities by introducing education and changes to communal food practices in faith settings; and
- Enhances City-wide campaigns by disseminating culturally tailored communications and education on CVD risk reduction to Brooklyn South Asian and Arab communities.

Progress and Impact

REACH FAR Brooklyn builds upon the team's success in implementing culturally tailored community-clinical linkage program for Asian Americans and other immigrant communities over the past several years. We have built upon these successful efforts to establish REACH FAR Brooklyn, which include the Keep on Track and DREAM Initiative Community Outreach programs.

Keep on Track

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

evidence-based train-the-trainer program developed by the NYC Department of Health and Mental Hygiene, to screen, monitor, and provide counseling to people with high blood pressure. Keep on Track has been implemented in 120 faith-based and community-based settings across New York City, but previously had not been adapted for or implemented in Asian American communities. REACH FAR activities are supported by a comprehensive social marketing campaign to raise awareness of hypertension prevention and treatment and to promote hypertension screening events at faith-based and other organizations. REACH FAR has also culturally adapted and disseminated materials on hypertension and nutrition created by the New York City DOHMH and the Centers for Disease Control Million Hearts initiative and distributed these materials in a variety of community venues such as health care settings, grocery stores, restaurants, and faith-based and community-based organizations.

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

Growing out of this work, as part of the Community Service Plan, REACH FAR has partnered with 6 mosques in Brooklyn, Lower East Side, and Long Island – using a three-pronged approach: (1) implementing the Keep on Track program in mosques within the CSP catchment area; (2) implementing nutritional strategies, including education and changes to communal food practices; and (3) providing culturally tailored communications and education.

Since 2022, REACH FAR has been implemented at the following mosques: Hazrat Belal Jaime Masjid, Bangladesh Muslim Center (Masjid), Darul Quran Masjid, Darul Jannah Masjid, Brooklyn Islamic Center, Nur Al Islam, Muslim Community Center, all located in Brooklyn; and expanded our work to our Long Island catchment area. REACH FAR's Community Health Workers trained 28 volunteers from these mosques, who are now capable of providing free monthly blood pressure screenings and basic hypertension reduction and management strategies to the mosque congregants. Through these efforts, we have reached 1,140 community members receiving blood pressure screening, access to healthy foods, and nutrition education and information.

DREAM Initiative Community Outreach and Education

The DREAM Initiative is implementing a culturally tailored CHW intervention to improve diabetes prevention and management outcomes in South Asian communities in a network of 20 community-based primary care practice settings. The initiative, supported in part by a grant from the National Institutes of Health, is being implemented in five community-based primary care practice settings in Brooklyn serving more than 5,000 South Asian and Arab American patients with diabetes or pre-diabetes. The initiative is also guided by input from community-based organizations in Brooklyn, including Council of People's Organizations (COPO), serving the South Asian population in Brooklyn and serving 13,000 clients annually and Arab American Family Support Center who serves 20,000 clients annually. The DREAM Initiative has reached 498 individuals that received our intensive CHW-led diabetes prevention intervention.

Beyond the implementation of this research study, in support of our community-engaged process, the Dream Initiative has worked with CBO partners to offer community-wide health education workshops which reinforce individual health coaching CHWs provide within clinical settings. Since 2022, Dream has reached 240 individuals at partners organizations in Queens, Brooklyn, and the Bronx to deliver nutrition, physical activity, diabetes and COVID-19 related health education and workshops.

CBO partners highlighted growing mental health needs among their clients post-pandemic. In collaboration with CBO partners, we conducted six mental health listening sessions with elderly South Asian community members facilitated by a licensed therapist and a CHW. During these sessions, the facilitators defined mental health for participants, asked participants to share sources of distress, and shared healthy coping strategies as well as mental health resources (free counseling services, mental health providers with proficiency in South Asian languages). Several participants described family tensions particularly for elderly participants who live with their adult children or in-laws. Other sources of distress included loneliness and isolation due to limited social opportunities for South Asian immigrants with limited English proficiency. Through these sessions, we reached 246 community members.

Enhancing Access to Clinical Research Opportunities

Our CSP efforts have been driven by staff with lived experience in the communities they serve who leveraged their leadership and trusted status to deliver culturally relevant health information and resources. Recognizing the crucial role that trusted gatekeepers play in enhancing access to clinical trials, we have leveraged our CSP efforts to support recruitment into a new longitudinal cohort study titled the Mediators of Atherosclerosis (hardening of the arteries) in South Asians Living in America (MASALA) Study, which is funded by the National Institutes of Health. The MASALA study is identifying risk factors related to the hardening of the arteries in South Asians. Each participant will receive a free comprehensive medical exam at an NYU Langone Health facility. In conjunction

with CSP efforts described above, we have disseminated information on the MASALA study to community members in Queens, Brooklyn, and Long Island and worked with NYU's Clinical Research Centers based in Brooklyn and Long Island to enroll 800 participants into the trial.

Plans

We will continue to implement KOT and fruit distribution efforts at mosques sites in Brooklyn, and expand our work with the Long Island mosque partner.

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

Leveraging this network of trained faith-based leaders and CHWs and building upon our existing Brooklyn-based partnerships including the Family Health Centers and NYU Langone Health - Brooklyn, we will develop a strategy with mosque and CBO partners to connect individuals with high blood pressure to the health care system. Individuals who need social service assistance will also be referred to the Family Health Centers and CBO partners.

REACH FAR's CHWs are trusted members of the community. In addition to providing KOT and Nutrition strategy training to the mosque and CBO volunteers, they will also provide trainings and workshops on diabetes prevention and management to the mosque members. REACH FAR will also develop a translated handbook on diabetes prevention and management to distribute to mosque and community members. We will continue to offer culturally tailored nutrition and physical activity demonstrations and videos at CBO and faith-based sites. As certified In-Person Assistors/Navigators (IPAs/Navigators) through NY State of Health Marketplace, REACH FAR CHWs will continue to assist mosque members with health insurance enrollment.

C. Neighborhood and Built Environment: Programs, Progress and Plans

1. Red Hook Community Health Network

Red Hook Community Health Network (RHCHN or Health Network) is a network of community-based organizations, residents, and health partners working to improve the health of Red Hook residents by expanding access to health services and organizing to address root causes of health disparities in the

community. The Network was developed in response to the Red Hook Community Health Needs and Assets Assessment (CHNAA), undertaken as part of previous NYULH CHNAA and published in 2018.

Red Hook Community Health Network Partners:

The Alex House Project

supports low-income families and young mothers to ensure they successfully transition into parenthood by providing access to parenting training, higher education, and employment opportunities.

Good Shepherd Services

partners with children, families, and youth to address basic needs, build on family strengths, promote belonging, expand developmental opportunities, and strengthen job readiness.

Red Hook Community Justice Center

provides the Red Hook community with peacemaking, community service, youth court learning opportunities. They also operate a housing resource center that provides support and information to residents with cases in housing court.

Red Hook Initiative (RHI)

supports youth and adult residents of the Red Hook Houses by providing youth development, career readiness, and community organizing opportunities. RHI also operates Red Hook Farms, a 4+ acre youth-centered urban farm and food justice program.

Progress and Impact

Network Structure:

In summer 2023, a dedicated group of community partners met to re-design the structure of the Health Network. This redesign resulted in the formation of the Health Network Advisory Committee and the Accountability Partners (see image below for details). The Network remains committed to facilitating workgroup spaces where emerging community needs are elevated and collaborative solutions are designed.

To date, the following groups are meeting:

- Network Advisory Committee (monthly)
- Health and Housing Organizers (monthly)
- Community Health Worker Workgroup (monthly)
- Accountability Partners (twice a year)

Network Advisory Committee

The Network Advisory Committee is composed of seven individuals representing three community-based organizations, one healthcare provider, one academic institution, the Community Health Worker program, and one Red Hook resident. This group guides the scope of work and priorities of the Health Network. It also provides guidance and feedback on day-to-day Network activities overseen by the Manager, in addition to matters that concern the strategic vision of the Health Network. Since January 2024, the Advisory Committee meets monthly to provide guidance in the following areas:

Building Relationships: The Red Hook Family Health Center opened in June 2023, providing a critically

important resource for all residents in the neighborhood. Since then, the Advisory Committee worked to enhance the clinic's connectivity within the neighborhood by strengthening connections between CBOs, residents, and the clinic and fostering opportunities for outreach and engagement.

In 2022, the Health Network conducted nine community listening sessions attended by 60 Red Hook residents to understand their experiences in accessing healthcare in the neighborhood. These findings and recommendations provided important information to the Health Network about resident expectations and desires as new healthcare partners moved into the neighborhood. As a result of this report, the Network began to build relationships with other healthcare providers in the neighborhood, specifically Rockwell Health and Addabbo Family Health Center.

Food Rx: in June 2024, the Health Network assisted Network member - the Red Hook Initiative - in launching their inaugural Food Rx program, which connects Red Hook public housing residents who have a chronic health condition with a $25 weekly voucher for use at the Red Hook Farms. The Network supported this process by working with Health Network member, Family Health Centers at NYU Langone, to enable their CHW to conduct initial intakes for potential participants and requested service providers associated with the Health Network to refer residents who may benefit from the program. In the span of 3 weeks, the program recruited over 40 families.

Medicaid Waiver: The Network partnered with staff from the Family Health Centers at NYU Langone to host meetings leading up to the 1115 Waiver to ensure service providers in the neighborhood understood how they might be able to leverage the Waiver to benefit neighborhood services and residents.

CHW Workgroup: In response to the Community Health Worker evaluation completed in 2023, the Advisory Committee helped conceptualize and launch a CHW Workgroup, tasked with designing a proposal for the expansion of CHWs in the neighborhood.

Community Health Worker Program

Recognizing the need to support Red Hook residents by connecting them with resources to address medical and social drivers of health, the Network created a Red Hook Community Health Worker program in 2020. Support and referrals include: unemployment, health insurance, benefits, primary care, NYCHA housing support, and specialty medical care. The Community Health Worker Program consists of one CHW who is trained and supported by the Family Health Centers at NYU Langone. The CHW is co-located in various settings throughout the neighborhood on a weekly basis in order to ensure accessibility and visibility in the community. Between September 2022 and July 2024, the CHW served 752 individuals in 1,194 sessions.

The CHW works onsite at three locations: the Red Hook Community Justice Center, Red Hook Initiative, and the Red Hook Family Health Center. By having a CHW on site, those locations have increased their capacity to address needs of clients and patients, and staff have learned more about how to help navigate people to the resources they need. In addition, the Health Network helps connect and refer residents to the CHW program through partnership building and regular meetings with staff from the Family Health Centers at NYU Langone to identify gaps and needs in the community.

In 2024, RHCHN worked with Network member - the Clinical and Translational Science Institute at NYU Langone - to conduct an evaluation of the CHW program in Red Hook. This evaluation sought to

understand what was working well with the program, what needed to be improved, and how the program should evolve. Interviews were conducted with the CHW, past clients, and host site staff. One of the key recommendations that stemmed from this evaluation was to expand the number of CHWs in the neighborhood to adequately address the needs of residents. As a result, the Health Network launched a CHW Workgroup in June 2024 dedicated to creating a plan for CHW expansion in Red Hook.

Health and Housing Organizers

The Network launched a Health and Housing Workgroup in November 2021 in response to the 2018 CHNAA, which illuminated concerns about the intersection of health and housing, particularly in the New York City Housing Authority (NYCHA) buildings in Red Hook, the second largest public housing development in New York. This workgroup has focused on health and housing needs in Red Hook's public housing community, developing strategies to identify gaps and address needs.

In November 2023, experienced and knowledgeable resident leaders assumed leadership of the group. Three resident leaders were chosen from among 20 applicants to be the inaugural Health and Housing Organizers. These organizers worked to articulate the housing issues faced by Red Hook public housing tenants and how poor conditions negatively impact health outcomes. To call attention to these issues, they have submitted public testimony at City and State government hearings. In the summer of 2024, resident leaders identified Red Hook Art Project to lead art activism work in the neighborhood that will engage public housing residents around these issues and continue to move the neighborhood towards action.

Accountability Partners

The Accountability Partners are Red Hook service providers, residents, healthcare providers, and others dedicated to keeping the Health Network accountable to responding to neighborhood needs and requests. This group meets bi-annually to provide feedback on the work of the Health Network and share and leverage existing resources with one another.

Plans

Expanding the Community Health Worker Footprint in Red Hook

The Network is committed to the success and expansion of the CHW program in Red Hook by creating new partnerships with organizations whose clients can benefit from Community Health Workers. Over the next three years, the Health Network's Community Health Worker will serve 1,440 Red Hook residents. As a way to address community concerns about indoor and outdoor air quality, we will equip

the Network CHW with air purifiers to distribute to at least 74 Red Hook families who report having an asthmatic individual and mold conditions in their household.

The Health Network will also use the plan developed by the CHW Workgroup in 2024 to expand the footprint of CHWs in the neighborhood – emphasizing local hiring and attending to needs identified by residents.

Food as Medicine

We will work with Network member, the Red Hook Initiative, to expand the Red Hook Food Rx program to reach more residents and become fiscally sustainable. The current program serves 30 families and we hope to at least double that number in three years. The need and relevance of this program is clear given the demand seen in 2024 with limited outreach (45 applicants).

Health and Housing Issues

In partnership with the Red Hook Art Project and the resident Health and Housing Organizers, we will design and execute at least two art activation projects that focus on health and housing by:

- Uplifting the lived experience of public housing residents and the value of public housing;
- Bringing awareness to the intersection of health and housing (mental and physical health): and
- Advocating for additional resources for Red Hook East and West developments to ensure safe, healthy housing conditions.

These art and activism activities will aid in bringing awareness to City and State campaigns to advocate for better housing conditions for public housing residents. The Health Network will support these advocacy movements by continuing to provide written and spoken public testimony at public hearings.

Network Growth and Sustainability

Over the next three years, the Red Hook Community Health Network intends to grow its base as a Network and deepen existing relationships. Our plans include:

- Continuing to engage and compensate residents, with the goal of reaching 10 total by 2028;
- Co-developing opportunities to grow ownership and meaningful involvement of community-based organizations, schools, and healthcare partners; and
- Creating pathways for partners to sign-on to and support advocacy measures introduced by working groups and other allies to further promote access to social drivers of health and healthcare resources.

2. Community Health Worker Research and Resource Center

The Community Health Worker Research & Resource Center (CHW-RRC or the Center) was established in 2018 with the mission to harness NYU Langone's extensive CHW-related expertise to enhance and support emerging and existing community health worker (CHW) and patient navigator programs. The CHW-RRC aims to improve health outcomes, reduce health inequities, and build CHW capacity and leadership across NYU Langone Health and in the broader community.

Progress and Impact

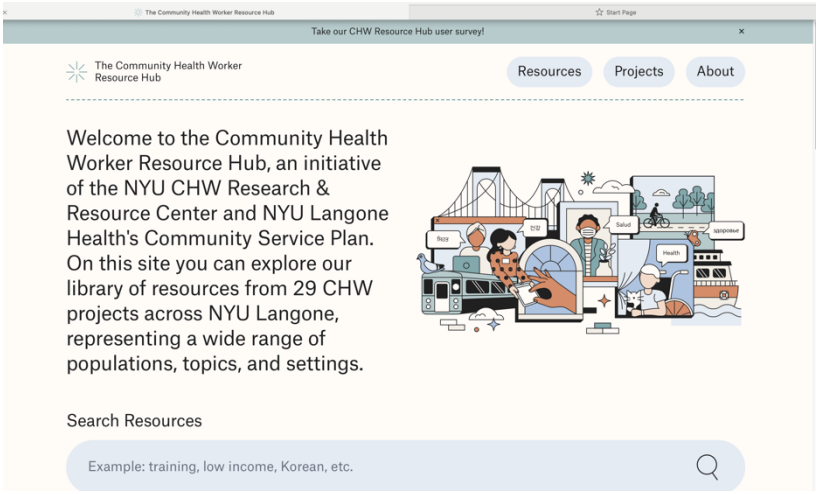
Outreach

Since fall 2022, the CHW-RRC has grown its public-facing email list from 2,100 to over 3,000 subscribers, expanding the Center's engagement with other institutions and community-based organizations both locally and nationally (see table below). The email list includes members across 42 states, with New York leading at nearly 2400 members. The majority hold CHW-type roles but outreach efforts have also reached program managers, directors, executives, researchers, social workers/case managers, and students. We use the email list to share announcements about CHW-RRC activities, events, and webinars. In addition, the quarterly CHW Learning Community Newsletter highlights the critical role of CHWs by showcasing professional and personal success stories and their creative projects.

CHW Resource Hub

Over the course of 2022-2023, the CHW-RRC worked with a web designer to create an online free and publicly available CHW Resource Hub as a way to compile and share the vast body of work developed for CHW interventions and initiatives across NYU Langone. The Hub was launched in September 2023 and is aimed at researchers, community members, and CHWs who are looking to develop, enhance, or evaluate CHW projects.

The CHW Resource Hub includes a living library of resources from 26 past and current CHW programs at NYU Langone Health, representing different topics, populations, settings, and languages. Features on the Hub include: a search page, with the ability to refine results by resource type, topic area, language, priority population, and setting; a projects page, which allows the user to browse the 26 programs; and pages for News & Announcements, Past CHW-RRC Events and Newsletters, and CHW Career Opportunities.



Sample screen shot from the CHW Resource Hub

Between November 27, 2023, and July 23, 2024, there were 2,777 total users (unique individuals who access the site), 3,899 total sessions, 13,481 page views, and 82 downloads. The engagement rate (users staying on the page for at least 10 seconds or 2 page views) was 64.9%, and the average session duration was just over 3 minutes. Individuals have visited the Hub from a total of 43 U.S. states and 8 countries.

The CHW-RRC began sending out monthly e-blasts in January 2024. These e-blasts aim to bring attention to Hub content and features and help to increase usage of Hub resources. In May 2024, the Center launched a CHW Career Opportunities page, which can be accessed from the CHW Resource Hub home page; since its publication, the page has been visited 624 times.

CHW Resource Hub metrics by month:

	Oct 2023*	Nov 2023*	Dec 2023	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
Views	2,999	931	1,776	3,272	1,293	1,645	1,566	1,294	1,110
Total Users	n/a	n/a	167	1,239	208	243	303	256	295
Sessions	830	272	292	1,420	293	356	419	384	373
Engagement rate	n/a	n/a	80.8%	47.5%	78.8%	76.4%	67.8%	70.3%	84.5%
Downloads	55	26	0	13	15	15	16	11	3

*Data from Adobe Analytics; all other data from Google Analytics (G4)

As described below, we will continue to develop and grow this resource to make it more useful to a larger audience, including CHWs.

Activities and Events

Webinars

Between September 2022 and August 2024, the CHW-RRC hosted six webinars for CHWs open for free to the public, attracting hundreds of attendees. Webinars focused on: COVID-19 vaccine access and inequities; updates on emerging COVID-19 variants; survey highlights from the National Association of CHWs; reproductive rights; and the launching of the CHW Resource Hub. All webinars are developed with a CHW audience in mind and moderated by a NYULH CHW staff member.

Date	Webinar Title	# Attended	# Organizations
10/13/2022	COVID-19 Town Hall for CHWs: Bivalent Boosters	135	124
1/30/2023	COVID-19 Town Hall for CHWs: Where Are We with Variants and Where Are We Headed? Part 3	180	176
3/3/2023	Data for Action: National CHW Survey and Takeaways for New York State	144	141
9/12/2023	Reproductive Rights Series for CHWs: What we know about abortion in the United States from 1973 to present	181	177
9/20/2023	COVID-19 Town Hall for CHWs: Where Are We with Variants and Where Are We Headed? Part 4, September 20, 2023	200	194
10/26/2023	CHW Resource Hub Tutorial	161	159

CHW Innovations Summit

Following the inaugural CHW Innovations Summit in 2020, the CHW-RRC has hosted two impactful summits since fall 2022, designed to advance the effectiveness, recognition, and sustainability of CHWs within the health systems and communities they serve. These summits provide a platform for experts across sectors to engage in meaningful dialogue, share best practices, and develop strategies to address critical challenges in the CHW domain.

The November 15-16, 2022, virtual summit titled "New Frontiers for Establishing a Health Equity Workforce," focused on the sustainability and scalability of the CHW model in the context of healthcare policy and the heightened recognition of CHWs' essential role during the COVID-19 pandemic.

On March 5, 2024, the CHW-RRC held our first in-person summit "Policies and Partnerships to Support Community Health Worker Programs: Insights from Maternal Health and Housing Interventions." This summit focused on the integration of CHWs into broader health systems through policy and partnerships, highlighting new policies in New York State that provide reimbursement for CHW services and exploring successful CHW programs in maternal health and housing interventions.

Dates	CHW Innovations Summit Theme	#Individuals Attended	#Organizations Attended
11/15/2022	New Frontiers for Establishing a Health Equity Workforce	415	407
11/16/2022		208	198
3/5/2024	Policies and Partnerships to Support Community Health Worker Programs: Insights from Maternal Health and Housing Interventions	263	137

Together, these summits have underscored the vital role that CHWs play in advancing health equity and the need for continued investment, policy support, and professional development to sustain and expand their impact. By fostering collaboration across sectors and highlighting innovative approaches, the CHW Innovations Summit series has become a cornerstone of our efforts to strengthen the CHW workforce and improve health outcomes in the communities they serve.

<u>Advocacy and Policy Work</u>

The CHW-RRC's advocacy work focuses on informing state and federal policies that provide sustainable support and funding for CHWs. By participating in policy discussions and submitting formal recommendations, the CHW-RRC strives to encourage legislative frameworks that support the CHW workforce. We aim to solidify the role of CHWs within the healthcare system, advocating for their contributions to be integrated into policy decisions and their impact on community health to be fully realized.

Letters to the Centers for Medicare & Medicaid Services (CMS)

As the CHW-RRC builds its expertise in Medicare and Medicaid policies as it relates to reimbursement of CHW services, we have provided feedback to CMS when they post questions. In September 2022, the CHW-RRC wrote a letter with compiled comments in response to their request for information on "Medicare Part B Payment for Services Involving Community Health Workers." The comments focused

on: supervision and employment arrangements (the ability of CHWs to work under the general supervision of physicians who should not replace existing CHW supervisors); services (the need for CMS to cover the full range of CHW services, including social support, advocacy, and coaching); and qualifications (the importance of not imposing certification requirements for CHWs). In September 2023, the CHW-RRC compiled and submitted additional comments on the "Notice of Proposed Rulemaking for the Medicare Physician Fee Schedule for Calendar Year 2024," specifically in relation to community health integration (CHI) and principal illness navigation services (PIN) to be conducted by CHWs and similar professionals. Our comments here focused primarily on emphasizing the importance of greater flexibility in referral pathways for CHW services and in the setting and duration of services. The CHW-RRC team aims to develop further expertise on this issue and share information on accessing funding streams with our network.

Policy Brief

In collaboration with the NYULH Institute for Excellence in Health Equity, the CHW-RRC co-authored a CHW Policy Brief published in November 2023. This brief advocates for greater support, funding, and integration of CHWs into healthcare systems to effectively address health disparities. The document highlights the essential role CHWs play in promoting health equity, particularly in underserved communities, and reinforces our commitment to strengthening the CHW workforce.

NACHW/PIH Advocacy Day

On March 12, 2024, two CHW-RRC members and one CHW joined NACHW and Partners in Health at the 2nd Annual Advocacy Day on Capitol Hill. More than 90 CHWs, allies, and advocates from across the country gathered to meet with their representatives and urge Congress to support the Community Health Worker Access Act (S.3892), a piece of legislation that would provide critical, sustained support to CHWs across the U.S., and to support a Congressional resolution to recognize National Community Health Worker Awareness Week.

With PIH-US and NAHCW combining forces, about 100 people were on hand for a day of advocacy on March 12, 2024, and a chance to educate members of Congress and their staff about the critical role of community health workers. Here, a large group of CHWs and members of PIH-US pose for a photo on the steps of the U.S. Capitol. *Photo by Melissa Lyttle for PIH*

National Policy Working Group

Following NACHW/PIH Advocacy Day, in April 2024, the CHW-RRC team joined the National CHW Policy Working Group, facilitated by NACHW and Partners in Health-US. This Working Group unites CHWs and allies to stay informed on federal CHW policy developments, explore national advocacy opportunities, and promote CHW unity. Led by CHWs and prioritizing CHW self-determination, the group encourages collaboration across all sectors of the CHW field. Our team continues to attend bi-monthly meetings.

Investigating clinical integration of CHWs in New York State

The CHW-RRC obtained a grant from the New York Health Foundation in April 2024 to investigate barriers and facilitators to clinical integration of CHWs in New York State. The team is conducting focus groups with various stakeholders throughout the State and analyzing data and will disseminate results to stakeholders and policymakers. This project is informed and guided by a Community Advisory Board whose members are compensated for their expertise and time. The foundation grant supports the project for 15 months, with additional staffing support provided by NYU Langone Hospital's Community Service Plan.

CHW Awareness Week

On Thursday, July 25, 2024, Senator Casey (PA) and Representative Raul Ruiz (CA) introduced resolutions in the Senate and House to formally recognize the 2nd Annual National CHW Awareness Week for August 26-30, 2024. In recognition of this significant development, the CHW-RRC organized its inaugural NYULH CHW Awareness Week. We hosted wellness workshops facilitated by NYU's Integrative Health, provided giveaways, and launched our first NYU Langone Health CHW and CHW Supervisor Awards Celebration. This event honored CHWs and CHW Supervisors nominated by their peers and colleagues across the NYULH institution and highlighted their incredible dedication and leadership.

<u>Technical Assistance/Collaborations and Partnerships</u>

The CHW-RRC is a key resource providing technical assistance and fostering collaborations both within NYU Langone Health and with external partners. These inquiries often include requests for letters of support for grant applications, guidance on available training opportunities, and assistance with hiring or understanding the CHW landscape, requests for speaking engagements and focus group participation. By responding to these requests, we provide valuable support and resources, helping to strengthen CHW programs and initiatives across different settings. Between September 2022 and August 2024, we received over 100 requests.

<u>CHW Clinical Research Training</u>

In partnership with the NYU Clinical and Translational Science Institute (CTSI), the CHW-RRC developed the Community Health Worker Training in Clinical Research. This training, with input from NYULH CHWs, equips CHWs and patient navigators with essential clinical research knowledge, tailored to the communities they serve. The course is available internally to NYULH staff and externally to partners for free. Our recent publication in *Frontiers in Pharmacology* details the course's development and impact. Faculty co-Director Amy Freeman will serve as a Co-I on an NIH UG3/UH3 grant proposal to be submitted by the CTSI to build on this training to further train CHWs to recruit community members into clinical trials.

Red Hook Community Health Network

The CHW-RRC has been providing technical assistance to the Red Hook Community Health Network (see Section II.C.1.) on its work related to the CSP-funded CHW program in Red Hook. Beginning in June 2024, this has included co-chairing a CHW Workgroup comprised of partner City agencies and neighborhood organizations and residents to envision an expansion of the CHW program.

CHW-RRC Advisory Group and CHW Learning Committee Engagement

The CHW-RRC Advisory Group meets every other month and plays a critical role in connecting CHW programs across the institution, setting priorities, and guiding the Center's vision. This group includes approximately 30 supervisors, project managers, researchers, and CHWs from the NYU Langone Health community and have met 11 times between September 2022-August 2024. Within this group, the CHW Learning Committee—comprising 4-6 CHWs—serves as leaders and liaisons for the broader CHW Learning Community. Committee members are selected to serve for 18 months and meet monthly (24 times between September 2022-August 2024), focusing on CHW staff social support and professional development opportunities.

For internal communications, the CHW-RRC produces a weekly digest for NYULH CHWs and related staff and faculty. Since Fall 2022, the weekly digest distribution list has roughly doubled, from 90 to 180. The Center has sent out over 100 digests between September 2022 and August 2024, providing timely updates and resources tailored to the CHW workforce.

CHW Wellness Survey

The CHW Wellness Survey was developed to better understand the needs of the CHW Learning Community as they adapted to new working environments during the COVID-19 pandemic. The survey results inform CHW-RRC's program planning, particularly in areas like professional development and staff support. Insights from the survey help shape initiatives addressing key concerns such as stress, work-life balance, and training preferences.

CHW Mental Health Support Group

In April 2021, insights gathered from the CHW Wellness Survey motivated us to launch a mental health support group tailored to our CHW staff's unique needs. This initiative was made possible through a collaboration with an NYULH clinician based in Long Island and social work intern facilitators who helped lead periodic sessions. Between September 2022 and August 2024, more than 10 support group sessions were made available to CHW staff, addressing key areas of mental health and well-being.

Capacity Building and Support

Capacity-building efforts are designed to promote career advancement opportunities, identify and provide essential training resources, and facilitate meaningful engagement in national conferences and forums. These initiatives empower CHWs with skills and knowledge to excel in their roles and promote their recognition as vital members of the healthcare system. These efforts include:

- Developing and implementing career ladders that support opportunities for professional growth;

- Providing speaking and program moderating opportunities to increase CHW visibility and demonstrate the active role CHWs play in shaping important conversations within the healthcare community;
- Supporting attendance at relevant conferences;
- Working with CHWs to develop a wellness survey to better understand how CHWs adapted to working environments during the COVID-19 pandemic; and
- Developing responsive programming and community-building activities.

Plans

Over the next three years, the CHW-RRC will become a leading resource for the CHW workforce by:

- Expanding CHW Resource Hub capacity by including resources for use by CHWs (e.g., materials and tools to support client interactions) and information and resources from non-NYULH CHW programs;
- Growing the Center's training capacity to conduct in-house core competency training for CHWs and creating new training modules relevant to CHWs' work in the community and clinic;
- Expanding the reach and impact of the CHW-RRC through partnerships, weekly digests, newsletters, events, the Resource Hub, and targeted outreach;
- Expanding CHW-RRC webinars' reach to non-English speaking communities by offering simultaneous interpretation during webinar events;
- Continuing to build CHW Learning Community capacity through targeted professional development activities, mentoring, and involvement in CHW-RRC committees and webinars;
- Promoting CHW wellness through community building, support, and engagement activities, including regular surveys, mental health and self-care support groups, recognition ceremonies, and celebrations;
- Continuing to advocate for policies that support CHWs n hiring and career advancement opportunities;
- Organizing an annual CHW Summit on a timely theme, drawing participants from across the country;
- Partnering on research and evaluation projects to strengthen and better understand the role of CHWs in promoting health equity for all populations; and
- Exploring ways to foster CHW community-clinical linkages, serving as a resource for understanding funding mechanisms and supporting CHW-relevant policy at the city, state, and federal level.

3. Fall Prevention and Exercise for the Elderly

Tai Chi for Arthritis for Falls Prevention:

Tai Chi for Arthritis for Falls Prevention program is an evidence-based program recommended by the Centers for Disease Control as a practical approach to preventing falls. Older people are more likely to fall, which can cause serious injury. The causes of falls in the elderly include:

- Muscle weakness
- Poor balance and vision
- Lack of confidence in moving about
- The effect of medication.

The program's goal is to reduce the risk for falls in adults over sixty. This is done by improving muscle strength, flexibility, confidence and endurance by teaching about weight transference. The program has been found to enhance balance both mentally and physically and significantly reduces the rate of falls of older adults and improves quality of life. The program is taught by a certified Tai Chi instructor and includes a pre- and post-balance assessment and a lecture portion on what Tai Chi is and its benefits related to fall prevention.

Matter of Balance:

Matter of Balance is an evidence-based exercise program designed to reduce the fear of falling and increase activity levels among older adults. The program includes eight two-hour classes presented to a small group of 8-12 participants led by trained coaches. The program enables participants to reduce the fear of falling by learning to view falls as controllable, setting goals for increasing activity levels, making small changes to reduce fall risks at home, and exercise to increase strength and balance.

The curriculum includes group discussions, mutual problem solving, role-play activities, exercise training, assertiveness training, and a few homework assignments. Participants learn about the importance of exercise in preventing falls and practice exercises to improve strength, coordination, and balance. Participants also conduct a home safety evaluation and learn to stand up and sit down safely. Additional topics include home safety, assertiveness, developing positive strategies for change, reducing barriers to exercise, identifying physical risk factors for falls, personal action planners, recognizing misconceptions about falls, and moving from self-defeating to self-motivating thoughts. Class size is between 8-12 participants.

The Otago Exercise Program:

The Otago Exercise Program is a 17-session workshop to improve strength and balance in older adults with a goal of reducing their risk of falls and enhancing their overall mobility and independence. The exercises can be conducted in the home, outpatient, or community setting by a Physical Therapist, Physical Therapist Assistant or other provider. Participants independently conduct their exercises 3 times a week, culminating in a series of four visits with the provider over an 8-week period. The program looks to:

- Reduce in falls by 35-40%
- Improve functional performance measures
- Improve perceived abilities in participants

Participants ultimately transition to a self-management phase for the next 4 – 10 months when they can independently do the exercises and have the opportunity to check-in with their provider via monthly phone calls, and an optional face-to-face check in at 6 months. The program launched September 2024, with a projection to reach 100 older adults in the next three years.

Chair Yoga

Chair Yoga for Wellness is a gentle, seated exercise evidence-informed program designed to improve flexibility, strength, balance, and overall well-being, particularly for individuals with limited mobility or chronic conditions. By using a chair for support, participants can perform modified yoga poses that promote physical health, reduce stress, and enhance mental clarity, all while minimizing strain on joints and muscles. This accessible program is ideal for older adults, individuals recovering from an injury, or anyone seeking a low-impact way to stay active and improve their quality of life.

Participants attend 1-hour weekly sessions conducted for 8 weeks. During this time, they develop better posture, enhance relaxation, reduce stress levels, increase flexibility and range of motion, and improve muscle strength. Exercises include seated leg lifts to strengthen core muscles, seated twist for spine and hip mobility and seated forward fold for hamstring and back stretching.

Progress and Impact

From September 2023 to September 2024, Tai Chi for Arthritis for Fall Prevention classes were held twice a week for 8 weeks at the Welcome Center, Premier Adult Day Care, Union Baptist Church in Hempstead and at various housing developments belonging to the Hempstead Housing Authority. The program reached a total of 99 participants.

From September 2023 to August 2024, A Matter of Balance Classes enrolled a total of 80 participants with classes held at The Welcome Center, places of worship and the Uniondale Public Library. The program continues to widen its reach and plans to remain committed to offering classes in and around the community to organizations that submit requests.

Chair Yoga is currently in its initial implementation phase, with sessions being offered to participants in the community and those discharged from the hospital. Early outreach efforts have begun, and we actively working to engage more participants through partnerships with local healthcare providers and community centers. As the program grows, we will continue to adapt and expand it to meet the needs of the community.

Here's what participants said about the program:

"I am certain that my ability to walk has become more controlled, and I firmly believe that continuing the Tai Chi will be an asset."

"The program helped with my overall well-being."

"The program did not only strengthen my muscles in my legs and arms, but it was also relaxing and peaceful."

"I am much more balanced now than from when I started the class."

Plans

Over the next three years, The NYU Long Island Welcome Center plans to reach over 250 Senior Adults with its Tai Chi for Arthritis for Falls Prevention workshops. Each class will continue to be assessed through a pre/post balance assessment for all participants.

A Matter of Balance is slated to reach 200 seniors over three years through partnerships between the Long Island Welcome Center and local community-based organizations including libraries, senior centers and faith-based organizations. The Welcome Center will also be offering The Otago Exercise program to the broader community.

Over the next three years, the Chair Yoga for Wellness plans on outreaching to local health care providers, senior centers and community-based organizations to educate them about the benefits of the program for their patients and clients. Through this outreach, we plan to reach 150 new participants.

D. Health Care Access and Quality: Programs, Progress and Plans

1. PlayReadVIP

PlayReadVIP (formerly Video Interaction Project or VIP) (www.playreadvip.org) is a strengths-based, evidence-based parenting program developed by faculty at NYU Langone and NYC H+H/Bellevue that uses videotaping and developmentally-appropriate toys, books, and resources to help parents utilize pretend play, shared reading, and daily routines as opportunities for strengthening early development and literacy in their children.

PlayReadVIP's core mechanism for promoting positive parenting activities is to engage and empower parents during pediatric primary care visits by making a video recording of each parent and child interacting together using a toy or book provided by the program, building on each parent's unique strengths and goals. Immediately after the recording is made, a PlayReadVIP Coach watches the video with the parent to highlight and reinforce the parent's strengths. The combination of practice during the interaction and self-reflection following the interaction empowers parents to feel more confident in their role in fostering their child's development. It also provides opportunities for parents to boost skills related to activities that will foster child development in the home.

PlayReadVIP sessions mostly take place in pediatric clinics on days of routine well-child visits between birth and age five years. At each session, families meet individually with their PlayReadVIP Coach for approximately 25 minutes to engage in the video recording described above. In addition:

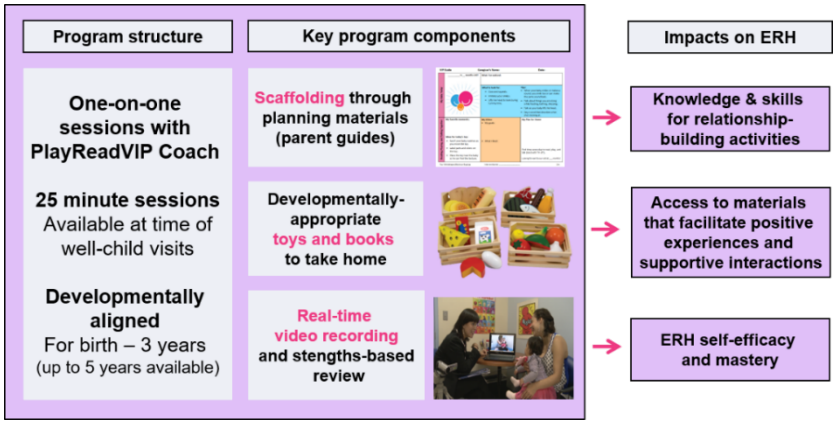
- The family is provided with a developmentally appropriate toy or book to take home, giving the family access to materials that facilitate rich interactions;
- The Coach leads a discussion about child development, suggests activities, and promotes goal setting and planning with the parent; and

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

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

1) Supporting parents and children early, beginning at birth, for strongest impacts ("primary prevention");
2) Engaging all poor and low-income households through pediatric primary care visits; and
3) Providing families with the confidence and skill to engage in behaviors supporting child development.

In addition, PlayReadVIP brings together three separate disciplines – pediatrics, developmental psychology, and early childhood education – and has been refined and tested in the context of multiple randomized controlled trials in NYC, Pittsburgh, and Flint, Michigan. As a result, PlayReadVIP has among the strongest evidence bases for any program presently seeking to address poverty-related disparities in school readiness. In addition to the proven impact (see below for details), this program is extremely cost effective. Implementation in healthcare builds on existing infrastructure and allows costs to remain low, estimated at $275 per child per year when delivered at scale. This is significantly lower than many other programs, which is particularly impressive given the strength of the impact of the program.



PlayReadVIP Overview and Impacts

Centralized support for all sites is provided by the PlayReadVIP National Center, based at NYU Langone's Department of Pediatrics at NYU Grossman School of Medicine, and includes support for program implementation, training, supervision, and maintenance of fidelity. In addition, the National Center works centrally to continuously study and optimize the program and adapt to the needs of new sites and populations. The National Center has developed a comprehensive implementation package so that PlayReadVIP can be delivered anywhere with quality and fidelity, and the program has been implemented at over 15 locations nationally as of 2024. Through the efforts of the National Center, the program is now positioned to expand even more rapidly, greatly increasing its impact on families. Our long-term goal is to bring

PlayReadVIP to 15,000-20,000 families over the next 5 years with a strong focus on NYC, building and strengthening partnerships with local sites and organizations.

What are the benefits of PlayReadVIP?

As shown in multiple analyses published in prominent peer-reviewed scientific journals and presented at high-profile academic and policy conferences, PlayReadVIP results in large impacts in three areas that are critical to reducing poverty-related disparities:

1) Enhanced parent-child relationships, including higher quantity and quality of parent-child interactions; increased reading aloud, talking, and teaching; increased quality and quality of parent-child interactions; increased reading aloud, talking, and teaching; increased quality of play; reduced screen time; and reduced physical punishment);

2) Reduced family stressors, including reduced maternal depression, reduced parenting stress, and enhanced parent self-efficacy; and

3) Enhanced child development, strongest in the area of social-emotional development including sustained reductions in behavior problems like hyperactivity and aggression together with improved attention, all critical for learning in school; additional impacts include some improvements in cognitive and language development and reduced need for Early Intervention referral.

Progress and Impact

PlayReadVIP was added to the Community Service Plan in September 2018, in response to community need for support for young children and parents. As a result, the program was implemented at the Sunset Park Family Health Center - Second Ave (5610 2nd Ave, Brooklyn, NY; "5610") in March 2019, and has since served over 1,100 families at that location.

In Sunset Park, the CSP's implementation at 5610 has taken place alongside a larger goal of expanding PlayReadVIP institution-wide across NYU Langone, with a priority on the Family Health Centers. Funding from the Stella and Charles Guttman Foundation has also facilitated expansion of the program across Sunset Park. In 2021, PlayReadVIP launched at the Seventh Avenue Family Clinic. Then in 2022, the program launched at the Family Support Center at NYU Langone. The Family Support Center offers a range of services for families and community members, including Special Supplemental Nutrition Program for Women, Infants and Children Women (WIC program), and English language classes. Since this is a community location, we are able to expand program eligibility to any interested family in the community, including families who are getting pediatric care at other locations in Sunset Park.

Last summer, we expanded to two additional FHC locations: the Family Physician Family Health Center (5616 Sixth Avenue, Brooklyn, NY, 11220) and the Park Ridge Family Health Center (6317 4th Ave, Brooklyn, NY 11220), both of which are family practice centers serving high-risk patients in Sunset Park. Expansion to these new sites brings the total number of locations offering PlayReadVIP up to five in Sunset Park, further increasing our impact on families.

In addition to these locations, funding from the Bezos Family Foundation will allow PlayReadVIP to expand to additional FHC locations in 2025 and onward. PlayReadVIP has also been actively engaged in collaboration with other CSP early childhood programs to develop linkages and synergies across collocated programs. For example, the PlayReadVIP Coach has worked to connect patients to local library resources through the Brooklyn Public Library. In addition, the PlayReadVIP National Center has been working to develop and pilot formal integration of PlayReadVIP into FHC's existing infrastructure of Maternal, Infant, and Child Health programs. For example, PlayReadVIP and Healthy Steps are co-located at multiple locations, and we are actively working with the CSP and the Family Health Centers team to develop integrations with Healthy Steps as a core component of their services.

Plans

Over the next three years, the CSP will support continued delivery of PlayReadVIP at 5610, as well as supporting expansion of PlayReadVIP to additional locations in Sunset Park. The program will continue to work with practice leadership, providers and staff to align pathways and processes for referral and implementation within the practice flow, and continue to build linkages with FHC clinical sites and community programs.

In addition, PlayReadVIP will continue to explore opportunities for integration with other partner programs, such as Healthy Steps, Reach Out and Read, Brooklyn Public Library, and others. This work will be taking place in collaboration with those programs and partners.

2. ParentChild+

The two critical aspects of young children's early literacy – social-emotional development and language development – are challenged when a child lives in a home environment that is stressful, unpredictable, or has limited resources. ParentChild+ (PC+), a national, evidence-based early literacy, parenting and school-readiness program, serves low-income, immigrant families in Sunset Park, Brooklyn (https://www.parentchildplus.org).

PC+ makes a significant difference in the lives of young children and their families by supporting families as they:

- Enhance positive parent-child verbal and non-verbal interaction;
- Enhance their positive parenting skills;
- Enhance their child's early literacy skills essential for school readiness; and
- Enhance their child's conceptual and social-emotional development.

The program provides intensive home visiting to families with children between the ages of 16 months and four years old who are challenged by poverty, low levels of formal education, and English language and literacy barriers. Home visiting is a "two generational approach," or a parent mediated intervention, where program outcomes are stronger when the primary focus of the visit is the caregiver/parent.

Families participate in two 30-minute home visits per week over a two-year period and receive educational materials to support positive interactions and development. During home visits, a trained Early Learning Specialist brings a book or educational toy as a gift for the family and uses it to facilitate parent and child play, verbal interaction, and reading to create a language-rich home environment. Parents set weekly goals that reflect family priorities.

PC+ meets all the best practice criteria set forth in the most recent research: it is a caregiver-focused early intervention/prevention model which focuses on school readiness fostered by the development of social and emotional competencies, language abilities, and cognitive readiness. These are facilitated by parent involvement and engagement through positive interactions, such as reading, playing, and talking. Program services are contextualized in best practices that honor each family's culture; use developmentally and linguistically appropriate books and toys; connect the family with community resources to address family support needs; and emphasize the importance of training and supervision of Early Learning Specialists. Services are delivered in the home languages of the families by staff reflective of the lived experiences, cultures and languages of participants. The program's design and activities also reduce risk factors associated with child abuse, maltreatment and neglect, and introduce or increase protective factors.

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

Here's what participants recently said about ParentChild+:

"My home visitor showed me how to communicate and respond to my child appropriately."

"I've learned how to understand my child's emotions more deeply."

"The program has helped me increase my knowledge about parenting. I am much calmer and patient with my children."

The Family Health Centers at NYU Langone leads this program in Sunset Park, supporting staff, resource development, design and implementation. Additional partners, such as Center for Family Life, provide parent workshops on navigating the childcare system and parental wellness; and Bank Street College of Education provides staff development opportunities on topics including supporting language development for emerging bilinguals.

Families are referred to an array of organizations, agencies, and providers to access needed services within and outside of the Family Health Centers network, including services for food and housing insecurity, legal needs, immigration, and domestic violence.

Progress and impact

ParentChild+ served 74 families during this reporting period. ParentChild+ provided:

- 4,509 home visits;
- 1,127 developmentally-appropriate books;
- 1,082 developmentally-appropriate educational toys;
- 12 family-learning trips and celebration events;
- 2 playgroups; and
- 9 Circle of Security Parenting Workshops series.

The program retained 92% of participants during the reporting period. This persistence speaks to families' resolve in ensuring that early childhood supports from both program staff and parents result in positive, on-track social-emotional development. The ParentChild+ leadership team's commitment to supervision and professional development, fidelity to the evidence-based model, and hiring and retaining culturally representative program staff also contributed to attaining the program's targeted outputs and outcomes.

During this reporting period, the program transitioned away from the model's original outdated assessment tools to others more in line with parent collaboration and support within the context of leadership development. In addition, the program now uses the ParentChild+ Reflection Record to

document home visits and guide conversations with families at the end of each visit. This approach generates discussion with the caregiver about their observations of their child's development, including the child's strengths and potential areas of focus, working to develop parent leadership skills as they self-reflect, set goals and begin to direct and inform programming. It also helps caregivers identify how the Early Learning Specialist can help support achievement of those goals. In this way, the Early Learning Specialist help parents identify ways to enjoy an activity with their child and guide them to observe and interpret the child's cues and respond to their interests, needs, or emerging skills.

The program has also comprehensively and successfully integrated Vroom into its model to support families. (Vroom (https://www.vroom.org/) is a national early learning initiative that empowers caregivers to play a proactive role in their children's early brain development.) Program staff curated Vroom tips – ideas on how to increase positive parent-child interactions to support early brain development during families' day-to-day activities – aligned with curricula to support families' goal attainments – and to have fun together!

Early Learning Specialists also provide families with resources and referrals when needed. They conduct formal screenings with families to identify basic social determinants of health needs, including housing insecurity, food insecurity, crisis intervention, domestic violence and mental health concerns. When a family screens positive, a referral to FHC's Family Support Services is made and the family is connected to needed services, including emergency food services, educational resources, mental health supports and access to health services.

During FY23, ParentChild+ used two validated tools – Parent and Child Together (PACT) and Child Behavior Traits (CBT) – to assess its impact. Both assessments were conducted by Early Learning Specialists, who observed the frequency with which parents and children demonstrated specific skills during sessions. These skills are related to the program's overarching focuses: effective parent-child interaction, the social-emotional development of the child and their pre-literacy skills development, all of which are essential components of a child's school readiness. Baseline assessments were conducted at the beginning of each program cycle and used to customize the support given to each family. Assessments were re-administered at the end of the program cycle to measure skill acquisition and/or maintenance based on demonstration "frequently" or "always" on the post-assessment.

The program's impact is reflected in the program's PACT and CPT outcomes in FY23. 100% of the 37 participating parents demonstrated improved knowledge of child development and increased use of positive parenting techniques. In addition, 100% of 37 children enrolled demonstrated improved social and emotional development, gaining school-readiness skills. surpassing our target.

As noted above, ParentChild+ phased out the use of the CBT and PACT measures in FY24. The field's understanding of how to assess child development and parent involvement has evolved since their inception, and there are better measures now than were available at the time ParentChild+ model was established. The program now utilizes the PIEL (Parental Involvement in Early Learning) to determine parental involvement in early learning in the home. The PIEL is a self-report survey for families to

complete. It shows an average total score of parental involvement in early learning in the home according to three domains: Connecting & Communicating, Teaching & Interacting, and Creating Learning Opportunities. The Ages and Stages (ASQ) Questionnaire and ASQ Social-Emotional Questionnaire (ASQ-SE) are also utilized to measure changes in a child's development and social-emotional functioning during their time in ParentChild+. The ASQ provides scores for each of the five developmental areas it measures (communication, gross motor, fine motor, problem-solving, and personal-social) while the ASQ-SE provides scores for social-emotional development (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people). Because this is the first year of implementation, and the tools measure outcomes over the full two-year intervention, data that demonstrates the program's success will be available in fall 2025.

Plans

Over the next three years, ParentChild+ will support 136 unique Sunset Park families. During their participation in the program, families will receive 6,256 home visits, 2992 educational toys, and 3,264 books. The program will retain 90% of enrolled families for the two-year program duration. At the end of the two-year intervention, 85% of enrolled parents will consistently demonstrate increased or sustained knowledge and awareness of child development and increased use of positive parenting techniques, while children will demonstrate on-target social and emotional development, indicating increases in school-readiness. ParentChild+'s objective is for 90% of the enrolled children to demonstrate on-target social emotional development by the end of the two-year program.

3. Family Support Services

The NYU Langone Hospital—Long Island Pediatric Center serves the largely Black and Hispanic population of Hempstead, a community with high levels of poverty – three times higher than in Nassau County overall. The families served by the Center are therefore more likely to experience risk factors for poor health such as food insecurity, homelessness, adverse neighborhood environments, and lack of access social services.

As noted in Section I.D.5., strong social supports, family structures and community programs can help prevent or ameliorate the impact of these stressors on childhood development and health. To address these needs, the Pediatric Center launched a Family Support Counselor program at the Pediatric Center to screen patients for socials needs, connect them to a network of local services, and follow up to ensure that care is received. This program is modeled after the Family Support program at the Family Health Centers at NYU Langone in Brooklyn, where bilingual Family Support Counselors work with families to address high rates of family stressors such as food insecurity, overcrowded homes, economic instability, low educational attainment and barriers due to immigration status. In 2024, 59% of all parents with children screened positive for SDOH needs in Family Health Centers' pediatric practices, including financial instability (99%), food insecurity (68%), housing instability (39%), and transportation barriers (23%).

In addition, to encourage language and literacy skills, the NYU Langone Hospital—Long Island Pediatric Center is implementing Reach Out and Read (ROR), an evidence-based pediatric early literacy program for children from birth to age five. In this program, doctors and other pediatric medical providers provide early literacy guidance, give out free, high quality and developmentally-appropriate books to their young patients during medical visits, and coach parents on how to create literacy rich environments at home. The families served by the Center are often low-income, low literacy, and immigrant population with very limited resources and children often have fewer opportunities for early learning activities with their parents including reading, teaching, and playing. Through participation in ROR, each family will receive at least 10 books by the child's fifth birthday, providing an opportunity to foster early child development and enhance parent-child relationship through reading aloud, talking, and playing. For families whose primary language is not English, ROR encourages literacy by providing books in many languages.

To support young families in the community, the NYU Langone Long Island Welcome Center partners with The Nassau County Department of Health to provide Cribs for Kids® programming for expecting parents and parents of infants and young children. Studies show that providing Safe Sleep education and materials to parents and caregivers significantly reduces the occurrence of infant deaths. The partnership provides in-home education on proper sleep positions and sleep environments for babies and provides portable cribs and other essential infant care items.
According to the Nassau County Department of Health, 4,500 infants die suddenly and unexpectedly during sleep each year in the United States. Many of these deaths are preventable, often resulting from accidental suffocation or strangulation due to unsafe sleeping environments. The program recognizes that there may be multiple potential barriers to adherence to safe sleep recommendations. These barriers can include financial inability to purchase a crib, cultural norms and family traditions that uphold bed-sharing or the placing of thick blankets or soft decorative items near baby, as well as alcohol, smoking or drug use in the home.

The Welcome Center accepts referrals from all over the local community as well as from the network of Pediatric and Women's Wellness practices. A trained staff member conducts safe sleep education with families in their homes and provides follow up care 3 months after education is administered to confirm whether safe sleep principles are being adhered to, and to provide redirection or referral to other resources as needed. Through the Cribs for Kids® program families receive a portable bassinet/play pen along with other tangible items which reinforce the Safe Sleep message.

Tangible Items provided to parents include:

- A pacifier, fitted crib sheet embossed with the safe sleep message, a safe sleep refrigerator magnet as well as safe sleep education materials, including brochures.
- Wearable Blanket/Sleep Sack: The Halo® SleepSack is a swaddle/wearable blanket meant to replace traditional blankets which can cause an infant to suffocate if baby becomes tangled in the fabric while sleeping. Parents are provided with two sleep sacks.

- Baby Book: The board book, entitled *Sleep Baby Safe and Snug*, written by Dr. John Hutton and illustrated by Leah Busch is included as a tangible item in the safe sleep kit. The book is distributed in English and Spanish and provides safe sleep messaging in an easy-to-read and clearly illustrated story.

Progress and Impact

Each year, the Family Support Counselor at The NYU Langone Long Island- Pediatric Center screens more than 400 families for social needs and risks. Consenting families are referred to a growing network of local service providers as well as local community organizations. The Family Support Counselor follows up with the provider as well as with the patient to confirm that services were accessed and to trouble shoot and assist as needed.

The Pediatric Center continues to support Reach Out and Read, with providers and office staff actively participating in the implementation of the program. From 2022 to 2024, over 9,000 books were provided to children between 0 and 5 years old.

Since the beginning of the partnership with the Nassau County Department of Health in 2022, a total of 23 cribs have been delivered to families with infants. These families have also been connected to other needed services in the community, such as diapers, formula and food pantries, immigration resources and early intervention services for other children in the family.

Beginning in 2023, the Long Island Welcome Center office staff and the Parent Education Department worked collaboratively to produce bi-annual community baby showers, one in April and one in August. The “We Can Bearly Wait, Baby” event is open to all pregnant people regardless of whether they will deliver at an NYU Langone facility and includes workshops and discussions led by NYU Langone Health doctors and labor and delivery nurses as well as parent education staff who run the parent education classes. Expecting parents are encouraged to ask questions about the process of labor and delivery as well as any pressing concerns they may have about the postpartum period and infant care. During the 2024 community baby shower sessions, a total of 33 mothers attended these workshops. They were able to walk away with needed supplies and valuable information to care for themselves and their infants.

Plans

We anticipate that the Family Support Counselor will continue to assist 500 patients per year, with that number potentially growing as screening systems are put into place and the program is replicated at other practices. We also anticipate that the Counselor’s relationship with community-based organizations and other resources will continue to grow and that data collected through this program will help identify gaps and needed services.

In addition, each year, the Pediatric Center's Reach Out and Read program will place over 6,000 books in the homes of participating families.

Over the next three years, the Long Island Welcome Center will continue to host both the Community Baby Showers as well as continue to grow a referral network for the Cribs for Kids Program, with a goal of reaching a total of 100 families over that timeframe. The Parent Education Department also plans to engage the community by delivering group childbirth preparation and infant care classes free of charge

by leveraging relationships with local organizations. With these initiatives, the program seeks to influence a long-term cultural shift toward safer sleep environments for infants and to decrease the Sudden Unexpected Infant Death (SUID) mortality rate.

4. Community-Oriented Virtual Primary Care and Technology (CARE Tech)

The Center for Community-Oriented Virtual Primary Care and Technology (CARE Tech) was added to the Community Service Plan in February 2024 to address inequalities in healthcare access in Flatbush, Red Hook, and Sunset Park, Brooklyn through a digital health lens. While digital health tools have the potential to increase access to high quality care, virtual care can often be inaccessible for certain populations due to disparities in technology and broadband access, digital and technology literacy, and language services.

With a service area of over 900,000 residents in central, northwest, and southwest Brooklyn, the FHC serves many patients who face technological and logistical barriers to digital health literacy. See Section I.D.1.

Grounded in the Community-Oriented Primary Care model, CARE Tech addresses the prevailing service area issues with a social and digital determinants of health lens. Digital health care tools can increase access to medical care but also risk exacerbating inequalities if interventions to increase use among at-risk populations are not considered, such as elderly individuals, persons with a disability, unstably housed individuals, individuals with limited English proficiency, or those with inconsistent access to digital health tools. The Center was created to proactively mitigate these potential disparities, with four overarching goals to direct the Center's activities:

- To develop and maintain a living library of resources for community-based partners, community members, and staff to access, refer to, attend, and disseminate, related to technology and device access (enrollments in device programs, community and research partnerships for devices), broadband access (reliable and affordable internet programs, community-based WiFi opportunities), and digital health literacy workshops, trainings, and enrollments.
- To improve digital health equity through the development and provision of quarterly professional development opportunities to promote a digital health workforce, based on focus group feedback and identified skills needed to develop digital health literacy and technology supporting programs in the community.
- To increase access to health care through collaboration with community-based organizations to assist individuals to access virtual visits where they live and work.
- To partner with community leaders, stakeholders, and local organizations/government to assess the current landscape, develop partnerships, share best practices, and advocate for sustainable virtual health care models.

CARE Tech operates out of the Family Health Centers at NYU Langone in Sunset Park, Brooklyn.

Progress and Impact

The initial development of CARE Tech was supported by the HHS - Health Resource and Service Administration (HRSA) Optimizing Virtual Care Grant awarded to the Family Health Centers at NYU Langone in March 2022. In February 2024, CARE Tech was added to the Community Service Plan to support its sustainability, recognizing the expanding role of telehealth and digital health resources in the provision of health services. CARE Tech was formally launched on February 1, 2024 at a Digital Health Equity event hosted for community members, with the participation of 11 community-based organizations, 2 health insurance organizations, local politicians, and 17 FHC and NYU Langone departments. Following this, CARE Tech established partnerships with various community-based organizations including the Chinese-American Planning Council, Fifth Avenue Committee, Mixteca, and Raising Health and initiated the development of a living library of digital health resources for FHC clinicians and community-based partners to access and disseminate to community members and patients.

Plans

CARE Tech intends to complete the following five objectives over the next three-year period:

- By January 2025, build a network of staff from at least 10 healthcare, community-based, health insurance, and governmental organizations dedicated to advancing digital health equity. Hold bi-monthly meetings with this group to discuss the current digital health landscape, develop partnerships, share best telehealth or digital health practices, and advocate for sustainable models for virtual health care delivery.

- By June 2025, develop a quarterly evaluation plans and framework rooted in health equity for tracking virtual health care utilization among FHC patients, enrollment in digital health professional development sessions, and attendance at digital health events and remote patients monitoring pop-up sessions.

- By June 2025, create a centralized digital library with at least 30 resources related to telehealth and telemedicine, mobile health, device and broadband access, digital literacy, and research and innovation in the digital health space. Ensure quarterly updates to this library and that 10 community-based partners and/or clinicians regularly access, refer to, and disseminate these resources.

- Starting in July 2025, organize four professional development sessions per year for clinical staff and Brooklyn-based community partners, aimed at increasing digital health skills. Each session will train at least 15 participants, with a goal of having 50% of trainees apply new skills to run digital literacy workshops or classes in settings like schools, faith-based communities, and libraries.

- By the end of 2027, increase access to virtual care by supporting the dissemination of at least 100 remote patient monitoring devices to community members in Flatbush, Red Hook, and Sunset Park, Brooklyn. Partner with 5 community-based organizations to provide client-facing telemedicine navigation training, aiming to have at least 50% of clients who attend trainings schedule a virtual visit with their provider within 3 months of the training.

Project implementation will occur in three phases over three years.

- The first phase (Months 1-6) will be a planning period in which project leadership will refine priority areas for the Center, begin development of a living library of digital health resources, conduct initial meetings with CBO partners to detail project goals and expectations, and conduct meetings to develop the evaluation plan.

- The second phase (Months 7-18) will begin with the launch of a Digital Health Resource Center and a kick-off symposium with Digital Health Equity Consortium member organizations to define consortium priority areas and build internal buy-in for the development of new virtual health and remote patients monitoring initiatives and research projects that are available in multiple languages, designed for low health literacy, and culturally adapted to the communities we serve. During this phase the Digital Health Equity Consortium will create and establish quarterly professional development opportunities for staff at health centers and community-based partners to promote a digital health workforce.

- The final phase (Months 19-36) will include rigorous evaluation and continuous quality improvement efforts, the dissemination of project findings, and the development of sustainability and replication strategies.

E. Education Access and Quality: Programs, Progress and Plans

1. ParentCorps

Low-income children experience steep inequalities – in academic achievement, mental health concerns, graduation rates, and more. One reason these inequalities persist is that pre-K programs, especially those in disinvested neighborhoods, lack the resources to create an optimal learning environment. Educators often report that they need more support to provide the kind of high quality, family-centered pre-K experience that sets the stage for children's long-term school success and well-being.

ParentCorps is an enhancement to pre-K programs that targets this gap. In partnership with educators, ParentCorps works to support an educational experience that engages parents as partners, and supports children's social-emotional well-being — to help unlock the full promise of early childhood education. ParentCorps offers close support for pre-K programs to implement three components:

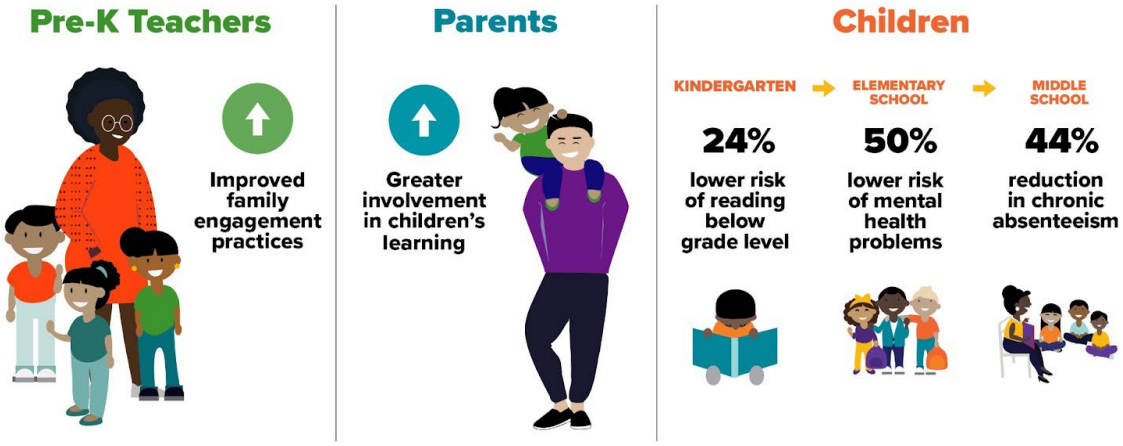
- Professional Development: Group-based experiential training and one-on-one coaching for pre-K school staff**.** Professional Development is designed to support school staff to form strong, culturally responsive relationships with families and promote children's social-emotional well-being. School staff engage in authentic dialogue — examining their beliefs, reflecting on the challenges families face, and learning the science of early childhood development — to build capacity to engage with children and families in new ways.

- Parenting Program: Group-based program for all families as part of the pre-K experience**.** The Parenting Program is designed to support families to promote children's early learning and development. In a culturally affirming environment, parents connect, share experiences, and

explore evidence-based ways to promote children's development – with a focus on honoring families' autonomy, culture, and expertise.

- Friends School**:** Classroom-based social-emotional learning program for pre-K children. Friends School is based on the wealth of evidence that young children's social-emotional learning is a critical foundation for school success and lifelong health. Children learn to communicate their thoughts and feelings, develop a positive sense of self, build healthy relationships — and have fun!

Randomized controlled trials conducted by NYU faculty (2005-present) with more than 1,200 children in low-income neighborhoods in NYC (see Appendix E) show that ParentCorps leads to meaningful, sustained impacts on children's academic achievement, mental health, and physical health, including a 24% reduction in reading below grade level in kindergarten, 50% reduction in mental health problems, and 50% reduction in obesity, through second grade; and a 44% reduction in chronic absenteeism, through sixth grade. In a cost-effectiveness analysis, ParentCorps was found to have a 4:1 return on investment over and above the well-documented benefits of pre-K. By working to transform children's learning environments early in life, when it matters most, ParentCorps represents a powerful vehicle to mitigate entrenched inequalities.



Progress and Impact

ParentCorps programming in Sunset Park is jointly funded by the Community Service Plan and philanthropic grants. ParentCorps' reach in the Sunset Park community has increased substantially from 650 children in the 2022-23 school year to 2,275 in 2023-24, and is projected to increase further in 2024-25.

ParentCorps' work in Sunset Park has benefited from numerous collaborations that have supported increased reach to families and children, including partnership with district schools, New York City Early Education Centers (NYCEECs), Family Health Centers, and the Together Growing Strong (TGS) CARE team, who provide community resources and programming to the Sunset Park community.

Below, we outlined adaptations, learnings and achievements by programs scaled in Sunset Park:

Community Advisory Board

ParentCorps began the 2022-23 school year partnering with nine district schools and NYCEECs as part of a Community Advisory Board (CAB). CAB meetings provided a monthly space for site leaders to come together for mutual support, resource sharing, and relationship building, and allowed the ParentCorps team to better understand the needs of Sunset Park sites and families. Meetings provided opportunities for support of ParentCorps implementation, cross-site collaboration to offer joint programming for families and troubleshooting of logistical barriers to programming. Additionally, CAB meetings provided space for leaders to discuss shared challenges, such as issues related to mental health and family engagement.

Over time, the CAB evolved to a new phase and was renamed the Community Integration Team (CIT). CIT served as a collaborative space for six family-facing staff to support one another, learn from each other, and discuss important topics related to family engagement, mental health support for families, and ParentCorps implementation. Shifting the group makeup to staff who work directly with families allowed the ParentCorps team to further understand site needs from a different perspective, and begin to address consistent barriers to implementation, including limitations in site capacity and resources.

Parenting Program

Over the past three years, ParentCorps has offered both virtual and in-person Parenting Programs in the Sunset Park community, increasing reach to new sites and families each year. Seeing the success of cross-site collaboration where one site hosted a Parenting Program and invited families from another site, as well as the strong attendance and impact of virtual Parenting Program for families from multiple sites, ParentCorps piloted a new "community hub" model in the spring of 2024. In this model, an elementary school hosted an in-person Parenting Program and invited families from both their school and from neighboring pre-K programs focusing on students who would likely feed into that elementary school for kindergarten. This new hub model provided an opportunity to consolidate limited resources while expanding reach in the Sunset Park community and aimed to bridge the gap between pre-K and kindergarten (frequently named as a concern by both parents and teachers).

Expanding ParentCorps reach to families through the hub model has also led to engagement with new sites. Initially, ParentCorps was working with only two of the 11 pre-K centers in District 20. Because the community hub model increased capacity, all 11 centers were able to invite families to Parenting Program. In total, families from 14 new sites (neighboring pre-K programs and all District 20 Pre-K centers), as well as families from the long-term sites, will be invited to the community hub Parenting Program offered virtually this year.

Because of ParentCorps' deep relationship-building with sites, opportunities to collaborate with other community organizations have organically emerged. A continued challenge is the capacity to offer the Parenting Program in multiple languages and at different times of the day, so that it is truly accessible to families. Building on the strong partnership between one of the veteran sites and the Chinese American Planning Council (CPC), the CPC after-school staff will now provide childcare while caregivers attend an evening Parenting Program.

To address the need for more site-based mental health professionals in the community, ParentCorps has provided outside facilitators for Parenting Program. Given the need for facilitators who spoke Spanish and Mandarin Chinese, ParentCorps trained bilingual part-time consultants, TGS CARE staff, and Family Health Centers staff.

One quote from a Chinese American parent attests to the impact of our program:

育儿小组让我学习到了很多新的育儿知识，也让我改变了很多在育儿中的一些不好的习惯，即使一些育儿知识没办法很好的应用起来，但是至少让我了解到了孩子的一些行为并不是无解的，并不是他在无理取闹，而是每一个情绪的背后都是有原因存在的，让我能更理解孩子们的一些行为是合理性的，减少了很多在育儿路上的焦虑 (The parenting group taught me a lot of new parenting knowledge and skills. It also helped me change many bad habits in parenting. Even if some parenting skills are not able to be put into practice well, it, at least, helped me to understand further about my children's behaviors; my children were not making trouble for no reason, but there are reasons behind every emotion. It allows me to better understand that some of the children's behaviors make sense, which reduced a lot of parenting anxiety for me.)

Building capacity for facilitation has led to numerous positive outcomes in family engagement. One of the Spanish-speaking consultants identified to facilitate was a Sunset Park parent. This consultant's close ties with the community made her an especially strong facilitator who connected deeply with families. At one veteran site, school leadership aimed to support the growth and development of their family worker, and therefore allocated her time to participate in training and coaching to co-facilitate the Parenting Program. This family worker brought new creative ideas and activities to her facilitation that deeply connected and resonated with the families who attended. The experience of facilitating the program empowered her to incorporate new family engagement strategies into her daily interactions with families.

<u>Friends School</u>:

Across the past 3 years, ParentCorps has worked with 13 pre-K classrooms through adapted child-centered activities, teacher coaching, or implementing the full Friends School program with high fidelity. This has included:

- Classroom activities focused on identifying and navigating feelings, skills identified by teachers as a central issue for children demonstrating anxiety in the wake of the pandemic.
- Using elements of Friends School with children who were already identified for supplemental social-emotional instruction.
- Group coaching for pre-K teachers and teaching assistants, where staff were able to reflect on and collaborate about topics such as centering social-emotional learning, understanding their role in supporting positive identity development, and increasing mindfulness in the classroom.

In addition, ParentCorps supported one Sunset Park site to implement Friends School in all four pre-K classrooms over the past three years. In the 2023-24 school year, their teaching staff received training and coaching to deliver Friends School with additional focus on community and child voice.

Professional Development:

ParentCorps Professional Development has been offered to site leaders, teaching staff, and mental health professionals at the nine sites to promote the use of evidence-based family engagement and social-emotional learning strategies. We also provided foundational Professional Development and 3-day Parenting Program training for staff from the Family Health Centers at NYU Langone and the TGS CARE team. Five members of the TGS CARE went on to co-facilitate Parenting Program in the 2023-2024 school year.

ParentCorps Tools:

Across the past three years, all staff who are offering programming have access to ParentCorps tools and resources through our online digital platform. Families who attend ParentCorps' Parenting Program also have access to a separate caregiver portal where they can download tools and materials connected to each of the session topics. The community at large can access free digital tools and materials on the ParentCorps website to promote children's social emotional learning.

Additionally, ParentCorps and the FHC are working together to explore ways to expand ParentCorps' reach in new settings. This has led to distribution of the ParentCorps Play Mat to Family Child Care (FCC) and Family, Friends, and Neighbor (FFN) providers. Over 200 ParentCorps Play Mats were delivered to these providers, who in turn distributed them to families of children in their care. The ParentCorps Play Mat was designed as a tool to support 3-year-olds in learning about their feelings. ParentCorps introduced the play mat to providers in workshops (in both Spanish and Mandarin Chinese) that conveyed the purpose and benefits of the tool, and how it can be used in the child care setting and at home. We also created materials to support families in using the play mat at home with their children (how-to videos and one-pagers in both languages).

Plans

Over the next three years, ParentCorps will continue to strengthen the community model for the Parenting Program in order to reach families served in all early care and education settings, including district schools, NYCEECs, community-based organizations, family child care settings, and friends/family/neighbor care.

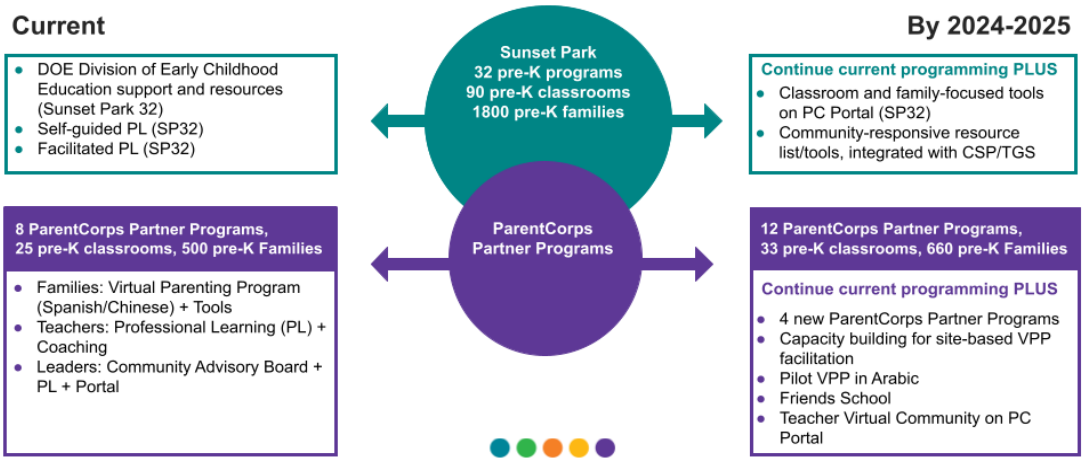
ParentCorps will continue partnering with the TGS CARE team to bolster outreach and recruitment efforts, to embed the Parenting Program as part of TGS CARE offerings, and to solidify a co-facilitation model to be able to consistently offer programming in the languages, formats, and times that are responsive to Sunset Park families. ParentCorps will also offer in-person Parenting Program in three of the nine long-term sites in languages spoken by families. Virtual Parenting Programs (in English, Spanish and Mandarin Chinese) will be offered more widely across the community to approximately 200 FCC and FFN families, 1000 TGS CARE families, and all families from the nine veteran sites and 14 new sites – a total of about 3475 families.

ParentCorps will continue to offer Friends School in one site with 4 pre-K classrooms, with ongoing coaching for the implementing teachers. ParentCorps will explore opportunities to expand Friends school to additional sites if interest arises.

ParentCorps will offer Professional Development to all new sites and FCC and FFN providers. ParentCorps will collaborate with leaders to best understand their current needs for professional development and provide support accordingly (e.g., >50% of teachers are new this year in some sites). ParentCorps will also explore opportunities to build sustainable, system-level partnerships with school districts in Sunset Park.

Based on the strong interest from FCC and FFN providers, ParentCorps will continue to support the use of social emotional learning tools and resources in their setting. ParentCorps will provide an additional workshop in two languages (Spanish and Mandarin Chinese) with the purpose of deepening the integration of the play mat into care settings and to support providers in promoting the community Parenting Program to their families.

Illustration of ParentCorps in Sunset Park 3-year Plan



2. Project SAFE

Project SAFE prevents unintended pregnancy and the spread of sexually transmitted infections (STIs) and HIV/AIDS through evidence-based interventions within a youth development framework that builds upon the existing strengths of young people. Project SAFE has been providing teen leadership, culturally appropriate sexual health information and services, and HIV peer education programming at the Project Reach Youth (PRY) site in Brooklyn since 1989. The program provides youth ages 11 to 24 with the support and opportunities to avoid risky behaviors and to develop to their full potential and become agents of change in their communities.

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

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

Progress and Impact

Multi-Session Workshop Series:

Project SAFE works with partners to provide pregnancy prevention workshops to youth in underserved communities in Brooklyn, including Sunset Park. The program utilizes evidence-based sexual health curricula that has been shown to increase knowledge and eliminate or reduce risky sexual behaviors – *Making Proud Choices* and *Making a Difference.* Topics covered during both of the eight-session workshop series include pregnancy and STI/HIV prevention, as well as confidence, pride, and respect-building activities. Since September 2022, Project SAFE has facilitated 66 cycles of *Making Proud Choices* and 13 cycles of *Making a Difference*, reaching a total of 1,833 youth in 18 high schools, middle schools, community-based organizations, and high school equivalency programs. New partnerships developed since September 2022 include Life Academy High School (for newcomers), Bushwick Community High School, Gotham Collaborative High School, Hunter College Campus High School, M.S. 51, Coalition for Hispanic Family Services (CBO), Fiver (CBO), I.S. 136 Charles O. Dewey, and Sunset Park Prep Middle School.

Program evaluations of workshops have shown that, because of the workshops, most participants know more about how to protect themselves from pregnancy or STIs and are more likely to practice safer sex or abstain from sex (93% and 81% respectively, as reported on a post workshop survey). Ninety-five percent of participants indicated they would recommend the workshops to a friend.

Peer Education Groups:

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

- *Theater:* Peer educators create and perform pieces that explore issues of safer sex, gender, culture, identity, and HIV/AIDS prevention using movement, poetry, and drama;
- *Media, Outreach and Branding:* Peer educators use social media, such as Instagram, Snapchat, Facebook, and YouTube, to reach high-risk youth and provide sexual health education;

- *Ambassadors:* Youth are trained to facilitate sexual health workshops for their peers at schools and community events; and
- *Social Activism:* Participants select a reproductive justice issue and, with the guidance of a facilitator, initiate a project (such as a workshop or social media campaign) to address the issue.

Since September 2022, Project SAFE has recruited and trained 92 Peers Educators. During this period, participating Peer Educators demonstrated increases in frequency of condom use (49 %), HIV knowledge (96%), and self-efficacy (78%). Seventy-five percent showed a gain in at least one of these areas.

Community Events and Single-Session Workshops:

Throughout the program year, peer educators and Project SAFE staff work collaboratively to organize community events to promote teen sexual health. The events typically include performances from the arts-based groups and an open mic session in which guests and community members can perform. Community events also offer on-site HIV testing and promote teen health services available through Project SAFE and other community organizations.

Since September 2022, Project SAFE has hosted or performed at 56 community events, reaching 1,094 youth. The events consistently received overwhelmingly positive feedback with 97% of participants rating their experience of the events as excellent or good. Additionally, 91% indicated that they would recommend Project SAFE events to a friend and 79% said they were likely to utilize an FHC Project SAFE Teen Clinic in the future.

Project SAFE has expanded to include a health education internship, funded by a new grant from the NYS AIDS Institute, training eight peer educators ages 18-24 to co-facilitate workshops and community events. The internship offers professional development opportunities and continued involvement after aging out of the core program.

Project SAFE also offers single-session peer-led sexual health workshops at community youth service organizations, after-school programs, and at community events. Since September 2022, we have reached 443 young people through 26 single-session sexual health workshops.

Teen Health Clinic:

Project SAFE partners with FHC's Park Slope Family Health Center to operate aTeen Health Clinic that provide young people with a health care experience tailored to their needs. The Project SAFE Teen Health Clinicoffers youth a non-judgmental, personal approach to sexual health, with a teens-only waiting room and a staff, including Project SAFE staff and peer educators, who are trained to use an empowering, strengths-based approach. The clinics address the barriers youth experience in accessing sexual health services such as stigmatization, fear of parental disapproval, and lack of access to confidential health coverage. Since September 2022, 933 teens received STI testing and other services at the Teen Health Clinic; over 2,000 teens were screened for pre- and post- HIV exposure prevention needs (PEP and PrEP) at the Teen Health Clinic, workshops, and community events.

Project SAFE continues to offer at-home HIV testing through a partnership with the New York City Department of Health and Mental Hygiene. Interested youth can call or text a Project SAFE health educator to request a test, which is then mailed to the client's home in confidential packaging with

pre- and post-test counseling provided over the phone. More recently, as the demand for virtual services has decreased since 2021, we are distributing the home testing kits at community events.

Workshops for People working with Young People and Parents:

Talking with young people about sex can be challenging for parents and staff that work with adolescents. Project SAFE provides workshops and other support to youth organizations and parents to make these conversations easier. The *Let's Talk about Sex* workshop covers basic principles of Motivational Interviewing, tips for starting the conversation, and making referrals to sexual health services. Since September 2022, seven workshops have been provided to 152 people working with youth and parents at partner schools and CBOs.

Plans

Over the next three years, Project SAFE will reach over 5,000 teens. Project SAFE plans to work with high schools connected to the Family Health Centers at NYU Langone school-based health center sites, other schools and organizations, and continue to expand our program reach to middle school students as well, reaching an anticipated 2,250 youth at high risk for HIV and/or unplanned pregnancy through 90 evidence-based workshop series cycles. Schools and community-based organizations will be selected based on whether they serve communities that have higher than average rates of teen pregnancy, teen births, or HIV. If data are available, factors such as history of unprotected sex would also be considered. Our collaborative model requires that partners commit to ensuring access to adolescents for all sessions of evidence-based intervention workshops.

Here's what teens said about Project SAFE programs:

"I stay involved in PRYSAFE because of the community within it. The people I've met are some of the most caring and understanding…they helped me find a community that I care about."

"I want to stay involved in Project Safe because I want to learn more about sexual health so I can have more knowledge on it and so I can also stay healthy myself."

- Peer educators and staff will facilitate 36 single-session workshops, reaching an anticipated 540 teen participants.
- Teens will host or perform at 18 community events over the next three years, reaching approximately 720 of their peers with core pregnancy, STI, and HIV/AIDS prevention and resource messages.
- One hundred and fifty-two new teens will move from the Teen Health Council to advanced peer education groups.

- The program will reach 102 people working with youth and parents through 18 single-session workshops.

To support protective factors against HIV such as educational achievement, Project SAFE will establish biannual college and career panels for peer educators. Panelists will include Project SAFE alumni with varied academic and professional backgrounds. The events will be designed to provide youth with insight into the details of each field and help students to envision their future as college students and professionals. Project SAFE staff will also facilitate an additional six college preparation workshops for junior and senior participants annually.

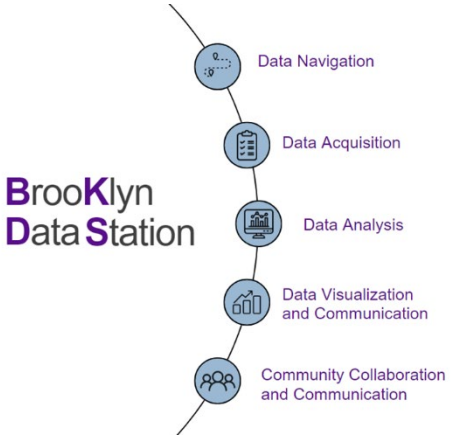
In addition to our existing programs, Project SAFE will expand to include a health education internship program, training eight youth aged 18-24 each year to co-facilitate EBP workshops alongside staff and assist with planning and hosting community events. This effective approach enhances relatability and impact as interns are close in age to the target population of teens and are recruited from the same communities. As a youth development program, Project SAFE recognizes the importance of creating further opportunities for growth for peer educators. This internship not only provides additional paths for professional development but also a pathway for peer educators to continue their involvement as they age out of the core program.

Finally, screenings will remain a core part of the program. Through Project SAFE workshops, community events, and the Teen Health Clinic, 400 teens will receive HIV screenings and 2,100 teens will receive PrEP and PEP screenings; Teens will continue to meet with a health educator for support and counseling and be connected to appropriate community resources and services. Building on efforts to provide comprehensive HIV prevention services, Project SAFE will begin to administer substance use screenings in order to expand the risk reduction scope of its services.

F. Measure and Enhance Population Health and Support Local Collaboration-Building

1. Brooklyn Data Station

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



Progress

The vision of the Brooklyn Data Station is to provide infrastructure to support users to turn data into action.

BKDS provides a suite of services to meet user needs across the data spectrum – from finding and acquiring data, to analyzing and visualizing data and communicating findings. BKDS also supports collaborations and knowledge sharing by leading a Data Analyst Working Group and participating in WebEx Communities facilitated by the Population Health Data Hub.

Since September 2022, the Brooklyn Data Station has increased its capacity to support partners through hiring two full-time clinical Data Analysts. In January 2023 BKDS began to more systematically track requests for data services and as of Aug 31, 2024 had received 57 requests ranging for short-term consultations to longer-term data analysis and communication support.

Select highlights of the work done since September 2022 are:

Data Navigation:

- Held conversations with users and incorporated their feedback to re-design and expand a Sharepoint Intranet site for NYULH faculty and staff. This site contains curated links to external sources of data and reports with a focus on local data for New York City and New York State, resources geared to data analysts, and resources to support data visualizations. Select pages are available in pdf format and made accessible to external members of the Coordinating Council of the CSP through OneDrive. Since its launch in March 2023 through August 2024, this site has had 280 unique visitors and over 2,600 site visits.

Data Acquisition:

- Work with NYULH legal office to amend a Data Use Agreement with the NYC Dept of Health and Mental Hygiene (DOHMH) to acquire restricted-use datasets from the Community Health Survey.

- Work with Family Health Centers and DataCore to write queries to extract electronic health records data to describe clinical health outcomes of patients using the Federally Qualified Health Center.

- Work with Family Health Centers and early childhood programs in Sunset Park to develop REDCap projects for primary data collection in two different languages (English and Spanish).

Data Analysis:

- Work with early childhood initiatives in Sunset Park to analyze data from several projects related to maternal mental health, school faculty perspectives on challenges and opportunities teaching in remote and hybrid settings, and pediatric health care provider and parent/caregiver perspectives of early childhood learning.

- Work with Family Health Centers to analyze data related to social determinants of health screening and referrals.

- Work with Health x Housing Lab to analyze and summarize data to describe the impact of a one-time conditional cash transfer to low-income individuals who contracted COVID-19 or were in quarantine after a known exposure to COVID-19.

- Work with Tobacco Free Community to analyze and summarize data from the Asian Nicotine Replacement Survey.

- Work with Community Service Plan team to summarize demographic, socio-economic and health related data for use in Community Health Needs and Assets Assessments for current neighborhoods of focus (Sunset Park, Red Hook, Lower East Side/Chinatown, Hempstead), and planned neighborhoods of focus (Uniondale, Roosevelt, Shirely, Mastic, and Mastic Beach).

Data Visualization and Communication:

- Work with NYU the Center for the Study of Asian American Health and community partners to create a one-page summary document of findings from the Brooklyn Arab American Needs Assessment, post copies in English and Arabic on NYULH CSP website, and print and distribute over 4,500 copies to community partners.

- Work with Beyond Bridges and the CHW-RRC to develop a summary of the existing Community Health Workers landscape.

- Work with Family Health Centers to develop and maintain Tableau dashboards to summarize social determinants of health screening and referrals.

- Work with Community Service Plan team and community-partners to create a community-facing report specific to the community health needs and assets for Hempstead and a one-page document in English and Spanish summarizing the findings to share back and distribute to community organizations.

Community Collaborations and Communication:

- Work with Together Growing Strong to develop and maintain a user-centered digital platform, The SPACE, that allows for community organizations and community members to find information about resources and events in the Sunset Park area. (See Section I.G.)

Plans

BKDS will continue to be a resource for data services to all existing CSP programs and will provide support as new programs are planned and developed in conjunction with planned growth of NYU Langone's service area.

Using community-engaged approaches, BKDS will understand needs for data products to promote communication of data findings and information in ways that are accessible and useful to community partners.

BKDS will continue to collaborate on research and quality improvement projects related to women's health and social determinants of health.

2. CSP Communications Network

Officially launched in early 2023, the Communications Network is a space for peer-knowledge sharing for programs within the CSP and community-based partners. Birthed out of a need to maintain and build connections during the COVID-19 pandemic, this group has evolved into an infrastructure that supports community engagement through innovative and adaptable communication strategies.

Through the dissemination of a quarterly newsletter, the Communications Network engages CSP community partners, staff and faculty from the Department of Population Health, providers from the NYU Brooklyn based FHCs, staff from NYU Long Island. Most recently, the Communications Network hosted its first Digital Dialogue – a series open to community partners, faculty and staff, dedicated to the strategies and tools we use to enhance community engagement.

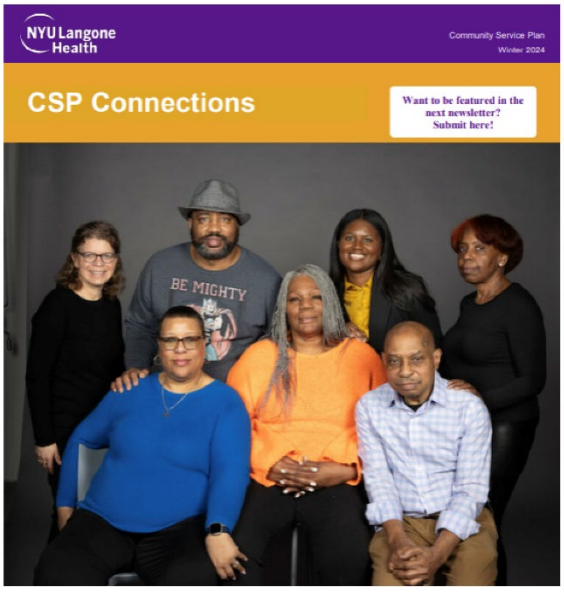
Progress and Impact

The vision of the Communications Network is to develop and implement effective communication strategies that enhance community engagement within the CSP catchment areas.

The Communications Network utilizes a shared learning model in its work. We embrace the expertise and interests that exist within the CSP to develop programming, products and services for our programs and partners.

Our primary goal is to support CSP programs in Sunset Park, Red Hook, Lower East Side/Chinatown and Hempstead and other emerging communities on Long Island. The Network also supports others who are interested in community engagement by consulting on newsletter development.

Our process is twofold: we want to strengthen the strategies and tools we already use while also finding innovative and adaptable ways to foster bi-directional communication with our community members.



Select highlights of our work since January 2023 are:

Digital products:

- Newsletter: Develop and maintain *CSP Connections*, a quarterly newsletter with 4 editions produced to date, an email list of 182 individuals and an average open rate nearing 60%.

- Directory: Develop and maintain CSP directory to strengthen communication among CSP programs and partners

Peer knowledge sharing:

- Digital Dialogue: Launch Digital Dialogue, a series dedicated to the strategies and tools we use to enhance community engagement. The inaugural session, held in spring 2024, focused on the topic "Interviewing Strategies: Tips and tricks to collect feedback and gain insights from clients, product users and focus groups" with people in attendance from community-based organizations, staff and faculty from DPH and Brooklyn FHCs.

- Monthly meetings: Develop and maintain a space for CSP programs to share knowledge and contribute to ideas for enhancing communication efforts.

Plans

Over the next three years, the Communications Network (CN) plans to focus on three areas:

01 Knowledge Sharing

With feedback from our Coordinating Council members, we plan to discuss Artificial Intelligence (AI) and its potential utilization in community engaged work during the fall 2024 Digital Dialogue series.

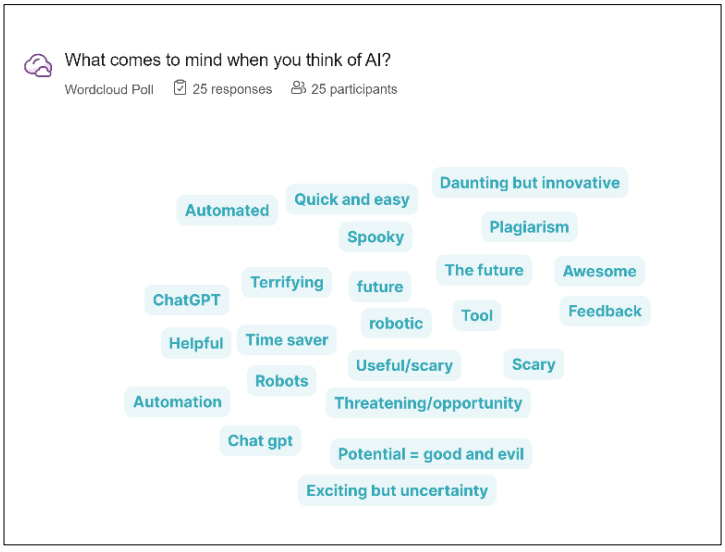
02 Best Practice Documents

The Communications Network will also create guides, tip sheets and documentation that will be accessible to all CSP members.

03 Policy & Advocacy

The CN plans to develop a central tracking system for policy topics of interest and efforts that are occurring within the CSP. The CN can increase the CSP's capacity to advocate for issues and align efforts with larger NYULH institutional goals.

The Communications Network plans to continue knowledge sharing through its Digital Dialogue series. The topics are selected based on interests and expertise of the members of the CSP.



Based on conversation with CSP programs, we recognize there is an interest to learn more about the potential use of AI in our work. Digital Dialogue provides the CSP the unique opportunity to learn new tools and strategies alongside our colleagues. We are in the process of developing sessions on sub-topics such as: the use of AI in research, utilization of AI within the context of a CBO, and general information about AI during fall 2024.

The Communications Network will finalize our newsletter guide and disseminate within the CSP. In the future, we hope to develop additional guides, tip sheets and best practice documents that can be accessible to our programs and other colleagues doing community engaged work.

Over the next three years, the Communications Network plans to strengthen relationships with colleagues who do community engaged work, as well as community partners in NYULH's growing landscape, and enhance our support of communication strategies with the communities with which we work.

III. Dissemination

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

Hard copies of the Community Health Needs and Assets Assessment, Community Service Plan and related documents are available without charge to anyone upon request and are regularly distributed to Community Board members, policymakers, local health centers, community-based organizations, community members, and other interested stakeholders. Through our outreach and engagement activities, we continually seek to keep the community informed about our activities and to get feedback and input. For example, this year, we presented and widely distributed the findings from the Arab American survey. The Needs and Assets Assessment for Hempstead, which was developed collaboratively with community partners, has been widely distributed and reviewed by organizations and residents throughout the community.

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

In addition, information about the Community Service Plan has been presented at conferences and in presentations to Primary Care Residents, medical students and undergraduate students, often in collaboration with community partners. We plan to conduct similar internal and external presentations for the 2025-2027 CHNAA/CSP. Many of our projects have developed strategies for disseminating information and providing training and outreach.

IV. Engaging Community and Addressing Health Disparities

The Community Service Plan Coordinating Council, composed of NYU Langone Health faculty and staff from across the institution, leadership and staff of our community partners, and other interested partners and policymakers, continues to meet quarterly. The Council coordinates Community Service Plan projects, ensuring that they are meeting milestones, maximizing their impact, and fostering

collaboration across institutions and sectors. We continue to find opportunities to learn and to work across projects and with colleagues throughout the institution and in the community. We also use this forum to distribute information about the NYULH Financial Assistance Policy.

In its first year (2013), the Coordinating Council collaboratively developed a set of principles to guide the CSP partnerships. These were incorporated in the memoranda of understanding with partners and provided guidance about information sharing, compensation of partners and community members, and responsibility for dissemination of findings.

In 2019, the Council revisited and strengthened these community-based participatory principles and then used those principles as a foundation for bringing a more direct and intentional focus on ensuring equal access and health for all. In 2020, the Council adopted a set of "guiding principles."

Over the course of the past five years, each CSP project has selected one or more of these principles as a focus for self-assessment and implementation.

CSP initiatives have **fostered deeper participation by community partners and residents**, in hiring and including and compensating community-based organizations and people with lived experience as program leaders, on advisory committees, and as speakers and moderators.

For example:

- To ensure that the partnership is building trust, enhancing capacity and engaging its partners, the Tobacco Free Community Initiative developed a Partner Support Team, which worked together to create the Asian and Immigrant Communities Against Smoking mission and vision statements and outreach materials. The group also developed and administered a self-assessment survey to reflect on, evaluate, and strengthen collaborative processes and collectively identify the priorities of community partners.

- The Center for Community-Oriented Virtual Primary Care and Technology (CARE Tech) is building a Digital Health Equity Consortium of healthcare, community-based, health insurance, and governmental organizations to meet bi-monthly to discuss the current landscape, develop partnerships, share best practices in digital health, and provide expertise and advice on community needs and assets.

- The Health x Housing Lab Advisory Committee includes five members with lived experience of homelessness. All Lab events feature speakers who have experienced homelessness or housing insecurity, recognizing their significant expertise. The Lab's "Flipping the Script" events explicitly aim to challenge traditional paradigms of who we think of as experts and teachers in medical education, positioning patients with lived experience of homelessness themselves as the expert teachers. In 2023, The Health x Housing Lab launched a Speakers Bureau and Peer Network with an inaugural cohort of ten members who have navigated homelessness or housing insecurity.

- In all hiring decisions, ParentChild+ has incorporated community voice, including current and former families. The program has also implemented a Community Ambassador program as a pathway for

program graduates to provide education and support for other community parents regarding early childhood development and language- and literacy skill-building.

- The Community Health Worker Research and Resource Center (CHW-RRC) collaborates closely with the CHW Learning Committee, a group of CHWs who help lead programming decisions. Committee members meet monthly and receive quarterly gift cards in recognition of their contributions. During the 2nd Annual CHW Awareness Week, the CHW-RRC held the inaugural NYULH CHW and CHW Supervisor Awards, honoring and celebrating the dedication of CHWs and their supervisors. The Center also leverages community strengths by involving CHWs as webinar moderators, providing them with opportunities to represent their fellow CHWs, develop public speaking skills, and lead discussions. Additionally, the CHW-RRC sponsors CHWs to attend national conferences, supporting their growth and sense of professional identity, and encouraging them to share knowledge with their peers and across the healthcare field.

- REACH FAR's outreach and education is led by CHWs, who, as members of the affected communities, have been able to reach community members with accurate information by engaging trusted leaders, and moderating and translating at community events.

- Project SAFE peer educators participate in interviews of all new staff hires and are involved in the development, dissemination, and review of program evaluation tools. Annual "Data Dialogues" are used to share back and discuss program implementation and outcome data to teens, staff, and other program stakeholders. These dialogues serve to inform continuous program improvement and adaptation. Notably, Project SAFE staff and youth developed their own language for describing community engagement to make the principles more youth-friendly, and program youth monitor how effectively the program adheres to the principles.

- PlayReadVIP actively works to ensure that processes for recruiting and hiring for positions and internships are as inclusive as possible. The initiative also works to ensure that staff have opportunities for mentorship, promotion, and career development, and that the work environment is supportive and inclusive.

- The Red Hook Community Health Network is committed to the integration of resident voice in all decision-making processes. This is approached by ensuring neighborhood residents and leaders are recruited and chosen to sit on workgroups, advisory committees, and other decision-making bodies. Residents are compensated for their time in the form of a monthly stipend and sign a community-member agreement form, which outlines participation expectations.

- The Health & Housing Consortium launched its Consumer Advisory Committee, composed of five members and co-led by an advocate with lived experience of homelessness and the Consortium's Director of Strategy and Engagement. The committee meets on a quarterly basis to guide the work, though the members expressed an interest in meeting more regularly so for the upcoming term, they will meet bimonthly. In March 2023, the Consortium merged its two borough-based Steering Committee into one Program and Policy Committee, which along with the Board of Directors added people with different experiences and identities into leadership roles.

- ParentCorps is deeply engaged with school principals, pre-K directors, school staff and teachers, creating an environment of mutual support around issues of social-emotional learning and family engagement. Sites collaborated to offer Parenting Programs in multiple formats and languages so that the program was truly accessible to their families. Parents have also played a major role in

shaping ParentCorps. In support of this work, ParentCorps collects data that provide multiple perspectives, including participant feedback surveys for all professional development and Parenting Program sessions.

- The primary focus of the Communications Network is to emphasize the expertise and knowledge of the communities we work with. The Network collaboratively creates materials that are accessible and adaptable for our programs and community partners. The Communications Network also features narratives from staff, who are integral to our community programming, in every edition of *CSP Connections*. By highlighting their work and the community members they work with, we are collaboratively defining community while learning from each other.

CSP initiatives have collaborated with partners in **building capacity, supporting sustainable efforts and developing an advocacy agenda.**

For example:

- The CHW-RRC has worked within NYULH to create tiered CHW job titles, providing clear career advancement while maintaining the community focus of the role. This ensures that CHWs are recognized, promoted, and compensated fairly. The CHW-RRC has worked to promote sustainable change by submitting policy recommendations to the Centers for Medicare and Medicaid Services and by participating in the National Association of Community Health Workers Advocacy Day in Washington, D.C. These efforts aim to secure long-term structural funding and support for CHWs within the healthcare system.

- The Health and Housing Consortium has played a strong role in supporting Medical Respite in New York and, since 2023, signed on to support more than 15 campaigns and has submitted six written testimonies and public comments on issues such as cash assistance, housing budgets, right to shelter, housing access for individuals leaving incarceration, zoning reform, and mental health crisis response. The Consortium also recently launched an Advocacy Spotlight series that offers partner organizations the opportunity to showcase their campaigns and to disseminate resources to support them.

In January 2025, the Coordinating Council reviewed the CSP engagement principles and began a process to update and refine them based on our years of experience in implementation. This process will continue over the next year.

V. Anticipated Impact and Performance Measures

The Coordinating Council will continue to oversee program implementation, work collaboratively to find points of synergy across programs, assess progress, and monitor and share insights about the implementation of the CSP Community Engagement Principles. In addition, each program collects data about levels of participation, participant satisfaction, and impact on health and well-being. This is done through attendance records, surveys, and other forms of data collection. Please see Appendix F for information about program outputs, outcomes and data sources.

Appendices

A. Reach and impact: September 2023 - August 2024
B. Data sources and references consulted
C. Input from persons who represent the broad interests of the community
D. Weather and health Effects
E. Evidence base for programs
F. Anticipated impact and performance measures

Appendix A

Community Service Plan

Reach and Impact: September 2023 - August 2024

NYU Langone Health

The **Community Service Plan (CSP)** supports programs to help meet the needs identified in communities near each of NYU Langone Health's hospitals. Leveraging the assets within these communities, Community Service Plan programs are developed to address needs and priorities identified by communities and tailored to provide services that are culturally relevant and in the languages spoken in the community. Community Service Plan programs also support healthcare, education, and social service workforce capacity locally and nationally through trainings, workshops, and digital resources.

17 programs

24 zip codes

59 locations

Locations for Community Service Plan programs providing direct program services, by New York State Prevention Agenda 2019-2024 focus areas

CSP programs provided services to:

33,000 individuals

18,000 families

CSP programs deliver services to support early childhood education, strengthen parent-child relationships, promote healthy eating, promote teen health, address food insecurity, connect people to social care, help people quit smoking, and promote exercise for older adults.

Some CSP programs are designed to offer repeat sessions with the same participants over weeks, months or years. Other CSP programs are designed to offer one time or limited sessions with each participant. All programs operate year-round to reach people.

CSP Programs Deliver Services
Where People Are

CSP programs deliver services in a variety of locations, including early childhood education centers, schools, places of worship, libraries, community centers, homes and apartment buildings, and health centers. Some locations are permanent and other locations rotate to offer services in more areas.

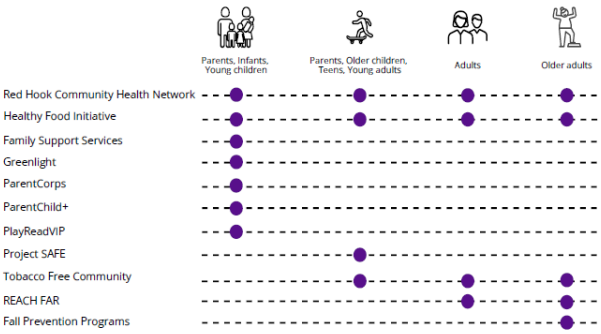
CSP Programs Deliver Services
In Multiple Languages

CSP programs deliver services in languages spoken by our community.

Services are offered in English, Spanish, Chinese, Bengali and Korean.

CSP Programs Support Individuals
Across the Lifespan

CSP programs promote well-being and foster social connection with activities that improve health across the lifespan.



CSP Programs Build Capacity

CSP programs support collaborations and workforce development through events, trainings, digital resources and newsletters geared towards community health workers, social service providers, early education providers, and health care providers.

10,000

Individuals sent **newsletters** with information about events, resources and research

150,000

Visits to **websites** and impressions from **social media**

88

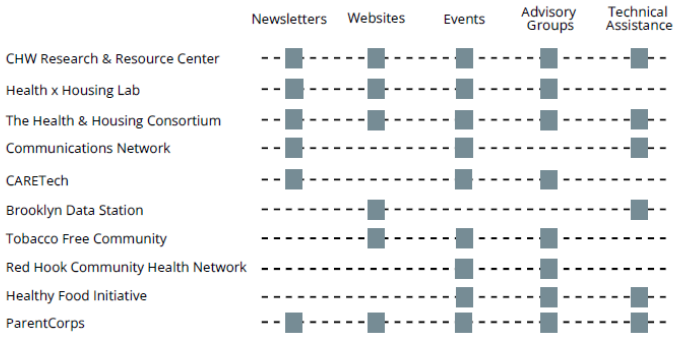
Trainings and events, including webinars and conferences, to share and build knowledge

63

Partner organizations serving local communities on advisory boards and coalitions

CSP Programs Foster Collaboration
Through Partnerships and Communications

CSP capacity building programs foster collaborations with community organizations and government agencies spanning multiple sectors including education, housing, healthcare and social services.



Fall Prevention Programs (L, S)

Evidence-based exercise programs to reduce the risk and fear of falling and increase physical activity levels among older adults.

Family Support Services (L, S)

An evidence-informed program that supports childhood health and development through family social needs screening and care coordination.

Greenlight (M, B, Q, S)

An evidence-based, literacy-sensitive, culturally adapted nutrition and lifestyle program to prevent early childhood obesity among children ages newborn to two years.

ParentChild+ (B, S)

A national evidence-based home visiting program that promotes early literacy, parenting, and school readiness by providing twice-weekly home visits to families with children between the ages of two and four.

PlayReadVIP (B, S)

An evidence-based parent education program that uses videotaping and developmentally appropriate toys, books, and resources to support parents in their child's early development and literacy.

Project SAFE (B, M, X, Q, S)

An evidence-based sexual health and youth empowerment program which aims to prevent unintended pregnancy and HIV/AIDS through a youth leadership and peer-education model.

REACH FAR (B, L, S)

A culturally-tailored, evidence-based program designed to prevent cardiovascular disease by increasing access to healthy foods and providing health coaching and messages.

Healthy Food Initiative (B, S, C)

An evidence-informed intervention to address food insecurity that includes emergency food assistance, screening and case management, community education, and community-wide food systems coalition.

ParentCorps (B, S, C)

An evidence-based, family-centered early childhood intervention designed for pre-K parents, educators, and children to improve child health, behavior, and learning.

Red Hook Community Health Network (B, S, C)

A network of community residents, community-based organizations, and health partners working to expand access to health and social services for Red Hook residents through a community health worker program and workgroups.

Tobacco Free Communities (M, S, C)

An array of programs that address high smoking rates among immigrant populations through smoking cessation programs, community-based partnerships, advocacy, outreach, and counseling.

Brooklyn Data Station (C)

A program that supports collaborations by providing analysis and technical support for needs assessments, program planning, evaluation, and data communication to improve population health.

Center for Community-Oriented Virtual Primary Care and Technology (CARETech) (C)

A collaborative network to increase access to virtual health care by improving digital health literacy and reaching patients in the communities where they live and work.

Communications Network (C)

A peer knowledge network that enhances community engagement through innovative and adaptable communication strategies.

Community Health Worker (CHW) Research & Resource Center (C)

A center that that serves as a hub for CHW-related knowledge and expertise to strengthen and support programs through training, professional development opportunities, technical assistance, research and advocacy.

The Health & Housing Consortium (C)

A collaborative network to improve health equity and housing stability through cross-sector partnerships, advocacy, and training of frontline workers.

Health x Housing Lab (C)

A center that builds the evidence base for initiatives, programs and policies and provides education to expand the reach of this evidence on health and housing.

Service Location:

M Manhattan · B Brooklyn · X The Bronx · Q Queens · L Long Island

Program Type:

S Service Delivery · C Capacity Building

Support for CSP programs is provided by NYU Langone Hospitals.
Many CSP programs receive additional funding through grants and philanthropic gifts.
Many programs operate in other locations not funded by CSP.

For more information about the CSP, contact
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Appendix B

Data Sources, References Consulted, and Methodology Notes

I. Secondary Data

American Community Survey - US Census Bureau

Demographic, housing, health insurance, and socioeconomic factors. Data obtained from:

- US Census Bureau (2018-2022)
- NYC Department of City Planning – Population Fact Finder (2018-2022)
- Census Reporter (2018-2022)

Census 2020 – US Census Bureau

Population and housing counts from decennial US Census. Data obtained from:

- US Census Bureau-- (2020)
- NYC Department of City Planning – Population Fact Finder (2020)

City Health Dashboard – NYU Langone Health

Social and health indicators for large cities. Data obtained from:

- City Health Dashboard

Community Health Survey – NYC Department of Health and Mental Hygiene

Health behaviors, health outcomes and access to care by race/ethnicity and select neighborhoods. Data obtained from:

- NYC Health Department – summary data provided to NYU Langone Health (2021-2022)

Indoor Environmental Complaints – NYC Department of Health and Mental Hygiene

Reports of indoor environmental air quality concerns reported to 311 and referred to DOHMH. Data obtained from:

- NYC Open Data: DOHMH Indoor Environmental Complaints

National Survey of Children's Health – Centers for Disease Control and Prevention

Children's health and development for New York State. Data obtained from:

- SHADAC analysis of National Survey of Children's Health public use files (2021-2022)

NYC Public Housing Residents – NYC Housing Authority

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

- NYC Housing Authority Official Map (2023)

NYS Opioid Data Dashboard – NYS Department of Health

Fatal and non-fatal opioid-related deaths and hospitalizations. Data obtained from:

- NYS Opioid Data Dashboard (2016-2022)

NYS Student Weight Explorer – NYS Department of Health

Public school student body weight status for NYS (excluding NYC). Data obtained from:

- NYS Student Weight Data Explorer (2021-2023)

Perinatal Data Profile – NYS Department of Health

Birth data from NYS Vital Statistics. Data obtained from:

- NYS Vital Statistics (2019-2021)

PLACES – Centers for Disease Control and Prevention

Health behaviors and outcomes. Data obtained from:

- CDC PLACES 2024 Data Release (2021-2022)

Rental Cost and Subsidies -- NYU Furman Center

Housing choice vouchers and rental subsidies. Data obtained from:

- NYU Furman Center – CoreData.nyc (2009-2022)
- NYU Furman Center – Neighborhood Indicators (2024 update)

SPARCS Hospitalization and Emergency Department Visits - NYS Department of Health

Potentially avoidable hospitalizations, asthma-related emergency department visits. Data obtained from:

- NYS Prevention Agenda Dashboard (2018-2021)

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

Teen birth and pregnancy rates. Data obtained from:

- NYC Health Department – Vital Statistics Summary (2012-2021)
- Citizens Committee for Children (2018-2020)

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III. Methodology Notes

Secondary data sources provide invaluable information about neighborhood health. However, neighborhood boundaries used in secondary data sources may not reflect the same boundaries used by community members. Further, neighborhood boundaries can differ between data sources.
In this report, the following neighborhood boundaries were used:

- Hempstead:
  - Census Designated Place, Hempstead Village (2020 boundaries)
  - Zip Code 11550
- Lower East Side/Chinatown:
  - New York City Department of City Planning, Community District Tabulation Area (CDTA), 2020 boundaries, for Manhattan CD 3
- Red Hook:
  - Brooklyn Census Tracts, 2020 boundaries: 53.01, 53.02, 53.03, 59, 85
- Sunset Park:
  - New York City Department of City Planning, Neighborhood Tabulation Area (NTA), 2020 boundaries, for Sunset Park West, Sunset Park Central, Sunset Park East/Borough Park West
  - Public Use Microdata Area (PUMA), 2020 boundaries, Community District Approximation, for Brooklyn CD 7
  - Zip Codes 11220, 11232
- Roosevelt:
  - Census Designated Place, Roosevelt (2020 boundaries)
  - Zip Code 11575
- Uniondale:
  - Census Designated Place, Uniondale (2020 boundaries)
  - Zip Code 11553
- Mastic:

    - Census Designated Place, Mastic (2020 boundaries)
    - Zip Code 11950
- Mastic Beach:
    - Census Designated Place, Mastic Beach (2020 boundaries)
    - Zip Code 11951
- Shirley:
    - Census Designated Place, Shirley (2020 boundaries)
    - Zip Code 11967

Appendix C

Input from persons who represent the broad interests of the community

Meetings with public health experts:

Agency	Dates
Airnyc	Multiple meetings and communication
Asian Smokers Quitline (ASQ)	Multiple meetings and communication
Bronx Health and Housing Consortium	Multiple meetings and communication from 2017 to present
Charles B. Wang Community Health Center	Multiple meetings and communication
Empire BlueCross BlueShield HealthPlus	Multiple meetings and communication
Enterprise Community Partners	Multiple meetings and communication
Greater New York Hospitals Association ・ Community Health Initiatives and Government Affairs	Multiple meetings and communication
Health + Hospitals ・ Test and Trace Corps ・ Office of Population Health, Safety Net Clinics at Bellevue and Woodhull	Multiple meetings and communication
Healthfirst/DOHMH Pediatric Bundle	Multiple meetings and communication
Maimonides Medical Center	Multiple meetings and communication from April 2017 to present
Nassau County Department of Health	Multiple meetings and communication
New York City Department of Health and Mental Hygiene ・ Division of Epidemiology/ Bureau of Epidemiology Services (data use agreements) ・ Division of Family and Child Health (KIDS Survey planning and results) ・ Tobacco Policy and Programs -Bureau of Chronic Disease Prevention	Multiple meetings and communication

Agency	Dates
• Bureau of Equitable Health Systems within the Division of Center for Health Equity and Wellness • Brooklyn Knows Steering Committee and Youth Subcommittee	
New York City Department of Health and Mental Hygiene – Brooklyn Community Action Team • El Puente • Peer Health Exchange • CAMBA • HEAT • THEO • North Brooklyn Prevention Coalition • New York City Teen Connection • Grand Street Settlement • Bedford YMCA • Bedford Stuyvesant Community Connections • Health Solutions • Center for Community Alternatives • The Healing center • United Community Centers • Planned Parenthood of Greater New York • For the Better • Diaspora • Callen-Lorde • Children's Village • FHC at NYU Langone	Monthly meetings
New York State Department of Health	Multiple meetings and communication
NYS Office of Child and Family Services • Division of Child Welfare and Community Services	Multiple meetings and communication
Public Health Solutions • NYC Smoke-Free	Quarterly meetings
United Hospital Fund	Multiple meetings and communication

Meetings with community groups and community leaders:

Organizations	Dates
Alex House Project	Multiple meetings and communication
Arab American Association of New York	Multiple meetings and communication
Arab American Family Support Center	Multiple meetings and communication

Organizations	Dates
Asian Americans for Equality	Multiple meetings and communication
Bangladeshi American Community Development and Youth Services	Multiple meetings and communication from 2017 to present
Bangladeshi Cricketer Association of North America	Multiple meetings and communication from 2019 to present
Bank Street College of Education ・ Continuing Professional Studies	Multiple meetings and communication
Breaking Ground	Multiple meetings and communication
Brooklyn Borough President's Office	Multiple meetings and communication
Brooklyn College Community Partnership	Multiple meetings and communication
Brooklyn Family Justice Center	Multiple meetings and communication
Brooklyn Grange	Multiple meetings and communication
CAMBA	Multiple meetings and communication
Center for Family Life	Multiple meetings and communication
Center for the Study of Asian American Health	Multiple meetings and communication
Center for Urban Community Services	Multiple meetings and communication
Chinese American Planning Council	Multiple meetings and communication
CHW Network of NYC	Multiple meetings and communication
City Harvest	Multiple meetings and communication
City's First Readers (NYC City Council Early Literacy Initiative)	Multiple meetings and communication
Community Board 3 (Manhattan)	Multiple meetings and communication from September 2013 to present
Community Board 6 (Manhattan)	Annual meetings
Community Board 7 (Brooklyn)	Multiple meetings and communication
Corporation for Supportive Housing	Multiple meetings and communication

Organizations	Dates
Council of Peoples Organization	Multiple meetings and communication from 2018 to present
Diaspora Community Services	Multiple meetings and communication
Empire BlueCross BlueShield HealthPlus	Multiple meetings and communication
EOC of Nassau County	Multiple meetings and communication
Family & Children's Association	Multiple meetings and communication
Fifth Avenue Committee	Multiple meetings and communication
Girls Scouts of Nassau County	Multiple meetings and communication
Good Shepherd Services	Multiple meetings and communication
Grandma's Love, Inc.	Multiple meetings and communication
Harlem Congregations for Community Improvement, Inc. (HCCI)	Multiple meetings and communication
HealthySteps	Multiple meetings and communication
Hempstead Hispanic Civic Association, Inc.	Multiple meetings and communication
Hispanic Brotherhood of Rockville Center	Multiple meetings and communication
Hispanic Counseling Center	Multiple meetings and communication
Homeless Services United	Multiple meetings and communication
human.nyc	Multiple meetings and communication
Korean Community Services	Quarterly meetings
LaGuardia Community College	Multiple meetings and communication
Legal Aid Society	Multiple meetings and communication from August 2018 to present
Literacy, Inc.	Multiple meetings and communication
Long Island Asthma Coalition	Multiple meetings and communication

Organizations	Dates
Make the Road	Multiple meetings and communication
Mixteca Community Organization	Multiple meetings and communication
Moroccan American House Association	Multiple meetings and communication
Nassau BOCES	Multiple meetings and communication
Nassau County Coordinator Agency for Spanish Americans (CASA)	Multiple meetings and communication
National Health Care for the Homeless Council	Multiple meetings and communication
New York City Housing Authority ・ Community Initiatives ・ Equal Opportunity ・ Health Initiatives ・ Smoke-Free NYCHA Health Initiative	Multiple meetings and communication
New York Community Engagement Alliance (CEAL)	Multiple meetings and communication
New York Immigration Coalition	Multiple meetings and communication
New York Legal Assistance Group (NYLAG) ・ LegalHealth	Multiple meetings and communication
North Shore Child & Family Guidance	Multiple meetings and communication
Noticia (Spanish Newspaper)	Multiple meetings and communication
NYULH – Brooklyn Arab Community Advisory Council	Multiple meetings and communication
NYULH – Brooklyn Chinese Community Advisory Council	Multiple meetings and communication
NYULH Latino Community Meeting	Multiple meetings and communication
Orbit Cricket Club	Multiple meetings and communication from 2015 to present
ParentChild+ National Center	Multiple meetings and communication
Project Independence	Multiple meetings and communication
Public Libraries ・ Brooklyn Public Library ・ East Meadow Public Library ・ Hillside Public Library ・ Garden City Public Library	Multiple meetings and communication

Organizations	Dates
• Williston Park library	
Reach Out and Read	Multiple meetings and communication
Red Hook Community Justice Center	Multiple meetings and communication
Red Hook Initiative	Multiple meetings and communications
RiseBoro Community Partnership	Multiple meetings and communication
RxHome	Multiple meetings and communication
Seasons 55+ Senior Community	Multiple meetings and communication
Settlement Housing Fund	Multiple meetings and communication
SHIP/AHEC	Multiple meetings and communication
Sunset Park Early Childhood Research Collaborative	Multiple meetings and communication
Sunset Park Early Learning Network	Multiple meetings and communication
Sunset Park Roundtable	Multiple meetings and communication
SUNY Downstate • Health Education and Alternatives for Teens (HEAT)	Multiple meetings and communication
SUNY Downstate • THEO Program BATES Planning Committee	Bi-monthly meetings
The Alex House Project	Multiple meetings and communication
The Door	Multiple meetings and communication
Together Growing Strong Leadership Group	Monthly meetings and communication
Trinity Church Wall Street	Multiple meetings and communication
Yes We Can Community Center	Multiple meetings and communication

Other health organization partners:

AIDS Service Center NYC
Arthur Ashe Institute
Be Well Primary Health Care Center
Boropark Care Center for Rehabilitation and Health Care

Bowery Residents Committee
Bridge Back to Life Center
Brooklyn AIDS Task Force
Buena Vida Nursing Home & Rehabilitation Center
Callen Lorde
Care for the Homeless
Caribbean Women's Health Association
Cerebral Palsy Association of NYS
Chinese American Medical Society (CAMS)
Coalition of Asian American Independent Practice Association (CAIPA)
Cobble Hill Health Center
Community Healthcare Network
Crown Nursing & Rehabilitation Center
Duane Reade Pharmacy
Ezra Medical Center
Gay Men's Health Crisis (GMHC), Inc.
Guild for Exceptional Children
Hamilton Park Nursing & Rehabilitation Center
Hatzolah of Boro Park
L'Refuah Health and Rehabilitation Center / Ezra Medical Center
Little Bangla Pharmacy (Since 2019)
Long Island Health Collaborative
Maimonides Medical Center
Memorial Sloan-Kettering Center for Immigrant Health
Menorah MercyFirst
Metropolitan Jewish Health System (Hospice)
Montefiore Health System's Healthy Steps Program
Mount Sinai Hospital
Nate's Pharmacy
New Dimensions
New York Presbyterian Hospital
Norwegian Christian Home and Health Center
ODA Primary Health Care Network
Park Slope Center for Mental Health
Pharmacy on Fifth
Premium Health Inc.

Providers of Health Care for the Homeless in New York City ・ Brightpoint Health ・ Callen-Lorde Health Center ・ Care for Homeless ・ Covenant House ・ Harlem United ・ Housing Works ・ ICL Health Care Choices ・ Project Renewal ・ New York Children's Health Project, a Program of the Children's Hospital at Montefiore & Children's Health Fund ・ The Floating Hospital ・ William F. Ryan Community Health Center FHC at NYU Langone
Ridgewood Bushwick Senior Citizens Council
Sephardic Nursing & Rehabilitation
South Beach Psychiatric Services
SUNY Downstate Medical Center
Union Community Health
Visiting Nurse Service of NY
White Glove Community Care

Faith-based partners:

Assafa Islamic Center
Baitul Mamur Masjid
Bangladesh Muslim Center
Bay Ridge Christian/ Sunset Park Community Church
Beit Al Maqdis
Brooklyn Islamic Center
CHIPS
Holding Hands Ministries
Holy Spirit Church
Jame Mohammadia Masjid
Madina Masjid
Masjid Al Rahman
Masjid Nur Al Islam

Masjid Omar
Mogjid el Roham
Muslim American Society Youth
Muslim Community Center
Muslim Community Center
Muslims Giving Back
Our Lady of Perpetual Help Church
Our Lady of Perpetual Help Church
Our Lady of Refuge Church
Our Lady of Solace Church
Redemption Church
Sacred Heart – Saint Stephen Church
Salam Arabic Lutheran Church
Salvation Army, Sunset Park
Salvation Army, Sunset Park
St. Agatha Church
St. Agatha R.C. Church
St. Brigid's Church (Westbury)
St. Michael's Church
St. Michael's R.C. Church
St. Rose of Lima Church
St. Rose of Lima R.C. Church
Visitation of the Blessed Virgin Mary Church

School partners:

PS 1	PS 172	MS 88
PS 2	PS 176	MS 136
PS 10	PS 179	MS 313
PS 12/ MS 484	PS 188	Abraham Lincoln High School
PS 15	PS 196	Boys & Girls High School
PS 18	PS 217	EBC High School for Public Service
PS 24	PS 282	Erasmus Academies
PS 28	PS 288	Frank J. Macchiarola Education Complex
PS 31	PS 295	High School of Telecommunication Arts and Technology
PS 32	PS 307	John Jay Educational Campus

PS 38	PS 329	Juan Morel Campos
PS 50	PS 335	Lower East Side Prep High School
PS 59	PS 352/ 375	South Brooklyn Community High School
PS 90	PS 369	South Shore Educational Complex
PS 92	PS 371	Sunset Park High School
PS 94	PS 503	School District 15
PS 96	PS 506	School District 20
PS 124	PS 736	Turtle Hook Middle School
PS 146	PS 971	Wingate Educational Campus
PS 153	IS 62	
PS 164	JHS 220	
PS 169	PS 176	

New York City Early Education Centers (NYCEEC) and Pre-K center partners:

7th Ave Preschool (KBVR)	Georgia L. Mcmurray BATKids Center
Bay Ridge Child Care Center (KBMB)	Happy Dragon Children and Family Center
Brooklyn Chinese American Association	Little Bell Childcare Corps (KCNJ)
Brooklyn Chinese American Association (BCAA) Center at 812 54th Street (KBMM)	Long Xing Day Care Center, Inc. (KBQB)
Brooklyn Chinese American Association Day Care (KBEP) at 713 43 Street	Our Lady of Perpetual Health
Brooklyn Chinese-American Association (KBVG) at 5002 8 Avenue	Red Hook Neighborhood School
Brooklyn Elite Center	Simple Growth Comprehensive
Brooklyn Treehouse Preschool (KCMK)	Star America Inc
BumbleBeesRUs (KBYQ)	Sweet Home Day Care Center
District 20 PreK	Wise Kidz
Early Head Start- Child Care Partnership - Grant Street Settlement	Yeshivas Boyan Tifereth Mordechai Shlomo
G & T Childcare Corp	Zion Day Care
Gateway City Church, INC. (KAHX)	

Appendix D

Introduction to Weather and Health Effects

Global temperatures and weather patterns are dynamic, with warming trends caused by the release of carbon dioxide, methane and other gases, into the atmosphere. Rising global temperatures can deleteriously impact population health through various mechanisms (Figure 1).

Extreme heat events are associated with high rates of heat-related illnesses and death, particularly for sensitive and at-risk populations. Higher temperatures cause extreme weather events like hurricanes to intensify, leading to injury, death, and hazardous exposures. Infectious diseases like malaria and Lyme disease are expanding their ranges, while water and air quality are affected by wildfires, flooding, and other weather-related events due to high global temperatures. Changing weather is also impacting global food supplies by disrupting farming practices and distribution routes. Extreme heat events also adversely affect mental health due to the aforementioned direct and indirect impacts of extreme heat. Extreme weather-related impacts are estimated to cost US$143 billion per year. The costs of weather disaster repair and adaptation are unequally distributed, with much of the financial impact falling on local governments and municipalities.

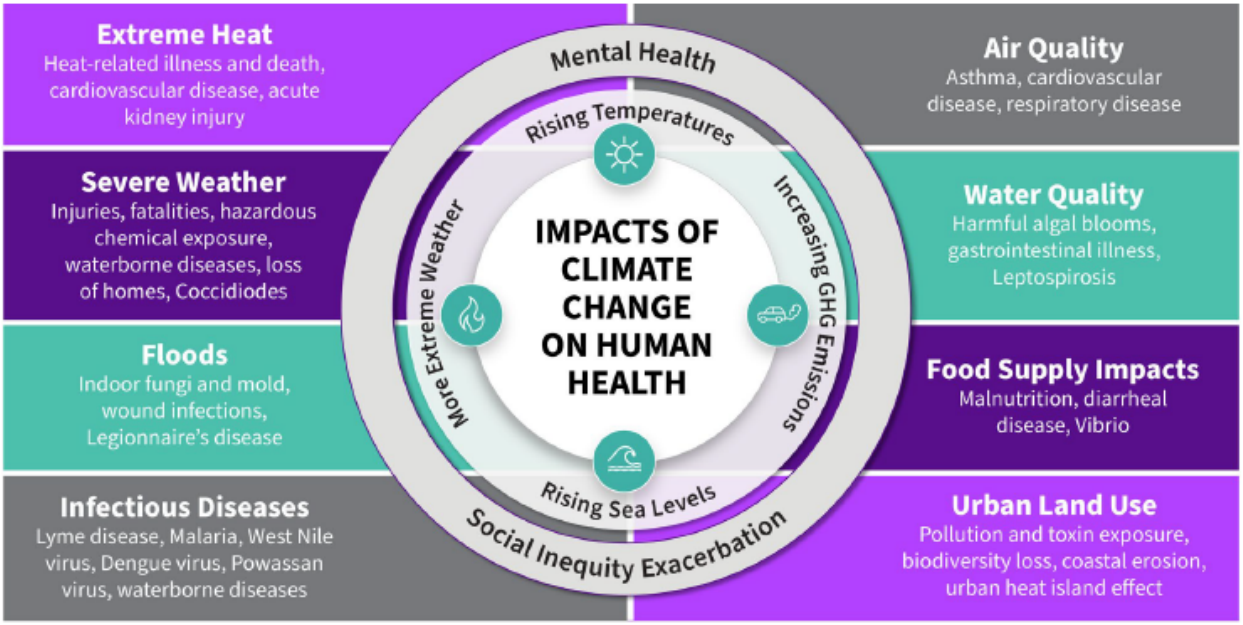

Figure 1: Rising global temperatures and extreme heat events drive key impacts that may exacerbate health outcomes within our populations. This figure shows those hazards and health impacts most relevant to NYU Langone Health and the communities it serves. Graphic adapted from the Centers for Disease Control and Prevention (CDC) and J. Patz and the California Department of Public Health.

All of these impacts are compounding social issues like homelessness, hunger, and educational and economic disruptions, as people living through an extreme weather event might lose their home, possessions, and access to food, clean water, education, and healthcare facilities. These communities may be located in areas more susceptible to extreme weather and they may have fewer adaptation resources. In the New York City metropolitan area, residents are exposed to extreme heat events, storm

surge, cloud burst flooding, and poor air quality. Understanding the health and social impacts of these extreme meteorological event is crucial for developing effective adaptation and mitigation strategies.

Heat Vulnerability for NYU Langone Health Patients

The Heat Health Index (HHI) is a national tool developed by the United States federal government. The HHI incorporates historical temperature, heat-related illness, and community characteristics data at the ZIP code level to identify areas most likely to experience negative health outcomes from heat and help communities to prepare for extreme heat events. Each ZIP code has a categorized ranking based on its overall HHI score that conveys the heat vulnerability of residents living in each ZIP code (**Error! Reference source not found.**).

Between September 1, 2023, and August 31, 2024, 202,704 unique New York City and Long Island residents were discharged from the following NYU Langone Health inpatient facilities (termed NYU patients): Tisch Hospital, Kimmel Pavilion, NYU Langone Orthopedic Hospital, Hassenfeld Children's Hospital, NYU Langone Hospital – Long Island, Long Island Community Hospital, and NYU Langone Hospital – Brooklyn.

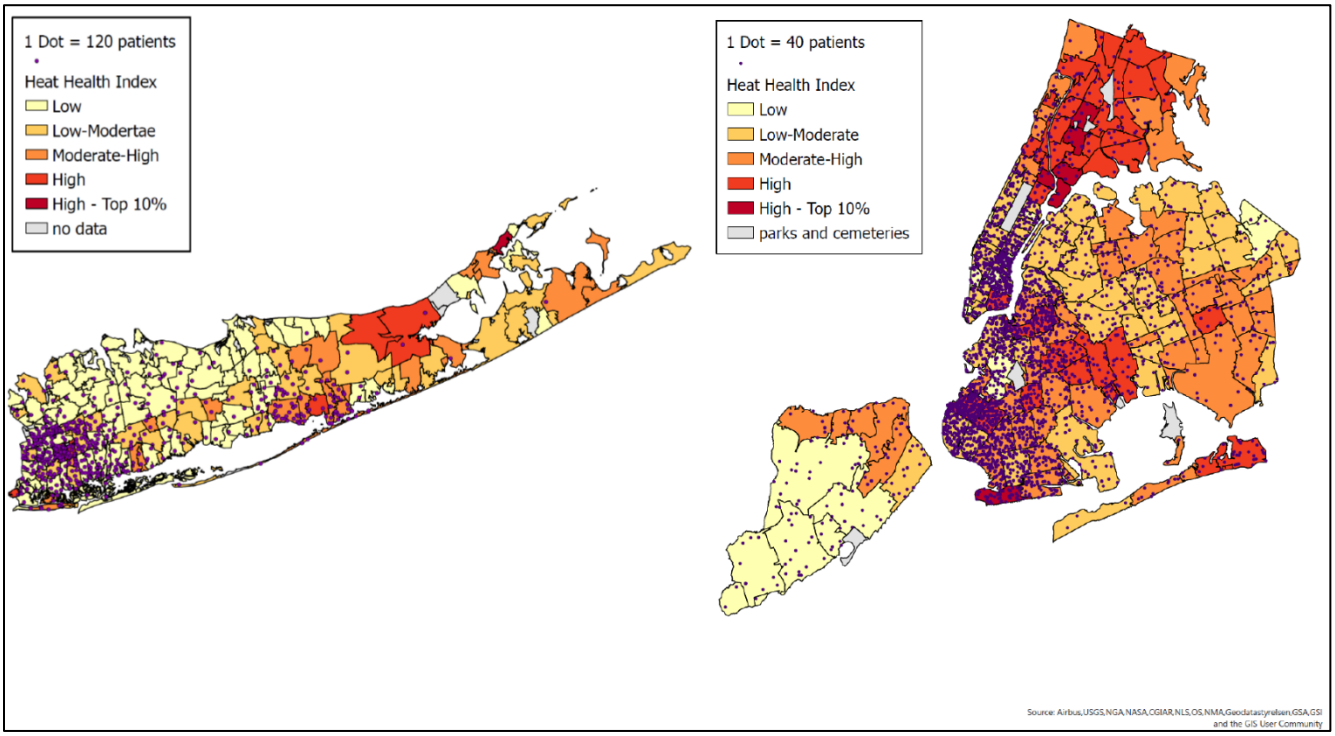

Figure 2: Heat Health Index and NYU patients residential zip code densities in Long Island (left) and New York City (right) metro areas.

Of these NYU Langone discharges, 45,154 patients (22.3%) live in low heat vulnerable zip codes, 67,170 (33.1%) live in low-moderate heat vulnerable zip codes, 48,371 patients (23.9%) live in moderately high heat vulnerable zip codes, 39,397 patients (19.4%) live in high heat vulnerable zip codes, and 2,612 patients (1.3%) live in exceptionally high (national top 10%) heat vulnerable zip codes.

For the remainder of this report, heat vulnerable neighborhoods will be defined as ZIP codes with high or exceptionally high HHI heat vulnerability scores. Below we describe various HHI domain-specific,

community-level heat vulnerabilities for heat vulnerable vs non-heat vulnerable ZIP codes where NYU Langone patients live.

Population Heat Health Vulnerabilities and Co-Morbidities

According to HHI, heat vulnerable neighborhoods have a higher percentage of heat- and air-quality vulnerability at a population level. In Figures 3 and 4, comparisons of co-morbidity prevalence and sociodemographic vulnerabilities between heat-vulnerable and non-heat-vulnerable neighborhoods are shown. All of these health conditions make individuals more vulnerable to the impacts of heat and heat-dependent air pollution.

HHI Adult Heat Co-Morbidity Prevalence		
	Heat-Vulnerable Neighborhoods	**Non-Heat Vulnerable Neighborhoods**
Coronary Heart Disease	5.8 per 100 adults	5.1 per 100 adults
Obesity	32.7%	26.6%
Diabetes Mellitus	14.0%	9.5%
Chronic Obstructive Pulmonary Disease	6.8%	5.2%
Asthma	12.1%	9.8%
Poor Mental Health	17.4%	13.4%

Figure 3: Heat co-morbidity prevalence between heat-vulnerable and non-heat vulnerable neighborhoods. Source: Heat Health Index (HHI)

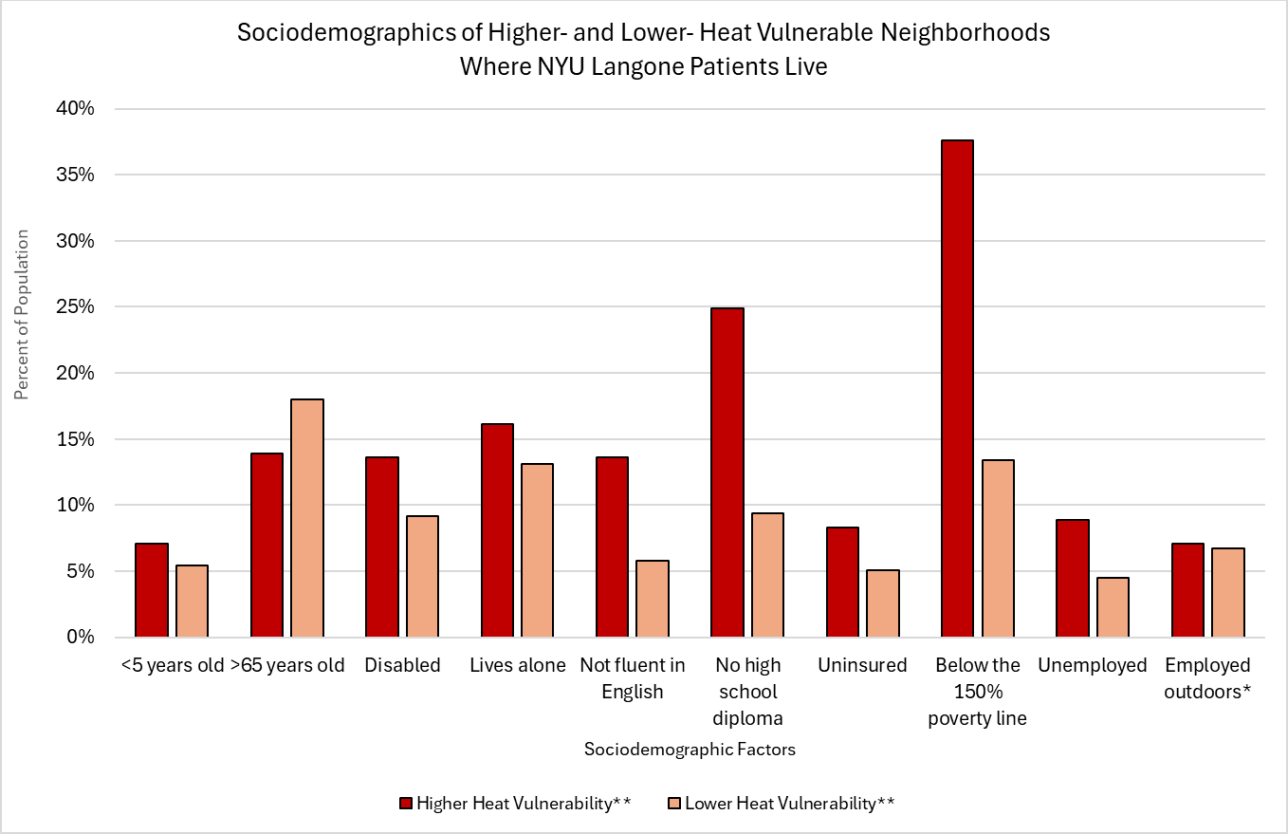

*Figure 4: Sociodemographics of neighborhoods where NYU Langone patients live. *Employed in natural resources, construction, or maintenance occupations. **Based on patient ZIP codes.*

The Built Environment and Heat Vulnerabilities

In heat vulnerable neighborhoods, an average 69.8% of land surface is covered by impervious surfaces and an average 9.8% of land surface is covered by tree canopy. In non-heat vulnerable neighborhoods, an average 50.6% of land surface is covered by impervious surfaces and an average 20.7% of land surface is covered by tree canopy.

People living in heat vulnerable neighborhoods experience an average annual mean of 3.7 days above the US EPA ground-level ozone (O_3) regulatory standards compared to 4.1 days above O_3 regulatory standards experienced by people living in non-vulnerable neighborhoods.

In-Person Needs Assessments: Community Engagement Sessions

In fall 2024, NYU Langone Health staff conducted pilot community engagement sessions to better understand opportunities and vulnerabilities of weather-driven health impacts, specifically from extreme heat and air quality.

Weather & Health Community Engagement Pilot Session Goals:

1. **Expand public understanding** of the increased health vulnerabilities from extreme weather impacts, focusing on extreme heat and air quality
2. **Identify opportunities** for health systems to educate patients, to conduct interventions, and to advocate and/or provide community infrastructure
3. **Understand unique perspectives** from community members on barriers for participation and challenges in accessing public resources

Structure of Engagement Sessions

These sessions were hosted in 3 sites within heat-vulnerable neighborhoods: the Older Adult Center at Shore Hill, the Older Adult Center at Sunset Park, and the Family Support Center (hosted by an adult English as a Second Language class) at Sunset Park. Older adults were prioritized, given their notable heat and air quality-related vulnerabilities.

The engagement included: 1) pre-session information sharing and surveys to understand participant existing knowledge of climate change, and 2) an in-person educational session, discussion and survey.

In preparation for the in-person sessions, participants reviewed weather and health key terms and completed surveys. Materials provided were in their native languages: Chinese, English, Russian, and Spanish. The participants then attended a 1-1.5 hour in-person session conducted by the Project Team with the assistance of facilitators and translators when necessary.

These sessions included a tailored presentation on extreme heat and poor air quality events and their respective health impacts. Information on public resources and the concepts discussed were provided to participants as a takeaway. Participants interested in further engagement were invited to contact the Project Team.

Survey Results

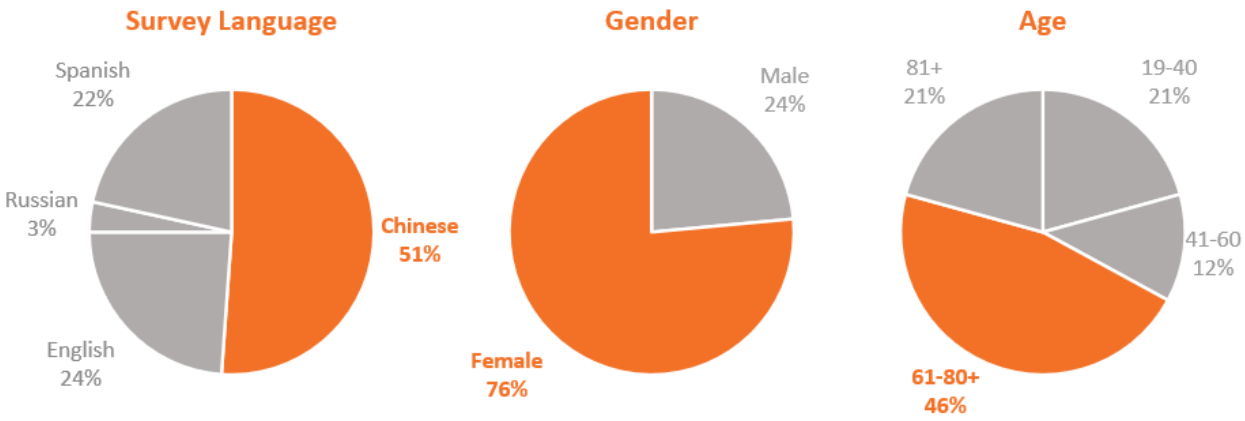

Figure 5: Demographics of Survey Respondents

88 participants completed the preliminary survey and reviewed weather and health key terms (**Error! Reference source not found.**).

A majority of respondents (>74%) agreed that extreme weather events were more frequent in recent year, and were affecting their livelihoods, health, and well-being (

Figure 4).

Most respondents recognized the negative impacts of extreme heat and poor air quality on their health; however, only about half reported knowing how to access information on air quality (54%, or 26% for checking the air quality index, specifically) or knowing places in their communities where they could stay safe from poor air quality (56%).

Even fewer reported monitoring air quality at home (16%) and owning and using an air purifier at home (35%).

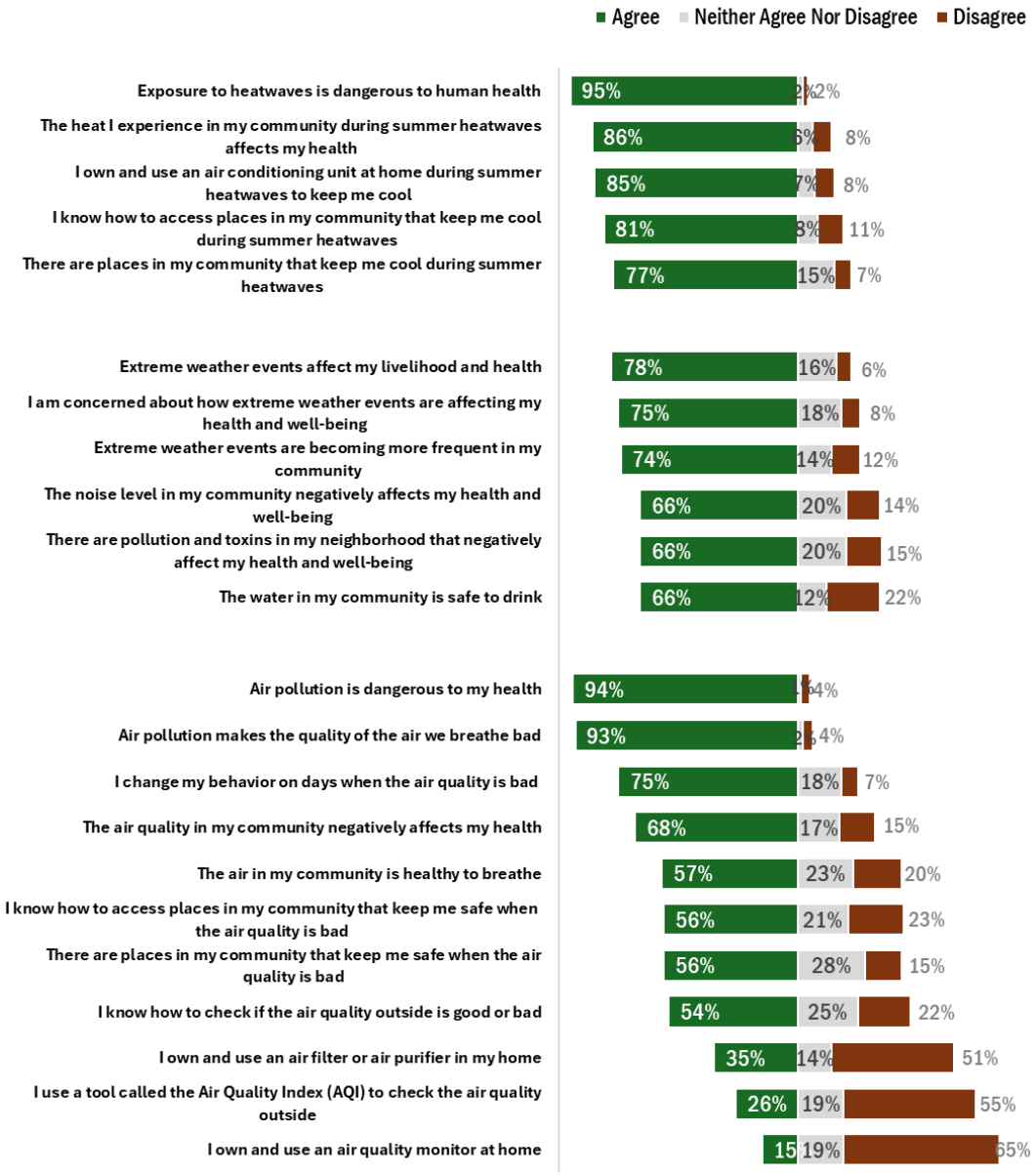

Figure 4: Summary of participants' pre-survey responses to questions about environmental and weather-related health risks.

Participant Feedback and Findings from In-Person Sessions

Participants represented a diverse range of education, age, and English proficiency. Each session was tailored to the audience to make sure the topics discussed were understood well enough for an engaging dialogue.

Participants in all locations felt that local government should be actively addressing these issues and protecting their health, for example by providing air filters. Many were concerned that they could not identify the symptoms or health issues that are driven by extreme heat or poor air quality, calling it "hard to tell." Participants at all locations shared experiences of heat exhaustion in underground public transportation, and modification of outdoor exercises due to poor air quality near major bridges and at certain times of day. They also recognized the value of living close to public pools and parks to reduce heat exposure while strengthening a sense of community. Participants rely on the news to learn about extreme heat and poor air quality days. Cellular devices generally are not used to obtain this type of information.

Following the educational segments on weather, extreme heat, and poor air quality, a post survey was distributed during the session to understand opportunities for engagement and programming. 58 attendees responded to the post survey during the in-person engagement sessions. Over 70% of respondents strongly agreed that they are interested in and would trust their primary care doctor (PCP) and/or clinic to discuss ways to stay safe from extreme heat and poor air quality (Figure 5). With the somewhat contradictory statement, 86% of respondents expressed concerns and worries about their PCP and/or clinic talking to them about these topics.

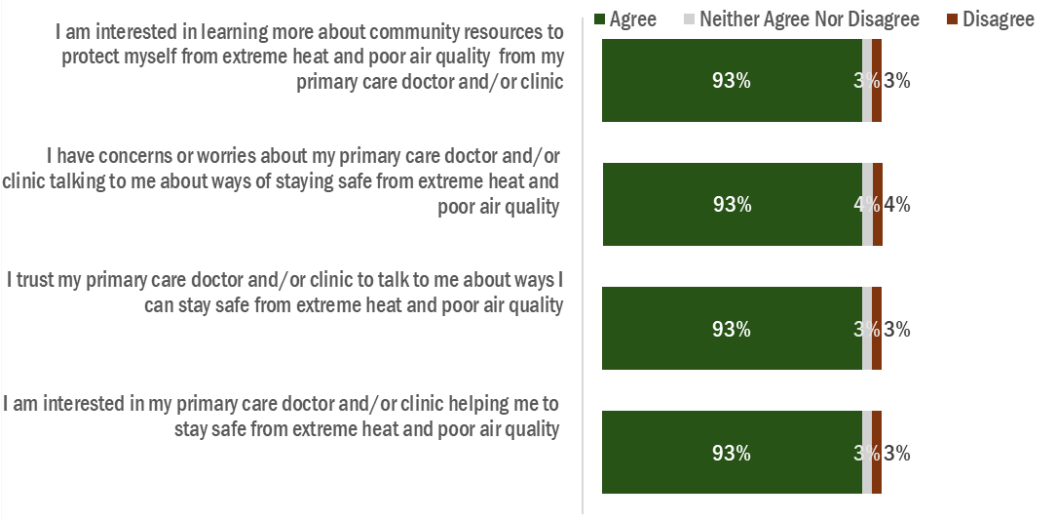

Figure 5: Participant Thoughts on Health System Engagement in Weather-Related Risk Mitigation and Adaptation

The Cantonese-speaking participants provided qualitative feedback on the session rather than completing a post survey. Participants felt that they could trust their PCP and/or clinic to talk about the health impacts of extreme heat and poor air quality. However, they expressed hesitancy to initiate questions to their PCP on these concerns because these are not typical topics they would discuss with them. This may explain, in part, the apparent contradiction between the answers given in the post-survey between potentially wanting clinicians to discuss these issues with them but having concerns regardless.

Community Session Quotes:

"When we breathe in air pollution into our bodies, it can affect our health in a lot of different ways. It can make your heart disease worse. Can make your lungs worse. It can affect our mental health as well. It can lead to depression."

Across all groups, participants were concerned that PCPs and clinic physicians would not have enough time or be willing to spend the time to discuss these concerns and share resources. However, if they had a good connection with their PCP or clinic, they felt comfortable receiving this information from them. This highlights, perhaps, the importance such messaging might hold if it were coming from busy clinicians. Several participants in different sessions expressed that they would value this information more coming from a specialist as it related to the care of certain conditions.

Reflections on Community Engagement Sessions

We encountered several challenges and learned important lessons in our community engagement sessions:

- Due to the wide range of education levels among participants, the in-person discussions on extreme heat and poor air quality events and their health impacts were either too elementary or advanced for many, which may have hindered dialogue.
- Facilitators reviewed extreme weather and health key words and concepts prior to each session in the participant's native language, but indicated challenges in translating industry-specific vocabulary, which may not exist in that language.
- The key terms and concepts were only discussed once with participants in 2 out of 3 sessions prior to the in-person session. This may have hindered thoughtful dialogue due to lack of understanding of these concepts. In the adult ESL class in Sunset Park, however, the facilitator, who is an adult education instructor, engaged with participants multiple times on the key concepts in anticipation of the in-person session. These participants demonstrated a good understanding of extreme weather and health and engaged in thoughtful dialogues.

Plans

In the near- and long-term, NYU Langone Health intends to expand this weather and health work, assessing and responding to extreme weather-related vulnerabilities in the communities we serve, through continued research, community engagement, and education.

Near-Term

Over the next 4 years, we plan to assess the needs and vulnerabilities of populations that are most at-risk for heat and air quality issues, including children, and people who are pregnant, have chronic cardiovascular and respiratory conditions, and people with cancer. Our community engagement sessions

showed that adults with children were being exposed to more extreme weather messaging and were especially concerned about effects for their families.

Faculty researchers and clinicians at the NYU Grossman School of Medicine are actively studying the impacts of heat and air quality on human health and well-being. Several are translating their research findings into actionable interventions, such as portable air cleaners for children with asthma and adults with uncontrolled hypertension, high albedo roofing interventions for families living in heat vulnerable neighborhoods, and patient-facing messaging technologies to help proactively counsel patients prior to and during extreme heat and air pollution events. We plan to explore ways to leverage these ongoing scholarly initiatives to pilot heat and air quality adaptative interventions to reduce vulnerability for our patients and their communities.

We will continue our community engagement sessions, aiming to hear from a broader demographic and geographic range of participants, including those living in higher heat-risk ZIP codes such as Suffolk County, central Queens, and the Bronx. We would also like to include participants from a broader age range, as most who participated in the engagement sessions were older than age 65. This will feed into a broader and more comprehensive strategy for community outreach.

We also plan to create a more granular post-survey to better understand participant feelings about discussing extreme weather driven health impacts with their PCPs/clinics to explore why we received conflicting opinions during our pilot engagement. We intend to complement this process with an additional post-engagement interview session with willing participants to obtain more detailed qualitative feedback, explore specific survey answers and get feedback on potential health system interventions.

Finally, we plan to educate community members and NYULH staff on relevant weather and health issues. We will create materials that can be displayed or distributed to patients during care visits, as well as additional materials for our community engagement sessions. We will also work to engage our clinical workforce and educate them on these issues, so they are better prepared to talk with patients about the impacts of heat and air quality on health. For existing health care providers (doctors, nurses, and community health workers), we will assess opportunities to integrate these topics into required online Continuing Medication Education training modules. We will additionally prepare materials for specialty-specific grand rounds presentations. For the trainees from our two medical schools and those we train in internships, fellowships, and graduate-level courses, we will assess the curriculum for opportunities to infuse these topics into existing lectures and courses, and we will develop individual lectures and special topics courses entirely devoted to extreme weather and health.

Long Term

We are very fortunate to have such high quality, detailed data on heat and air quality risks for the communities we serve thanks to the work of New York City. We would like to expand our work beyond the NYC metro area, recognizing that other geographies we serve may not have as granular data. In addition, we would like to look beyond heat and air quality risks to see what our health system can do to assist communities in preparation for flooding and other likely extreme weather risks in their communities.

Key long-term priorities include, but are not limited to:

- Extreme weather adaptive interventions: Evaluate potential interventions through community stakeholder engagements to tailor approaches to key vulnerable populations. Prioritize and implement interventions and measure results on health outcomes, participation, and ability to scale.

- Clinical staff training: Create standardized training on extreme weather and health effects for clinical staff. Empower clinical staff and build confidence to discuss these issues with vulnerable patients. Continue to develop medical school curriculum on extreme weather and health to train the next generation of physicians.

- Interdepartmental participation: Coordinate and expand extreme weather and health priorities across the institution's departments, practices, research, and operations.

    - Recognize and pursue research on extreme weather, resiliency and health to build industry knowledge.

    - Integrate extreme weather-driven health hazards into the health system's emergency preparedness response plans, as a response to community health needs and to recognize the risk and vulnerabilities to extreme weather events.

    - Design and build our facilities and integrate them into the surrounding communities with a focus on protection from extreme weather events.

References available upon request

Appendix E

Evidence Base for Community Service Plan Projects

Intervention	Evidence	Citations
Promoting Economic Stability		
Healthy Food Initiative	Our initiative employs promising practices and proven strategies to improve food security. Our model includes core strategies and activities in McCullum et. al. evidence-based Three-Stage Community Food Security Continuum, including: • Connecting emergency food programs with local urban agriculture projects ○ There is some evidence that food pantries that use healthy food initiatives increase fruit and vegetable consumption, improve diet quality, and increase food security. Program evaluations of comprehensive healthy food initiatives similar to ours are associated with significant improvements in food security, self-sufficiency, and diet quality over time. Initiative components that have been associated with these outcomes are:	• McCullum, C., Desjardins, E., Kraak, V. I., Ladipo, P., & Costello, H. (2005). Evidence-based strategies to build community food security. *Journal of the American Dietetic Association*, *105*(2), 278–283. https://doi.org/10.1016/j.jada.2004.12.015 • An R, Wang J, Liu J, et al. A systematic review of food pantry-based interventions in the USA. Public Health Nutrition. 2019;22(9):1704-1716. • Grabow KN, Schumacher J, Banning J, Barnes JL. Highlighting healthy options in a food pantry setting: A pilot study. Family and Consumer Sciences Research Journal. 2020;48(3):263-275. • Martin A, Booth JN, Laird Y, et al. Physical activity, diet and other behavioural interventions for improving cognition and school achievement in children and adolescents with obesity or overweight. Cochrane Database of Systematic Reviews. 2018;(3):CD009728. • Mabli J, Ohls J, Dragoset L, Castner L, Santos B. *Measuring the Effect of SNAP Participation on Food Security.* Alexandria, VA: US Department of Agriculture, Food and Nutrition Service; 2013. • Chloe East, "The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility," September 2, 2016, http://cneast.weebly.com/uploads/8/9/9/7/8997263/east_jmp.pd • J. Kim, "Are Older Adults Who Participate in the Supplemental Nutrition Assistance Program Healthier Than Eligible Nonparticipants? Evidence from the Health and Retirement Study," *The Gerontologist*, 55 (Supplement Issue 2):672, November 1, 2015, https://academic.oup.com/gerontologist/article/55/Suppl_2/672/2489

Intervention	Evidence	Citations
	▪ Client choice model with a variety of healthy food options; ▪ Connections to community resources and services; ▪ A respectful and welcoming environment; and ▪ On site opportunities for clients to build skills. • Counselling clients to maximize access to existing programs providing food and nutrition assistance, social services, and job training; ○ Our model helps at-risk residents connect to food and financial resources (and other health and wellbeing resources) that can improve food security, and access to and consumption of healthy food. For example, participating in SNAP is associated with increased food insecurity, improved current and long-term health and health outcomes (for children, adults, and seniors), and reduced health care costs. ○ Motivational interviewing is an evidence-based strategy to support behavior changes.	• Compilation of additional SNAP evidence: Carlson, Steven and Keith-Jennings, Brynne, SNAP Is Linked with Improved Nutritional Outcomes and Lower Health Care Costs, Center on Budget and Policy Priorities, 2018. • Britt E, Hudson SM, Blampied NM. Motivational interviewing in health settings: a review. Patient Educ Couns. 2004 May;53(2):147-55. doi: 10.1016/S0738-3991(03)00141-1. PMID: 15140454. • Kucklick, A, Manzer, L. Overlooked and Undercounted: Struggling to Make Ends Meet in New York City 2023. Prepared for the Fund for the City of New York and United Way of New York City. April, 2023.

Intervention	Evidence	Citations
	• Creating multi-sector partnerships and networks. ○ Our model includes networks for food access, community counseling, education, and food system coordination across Sunset Park providers.	
The Health and Housing Consortium	Evidence that illustrates how partnerships between healthcare and housing sectors affect health outcomes: • Cross-sector collaboration • Coordinated care and referral programs • Medical respite • Investment and advocacy in housing, SDOH, and community health	• Freeman AL, Mohan B, Lustgarten H, et al. The Development of Health And Housing Consortia In New York City. Health Affairs 2020; 39(4): 631-638. DOI: 10.1377/hlthaff.2019.01580. • Mohan B, Freeman AL, Doran KM. Health And Housing Consortia: Responding To COVID-19 Through Cross-Sector Learning And Collaboration. Health Affairs Forefront 2020. DOI: 10.1377/forefront.20200420.917823. • The Health & Housing Consortium. http://www.healthandhousingconsortium.org/. • Koeman J, Mehdipanah R. Prescribing Housing: A Scoping Review of Health System Efforts to Address Housing as a Social Determinant of Health. Population Health Management 2021. DOI: 10.1089/pop.2020.0154. • Velasquez DE, et al, Health system-based housing navigation for homeless patients: A new care coordination framework. J Healthcare 2022; 10(1): 100608. DOI: 10.1016/j.hjdsi.2021.100608. • Potter AJ, Wilking J, Nevarez H, Salinas S, Eisa R. Interventions for health: why and how health care systems provide programs to benefit unhoused patients. Popul Health Manag 2020; 23:445–452. DOI: 10.1089/pop.2019.0217. • Bailey P. Housing and Health Partners Can Work Together to Close the Housing Affordability Gap [report]. Center on Budget and Policy Priorities 2020. https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability.

Intervention	Evidence	Citations
		• Scally CP, Waxman E, Gourevitch R, Adeeyo S. Emerging Strategies for Integrating Health and Housing: Innovations to Sustain, Expand, and Replication. Urban Institute 2017; 1-30. https://www.urban.org/sites/default/files/publication/91941/emerging_strategies_in_integrating_health_and_housing_final_6.pdf. • Spillman BC, Allen EH, Leopold J, Walker K. Making it real, keeping it real: implementing housing and health collaborations [report]. Urban Institute 2017. https://www.urban.org/sites/default/files/publication/89586/housing_makingitreal_final.pdf. • National Institute of Medical Respite Care. 2021. Building Evidence for Medical Respite Care: A Participatory and Inclusive Research Agenda. • New York State Department of Health. 2024. Medical Respite Program. • New York State Department of Health. 2024. 1115 Medicaid Redesign Team Waiver Webinar: NYHER.
Health x Housing Lab	• Partnerships with multiple stakeholders, especially with individuals with lived experience, can lead to innovative solutions to housing insecurity and health inequities. • Health care systems and academic medical centers can play a role in addressing patients' housing insecurity and other social determinants of health. • Community-engaged research can improve the design,	• Taylor, L. (2018). Housing And Health: An Overview Of The Literature. Health Affairs. https://doi.org/10.1377/hpb20180313.396577. • Bailey, P. (2020, January). Housing and Health Partners Can Work Together to Close the Housing Affordability Gap. Center on Budget and Policy Priorities. • Del Buono, B.C., Salhi, B.A., Kimmel, A.E., Santen, S.A., Jarrell, K.L., White, M.H., Brown, C.K., & Moll, J.L. (2022). Prioritizing homelessness in emergency medicine education: A concept paper. AEM education and training, 6(Suppl 1), S85–S92. https://doi.org/10.1002/aet2.10753. • Department of Health & Human Services Centers for Medicare & Medicaid Services. (2021, January). Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

Intervention	Evidence	Citations
	implementation, and evaluation of health and housing interventions. • Improved translation, dissemination, and communication of high-quality research to broader audiences can better influence policies at the intersection of health and housing. • The population experiencing homelessness is rapidly aging and has unique health and social needs. Research is warranted on the best ways to help homeless older adults regain housing. • Overdose is the leading cause of death among people experiencing homelessness. Understanding interventions to address substance use and homelessness is necessary to improve health and housing outcomes.	• Health Research & Educational Trust. (2017). Social determinants of health series: Housing and the role of hospitals. Chicago, IL: Health Research & Educational Trust. https://www.aha.org/ahahret-guides/2017-08-22-social-determinants-health-series-housing-and-role-hospitals. • Hernández, D. (2019). Housing-Based Health Interventions: Harnessing the Social Utility of Housing to Promote Health. American Journal of Public Health, 109(S2), S135–S136. https://doi.org/10.2105/AJPH.2018.304914 • Hernández, D., & Swope, C.B. (2019). Housing as a Platform for Health and Equity: Evidence and Future Directions. American Journal of Public Health, 109(10), 1363–1366. https://doi.org/10.2105/ajph.2019.305210 • Koeman, J., & Mehdipanah, R. (2021). Prescribing Housing: A Scoping Review of Health System Efforts to Address Housing as a Social Determinant of Health. Population health management, 24(3), 316–321. https://doi.org/10.1089/pop.2020.0154 • Kumar, S.L., Calvo-Friedman, A., Freeman, A.L. et al. (2023). An Unconditional Cash Transfer Program for Low-Income New Yorkers Affected by COVID-19. J Urban Health 100, 16–28. https://doi.org/10.1007/s11524-022-00693-9. • Leifheit, K.M., Schwartz, G.L., Pollack, C.E., et al. (2022). Building health equity through housing policies: critical reflections and future directions for research. J Epidemiol Community Health, 76:759-763. https://doi.org/10.1136/jech-2021-216439. • Padwa, H., Henwood, B.F., Ijadi-Maghsoodi, R. et al. (2023). Bringing Lived Experience to Research on Health and Homelessness: Perspectives of Researchers and Lived Experience Partners. Community Ment Health J 59, 1235–1242. https://doi.org/10.1007/s10597-023-01138-6 • Rodríguez, L., Banks, T., Barrett, N., Espinoza, M., Tierney, W.M. (2021) A Medical School's Community Engagement Approach to Improve Population Health. J Community Health, 46(2):420-427. doi: 10.1007/s10900-021-00972-7. • Scally, C., Waxman, E., Gourevitch, R., & Adeeyo, S. (2017, July). Emerging Strategies for Integrating Health and Housing.

Intervention	Evidence	Citations
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Social and Community Context		
Greenlight Early Childhood Obesity Prevention Program	• As part of the NIH-funded multi-site cluster randomized study, children who received Greenlight had a lower BMI z-score at 4, 6, 12, 15 and 18 months of age. o There were also reductions in obesogenic behaviors, including less juice consumption by children, among families who received Greenlight.	• Heerman WJ, Rothman RL, Sanders LM, Schildcrout JS, Flower KB, Delamater AM, Kay MC, Wood CT, Gross RS, Bian A, Adams LE, Sommer EC, Yin, HS*, Perrin, Eliana M; on behalf of the Greenlight Team. *Joint senior author. A Digital Health Behavior Intervention to Prevent Childhood Obesity: The Greenlight Plus Randomized Clinical Trial. JAMA. 2024:332(24):2068-2080.DOI: 10.1001/jama.2024.22362 • Duh-Leong C, Au L, Chang LY, Feldman NM, Pierce KA, Mendelsohn AL, Perrin EM, Sanders LM, Velazquez JJ, Lei Y, Xing SX, Yin HS. Infant feeding outcomes from a culturally-adapted early obesity prevention program for immigrant Chinese American parents. Academic Pediatrics 2024; 24(8): 1276-1284.

Intervention	Evidence	Citations
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Tobacco Free Community	• Culturally tailored community social media-based peer-group mobile messaging smoking cessation interventions have been shown to be effective in reaching and	• Jiang N, Rogers ES, Cupertino P, et al. Development of a WeChat-based mobile messaging smoking cessation intervention for Chinese immigrant smokers: Qualitative interview study. *JMIR Form Res.* 2022;6(6):e36091. doi: 10.2196/36091.

Intervention	Evidence	Citations
	engaging populations that experience health disparities. • Cultural and linguistic utilization of the WeChat-based tobacco treatment has been shown to be effective in reaching low use of cessation treatment in Chinese immigrant smokers. • Quiteline interventions, particularly proactive quitlines (i.e. those that offer follow-up counseling calls) have been shown to be effective. For example, telephone counseling found to be effective for Chinese-, Korean-, and Vietnamese-speaking smokers measuring 6-month prolonged abstinence rates. • Patient navigation programs have been shown to be effective. Patient navigator model has been well studied and implemented by the American Cancer Society. For example, an intervention delivered by peer health advocates was able to increase utilization of treatment programs and smoking abstinence among public housing residents. • Mobile health (mhealth) strategies, such as automated text messaging or short message services (SMS) programs and social media-based (e.g. Facebook or Twitter) smoking	• Jiang N, Zhang Y, Qian X, Thorpe L, Trinh-Shevrin C, Shelley D. Chinese immigrant smokers' access barriers to tobacco cessation services and experience using social media and text messaging. *Tob Prev Cessation* 2020;6:52. • Jiang N, Zhao A, Rogers ES, et al. Feasibility and preliminary effects of a social media-based peer-group mobile messaging smoking cessation intervention among Chinese immigrants who smoke: Pilot randomized controlled trial. *JMIR Mhealth Uhealth.* 2024;12:e59496. • Jiang N, Rogers ES, Cupertino P, et al. Development of a WeChat-based mobile messaging smoking cessation intervention for Chinese immigrant smokers: Qualitative interview study. *JMIR Form Res.* 2022;6(6):e36091. doi: 10.2196/36091. • Kuiper N, Zhang L, Lee J, et al. A national Asian-language smokers' quitline — United States, 2012-2014. *Prev Chronic Dis*. 2015;12:E99. • Zhu SH, Wong S, Stevens C, Nakashima D, Gamst A. Use of a smokers' quitline by Asian language speakers: results from 15 years of operation in California. *American Journal of Public Health.* 2010;100(5):846-852. • Fiore, M. Treating tobacco use and dependence: 2008 update: Clinical practice guideline. DIANE Publishing, 2008. • Esparza, A. Patient Navigation and the American Cancer Society. *Seminars in Oncology Nursing*. May 2013;29(2):91-96 • Your online guide of what works to promote healthy communities. The Guide to Community Preventive Services (The Community Guide). http://www.thecommunityguide.org/ tobacco/RRquitlines.html. Published December 1, 2016. Accessed March 12, 2019. • Kong, G., Ells, D. M., Camenga, D. R., & Krishnan-Sarin, S. (2014). Text messaging-based smoking cessation intervention: a narrative review. *Addictive behaviors*, *39*(5), 907–917. • Scott-Sheldon, L. A., Lantini, R., Jennings, E. G., Thind, H., Rosen, R. K., Salmoirago-Blotcher, E., & Bock, B. C. (2016). Text Messaging-Based Interventions for Smoking Cessation: A Systematic Review and Meta-Analysis. *JMIR mHealth and uHealth*, *4*(2), e49.

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	cessation interventions are effective in promoting quit outcomes.	• Whittaker, R., McRobbie, H., Bullen, C., Rodgers, A., & Gu, Y. (2016). Mobile phone-based interventions for smoking cessation. *The Cochrane database of systematic reviews*, *4*(4), CD006611. • Naslund, J. A., Kim, S. J., Aschbrenner, K. A., McCulloch, L. J., Brunette, M. F., Dallery, J., Bartels, S. J., & Marsch, L. A. (2017). Systematic review of social media interventions for smoking cessation. *Addictive behaviors*, *73*, 81–93.
REACH FAR Brooklyn: Racial and Ethnic Approaches to Community Health for Asian and Arab Americans in Brooklyn	• Culturally tailored community health worker programs have been shown to be effective in reaching and engaging populations that experience health disparities. • Faith-based outreach programs have been shown to be effective in engaging populations and fostering behavior change. • Cultural adaptation has been shown to be essential in reaching immigrant and minority populations. • Community-based culturally appropriate outreach efforts have shown effectiveness in public health emergency like COVID-19.	• Islam NS, Wyatt LC, Taher M, et al. A culturally tailored community health worker intervention leads to improvement in patient-centered outcomes for immigrant patients with type 2 diabetes. Clinical Diabetes. 2018:cd170068. • Islam NS, Zanowiak JM, Wyatt LC, et al. Diabetes prevention in the New York City Sikh Asian Indian community: a pilot study. International journal of environmental research and public health. 2014;11(5):5462-5486. • Yi S, Wyatt L, Patel S, Choy C, Dhar R, Zanowiak J, Chuhan H, Taher MD, Garcia M, Kavathe R, Kim S, Kwon SC, Islam N. A Faith-Based Intervention to Reduce Blood Pressure in Underserved Metropolitan New York Immigrant Communities. Preventing Chronic Disease. 2019 Aug 8;16:E106. doi: 10.5888/pcd16.180618. • Lim S, Wyatt LC, Mammen S, Zanowiak J, Mohaimin S, Goldfeld K, Shelley D, Gold H, Islam N. The DREAM Initiative: Study Protocol for a Randomized Controlled Trial Testing an Integrated Electronic Health Record and Community Health Worker Intervention to Promote Weight Loss among South Asian Patients at Risk for Diabetes. Trials. 2019 Nov 21;20(1):635. doi: 10.1186/s13063-019-3711-y. • Peretz P, Islam N, and Luz A. Community Health Workers and COVID-19: Addressing the Social Determinants of Health in Times of Crisis and Beyond. New England Journal of Medicine. [published online ahead of print, 2020 Sept 23)

Intervention	Evidence	Citations
		• Ali SH, Islam NS, Commodore-Mensah Y, Yi SS. Implementing Hypertension Management Interventions in Immigrant Communities in the U.S.: a Narrative Review of Recent Developments and Suggestions for Programmatic Efforts. Curr Hypertens Rep. 2021 Jan 22;23(1):5. doi: 10.1007/s11906-020-01121-6. PMID: 33483867. • Beasley JM, Shah M, Wyatt LC, Zanowiak J, Trinh-Shevrin C, Islam NS. A Community Health Worker-Led Intervention to Improve Blood Pressure Control in an Immigrant Community With Comorbid Diabetes: Data From Two Randomized, Controlled Trials Conducted in 2011-2019. Am J Public Health. 2021 Jun;111(6):1040-1044. doi: 10.2105/AJPH.2021.306216. PMID: 33950735. • Busse KR, Lemon SC, Comerford BP, Islam NS, Ulin BF, Eriksen MP; Ammerman AS. Prevention Research Centers And COVID-19: Models Of A Community-Engaged Response To A Public Health Emergency. Opens in a new tab. Public Health Reports. 2022 Jan 21; 333549211059491 • Kalyanaraman MRoopa, Dolle J, Tariq A, Kaur S Wong L, Curcio J, Thachil R, Yi, SS; Islam N. Disaggregating Asian Race Reveals COVID-19 Disparities Among Asian American Patients At New York City's Public Hospital System. Opens in a new tab. Public Health Reports. 2021 Dec 30; 333549211061313 • Ursua RA, Aguilar DE, Wyatt LC, et al. A community health worker intervention to improve blood pressure among Filipino Americans with hypertension: A randomized controlled trial. Preventive Medicine Reports. 2018;11:42-48. • Kwon S, Patel S, Choy C, et al. Implementing health promotion activities using community-engaged approaches in Asian American faith-based organizations in New York City and New Jersey. Translational behavioral medicine. 2017;7(3):444-466. • Berra K, Franklin B, Jennings C. Community-based healthy living interventions. Progress in cardiovascular diseases. 2017;59(5):430-439.

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		• Walton JW, Snead CA, Collinsworth AW, Schmidt KL. Reducing diabetes disparities through the implementation of a community health worker–led diabetes self-management education program. Family & community health. 2012;35(2):161-171. • Dallo, F. J., et al. (2019). "Diabetes management among Arab Americans who sought care at a large metropolitan hospital system in Michigan." Journal of immigrant and minority health 21(3): 490-496. • Zayed, L., et al. (2020). "Health Assessment of the Arab American Community in Southwest Chicago." Journal of community health: 1-7. • Abuelezam, N. N., et al. (2018). "The Health of Arab Americans in the United States: An Updated Comprehensive Literature Review." Frontiers in Public Health 6(262). • Hammoud MM, White CB, Fetters MD. Opening cultural doors: Providing culturally sensitive healthcare to Arab American and American Muslim patients. American journal of obstetrics and gynecology. 2005;193(4):1307-1311.
Neighborhood and Built Environment		
Red Hook Community Health Network	• The practice and evidence on using place-based community health networks to address health outcomes are emerging. Researchers, public health professionals, clinicians, community members, and policy makers have distinct responsibilities to ensure the health and well-being of individuals, families, and communities. Collectively, through integrity-ethical-based leadership, we can promote the reduction of	• Holden, Kisha et al. “Community Engaged Leadership to Advance Health Equity and Build Healthier Communities.” *Social sciences (Basel, Switzerland)* vol. 5,1 (2016): 2. doi:10.3390/socsci5010002 • Skinner D, Franz B, Kelleher K, Penfold R. Community Perceptions of Hospitals and Shared Physical Space: A Qualitative Study. Cult Med Psychiatry. 2018 Mar;42(1):131-158. doi: 10.1007/s11013-017-9546-7. PMID: 28726015. • Dankwa-Mullan, I., & Pérez-Stable, E. J. (2016). Addressing Health Disparities Is a Place-Based Issue. *American journal of public health*, *106*(4), 637–639. https://doi.org/10.2105/AJPH.2016.303077 • Kangovi, Shreya et al. “Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial.” American journal of public health vol. 107,10 (2017): 1660-1667. doi:10.2105/AJPH.2017.303985

Intervention	Evidence	Citations
	health disparities and advance health equity. • Our network model applies recommendations and promising practices from the field, such as Holden et al, Skinner et al, and Danka-Mullan et al. The community-priority network workgroups will consult evidence to inform strategies. • Evidence suggests Community Health Worker interventions can improve health outcomes and address social needs including, but not limited to: ○ Improved patient health outcomes in diabetes, obesity, smoking, and mental health; ○ Reduced total hospital days and hospitalizations across multiple settings, including hospitals, academic primary care clinics, Veterans Affairs, and federally qualified health center primary care practices; ○ Return on investment of $2.47 for every dollar invested by a Medicaid payer for addressing patients' social determinants of health; and ○ Increased patient engagement through higher patient	• Vasan, Aditi et al. "Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials." Health services research vol. 55 Suppl 2, Suppl 2 (2020): 894-901. doi:10.1111/1475-6773.13321 • Kangovi, Shreya et al. "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment" Health affairs vol. 39, 2 (2020). doi.org/10.1377/hlthaff.2019.00981 • Kangovi S, Mitra N, Grande D, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. JAMA Intern Med. 2014;174(4):535–543. doi:10.1001/jamainternmed.2013.14327 • Veldheer, S., Scartozzi, C., Bordner, C. R., Opara, C., Williams, B., Weaver, L., Rodriguez, D., Berg, A., & Sciamanna, C. (2021). Impact of a prescription produce program on diabetes and cardiovascular risk outcomes. *Journal of Nutrition Education and Behavior*, *53*(12), 1008–1017. https://doi.org/10.1016/j.jneb.2021.07.005 • Rolfe, S., Garnham, L., Godwin, J. et al. Housing as a social determinant of health and wellbeing: developing an empirically-informed realist theoretical framework. BMC Public Health 20, 1138 (2020). https://doi.org/10.1186/s12889-020-09224-0

Intervention	Evidence	Citations
	activation scores, primary care utilization, and high-quality quality discharge communication with providers. ○ Growing research suggests that prescription food, or food as medicine, programs improve chronic health outcomes such as diabetes and heart disease. While additional research is still necessary, providing access to affordable fruits and vegetables is critical for low-income communities. ○ There is strong evidence for the impact housing conditions have on the physical and mental health of tenants, specifically in sub-standard housing such as public housing.	
CHW Research and Resource Center	• There is strong evidence for the value of community health workers in addressing health equity issues across populations. Evidence base exists for: ○ CHW intervention effectiveness for addressing chronic diseases and social determinants of health;	• Shah MK, Wyatt LC, Gibbs-Tewary C, Zanowiak JM, Mammen S, Islam N. A Culturally Adapted, Telehealth, Community Health Worker Intervention on Blood Pressure Control among South Asian Immigrants with Type II Diabetes: Results from the DREAM Atlanta Intervention. J Gen Intern Med. 2024 Mar;39(4):529-539. doi: 10.1007/s11606-023-08443-6. Epub 2023 Oct 16. PMID: 37845588; PMCID: PMC10973296. • Dannefer R, Seidl L, Drackett E, Wohlman A, Campbell S, Herrera D, Sealy C, Perez V, Mata A, Pinzon J, Islam N, Thorpe LE, Brown-Dudley L, Manyindo N. Harlem Health Advocacy Partners: A Local Health

Intervention	Evidence	Citations
	○ The value of building outreach and research capacity of CHWs; and ○ Need for advocacy for CHW workforce sustainability and equity through funding for programs and building a CHW career trajectory.	Department's Place-Based Community Health Worker Program. J Ambul Care Manage. 2024 Jul-Sep 01;47(3):168-186. doi: 10.1097/JAC.0000000000000497. Epub 2024 May 27. PMID: 38787619; PMCID: PMC11142885. • Ahmed K, Presley-Cantrell L, Moeti R, Wong D, Freese KL, Taplin C, Rodrigue J, Spencer TD, Hacker K. The Community-Based Health Workforce in Public Health and Health Care Delivery. J Public Health Manag Pract. 2024 Sep-Oct 01;30(5):E264-E269. doi: 10.1097/PHH.0000000000001911. Epub 2024 Jul 22. PMID: 39041776. • Yakubov A, Pimenova D, Ahmed A, Corvacho R, Madigan J, Naik J, Lyu C, McFarlane A, Foster V, Haseltine M, Trifonov A, Cabrera I, Rios C, Gross R, Jay M, Lord A, Gold-von Simson G, Roy B, Freeman A, Islam N, Holahan J. The development of a clinical research educational training for community health workers using the joint task force for clinical trial competency framework. Front Pharmacol. 2023 Dec 7;14:1295281. doi: 10.3389/fphar.2023.1295281. PMID: 38130403; PMCID: PMC10733486. • Kirkland C, Dill JS, Karnik H. Retention of Community Health Workers in the Public Health Workforce: Public Health Workforce Interests and Needs Survey, 2017 and 2021. Am J Public Health. 2024 Jan;114(1):44-47. doi: 10.2105/AJPH.2023.307462. Epub 2023 Nov 30. Erratum in: Am J Public Health. 2024 Aug;114(8):839. doi: 10.2105/AJPH.2023.307462e. PMID: 38033282; PMCID: PMC10726946. • Rodela K, Wiggins N, Maes K, Campos-Dominguez T, Adewumi V, Jewell P, Mayfield-Johnson S. The Community Health Worker (CHW) Common Indicators Project: Engaging CHWs in Measurement to Sustain the Profession. Front Public Health. 2021 Jun 22;9:674858. doi: 10.3389/fpubh.2021.674858. PMID: 34239855; PMCID: PMC8258143. • Basu S, Patel SY, Robinson K, Baum A. Financing Thresholds for Sustainability of Community Health Worker Programs for Patients

Intervention	Evidence	Citations
		Receiving Medicaid Across the United States. J Community Health. 2024 Aug;49(4):606-634. doi: 10.1007/s10900-023-01290-w. Epub 2024 Feb 4. PMID: 38311699; PMCID: PMC11306546. • Chokshi DA. People and Places for the Future of Public Health. JAMA Health Forum. 2021;2(3):e210423. doi:10.1001/jamahealthforum.2021.0423 https://jamanetwork.com/journals/jama-health-forum/fullarticle/2777814 • Kim K, Choi JS, Choi E, et al. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. Am J Public Health. 2016;106(4):e3-e28. https://pubmed.ncbi.nlm.nih.gov/26890177/
Health Care Access and Quality		

PlayReadVIP	Multiple randomized control trials have demonstrated PlayReadVIP's impacts including:
	• Large impacts on positive parenting activities
	  ○ reading aloud;
	  ○ teaching;
	  ○ talking & back-and-forth conversation; and
	  ○ playing together.
	• Reduced harsh discipline
	• Enhanced coping with parenting
	  ○ reduced parenting stress;
	  ○ fewer depressive symptoms.
	• Enhanced parent-child relationships
		• Roby, E., Canfield, C. F., Seery, A. M., Dreyer, B., & Mendelsohn, A. L. (2024). Promotion of positive childhood experiences and early relational health in pediatric primary care: accumulating evidence. Academic Pediatrics, 24(2), 201-203.
		• Piccolo, L.R., Roby, E., Canfield, C.F. et al. (2024). Supporting responsive parenting in real-world implementation: minimal effective dose of the Video Interaction Project. Pediatric Research 95, 1295–1300. https://doi.org/10.1038/s41390-023-02916-4
		• Miller, E. B., Canfield, C. F., Roby, E., Wippick, H., Shaw, D. S., Mendelsohn, A. L., & Morris-Perez, P. A. (2023). Enhancing early language and literacy skills for racial/ethnic minority children with low incomes through a randomized clinical trial: The mediating role of cognitively stimulating parent–child interactions. Child Development, 00, 1–14.
		• Canfield, C., Miller, E., Taraban, L., Aviles, A., Rosas, J., Mendelsohn, A., Shaw, D. (2023). Impacts of a tiered intervention on child internalizing and externalizing behavior in the context of maternal depression.

Intervention	Evidence	Citations

	• Enhanced child development across domains
	  ○ most strongly for social-emotional development;
	  ○ reductions in hyperactivity and attention problems sustained into school entry; and
	  ○ Impacts on child development occur through impacts on both parent coping with psychosocial stressors and positive parenting activities.
	• Impacts on positive parenting and child social-emotional development sustained 1.5 years after program completion
	• Potential for further increasing impacts through linkages with community-based services, such as libraries
	• Impacts on positive parenting demonstrated in geographically distant sites with parents from racially and ethnically diverse backgrounds
	• A single PlayReadVIP visit has shown benefits and is associated with a significant change in parents' use of well-established
		Development and Psychopathology, 1-11. https://doi.org/10.1017/S0954579423001475
		• Taraban, L., Shaw, D. S., Morris, P. A., & Mendelsohn, A. L. (2023). An exploration of the domain specificity of maternal sensitivity among a diverse sample in the infancy period: Unique paths to child outcomes. Child Development, 00, 1–14. https://doi.org/10.1111/cdev.14000
		• Cates, C. B., Roby, E., Canfield, C. F., Raak, C., Johnson, M., Dreyer, B., & Mendelsohn, A. L. (2023). Parental report of the cognitive home environment: Validation of the StimQ2. PLOS ONE
		• Miller, E. B., Roby, E., Zhang, Y., Coskun, L., Rosas, J. M., Scott, M. A., Gutierrez, J., Shaw, D. S., Mendelsohn, A. L., & Morris, P. A. (2023). Promoting cognitive stimulation in low-income parents across infancy and toddlerhood: A randomized clinical trial. The Journal of Pediatrics
		
		For a larger list of publications, visit https://www.playreadvip.org/publications

Intervention	Evidence	Citations
	positive parenting behaviors, which were increased even further after the second visit • Participation in PlayReadVIP increased participation for families in higher intensity/higher touch programs (e.g., Family Check Up), especially for families with identified high needs • Early impacts of PlayReadVIP from 6 to 24 months on parenting resulted in increased 4 year vocabulary and early literacy	
ParentChild+	• ParentChild+ (PC+) is a national model that has been shown to reduce the achievement gap between low-and middle-income children. PC+ is a cost-effective approach that impacts school readiness, long-term school success, and strengths-based parenting, as demonstrated in many studies, including matched comparison group and randomized control group studies. The model is replicated with high fidelity in Sunset Park. • Compared to control groups, PC+ child graduates have: o stronger social emotional and language skills(core	ORS Impact (2015), Long-Term Academic Outcomes of Participation in the Parent-Child Home Program (PCHP) in King County, WA. Seattle, WA. Astuto J. Playful learning, school readiness, and urban children: Results from two rcts. PCHP Annual Meeting. Uniondale, NY. May 2014. New York University Lazar I, Darlington R. Lasting effects of early education: A report from the Consortium of Longitudinal Studies. *Monographs of the Society for Research in Child Development*. 1982;47(195). Levenstein P, Levenstein S, Shiminski JA, Stolzberg JE. Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the Mother-Child Home Program. *Journal of Applied Developmental Psychology*. 1998;19:267-285. Madden J, O'Hara JM, Levenstein P. Home again. *Child Development*. 1984;55:636-647. Rafoth M, Knickelbein B. Cohort One Final Report: Assessment Summary for the *Parent Child Home Program.* An evaluation of the Armstrong Indiana County Intermediate Unit PCHP program, Center for Educational and Program Evaluation located at Indiana University of Pennsylvania. 2005.

Intervention	Evidence	Citations
	school readiness indicators); o higher levels of English proficiency in kindergarten; o higher third-grade reading and math scores; o a significant reduction in need for special education by third grade; and o higher high school graduation rates. • Compared to control groups, PC+ parent graduates have: o higher pro-social competence and sustained higher-frequency and quality interactions two years after the program that correlates with children's first grade cognitive and emotional skills.	Kamerman SB, Kahn, AJ. *Starting Right, New York.* Oxford University Press; 1995. Levenstein, P., Levenstein, S., & Oliver, D. (2002). First grade school readiness of former child participants in a South Carolina replication of the Parent-Child home program. *Journal of Applied Developmental Psychology*, 23, 331-353. (S.C. Study) Smith, Charles & Peck, Stephen. (2020). Impact Evaluation for the Parent Child Plus Program, Newark Trust for Education. PlayLabNYU. (2018). Learning More about Home Visitation: RCT Evaluation of the ParentChild+ Program for Black and Latino Children Living in Poverty. A technical report to ParentChild+. PlayLabNYU. (2018). Learning More about Home Visitation: RCT Evaluation of the ParentChild+ Program for Latino Spanish Speaking Children of Immigrants. A technical report to ParentChild+.
Family Support Services	• NYC adults who experienced one or more material hardships had five times higher incidence of serious psychological distress than adults who did not experience material hardships (15% compared with 3%). Those who did not have enough money for food had six	• Tuskeviciute R, Hoenig JM, Norman C. The social determinants of mental health among New York City adults. New York City Department of Health and Mental Hygiene: Epi Data Brief (115); 2019 https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief115.pdf • Canfield CF, Seery A, Weisleder A, Workman C,…Mendlesohn A. Encouraging parent-child book sharing: Potential additive benefits of literacy promotion in health care and the community. Early Childhood Research Quarterly. 2020(50) 221-229.

Intervention	Evidence	Citations
	times higher incidence (25% compared with 4%) and those who experienced environmental stressors at home (such as no heat, mold, or pests) had about two times higher incidence (11-12% compared with 6%). • Children born into poverty are at risk for far-reaching negative physical and mental health effects, perpetuating cycles of disadvantage into adulthood. Strong social supports, family structures and community programs can help prevent or ameliorate the impact of ACEs on childhood development and health.	
Community-Oriented Virtual Primary Care and Technology	• Strong evidence demonstrates that digital health has the potential to reduce health care costs, increase access to care, and improve health outcomes. • However, evidence also suggests that digital health can reinforce, exacerbate, and even create health disparities. Hence, developing and disseminating digital health tools that actively work to reduce health disparities and promote health equity for socially disadvantaged patient populations is crucial.	• Lawrence K. Digital Health Equity. In: Linwood SL, editor. Digital Health [Internet]. Brisbane (AU): Exon Publications; 2022 Apr 29. Chapter 9. Available from: https://www.ncbi.nlm.nih.gov/books/NBK580635/ doi: 10.36255/exon-publications-digital-health-health-equity • Badr J, Motulsky A, Denis JL. Digital health technologies and inequalities: A scoping review of potential impacts and policy recommendations. Health Policy. 2024 Aug;146:105122. doi: 10.1016/j.healthpol.2024.105122. Epub 2024 Jul 2. PMID: 38986333. • Chidambaram S, Jain B, Jain U, et al. An introduction to digital determinants of health. *PLOS Digit Health*. 2024;3(1):e0000346. Published 2024 Jan 4. doi:10.1371/journal.pdig.0000346 • Richardson, S., Lawrence, K., Schoenthaler, A. M., & Mann, D. (2022). A framework for digital health equity. *NPJ digital medicine*, *5*(1), 119. https://doi.org/10.1038/s41746-022-00663-0

Intervention	Evidence	Citations
	• Evidence of inequities are evident amongst elderly individuals, persons with a disability, unstably housed individuals, non-English speakers, and others with low technology literacy or inconsistent access to digital health tools. • The Digital Health Equity framework postulates that digital determinants of health at the individual level include digital literacy, digital self-efficacy, technology access, and attitudes towards use. • Universal strategies and solutions can be used to address digital determinants of health regardless of the specific community under focus.	• Holmes Fee C, Hicklen RS, Jean S, et al. Strategies and solutions to address Digital Determinants of Health (DDOH) across underinvested communities. *PLOS Digit Health*. 2023;2(10):e0000314. Published 2023 Oct 12. doi:10.1371/journal.pdig.0000314

Fall Prevention and Exercise for the Elderly	• A Matter of Balance: 8-session workshop to reduce fear of falling and increase activity among older adults in the community
	  ○ 97% of participants feel more comfortable talking about their fear of falling
	  ○ 99% of participants plan to continue exercising
	  ○ $938 savings in unplanned medical costs per Medicare beneficiary
		These programs are included in the National Council on Aging comprehensive list of evidence-based falls prevention programs: https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults-2/
		
		• Klempel N., Blackburn N.E., McMullan I.L., Wilson J.J., Smith L., Cunningham C., O'Sullivan R., Caserotti P., Tully, M.A. The Effect of Chair-Based Exercise on Physical Function in Older Adults: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health 2021 Feb;18(4):1902

Intervention	Evidence	Citations

	• Tai Chi for Arthritis for Falls Prevention: Balance and gait training program of controlled movements for older adults and people with balance disorders
	  ○ 55% reduction in falls rate
	  ○ $530 net benefit per participant
	  ○ 509% ROI
	• The Otago Exercise Program: A 17-session workshop to improve the strength and balance in older adults, reducing their risk of falls and enhancing their overall mobility and independence.
	  ○ 35-40% reduction in falls
	• Chair Yoga: An 8 week evidence – informed workshop for individuals with limited mobility, seniors, people recovering from injury or surgery and those seeking a low-impact exercise option.	

Education Access and Quality		
ParentCorps	• Two randomized trials show that ParentCorps' full model has meaningful and sustained impacts on children's academic achievement, mental health and physical health - one of very few early childhood programs with	• Brotman L, Kingston S, Bat-Chava Y, Caldwell M B, Calzada E J. Training School personnel to facilitate a family intervention to prevent conduct problems. *Early Education and Development* 2008; *19*(4), 622-642. doi:10.1080/15374410802231057 • Brotman LM, Calzada E, Kingston S, et al. Promoting effective parenting practices and preventing child behavior problems in school among

Intervention	Evidence	Citations
	demonstrated impact on all three critical areas of development. • Children in pre-K programs enhanced with ParentCorps: Performed better on academic tests, particularly in reading, with a 24% lower risk of reading below grade level at the end of kindergarten; were 50% less likely to develop mental health problems, including both emotional and behavioral problems at school, through second grade; and were 50% less likely to be obese, through second grade. In middle school, children were 44% less likely to be chronically absent (i.e., missed more than 10% of days in the school year) at the critical transition into middle school. • Parents showed greater involvement in their children's learning, increased parenting knowledge, and increased use of evidence-based practices (such as positive reinforcement). Parents who reported the lowest levels of confidence in their ability to support their children's learning at the beginning of pre-K were shown to benefit from ParentCorps the most.	ethnically diverse families from underserved, urban communities. *Child Development*. 2011;82(1):258-276. PMID: 1291441. • Brotman LM, Dawson-McClure S, Huang KY, et al. Early childhood family intervention and long-term obesity prevention among high-risk minority youth. *Pediatrics.*2012; 129:621-628. PMCID: PMC3289522 • Brotman LM, Dawson-McClure S, Calzada EJ, et al. randomized controlled trial of *ParentCorps*: Impact on kindergarten academic achievement. *Pediatrics.* 2013;131: e1521-1529. PMCID: PMC39641414 • Huang K, Nakigudde J, Calzada E, Boivin M J, Ogedegbe, G, Brotman L M. Implementing an early childhood school-based mental health promotion intervention in low-resource ugandan schools: Study protocol for a cluster randomized controlled trial. *Trials.* 2014; 15(1). doi:10.1186/1745-6215-15-471 • Brotman LM. A population-level approach to promoting healthy development and school success in low-income, urban neighborhoods: Impact on parenting and child conduct problems. *Prevention Science.*2015;16(2):279-290. PMCID: PMC4156570. • Brotman LM, Dawson-McClure S, Kamboukos D, et al. Effects of ParentCorps in prekindergarten on child mental health and academic performance: Follow-up of a randomized controlled clinical trial through 8 years of age. *JAMA Pediatrics*. 2016;170(12):1149-1155. PMCID: PMC5642293. • Dawson-McClure S, Calzada E, Huang KY, et al. A population-level approach to promoting healthy development and school success in low-income, urban neighborhoods: Impact on parenting and child conduct problems. *Prevention Science.* 2015;16(2):279-290. PMCID: PMC4156570. • Hajizadeh N, Stevens ER, Applegate M, et al. Potential return on investment of a family-centered early childhood intervention: A cost-effectiveness analysis. *BMC: Public Health*. 2017;17(1):796. PMID: 29017527. PMC: 5635549. • Huang K, Nakigudde J, Rhule D, Gumikiriza-Onoria L, Abura G, Kolawole B, Brotman L. Transportability of an evidence-based early childhood

Intervention	Evidence	Citations
	• In a cost-effectiveness analysis, ParentCorps was found to have a 4:1 return on investment over and above the well-documented benefits of pre-K. • Strong evidence from an NIH-funded randomized controlled trial in Uganda indicate that ParentCorps Professional Development results in meaningful increases in teachers' knowledge of evidence-based SEL practices; use of those practices to create safe, nurturing and predictable classroom environments; and student social-emotional learning. ▪ Two recently completed trials in NYC affirm the power of ParentCorps Professional Development (PD) as a standalone component of our model. The trials evaluated the impact of ParentCorps PD, implemented at scale in partnership with NYC Public Schools, in elementary schools and early education centers serving high concentrations of families living in poverty. Based on analysis of	intervention in a low-income African country: Results of a cluster randomized controlled study. *Prevention Science.* 2017; *18*(8), 964-975. doi:10.1007/s11121-017-0822-0 • Dawson-McClure S, Rhule D, Hamer K, Calzada E, Kolawole B, Mondesir M, Rosenblatt K, Brotman L. Understanding ParentCorps' essential elements for building adult capacity to support young children's Health and Development. *Research on Family-School Partnerships*. 2021; 53–72. https://doi.org/10.1007/978-3-030-74617-9_4 • Dawson-McClure, Kamboukos, Cheng, Olson, Linares Torres, Barajas-Gonzalez, Ursache, Huang, Illenberger & Brotman. Impact of ParentCorps Professional Development for Pre-K Teachers on Family-School Connections. In Panel, *Partnership Approaches to Supporting Quality and Equity in the Context of Expanding ECE Access*. Arlington, VA, 9/2023

Intervention	Evidence	Citations
	district-administered surveys of over 9,000 parents across four years, both trials demonstrate that ParentCorps PD improves home-school connections and parents' trust in teachers and school leaders. These studies are the first randomized controlled trials of Professional Development implemented at scale to demonstrate impact on pre-K teachers' and leaders' capacity to build home-school connections in general, and trustworthiness in particular – an essential aspect of transforming the pre-K experience for families of color in historically disinvested neighborhoods	
Project SAFE	• The program uses evidence-based sexual health curriculum in the multi-session workshop series that has-been shown to increase knowledge and eliminate or reduce risky sexual behaviors: *Making Proud Choices! (MPC)*	• Jemmott JB III, Jemmott LS, Fong, GT. Reductions in HIV risk-associated sexual behaviors among Black male adolescents: Effects of an AIDS prevention intervention. *American Journal of Public Health.* 1992;82(3):372–377. • Jemmott, J. B. III, Jemmott, L. S., & Fong, G. T. (1998). Abstinence and safer sex HIV risk-reduction interventions for African American

Intervention	Evidence	Citations
	• Teens participating in Project SAFE peer education groups from 2012-2015 were part of the Complementary Strengths Research Project conducted by Cornell University and demonstrated statistically significant increases in: frequency of condom use; HIV knowledge; knowledge of HIV status; and knowledge of STD status. In addition, participants demonstrated increases in school connectedness and self- efficacy, which have been shown to be protective factors against HIV infection.	adolescents: A randomized controlled trial. Journal of the American Medical Association, 279 (19): 1529-1536. • Jemmott JB III, Jemmott LS, Fong GT, McCaffree K. Reducing HIV risk-associated sexual behavior among African American adolescents: Testing the generality of intervention effects. *American Journal of Community Psychology*.1999;27(2):161-87. • Taylor, R. J., Shade, K., Lowry, S. J. & Ahrens, K. (2019). Evaluation of reproductive health education in transition-age youth. Children and Youth Services Review 108 (January 2020): 104530.

Appendix F

Anticipated Impact and Performance Measures

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
Promoting Economic Stability: Programs, Progress and Plans						
Program: Healthy Food Initiative						
Emergency food pantry	• 6000 households • 71 services • 18,200,000 food packages distributed • 5 satellite pantry locations	• 6,000 households • 71 services • 18,200packages distributed • 5 satellite pantry locations	• 6,000 households • 71 services • 18,200packages distributed • 5 satellite pantry locations	• The emergency food pantry is focused on short-term outcomes: addressing emergency food needs, increasing awareness of food, financial, and health community resources	• Improved food security/ reduced food insecurity in Sunset Park • Improved health of Sunset Park residents (overall health, better maintenance of chronic illness) • Cohesive cross-sector food systems network in Sunset Park ○ Improved community resiliency and emergency preparedness (more timely detection, cross-sector coordination of response activities, continuity of services during emergencies)	• Program administrative/ operations records
Screening, Case Management and Nutrition Education	• ~3200 people • 1,900 of benefits applications supported or submitted • 5 community cultivation events. • 5 locations/ orgs sessions took place at/ through	• ~3200 people • 1,900 of benefits applications supported or submitted • 5 community cultivation events. • 5 locations/ orgs sessions took place at/ through	• ~3200 people • 1,900 of benefits applications supported or submitted • 5 community cultivation events. • 5 locations/ orgs sessions took place at/ through	• Participants access community resources to support food and financial stability • Participants have more money available for basic living costs • Participants have increased skills and knowledge to support healthy food and beverage choices		• ~3200 people • 1,900 of benefits applications supported or submitted • 5 community cultivation events. • 5 locations/ orgs sessions

* **Objectives that are "specific, measurable, achievable, realistic, time-bound, inclusive, and equitable."**

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				• Participants have decreased reliance on emergency food • Participants report increased food security • Participants have decreased stress/ fewer poor mental health days • Participants have improved or sustained access to healthy/ nutritious food • Participants improve or maintain high compliance with healthy living recommendations (5-2-1-0/ MYPlate)		
Sunset Park Community Coalition	Targets to be finalized in Year 1: • Integration of any additional members. Coalition members, number and type • Gaps analysis of food insecurity initiatives. Other outputs aligned with activities and goals. • Identify opportunities to increase capacity to address food insecurity via 1115 waiver.	Targets to be finalized in Year 1: • Coalition members, number and type • Develop plan to address identified gaps in food insecurity initiatives. • Leverage coalition to secure additional funding to support coalition initiatives. • Other outputs aligned with activities and goals.	Targets to be finalized in Year 1: • Coalition members, number and type • Other outputs aligned with activities and goals	• Improved coordination and integration of food security services between Sunset Park stakeholders		• Agenda and meeting minutes MOU

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
Program: Health & Housing Consortium						
Foster cross-sector relationships among health care, housing, homeless and social service organizations and government partners to inform policy and build capacity of frontline workers to support New Yorkers with unmet health and housing needs.	• 6 Program and Policy Committee meetings, 6 Consumer Advisory Committee meetings, and 3 Medical Respite Task Force meetings • Approx 30 events, including: at least 25 trainings, 2 case conferences, 1 Convening, 1 housing marketplace, 2 Flipping the Script events, 3 advocacy spotlight sessions • Biweekly newsletter • 8 policy campaign participation deliverables (sign-on letters, testimony, public comment, etc.) • 3-5 New member organizations • 1 New training staff person • Launch of a Workforce Development Training Program (contingent on funding) • Partnership with Social Care	Continue with Year 1 program planning, needs assessment and implementation activities, plus: • 3-5 New member organizations • 1-2 Consortium-led advocacy campaigns • Launch of medical respite institute (contingent on funding)	Continue with Year 1 program planning, needs assessment and implementation activities, plus: • 3-5 New member organizations • Establishment of Training Department with staff and capacity to provide more in-house trainings • 1 New policy staff person • Development of new committee focused on advocacy	• Improved member readiness to participate in SCNs • Increased membership and member engagement • Increased staff capacity to expand into priority areas • Increased capacity and confidence of the health and human services workforce to serve people with health and housing needs • Increased awareness and interest in medical respite among our members and partners • Reach: 6000 members and 20 partners organizations annually across NYC-based healthcare, homeless and social services organizations, and government partners	• Improved coordination and communication between healthcare, housing, and homeless services systems in NYC • Increased resources for housing insecure residents • Increased political and leadership support for issues at the intersection of health and housing • Increased access to medical respite services for all	• YourMembership data • Zoom and in-person registration and attendance data • Evaluation data • Meeting minutes • Workgroup feedback/recommendations

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	Networks to provide training and technical assistance to their network partners					
Program: Health x Housing Lab						
Conduct research to build the evidence base for initiatives, programs, and policies at the intersection of health and housing; inform policy and programs related to health and housing through evidence-based advising and research dissemination; and provide education to expand the reach of practice-relevant evidence on health and housing.	*Engagement* • At least 4 meetings with Advisory Committee *Education and Programming* • 3 event recordings • 4 newsletter issues • 1 webpage featuring engagements with SBPN members (OpEds, webinar recordings, etc.) • Summer consultant and scholar deliverables *Research* • OATH study: at least 2 peer-reviewed articles • 2 research summary deliverables	*Engagement* • At least 4 meetings with Advisory Committee *Education and Programming* • 3 event recordings • 4 newsletter issues • 1 webpage featuring engagements with SBPN members (OpEds, webinar recordings, etc.) • Summer consultant and scholar deliverables *Research* • OATH study: at least 1 dissemination event and 2 advocacy deliverables • 2 research summary deliverables	*Engagement* • At least 4 meetings with Advisory Committee *Education and Programming* • 3 event recordings • 4 newsletter issues • 1 webpage featuring engagements with SBPN members (OpEds, webinar recordings, etc.) • Summer consultant and scholar deliverable *Research* • OATH Study: at least 1 disseminati-on event and 2 advocacy deliverables • 2 research summary deliverables	• Increased opportunities for Speakers Bureau members to contribute their expertise to stakeholders on relevant policy, education and research • Expanded Lab contributions to health and housing research • Increased dissemination of research to non-academic audiences • Increased number of healthcare providers with knowledge to improve care for housing-insecure patients • 1000 event registrants per year and 4000 newsletter subscribers that include policy leaders, advocates, academics,	• Increased knowledge from policy makers and practitioners around evidence-based health and housing initiatives • Increased understanding of the importance of integrating perspectives of lived experience in education, research and policy • Improved homeless and healthcare services that better foster people's broadly defined health and wellbeing	• Advisory Committee meeting minutes • Zoom data • Mailchimp analytics • Resource Library • Research project findings • Semi-structured interviews and focus group transcripts • Speakers Bureau webpage analytics and inquiries • Speaking engagements and conference attendance tracking

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				housing and healthcare providers, individuals with lived experience and other stakeholders		
Social and Community Context: Programs, Progress and Plans						
Program: Greenlight Early Childhood Obesity Prevention Program						
Delivery of Greenlight intervention as part of well-child visits between 0-2 years (newborn, 1, 2, 4, 6, 9, 12, 15–18-month check-ups)	• Greenlight used at 6000+ well-child visits • Program reach of 80% of 0-2y children (main site) • 1800 families reached • 8000+ booklets distributed • 2000+ tangible tools (e.g. portion size snack cups) distributed • 40 providers (physicians, nursing staff, health ed.) engaged 5 sites • 2 sites at CBWCHC (Walker site and Flushing 45th) • NYU 7th Ave FHC • NYU Hempstead • Bellevue Hospital	• Greenlight used at 6500+ well-child visits • Program reach of 80% of 0-2y children (main site) • 2000 families reached • 9000+ booklets distributed • 2500+ tangible tools • 50 providers engaged 5 sites • 2 sites at CBWCHC (Walker site and Flushing 45th) • NYU 7th Ave FHC • NYU Hempstead • Bellevue Hospital NYU Sunset Park FHC	• Greenlight used at 6500+ well-child visits • Program reach of 80% of 0-2y children (main site) • 2000 families reached • 9000+ booklets distributed • 2500+ tangible tools • 50 providers engaged 5 sites • 2 sites at CBWCHC (Walker site and Flushing 45th) • NYU 7th Ave FHC • NYU Hempstead • Bellevue Hospital • NYU Sunset Park FHC	Children/Families • Families supported to engage in healthy child eating behaviors / practices • Families supported to engage in healthy child physical activity-related behaviors / practices • Families with tools in the home to support healthy eating/ activity-related activities Clinical sites /providers • Increased provider delivery of evidence-based healthy eating/activity recommendations • Increased provider use of evidence-	Children/Families • Intermediate outcomes plus • Families with greater self-efficacy related to healthy eating and activity-related behaviors • Decrease the percentage of 2–3-year-old children who are overweight / obese at sites served Clinical sites/Providers • Intermediate outcomes plus • Increased site capacity to support families in engaging in healthy eating / activity-related behavior Reach: 2000 children and their families (in	• EHR data to track Greenlight program process measures (e.g. provider/health educator counseling, booklet /tangible tool distribution) and child ht/ wt data • Staff tracking sheets (e.g. booklet, tangible tools) • Parent surveys (by health educator, program staff) • Provider surveys • Analytics from Greenlight website (# downloads / views of program booklets)

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	• NYU Sunset Park FHC			based health communication strategies	Chinatown, Manhattan, Sunset Park, Brooklyn, and Hempstead, Long Island; Charles B. Wang Community Health Center (Walker site [Manhattan], 45th Ave site [Flushing, Queens]), NYU Langone Brooklyn (7th Ave Family Health Center, Sunset Park Family Health Center), NYU Langone Hempstead, Bellevue Hospital	• Notes from meetings of parent advisory group/community advisory board
Greenlight waiting room program	• Maintain delivery to 50% eligible children (main site) - 400 families reached • Peer training of new staff, including at new site • Develop training curriculum for health educator	• Maintain delivery to 50% eligible children (main site) – 500 families reached • Peer training of new staff,	• Maintain delivery to 50% eligible children (main site) – 500 families reached • Peer training of new staff			
Technology enhancement of Greenlight	• Digital online Greenlight flipbooks (Eng, Span, Chinese) • Explore social media platforms to promote Greenlight	• Digital online Greenlight flipbooks (Eng, Span, Chinese) • Greenlight flipbooks used in waiting room • Promote Greenlight via social media platform	• Digital online Greenlight flipbooks (Eng, Span, Chinese) • Greenlight flipbooks used in waiting room • Promote Greenlight via social media networks			
Partnership with parents and community leaders	• Quarterly meetings of community advisory board (4-5 participants)	• Maintain community advisory board (CAB) • Quarterly meetings	• Maintain community advisory board • Quarterly meetings			
Program: Tobacco Free Community						
AICAS Partnership: A cross-sector partnership for reducing tobacco use and exposure to environmental tobacco smoke in immigrant	• Through quarterly meetings, partners are informed of interventions, best practices, resources, and policies; and collaborate on	• Through quarterly meetings, partners are: 1) informed of interventions, best practices, and policies; and 2) obtain consensus and shared	• Through quarterly meetings, partners are: 1) informed of interventions, best practices, and policies; and 2) obtain consensus and shared	• Engage and collaborate with at least 20 community-based organizations, healthcare providers,	• Reduce tobacco use and disparities experienced by immigrant populations • Reduce smoking and e-cigarette	• AICAS program documentation (meeting minutes, agendas, consensus building activities results

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
communities through prevention, advocacy, and cessation support	advocacy and capacity building • Repository Workgroup continues to grow Repository site and outreach • Engage 1 new organization that serves Asian and immigrant communities with high smoking prevalence to collaborate on activities or join AICAS Partnership • Identify relevant policy and advocacy opportunities and develop advocacy strategy • Continue partnership with DOHMH, supporting tobacco education and outreach efforts	decisions on group activities • Organize and train AICAS partners to enhance knowledge of and build capacity in advocacy work • Continue partnership with DOHMH, supporting tobacco education and outreach efforts	decisions on group activities • Execute identified policy/advocacy agenda to coordinate and engage partners in advocacy work (i.e. meeting with local officials or submitting public comment) • Continue partnership with DOHMH, supporting tobacco education and outreach efforts	policymakers, researchers, and government agencies • Increase knowledge about the barriers to accessing smoking cessation resources among Asian and immigrant people who smoke • Strengthen community-based capacity to implement tobacco prevention services	(vaping) initiation by youth population • Reduce smoking and treatment access-related disparities in adult population	• Evaluation data • Resource Repository • AICAS Website • Logic Model • Self assessment survey
Recruit and refer smokers to Tobacco Treatment Services	▪ Leverage community partners' social media platforms to promote WeChat Quit Coach Program and other tobacco treatment resources ▪ Enroll 30 smokers in WeChat Quit Coach Program ▪ Offer NRT for up to 8 weeks by mail	• Leverage community partners' social media platforms to promote WeChat Quit Coach Program and other tobacco treatment resources • Enroll 30 smokers in WeChat Quit Coach Program • Offer NRT for up to 8 weeks by mail	• Leverage community partners' social media platforms to promote WeChat Quit Coach Program and other tobacco treatment resources • Enroll 30 smokers in WeChat Quit Coach Program • Offer NRT for up to 8 weeks by mail	• Increase quit attempts, smoking reduction, NRT use, and self-efficacy at 6 months compared to baseline • Reduced tobacco uses disparities experienced by immigrant populations • Increase awareness of the danger of tobacco products,	• Reduce tobacco use and exposure to environmental tobacco smoke in immigrant communities through prevention, advocacy, and cessation support. • By August 31, 2028, reach a total of 3,750 community members	▪ Survey data collected by CSP ▪ Community outreach tracking document (community partners complete) ▪ Program documentation (meeting minutes, agendas)

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	upon request of participants ▪ Phone surveys at baseline, 8 weeks, and 6 months ▪ Engage community partners to conduct outreach to increase awareness of tobacco treatment ▪ Leverage community partners' social media platform, community events, education workshop to promote tobacco treatment resource. ▪ Reach out to 1000 people.	upon request of participants ▪ Phone surveys at baseline, 8 weeks, and 6 months ▪ Leverage community partners' social media platform, community events, education workshop to promote tobacco treatment resource. ▪ Reach out to 1250 people	upon request of participants • Phone surveys at baseline, 8 weeks, and 6 months • Leverage community partners' social media platform, community events, education workshop to promote tobacco treatment resource. • Reach out to 1500 people	including e-cigarettes among the youth population • Increased tobacco treatment cessation rate among Asian American smokers • Increase public awareness of cancer screening related to tobacco use	• Increased use and access to evidence-based smoking cessation programs • Increased referrals to the WeChat Quit Coach Program • By August 31, 2028, enroll at least 90 smokers in WeChat pilot and provide NRT by mail upon request • Increased quitting rates among participants of WeChat Quit Coach • Increased awareness of attendees at workshop about exposed to secondhand smoke in their homes • Increase awareness and access to lung and oral cancer screening	
Program: REACH FAR Brooklyn: Preventing Chronic Disease through Engagement with Community and Faith-Based Organizations						
Implement nutritional policy in faith-based settings (FBO)	• Continue to engage health committee leadership at two FBOs and host implementation planning meetings • Conduct baseline organizational assessment	• Identify champion or health committee at 2 additional FBOs • Engage with FBO leadership and host implementation planning meetings	• Conduct quarterly monitoring of nutritional policy change FBOs • Organize 5 food table to serve free food to 500-600 community members	• Increased reach of food table • 300 community residents will be reached through the food table in the first 5 months.	• Increased access to healthy foods and beverages at communal meals. • Improved food security	• Organizational assessment survey • Tracking the number of individuals receiving service from each food table

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	• Implement nutritional change reaching all congregants • Organize 5 food table to serve free food to 500-600 community members	• Conduct baseline organizational assessment • Implement nutritional change reaching all congregants • Organize 5 food table to serve free food to 500-600 community members				
Implement blood pressure screening program in FBO and CBO setting	• Provide KOT refresher training to volunteers at Brooklyn FBOs • Conduct monthly blood pressure screening with 50 congregants at each site	• Provide KOT training to 10 volunteers at two Long Island FBOs • Planning implementation of KOT, develop protocol • Continue monthly blood pressure at Brooklyn sites	• Conduct monthly blood pressure screening with 25 participants at each site	• Increased prevalence of self-reported blood pressure screening	• Increased percentage of controlled hypertension (systolic BP<140, diastolic BP<90) among those with hypertension	• Baseline and follow-up survey among participants enrolled in the program • Participant tracking cards
Diabetes prevention and management	• Develop culturally tailored handbook on diabetes prevention and management • Planning for conducting workshops and dissemination of handbook	• Conduct 4 in-person or live on-line seminars on diabetes prevention and management to reach 200 community members • Distribute 500 copies of handbook to mosque members, ethnic doctors' offices, and CBO members	• Conduct 4 in-person or live on-line seminars on diabetes prevention and management to reach 200 community members • Distribute 500 copies of handbook to mosque members, ethnic doctors' offices, and CBO members	• Availability of culturally tailored handbook on diabetes management for community members	• 1200-1500 community residents will have tools available to enhance skills on diabetes management and prevention	• Tracking the number of community members receiving the handbook and knowledge on diabetes related skills from seminars
Referral to Mediators of Atherosclerosis in South Asians Living	• Conduct annual follow-up with 50 Bangladeshi and Pakistani	• Conduct annual follow-up with 50 Bangladeshi and Pakistani	• Conduct annual follow-up with 50 Bangladeshi and Pakistani	• Follow-ups completed with study participants	• 150 Bangladeshis and Pakistani community members will	• Tracking the number referrals made to MASALA study.

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
in America (MASALA) Study	community members enrolled in MASALA Study	community members enrolled in MASALA Study	community members enrolled in MASALA Study		contribute to understand the risk factors of cardiovascular disease among the South Asian Americans	
Health Insurance Enrollment	• 50 community members will receive assistance on health insurance information and enrollment	• 50 community members will receive assistance on health insurance information and enrollment	• 50 community members will receive assistance on health insurance information and enrollment	• Increased enrollment into health insurance	• Increased access to healthcare system for chronic disease prevention and management	• Tracking the number of individuals receiving assistance on health insurance
Neighborhood and Built Environment: Programs, Progress and Plans						
Program: Red Hook Community Health Network (RHCHN)						
Network Initiatives	*CHW Program* • 30 Red Hook residents are served by the CHW monthly *Food as Medicine Program* • 30 Red Hook households experiencing food insecurity and/or chronic health issues receive weekly vouchers (totaling $550/family) for fresh, culturally-responsive produce and eggs.	*CHW Program* • 40 Red Hook residents are served by the CHW monthly *Food as Medicine Program* • 30 Red Hook households experiencing food insecurity and/or chronic health issues receive weekly vouchers (totaling $550/family) for fresh, culturally-responsive produce and eggs.	*CHW Program* • 50 Red Hook residents are served by the CHW monthly *Food as Medicine Program* • 30 Red Hook households experiencing food insecurity and/or chronic health issues receive weekly vouchers (totaling $550/family) for fresh, culturally-responsive produce and eggs.	*CHW Program* • The CHW is viewed as a trusted resource by Red Hook residents and staff • RHCHN has an increased understanding of community health and SDOH needs *Food as Medicine Program* • Participants report an increase in the amount of fruits and vegetables households consume. • Participants report an increase in the	*CHW Program* • Red Hook residents have improved access to quality health and SDOH services (particularly in community-identified priority/ need areas, including chronic disease prevention and management) • Red Hook residents report improvements in health and/or SDOH needs *Food as Medicine Program* • Participants report	• Administrative and operations records • Participant assessment and self-reporting • Network member assessment

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	Health and Housing • 3 art and activism projects are launched • The Health Network submits 4 public testimonies at the City, State, and/or Federal level • The Health Network develops a mechanism for enabling CBOs, schools, health entities, and residents to sign-on/support public testimonies	*Health and Housing* • Workgroup continues to meet monthly and respond to emerging community needs • The Health Network submits 4 public testimonies at the City, State, and/or Federal level	*Health and Housing* • The Health Network submits 4 public testimonies at the City, State, and/or Federal level • Workgroup continues to meet monthly and respond to emerging community needs	variety of produce participants consume. *Health and Housing* • Elected officials have information specific to health issues facing Red Hook residents • Issues of health and housing in Red Hook are elevated through press and public testimonies	• improved health due to participation in the Food as Medicine program *Health and Housing* • Conditions in Red Hook Houses are improved, positively impacting Red Hook residents' health • Red Hook residents contribute to positive changes through policies impacting their health • Policy makers representing Red Hook are aware of health and housing issues impacting the neighborhood • Residents have ways to voice concerns/outrage about health issues. And those concerns are heard.	
Network Growth and Sustainability	• 10 organizations are represented and active within the Network • 6 residents active within the Network	• 10 organizations represented and active within the Network • 8 residents active within the Network	• 10 organizations represented and active within the Network • 10 residents active within the Network	• 80% of partners find meaning and value in being connected to the work of the Health Network	• Red Hook community organizations, residents, and health partners are better connected • Residents know and trust their care providers in the neighborhood.	• Administrative and operations records • Gaps, resources, and strategy inventory • Network member assessment

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
Program: Community Health Worker Research and Resource (CHW-RRC)						
The Community Health Worker Research & Resource was launched in 2018 to create a strategic approach to leveraging NYU Langone's extensive CHW–related knowledge and expertise to strengthen and support emerging and existing CHW and patient navigator programs across NYU Langone Health.	Programming planning • Hold 6 CHW Advisory Group meetings • Hold 10-12 CHW Learning Committee meetings • Recruit 4-6 CHW Learning Committee members at the end of each 18-month cycle • Conduct annual CHW Wellness Survey • Hire CHW Resource Hub Coordinator • Host high school and/or college intern Development & implementation • Disseminate 4 CHW Learning Community Newsletters and 10-12 CHW Resource Hub e-blasts, reaching 3,000+ subscribers; ~50 weekly digests, reaching 180+ internal subscribers	Continue with Year 1 programming planning and development & implementation activities • Begin adding external/community content to the CHW Resource Hub • Hire CHW Training Coordinator and/or CHW Policy and Advocacy Coordinator Build out comprehensive tracking measures including: • # events and attendees • # CHW Newsletters published • # CHW-RRC weekly digests sent • # CHW Resource Hub e-blasts sent • # new resources added to the CHW Resource Hub • # research projects assisted/partnered on • Annual CHW Awareness Week events hosted • # and type of technical assistance and research requests	Continue with Year 1 programming planning and development & implementation activities • Develop internal training activities for CHWs and clinicians • Increase advocacy efforts related to supporting the CHW workforce in New York State	**More Cohesive CHW Community:** Sustained and meaningful communication, outreach, and appreciation activities will improve overall connection of CHWs and CHW programs **More Robust Data:** More streamlined data tracking will allow us to better describe the CHW community, usage of the CHW Resource Hub, and align our internal expertise with requests for TA **Increased CHW Capacity and Leadership:** CHWs will develop leadership, advocacy, and research skills through active engagement in webinars, advisory groups, and technical assistance projects **Continued Growth and Relevance of the CHW-RRC:** Communications, outreach, events, research, the Hub, and educational activities will grow our network and more people will be aware of and seek out	**Broader Knowledge Sharing:** The CHW Resource Hub will grow as a vital tool for CHW programs at NYULH and nationwide, offering comprehensive program development resources, training modules, and best practices to support the CHW workforce **New York State and National Leadership**: The CHW-RRC will be recognized as a NY state and national leader in CHW training, advocacy, research, and program development, participating in policy discussions and sharing best practices across the country. **Established Internal Training program:** Team capacity will expand to offer trainings for clinical staff about the CHW workforce and trainings for CHWs on core competencies, research, and recruitment skills	• Mailchimp and Google Analytics: Track engagement metrics for newsletters and the CHW Resource Hub • Meeting Minutes: Collect insights from Advisory Group and Learning Committee meetings to inform future activities • Webinar and Summit Data (Zoom, Eventbrite): Registration, attendance, and survey data for each webinar will be used to assess reach and impact • CHW Wellness Surveys: Gather data on CHW job satisfaction, supervision, and overall well-being, with results used to shape interventions and programs • Research Reports: Data

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	• Host 1 CHW Innovations Summit, with at least 300 in-person/400 virtual participants • Conduct 4-6 webinars with ~1,000+ attendees across sessions • Expand webinar reach to more non-English speaking communities by offering simultaneous interpretation during webinar events • Add resources from 2-4 new CHW programs to the CHW Resource Hub; work to increase web traffic via e-blasts • Host Annual CHW Awareness Week and 2 social events • Create a streamlined system for tracking TA and research collaboration requests • Provide technical support for projects aimed at CHW workforce • Take part in national and state-wide CHW advocacy efforts	• # email list subscribers		our Center's resources and services		from research projects will help to inform state policy and future research opportunities • HR Records: Track CHW staff at NYU Langone to be able to enumerate and describe the CHW workforce at NYULH

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	• Disseminate findings from CHW clinical integration study					
Program: Fall Prevention and Exercise for the Elderly						
Otago Exercise Program: Once a week two-hour class for 17 weeks with adults and a trained coach	• Distribute 33 Otago Exercise Program Activity Booklets • Distribute 33 Walking Tips • Distribute 33 Exercise Calendars • Distribute 33 Exercise Diaries	• Distribute 33 Otago Exercise Program Activity Booklets • Distribute 33 Walking Tips • Distribute 33 Exercise Calendars • Distribute 33 Exercise Diaries	• Distribute 34 Otago Exercise Program Activity Booklets • Distribute 33 Walking Tips • Distribute 34 Exercise Calendars • Distribute 34 Exercise Diaries	• Increased confidence in their ability to perform daily activities safely. • Increased balance control and stability. • Reducing falls among the adult population • Improved overall mobility	• Participants will sustain strength and balance • Participants will reduce fall risk hazards in the home and community. • By maintaining strength, balance, and mobility, participants are better able to maintain their independence and continue living actively. • 80% of program participants will have increased activity levels and reduced fear of falling	• Attendance data • Participant Entry Form • Participant Exit Form • Otago Visit Chart • 1, 6, 8, and 12-month post follow-up • Documentation of the number of sessions
Tai Chi for Arthritis: Twice-weekly classes for 8 weeks with adults and Tai Chi instructor	• Recruit and train 2 new staff members • Conduct pre and post balance assessments for 84 adults • Retain 80% of registered adults for each class • Distribute 84 Tai-Chi educational materials to each participant	• Conduct pre and post balance assessments for 84 adults. • Retain 80% of registered adults for each class • Distribute 84 Tai-Chi educational materials to each participant	• Conduct pre and post balance assessments for 82 adults. • Retain 80% of registered adults for each class • Distribute 82 Tai-Chi educational materials to each participant	• Educate participants on proper body mechanics • Reducing falls among the adult population • Improve the health of adults without exacerbating existing impairments	• Adults will enhance their balance both mentally and physically • Improving muscle strength, flexibility, confidence and endurance via weight transference • Decrease the annual rate of hospitalizations due to falls by 5%.	• Attendance data • Participant information Form • Pre/Post Balance Assessments • Participant Post Program Survey • 1- and 3-month post survey • Documentation of the number of sessions

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
A Matter of Balance: Once a week two-hour class for 8 weeks with adults and a trained coach	• Recruit and train 2 new staff members • Distribute 67 PAR-Q and Participant Agreements • Retain 80% of registered adults for each class • Distribute 67 A Matter of Balance Participant Workbooks	• Distribute 67 PAR-Q and Participant Agreements • Retain 80% of registered adults for each class • Distribute 67 A Matter of Balance Participant Workbooks	• Distribute 66 PAR-Q and Participant Agreements • Retain 80% of registered adults for each class • Distribute 66 A Matter of Balance Participant Workbooks	• Increased knowledge on how to reduce fall risk at home • Increased activity/exercise levels • Reducing falls among the adult population	• Participants will view falls and fear of falling as controllable • Participants will reduce fall risk hazards in the home and community • increase the percentage of adults who have reduced their fear of falling and increase activity levels by 80%.	• Attendance data • Participant information Form • Participant Agreement Form • Participant Post Program Survey • 1- and 3-month post survey • Documentation of the number of sessions
Health Care Access and Quality: Programs, Progress and Plans						
Program: PlayReadVIP (previously called Video Interaction Project [VIP])						
Delivery of PlayReadVIP program	• Provide one-on-one PlayReadVIP visits to 250-400 families • Complete 500-1,000 one-on-one visits	• Provide one-on-one PlayReadVIP visits to 250-400 families • Complete 500-1,000 one-on-one visits	• Provide one-on-one PlayReadVIP visits to 250-400 families • Complete 500-1,000 one-on-one visits	Parents: • Increased positive parenting activities (reading aloud, playing together, etc.) • Increased learning materials in the home (toys and books) that support positive parenting activities • Enhanced capacity for coping with stressors - e.g., reduced parenting stress, reduced depressive symptoms Child: • Enhanced early child development	Parents: • Increased positive parenting activities (reading aloud, playing together, etc.) by at least 25%, resulting in long-term enhancement of child social-emotional development • Increased learning materials in the home (toys and books) that support positive parenting activities • Enhanced capacity for coping with stressors (e.g., reduced parenting	• Attendance and visit documentation notes • Parent surveys • Research findings from previous randomized controlled trials

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				• Enhanced social-emotional development	stress, reduced depressive symptoms) Child: • Enhanced school readiness (as a result of enhanced social-emotional development)	
Linkages with other early childhood programs and organizations	• Continue to refine linkages between PlayReadVIP and other co-located or local programs (e.g., Reach Out and Read, HealthySteps, ParentChild+, VROOM, Brooklyn Public Library)	• Continue to refine linkages between PlayReadVIP and other co-located or local programs (e.g., Reach Out and Read, HealthySteps, ParentChild+, VROOM, Brooklyn Public Library)	• Continue to refine linkages between PlayReadVIP and other co-located or local programs (e.g., Reach Out and Read, HealthySteps, ParentChild+, VROOM, Brooklyn Public Library)	• Strengthened impact of messaging across programs, resulting in increased reading aloud and access to learning materials in the home	• Enhanced school readiness	• Documentation of refinement processes
Program: ParentChild+						
Twice-weekly home visits with parent(s), child, and ParentChild+ Early Learning Specialist	• Provide home visiting services for 68 families • Conduct a total of 3128 home visits • Retain 90% of enrolled families for duration of program year • Distribute 748 educational toys and 816 books to participating families	• Provide home visiting services for 68 families • Conduct a total of 3128 home visits • Retain 90% of enrolled families for duration of program year • Distribute 748 educational toys and 816 books to participating families	• Provide home visiting services for 68 families • Conduct a total of 3128 home visits • Retain 90% of enrolled families for duration of program year • Distribute 748 educational toys and 816 books to participating families	• Parents: Increased (or sustained frequent) use of positive parenting techniques and knowledge and awareness of child development • Children: Improved (or sustained on-target) social and emotional development and early literacy skills essential for school readiness • 90% of enrolled young children will demonstrate on-target social	• Children will outperform the statewide average on their third-grade state math achievement test • Children will graduate from high school at the same rate as their middle-class peers, eliminating disparities in education attainment based on income	• Program administrative data • The Parent Involvement in Early Literacy (PIEL) assessment administered to parents at beginning, middle and end of program participation • Ages and Stages Questionnaire (ASQ) administered at the beginning, middle and end

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				emotional development at the end of the program		of program participation • Ages and Stages Social Emotional Questionnaire (ASQ-SE) administered at the beginning, middle and end of program participation
Program: Family Support Services						
Implement Family Support Counselors in the pediatric practice at Hempstead Pediatric Primary Center Implement Reach out and Read (ROR) Program	• Screen 500 families for social needs and ROR. • Connect/refer each family to services • Follow up with each family to make sure services were rendered • Distribute 10 books per family by the child's fifth birthday • Distribute 3000 books to participants in the ROR program	• Screen 500 families for social needs and ROR. • Connect/refer each family to services • Follow up with each family to make sure services were rendered • Distribute 10 books per family by the child's fifth birthday. • Distribute 3000 books to participants in the ROR program.	• Screen 500 families for social needs and ROR. • Connect/refer each family to services • Follow up with each family to make sure services were rendered • Distribute 10 books per family by the child's fifth birthday. • Distribute 3000 books to participants in the ROR program	• Connect families to the social services needed • Improve access to social service resources • Improve parent knowledge, attitudes, and practices related to their child's development • Exposing children to positive childhood experiences	• Improve health equity by addressing social determinants of health • Nurturing young minds through reading and storytelling • 75% of families screened will have improved access to social and economic community services	• Attendance data • Social Service Needs Screening Form • Literacy Screening Form • Documentation
Program: Community-Oriented Virtual Primary Care and Technology						
Digital Health Resource Center	• Digital health and technology access resources such as trainings,	• User-friendly website developed for clinicians and CBO staff to access	• Resource center updated monthly	• Increased access to digital health and technology access resource and	• Improved health equity for FHC patients and the	• Baseline Digital Health Resource Center Survey

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	workshops, classes, support services and programs, research grants and projects, and informational materials collected from 10 partners including FHC programs and CBOs	digital health and technology access resources within the community • All digital health and technology access resources organized using tags • Materials collected from an additional 10 partners		services such as trainings, workshops, classes, support services and programs, research grants and projects, and informational materials • Improved digital literacy within the community • Increased technology and broadband access	surrounding community • Increased access to both in-person and virtual primary care services in underserved communities • Reduced disparities in primary care utilization, chronic condition prevention and management, and avoidable adverse health outcome	• Community needs and assets assessments • Number of virtual care visits offered and conducted • Number of new patients accessing in-person primary care following virtual visits • Number of organized digital health events • Number of attendees at development opportunities • Number of new enrollees in digital health apps • Number of completed preventative screenings among new patients as a result of initial virtual health visits • Percentage of patients using digital health apps post enrollment (one year) • Assessment of barriers to accessing virtual health care
Establish Digital Health Equity Consortium	5 partners and local leaders meeting bi-monthly to discuss the current digital health landscape, develop partnerships, share best practices, and advocate for sustainable virtual health care models	10 partners and local leaders meeting bi-monthly to discuss the current digital health landscape, develop partnerships, share best practices, and advocate for sustainable virtual health care models	15 partners and local leaders meeting bi-monthly to discuss the current digital health landscape, develop partnerships, share best practices, and advocate for sustainable virtual health care models	• Exchange of knowledge and best practice related to digital health across communities and health systems • Promotion of digital health workforce		
Digital Health Professional Development Opportunities	• Two development opportunities or trainings for health center and CBO staff developed and facilitated by consortium • 10 health center -and/or CBO staff trained	• Bi-monthly (6) development opportunities or trainings for health and CBO staff developed and facilitated by consortium partners • 10 health center and/or CBO staff trained	• Bi-monthly (6) community-based workshops on digital literacy • 30 community-based members undergo training workshops	• Promotion of digital health workforce • Strengthened community-based workshops and classes taking place at CBOs, in fait-based communities, bodegas, schools, and libraries		
Remote Patient Monitoring Device Program Support	• Partnerships developed with remote patient monitoring programs • Instructional guides for remote	• Quarterly oversight through data reporting for equitable distribution of RPM devices provided to all RPM programs	• Quarterly oversight for equitable distribution of RPM devices provided to all RPM programs	• Increased access to RPM devices and virtual health services		

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	patient monitoring devices developed	taking place at the health center • Quarterly RPM support sessions held with at least 5 attendees per session	taking place at the health center • Quarterly RPM support sessions held with at least 5 attendees per session			• Digital determinants of health screenings among FHC patients • EHR and MyChart data and analytics
Education Access and Quality: Programs, Progress and Plans						
Program: ParentCorps						
Provide ParentCorps professional development to all partner sites, FCC providers, FFN care providers	• 9 veteran sites (approximately 27 classrooms). • 14 new partner sites (approximately 42 classrooms). • Family Child Care and Family Friends Neighbor providers (approximately 25).			• Pre-K programs increased use of evidence-based and culturally relevant policies and practices in support of Family Engagement and Social Emotional Development. • Positive ratings on the annual NYC School Survey (e.g., home-school connection). • Families are engaged in the school community and perceive school as a welcoming and supportive place. • Parents feel valued and empowered to support and advocate for their children. • Children build foundational skills	• Pre-K programs same as intermediate outcomes • Families: children engage in healthful behaviors, are confident problem-solvers and see themselves as important members of the school community. • Improvements in children's mental and physical health and school performance. • By August 2028, we will reach 3475 families annually.	• Attendance and Feedback Forms for all activities (Teacher and Leader Professional Development, ParentCorps Program Facilitator Training, Parenting Program) • Facilitator Self-Reflection Forms (Parenting Program) • Classroom Visit, Teacher Interview, Coach End-of-Year Rating Forms • Focus Groups for Teachers and Families
Offer ParentCorps' Parenting Program in 3 languages (Spanish, English, Mandarin Chinese) in-person at 3 veteran sites	• Families at 3 veteran sites (13 classrooms, approximately 234 families)					
Offer ParenCorps' parenting program virtually to the community and increase outreach through partnerships in the Sunset Park community	• Approximately 2275 families at 9 veteran sites and 14 new partner sites (142 classrooms), 200 families in FCC/FFN settings, and 1000 families in TGS CARE programming (3475 families total).A					
Implement ParentCorps' Friends School at veteran or new sites	• Sustain Friends School at 1 veteran site (4 classrooms, approximately 72 children). • If new sites express interest, explore the opportunity to expand Friends School to new sites and classrooms.					

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				for learning and healthful development. • Increased use of evidence-based and culturally relevant practice to promote Social Emotional Development at home.		
Program: Project SAFE						
Multi-Session Workshop Series	• Conduct 30 cycles of Making Proud Choices! (MPC) and Making a Difference! (MAD) • Curricula administered with high fidelity • Reach 750 youth • 75 youth referred to social and health services • Expand to 1 new site • 75% of workshop participants will complete 75% of workshops	• Conduct 30 cycles of Making Proud Choices! and Making a Difference! (MAD) • Curricula administered with high fidelity • Reach 750 youth • 90 youth referred to social and health services • Expand to 1 new site • 75% of workshop participants will complete 75% of workshops	• Conduct 30 cycles of Making Proud Choices! and Making a Difference! (MAD) • Curricula administered with high fidelity • Reach 750 youth • 105 youth referred to social and health services • Expand to 1 new site • 75% of workshop participants will complete 75% of workshops	• Improved behavior change - intent to use and actual use of skills, practices, and resources • Increased number of sexually active youth who consistently use condoms • Increased number of sexually active youth using contraception to prevent unintended pregnancy • Increase the number of youth who delay the onset of sexual activity	• Reduced teen pregnancy • Reduced disparities in teen pregnancy rate for Hispanic and African American youth in relation to white youth • Reduced teen birth rate • Reduced disparities in teen birth rate for Hispanic and African American youth in relation to white youth • Reduced disparities in teen birth rate for youth with Medicaid in relation to youth not on Medicaid • Reduce STI and HIV rates among male and female adolescents and young adults	• Pre/post survey • Referral sheets, including documentation confirming first visit • Implementation data
Single-Session Workshops	• Peer Educators and staff facilitate 12 single-session workshops • Reach 180 teen participants	• Peer Educators and staff facilitate 12 single-session workshops • Reach 180 teen participants	• Peer Educators and staff facilitate 12 single-session workshops • Reach 180 teen participants	• Single-session workshops are focused on short-term outcomes: increased knowledge and awareness of STD, HIV, and pregnancy prevention;		• Post workshop survey • Implementation data

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				increased knowledge of prevention and intervention resources	• By August 2028, 65% of Peer Educators will improve in at least two pregnancy-prevention behavior areas by the end of the program. • Reach: Over 5,000 youth 11-24 years old	
Peer Education Groups	• Recruit and train 56 youth • 42 youth serve as Peer Leaders • Retain ≥ 70% of enrolled youth	• Recruit and train 56 youth • 42 youth serve as Peer Leaders • Retain ≥ 70% of enrolled youth	• Recruit and train 56 youth • 42 youth serve as Peer Leaders • Retain ≥ 70% of enrolled youth	• Increased number of sexually active youth who consistently use condoms • Increase the number of youth who delay the onset of sexual activity • Enhanced social skills of youth that can be utilized in peer-to-peer relationships to diminish the risk of HIV infection. • Increased number of sexually active youth using contraception to prevent unintended pregnancy		• Complementary Strengths Survey – baseline assessment, re-administered every six months of participation in the program • Implementation data
Community Events	• Host or perform at 6 community events • Reach 240 youth • 35 youth receive HIV screening at Project Reach Youth (PRY) hosted events • Additional 75 tested at cohosted events	• Host or perform at 6 community events • Reach 240 youth • 35 youth receive HIV screening at PRY hosted events • Additional 100 tested at cohosted events	• Host or perform at 6 community events • Reach 240 youth • 35 youth receive HIV screening at PRY hosted events • Additional 100 tested at cohosted events	• Community events are focused on short-term outcomes: increased knowledge and awareness of STD, HIV, and pregnancy prevention; increased knowledge of prevention and intervention resources		• Post-event survey • Screening records

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (SMARTIE Objectives*)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
Teen Health Clinic	• 350 youth receive screenings and other services at the Teen Health Clinic and School Based Health Centers (SBHCs) • 650 youth receive PrEP and PEP services and screenings	• 350 youth receive screenings and other services at the Teen Health Clinic and SBHCs • 700 youth receive PrEP and PEP screenings and services	• 350 youth receive screenings and other services at the Teen Health Clinic and SBHCs • 700 youth receive PrEP and PEP screenings and services	• Increased number of sexually active youth using contraception to prevent unintended pregnancy • Increased number of sexually active youth screened for STIs and HIV		• Appointment records
Staff and Parent Workshops	• Staff facilitate 6 single-session workshops for staff and parents • Reach 34 adult participants	• Staff facilitate 6 single-session workshops for staff and parents • Reach 34 adult participants	• Staff facilitate 6 single-session workshops for staff and parents • Reach 34 adult participants	• Improved communication with youth about sexual health		• Post workshop survey • Implementation data