



NYU Langone Hospitals

Community Health Needs and Assets Assessment and Implementation Plan/Community Service Plan 2022-2024

Adopted May 2022
NYU Langone Hospitals Board of Trustees

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

The Executive Summary of our Community Health Needs 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 Sue A. Kaplan, JD, Research Professor, Department of Population Health, and Director of the Community Service Plan at: sue.kaplan@nyulangone.org; Kathleen Hopkins, Vice President for Community Programs, Family Health Centers at NYU Langone at: kathleen.hopkins@nyulangone.org; or Kymona Tracey, Director, Community Education, Outreach and Health Benefit Administration, NYU Langone Hospital – Long Island at: kymona.tracey@nyulangone.org.

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Mission

NYU Langone Health is one of the nation's premier academic medical centers. Composed of NYU Langone Hospitals ("NYULH"), NYU Grossman School of Medicine ("NYUSoM"), and NYU Long Island School of Medicine ("NYULISoM"), NYU Langone Health has a trifold mission: to serve, teach and discover. Located in the heart of Manhattan, with additional facilities throughout the New York City area, NYULH currently operates the following six 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 (formerly known as Hospital for Joint Diseases), 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 (formerly known as NYU Lutheran Medical Center), a full-service teaching hospital and Level I Trauma Center located in Sunset Park, Brooklyn
- NYU Langone Hospital – Long Island (formerly known as NYU Winthrop Hospital), which provides inpatient and outpatient medical care throughout Long Island

NYU Langone Health also recently affiliated with Long Island Community Hospital at NYU Langone Health, a community hospital in Suffolk County, 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, an affiliate of NYULH, is a Federally Qualified Health Center network, which includes eight primary care health centers in Brooklyn and over 40 school- and shelter-based extension clinics.

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

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:

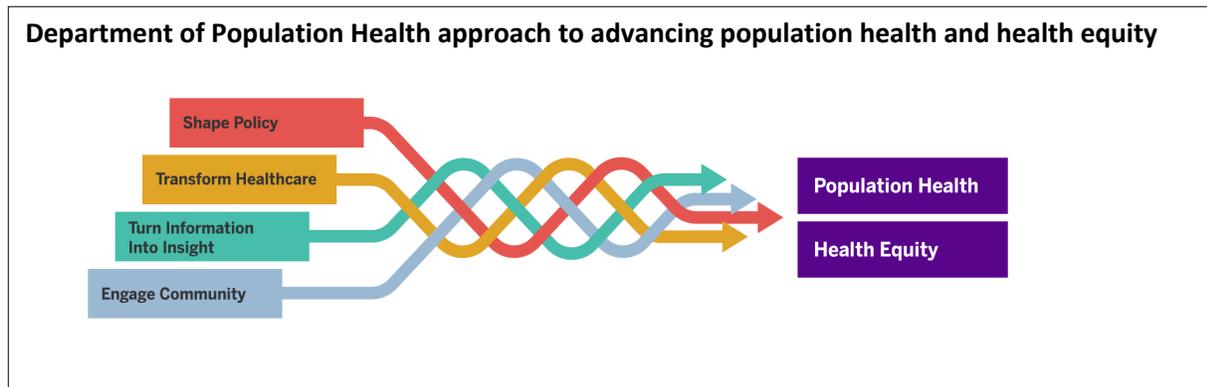
<https://nyulangone.org/insurance-billing-financial-assistance>

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

Growing out of our Community Health Needs and Assets Assessment (CHNAA) and aligning with the New York State Prevention Agenda and New York City and Nassau County public health priorities, the NYU Langone Hospitals three-year implementation plan (the Community Service Plan, “CSP”) focuses on **Preventing Chronic Diseases** by promoting healthy eating and food security, decreasing tobacco use and exposure to secondhand smoke, addressing the intersection of health and housing, supporting disease self-management, and connecting people to resources that address social and health risk factors. The Plan also **Promotes Healthy Women, Infants and Children** through parenting programs, by connecting families to needed resources, and through early childhood and teen pregnancy prevention programs. We also have an emerging portfolio of projects that focus on **Promoting a Healthy and Safe Environment** by reducing falls among vulnerable populations. Our Community Service Plan programs span multiple sectors: early childhood settings and schools, primary care, housing, and community settings, such as faith-based organizations and social service providers.

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



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

Beginning in 2022, the CHNAA and CSP expanded to include NYU Langone Hospital – Long Island (formerly Winthrop Hospital), focused initially on building community partnership and developing programs to meet the needs of the Hempstead community. (See Section I.C.5.)

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, and Sunset Park and Red Hook in Brooklyn; we recently also completed an initial needs and assets assessment in Hempstead in Nassau County and are beginning to implement CSP programs there as well.

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

The FHCs are nationally recognized for innovative, affordable, high-quality care and are one of the largest employers within the communities they serve. The FHCs established the nation's largest dental residency program, the largest school health program in New York, a community medicine program serving more than 7,000 homeless New Yorkers, and one of the first health-focused AmeriCorps programs. In fiscal year 2021 alone, the FHCs provided over 15,000 individuals with direct assistance to obtain public benefits, adult literacy classes, legal services, health referrals, and emergency food.

Priority Areas of Focus

Preventing Chronic Diseases

- 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.
- **Greenlight**, an early childhood obesity prevention program to improve health literacy and foster healthful diet- and activity-related behavior, is being adapted and implemented in partnership with the Charles B. Wang Community Health Center and the Seventh Avenue Family Health Center at NYU Langone in Sunset Park. In the next CSP cycle, it will be extended to the Sunset Park Family Health Center at NYU Langone, as well as the NYULH pediatric practice in Hempstead, Long Island.
- **Racial and Ethnic Approaches to Community Health for Asian and Arab Americans (REACH FAR)**, an evidence-based program designed to prevent cardiovascular disease by increasing access to healthy foods and providing culturally tailored health coaching and messages, is being implemented in mosques on the Lower East Side, Manhattan and in Sunset Park and Kensington, Brooklyn.
- **Tobacco Free Community** includes an array of programs to address high smoking rates among immigrant populations, particularly Asian American men: a community navigator program; a Citywide coalition that is addressing tobacco-related policies, facilitating access to smoking cessation

treatment and developing a repository of resources; and a program to educate youth about e-cigarettes. These programs are being implemented in partnership with Asian Americans for Equality, the Charles B. Wang Community Health Center, the Chinese American Planning Council, the New York City Housing Authority, and the NYC Department of Health and Mental Hygiene – Tobacco Policy and Program.

- The [Stanford Chronic Disease Self-Management Program](#), an evidence-based educational program designed to build disease management skills and confidence, is being implemented in libraries and other community settings in Nassau County.
- The [Red Hook Community Health Network](#) is a network of community-based organizations 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 health disparities of 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, providing social and professional development opportunities for CHWs within the NYULH system, and providing technical support, evaluation, and convening opportunities to support community-based organizations, health systems, municipal agencies, and research organizations to strengthen and better understand the role of CHWs in promoting the health of vulnerable communities.
- The [Brooklyn 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 Brooklyn residents 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.

Promoting Healthy Women, Infants and Children

- [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 between two and four years old who are challenged by poverty, low levels of education, language and literacy barriers and other obstacles.
- [ParentCorps](#), an evidence-based family-centered early childhood intervention to improve child health, behavior and learning, has been assessing needs and providing responsive support to the early childhood community in Sunset Park, including ParentCorps Professional Development and programming. The program will expand to reach 12 pre-K programs and offer resources system-wide.

- The [Video Interaction Project \(VIP\)](#), an evidence-based parenting program that uses videotaping and developmentally-appropriate toys, books and resources to help parents strengthen early development and literacy in their children, will continue to serve Sunset Park and extend its reach to additional locations.
- [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.
- Enhanced [Family Support Services](#) will be provided at the NYU Langone – Long Island Pediatric Practice in Hempstead where a Family Support Counselor will screen patients for social needs, connect them to a network of local services, and follow up to ensure that care is received. The Practice will also implement Reach Out and Read, an evidence-based early literacy program.

Promoting a Healthy and Safe Environment

- [Tai Chi for Arthritis for Falls Prevention](#) and [A Matter of Balance](#), two evidence-based fall prevention programs, are being implemented at the Long Island Hospital Wellness Center, two libraries and other community settings.

The CSP [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.

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

I. Community Health Needs and Assets Assessment

A. Definition and Brief Description of Communities Served

As a major academic medical center, NYU Langone Health serves a broad community of diverse populations with a wide range of healthcare needs. Its primary service area includes Manhattan, Brooklyn, 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 A. Based on that review (described for each community below) and in light of our commitment to continuing our CSP partnerships and work, the 2022-2024 Community Service Plan continues to focus on the communities served through the previous Plans: the Lower East Side and Chinatown in Manhattan, and Sunset Park and Red Hook in Brooklyn. In addition, over the course of the past year, following the

merger with Winthrop Hospital (now NYU Langone Hospital – Long Island), we have undertaken a CHNAA focused on the Village of Hempstead in Nassau County and have begun to develop programs to meet the need and priorities of this vibrant but under-resourced community. Our 2022-2024 Plan extends to that community as well.

These communities – the Lower East Side and Chinatown in Manhattan and Sunset Park and Red Hook in Brooklyn, and Hempstead in Nassau County – were selected based on the need for services as evidenced by social determinants of health, health disparities, risk factors, and utilization data. Although these communities are not geographically contiguous, they share important similarities, including the diversity of their populations and 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 three years. We have engaged a range of stakeholders – with a particular focus on medically underserved residents – to assess community needs; set priorities; develop, design, and implement programs; and share and celebrate progress and results. We employ diverse, often multi-pronged strategies and rely on our extensive network of community partners and advisory boards and committees to provide ongoing outreach and program development. The Family Health Centers at NYU Langone advisory structure includes the Sunset Park Health Council as the community governing board; culturally-specific advisory groups; and program-specific councils, including the Teen Health Council. The NYULH Community Service Plan Coordinating Council, which brings together NYU Langone faculty and staff, community partners, and policymakers, meets quarterly to oversee program implementation, share findings, provide insight into community need, and identify priorities. In addition, each CSP project has developed deeper community relations over the past three

Collection, analysis, presentation and discussion of data

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

years and these have provided an important way for us to understand and shape our CHNAA and guide our program implementation and assessment.

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

To understand more about community need and to support policymakers, providers and community groups in understanding community demographics, and community assets and needs including housing and health outcomes (a high community priority), we undertook an analysis of existing sources of data. (See Appendix A for a list of data sources.)

The City Health Dashboard: a CHNA Resource

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

Summaries and updates of the CHNAA and CSP are shared with community partners and coalitions, as well as with Community Boards. These meetings include residents, as well as representatives from businesses, and government and community-based organizations.

These summaries are also used to inform and solicit input from NYULH – Brooklyn and Family Health Centers at NYU Langone advisory groups and frontline staff and from community partners, including members of the CSP Coordinating Council.

We have solicited written comments from the public on our previous CHNAA and

implementation plan both through our website and at public meetings. Although no written comments were received, comments and discussion followed public presentations at community meetings.

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

Below, we describe CHNAAs for each community. We begin with a profile of each of these communities. This is followed by an in-depth assessment of specific needs related to the impact of COVID, and priorities for preventing chronic diseases, including the connection between health and housing, healthy eating and food security, and tobacco prevention and cessation. We also assess the needs and assets related to promoting healthy women, infants and children, including maternal/child exposure to adversity and teen pregnancy.

C. Community Profiles

1. Sunset Park Needs and Assets

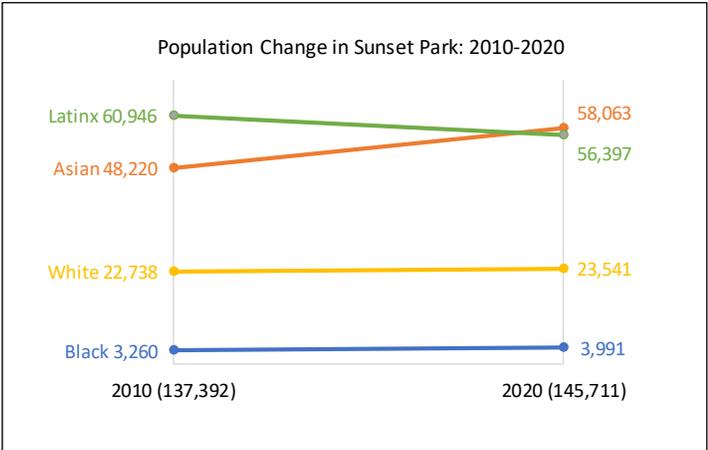
Sunset Park residents make up the highest percentage of individuals who use NYU Langone Hospital – Brooklyn and Family Health Centers at NYU Langone. The neighborhood is a mixed residential, industrial, and commercial community in Southwest Brooklyn, adjoining the waterfront. Sunset Park can be described as encompassing three geographic areas: Sunset Park West, Sunset Park Central, and Sunset Park East/ Borough Park West. The population in each of these areas has grown between 2010-2020 and today is home to about 146,000 residents in aggregate. This growth has been driven by an increase in the number of Asian residents, which has offset a decline in the number of Latinx*



Overall, 40% of the residents are Asian, 39% are Latinx, and 16% are White. In Sunset Park West, most residents are Latinx (56%) while in Sunset Park Central and Sunset Park East/Borough Park West, most residents are Asian (57% and 55% respectively). About 41% of the Latinx residents are of Mexican origin, and about 91% of the Asian residents are of Chinese origin.

For nearly 200 years, Sunset Park has served as a first destination for immigrants – today, 50% of residents are born outside the United States. Although, as described in Section I.D.1. local businesses have been hit hard by the pandemic, two vibrant commercial corridors of shops, restaurants, and small businesses continue to serve this multi-cultural community.

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



* We use the gender-neutral term “Latinx” after consultation with several community partners, but recognize that the terminology is in flux and not universally used or accepted.

best served in a language other than English; 78% 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 (30%) being most common. Fifty-four percent of residents ages 5 years and older have limited English proficiency.

Housing in Sunset Park

- Nearly half of all Sunset Park renters experience rent burden (>35% of income on rent), with 1 in 3 renter households experiencing severe rent burden (>50% of income on rent).
- Without any NYCHA public housing options and a limited supply of subsidized housing (6% of all units compared with 12% citywide), Sunset Park has little protection against rising housing costs. The neighborhood has a higher gross median rent (\$1,458) than NYC as a whole (\$1,443).
- Sunset Park ranks among the highest in severely crowded households among NYC neighborhoods, with nearly 10% of renters having more than 1.5 people per room compared with 4% citywide.

Social, economic, and environmental issues continue to be top priorities identified by community members. Sunset Park is a community that grapples with high levels of poverty, low educational attainment, and health disparities. Twenty-six percent of residents live below the Federal Poverty Level compared to 18% of residents in New York City. From 2010 to 2019, the percentage of wealthiest residents (making five times or more of the poverty level) increased from 12% to 16% while the percentage of residents who experienced poverty remained roughly the same (from 27% to 26%). With median earnings for Sunset Park workers at just over \$26,000, compared with nearly \$41,000 for workers citywide, many of those who work still experience poverty. Poverty is

particularly acute among children – 36% of children under 18 live below the poverty level. About 43% of adults ages 25 years or older have less than a high school diploma, including 22% 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 schools in Sunset Park are consistently at or above the citywide rate.

Prior to the COVID pandemic, unemployment was 6% in Sunset Park, similar to NYC (6%); however nearly one-quarter of employed Sunset Park residents worked in the arts, entertainment, recreation, accommodation and food services industry and many employed in these sectors lost jobs during the pandemic. In recent conversations with community partners, all have stressed the need for workforce development for documented and undocumented immigrants across a realistic range of job types, noting that addressing adult literacy is a prerequisite to successful training and employment.

Sunset Park residents are nearly twice as likely to lack health insurance than residents citywide (14% vs. 8%), with rates varying by age. While nearly all children in Sunset Park and citywide have some health insurance, about 20% of adults ages 18-64 years are uninsured. Overall, fifty-seven percent of Sunset Park residents have health insurance through public coverage (e.g., Medicaid or Medicare).

Sunset Park has a strong network of trusted community-based organizations many of which have served the community for several generations. In conversations with

One of the valuable assets of Sunset Park is its network of culturally-specific community-based organizations that serve immigrant residents. **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.

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.

2. Needs and Priorities of the Arab American Community in Southwest Brooklyn

Background and Methods:

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. A health needs assessment for the Brooklyn Arab American community was last conducted in 2008. In September 2018 at the Arab American Community Advisory Group Quarterly Meeting at NYU Langone Hospital--Brooklyn, Arab American community partners advocated for an up-to-date assessment of health needs and priorities to better inform NYU Langone Hospital- Brooklyn strategies for engaging the Arab community. (See Appendix B for a full list of the participating partners.) The purpose of this assessment was to describe the health needs, priorities, and barriers to health care specific to the Arab American community in Brooklyn.

Members from community-based organizations and health organizations formed a working group to develop the survey. A convenience sample approach was used to recruit participants. Partner organizations invited their program participants to answer the survey and also worked with mosques, churches, and other programs serving the Brooklyn Arab American community to invite community members to participate. Participants were eligible if they were at least 18 years old, self-identified as Arab American, and lived 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. Data collection took place between September 2019 and December 2019.

Survey Working Group Members:

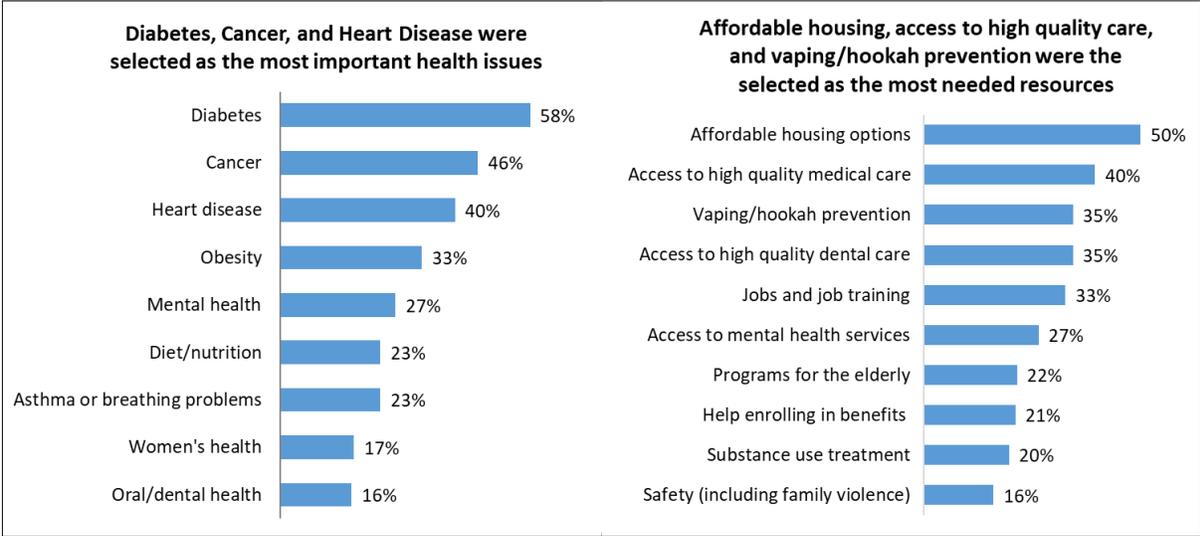
- Arab American Association of New York
- Arab American Family Support Center
- Moroccan American House Association
- Arab Health Initiative of Memorial Sloan Kettering Cancer Center
- Family Health Centers at NYU Langone
- NYULH Center for the Study of Asian American Health
- NYU Langone Hospital –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

Key Findings:

A total of 511 Arab American adults living in Brooklyn responded to the survey. Most participants were between the ages of 25-64 years (69%), female (60%), and responded to the survey in Arabic (58%). Respondents were born in a variety of countries, including Yemen (25%), Morocco (24%), Egypt (14%), United States (11%), Palestine (7%) and Syria (7%). Annual household income was less than \$25,000 for 45% of participants.

Diabetes, cancer, heart disease, obesity and mental health were selected by participants as the most common health issues facing the Brooklyn Arab American community. These issues align with prevalent health conditions identified in this survey. For example, diabetes was more common among Arab American adults in this survey (16%) than among adults in New York City (11%); a pattern similar to a study conducted in Michigan. Risk factors for heart disease, like high blood pressure and high cholesterol were also common among survey participants (25% and 26%, respectively). Among participants who reported a height and weight, about 24% were obese. About 20% of adults in the survey were at risk for current depression.

Top Health Issues and Needed Resources for the Brooklyn Arab American Community

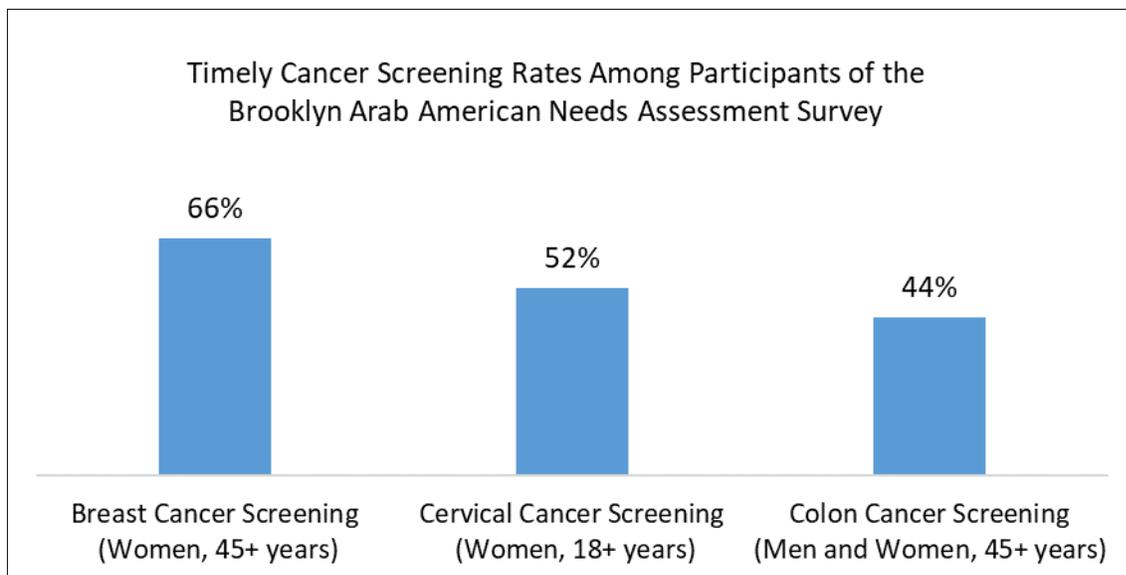


Affordable housing and access to quality medical care were selected by participants as the most common resources needed to support the health of the Brooklyn Arab American community. These resource needs also align with conditions identified in the survey. For example, about 20% of participants reported not having enough money to pay their rent/mortgage. This percentage is likely even higher now, as the impacts of unemployment and higher cost of living due to the COVID pandemic continue to be felt.

While 95% of participants reported having health insurance, about 28% of participants reported not being able to get needed medical care in the past year—more than twice the percent of adults in New York City overall. Among those who could not get needed care, transportation problems and cost were the most common barriers noted.

Cancer was a main health concern noted, and timely cancer screening was found to be lower among Brooklyn Arab American participants than New York City adults overall. About 44% of participants aged 45 years or older had a timely colon cancer screening test, compared to about 69% of adults age 50 years or older citywide.

About 66% of female participants ages 45 years or older had a timely breast cancer screening (mammogram), compared to about 76% of women ages 40 years or older citywide. About 52% of female participants had a timely cervical cancer screening test, compared to about 85% of women citywide.



Results from this survey were presented by a workgroup member from a community-based partner organization at a virtual meeting of the Arab American Community Advisory Group in February 2021. These results were also presented to executive leadership of the Family Health Centers at NYU Langone. See II.C.3., below, for a description of how these needs are being addressed.

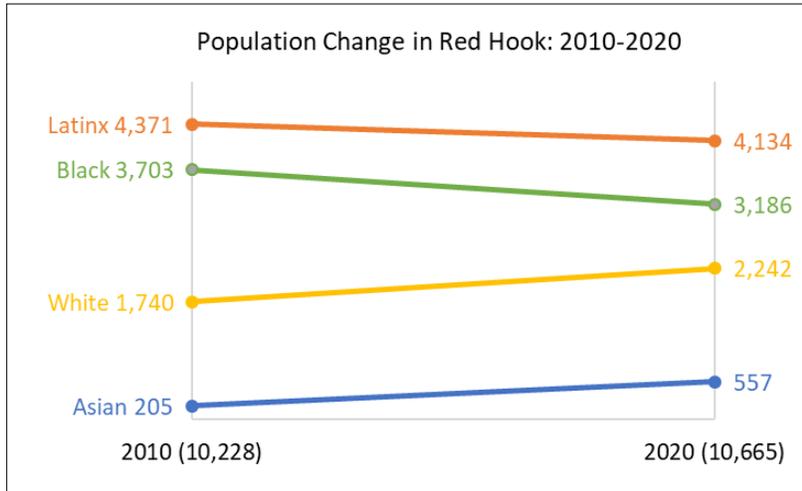
3. Red Hook Needs and Assets

Red Hook is a resilient, diverse and lively waterfront community in Brooklyn. The neighborhood is home to New York’s second largest public housing complex, the Red Hook Houses. More than half of Red Hook residents live in public housing.

The majority of Red Hook residents are racial and ethnic minorities. Thirty-nine percent identify as Latinx, 30% Black, 21% White, and 5% Asian. Although the overall population of Red Hook has remained relatively steady between 2010-2020, there has been an increase in the White and Asian population and a decrease in Latinx and Black population. About one-third of Red Hook residents ages five years and older speak a language other than English at home, with Spanish being most common (25%). Twenty-three percent of Red Hook’s approximately 11,000 residents are under the age of 18.



Image source: [Red Hook, Brooklyn](#) by [Todd Crusham](#) is licensed under [CC BY 2.0](#)



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 43% in 2015-2019. While the poverty rate for Red Hook overall is 36%, the rate is three times higher in the census tract containing Red Hook Houses compared with the surrounding census tracts (45% vs 15%).

Poverty, high unemployment, and low educational attainment are challenges in the community. Forty-three percent of children under the age of 18 Red Hook live in poverty. Prior to the Covid-19 pandemic, 19% of residents 16 and older were unemployed, compared with 6% of residents citywide. About 27% of workers were employed in educational, health care or social assistance industry and about 15% of workers were employed in retail trade. Thirty-one percent of adults have not completed high school.

Red Hook is geographically isolated. Many residents live far from the subway system and the neighborhood is cut off from the rest of Brooklyn by the Brooklyn Queens Expressway, causing difficulty in accessing resources not available in the community. Community concerns about access to healthcare and affordable food have increased with the closures of Long Island College Hospital in 2013 and Pathmark in 2015. This isolation, however, also fosters social cohesion, neighborhood pride, and resiliency.

Red Hook is home to a dedicated network of non-profits, arts and cultural organizations, religious institutions, and resident-led community building activities. [In our survey of community residents](#), 39% of community members rated community-based organizations as a top strength in Red Hook.

Housing in Red Hook

- Close to 2,900 housing units in Red Hook are in public housing, accounting for more than half of Red Hook housing units and offering some protection against rising housing costs.
- In a [community health needs and assets assessment](#) supported by the CSP, Red Hook residents noted that despite poor housing conditions, affordable housing is a key community asset.
- Red Hook community members identified “home repairs” as the most essential service needed to improve health and wellbeing in Red Hook. Focus group participants cited needed home repairs, rent increases, and housing insecurity as key causes of stress, anxiety and depression.
- Due to the availability of subsidized and public housing, the share of renters who experience any rent burden (37%) is less than the citywide share (43%).

Red Hook was greatly affected by Superstorm Sandy and recovery efforts continue. Most of the Red Hook Ballfields were closed in 2012 and again in 2015 because of lead soil contamination. Two are now open and efforts are underway to fix the third.

Many Red Hook residents are also impacted by poor housing conditions that affect the entire NYCHA system, such as heat and hot water outages, mold, and risk for lead exposure. Red Hook is also experiencing a period of rapid development and major reconstruction, which has had a substantial effect on the health and well-being of residents.

Stressors include: loss of green space, air and noise pollution, and potential exposure to mold and lead due to the ongoing construction within and around the NYCHA Red Hook Houses. Additionally, the construction of trucking delivery facilities in Red Hook has introduced an influx of commercial trucks driving and idling on the streets of Red Hook, causing concern for those with respiratory issues.

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.

4. The Lower East Side and Chinatown Needs and Assets

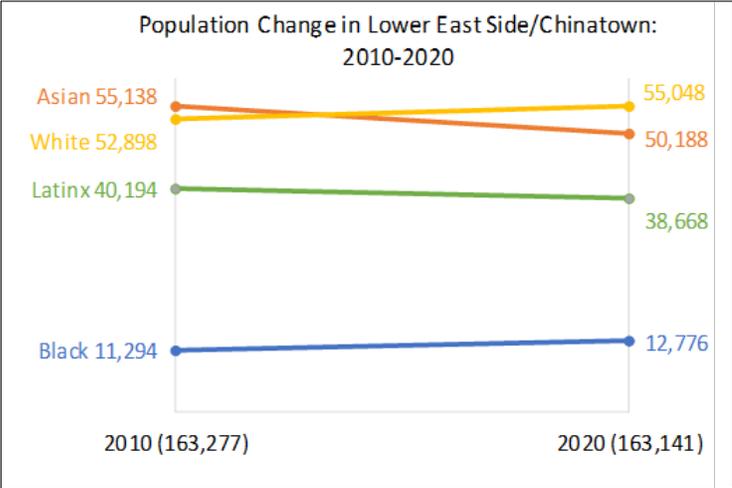
To increase our impact and create opportunities for synergy across programs, starting with the 2013-2016 CHNAA, NYULH focused on the area closest to the Manhattan campus with the greatest need: the Lower East Side and Chinatown. The Lower East Side/Chinatown Community District (Manhattan Community District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



https://commons.wikimedia.org/wiki/File:Chinatown_NYC_June_2019.jpg by Wil540 art is licensed under [CC BY-SA 4.0](https://creativecommons.org/licenses/by-sa/4.0/), original image cropped

Located along the eastern shore of lower Manhattan, this neighborhood is one of the earliest areas settled in New York City and was a historic stop for immigrants in the 19th and early 20th century. Today, the Community District is home to about 163,000 residents, including 34% born outside the United States. Immigrant populations comprise a large percentage (56%) of residents in the Chinatown neighborhood. Today, the District’s population is about 34% White, 31% Asian, and 24% Latinx. The Latinx population is largely Puerto Rican (59%) and Dominican (17%) while the Asian population is primarily Chinese (86%).

Overall, 27% of the population in Manhattan Community District 3 have limited English proficiency. Among the Chinese language speakers, 77% speak English “less than very well” compared with 57% for Chinese language speakers in Manhattan as a whole. Compared with NYC (14%), Manhattan CD 3 has a higher percent of adults ages 65 years and older—19% of the population overall, with higher percents the Chinatown neighborhood area (28%).



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 information and access health and social services.

With 27% of individuals living below poverty, the Lower East Side/Chinatown stands in stark contrast to the surrounding neighborhoods in Lower Manhattan – the Financial District and Greenwich Village/SoHo – which rank among the neighborhoods with the lowest poverty rates in all of New York City (6% and 8% respectively). Yet even within the Community District, there are areas of wealth, with 27% of residents having incomes five times higher than poverty level. Newer wealthier developments are arising alongside older housing stock home to residents with lower incomes.

About 28% of all public housing units in Manhattan are located in Community District 3 (about 8% of the total for NYC); yet as the neighborhood continues to gentrify, there is growing community concern about access to affordable housing. Nearly 90% of housing units are renter-occupied and 24% of renter-households are severely rent-burdened (spend more than 50% of income on rent).

Key Community Partners:

Since its founding in 1974, **Asian Americans for Equality** (AAFE) has evolved into a nationally recognized affordable housing developer and social service provider, serving New York City's one million Asian American residents. Services include community development and housing preservation, housing legal services, community education, citizenship preparation, and social services. AAFE has led campaigns to promote equal employment, affordable housing, fair housing, transportation equity, local economic development, community lending, civic participation, healthcare access, immigrant rights, and educational access.

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

The Chinese-American Planning Council'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) in the summer of 2019, we launched an in-depth, community-engaged needs and assets assessment, focusing initially on the Village of Hempstead, which is responsible for the greatest number of hospital discharges and emergency department visits and which, as described below, is an area of high need.

Beginning in July 2021, ten local CBOs, together with relevant staff, have been meeting monthly to identify what is known and what information is missing about community health needs, assets, and priorities. The group reviewed analyses from secondary data sources and then developed data collection and engagement strategies, including coordination with a survey being conducted by the Long Island Health Collaborative. The group also helped to host six group discussions with 37 participants,

Participating Community Based Organizations:

- EOC of Nassau County – Head Start
- Family & Children's Association Hempstead Prevention Coalition
- Hempstead Community Land Trust
- Hispanic Counseling Center
- Long Island FQHC, Inc.
- Mental Health Association of Nassau County
- NYU Langone Long Island Pediatric Center
- RotaCare
- St. George's Episcopal Church
- The Salvation Army

including staff members from the Pediatric Center and the Mental Health Association of Nassau County, and conducted several one-on-one interviews with staff who live in the community.

This process will continue as part of our on-going commitment to community engagement and to community participation in program development, implementation and assessment. We report here on our findings to date and expect to learn more over the coming months and years.

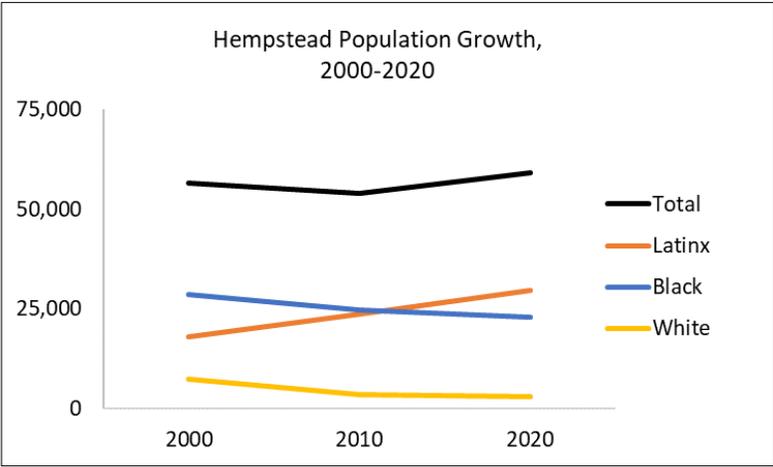
About Hempstead:

Brief History

Like many communities across Long Island, Hempstead was settled in the mid-1600’s by English immigrants on land purchased from Native Americans. By the mid-1800’s Hempstead was a thriving settlement and important center of trade for communities on Long Island. In 1853, the Incorporated Village of Hempstead became the first self-governing community in what was then Queens County. In the early 1900’s, the Town of Hempstead built a Town Hall in the Village and today the Village remains home to Town government offices. Hempstead was a commercial, civic, and transportation center long before the post-War housing and population boom that transformed the surrounding areas in Nassau County. Yet, what may be viewed as a boom for other communities also contributed to dis-investment and loss of businesses within the Village of Hempstead during the 1970’s-1980’s. In the 1990’s there was a concerted effort to redevelop and re-invest in the Village to strengthen its position as a Town government center and re-establish its commercial retail presence.

Recent Population Growth

The population of Hempstead has grown in the past two decades and today is the most populous village in Nassau County with 59,000 residents according to the 2020 Census. This overall population increase is driven by an increase in the Latinx population which today numbers nearly 30,000 accounting for 50% of the population. Between 2000 and 2020, there has been a decrease in the number of Black residents; in 2020, 39% of the population was Black, down from 51% in 2000. In Nassau County overall in 2020, 56% of the population was White, 18% Latinx, 12% Asian, and 11% Black.



Hempstead Today - Community Perspectives

In talking with people who live and/or work in Hempstead some common themes emerge. People speak about Hempstead with pride. The diversity of the community is valued. Neighbors are described as nice people, friendly, willing to help, and the community looks out for one another. There is a strong focus on the importance of family. Community members described numerous assets available in Hempstead, including the African American Museum of Nassau County, retail options, churches, convenient location, walkability, transportation options, a public library, and parks. Many mentioned resources available through the many community-based organizations. Community members also described some areas of need to make Hempstead an even better place to live and be healthy.

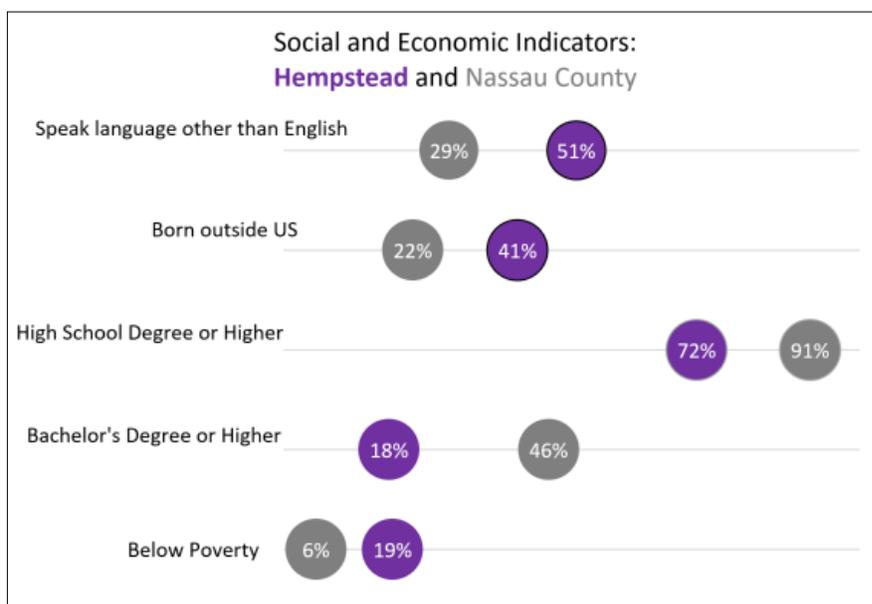


Secondary Data Sources:

While secondary data sources are useful in describing community-level indicators and making comparisons with other areas, we recognize that secondary sources of data cannot tell a complete story of a community. In this section, we used information gathered from multiple community conversations to contextualize some core indicators.

Nativity and Language

About 41% of Hempstead residents are immigrants. Top birth countries for the immigrant population are: El Salvador (34%), Jamaica (13%), Honduras (12%), and Haiti (8%). About 49% of Hempstead residents ages five years or older speak only English and 43% speak Spanish. Among Spanish-speakers, nearly two out three speak English less than "very well".



As one community member highlighted, many immigrants leave their lives behind and must start over when they arrive in Hempstead. Some have fled violence and poverty in their home countries. Others followed family members who settled in Hempstead, further strengthening the strong family ties within the community. Many come to Hempstead speaking only Spanish and the lack of bi-lingual services and information can be a barrier to accessing care and other needs. In addition, anti-immigrant rhetoric and fear of

deportation for themselves or family members can impact access to needed services. Yet, this shared sense of experience also contributes to the sense of belonging.

Educational Attainment

About 72% of Hempstead residents ages 25 years or older have at least a high school degree and 18% have a bachelor's degree or higher. In Nassau County overall, 92% have at least a high school degree and 47% have a bachelor's degree or higher.

While educational attainment in part reflects limited educational opportunities available in countries outside the US, for many years high school graduation rates for Hempstead were much lower than other communities although gains have been made more recently. Parents in the community spoke about the importance of education for their children and expressed concern about the quality of the local public schools. In February 2020, New York State assigned a monitor to oversee operations of the Hempstead School District. Private and charter schools in the area are expensive or based on a lottery admission process, further adding stress to parents concerned about how to provide their children with better educational opportunities.

Income and Poverty

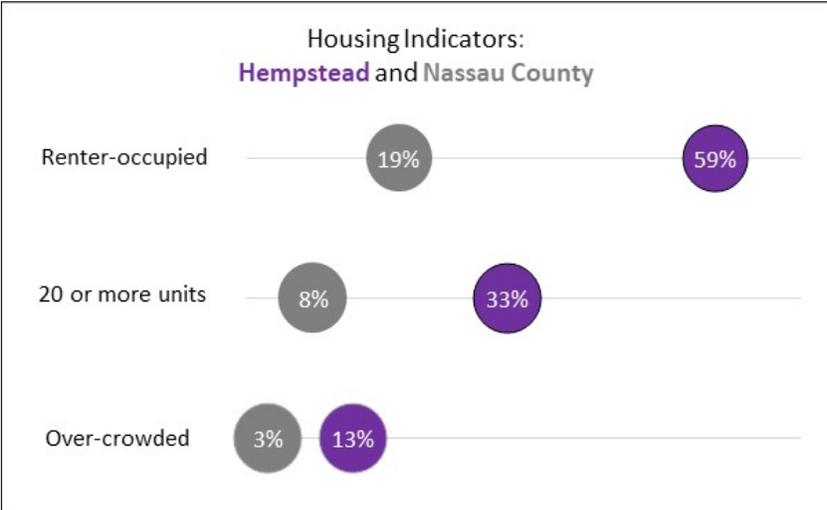
The median household income in Nassau County is \$118,453, making it one of the wealthiest counties in America. But not every community in the county experiences this level of prosperity. In Hempstead, median household income is \$62,569, and 41% of household earn less than \$50,000 per year. Poverty is three times higher in Hempstead than in Nassau County (19% vs 6%).

Many of the focus group participants and community partners mentioned financial insecurity as a struggle in the community. In part, limited employment opportunities mean that residents can only find work in low-wage occupations and often have to work multiple jobs to support themselves and their families. Limited income was also noted as a barrier to accessing healthcare, particularly preventive services.

Housing

The housing landscape in Hempstead is comprised mostly of multi-unit housing (55%), including 33% of housing units in structures containing twenty or more units. About 45% of housing units in Hempstead are single unit, compared with 79% in Nassau County. There are four public housing developments in Hempstead, including two developments dedicated to housing seniors.

About 10% of housing units in Hempstead are crowded (1.01 to 1.50 people per room), with an additional 3% considered severely crowded (1.51 or more people per room). In Nassau County, 2% of housing units are



crowded and 1% are severely crowded.

Most housing in Hempstead is renter-occupied (59%); compared to 19% of housing units in Nassau County. About 36% of renter-occupied housing units in Hempstead are severely rent-burdened (rent is 50% or more of income), compared with 31% in Nassau County.

Focus group participants noted the need for affordable housing, as well as services and housing for people experiencing homelessness. Some noted that multiple generations of a family live together, providing valued family support but also resulting in crowding.

Transportation

Hempstead is a major transit hub, with a Long Island Railroad (LIRR) station terminus and Nassau Inter-County Express (NICE) Bus terminal located at the Rosa Parks Hempstead Transit Center. Hempstead households are less likely to have a vehicle available; 24% of households have no vehicle available, compared with 7% in Nassau County.

While public transportation options are more plentiful in Hempstead relative to other parts of Nassau County, transportation options within Hempstead are limited and some cited this as a barrier to accessing medical care and other services.

Food security

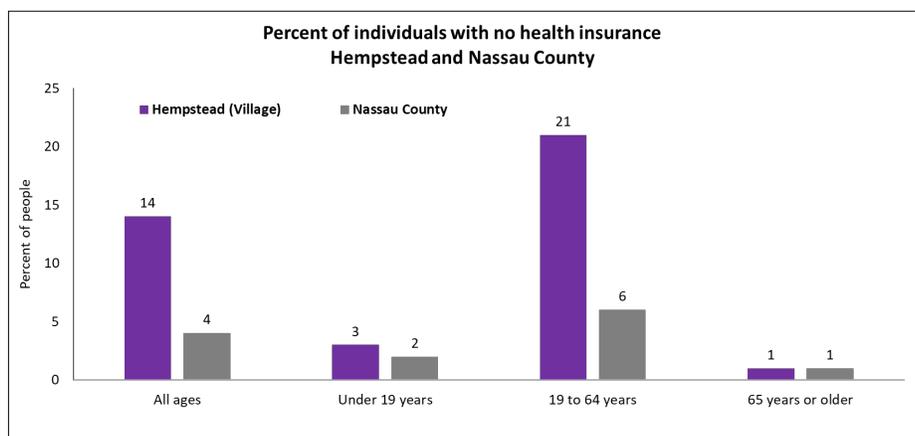
A report from the Nassau County Comptroller's Office highlighted five census tracts in Hempstead considered to have limited access to food—areas where 33% or more of the population lived more than ½ mile from the nearest supermarket or large grocery store—including two census tracts considered food deserts due to limited vehicle availability.

A lack of healthy food choices at the supermarket was noted as a factor that makes it hard to stay healthy. Access to food was noted as a need; which some community partners are already helping to fill. For example, St. George's Episcopal Church and the Salvation Army have food pantries.

Health Care Access, Outcomes and Behaviors

➤ *Health insurance*

Overall, 14% of Hempstead residents do not have health insurance -- more than three times the rate for Nassau County overall (4%). This is driven by the percent of residents ages 19-64 years who do not have coverage (21% in Hempstead, compared to 6% in Nassau County). Nearly all children and older adults in Hempstead have health insurance, similar to Nassau County.



➤ *Cancer Screening*

Timely breast cancer screening (76%) and cervical cancer screening (86%) rates are similar for women in Hempstead and Nassau County. Timely screening for colon cancer is lower in Hempstead than Nassau County (54% vs 62%).

➤ *Hospital Visits*

Potentially avoidable hospitalizations are defined as those that may be prevented with better access to primary care. Hempstead (zip code 11550) had the second highest rate of potentially avoidable hospitalizations (251 per 10,000 adults) of all zip codes in Nassau County. Falls are the leading cause of injury-related deaths and hospital visits among adults ages 65 years and older in New York State. The falls-related hospitalization rate is higher among older adults in Nassau County (237 per 10,000) compared with older adults statewide (194 per 10,000).

➤ *Children's Health*

In addition to describing the burden of deaths before age one year, the infant mortality rate is often used as a marker of community health status given its relation to structural factors that impact health. The infant mortality rate in Hempstead was 4 per 1,000 live births, slightly higher than Nassau County overall (3 per 1,000). Hempstead (zip code 11550) had the highest rate of asthma-related emergency department visits among children of all zip codes in Nassau County. Hempstead (zip code 11550) had the second highest teen pregnancy rate of all zip codes in Nassau County (69 per 1,000 females ages 15-19).

➤ *Chronic Disease and Mental Health*

Overall, Hempstead residents suffer disproportionately from chronic disease and mental distress as compared with the rest of Nassau County. About 36% of Hempstead adults are obese, compared with 25% in Nassau County. Among students attending school in the Hempstead School District, 25% of elementary students are obese and 31% of middle/high school students are obese. (By contrast, In Nassau County, 16% of elementary school students and 15% of middle/high school students are obese.) About 35% of Hempstead adults have high blood pressure, compared with 25% in Nassau County. About 15% of Hempstead adults have diabetes, compared with 8% in Nassau County. About 15% of Hempstead adults experienced frequent mental distress (feeling like mental health was not good for 14 or more days in past month), compared with 11% in Nassau County.

➤ *Health Behaviors*

About 33% of Hempstead adults were not physically active compared with 20% in Nassau County. About 17% of Hempstead adults smoke, compared with 12% in Nassau County.

Community Perspectives on Health and Needs for Improved Health:

Community members described health in very holistic terms, including physical, emotional, and mental health. While many reflected on health as being more than healthcare, some also noted lack of access to healthcare as a top need. Many cited the need to address language and transportation barriers related to healthcare access. Many also noted a need for more healthcare facilities, especially sites offering low-cost or sliding scale options and a 24-hour pharmacy.

Many interviewees noted the importance of getting exercise as a key element to staying healthy. As described above, parks were cited as a community asset; some suggested that it would be beneficial if there were more structured activities available at parks – to promote physical activity and community building. Concern was expressed about the limited hours that parks are open and several people noted safety concerns, in terms of physical infrastructure (i.e., lack of fences around playgrounds to prevent young children from running out of the area) and crime. Concerns about crime and safety were also noted as barriers to walking alone. In one group, it was suggested that a recreation center for teens would help promote physical activity and potentially help reduce crime.

Good nutrition and healthy eating were also mentioned as key to good health. Some interviewees noted that food prices and lack of access to nutritious foods made it hard to stay healthy, particularly for residents with chronic conditions like diabetes. Some suggested supplementing increased access to healthy food options with nutrition programs aimed at developing skills needed to cook healthier meals. Community members also noted a number of resources and services that were available through local community-based organizations as an asset to support health and well-being. Both residents and CBOs cited a need for increased awareness of available services, and noted the need for organizations to build trust and actively engage in outreach. Suggestions included creating a repository or guide, as well as advertising in community spaces like laundromats and through social media.

D. Assessment and Selection of Public Health Priorities

At the January 10, 2022 meeting of the Coordinating Council, we asked participants to use a Google Jamboard to share the two or three greatest strengths and the two to three greatest needs they see in the communities they serve. Key themes are presented below:





Below, we discuss key priorities and concerns that have emerged in our communities: the impact of COVID, the intersection of health and housing, healthy eating and food security, tobacco prevention and cessation, and maternal and child health outcomes and children’s social-emotional development.

1. Impact of COVID

Since the first case of COVID was identified in NYC on February 29, 2020, nearly two million cases have been confirmed through February 1, 2022. As of that date, more than 38,000 NYC deaths have been attributed to COVID, with death rates higher among Latinx and Black New Yorkers. While these numbers are staggering, they do not account for the economic and emotional impacts brought on by this pandemic. Across our Community Service Plan, programs and partners mobilized swiftly to respond to the devastating impact of the COVID-19 pandemic on the health and well-being of our communities. As we have pivoted to collect information and respond to urgent needs, we have developed a deeper understanding of community resilience, inequities, and system failures. A summary of the demographics, needs and assets of each community is provided in Section I.C.

Impact on residents of public housing:

According to data from the NYC DOHMH, NYCHA residents constitute about 4% of the City’s population but made up roughly 7% of the City’s total deaths from COVID between March 2020 and June 2021. The impact of this has been felt in the vast swath of public housing on the Lower East Side and in Red Hook Houses, the second largest public housing complex in New York City. Red Hook’s COVID risk highlights these disparities. Census tract 85 (dominantly residents living in public housing) is at the highest risk for COVID infection and more severe COVID outcomes (10 out of 10), yet the two surrounding census tracts are at the lower end of the spectrum (2 and 3 out of 10). Community partners in Red Hook note that the pandemic has exposed and deepened inequities in health, housing, education, the built-environment, economic mobility and community safety in Red Hook.

As we look towards recovery from COVID-19, vaccine distribution and access become critical components to ensuring the resiliency of Red Hook. In February 2022, nearly 82% of residents in the wealthier part of Red Hook had received one or more doses of the COVID-19 vaccine, while only 60% of residents in the Red Hook Houses had received one or more doses.

Here, we briefly describe the many challenges arising from the pandemic that are shared across all of the CSP communities.

Economic Burden:

The CDC Social Vulnerability Index and NYULH [City Health Dashboard](#) COVID Local Risk indices highlight widespread vulnerability in some of our communities and pockets of need and disparities in others. These neighborhoods are at greatest risk of human suffering and financial loss compared with other New York State and US communities, and are most likely to need sustained support before, during, and after public health emergencies.

All of our communities have been hit hard by the economic fallout of the pandemic. For example, prior to the pandemic, about one-third (34%) of employed adults in Sunset Park worked in service occupations, which were largely shut down due to the pandemic, compared to 23% of workers in NYC.

The small businesses that line the vibrant streets of Sunset Park and Chinatown have been hit particularly hard. A recent study by the NYULH Center for the Study of Asian American Health documented the severe impact of COVID-19 on businesses in the Chinese ethnic neighborhoods of these communities. Many businesses are now beginning to return, but Asian American and immigrant-owned small businesses face obstacles to recovery. Access to financial relief is often inaccessible in other languages, and a lack formal payment systems in some family-owned enterprises makes it difficult for them to provide necessary documentation to qualify for help. In addition, the surge of anti-Asian crimes, and misplaced fear of higher contagion in Asian populations, have hampered the revitalization of many Asian-owned businesses.

Black, Latinx and Asian populations – groups that largely comprise our CSP communities – have experienced greater financial stress resulting from the COVID-19 pandemic than White New Yorkers. In April 2020, nearly half (47%) of adults reported that they or someone in their household had been laid off or had to work reduced hours because of the COVID- 19 pandemic. This was more commonly reported by Black adults (51%) compared with White adults (43%).

Discrimination:

Violence against Asian Americans has increased – 7-fold according to the NYC Commission on Human Rights – due to hostility fueled by the political rhetoric about the virus’s origins. As a result, members of the Chinese communities in Sunset Park and Chinatown have reported increased stress, anxiety and isolation. At the same time, anti-immigrant sentiment and the continuing violence against Black Americans have deepened the stress and fear already felt by many residents in our diverse communities. Fear of discrimination has not only affected individual mental health but also fueled vaccine hesitancy and unwillingness to seek COVID-19 testing.

In Hempstead, where the population is largely Black and Latinx, community partners have reported that the lack of trust arising from the legacy of discrimination and structural racism, and fear of reprisal for undocumented status, have kept many members of the community from accessing needed services, even when they are available.

Stress for Frontline Staff:

In all of our communities, community organizations and residents have rallied to support their neighbors, reaching out to those who are vulnerable through tenant organizations, community health worker programs, and support groups. Community Health Workers and other frontline staff at local

CBOs, many of whom themselves are community residents – and many of whom have feared violence and discrimination – have provided a vital link to trusted and needed services particularly at the height of the pandemic.

In all of our communities, community-based organizations have stepped in to provide essential services, connecting people to health care and social service resources; providing outreach and education about COVID prevention, vaccination, testing, and treatment; and offering emotional support for those experiencing stress and isolation. At a meeting of the Community Service Plan Coordinating Council in October 2021, CBO leaders and staff described some of the acute challenges experienced by people working on the frontline. Although the number of people in need has increased – and thankfully supplemental resources and benefits have been made available – the funding and number of employees at most CBOs have not grown. Indeed, for many CBOs it has been difficult to fill positions, especially those that require specific language and cultural competencies.

Similarly, at meetings of the Health & Housing Consortium Steering Committee and at the [Annual Convening of our Health & Housing Consortium](#) (December 7-8, 2021), participants described how the COVID-19 pandemic has exacerbated pre-existing staffing shortages across all human services sectors. Low salaries and wage stagnation, fear of contagion, and stressful work have made it difficult to recruit and retain staff, even as the need for the services they provide has grown.

As a result, workload of existing staff has increased. Staff are serving more clients with greater needs, adapting program models to address the constraints imposed by the pandemic, struggling to overcome technological barriers to care, and complying with new reporting requirements, all without an increase in funding or staffing.

Many reported that they and their colleagues are “burned out.” Several frontline staff described a disheartening feeling of powerlessness as they encounter the same problems over and over: “The lack of systematic change is frustrating and tiring...We are doing so much work and see so little changes or improvement; it feels like we’re just putting out fires.” The deep commitment that many feel towards their clients adds to the emotional toll of the work. As one person noted, “the mental health and social issues experienced by clients become something the staff feel too.”

In interviews with **teachers and social workers**, we learned about the stress experience by members of the school community and strategies that they used to support each other emotionally and professionally, including shared lesson planning, support with information technology, and check-in meetings. Rather than focusing on their own needs, many teachers and social workers expressed concern about their students and families, calling caregivers the real “heroes” of the pandemic.

Many of the staff at local CBOs are themselves community residents and so may be subject to the same stressors, fears, and concerns about economic instability and health as the clients they serve. One partner noted: “our staff are in need of the same services they help their clients with.” Often, staff are supporting and caring for family members and friends who themselves may be newly unemployed, ill, or otherwise vulnerable.

The CSP Community Health Worker Research and Resource Center (described in Section II.C.7. below), has worked to support CHWs and other frontline workers, offering educational programs and support to staff within NYULH and at our partner organizations. Over the course of the pandemic, these programs have expanded to reach frontline staff across the City and nationally. To understand and respond to the needs of this workforce at NYULH, the CHW-RRC has fielded quarterly wellness surveys of CHWs beginning in March 2020. The survey results echo the concerns and issues raised at the Coordinating

Council meeting and the Health & Housing Consortium meetings. Many respondents reported having caregiving responsibilities for family members and elderly or sick adults. And their concerns – about financial security and the mental and physical health for themselves and their families – mirror the stresses they see in the communities they serve. As one person wrote: “It has been very challenging. I lost my family members and listened to my participants, who sometimes lost family members and lost jobs.” Some described a sense of isolation, which is particularly challenging when dealing with complex and urgent client needs and addressing the challenge of “civil tensions and how to talk to community members who may hold different opinions on what’s happening in the country right now.” Many became CHWs because they value the relationships with clients and they miss those in-person interactions: the “personal contact with folks is vital to my work: patients, colleagues, staff and faculty.” Responding to these challenges, the CHWs have become adept at using technology and in implementing new strategies for connecting with each other and with clients remotely. As described in Section I.D.1., the CHW workforce has played a vital role in reaching out to the most vulnerable residents in all of our communities.

Alongside the work of the CHW-RRC, partner CBOs have also been working hard to support staff, implementing mental health programs, promoting self-care, and creating social networks and support groups, all strategies that have been found to promote the resilience and reduce the risk of adverse physical and psychological outcomes.

Increased Need for Digital Access:

Technology is now an essential tool for accessing health care, education, and social services. Through our CHNAA, we have seen how the COVID-19 pandemic has 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. Yet disparities in digital literacy and broadband access persist for many living in high-poverty neighborhoods.

For example, in Sunset Park, about 20% of households report no access to the internet, compared to 15% citywide and 9% in a more affluent neighboring community. This pattern is also seen citywide, where households in very high poverty neighborhoods are three times more likely to have no internet access than households in low poverty neighborhoods (26% vs. 9%). Even when members of low-income communities do have access to the internet, residents report that the connection speed too slow to support meaningful access to many services. Many lack the language and literacy skills to take advantage of programs that are available, such as the Emergency Broadband Benefit program.

“So many of our students lack access to Wi-Fi, as well as adults who can help them, which impedes their learning. If one student cannot connect to remote learning, that is one student too many.”

**Sunset Park Elementary School
Principal**

As a result, many residents of the CSP communities, especially immigrants, the elderly, and those without a high school diploma – struggle with scheduling appointments, accessing healthcare appointments and records, and applying for the numerous public benefits to which they are entitled. For example, behavioral healthcare quickly pivoted to virtual platforms; given the rise in stress and anxiety during the pandemic, ensuring access to these virtual services is vitally important.

Sunset Spark

Sunset Spark is a local non-profit technology organization with a focus on equitable access to modern technology education for immigrant families. They partner with several local schools to provide computer science (CS) instruction in the classroom and in out-of-school time. During the pandemic, Sunset Spark provided weekly tech support to schools and families and guidance to teachers on how to structure communication and online classes to better support the technology usage of immigrant families. At the City level, they are a key partner with the DOE's Computer Science for All initiative, where they write student curricula, lead teacher trainings, and review new computer science and digital fluency standards.

Once again, community-based organizations and frontline staff have filled in these gaps. Many CSP partner organizations stayed open throughout the COVID pandemic, including during the surge in 2020, in order to provide in-person contact with vulnerable residents. At the same time, many groups are working at the community level through advocacy and outreach to improve digital access. In Sunset Park, the Digital Inclusion Group (DIG), composed of educators, community leaders, public health experts, a tech-focused nonprofit, social service providers, and healthcare providers, is working to increase equitable access to Wi-Fi, technological devices, and digital literacy in the Sunset Park community.

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

As highlighted in the NYS Prevention Agenda 2019-2024, access to safe housing is a key determinant of health. Tackling issues at the intersection of health and housing has been a long-standing priority in our CSP communities and emerged with even greater urgency during the 2019-2021 CHNAA/CSP cycle, resulting from New York City's decades-long housing crisis and exacerbated by the COVID-19 pandemic. For this reason, we have done an in-depth needs assessment on this topic and, as described in Sections II.C. 8 and 9, have strengthened and grown our CSP projects that address the intersection of health and housing.

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. The following sections describe how housing issues affect the health and wellbeing of our communities in New York City, and in the neighborhoods where our CSP projects are focused in particular.

Types of Housing Instability and Related Health Conditions		
Housing Issue	Examples	Related Health Conditions
Homelessness	<ul style="list-style-type: none">• Total lack of shelter• Residence in transitional or emergency shelters	<ul style="list-style-type: none">• Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis)• Mental health issues, including depression and elevated stress• Developmental delays in children
Lack of affordable housing	<ul style="list-style-type: none">• Severe rent burden• Overcrowding• Eviction or foreclosure• Frequent moves	<ul style="list-style-type: none">• Stress, depression and anxiety disorders• Poor self-reported health

		<ul style="list-style-type: none"> • Delayed or diminished access to medications and medical care
Poor housing conditions	<ul style="list-style-type: none"> • Structural issues • Allergens like mold, asbestos or pests • Chemical exposures • Leaks or problems with insulation, heating and cooling 	<ul style="list-style-type: none"> • Asthma or other respiratory issues • Allergic reactions • Lead poisoning, harm to brain development • Other chemical or carcinogenic exposures • Falls and other injuries due to structural issues

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

Homelessness:

Addressing the homelessness crisis has emerged as a top priority in New York City. Sheltered homelessness increased 77% in the past decade, with approximately 65,000 individuals—including 22,700 children—sleeping in a municipal homeless shelter each night throughout 2021. Racial disparities persist among this population, with 58% of NYC residents identifying as Black, 31% Latinx, 7% White, 1% Asian American, and 3% other. This population is also rapidly aging; after tripling between 2004 and 2017, researchers identified 17,000 homeless shelter residents ages 50 and older in 2017 and forecast this population to reach 25,000 by 2030.

Additional thousands of homeless New Yorkers are unsheltered and sleep on streets, within public transit systems, and other public spaces. Surveying these areas, New York City Department of Homeless Services (NYC DHS) identified 3,857 unsheltered individuals on the night of January 27th, 2020 as part of its annual point-in-time Homeless Outreach Population Estimate (HOPE). With support of the NYULH Community Service Plan, the Health & Housing Consortium led the [Hospital Homeless Count](#)—an independent effort to identify homeless individuals seeking care or shelter in hospitals alongside the 2020 HOPE count—to draw attention to the needs of a population who would otherwise remain hidden from New York City’s official homeless census. Among 30 participating hospitals, the Consortium identified 226 people experiencing homelessness who were spending the night in emergency department (ED) treatment areas, waiting rooms, and other non-medical locations such as lobbies and hallways. Among those who responded to additional survey questions, 69% (n=45) reported not having a regular doctor outside of the emergency department, and 76% (n=39) reported 10 or more ED visits within the past year. Recommendations of the Hospital Homeless Count focus on increasing care coordination between hospitals and homeless and social services, as well as investing in collaborative approaches to supportive and affordable housing (Figure 1).

Homelessness creates and exacerbates poor physical and mental health conditions, and vice versa. In a [NYC DHS 2020 report](#), the most common self-reported medical health issues among adults living in three types of homeless shelters (single adults, adult families, and families with children shelters) at the time of intake/assessment were asthma, hypertension and high blood pressure, diabetes, and other chronic diseases (Table 2). NYC DHS also reported that, among 3,973 children at intake/assessment for families with children shelters, approximately 700 children (18%) lived with at least one chronic medical issue in 2020, with asthma as the leading condition.

Depression, anxiety, and bipolar disorder/manic depression were the top three behavioral health conditions identified among DHS-sheltered adults. Additionally, 428 individuals reported entering a homeless shelter after having been discharged from a hospital, indicating an urgent need for health care systems to understand the housing status and needs of its patients.

As described in Section II.H. below, several of the NYULH CSP initiatives are addressing these issues and, importantly, including people with lived experience of homelessness as full and compensated partners as we develop, implement and assess our work.

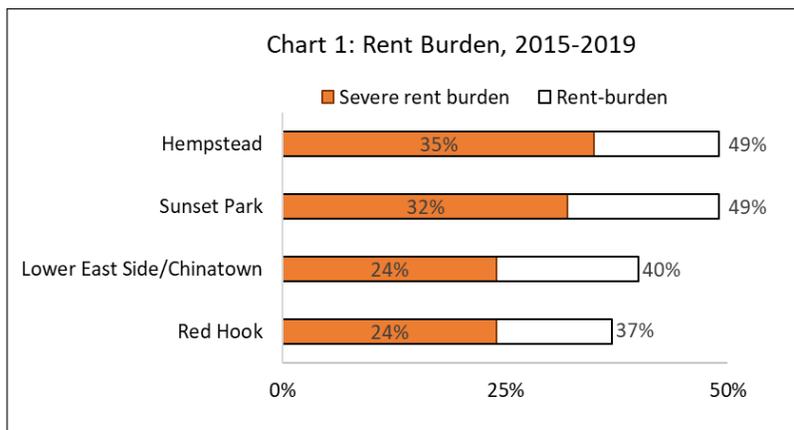
Figure 1. Hospital Homeless Count 2020 Recommendations

- Allocate resources for homeless services based on the number of people within emergency departments.
- Provide homeless outreach teams with resources to engage homeless patients inside hospitals.
- Expand medical respite services for people in hospital EDs and inpatient beds who cannot be discharged because they have no home.
- Invest in more supportive and affordable housing with appropriate resources for housing providers to support medically vulnerable patients.
- Utilize shared homeless data systems to identify their patients in the shelter system.

Lack of Affordable Housing:

The lack of affordable housing and the downstream risk of eviction are key drivers of homelessness and disproportionately affect Black and Latinx households. Based on five year estimates between 2015 and 2019, more than 40% of renter households citywide experienced rent burden (spending more than 35% of household income on rent), with more than 25% experiencing severe rent burden (spending more than 50% of their household income on rent). The shares of households experiencing rent burden in Hempstead (49%) and Sunset Park (49%) were significantly greater than the citywide share (Chart 1).

The pandemic worsened the City’s already acute housing crisis. According to the National Equity Atlas, approximately 652,000 households were behind on rent in the New York City metro area in 2021, owing \$2 billion in debt. Despite efforts such as the eviction moratorium and disbursement of emergency rental assistance, approximately 67,000 eviction notices were filed citywide from March 2020 to



January 2022. With the pandemic-related loss of employment disproportionately impacting Black and Latinx households, racial inequities in rent burden and risk of eviction have only been exacerbated.

With limited access to affordable housing, families “double up” in overcrowded apartments (>1.5 people per room). According to the City Comptroller’s Office, around 290,000 units were overcrowded in 2018, a 17% increase from 2008. Latinx and Asian Americans, who are more likely to live in multigenerational households, disproportionately live in overcrowded units, further increasing their risk of exposure to

COVID-19. (See Section I.C. for how the housing affordability crisis affects the neighborhoods where our CSP projects are located.)

Poor Housing Conditions:

Severe asthma and other respiratory illnesses are often triggered by poor housing quality. Indoor environmental complaints in New York City increased by 42% the past decade, with 7,234 calls made to 311 reporting the presence of asbestos, poor air quality, sewage issues, and mold in the home in 2021. The New York Legal Assistance Group (NYLAG), which is a partner in the Health and Housing Consortium, estimates that the prevalence of these hazards is likely much higher since patients and frontline workers do not always understand the link between housing conditions and health and because immigrant populations may be fearful of reporting the need for home repairs.

Through a [community health needs and assets assessment](#) supported by the CSP, Red Hook residents identified home repairs as the number one needed service to improve health and reduce stress. Older and poorly maintained housing are often more in need of significant and ongoing repairs; in Sunset Park, 60% of housing units were built before 1940, compared to the citywide share (41%). The community-based organizations that comprise the Brooklyn Consortium's Steering Committee (described in Section II.C.8., below) prioritized the need to address poor housing conditions, noting the particular vulnerability of elderly and aging residents.

Community Feedback on Housing and Health Needs:

In May 2021, we convened an Advisory Committee for the newly formed Health x Housing Lab (see Section II.C. 9., below). The Committee is composed of experts representing community-based organizations, hospitals, and other leaders across the City, including individuals with lived experience of homelessness.

We asked the Advisory Committee in a Google Jamboard to write on "sticky notes" to share the most pressing 2-3 problems they saw related to health and housing in New York City. Key themes from the full exercise (see below) include:

- Housing affordability, access, eligibility and accessibility;
- Healthcare quality, access and navigation, and lack of medical respite;
- Housing and health silos, lack of communication and coordination;
- Criminalization of homelessness and lack of trust, empowerment, autonomy or engagement;
and
- Lack of city agency coordination.

Even before the pandemic, nearly 1 in 10 adults in New York City “often” or “sometimes” did not have enough food to eat. Food insecurity is more common among Latinx (18%), Black (10%), and Asian/Pacific Islander (6%) adults compared with White (4%) adults. Similar racial and ethnic disparities in food insecurity were found in Sunset Park and the Lower East Side and Chinatown. Although statistically representative data are not available at the Red Hook community level, citywide, food insecurity was nearly twice as high among adults living in public housing compared with adults living in other types of housing (16% versus 9%). While data specific to the Arab-American community are lacking in population-based surveys, our community-based survey found more than one in three Brooklyn Arab-American adults experienced food insecurity.

Consistent access to healthy food has been challenging for many residents in our CSP communities. 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 2018 and continues to be a top concern, exacerbated by geographical isolation. While most neighborhoods in lower Manhattan have the lowest rates of food insecurity in the City, the Lower East Side/Chinatown stands out as a glaring exception with one in three residents experiencing food hardship. During the pandemic, many supermarkets and local food vendors permanently closed. The Community District Needs Assessment notes that this, combined with increased unemployment, has contributed to the problem of food insecurity, made more challenging by the dietary needs of the aging population. Food insecurity is also a concern in Hempstead. As highlighted by the Nassau County Comptroller, five census tracts in Hempstead have limited food access, including two that were classified as food deserts based on distance to supermarkets and lack of vehicle availability. Increased food access and healthy food options were also noted as needs in Hempstead community focus groups.

The COVID pandemic has increased the economic barriers to food security across New York City and in Nassau County. Consistently during the first year of the pandemic (April 2020-March 2021), about 20% of NYC adults were unable to buy groceries due to lack of money and about 70% of NYC adults reported that price increases impacted their ability to get the food they need. Throughout this period, Latinx and Asian adults were more likely than White adults to report reduced income as a barrier to getting the food they needed. Households with children have been particularly vulnerable. *Feeding America* estimates that food insecurity for children has increased from 20% to 29% in Brooklyn, 14% to 22% in Manhattan, and 8% to 14% in Nassau County.

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. A survey of a sample of families in Sunset Park in the late spring 2020 found that Spanish-speaking parents were 5 times more likely than English-speaking parents to be worried about not having enough food (79% vs. 15%).

The Family Health Center’s emergency food pantry (The Table) saw an over 700% increase in the number of families served during the pandemic. 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.C.1.), as well as other local food pantries and social service organizations across all of 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.

Healthy Eating:

Obesity continues to be epidemic: more than half of adult New Yorkers are overweight (34%) or obese (25%). Data show that obesity begins early in life: One out of five NYC public school children in grades K-8 is obese and one out of four Hempstead public school students in grades K-12 is obese. 43% of Family Health Centers' pediatric population (ages 3 to 17 years old) was overweight or obese in 2019. Childhood obesity is also common among patients cared for at the Hempstead pediatric practice. 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.

Disadvantaged urban communities are disproportionately affected by obesity, in part due to lack of neighborhood resources, such as the availability of healthy food and safe places for physical activity. In New York City, as in the rest of the country, there are clear income and racial disparities with regard to obesity. Obesity prevalence is more than 1.5 times as high among adults who live in very high poverty neighborhoods compared with adults who live in low poverty neighborhoods (34% vs. 22%).

Obesity continues to be a concern among community residents and leaders in Chinatown, the Lower East Side and Sunset Park, and was identified as a concern by the Brooklyn Arab American community. Similarly, obesity is a concern in Hempstead, where about 36% of adults are obese, compared with 25% in Nassau County. Perhaps because of the high rates of obesity, rates of high blood pressure and diabetes in Hempstead are also higher than in the Nassau County. (See Section I.C.5.)

In Chinatown and the Lower East Side, obesity rates are lower than City rates, and Sunset Park obesity rates are similar to citywide rates. Yet, these rates are still concerning and children in both communities remain vulnerable. 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

Obesity-related disparities:

- Obesity rates are higher among adult Black (35%) and Latinx (33%) New Yorkers compared with White adults (20%).
- The prevalence of overweight and obesity among NYC public high school students varies by race and ethnicity: Latinx students (37%), Black students (35%), Asian students (22%) and White students (20%).
- Given emerging 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.
- The rates of overweight and obesity are lower among Asian Americans overall (37%), masking differences among groups; rates of overweight and obesity are higher among Asian Indian adults (57%) than Chinese adults (28%). Considering that a significant portion of South Asians live in poverty, have limited English proficiency, and lack of access to culturally appropriate community resources, culturally tailored and effective interventions to prevent obesity and diabetes among South Asian Americans are sorely needed.

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.

Section II.C. describes the programs we have developed to address these needs.

4. Needs and Assets: Tobacco Prevention and Cessation

New York City has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 10.9% in 2020. But the rates of reduction across populations have been uneven, and income-related, gender, and racial and ethnic disparities persist. Despite the high cost of cigarettes, the smoking prevalence among low-income (<200% Federal Poverty Level) New Yorkers is 14%, nearly twice that of higher-income (≥400% Federal Poverty Level) New Yorkers (8%). As noted in a recent NYC DOHMH report, *Health of Asian and Pacific Islanders in New York City*, smoking rates are nearly six times higher among Asian/Pacific Islander men than women. In 2020, 19% of Asian Pacific Islander men smoked, virtually unchanged from the rate in 2002 (20%). In addition, Asian New Yorkers who smoke are significantly less likely to have used nicotine replacement therapy (NRT) (1 in 10) than those identifying with any other race or ethnicity.

The NYC DOHMH now recognizes smoking among Asian American men as a health disparity. As described below, the CSP Asian American Tobacco Free Community Initiative has been working in partnership with the DOHMH to understand this disparity and to help develop strategies to address it.

As part of this effort, we conducted 50 in-depth interviews and surveyed 49 Chinese American smokers. We sought to understand their quitting experience and challenges, perceptions about the existing smoking cessation services, barriers to accessing and using these services, and perspectives about what might assist them in quitting. The following summarizes our findings about these needs and assets:

→ *Low quit intention*

- Most of the Chinese American smokers we interviewed were in pre-contemplation stage (not planning to quit within the next 6 months). Although they were familiar with the generic health warning that smoking is harmful, most were uncertain about the exact harms of smoking and benefits of quitting.
- A common misconception was that quitting smoking would endanger smokers’ health, particularly for those who have smoked for years.
- Smoking was also described as a relatively benign way to relieve anxiety and loneliness, better than drinking or gambling.
- Some were not interested in quitting due to previous unsuccessful quit attempts.

Quotes from participants:

“Cigarette is not like drugs such as heroin that causes tremendous harms to health... If you smoke for a decade or two, or even thirty or forty years, you will get lung cancer. But it doesn't make other damages to your body. Smoking may make you skin age faster, but that's a slow process. Nobody cares...I don't plan to quit because there are no immediate harms of smoking.”

“Mao Zedong suffered from health issues after he quit smoking, so did Deng Xiaoping. These great men both had health problems after quitting.”

- Saving money was not a key factor in motivating smokers to quit. Light smokers noted that the cost of smoking is only a small portion of their daily expenses. Heavy smokers reported that they have access to cheaper cigarettes (e.g., through friends who bring cigarettes from China or on the black market).

→ *Challenges to smoking cessation*

- Social norms, which include smoking when spending time with friends or co-workers, and offering and receiving cigarettes, pose a major challenge for quitting.
- Many use smoking as a way to take a break from stressful and busy jobs.

→ *Access barriers to available smoking cessation services*

- Many do not know that smoking cessation services and quitlines are available.
- Some expressed skepticism about treatment efficacy, including NRT; many smokers believe that willpower is the only way to quit.
- Many of the participants reported having long working hours, which hampers them from using smoking cessation services including quitlines and in-person cessation programs.

Quotes from participants:

“Some of my coworkers smoke. I offer them cigarettes and they also offer me cigarettes. We smoke together. That makes it easier for us to get along.”

“I don’t see the possibility to quit because my job [at a restaurant] requires high-intensity labor...We have no breaks because the boss doesn’t allow it. I have the excuse because I smoke so I can take a short break. If I quit, I would have no excuse. So I’m not going to quit unless I change the job.”

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: 17% of Hempstead adults smoke, compared with 12% 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 new smoke-free public housing policy, there is a growing demand for information and access to services to help support public housing residents quit or reduce their dependence on tobacco. Given the large public housing developments in Red Hook and on the Lower East Side, community partners are interested in building their capacity to meet this need.

The portfolio of CSP projects that address these issues is described in Section II.C.4., below.

5. Needs and Assets: Reducing Disparities in Maternal and Child Health Outcomes and Supporting 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, 15% of children experience two or more adverse childhood events (ACE), defined as traumatic experiences occurring before the age of 18, such as poverty, parental mental illness, parental substance abuse, neglect or abuse, exposure to domestic violence, and other traumas.

Existing sources of population-based data on children’s health and development are limited in geographic and racial/ethnic scope. To obtain data specific to young children in Sunset Park, NYULH worked with the New York City Department of Health and Mental Hygiene and Abt Associates to conduct an oversample of Sunset Park children ages 1 to 4 years as part of the KIDS 2019 survey. Results from this survey further highlighted the need for enhanced supports for children’s social-emotional well-being. Young children in Sunset Park were more likely than other NYC children to have a parent concerned about their emotional or behavioral development (21% vs 15%), and children 3 to 4 years in Sunset Park were twice as likely as other NYC children to be at risk for social-emotional health issues (31% vs 18%). Reflecting the multi-cultural diversity of the community, most young children aged 1 to 4 years in Sunset Park (82%) have an immigrant parent and fewer speak English at home compared with other young children in NYC (39% vs. 79%). This underscores the importance of having culturally adapted and linguistically appropriate programs to support families and early childhood development.

Adverse Childhood Events:

Children born into poverty are at risk for far-reaching negative physical and mental health effects, perpetuating cycles of disadvantage into adulthood. Maternal stressors during the prenatal period increase the risk of pre- and postnatal depression, the likelihood of pregnancy complications and adverse birth outcomes. Strong social supports, family structures and community programs can help prevent or ameliorate the impact of ACEs on childhood development and health.

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. For example, teachers and social workers we interviewed described the many challenges faced by families, including limited English language proficiency, lack of technology and Internet access, small and crowded family homes, limited resources, and fear. Many educators expressed the need for more culturally diverse and sensitive books that reflect the lived experiences of their students, noting a desire to address equity, racism, anti-Asian violence, and Black Lives Matter in their classrooms. They worried about educational loss among students and anticipated that students would have more separation anxiety and trouble with socialization, sharing, rule following, and independence the following year. Educators provided suggestions for how to help pre-K students transition into kindergarten including meeting students and families before the year starts, having open houses and tours of the school, and sending toolkits home to their future students. (See Section II.D. for a description of CSP programs that respond to these needs.)

The CSP communities are also concerned about high rates of teen pregnancy. NYC DOHMH *Take Care New York 2020* highlights the higher rate of teen pregnancy among low-income populations, noting that “[l]ower-income girls need access to the same reproductive health education and resources available to higher-income girls.” While teen birth rates in NYC have declined across all poverty levels between 2010 and 2019, the disparity between teens living in low poverty and very high poverty neighborhoods has increased. In 2019, the teen birth rate in very high poverty neighborhoods was 5.0 times higher than that of low poverty neighborhoods, compared with 3.9 times higher in 2010. Furthermore, teen birth rates in very high poverty neighborhoods remain high (19.9 per 1,000 compared with 12.3 citywide).

While the disparities for Latina and Black teens are narrowing, they are still overrepresented among teen births and remain high compared to non-Hispanic White teens. In 2019, the teen birth rate for Latinas was 20.0 per 1,000, 3.7 times higher than that of non-Hispanic White teens. Fifty-nine percent of all NYC teen births were to Hispanic teens. The teen birth rate among non-Hispanic Black teens was 2.5 times higher than White teens (13.3 compared with 5.4 per 1,000). Asian and Pacific Islanders in New York City have the lowest teen birth rate (2.8 per 1,000 compared with the 12.3 citywide rate). Black and Latina teens are also overrepresented in teen pregnancy rates (47.2 and 38.8 per 1,000 respectively, compared with 32.1 citywide).

Teen pregnancy and birth rates are notable in Hempstead and Sunset Park. Hempstead has the second 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 69.1 per 1000 girls ages 15-19 compared with 14.1 in Nassau County, and the teen birthrate is 38.6 compared with 6.4 countywide. Sunset Park has the 12th highest teen birth rate among the 59 community districts in the City, with 19.6 births per 1,000 girls ages 15-19 (compared with 12.3 per 1,000 citywide).

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

6. Community Needs Not Addressed and Why

Across New York City 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 2019-2024* identifies 20 focus areas under five overarching priority areas.

Many health needs and social risks have been highlighted and amplified by the COVID pandemic. Mental health, which has consistently emerged as a top concern in the communities we work with, has become an even more pressing concern as people struggle to cope with the economic, health and social consequences of the pandemic.

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.

New York City Department of Health advises, "Equity in mental health outcomes can be achieved by addressing social determinants of health through policy, programs, and environmental changes."

A 2019 *Epi Data Brief* noted:

New York City 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 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%).

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

7. 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.

To truly understand community needs, assets and priorities, we are in a continual cycle of engagement and assessment, as questions arise and new priorities emerge. Assessment methodologies have included: surveys (see Section I.C.2., which describes the survey of the Arab American community in Brooklyn); secondary data analysis supplemented by focus groups and community meetings (see Section I.C.5., 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.

8. Existing Assets, Facilities, and Resources

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 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.

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 B) and serve on program advisory committees or our CSP Coordinating Council. In addition, we collaborate with other health care

Hempstead use of the Hite Site:

In Hempstead, the CHNAA planning group identified open questions about the availability of services generally and for specific population groups (e.g., undocumented residents, Spanish-speakers, children). Using the HITE site, the group created an inventory of housing-related resources, immigrant support services, mental and physical health services, education and employment resources, financial assistance, food assistance, youth and family services, and social support services. In addition to their collective knowledge, this now serves as a resource that will be used in their ongoing work.

providers: hospitals across New York City participate in convenings and workshops offered by our Brooklyn Health & Housing Consortium; numerous health care providers have attended events and trainings offered by the Community Health Worker Research and Resource Center. The Nassau University Family Health Center is a member of the Hempstead CHNAA planning group.

An overarching finding of our resource and asset assessment is that essential service providers are universally seeking opportunities for shared information, coordination and cohesion. The COVID pandemic has even further illuminated complex, interconnected needs. 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, NYULH’s three-year Community Service Plan takes a family-centered, multi-sector and holistic approach to improving health in Manhattan’s Lower East Side and Chinatown (Manhattan Community District 3), the Sunset Park and Red Hook neighborhoods of Brooklyn, and Hempstead in Nassau County.

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

Aligning with New York State Prevention Agenda and New York City public health priorities, the Community Service Plan focuses on **Preventing Chronic Diseases**; **Promoting Healthy Women, Infants and Children**; and **Promoting a Healthy and Safe Environment**. Each of our Community Service Plan programs is supported by a strong evidence base. Please see Appendix D for a description of the evidence for each initiative, together with relevant citations.

B. Addressing Health Disparities

Each of the programs addresses a health disparity: unstable housing for low-income and minoritized populations; the high risk for food insecurity and obesity among immigrant and 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.

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

In the sections that follow, we briefly describe our programs, our progress to date, and our goals under the 2022-2024 Plan.

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

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



C. Programs, Progress and Plans: Preventing Chronic Diseases

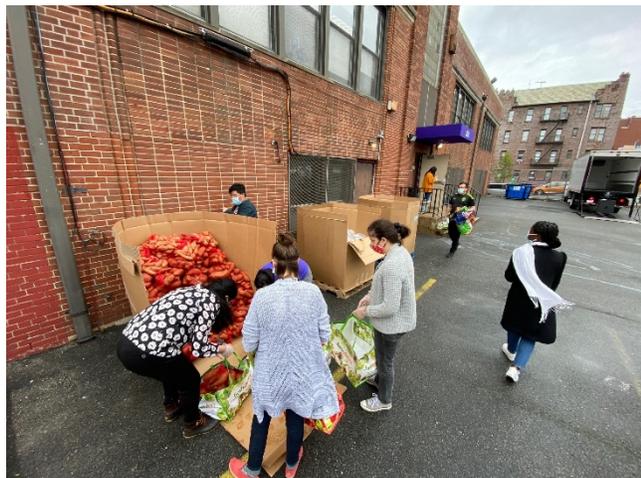
1. Healthy Food Initiative

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 and Get the Good Stuff Now. The initiative includes emergency food assistance, screening and case management, community education, and a community-wide coalition of food systems stakeholders.

Emergency Food Pantry:

The Family Health Centers (FHC) 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 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 shelf-stable staples and fresh fruits and vegetables to anyone who needs food. There are no income eligibility requirements. The Table is grounded in a *client choice* model, which is similar to shopping in a grocery store, enabling clients to choose items that are the best fit for their needs and preferences. The client choice model improves diet-quality outcomes and self-sufficiency, as opposed to more traditional program models. The Table experienced a 700% increase in demand during the peak of the pandemic and transitioned to a hybrid, outdoor grab-and-go model to ensure safety and meet the



increased demand for emergency food. The program will continue to assess opportunities to return to the client choice model in Year 1 of the upcoming Community Service Plan.

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 – such as Baked in Brooklyn, H & L Bagels, Sam's Bagels, Bagel Villa, and 3 Guys From Brooklyn – to provide freshly baked bread directly to pantry clients. The Table also has a sustained relationship with The 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 various cultural groups served. Through this partnership, the Brooklyn Grange provides The Table with a bountiful standing order of culturally-specific market crops that are selected based on community feedback. In partnership with NYU's Center for the Study of Asian American Health, The Table's emergency food packages include culturally-tailored recipes and meal preparation tips (in English, Chinese, and Spanish, the dominant languages spoken by area residents). Periodic cooking demonstrations are also offered to increase community members' comfort in preparing foods with ingredients that are provided through the pantry.

The program addresses immediate food needs and also helps to alleviate sustained exposure to food insecurity by connecting community residents to services. The Table is located at the Family Health Centers' Family Support Center to support ease of access to case management and other family services offered at the site. Clients receive information about these and other food, health, and wellbeing services in the Sunset Park area in their food packages.

Screening, Case Management and Nutrition Education:

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.

Counselors and FANs are located at the Family Support Center (the site of The Table food pantry) and at community partner sites throughout Sunset Park including schools, primary care providers 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 application process. Counselors and FANs are representative of the dominant cultural groups in the community.

Sunset Park Community Coalition:

The CSP, in partnership with the Chinese American Planning Council 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, and 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 effort to reduce food insecurity and address the underlying social determinants 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. Since this time, 14,754 households and 44,262 individuals have received food security services through the Healthy Food Initiative.

Emergency Food Pantry:

10,810 households received emergency food packages with 194,580 pounds of shelf-stable food and locally-grown produce through The Table.

The program expanded emergency food access models to adapt to community needs. Beginning in April 2020, the program began providing food packages to in-need patients being discharged from NYU Langone Hospital – Brooklyn’s Emergency Department, delivering an average of 30 food packages every Friday. From mid-May to August 2020, The Table also delivered weekly food packages to participants who were not able or willing to travel to the site. In response to the sustained burden and instability for families with young children, in summer 2021, The Table launched special food service events for families with children aged 0-5. These events consist of food distribution, a live cooking demonstration, and outdoor activities/giveaways for children. These special services have reached 16,622 family members, including 2,027 children ages 0-5.

The Table leveraged its interaction with many high-need members of the community to provide general information about COVID-19 testing/vaccination and safety, tips on how to support children and elderly family members during quarantine, and connection to a continuum of wrap-around services available at the FHC’s Family Support Center.

All participants who visited the pantry between April 2019 and August 2020 were invited to participate in the web-based survey via text. We received 351 responses suggesting that The Table is helping in-need community residents access healthy, community-tailored food:

- 85% indicated they were “satisfied” or “very satisfied” with The Table food pantry program (298 of 351 respondents);
- 86% indicated the pantry had a friendly environment (300 of 349 respondents);
- 89% indicated some or most items were the kind of food their household wanted to eat (312 of 349 respondents); and
- 99% of participants who reported visiting our food pantry to provide their household with healthy foods indicated they successfully accessed healthy food through their visit (148 of 149 respondents).



Responses also suggest that The Table may help alleviate broader financial resource strain. Accessing the food pantry in order to be able to use financial resources to meet other needs was the most cited reason for visiting The Table (48%). Ninety percent of those respondents indicated the food they received helped them have more money to pay bills or buy other necessities. Many also reported using the pantry in order to provide healthy food for their household (43%). Thirty eight percent of respondents who visited The Table in 2020 visited because food was running low.

In January 2022, we fielded a survey asking The Table participants to provide feedback on the fresh farm produce they received during the pandemic. The results of this survey will be used to inform future program design and it will guide the Brooklyn Grange in crop planning for the 2022-2023 season.

Screening, Case Management and Nutrition Education:

During this reporting period, 4,102 heads of household (HOH) received food-security case management services through 6,076 case management sessions. The majority received support with benefits applications:

- 2,944 HOH were assisted with SNAP applications, including new applications and re-certifications;
- 606 HOH were assisted with Cash Assistance applications.

We are currently expanding the availability of screening and case management to community partners. We are recruiting 10 AmeriCorps members to serve as AmeriCorps Food Access Navigators (FANs) in five sites throughout Sunset Park. The FANs will work directly with Coalition partners to build their capacity to address immediate and ongoing food needs. The planned program start is June 2022.

Recruitment of partners and AmeriCorps members has begun. We are developing an integrative roll out plan in conjunction with partners with a focus on curriculum, workflow, documentation, outreach, and supervision. Workshops will begin in summer or fall 2022.



Sunset Park Community Coalition:

The Sunset Park Community Coalition convened 7 times since its launch in June 2021. During this time, multi-sector partners included Arab American Association of New York, the Center for Family Life, Chinese-American Planning Council, Family Health Centers at NYU Langone, Grandma’s Love, NYU Grossman School of Medicine, Holding Hands Ministries, Mixteca Organization Inc., P.S. 169, P.S. 94., P.S. 503/506, City Harvest and the Brooklyn Grange. The Coalition developed a community emergency food resource list, launched mini-grants to support Coalition partner projects that extend food security resources, and created a new partnership with P.S. 503/506 and Grandma’s Love to provide fresh produce via The Brooklyn Grange rooftop farms to families in need. The mini-grants supported organizations interested in purchasing equipment, emergency food, and technology to assist with their food distribution operations.

Plans

Over the three years of the 2022-2024 CSP, the Healthy Food Initiative will reach over 37,000 residents experiencing or at-risk of food insecurity over the next three years. By August 2025, 60% of those served will have improved food or financial security.

The Table will continue to operate weekly, distributing food packages to 800 unique families per month. The Table will reach 13,500 unique households by 2025. For this next phase of the CSP, we will continue our relationship with The Brooklyn Grange and other local businesses to provide fresh, local food in our emergency food packages. Building upon the fresh produce offerings, The Table will continue to partner with NYU's Center for the Study of Asian American Health to develop culturally specific recipe cards that correspond to the produce grown by The Brooklyn Grange for distribution in food packages. The Healthy Food Initiative will serve 8,760 residents through screening and case management provided by Family Support Services counselors at the Family Support Center and AmeriCorps Food Access Navigators (FANs) at Sunset Park Community Coalition sites. We anticipate the FANs will be fully recruited by September 2022 and will serve as a 'connective tissue', fostering ongoing communication and collaboration between organizations through Sunset Park. We will provide 20 workshops to 350 community residents on core healthy living, food access, and financial stability topics.

The Sunset Park Community Coalition will continue to leverage existing community resources in an effort to create an integrated system that supports food security. During the first year of the new CSP, the Coalition will develop processes for ongoing assessment of community need, undertake a landscape analysis of available services and gaps in care, define goals and outcomes for the Coalition, set criteria for membership in the Coalition, and develop a cross-sector workflow to facilitate sharing of resources among member organizations and their participants.

2. Greenlight Early Childhood Obesity Prevention Program

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.

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.

The collaboration began with support from the 2014-2016 Community Service Plan, with implementation at the CBWCHC site in Manhattan's Chinatown and has since expanded with CSP support to a second CBWCHC site in Flushing, Queens, as well as Seventh Avenue Family Health Center at NYU Langone in Brooklyn. Each of these sites serve predominantly Chinese-American families.

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

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

- Low literacy toolkits to support physician counseling around diet and activity-related behaviors at well-child visits starting 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 D for evidence of the effectiveness of the Greenlight program resulting from an NIH-funded multi-site cluster randomized study.



Updated 15-18 month booklet, showing a sample meal plate.



Updated 6 month booklet, showing green and red "traffic light" behaviors.

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 within a green “traffic light.” 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.

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. 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 20 health care providers and 5 health educators trained in the use of the tools. Yearly trainings are offered to all staff members to ensure program updates are communicated across all sites.

From September 2019 through December 2021, the CBWCHC Chinatown site distributed 3200+ booklets and 2600+ tangible tools. During this period, which included the lockdown of New York City during the

Participating families and providers have been enthusiastic about the program:

- 94% of families said they would recommend the Greenlight program to a friend.
- 74% said they shared the Greenlight booklet to 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.

COVID-19 pandemic, we have reached 960+ unique children and families (~98% of unique eligible patients visiting each year). Of the 3500+ well-child visits of children 2-24 months of age that took place since September 2019, nearly 90% of visits included Greenlight intervention with a health educator or with a pediatrician.

In September 2020, the Greenlight program was expanded to one additional CBWCHC site in Flushing, Queens. From September 2020 to December 2021, the CBWCHC Flushing site program distributed 200+ core booklets and reached nearly 100 children and their families. Of the 400+ well-child visits of children 2-24 months of age that took place in this cycle, about 60% of visits included Greenlight intervention with pediatrician.

Implementation at Seventh Avenue FHC:

Due to COVID-19 disruptions, implementation of the Greenlight program at Seventh Avenue FHC was delayed until 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 at Seventh Avenue FHC. 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 28,000 patient visits per year, including over 6,000 pediatric patient visits. The team of health care providers includes family medicine providers, pediatricians, and an Ob/Gyn. The majority of families seen at the clinic are recent immigrants from Fuzhou, in southern China.

Between October 2020 and December 2021, we distributed 1500+ booklets and 800+ tangible tools. Despite the challenges presented by COVID-19, our booklet distribution numbers have exceeded our proposed benchmark of 300 booklets. To date, Greenlight has been used as part of 882 well child visits, reaching about 300 unique children and families, surpassing our original goal of 100 children and families.

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 is in progress.

At Seventh Avenue FHC, baseline data on behaviors were obtained on a subset of 68 parent/child pairs before recruitment was stopped due to New York City’s COVID-19 lockdown order. 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. One manuscript has been published in the *Journal of Immigrant and Minority Health*, “Material Hardship and Stress from COVID-19 in Immigrant Chinese American Families with Infants” with another currently under review, “Infant Feeding Practices and Social Support Networks in Immigrant Chinese American Mothers.” 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.



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 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 are being 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. Our team is in the process of uploading updated booklets to the main site and a fully Chinese version of the website is also being built, with a plan to launch in spring 2022.



Updated 9-month booklet, showing a sample meal schedule.

COVID-19 and Greenlight:

Beginning in March 2020, the COVID-19 pandemic caused significant workflow and staffing changes that affected the Greenlight program. Parents and families have been hesitant to be onsite at the clinic for healthcare. Because the Greenlight intervention is flexible and easily incorporated into the workflow, we were able to keep the program going. For example, when health educators were not available, health care providers provided more of the counseling related to the Greenlight materials during the well-child visit.

Greenlight materials have also filled gaps in care when other services, such as WIC, were not as accessible to families. Due to COVID, there has also been increased use of virtual video visits for delivery of primary care at CBWCHC, which has included delivery of various components of the Greenlight program.

In addition, the Greenlight program has been able to foster new partnerships to promote healthy behaviors and child development. As of July 2020, we are now working together with staff from the national Healthy Steps Program (specialist) at the CBWCHC Chinatown site. Greenlight materials are being used by CBWCHC Healthy Steps staff; shared materials and common messages regarding for healthy lifestyle behaviors reinforce positive parenting styles. Despite challenges faced during the pandemic, Greenlight use remained high, with high rates of distribution of materials, and successful program expansion to other sites.

Plans

As part of the 2022-2024 CSP, 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 Latinx and Chinese families), and NYU Langone Hospital – Long Island Pediatric Center (which serves predominantly Latinx 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.

We anticipate that Greenlight will be used at 2200+ well child visits, reaching over 1000 families each year, with distribution of at least 2700 booklets and 1700 tangible tools each year across the participating sites. This will include continued, routine engagement and training of 40-50 providers at these sites (training/informational sessions annually at minimum, and more frequently, if needed). We anticipate continuing to maintain the Greenlight waiting room program at CBWCHC Chinatown, reaching 300 families per year. At the NYU Langone Hospital – Long Island Pediatric Center, a new health educator will be trained, and the Greenlight waiting room program launched 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. In addition, with the increase in telehealth visits due to the ongoing pandemic, we plan to pilot remote delivery methods of Greenlight materials to families.

To further strengthen our partnership with parents and community leaders, a community advisory board (CAB) will be formed, consisting of families, providers, and representatives from community organizations. We will begin by surveying families (n=25-30) receiving care at participating sites. This feedback will inform the Greenlight team and its community advisory board, which will meet quarterly. By working closely with the CAB, 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.

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 notes from meetings of parent advisory group/community advisory board. This will include exploring collection of key diet and activity-related outcomes at each age timepoint by leveraging the health educator/waiting room program.

3. Reach Far Brooklyn: Racial and Ethnic Approaches to Community Health for Asian and Arab Americans in Brooklyn: Preventing Chronic Disease through Engagement with Community and Faith-Based Organizations in Brooklyn

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.

Our program, Racial and Ethnic Approaches to Community Health for Asian and Arab Americans in Brooklyn (REACH FAR Brooklyn) recognizes the important role that faith- and community- based organizations can play in improving the health of immigrants and racial and ethnic minority populations. REACH FAR Brooklyn partners with mosques, social service agencies, 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, we:

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

Progress and Impact

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



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, 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 Department of Health and Mental Hygiene and the Centers for Disease Control Million Hearts initiative and distributed these materials in a variety of community venues

such as health care settings, grocery stores, restaurants, and faith-based and community-based organizations.

As a result of these efforts, 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 NYCDOHMH to scale and implement diabetes prevention and diabetes management program in South Asian communities over the past four years, offering a prime opportunity to enhance referral to and support sustainability mechanisms for existing programs

Growing out of this work, as part of the Community Service Plan, we partnered with two mosques on the Lower East Side, Manhattan – Assafa Islamic Center and Madina Masjid – two mosques in Sunset Park, Brooklyn – Muslim Community Center and Jame Mohammadia and two mosques in Kensington, Brooklyn—Brooklyn Islamic Center and Masjid Nur Al Islam – to extend the REACH FAR program. Our efforts were designed to improve blood pressure control and promote healthy eating using a three-pronged approach: (1) implementing the Keep on Track program in mosques within the CSP catchment area; (2) implementing nutritional strategies, including education and changes to communal food practices; and (3) providing culturally tailored communications and education.

Assafa has a total of 1500 congregants and average weekly attendance of 250 congregants at the Friday Jummah prayers. Madina Masjid has a congregation of 2000 and average weekly attendance of 400 congregants at the Friday Jummah prayers. The Muslim Community Center has a congregation size of 500 and average weekly attendance is about 200 at the Friday Jumma prayer. Jame Mohammadia has a congregation size of 200 and average attendance is about 100 at the Friday Jumma prayer. Brooklyn Islamic Center has a congregation size of 700 and average attendance is about 300 at the Friday Jumma prayer. Masjid Nur Al Islam has a congregation size of 400 with an attendance of 250 mosque members at Friday's Jumma prayer.

To facilitate Keep on Track program, REACH FAR's Community Health Workers trained 38 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. Prior to the outbreak of COVID-19, about 500 mosque members received free blood pressure screening and counseling from KOT program.

COVID-19: REACH FAR Community Response and Resiliency:

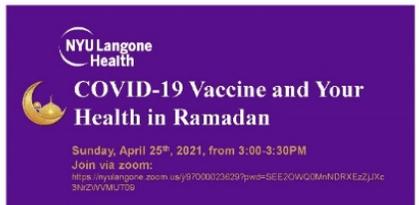
KOT programmatic activities have been paused since March of 2020 due to the closure of many faith-based organizations resulting from the COVID-19 pandemic. Mosques remained closed and in-person blood pressure screening was not possible.

The Muslim community was hit hard by the pandemic. Translated, accurate information on preventing exposure to COVID and on how to navigate existing resources was largely unavailable. This fueled fear as the death toll rose and many were hospitalized with severe disease. Moreover, many lost jobs or were unable to work, leading to a loss of health insurance, and the need for unemployment insurance, mental health support, food, and other daily necessary goods. Elderly community members, especially, could not go out to get needed medication.

REACH FAR’s CHWs responded quickly in partnership with mosque leaders and volunteers and shifted focus to help community members meet these immediate needs. The CHWs quickly translated information on how to stop the spread and flatten the curve; this information was widely disseminated through social and electronic media, text messages, or even by relaying information over the phone, reaching more than 10,000 community members.

REACH FAR directly supported COVID vaccination outreach, working to address vaccine hesitancy, disseminate accurate information on the vaccine, bring mobile vaccine vans to community settings, set-up pop-up clinics at mosques, and make vaccine appointments for the community members. They conducted in-language (Arabic, Bengali, Hindi, Urdu) live community forums and seminars on COVID-19 vaccination information to address myths and facts of vaccination via ethnic TV channels, Zoom and Facebook-Live.

These events reached about 19,000 community members, locally, nationally, and internationally. Moderated by REACH FAR’s CHWs, mosque imams were present as guest speakers to provide accurate religious information to debunk myths on the vaccine, and ethnic trusted doctors shared expert opinions; local social and ethnic media widely shared the information with support from youth-sports organizations and community-based organizations. REACH FAR also worked with two local ethnic media newspaper (each with a weekly circulation of 8,000) and published accurate information on the vaccine. REACH FAR also conducted in-language (Bengali and Arabic) mental health-related community forums and seminars via Zoom and Facebook-Live with South Asian and Arab American community partners to address COVID-19 related stressors, reaching more than 4,000 community members.





To help community members with personal protective equipment (PPE), foods, groceries, and medicine delivery, the CHWs worked with mosque volunteers, local restaurants, youth-sports organizations, and community-based organizations. They delivered food, medicine, and groceries to the doorsteps of vulnerable community members, in addition to distributing hot meals and PPEs by organizing a number of food pantry/table at common community sites, mosques, and businesses. More than 2,000 individuals and families were reached through these efforts.

In partnership with community-based and faith-based partners and with support from NYC Health + Hospital, REACH FAR jointly hosted pop-up vaccine clinics and vaccine vans at local mosques and community-based organizations and provided volunteer support with language interpretation. Through this outreach, approximately 1000 community members received COVID-19 vaccines. In partnership with NYU Center for the Study of Asian American Health (NYU CSAAH), REACH FAR's CHWs provided cultural competency training on South Asian culture to 1,400 COVID-19 contact tracers of New York State Department of Health.

Prior to the pandemic, from September 2019 to December 2019, REACH FAR conducted two in-person community seminars on diabetes and hypertension management, attended by 35 women. REACH FAR also distributed fresh fruits as a healthy food option to approximately 800 mosque congregants. Additionally, in November and December of 2019, led by Arabic speaking CHW, we conducted two in-person seminars on breast and cervical cancer screening awareness for Muslim women in Brooklyn attended by 65 women.

Once the pandemic began, REACH FAR pivoted to provide services virtually. For example, REACH FAR's CHWs organized a live Zoom workshop on hypertension and diabetes management during Ramadan of 2021 attended by 50 community members. CHWs also expanded their services to meet urgent needs, for example, by assisting community members in applying for unemployment insurance either by directly applying for them or by connecting them to the appropriate resources. Since September 1, 2019, close to 100 community members received assistance with health and unemployment insurance applications through REACH FAR. REACH FAR also worked with two ethnic media newspapers to disseminate information on health insurance and unemployment insurance.

DREAM Initiative:

In our previous work, we have demonstrated the efficacy of a culturally tailored CHW intervention to improve diabetes prevention and management outcomes in South Asian communities. Building upon this work, the National Institute of Health-funded DREAM Initiative is testing the effectiveness of the intervention across South Asian communities receiving care in network of 20 community-based primary care practice settings. The initiative is being implemented in five community-based primary care practice settings in Brooklyn serving the South Asian and Arab American communities, serving more than 5,000 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 (COPPO), 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.

Plans

Because of COVID-19, REACH FAR could not fully implement KOT and Nutrition Strategy programs at two of the new sites—Brooklyn Islamic Center and Masjid Nur Al Islam. As soon as in-person work becomes more feasible, in Year 1, we will resume these programs at these sites. We will also work with the volunteers of Muslim Community Center (MCC) and Jame Mohammadia Masjid to restart the KOT program.

Prior to the outbreak of COVID-19, from September 1, 2019 to December 31, 2019, in partnership with Arab American organizations in Brooklyn, REACH FAR led the Arab American Community Health Needs Assessment in Brooklyn described in Section I.C. 2. The results, which were shared with community partners, local leaders, and healthcare providers, together with follow-up meetings with partners, will guide implementation of targeted programs in the community.

Responding to the needs identified, we will continue to conduct the breast and cervical cancer awareness program for Muslim women (MARHABA). Through this program, group education sessions will be conducted for women in community and faith-based settings to raise awareness of breast and cervical cancer screening. Women who need screening assistance will be connected to the Perlmutter Cancer Center.

Since high blood pressure emerged as one of the top priority health issues, several of the community partners showed interests in hosting KOT program at their sites once in-person implementation becomes possible. Building upon the success of KOT implementation through REACH FAR and our previous CSP-supported efforts, towards the end of Year 1 and at the beginning of Year 2, we plan to work with the two Brooklyn based Arab American CBOs —Arab American Association of New York and Arab American Family Support Center to implement the KOT program. These two organizations serve a large number of Muslim Arab American and South Asian populations with a combined annual reach of 35,000 community members. They were two key partners in the Arab American Community Health Needs Assessment and played a significant role in planning, data collection, analysis, and dissemination of results.

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

Leveraging this network of trained faith-based leaders and CHWs and building upon our existing Brooklyn-based partnerships including NYU Langone Health Family Health Center and Brooklyn Hospital,

we will develop a strategy with mosque and CBO partners to connect individuals with high blood pressure to the health care system. In addition, 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 work with the DREAM Initiative CHWs to develop a translated handbook on diabetes prevention and management to distribute to mosque and community members. DREAM Initiative CHWs will also offer culturally tailored nutrition and physical activity demonstrations and videos at CBO and faith-based sites. As the REACH FAR CHWs are certified In-Person Assistors/Navigators (IPAs/Navigators) through NY State of Health Marketplace, they will continue to assist mosque members with health insurance enrollment. Moreover, we will continue to build on our partnership with ethnic social and electronic media, ethnic doctors, community and religious leaders, businesses, sports teams, CBOs and NYC Health + Hospital to combat COVID-19 by providing culturally tailored accurate information on preventing the spread, testing, and vaccination. In partnership with faith-based organizations and CBOs, we will also continue to conduct seminars on breast and cervical cancer awareness and mental health support, and connect people to needed services.

Finally, REACH FAR will refer eligible and interested participants to 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 (NIH) and is being conducted at NYU Langone Health at the Department of Population Health. The MASALA study is identifying i risk factors related to the hardening of the arteries in South Asians. Each participant will receive a free comprehensive medical exam at an NYU Medical Center facility.

4. Tobacco Free Community

Progress and Impact

Smoker Navigator Program:

Since the Smoker Navigator Program launched in partnership with Asian Americans for Equity (AAFE) in 2014, we have worked in a concerted effort to address the disparities in tobacco use among Chinese Americans in the Lower East Side, Chinatown, and Sunset Park. AAFE, an affordable housing developer and social service provider, has partnered with the CSP to provide linguistically and culturally competent tobacco use cessation and prevention services, and serve as a resource for other organizations to address the disparities in tobacco use among Chinese American smokers. Studies have shown that community-based navigation is an effective intervention to address the barriers to accessing tobacco cessation treatment services among low-income smokers. The Smoker Navigator Program has been staffed by two AAFE Navigators who completed the



Rutgers Certified Tobacco Treatment Specialist Training Program. Our aims are to: (1) identify and recruit smokers through community outreach, (2) educate and motivate smokers to quit or try to quit, and (3) refer smokers to evidence-based smoking cessation resources (e.g., Asian Smoker Quitline).

The AAFE Navigators reach out to community members who seek support from AAFE's community services programs, including those that address housing needs, insurance, and small business development. The Navigators also engage in other forms of community outreach, such as community-based education workshops, and provider referrals. Smokers are provided with brief cessation counseling in-person or by phone and offered free nicotine replacement therapy (NRT). Participants are then referred to the Asian Smokers Quitline (ASQ) for more intensive cessation counseling to provide additional support to increase smokers' chance of quitting. Studies have shown that the more intense the treatment intervention, the greater the abstinence rate. In addition, the Smoker Navigator Program has strong relationships with nearby community-based organizations, senior centers, health providers, and insurance companies. These partners have hosted community outreach activities such as virtual workshops and health events to educate the community about the harms of smoking and the dangers of secondhand smoke exposure, promote smoking cessation services, and offer guidance on making homes smoke-free.

The Smoker Navigator Program pivoted during the pandemic, suspending all in-person counseling services and delivering services remotely – by telephone, text, and video conferencing – to ensure community members continue to receive assistance. Additionally, to enable physical distancing, smokers have had the option to pick up the NRT at the organization's office or receive the NRT through the mail after the initial counseling session. We also partnered with ASQ to facilitate a training on phone counseling.

The Smoker Navigator Program has also used radio and television to increase awareness and conduct outreach through virtual workshops. For example, we collaborated with the Chinese American Medical Society (CAMS) on a 2020 Chinatown Smoke-Free Day, recording a radio segment about smoking cessation with the Chinese Radio Network. The Smoker Navigator Program has also collaborated with CAMS on a pilot Physician Referral Program, which created a streamline process that allowed participating physicians to refer smokers to AAFE for cessation service.

Navigator report:

Participant struggles with quitting as he has had multiple attempts in the past. He wanted to create a healthier home environment for his daughter. The reasons he had multiple failed attempts were stress-related as was as the majority of the people around him also smoke.

"The advice the Navigator gave me plus the NRT was very helpful in terms of controlling the number of cigarettes I smoke per day."

NYCHA resident

In partnership with the NYC Housing Authority (NYCHA), the Smoker Navigator Program has worked to support the Smoke-Free NYCHA Liaison Program. Since the beginning of 2019, the Navigators have connected with several NYCHA Resident Association presidents to talk about AAFE's smoking cessation services in their regularly held Resident Association meetings. The Navigators have also reached out to residents directly through a door-knocking campaign to inform NYCHA residents of AAFE's cessation program.

The Smoker Navigator Program has continued to expand its collaboration with the Smoke-Free NYCHA Liaison Program, linking Chinese-speaking smokers in NYCHA housing to culturally competent cessation services.

September 2019 to December 2021	
	(N)
Counseled	137
Receiving nicotine replacement therapy (NRT)	131
At 2 weeks follow-up: reported using NRT	72
At 6 weeks follow-up reported quit attempts	39
At 6 weeks follow-up observational quit rate*	23
Referred to ASQ or NYS Quitline	70
*Participants who reported that they did not smoke in the past 7 days	

Participants in the Smoker Navigator program noted that AAFE counselors were supportive in the counseling sessions. "Encouragement to quit" was the most frequently response to "What did you find the most helpful in the Navigator program?" and 54% reported that the Smoker Navigator Program was "very helpful." In addition, AAFE reached out to and informed over 5,000 people about the Smoker Navigator Program through community outreach activities.

Partnership:

Growing out of our CSP partnership and with the support of the RCHN Community Health Foundation, in 2015, the Charles B. Wang Community Health Center (CBWCHC) launched a City-wide initiative, which worked with the New York City Department of Health and Mental Hygiene to recognize smoking among Asian American men as a health disparity and to commit resources to a culturally relevant and language-accessible campaign to reduce smoking in the Asian American community. These efforts grew into a Smoking Partnership, which includes: four Federally Qualified Health Centers (CBWCHC, the Family Health Centers at NYU Langone, Community Healthcare Network and Union Community Health Center), AAFE, Korean Community Services of Metropolitan New York (KCS), the Chinese-American Planning Council, the Chinese American Medical Society, the Chinese American Independent Practice Association, NYC Smoke-Free at Public Health Solutions, NYC DOHMH, NYCHA, and NYU School of Global Public Health.



Members of the AATFCI/Smoking Partnership participating at a 2019 rally in support of legislation to outlaw flavors in electronic-cigarette and other nicotine delivery products.

From 2018-2020, the Partnership supported the participating CBOs in seeking New York City Council funding to expand the Smokers Navigator program. This effort resulted in funding for KCS and the Northern Manhattan Coalition for Immigrant Rights to expand the Smokers Navigator Program to Korean Americans and other limited English proficient immigrant populations.

From 2020-2021, in an effort to better understand organizational needs related to addressing high smoking prevalence within Asian American and other limited English proficient communities, the Partnership engaged the partners through meetings and surveys to identify collective priorities for the next three years. Through this needs assessment, the Smoking Partnership identified the following as priorities: development of an online smoking-related resource repository; partner networking and communications; and smoking-related policy development and advocacy. As described below, activities are underway or planned to address all of these areas.

Survey and E-cigarette Education Workshop:

In 2019, an outbreak of lung injury associated with the use of e-cigarette and vaping products among youth warranted a public health concern. Data from the National Youth Tobacco Survey showed that, from 2011 to 2018, current (past 30-day) e-cigarette use increased from 1.5% to 20.8% among high school students and increased from 0.6% to 4.9% among middle school students. To address e-cigarette use among youth and young adults in New York City, we collaborated with the Charles B. Wang Community Health Center's Teen Resource Center (TRC) and Chinese American Planning Council's Community Health Services (CHS) to conduct a series of workshops that focused on e-cigarette use among youth.

The Charles B. Wang Community Health Center Teen Resource Center (TRC):

The mission of the TRC is to provide a safe space for Asian American and other underserved youth to learn new skills, develop confidence, build support networks, and serves as community health advocates.

We leveraged the strong partnerships between the TRC and CHS and schools located in Lower East Side and Chinatown in Manhattan, and Sunset Park in Brooklyn, and the extensive experience of the NYULH Ronald O. Perelman Department of Emergency Medicine's Prevention and Education Partnership (PEP) Talks team in nicotine education to reach adolescents who live, recreate, or attend school in the area. The TRC and CHS staff received e-cigarette prevention training from the PEP Talks program. A total of 282 students participated in the workshops.

After the workshops, 84% of the students reported that they were "very satisfied" or "somewhat satisfied" with the workshop. In addition, student expressed interest in learning more about marijuana, and about e-cigarette quitting resources.

E-cigarette Use in Asian American Youth and Youth Adults in NYC:

To understand more about e-cigarette use by Asian American youth, we partnered with the Chinese American Planning Council, Community Health Services in fielding an online survey among Asian American youth and young adults in New York City. The survey was conducted from December 2019 to August 2020. A total of 945 young people completed the survey.

Key findings:

- Current e-cigarettes use rates are low among Asian American youth (2.7%) and young adults (4.7%);
- Most participants perceived e-cigarettes as extremely/very harmful;
- Fruit flavors were the most commonly used flavor, followed by menthol/mint; and
- Convenience stores were the most commonly reported source of e-cigarette advertising exposure, followed by the Internet; TV was the least commonly reported source of exposure.

The Chinese American Planning Council, Community Health Services (CHS):

CHS offers multiple health services that educate, inspire, and empower healthy outcomes through outreach, prevention education, program development, and community advocacy.

Although, according to the latest NY Youth Tobacco Survey, the rates of e-cigarette use among high school students has decreased from 27.5% in 2018 to 22.5% in 2020, community concern, particularly about flavored products, has led the Smoking Partnership to include this issue on its advocacy agenda.

WeChat Quit Coach Pilot Program:

Mobile messaging interventions have the potential to reach large audiences and expand smokers' access to cessation programs. Taking advantage of the popularity of WeChat in the Chinese American community, we piloted a culturally-adapted and linguistically-appropriate WeChat-based mobile messaging smoking cessation intervention. (WeChat, the most frequently used social media platform among Chinese globally, has 1.2 billion monthly active users worldwide as of May 2020.) We culturally adapted messages from two text messaging smoking cessation programs (SmokefreeTXT and Decidetexto).

We also developed new messages tailored to Chinese immigrant smokers who are not ready to quit smoking or face barriers to quitting. Next, we conducted in-depth interviews with 20 Chinese immigrant in New York City between July and August 2021. The interviews explored participants' smoking and quitting experiences, followed by the assessment of messages. The preliminary data resulted in a grant to conduct randomized controlled trial to test the feasibility and acceptability of the WeChat cessation intervention in group setting. Participants in the intervention group will receive a 6-week WeChat Quit Coach Intervention.

Plans

Smoker Navigator Program Tobacco Cessation Outreach:

The Navigators will continue their outreach with the goal of enrolling at least 85 smokers in the Smoker Navigator Program each year, providing NRT to at least 50 smokers, and referring at least 35 smokers to ASQ or New York State Smokers' Quitline. In addition, each year, the Navigators will do broader community education and outreach through workshops, community events and health fairs in collaboration with other community-based organizations. We anticipate that they will reach about 1,000 people each year in this way.

NRT Usage Evaluation:

Studies have demonstrated that distribution of free NRT through community-based organizations is a feasible and effective way to access this evidence-based treatment for the immigrants who smoke. However, NRT use is low among Asian American smokers attempting to quit (only 8.6%). To evaluate the quitting experiences and barriers to NRT use among Chinese smokers, the Navigators will reach out to current and past program participants (~50) to understand their experiences with NRT. The Navigator program will collaboratively develop a questionnaire to identify the reasons and challenges for program participants who did not use the full two weeks supply. We will use this information to help guide the Navigator's approach to recommending and distributing NRT.

Residential Services:

In addition, the Program will expand to provide residential services in tenants on the Lower East Side and Chinatown:

- The Navigators will partner with AAFE's new Residential Services at the 111 Norfolk Street Community Resource Center, which provides housing and support for people who have been unhoused, seniors, and people experiencing mentally illness and chemical dependency. The Navigators will provide outreach to residents and others who receive services at this site, offering smoking cessation counseling and services.
- AAFE has been actively working with Jacob Riis Housing and community leaders and policymakers to serve as a cultural liaison and to bridge the language access gap at this NYCHA site. In this next 3-year cycle, we will build on this relationship to expand our smoking cessation navigation program to this under-served Chinese American population.

The annual target across these 2 new residential sites is to reach and educate at least 20 smokers and refer 10 smokers to ASQ.

The Smoker Navigator Program will also work with AAFE as it expands its electronic outreach through the Twillo app to reach residents about smoking cessation services. This app enables AAFE to send mass texts to AAFE's 600 tenants within Chinatown and the Lower East Side. Participants in our smoking cessation program will also have access to wellness workshops, including free Tai Chi, Yoga, pantry services, and monthly acupuncture.

Smoker Navigator Lung Screening and Smoking Cessation Referral Project:

Due to the high rates of smoking, lung cancer is a concern for the Chinese American community. Over the next three years, the Smoker Navigator Program will increase awareness of lung cancer screening and develop a referral pathway to connect smokers to lung cancer screening and smoking cessation services. The project aims to create a bi-directional partnership between AAFE and NYU Langone's Lung Cancer Screening Program to connect smokers to culturally- and linguistically-appropriate resources on smoking cessation and lung cancer screening.

The primary focus of the first-year partnership is to develop a referral pathway including methods of communication, strategies for incorporating awareness of lung cancer screening in outreach events, and project monitoring and evaluation. AAFE will work with NYU Langone's Lung Cancer Screening program by implementing simple smoking cessation/lung cancer-related questions during cessation counseling or

the lung cancer screening process. If any participant or family member expresses interest in the lung cancer screening program, AAFE's Navigators will forward the contact information to NYU's Lung Cancer Screening program representative. The Smoker Navigator Program will educate at least 35 smokers about lung cancer screening annually.

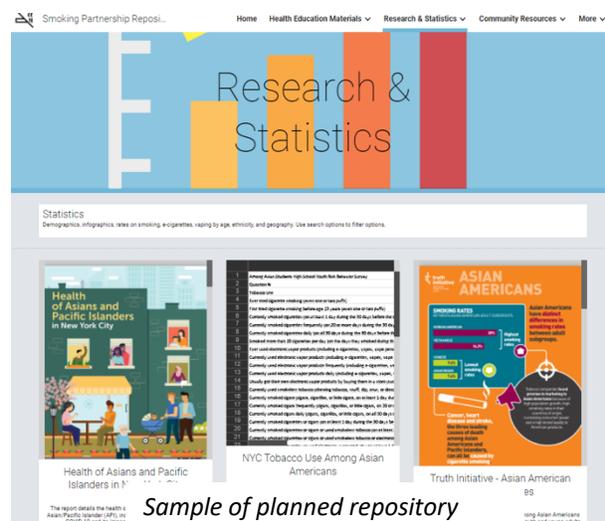
Pilot Acupuncture and Smoking Cessation Service:

As part of the wellness program at the 111 Norfolk Street Community Resource Center, AAFE is developing a pilot acupuncture program intended to help reduce smoking craving and stress among program participants. The Navigators will work with the acupuncturist to identify the best approach and treatment method for smokers interested in the acupuncture program. The Smoker Navigator Program will also develop evaluation tools and collect feedback from smokers participating in acupuncture sessions.

Partnership:

Led by the Charles B. Wang Community Health Center, the Smoking Partnership will continue to coordinate and strengthen community-based capacity to implement smoking cessation programs and prevention services within the Asian American community in New York City, with a specific focus on the Lower East Side and Chinatown neighborhoods of Lower Manhattan and within Brooklyn. In the next three years, the Partnership will focus on:

- Better understanding the partners’ perspectives on tobacco-related policies, informing the partnership of relevant policy and advocacy opportunities, and developing an advocacy strategy;
- Improving engagement with partners to encourage greater participation and ownership of the partnership and its related activities through consensus building activities and the development of shared goals;
- Collaboratively developing a Resource Repository website of tobacco-related resources; and
- Collaboratively designing and implementing an evaluation of the Partnership.



5. Stanford Chronic Disease Self-Management Program

The Stanford Chronic Disease Self-Management Program, an evidence-based educational program designed to build disease management skills and confidence, is being implemented in libraries and other community settings in Nassau County. The education/workshop series focuses on disease management skills, addressing decision-making, problem-solving, and action planning. Chronic diseases, such as heart disease, cancer, diabetes, stroke, and arthritis, are the leading causes of disability and death in New York

State. This program is designed to help people with many different physical and mental health conditions learn the skills, practical tips, suggestions, and strategies to build confidence in managing chronic conditions and symptoms daily while doing what they need and want to do.

Program staff facilitate the sessions using a comprehensive manual. Participants attend 2.5-hour weekly sessions conducted over six weeks. During this time, they develop individual approaches to setting goals, making decisions, and finding resources and support to live a healthy life with chronic conditions.

The workshop sessions cover such topics as becoming an active self-manager; finding and assessing resources; understanding and managing common symptoms; finding ways to be active; managing medications; communicating effectively with family, friends, and health professionals; nutrition; evaluating new treatments; and planning for the future. Sessions also cover the management of specific diseases, including chronic lung disease, heart disease, high blood pressure, stroke, and diabetes.

Studies have found that participants are more active and experience less depression, fear and worry about their health. They also experience a reduction in symptoms and increased confidence in their ability to manage their condition.

Progress and Impact

The Long Island-based Stanford Chronic Disease Self-Management program partnered with four community-based organizations, reaching a total of 36 participants for the six-session series:

- Hillside Public Library in New Hyde Park: 11 participants;
- Seasons 55+ Senior Community in East Meadow: 8 participants;
- "Yes We Can" Community Center in Westbury: 10 participants; and
- Garden City Public Library: 7 participants.

The program is very interactive and fosters and relies on group participation. The facilitators present information and guide the participants to their own decisions by brainstorming and suggestions from the group.

The planned continuation and expansion of the program was put on hold due to the pandemic, but as described below, it is starting up again and will grow in the coming years.

Here's what participants said about the program:

"I recently attended a six-week course offered by the Hospital. Each session dealt with specific topics, such as self-management, problem-solving techniques, dealing with emotions, safety in and out of the home, decision-making strategies, and the importance of sleep, exercise, socialization, healthy eating, and humor as we age. Each week we were challenged to become a better version of ourselves by employing these different techniques. The goal of the course is to empower each of us to deal with aging, illness, and loss. I may not be able to stop the clock on any of these realities, but I'm better prepared to face them after this course."

"The nurses had good skills communicating with the group—knowledgeable, pleasant, and whenever questions came up, they gave a sufficient answer. They were important to the success, and I would readily recommend this type of meeting to my friends. I learned a great deal and found I had misconceptions about some things regarding medications, recording them, and keeping the doctor aware of any changes. I feel this program enhanced my ability to have a more healthy lifestyle which was my goal when I joined the group. Most important, less need for the E.R".

Plans

Over the next three years, the Stanford Chronic Disease Self-Management Program will expand to two additional libraries in Nassau County. Other referrals will come through planned outreach to 25 health care providers and community-based organizations to educate them about the benefits of the program to their patients and clients. Through this outreach, we plan to reach 128 new participants.

To strengthen program content, we plan to add a social worker and pharmacy representative to the sessions. To evaluate the program's effectiveness, we will develop a survey of participants to be collected at baseline, immediately post-program, and six months later.

6. Red Hook Community Health Network

Red Hook Community Health Network (RHCHN) is a network of community-based organizations 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 of 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. The Red Hook CHNAA served as an outlet for residents to articulate important health issues, neighborhood strengths, and needed programs and services to improve the health and wellbeing of Red Hook residents.

These recommendations and issues are at the core of RHCHN's focus. The Network steering committee is composed of the following organizations: Alex House Project, Red Hook Community Justice Center, Good Shepherd Services, Red Hook Initiative, Family Health Centers at NYU Langone, and Department of Population Health at NYU Grossman School of Medicine. (See Section I.C.3 for a description of these community-based organizations.)

Progress and Impact

Community Health Worker Program:

Recognizing the need to support Red Hook residents by connecting them with resources to address medical and social determinants of health, the Network created a Red Hook Community Health Worker program, which launched in 2020. Support and referrals include: unemployment, health insurance, benefits, primary care (including COVID testing and vaccination), and specialty medical care. Referrals lead to food security resources in Red Hook, connection to health and mental health services (including telehealth), and benefits application assistance. The Community Health Worker Program consists of one CHW who is trained and supported by the Family Health Centers of 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.

The CHW program has significantly enhanced the capacity of existing community organizations and schools especially since the CHW was able to work onsite at three locations (PS 15, Red Hook Community Justice Center, and the Red Hook Initiative). To date, Network partners have referred 165 Red Hook residents to the CHW who has connected them to medical, social, and economic resources through direct service and referrals.

Network Workgroups:

The RHCHN continues to primarily meet virtually due to the ongoing COVID-19 pandemic. This, however, has not inhibited the expansion of the Network's work and partnerships. In August 2021, a new Network Manager was hired and new partnerships began to form as the Manager began building new relationships in Red Hook. The Network is also building deeper relationships with schools in the neighborhood, including PS 15, PAVE Academy, PS 676, and Summit Academy. These schools provide an important safety net for families in Red Hook and continue to provide valuable insight and information to the RHCHN.

The Network has refined and developed the mission and structure of the RHCHN and has formed several workgroups, with the goal of consistently having three Workgroups activated every year: the Network Steering Committee and at least two community-priority Workgroups. The community-priority Workgroups will advance access and resident health and wellbeing by identifying emerging community needs, assessing the resource landscape within and beyond Red Hook, and identifying opportunities for advocacy and resource coordination or development.

To date, the following groups are meeting on a monthly basis:

- Network Steering Committee
- Health and Housing Workgroup
- Access to Care Workgroup

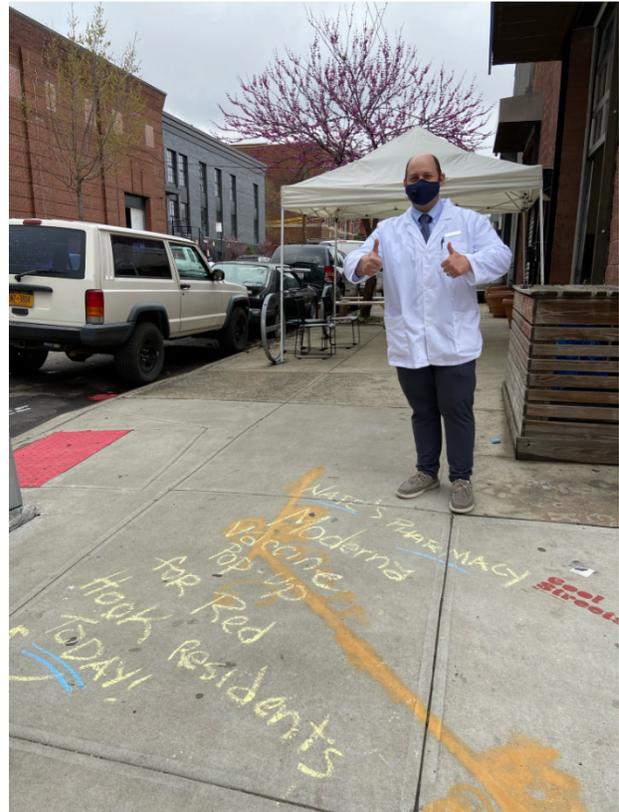
Network Steering Committee

The Red Hook community has felt the consequences of the COVID-19 pandemic (see Section I.C.3) and continues to be a place where resources for testing and vaccinations are limited. During the pandemic, the Network Steering Committee has spearheaded the coordination of COVID-19 response efforts, mobilizing to ensure Red Hook residents have the latest information about the virus and have access to essential resources. Although this work was done in-person when possible, much of the resource-sharing was accomplished through the [Red Hook HUB](#), a website where anyone can post information and resources relevant to Red Hook.

The Network also supported Alex House Project in obtaining a grant of \$30,000 that enabled them to provide families with mini-grants to alleviate financial strain exacerbated by the pandemic.

Since the beginning of 2021, the Network has worked to expand access to vaccines and testing, focusing on Red Hook Houses, where we learned that the vaccine rates were only at 51% compared with 74% in the greater 11231 zip code, which also includes higher income neighborhoods such as Carroll Gardens and Cobble Hill. In order to respond to the diverse needs surrounding the vaccine, particularly education and access, the Network facilitated the following outcomes:

- Six vaccine and COVID-19 education events with CBOs and schools in Red Hook featuring medical professionals from the NYU Langone Health network;
- 1,000+ individuals vaccinated through vaccination days in partnership with Nate's Pharmacy, including mass vaccination days serving 250 people per day;
- Weekly booster shot opportunities in partnership with Nate's Pharmacy averaging around 20 individuals receiving their booster shots per day; and
- A vaccine pop-up at PS 15 in partnership with Family Health Centers at NYU Langone.



Health and Housing Workgroup

The Network launched a Health and Housing Workgroup in November 2021 in response to the health concerns illuminated in the CHNAA that revolve around the intersection of health and housing, particularly in New York City Housing Authority (NYCHA). This workgroup is focused on health and housing needs in Red Hook's public housing community, the current strategies aimed at addressing needs, and conducting a gap analysis to identify potential areas of focus moving forward.



Workgroup members have also been collaborating on how to better support and advocate for NYCHA tenants who are eligible for submitting reasonable accommodation requests. These requests allow public housing residents to relocate or get improvements to their apartments based on disability or medical condition. They require the approval of a medical provider, which can be a barrier for some residents. The Network coordinated a training session with NYCHA, Red Hook Initiative, Red Hook Community Justice Center and the Network's Red Hook Community Health Worker, and is also leveraging the

relationships within NYU Langone Health’s network for improving the medical provider documentation process.

Access to Care Workgroup

Addressing the shortage of healthcare providers in the neighborhood, the Network took a two-prong approach, focusing on (1) increasing access to care opportunities that exist outside of Red Hook; and (2) working to bring more healthcare services into the Red Hook community. In collaboration with the Family Health Centers at NYU Langone, Network partners have begun to plan for the opening of a Family Health Center in Red Hook at the beginning of 2023.

The Access to Care Workgroup is committed to centering community voice and needs within the services of the health center including, but not limited to, employment opportunities, health center partnerships with existing Red Hook organizations, and the services provided at the center.

Plans

Over the next three years we anticipate reaching 750 Red Hook residents, and engaging eight organizations and service providers through RHCHN initiatives.

Community Health Worker Program:

The Network is committed to the success and expansion of the CHW program in Red Hook by ensuring that we facilitate new partnerships with organizations whose constituents can benefit from community health workers. Each month the Network aims to refer at least 20 Red Hook residents to the CHW, reaching 750 Red Hook residents over the next three years. Our goal is for 80% of Red Hook residents who received CHW services to have improved access to health and wellbeing resources.

Network Workgroups:

Over the next three years, the Red Hook Community Health Network plans to grow its membership to include six new Network members who can support the critical work around access to care and health and housing. The Network also plans to engage more community residents by providing leadership roles as co-chairs of the workgroups and more structured pathways to facilitate their participation. Strategies for this process will be in line with those outlined in the Community Service Plan’s CBPA and anti-racist principles.

We will grow from six to eight community organizations and from four to six community residents actively serving on RHCHN Workgroups. Year 1 Workgroups will include Steering Committee, Health and Housing, and Access to Care. Each group will conduct gap analyses. The Steering Committee will continue to oversee the structure and mission of the RHCHN. The Health and Housing Workgroup places public housing residents at the forefront and will identify and implement evidence-based strategies to address mold, lead, and other housing issues that significantly impact the health of NYCHA tenants in Red Hook. The Access to Care Workgroup will focus on the Red Hook Family Health Center opening in 2023. The Network will continue to advocate for ways Red Hook residents can continually provide the health center with helpful feedback and support to ensure the care residents receive is appropriate and congruent with their needs. The Access to Care Workgroup will develop a shared understanding of goals and strategies to support the health center and ensure that medically underserved Red Hook residents, particularly those residing in NYCHA housing, are connected to services.

7. Community Health Worker Research and Resource Center

The Community Health Worker Research and Resource Center (CHW-RRC) 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 and in the community. The overarching aim of the CHW-RRC is to improve health, reduce health inequities, and recognize and help build CHW capacity and leadership.

The CHW-RRC works towards this goal by cultivating opportunities to enhance CHW leadership and support bi-directional learning between CHWs and healthcare systems, providing support and professional development opportunities to this workforce, supporting community-clinical linkage models, and stimulating cross-project learning of best practices in community and patient engagement.

Our CHW initiatives are located in various settings, from community- and faith-based organizations to primary care practices, hospitals, senior centers, barbershops and hair salons, and low-income housing. Initiatives are culturally adapted in close partnership with community-based organizations and community residents to address diverse populations' needs, and they have addressed a wide array of medical and socioeconomic issues. We seek to build on successful partnerships with community-based organizations and our experience working directly with community members to advance resident health and improve health equity through effective CHW programs.

Progress and Impact

Since its launch in 2018, the CHW-RRC has significantly expanded its scope and reach. While much of our focus remains on strengthening the work and capacity of CHWs at NYULH who work in diverse communities, we have greatly broadened our engagement with other institutions and CBOs in New York City and nationally. We currently maintain an email list of over 2,100 subscribers.

The [CHW-RRC Stakeholder Group](#) has continued to meet regularly to set priorities and implement the Center's vision. This group includes researchers, staff, and CHWs from the NYULH community. An essential component of the CHW-RRC is the [CHW Learning Community](#), which leverages CHW thought-leadership and strategic planning to foster social support and provide professional development opportunities for staff across the NYU Langone system who work as CHWs, patient navigators, and similar positions. The CHW Learning Community met in-person quarterly throughout 2019 and, since the onset of the COVID-19 pandemic, has shifted to more frequent virtual events, trainings, and

Priority Action Areas

- Foster social support and provide professional development and leadership opportunities for staff across the NYU Langone system who work as CHWs and patient navigators, and in similar roles;
- Provide technical support related to CHW programs at any point in the lifecycle of a project;
- Maintain a living library of templates and resources for organizations and researchers to access as they launch or refine CHW programs and studies; and
- Bring together staff of CHW initiatives across New York City to discuss the current landscape, develop partnerships, explore sustainability models, and advocate for resources.

workshops to build and sustain community across programs. It is advised and led by a rotating group of 5-6 CHWs who comprise the [CHW Learning Committee](#).

In March 2020, when NYC became the epicenter of the COVID-19 pandemic, the CHW-RRC developed the CHW Wellness Survey in response to CHW Learning Committee suggestions. The survey aims to better understand the needs of the CHW Learning Community as staff adjusted to new working environments and were experiencing acute challenges, both professionally and personally. We have used results of this quarterly survey for program planning, such as a six-week mindfulness training series for CHWs to support personal wellbeing and build competencies in integrative health techniques for self-care among CHWs. In April 2021, we launched a monthly virtual mental health support group specifically for CHWs, facilitated by a clinician at NYU Langone–Long Island.

COVID-19 Vaccination, Pregnancy, and Maternal and Infant Health

Hosted by the NYU Community Health Worker Research & Resource Center (CHW-RRC), Caribbean Women's Health Association (CWHIA), NYU Community Engagement Alliance (CEA) Initiative, NYU-CUNY Prevention Research Center, and NYU IHH Clinical and Translational Science Institute

This webinar is geared primarily towards community health workers, doulas, and frontline staff working directly with community members. Join us to learn about the safety and efficacy of COVID-19 vaccines for expecting parents, navigating vaccination during and after pregnancy, and resources for talking to pregnant clients and new parents about vaccinations.

Michelle Morse, MD, MPH
Chief Medical Officer & Deputy Commissioner for Center for Health Equity & Community Wellness, NYC Dept. of Health & Mental Hygiene

Tasha Phifer
Doula, Caribbean Women's Health Association

Terri-Ann Bennett, MD
Clinical Assistant Professor, Dept. of Obstetrics & Gynecology, NYU Grossman School of Medicine

Discussion moderated by **Clarissa Rios**
Community Health Worker, Family Support Service, Family Health Centers at NYU Langone and Red Hook Initiative

Thursday, November 18th, 2021
11:00 AM - 12:00 PM
Register and submit questions here: tinyurl.com/5dd8bpxx

For questions, email dina.pimenova@nyulangone.org
The CHW-RRC is supported by the NYU Langone Health Community Service Plan

The survey results also helped us identify webinar topics of interest for the CHW Learning Community. While some professional development webinars and trainings are for NYULH staff, the majority of our webinars and training during the COVID-19 pandemic are open to the public and our community partners to provide tools and information to frontline health workers.

Between May 2020 and December 2021, the CHW-RRC hosted nine webinars on topics related to COVID-19, reaching 1,290 attendees from over 300 organizations across the United States, featuring speakers from NYC Department of Health and Mental Hygiene, community-based organizations, academic institutions, and medical practices. Each community-facing webinar is moderated by a CHW. Webinar topics included “Tobacco Prevention,” “Nutrition Management,” and “Mental Health,” reaching over 100 attendees from more than 20 organizations. Professional development webinars covered “Career Growth and Development” and “Patient Recruitment and Outreach.” reaching over 370 attendees across nearly 130 organizations.

In addition to these trainings, on September 28th, 2021, five CHWs participated in a lecture and panel discussion for third year medical students at NYU Grossman School of Medicine. This was a two-session panel discussion which gave medical students the opportunity to learn directly from CHWs regarding their critical role in addressing the social determinants of health and gave medical students the opportunity to ask CHWs questions directly to better understand how CHWs can serve as a bridge between the community and the



clinic. Both CHWs and medical students found this to be a very rewarding session, and these panel discussions have become a regular component of medical student education.

In July 2020, the CHW-RRC published the first volume of the quarterly [CHW Learning Community Newsletter](#), which highlights CHWs and patient navigators' critical role by showcasing professional and personal success stories and Learning Community members' creative projects. The newsletter is distributed to a listserv, which includes members of the CHW-RRC Learning Community and Stakeholder Group, CHW supervisors, and a growing network of community partners and organizations. The sixth volume of the newsletter will be published in February 2022.

Additional activities of the CHW-RRC include:

- The CHW-RRC has provided technical support and guidance to partner CBOs, such as Grand Street Guild, Henry Street Settlement, Caribbean Women's Health Association, and Harlem Congregations for Community Improvement, Inc., as well as government organizations such as the New York City Housing Authority and Cambridge Housing Authority as they launched or evaluated their CHW projects and programs.
- The CHW-RRC is a collaborating partner on a pilot project with Mount Sinai and NYC Health + Hospitals/Queens Hospital, "Community Healthcare Workers Promoting Equity in Vaccine Access and Trust during the COVID-19 pandemic (CHWs PREVENT COVID)." We helped to develop and facilitate a training on "Using Motivational Interviewing Skills to Talk to Patients about COVID-19 Vaccine Hesitancy," as well as a pre-post survey for evaluating training effectiveness.
- We have been serving as a human resources hub for programs looking to hire CHWs by sharing job opportunities with CHW training programs in NYC at Make the Road New York and LaGuardia Community College, and have helped facilitate resume exchanges between projects across NYULH.
- We continue in the planning stages of an online public-facing document repository that will include resources such as hiring and interview guides, training resources, surveys, data collection forms, participant education modules, consent forms, and grant proposals. We conducted end-user interviews with internal and external CHW program supervisors and have started the process of collecting relevant documents from CHW projects at NYULH to include in the repository. Compiled documents and resources to date are inventoried on an Excel spreadsheet with hyperlinks to files currently hosted in a OneDrive folder.



To strengthen capacity and increase knowledge at the local level, the CHW-RRC brings together staff and leadership of CHW initiatives across New York City to discuss the current CHW workforce landscape, develop partnerships, explore sustainability models, and advocate for resources. More than 350 people

from 31 organizations across the United States attended our inaugural CHW Innovations Summit in November 2020, “Making Models Last – Current and Future Sustainability for the Community Health Worker Workforce.”

Plans

Responding to the COVID-19, the CHW-RRC pivoted to support CHW staff and the communities they serve, addressing the needs outlines in Section I.D.1. Plans for 2022-2025 return to and extend some of the earlier program priorities:

- Expand the reach and impact of the CHW-RRC, continuing to grow our network;
- Complete development of a Repository of documents and resources in partnership with NYULH digital communications and an external consultant;
- Synthesize best practices for CHW program implementation and create standardized protocols for supervision, training, outreach, and case management, and assist with adaptation to specific programs;
- Continue to build CHW Learning Community capacity through targeted professional development activities, mentoring, and involvement in CHW-RRC committees and webinars;
- Continue to promote CHW wellness through a range of community building, support, and engagement activities, including regular surveys, mental health and/or self-care support groups, recognition ceremonies, and celebrations;
- Engage external partners in NYC to establish a centralized website for posting CHW job opportunities;
- Continue to advocate for CHW equity in hiring and career advancement opportunities;
- Organize an annual CHW Summit on a timely theme;
- Partner on research and evaluation projects aimed at strengthening and better understanding the role of CHWs in promoting the health of vulnerable communities;
- Integrate CHW-RRC activities with programs to develop an integrated community-clinical linkage model to improve health and wellness outcomes in Sunset Park, Brooklyn; and
- Expand webinar reach to more non-English speaking communities by offering simultaneous interpretation during webinar events.

8. Brooklyn Health & Housing Consortium

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

With an initial focus on Southwest Brooklyn, we invited experts across the NYU Langone Health system and various community partner organizations to join the Brooklyn Consortium Steering Committee. Since June 2018, the Committee has expanded and meets regularly to advise and oversee the development of the Brooklyn Consortium's mission and goals as well as its progress in associated activities that have expanded across Brooklyn. From June 2020 to October 2020, we formed an ad-hoc Strategic Planning Group within the Steering Committee to update the Brooklyn Consortium's mission statement and to refine priority areas.

Current member organizations of the Steering Committee include: Breaking Ground, CAMBA, Corporation for Supportive Housing, Empire BlueCross BlueShield HealthPlus, Enterprise Community Partners, the Family Health Centers at NYU Langone Health, NYU Langone Hospital-Brooklyn, Maimonides Medical Center, RiseBoro Community Partnership, and the Bronx Health & Housing Consortium.

The mission of the Brooklyn Consortium is to act as 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 Brooklyn residents with unmet health and housing needs. Through capacity-building activities and cross-sector collaboration, the priorities areas of the Brooklyn Consortium are to:

- Provide trainings, events and activities to educate and build relationships among frontline workers and organizations across Brooklyn;
- Explore best practices and advocate for improved screening and data sharing across sectors throughout Brooklyn and New York City;
- Lend support and technical assistance to other health- and housing-related efforts to share learning, promote best practices, avoid duplication, and bring successful efforts to scale; and
- Develop a vision statement concerning the need to address structural racism as root causes of housing and health inequities, and integrate a diversity, equity, inclusion and accessibility lens to the Brooklyn Consortium's work.

Progress and Impact

Since September 2019, the work of the Brooklyn Consortium has accelerated, transformed and expanded in response to the intersecting health and housing crises exacerbated by the COVID-19 pandemic.

Brooklyn Health & Housing Consortium Goals

- Expand understanding of the health care, housing, and related needs of Brooklyn residents
- Build and strengthen relationships and communication among stakeholders serving a shared population
- Share, develop, and advocate for resources and policies that address inequities in health and housing, and amplify the work of partners doing similar work
- Support policies and practices that address the impact of structural racism on health and housing

Responding to a need for better care coordination for housing-insecure clients and patients, the Brooklyn Consortium hosted one in-person and three virtual interagency case conferences that brought together stakeholders from homeless outreach, supportive housing and social service staff with hospital emergency department clinicians, inpatient social workers, and discharge planners. Through presenting case studies and workflow issues, participants offered expertise and shared resources to collaboratively troubleshoot solutions for their patients and clients as well as build relationships with providers across sectors. The Program Director of Breaking Ground’s Street to Home Program, who is a Brooklyn Consortium Steering Committee member, facilitates these meetings and partners from NYC Health + Hospitals’ Safety Net Clinics, NYU Langone Hospital-Brooklyn, and Comunilife frequently participate.

In partnership with the Legal Aid Society and New York Legal Assistance Group’s (NYLAG) LegalHealth division, as well as our colleagues at the Bronx Health & Housing Consortium, we organized a number of trainings to help build the capacity of frontline staff in addressing housing and health-related needs. Our most popular trainings have focused on topics surrounding eviction and homelessness prevention, including 6 sessions on rental assistance (CityFHEPS and the Emergency Rental Assistance Program), 3 on shelter rights, 3 on housing court proceedings, and 3 on coordinated data sharing systems. Between September 2019 and February 2020, the Brooklyn Consortium hosted 4 in-person trainings with 126 participants in Downtown Brooklyn and Sunset Park. Our transition to virtual trainings due to the COVID-19 pandemic increased people’s ability to attend our trainings as well as our capacity to host them. Since March 2020, we have organized 19 trainings and expanded our reach to approximately 2370 participants across the City.

As part of our COVID-19 pandemic response, the Brooklyn and Bronx Consortia co-organized 12 town halls that provided the opportunity for frontline staff to learn about citywide resources and updated guidance for homeless patients and housing insecure clients. Featuring presentations and Q&A discussions, more than 1,100 participants across over 170 organizations were able to hear directly from government agency representatives and health experts. All recordings and resources from these town halls were disseminated via our newsletter and posted on the Bronx Consortium’s webpage. Throughout these town halls, 97% of survey respondents (n=283) agreed or strongly agreed that they planned to apply information used during a town hall in their work.

Example COVID-19 Town Hall Topics:

- Isolation and De-densification Hotels
- Food Assistance
- Substance Use Treatment
- Emergency Rental Assistance
- Vaccinations for Homeless Individuals
- Mental Health for Frontline Workforce

Example Guest Speaker Affiliations:

- Janian Medical Care
- NYC Dept. of Homeless Services
- NYC Health + Hospitals Corporation
- NYC Office of Emergency Management
- NYC DOHMH
- NYC Human Resources Administration
- NYU Grossman School of Medicine
- Manhattan Outreach Consortium
- St. Barnabas Health System

Starting in December 2020, the Brooklyn Consortium joined the Bronx Consortium to co-organize their [Annual Convenings](#). These two-day events, now virtual, have highlighted pressing issues, cross-sector program innovations, and policy changes in response to the COVID-19 pandemic, as well as lessons learned and opportunities for further collaboration. Engaging with 878 total viewers in topics relevant in New York City, more than 40 speakers from our two convenings featured representatives from multiple community based organizations; housing, health care and social services providers; government agencies and elected officials; and advocacy organizations.

Other activities of the Brooklyn Consortium have included:

- Following the Bronx Consortium model, housing marketplaces are networking opportunities for supportive housing providers and frontline staff to explore housing options for specific populations. At our March 2021 housing marketplace (199 attendees), we showcased five housing providers (CAMBA, Catholic Charities, Comunilife, Concern for Independent Living, and SUS) who offer services for clients with severe mental illness. After the providers gave brief overviews of their programs, participants transitioned to Zoom “breakout rooms” and took turns asking further details surrounding eligibility, referral steps, COVID-19 related protocols, onsite health services, and overall “fit” in potential housing placement. This information was compiled in a packet and distributed to event participants. With NYC Continuum of Care (CoC)’s new Coordinated Assessment Placement System (CAPS) to streamline housing program referrals and applications, we convened a data sharing workgroup to strategize the transition from housing marketplaces to virtual CAPS trainings.
- The Hospital Homeless Count aims to better understand and advocate for the “hidden homeless” population who would otherwise be missed from New York City’s official point-in-time count, and to learn about the implications of homelessness on the health care system (see Section I.D.2). The Brooklyn Consortium helped build relationships with hospital emergency department teams throughout New York City, engaged our network to recruit volunteers, and assisted with survey design and write up of a final report with [key findings](#). On January 27, 2020, we identified 226 individuals experiencing unsheltered homelessness sleeping and/or seeking care in 30 hospitals. Due to the COVID-19 pandemic, our Count was cancelled in 2021 and postponed in 2022.
- In early 2020, the Brooklyn Consortium and other CSP team members were asked by NYC DOHMH’s Center for Health Equity and Wellness to evaluate the Bureau of Equitable Health System’s *Healthcare Referrals for Homeless Prevention (HRHP)* pilot program, a closed loop standardized referral mechanism between hospitals and homelessness prevention community-based (Homebase) organizations to address housing instability and improve health outcomes. After conducting 11 in-depth interviews and 3 focus groups with representatives from Homebase programs, hospitals, and city agencies, the team provided recommendations on optimizing program implementation.



Another vital aspect of the Brooklyn Consortium’s work involves discussing, disseminating, and mobilizing our network to support programs and policy recommendations that address inequities at the intersection of health and housing. Some of our activities in this area have included:

- In early April 2020, the Consortium co-wrote and disseminated a *Letter from Hospital Providers Regarding COVID-19 and Homelessness in New York City*, which was submitted to local and state officials with signatures from 503 New York City frontline physicians, social workers, nurses, nurse practitioners, physician assistants, care managers, and other health professionals. Policy recommendations included: streamlining the discharging process among homeless patients, de-densifying congregate homeless shelters and moving individuals into private rooms, ending street sweeps of homeless encampments, and increasing city transparency regarding COVID-19 infection and death among the homeless population. This letter received press coverage on *Politico* and *VICE*.
- With the United Hospital Fund, in October 2019, we participated in a roundtable discussion and provided recommendations that appear in *The Road Forward: Framework for a Population Health Approach to Health and Housing Partnerships*, a project of the New York City Population Health Improvement Program to better understand health and housing interdependencies and advance a viable framework. The Consortium was featured in the report as well as in a commentary piece as a helpful model for multisector collaborations.
- We provided recommendations that were included in the *United for Housing Campaign*, which defined a new affordable housing platform for the next 2021 New York City mayoral administration.
- In partnership with the Bronx Health & Housing Consortium, in May 2020 we started a biweekly e-newsletter that includes Consortia events and activities, helpful resources for frontline providers, noteworthy developments in health and housing advocacy and research, and upcoming events hosted by partner organizations. In 2021, we sent out 27 newsletter issues and gained 1,988 new subscribers, reaching a total of 3,750 subscribers.
- In April 2020, we contributed to the *Health Affairs’* special issue on integrating social services and health with a paper titled “The Development of Health and Housing Consortia in New York City,” and *Health Affairs Blog* piece titled “Health & Housing Consortia: Responding to COVID-19 Through Cross-Sector Learning and Collaboration.”
- In April 2021, we developed a public webpage that describes our mission, goals, and activities within the Community Service Plan section of the NYU Langone Health website.

Plans

Over the course of the next three years, the Brooklyn Consortium will engage in a strategic planning process with the Bronx Consortium to establish plans for consolidating the work of both Consortia under one umbrella. During this time, the Brooklyn Consortium will continue with its programmatic activities, including those in partnership with the Bronx Consortium, and take on or develop new projects as needs arise. We anticipate those to include:

- Continue offering, with legal partners, a robust training series for front-line workers on eviction prevention, rental arrears, income maximization, and obtaining affordable housing benefits;
- Organizing additional training series focused on social determinants of health and specific vulnerable populations;

- Continue co-organizing an Annual Convening that includes current topics at the intersection of health and housing relevant to health care and housing providers;
- Continue collaborating with the Bronx Consortium on the annual Hospital Homeless Count;
- Co-organizing with the Bronx Consortium a convening on medical respite and funding for new medical respite pilots through the NYS Medicaid Office;
- Continuing the Brooklyn-focused interagency case conferences to improve communication between hospitals and homeless service providers, and with Department of Homeless Services;
- Expanding membership of the Brooklyn Consortium’s Steering Committee to other health and housing advocates not yet represented and modifying or expanding priority areas as needed based on new membership;
- Leading a workgroup and/or convening on developing a citywide hospital housing security screener and standardized data collection of housing status;
- Pursuing new collaborations with other community partners and Community Service Plan projects on relevant projects, events, and research; and
- Offering assistance to partner organizations’ health and housing efforts.

9. Health x Housing Lab

Recognizing the importance of safe and stable housing for health, the Health x Housing (“health by housing”) Lab was created in 2021. The Lab’s mission is to provide evidence-based guidance for initiatives sitting at the intersection of health and housing and 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:

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

A portion of the Health x Housing Lab’s work is supported by the NYU Langone Community Service Plan, with other funding from external grants and internal Department of Population Health resources. As part of the Community Service Plan, the Lab follows its guiding principles and commitment to improving health equity and addressing the role of structural racism in health disparities through a community-based participatory approach to program development, implementation, evaluation, and research.

The Lab’s Advisory Committee includes people with lived expertise of homelessness and housing instability, as well as representatives from organizations across sectors relevant to health and housing.

The Committee developed the Lab’s mission and advises and guides the Lab’s priorities. Committee members have also participated in or helped to organize Lab events. The first Advisory Committee meeting was held on May 17th, 2021 and the committee has met bimonthly since then.

The Health x Housing Lab’s activities are guided by the following values, which were written collaboratively with the Advisory Committee:

- Housing and health care are human rights and should be provided as public goods.
- Health care, housing, and homeless services systems should do no harm.
- Housing and homeless services should foster health and wellness across the lifespan.
- People who have experienced homelessness and housing instability are experts by experience and their perspectives and input should be valued, uplifted, and integrated with other forms of evidence such as that produced by rigorous research.
- Systemic racism—which has produced inequities in housing and health—must be confronted directly, including in developing, conducting, and disseminating research.

The Lab Advisory Committee:

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

- Settlement Housing Fund
- Trinity Church Wall Street
- Homeless Services United
- NYC Department of Health and Mental Hygiene
- RxHome (year one)
- National Health Care for the Homeless Council
- Center for Urban Community Services
- NYC Health + Hospitals

Progress and Impact

Since its launch in 2021, the Health x Housing Lab has made significant progress towards developing its key focus areas. In addition to establishing the Advisory Committee, the Lab’s educational activities have included the launching of a Postdoctoral Fellowship and Summer Scholars Program, which both are intended to foster the education and career development of future leaders at the intersection of health and housing.

The Postdoctoral Fellowship aims to develop new faculty leaders in research related to health and housing. We host one fellow for a two-year term; the first postdoctoral fellow was hired in June 2021. The goal of the 10-week Lab Summer Scholars Program is to build a pipeline and foster the career development of individuals dedicated to future work at the intersection of health and housing. Students with a history of lived experience of homelessness or housing insecurity or who come from racial or ethnic backgrounds underrepresented in medicine are particularly encouraged to apply. We hosted our first Summer Scholar from June–August 2021. Among other projects, the Summer Scholar collaborated with the organization New Alternatives to organize an event to educate medical students about challenges faced by homeless youth and led a personal hygiene supply drive.

The Health x Housing Lab has hosted seminars and events with the goal of disseminating evidence-based information, amplifying the voices of people with lived experience of homelessness and housing insecurity, and educating a wide audience across sectors. In July 2021, the Lab hosted and co-sponsored a virtual event titled, “Flipping the Script: A Homeless Teach-In for Health Care Workers.” People with lived experience of homelessness taught attendees about how homelessness and housing insecurity affect health, and how better care can be provided. The 440 attendees included health care students and trainees, health care practitioners (e.g., physicians, nurses), care managers, homeless services providers, policymakers, and others. Flipping the Script webinars will be a recurring Health x Housing Lab event that fill a gap in medical education on housing and homelessness, and re-envision how that education is provided.



Flipping the Script: Homeless Teach in for Health Care Workers

In addition to Flipping the Script events, the Health x Housing Lab hosts a Seminar Series that highlights work and research at the intersection of health and housing, with a focus on moving research to action. Seminars incorporate knowledge from research, practice, and lived experience. The inaugural seminar, titled *Crisis Response, Durable Lessons: Hotel Moves and Health During the COVID-19 Pandemic*, was held on November 22nd, 2021. This event featured panelists from academia and the homeless services sector presenting qualitative and quantitative evidence on the health impacts of the pandemic hoteling initiative, and panelists who discussed their own experiences living in these hotels. The 150 attendees spanned academia, government, nonprofit organizations, foundations, advocates, and people with lived experience of homelessness themselves, both from NYC and from around the country.

In addition to these educational activities, the Health x Housing Lab has begun to develop its research portfolio. With assistance from a grant from the Robin Hood Foundation, we are partnering with NYC Health + Hospitals and Test & Trace to evaluate a \$1,000 unconditional cash transfer program that they implemented for low-income New Yorkers who contracted or were exposed to COVID-19. As part of this mixed-methods evaluation, Lab team members developed a quantitative survey and qualitative interview guide to assess the impact of the cash transfer program on recipients’ lives. Team members are collecting surveys in English and Spanish from a random sample of 150 program recipients, and a qualitative researcher is conducting in-depth interviews with 20 survey respondents. This research will add to the growing evidence base about the effectiveness of unconditional cash transfer programs for low-income populations.

We have also begun planning an evaluation of a nurse triage line service offered at NYC Department of Homeless Services shelters. For this project, Health x Housing Lab team members will conduct in-depth interviews with shelter residents and staff with experience implementing and/or utilizing the nurse triage line. Combined with quantitative analysis being conducted by other NYU faculty, this research will assess the acceptability, feasibility, and effectiveness of nurse triage lines in homeless shelter settings as a means to enhance access to needed medical care and reduce emergency department and 911 use. Support from the Community Service Plan allows the Health x Housing Lab to offer significant in-kind resources in conducting high-quality, program- and policy-relevant research projects with government and community stakeholders.

Other key activities of the Health x Housing Lab over the past year include:

- In May 2021, the Lab Director presented at the British Medical Journal COVID Unknowns webinar series on COVID-19 and homelessness. Over 1,800 people registered for the event.
- In September 2021, the Lab postdoctoral fellow presented research on renter insecurity as an indicator of federal fair housing progress at a Centre for Homelessness Impact Research Network virtual meeting.
- In October 2021, the Lab Director was an invited presenter at the webinar *Ending Homelessness in NYC: Where Do We Stand?* hosted by Care for the Homeless with over 200 attendees.
- In November 2021, the Lab postdoctoral fellow presented at the Federal Reserve Community Development Research Seminar Series webinar, *Toward an Inclusive Recovery: Increasing the Housing Security of Vulnerable Renters Through Rental Assistance*, on homelessness and housing insecurity and the associated implications for equity and health.
- In December 2021, the postdoctoral fellow presented on the links between housing policy and health at the *Health is Housing | Inspiration Series* webinar presented by the organization Science & Purpose.
- In December 2021, the Director presented the closing remarks at the Health & Housing Consortium's virtual Annual Convening.
- In December 2021, the Director was an invited speaker at the *White House Health and Housing Forum*, hosted by the White House Office of Public Engagement.
- In December 2021, the Director was an invited speaker at the online event, *Homelessness & Health: What's the Connection?*, hosted by United to End Homelessness.

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. We hope to expand the Lab's capacity and reach through the following activities:

- Continue to host regular seminar and teach-in events;
- Provide 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;
- Partner with an organization such as the Op-Ed Project to provide a private group workshop and mentoring for individuals experiencing homelessness and housing insecurity to develop their skills in writing and successfully pitching op eds;
- Create a Health x Housing Lab Speakers Bureau to support and promote the voices of people with lived experience of homelessness and housing instability. The Speakers Bureau would provide a public, searchable website that includes profiles of people with lived experience of homelessness and housing insecurity who are available for speaking engagements;

- Incorporate people with experience of homelessness and housing insecurity into the planning and organization of Lab events and provide compensation for this work; and
- Continue to grow our capacity to study and evaluate interventions aimed at eliminating homelessness and housing insecurity, and improving health and health equity.

10. Healthy Habits Program/Programa de Hábitos Saludables

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

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

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

The customized nutrition education component is facilitated by a nutritionist and focuses on the 5-2-1-0 model, a nationally recognized, research-validated childhood obesity prevention program based on evidence-informed recommendations from the [American Academy of Pediatrics](#) and the [U.S. Department of Health and Human Services](#). The family meal preparation component was added to the program in 2018 through a partnership with [Common Threads](#). Their research-based methodology addresses the many factors that influence a child's decision-making -- personal, interpersonal, and environmental -- in order to effect long-term behavior change. The organization's family cooking classes have shown promise in improving family vegetable consumption (a goal of the Healthy Habits program), which can lead to long term positive health outcomes. Separate support groups for children and parents offer opportunities to address questions and challenges, help them adopt strategies for setting limits and promoting healthy behaviors, and build peer support. The physical fitness component focuses on low- or no-cost activities that can be done in the home or through local community resources.

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

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

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

Progress and Impact

The Healthy Habits Program/ Programa de hábitos saludables was suspended after the winter cycle of 2019 in response to the changing needs in the Sunset Park community during the COVID-19 pandemic. Our school partners reported an increase in the number of families that were experiencing food insecurity during this time. In addition, many residents experienced high rates of job loss due to their employment in hard-hit sectors such as the restaurant industry; many also faced challenges in accessing crucial benefits due to their immigration status. A dramatic increase in the demand for emergency food and social services in the community led us to focus on prioritizing the immediate food security needs of Sunset Park families through the Healthy Food Initiative (see Section II.C.1). We ensured that the school community received information about how to access needed emergency food pantries and case management services, as well as connecting past Healthy Habits participants to cooking and nutrition educational webinars provided by our partner, Common Threads.

Plans

We anticipate a sustained focus on the Healthy Food Initiative for the duration of this Community Service Plan cycle. We do not plan to resume the Healthy Habits Program/ Programa de hábitos saludables at this time, but we will continue to monitor community needs and resources, and will assess opportunities to resume programming if/as needed.

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

1. 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+; formerly known as the Parent-Child Home Program), a national, evidence-based early literacy, parenting and school-readiness program, serves low-income, immigrant families in Sunset Park, Brooklyn (<https://www.parentchildplus.org>).

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

- Build positive parent-child verbal and non-verbal interaction;
- Develop positive parenting skills;
- Develop their child’s early literacy skills that are 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 two and four years old who are challenged by poverty, low levels of formal education, English language and literacy barriers, and other inequities. PC+ families participate in two, 30-minute home visits per week over a two-year period, and receive educational materials to support positive interactions and development. During home visits, a trained Early Learning Specialist brings a book or educational toy as a gift for the family and uses it to model for the parent and child, play, verbal interaction, and reading activities that help to create a language-rich home environment.



Here's what participants said about ParentChild+ 2019-2022:

- “This program has taught me how to better accompany and grow with my children.”
- “You have done a great job. As a parent, I really appreciated the program. It helped a lot in my child's growth (and) taught me how to use toys and books to interact with my child and learn.”
- “As a parent, I really appreciate the program. It helped my children grow and also taught me how I can interact with my children and learn to grow together.”
- “I also want to thank [my Early Learning Specialist] for her patient help and teaching me how to interact, learn and communicate with my children. Every week, activity tips were sent to me, which helped me a lot. Because of the pandemic ... we did not stop learning ... which I feel most happy about. Thank you!”

PC+ meets all the best practice criteria set forth in the most recent research: it is an early intervention/prevention model; it focuses on early literacy within social-emotional and cognitive/language development contexts; and it emphasizes parental responsibility. It also honors each family's culture, uses developmentally and linguistically appropriate books and toys, connects the family with community resources to address family support needs, and emphasizes 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 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.

The Family Health Centers at NYU Langone leads this program in Sunset Park, supporting staff, resource development, design and implementation. Additional partners, such as IncludeNYC, provide parent workshops on critical early childhood topics such as understanding children with different abilities and guided play; 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 legal needs, immigration, and domestic violence.

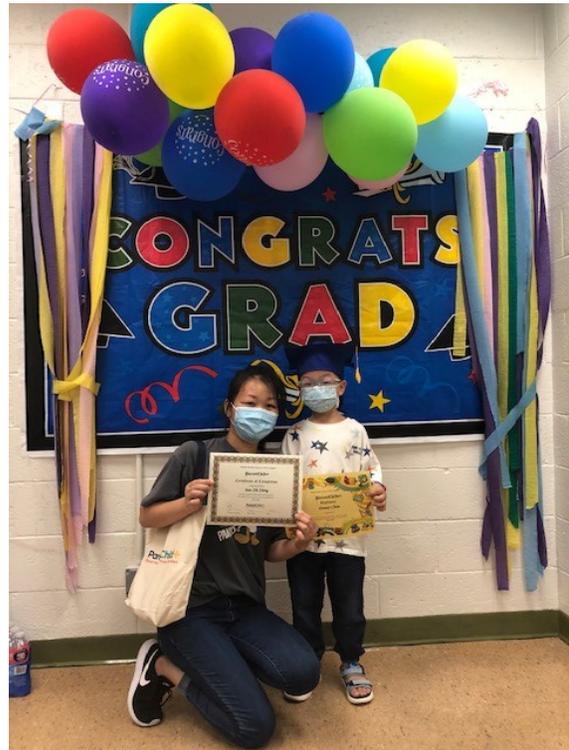
Progress and impact

During the reporting period, ParentChild+ served 87 families. Through ParentChild+:

- 5,924 home visits were completed;
- 1,549 developmentally-appropriate books were provided to families;
- 1,410 developmentally-appropriate educational toys were provided to families;

- 10 family-learning trips and celebration events were offered;
- 23 virtual playgroups were hosted; and
- 4 parent workshops were offered.

The program retained 97% capacity during the reporting period, an extremely high retention rate considering the many challenges faced by families because of the COVID-19 pandemic. This persistence speaks to families' resolve in ensuring that early childhood supports from both program staff and parents continued, uninterrupted, resulting in positive, on-track social-emotional development. Families also demonstrated great resiliency, pivoting immediately to remote visits in March 2020. 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.



ParentChild+ creatively transitioned from in-person visits to virtual home visitation at the onset of the pandemic. All Early Learning Specialists maintained their home visit schedule and connected with each family twice a week via Zoom. The visits maintained the original intent of programming: to support parent-child interaction and the development of children's early literacy skills by engaging families in reading and play activities, while also providing additional tips and educational resources to encourage parents to interact with their children throughout the day. Staff work to help families establish structures and routines to help alleviate stress and build protective factors.

They successfully used Vroom Tips to support families during this period of change. (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 observed the stress the pandemic has had on children and curated tips to help parents regulate their children's emotions and provide calming techniques. Our program delivered program books and toys to families' homes for use during and after the virtual home visits.

While Early Learning Specialists have traditionally provided families with resources and referrals as needed, the COVID-19 crisis necessitated a more formal approach. ParentChild+ implemented formal screenings with families to identify basic needs that pre-existed or arose due to the pandemic, including wage loss, food insecurity, domestic violence and mental health concerns. The screening tool also assessed a family's access to and ability to use technology to effectively participate in programming as well as other needed services. When a parent screens positive, a referral to FHC's Family Support Services is made and the family is connected to needed services. Resources obtained by families include emergency food services, educational resources, mental health support and access to health services.

ParentChild+ uses two validated tools – Parent and Child Together (PACT) and Child Behavior Traits (CBT) – to assess its impact. Both assessments are conducted by Early Learning Specialists, who observe the frequency with which parents and children demonstrate 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 are conducted at the beginning of each program cycle and are used to customize the support given to each family. Assessments are re-administered at the end of the program cycle to measure skill acquisition and/or maintenance. The program works to support parents and children in demonstrating these skills “frequently” or “always” on the post-assessment.



The program’s impact is reflected in the outcomes of the 55 families that completed the full two-year intervention. After two years of program participation, 45 parents (82%) frequently demonstrated effective engagement and interaction skills and 51 of the 55 graduating children (93%) frequently demonstrated school-readiness and pre-literacy skills at the conclusion of the program, surpassing our target.

Plans

Over the next three years, ParentChild+ will support 120 unique Sunset Park families. During their participation in the program, families will receive 8,280 home visits, 1,980 educational toys, and 2,160 books. The program will retain 90% of enrolled families for the two-year program duration, and will provide both in-person and remote services depending on the requirements of the pandemic. At the end of the two-year intervention, 85% of enrolled parents will consistently demonstrate increased knowledge and awareness of child development and increased use of positive parenting techniques, while children will demonstrate improved social and emotional development, indicating increases in school-readiness. ParentChild+’s 2022-2024 objective is for 90% of the enrolled children to demonstrate on-target social emotional development by the end of the two-year program.

2. ParentCorps

A wealth of research shows that early childhood education can have profound impacts on children’s lifelong health and well-being. This evidence has fueled the rapid expansion of pre-kindergarten, which is considered a powerful policy lever for children of color facing inequities rooted in structural racism. Though the expansion of pre-K holds promise, decades of research and practice at the Center for Early Childhood Health & Development (CEHD) highlight that educators often feel unprepared to engage with families, especially families whose culture and lived racial experiences are different from their own. In close partnership with pre-K programs, ParentCorps works to build a different pre-K experience — one

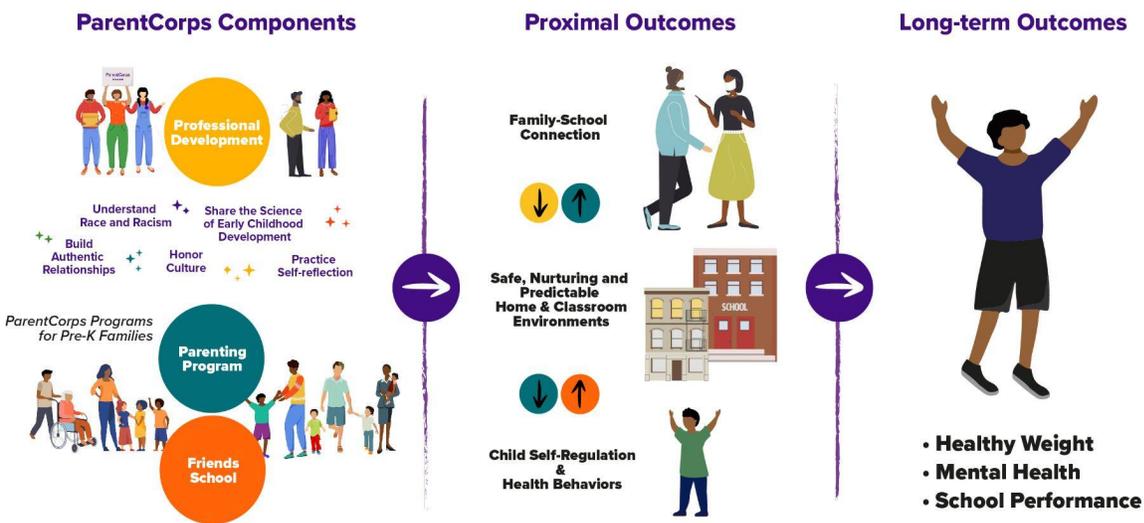
that centers race and culture, engages parents as partners, and supports children’s social-emotional well-being — to help unlock the full promise of early childhood education.

ParentCorps includes three components to help school leaders, teachers and parents create environments that are safe, predictable, and nurturing for children:

- **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. 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 parenting practices they may choose to incorporate at home, in alignment with their values.
- **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 (with a focus on racial and cultural identities and family pride), build healthy relationships — and have fun!

Strong evidence of ParentCorps’ impact on children, families and teachers comes from two randomized controlled trials with more than 1,200 Black and brown children in low-income neighborhoods in NYC (see Appendix E). 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.

ParentCorps Theory of Action



Progress and Impact

With support from NYU Langone’s Community Service Plan, and building on its success in scaling its model to more than 50 pre-K programs across the City, over the past three years, ParentCorps has applied an intentional place-based, community-engaged strategy to integrate ParentCorps in Sunset Park. This work has included four phases:

Phase 1: Assessing interest and fit (September 2019-March 2020)

In September 2019, we designed a mixed methods approach to assess: 1) pre-K program leaders’ interest in ParentCorps; 2) readiness of program leadership and staff to implement programs; and 3) the need to tailor program content or delivery strategies for the Sunset Park community. Before COVID-19, this assessment (involving interviews with leaders from three pre-K programs and in-depth focus groups with teachers from two pre-K programs) found:

- Pre-K programs in Sunset Park had strong interest in ParentCorps;
- Pre-K programs had the capacity to engage in Professional Development as a first step;
- There were no explicit needs to modify program content, and the flexibility built into ParentCorps’ program model – to meet the needs of schools and centers across NYC – held true in this context.

Phase 2: Responsive approach to the needs of pre-K programs during early phase of COVID-19 (March-August 2020)

In order to better understand needs arising from the COVID-19 pandemic and the related closure of schools, we distributed leader surveys to 32 pre-K programs (receiving responses from seven). All respondents indicated the usefulness of: 1) online communities for teachers, leaders, and parents; 2) social emotional learning resources for families; and 3) a community resource guide for families. We also conducted two focus groups with school staff in May of 2021, centered on digital tools and technology used in the work of Sunset Park pre-K programs. The data highlighted two additional areas of support: 1) digital resources for school-based staff and families; and 2) support around access to and use of digital tools and platforms.

Based on the needs identified, we moved to share responsive parenting and social-emotional learning supports to as many Sunset Park pre-K programs and caregivers as possible:

- In the early months of school closures, we packaged supportive tools (including handouts, educational videos, podcasts, and more) and sent them to all 32 pre-K programs and one kindergarten program (PS 94), in addition to sharing tools directly with caregivers in other programs via texts and emails.
- In the summer of 2020, we created and offered two leader-focused professional development sessions titled “Leading through Crisis: Supportive Leadership in Sunset Park during COVID-19,” covering practical strategies to support grief and loss and promote trauma-informed practices, and to support the transition back to school. Leaders from four programs attended at least one of the two sessions; they expressed deep appreciation for the supportive space, sense of affirmation and community provided to them, and access to ParentCorps tools.

Phase 3: Responsive programming during the 2020-2021 school year

We established the Sunset Park ParentCorps Community Advisory Board (CAB) in September 2020, including leaders from six pre-K programs and one elementary school. The CAB also included a racially, ethnically, linguistically and positionally diverse team of six individuals from NYU's Center for Early Childhood Health and Development, who were active participants in meetings and collectively assessed the process and progress of the CAB.

The CAB met a total of seven times in the first year focusing on three main agenda items:

1. Identifying pre-K community priorities, needs and interests;
2. Sharing ways to increase engagement with families and caregivers, and include greater input from the community in identifying needs and guiding program implementation; and
3. Creating a feedback loop to inform programmatic adaptations and ensure that services are culturally-relevant, useful and linguistically appropriate for families, educators and leaders across pre-K programs.

Data collected from all CAB members during in-session discussions and post-session feedback reflected high satisfaction with the planning, implementation, collaboration, and support within the meeting space throughout all meetings.



Snapshot of Sunset Park Community Advisory Board Meeting in November 2021

In addition to forming the CAB, ParentCorps continued to respond to the need, highlighted by CAB members, for spaces and strategies to support the well-being of teachers, leaders and families, and strengthen their ability to respond to the challenges faced at both home and school. In response, ParentCorps offered the following programs:

- **Professional Learning:** The ParentCorps team facilitated a total of seven virtual professional learning sessions for the Sunset Park Community (five for teachers and two for leaders) that focused on Empathy for Self and Others, Anxiety in Young Children and Adults, and Culturally Responsive Education. Eleven Sunset Park schools were represented across the teacher sessions. We also provided four self-guided Professional Learning modules to all Sunset Park pre-K programs and program families.

Data collected from the Sunset Park facilitated Professional Learning sessions demonstrated a high level of appreciation for and relevance of the professional learning content and space. Across all five sessions, most Teachers ($\geq 73\%$) expressed interest in continuing virtual conversations with other educators around the topics discussed. The attendance at these sessions demonstrated the relevance of the topics (42 educators attended the sessions on Empathy; 40 educators attended the sessions on Anxiety; 12 educators attended the sessions on Culturally Responsive Education). Teachers and leaders expressed appreciation for the opportunity to self-reflect and share openly with colleagues, and discussions demonstrated the need for more mental health support for teachers.

- Parenting through the Pandemic: This four-session series for caregivers was culturally adapted and offered in Spanish and Mandarin, reaching 100 families from 14 pre-K programs. These provided space for community support as well as sharing of strategies helpful for caregivers of young children. From feedback collected across the series, we learned that even though the series was only four sessions, there was still a sense of rapport and community established among participants and facilitators; almost all caregivers (98% of 180 respondents) “agreed” or “strongly agreed” that the session provided a space for connection, community-building and support.
- Ready for Kindergarten workshops collaboration: The ParentCorps team co-developed and facilitated two of a five-part Ready for Kindergarten workshops for caregivers in June-August 2021: “Session 2: What to expect in the classroom and how to support the transition” and “Session 4: Supporting the development of emotional and social skills in young children.” These workshops were well attended and received by Sunset Park caregivers (144 in Session 2; 93 in Session 4).

Phase 4: Responsive programming during the 2021-2022 school year

Our programming decisions this year were based on clear feedback from the 2020-21 school year that Sunset Park teachers and leaders continue to need support in the form of virtual professional learning and coaching.

Community Advisory Board: In its second year, the Community Advisory Board (CAB) expanded to include leaders from eight programs (seven pre-K programs + one school without pre-K), with new representation from Grand St. Settlement Sunset Park Child & Family Center and the Brooklyn Chinese-American Association. These eight partner programs represented in the CAB have a total 25 pre-K classrooms, approximately 27% of the pre-k classrooms in Sunset Park, Brooklyn.

In addition to monthly meetings, the CAB members connect via the ParentCorps Portal (ParentCorps’ online hub) to maintain communication, and access family engagement and social-emotional learning resources. Based on feedback from teachers and leaders, we also distributed eight tablets to all CAB programs to facilitate access to the ParentCorps Portal among their staff. The CAB continues to be a space to plan, implement, collaborate, connect, and support ParentCorps expansion in Sunset Park. The ParentCorps team is currently strategizing ways to engage other community voices (teacher, caregiver) to help guide program implementation.

Parenting Program: Later this year, we will offer a virtual version of ParentCorps’ evidence-based Parenting Program to all eight pre-K partner programs in Spanish and Chinese, led by ParentCorps facilitators. We also are providing tote bags (packed with social-emotional learning tools for families) to pre-K families at CAB programs (25 classrooms total; approximately 500 families).

Professional Learning: In the remainder of the 2021/22 school year, we will offer:

- Three Professional Learning sessions to pre-K teachers and leaders at Sunset Park's 32 pre-K programs (targeting a maximum of 90 classrooms serving 1800 pre-K families) on Empathy for Self and Others; Anxiety in Young Children and Adults; and Culturally Responsive Education;
- Six self-guided Professional Learning modules to all Sunset Park's 32 pre-K programs (Empathy to Build Relationships, Anxiety in the Classroom, Positive Reinforcement and Behavior Change, Culturally Responsive Education, Intro to Family Engagement, Family Engagement Part 2);
- ParentCorps Fundamentals (ten-session Professional Learning series focused on an introduction to ParentCorps philosophy and fundamentals of family engagement and social-emotional learning with a racial equity lens) to the eight ParentCorps partner programs (25 pre-K classrooms serving 500 pre-K families); and
- One-on-one coaching to four partner programs to support teachers and classrooms.

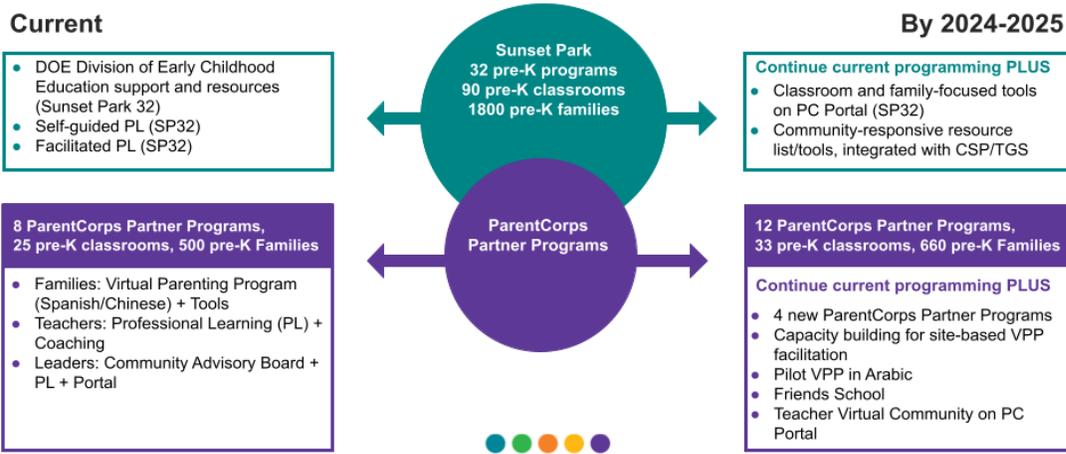
Plans

For this next three-year phase of the Community Service Plan, we plan to support 12 pre-K programs to adopt the full ParentCorps model (Professional Learning, Parenting Program, Friends School) over three years reaching 660 pre-K families annually by 2025. This will involve adding four new pre-K programs to our existing Community Advisory Board and core group of partner programs.

Our support will include capacity building (training and coaching) for site staff to directly facilitate Parenting Program (in languages spoken by families); piloting Parenting Program in Arabic; capacity building for site staff to implement Friends School, our classroom-based social-emotional learning program; extending virtual community from only leaders to also teachers on the ParentCorps Portal; and continuing to provide social-emotional learning and family engagement tools on the Portal.

We also aim to extend our reach broadly across Sunset Park's early childhood ecosystem by providing access to ParentCorps tools to leadership and educators of all 32 pre-K programs (serving 1800 families) via the ParentCorps Portal; and partnering with Family Health Center and Community Service Plan teams contributing to a community resource list to be shared with all Sunset Park pre-K programs. We will continue to offer both facilitated and self-guided Professional Learning to all Sunset Park pre-K programs, targeting 90 classrooms serving 1800 families.

Illustration of ParentCorps in Sunset Park 3-year Plan



3. Video Interaction Project

The Video Interaction Project (VIP: www.videointeractionproject.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.

VIP’s core mechanism for promoting positive parenting activities is to engage and empower parents during pediatric primary care visits by making a video recording of each parent and child interacting together using a toy or book provided by the program, building on each parent’s unique strengths and goals. Immediately after the recording is made, a **VIP 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.

VIP sessions 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 VIP Coach for approximately 25 minutes to engage in 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 VIP Coach leads a discussion about child development, suggests activities, and promotes goal-setting and planning with the parent; and

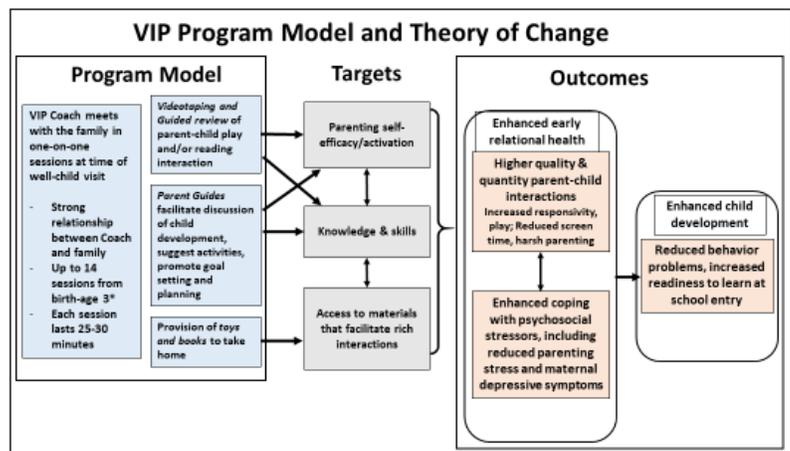
- After about 5-10 minutes of discussion regarding parenting activities and the child’s development, the parent is videotaped playing and/or reading with the child and then given a guided review of these interactions.

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

- 1) 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, VIP 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, VIP 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 \$250 – 300 per child per year when delivered at scale. This is significantly lower than many other programs (for example, VIP is 1/10 the cost of home-visiting), which is particularly impressive given the strength of the impacts of VIP.

Centralized support for all sites is provided by the VIP Center of Excellence (VIP COE), 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 VIP COE works centrally to continuously study and optimize VIP, and adapt to the needs of new sites and populations. The VIP COE has developed a comprehensive implementation package so that VIP can be delivered anywhere with quality and fidelity, and VIP has been implemented at 12 locations nationally as of 2021. The VIP COE is poised for the next stage of expansion with a 5-year plan for expanding to 50-100 sites in order to be able to reach 30,000 – 40,000 children per year.



What are the benefits of VIP?

As shown in multiple analyses published in prominent peer-reviewed scientific journals and presented at high-profile academic and policy conferences, VIP 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.

Note about COVID-19:

The COVID-19 pandemic has been a catastrophe for families with very young children, even though children have been relatively spared from the disease itself. Parents and caregivers of infants and toddlers were required to shelter in place at home; preschools, childcare centers, playgrounds, and in-person support groups were closed or restricted; and many other vital services were cut or rendered inaccessible. As a model, VIP has the potential to protect children against long-term impacts on mental health and school achievement by helping parents cope with the stressors of this crisis and even maintain some possibility of normalcy in their relationships and activities with their children.

In response to the COVID-19 pandemic, VIP developed a virtual delivery model ('Virtual VIP', or VVIP) for remote delivery of VIP through phones, tablets, and other devices. The VIP COE team engaged in extensive work in spring 2020 to develop, standardize, and manualize this model and to quickly pivot to VVIP across all sites to ensure continuity of services at a time when it was critically needed by families. We have continued to engage in ongoing work to refine and optimize VVIP delivery, and we anticipate that VVIP will be utilized in a significant way even after the pandemic, including for difficult-to-reach populations and to provide additional parenting support between in-person VIP sessions at health care visits. Feedback from families indicates that participants are receptive and eager to converse with VIP Coaches. Although most of our sites have transitioned back to delivering VIP in-person, we will continue to utilize a hybrid model of delivery for the foreseeable future for patients who cannot complete their session at the time of their pediatric visit or who prefer a remote session at this time. The families who have returned for in-person sessions have been enthusiastic and grateful to complete a session in-person again.



Progress and Impact

VIP 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, VIP was implemented at the Sunset Park Family Health Center - Second Ave (5610 2nd Ave, Brooklyn, NY; e.g., "5610") in March 2019, and has since

served 526 families at that location, with over 1,365 visits completed as of 12/31/2021.

In Sunset Park, the CSP's implementation at 5610 has taken place alongside a larger goal of expanding VIP institution-wide across NYU Langone, with a priority on the Family Health Centers. Funding from the Stella and Charles Guttman Foundation in 2021 allowed expansion of VIP to the Seventh Avenue Family Clinic in October 2021, where VIP has since been delivered to 35 Chinese-speaking families. In addition, funding from the Bezos Family Foundation will allow VIP to expand to additional FHC locations in 2022 and onward.



In addition to program delivery in Sunset Park, VIP has been actively engaged in collaboration with other CSP and early childhood programs to develop linkages and synergies across collocated programs. For example, the VIP Coach has worked to connect patients to local library resources through the Brooklyn Public Library. In addition, the VIP COE has been working to develop and pilot formal integration of VIP into FHC's existing infrastructure of Maternal, Infant, and Child Health programs. For example, we plan to pilot integration of VIP into the Healthy Steps program as a core component of Tier 3 services.

Plans

Over the next three years, the CSP will support continued delivery of VIP at 5610, with a goal of reaching 300-400 families per year at that location. 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 the Sunset Park Family Health Center and community programs.



Having set this stage and developed these relationships, VIP plans to engage in large-scale expansion of VIP, including across multiple locations in Sunset Park. This work includes expansion of VIP to 3-4 additional locations in Sunset Park in the upcoming two years, with locations including a mixture of FHCs and community sites. In addition, VIP will continue to engage in collaboration and 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.

4. Project SAFE

Project SAFE prevents unintended pregnancy and the spread of STDs and HIV/AIDS through evidence-based interventions within a youth development framework that builds upon the existing strengths of

young people. Project SAFE has been providing teen leadership, culturally appropriate sexual health information and services, and HIV peer education programming at the Project Reach Youth (PRY) site in Brooklyn since 1989. The program provides youth ages 13 to 24 with the support and 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 an evidence-based sexual health curricula that has been shown to increase knowledge and eliminate or reduce risky sexual behaviors – [Making Proud Choices](#). Topics covered during the eight-session workshop series include pregnancy and STD/HIV prevention, as well as confidence, pride, and respect-building activities. To accommodate schools that shifted to remote work due to the COVID-19 pandemic, Project SAFE created an adapted virtual version of the *Making Proud Choices* curriculum that was approved by the EBI developer. Health educators facilitated five 'pilot' cycles and then made additional modifications based on feedback from students and facilitators. Since September 2019, Project SAFE has facilitated 65 cycles of *Making Proud Choices*, reaching a total of 1,661 youth in 15 high schools, community-based organizations, and high school equivalency programs. New partnerships developed since September 2019 include Brooklyn Ascend Charter School, Cyber Arts Studio Academy, and the P.S 753 – School for Career Development.

Program evaluations of virtual workshops have shown that, as a result of the workshops, most participants know more about how to protect themselves from pregnancy or STIs and are more likely to practice safer sex or abstain from sex (75% and 77% respectively, as reported on a post workshop survey). Ninety-eight percent of participants indicated they would recommend the workshops to a friend. Seventy-nine percent of workshop participants completed at least 75% of workshop sessions.

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. Since September 2019, Project SAFE has recruited and trained 67 Peers Educators. The current groups include:

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



Teens participating in peer education groups from 2019 to the present demonstrated increases in: frequency of condom use; HIV knowledge; knowledge of HIV status; and knowledge of STD status. Seventy percent of youth (33 of 47 youth who took and baseline and follow up survey in 2021) showed a gain in at least one of these areas.

Community Events and Single-Session Workshops

Throughout the year, peer educators and Project SAFE staff work collaboratively to produce a series of community events to promote teen sexual health. The events typically include performances from the arts-based groups and an open mic session in which guests and community members can perform. Community events also offer on-site HIV testing and promote teen health services available through Project SAFE and other community organizations. During this reporting period, many events were hosted virtually.

In 2019, Project SAFE partnered with BRIC Media Arts to create a Teen Health Clinic Outreach video. The video, scripted and filmed by youth with support from a BRIC producer, details the Teen Health Clinic services and how to make an appointment through a narrative created by the teens. This video (<https://bit.ly/2P5Vjou>) was screened at BRIC on February 12, 2020 and was aired on Brooklyn Free Speech channel.

Since September 2019, Project SAFE has hosted or performed at 58 in-person and virtual community events, reaching 1,066 youth. The events consistently received overwhelmingly positive feedback with 95% of virtual event participants and 96% of in-person participants rating their experience of the events as excellent or good (306 of 323, and 293 of 304, respectively). Additionally, 93% of participants who completed a survey for an in person event indicated that they would recommend Project SAFE events to a friend and 79% said they were likely to utilize a Project SAFE Teen Clinic in the future (283 of 304, and 241 of 304, respectively).

Project SAFE also offers single-session peer-led sexual health workshops. Since September 2019, we have reached 528 young people through 21 in person and virtual single-session sexual health workshops. Of our youth-led virtual workshops, 96% (27 of 28 participants who completed a post-workshop survey) reported good or excellent HIV knowledge after the workshop (compared to 64% before the workshop).



Teen Health Clinic

Project SAFE partners with the Family Health Centers to run the Teen Health Clinics providing young people with a health care experience tailored to their needs. The Project SAFE Teen Health Clinic offers youth a non-judgmental, personal approach to sexual health, with a teens-only waiting room and a staff, including Project SAFE staff and peer educators, who are trained to use an empowering, strengths-based approach. The 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.

The two clinics in Park Slope and Sunset Park offer a full range of sexual health counseling and clinical services. Since September 2019, 933 teens received STI testing and other services at the Teen Health

Clinics, Additionally, over 2,000 teens were screened for pre- and post- HIV exposure prevention needs (PEP and PrEP) at the Teen Health Clinics, workshops, and community events.

Starting in June 2020, Project SAFE began offering at-home HIV testing in response to COVID-19 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.

Workshops for Youth Workers and Parents

Talking with youth 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 2019, six workshops were provided to 82 youth workers and parents at four partner schools.

Here's what teens said about Project SAFE programs since 2019:

- "It is fun but at the same time it is an educational place where we learn to stay safe. Also the environment is very welcoming and you know everyone here."
- "Being in SAFE is like a family. We learn, we play, we help each other, we help others, and it's just an amazing atmosphere."

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 expand our program to reach middle school students as well, reaching an anticipated 2,100 youth at high risk for HIV and/or unplanned pregnancy through 84 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 then we would also look at factors such as history of unprotected sex that indicates an increased risk for unplanned pregnancy and HIV. Finally, partners need to commit to ensuring access to adolescents for all sessions of evidence based intervention workshops.

Peer educators and staff will facilitate 30 single-session workshops, reaching an anticipated 450 teen participants. Teens will host or perform at 17 community events over the next three years, reaching approximately 680 of their peers with core pregnancy, STD, and HIV/AIDS prevention and resource messages. One hundred and fifty-two new teens will move from the Teen Health Council to advanced peer education groups. The program will reach 100 youth workers 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.

Screenings will remain a core part of the program. Building on efforts to provide comprehensive HIV prevention services, Project SAFE will begin to administer substance abuse screenings. It is anticipated that through Project SAFE workshops, community events, and the Teen Health Clinic: 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.

5. Family Support Services

The NYU Langone Hospital—Long Island Pediatric Center serves the largely Black and Latinx 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 the risk factors identified by the NY State Prevention Agenda “such as food insecurity, homelessness, employment conditions, poverty, adverse neighborhood environments, inadequate health care, lack of educational opportunities, social exclusion, racism and discrimination, lack of social support, and gender-based inequities.”

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 is launching a Family Support Counselor program at the Pediatric Center is to screen patients for social needs, connect them to a network of local services, and follow up to ensure that care is received.

Family Support Counselors at the Family Health Centers at NYU Langone in Brooklyn have found high rates of food insecurity among pediatric patients, as well as family stress resulting from overcrowded homes, economic instability and immigrant status. 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.

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. Patients have fewer opportunities for early learning activities with their parents including reading, teaching, and playing. Through participation in ROR, the families will receive at least 10 books by the child's fifth birthday, providing an opportunity to foster early child development and enhanced 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.

Progress and impact

Over the past year, clinicians and administrator from the Pediatric Center have been working with the Family Health Centers’ pediatric practice to learn about, adapt and replicate their Family Support Counselor model and Reach Out and Read for implementation in the coming year. In addition, staff have been working to identify a network of local service providers to enhance the Center’s connection to resources.

Plans

In year one of the 2022-2024 CSP, the Pediatric Center plans to hire a Family Support Counselor who will be fully integrated into the Center's practice, screening families for social needs and risks, developing relationships and making referrals to local services, and following up to ensure that connections are made. The Counselor, together with the group of community leaders who have worked on the Hempstead Needs and Assets Assessment (see Section I.C.5.), will develop relationships with community-based organizations and other resources, and identify gaps and needed services.

We anticipate that, the Family Support Counselor will assist 500 patients in year one, with that number growing as screening systems are put into place. In addition, each year, the Pediatric Center's Reach Out and Read program will place over 3,000 books in the homes of participating families.

E. Programs, Progress and Plans: Promoting a Healthy and Safe Environment

1. Falls Prevention Programs

We have an emerging portfolio of projects that focus on [Promoting a Healthy and Safe Environment](#) by reducing falls among vulnerable populations. This includes two evidenced-based fall prevention programs that are being implemented at the Long Island Hospital Wellness Center, and at two libraries and other community settings in Nassau County: [Tai Chi for Arthritis for Falls Prevention](#) and [A Matter of Balance](#).

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; and
- 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-base 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.

Progress and Impact

From Sept 2019 until March 2020, the Tai Chi for Arthritis for Falls Prevention program met twice a week for eight weeks at the Welcome Center, Williston Park Library, and the Garden City Library, implementing the evidence-based curriculum described above. During this period, we reached 84 senior citizens.

In March 2020, all in-person classes were suspended due to COVID-19. In March 2021, the program pivoted to provide the classes virtually and 67 senior citizens participated with some modifications; 75% stated on their post evaluations that their balance had improved because of this program and reported that they will continue in other exercise programs and create a safer environment in their homes.

Plans

Over the next three years, we plan to reach out to community-based organizations, libraries and senior centers to assist them in implementing the Tai Chi for Arthritis for Falls Prevention, reaching over 250 senior adults. Each class will be assessed through a pre/post balance assessment for all participants.

The Matter of Balance program started in May 2022 with a training of the fall prevention staff at the Welcome Center. Over the next three years, the program will be implemented, reaching 100 seniors through the Welcome Center and 100 seniors in partnership with local community-based organizations (libraries and senior centers).

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."

F. Brooklyn Data Station

The Brooklyn Data Station (BKDS) provides the infrastructure to support our several community health needs assessments, to target resources by identifying areas of need, and to monitor trends. Its focus is primarily in Sunset Park and Red Hook in Brooklyn, but the Data Station has also provided support for our needs assessments in the Lower East Side and Chinatown 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 data, to acquiring data, to storing and analyzing 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 2019, the Brooklyn Data Station has increased its capacity to support partners through hiring an additional full-time community health Data Analyst and is in the process of hiring a full-time clinical Data Analyst.

Select highlights of the work done since September 2019 are:

Data Navigation:

- Create and maintain a Sharepoint Community Page for NYULH faculty and staff with curated links to external sources of data and reports for New York City neighborhoods.

Data Acquisition:

- Work with NYULH legal office to develop a Data Use Agreement with the NYC Dept of Health and Mental Hygiene (DOHMH) to acquire restricted-use datasets from the Community Health Survey and KIDS surveys;
- Work with early childhood programs in Sunset Park to develop REDCap projects for primary data collection in three different languages (English, Spanish and Simplified Chinese), including methods to collect data via Mobile App;
- Work with early childhood initiatives to conduct qualitative interviews with school faculty to understand challenges and needs in helping students and families during COVID pandemic; and
- Work with the Health X Housing Lab to develop REDCap project for primary data collection and assist with interviews of participants enrolled in an unconditional cash transfer program.

Data Repository:

- Work with MCIT to create restricted-use folders on shared research drive to store analytic datasets from various projects including: Arab American Needs Assessment; Community Health Survey; KIDS surveys; Sunset Park Mental Health Survey.

Data Analysis:

- Work with NYU Center for the Study of Asian American Health (CSAAH) and community partners to analyze data collected for the Brooklyn Arab American Needs Assessment (see Section I.C.2.);
- Work with early childhood initiatives in Sunset Park to analyze data from a number of projects including:
 - Waiting Room Survey: a survey of parents of young children to assess child care arrangements and resources needed to support child development;
 - COVID Community Engagement Survey: a survey of program participants conducted in the early months of the COVID pandemic to assess social needs and usefulness of text messages sent during virtual engagement activities;
 - KIDS 2017 and 2019: population-based surveys conducted by DOHMH to describe child health and development, including an oversample of Sunset Park children ages 1 to 4 years in 2019; and
 - Sunset Park Mental Health Survey, 2021: a survey of pregnant women and mothers of children under age five years living in or receiving services in Sunset Park to assess mental health needs and stressors conducted in English, Spanish, and Simplified Chinese/Mandarin.
- Work with Community Service Plan team to summarize demographic, socio-economic and health related data for use in Community Health Needs Assessments for neighborhoods of focus (Sunset Park, Red Hook, Lower East Side/Chinatown, Hempstead).

Data Communication and Dissemination:

- Work with NYU CSAAH and community partners to visualize data collected for the Brooklyn Arab American Needs Assessment and create a slide deck that can be shared with community partners;
- Work with Family Health Centers to plan and organize the 2nd and 3rd Annual Community Research Exchange Days, which were held virtually due to COVID, as a way to share knowledge and findings from projects serving FHC patients and communities; and
- Work with Community Service Plan team to share findings with community partners in Hempstead obtained from secondary data sources and community surveys to inform the Hempstead Needs Assessment.

Plans

With the addition of a full-time data analyst, BKDS plans to increase its capacity to support partners with clinical data analysis, from NYU Epic data as well as population-based sources of health claims data, to better respond to partner needs for clinical health outcomes data.

BKDS also plans to develop a user-centered digital platform to support collaborations related to early childhood health and development in Sunset Park.

The Data Station will also work more closely with Family Health Centers and Community Service Plan partners to develop dashboards to describe clinical and community indicators relevant to supporting population health.

G. Dissemination

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

Hard copies of the Community Health Needs and Assets Assessment, Community Service Plan and Progress Reports are available without charge to anyone upon request and are regularly distributed to Community Board members, policymakers, local health centers, community-based organizations, community members, and other interested stakeholders. Through our outreach and engagement activities, we continually seek to keep the community informed about our activities and to get feedback and input. 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, is being 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 2022-2024 CHNAA/CSP. Many of our projects have developed strategies for disseminating information, and providing training and outreach.

H. Community Engagement and Health Equity

The Community Service Plan Coordinating Council, composed of NYU Langone Health faculty and staff from across the institution, leadership and staff of our community partners, and other interested partners and policymakers, continues to meet every three months. 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 anti-racism focus to the work. In 2020, the Council adopted the following guiding document:

Guiding principles to increase authentic community engagement, improve health equity, and implement an anti-racist agenda

We commit to:

1. Collaboratively defining the community with which we are working, understanding the causes and consequences of health inequities and the impact of structural racism* on community health and well-being, and understanding our roles – as individuals and as members or representatives of organizations;
2. Building relationships of trust and appreciation, and to taking the time to continually reflect on, evaluate, and strengthen our collaborative processes;
3. Building on and leveraging strengths and resources within the community;
4. Collaboratively defining the roles of all partners in all phases of the work in a way that leverages expertise, minimizing barriers to participation, particularly for those who have been underrepresented in the past, and ensuring that the contribution of all participants is recognized and appropriately compensated;
5. Learning from each other and building our capacities and skills;
6. Ensuring that all partners have the opportunity and resources to participate in the communication of findings and knowledge gained, recognizing the need for privacy and protecting participants and the community from inadvertent harm; and
7. Making a long-term commitment and working to make sustainable change.

To hold ourselves accountable, we will:

- Collaboratively develop a plan for each initiative, and for the CSP as a whole, to increase authentic community engagement, improve health equity, and implement an anti-racist agenda;
- Develop mechanisms to review our plans, to measure progress, and to learn from our successes and challenges; and
- Share what we learn along the way, internally and with other interested collaborations.

* As defined by Dr. Mary Bassett and colleagues, “Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.”

Over the course of the past year and a half, each CSP project has selected one or more of these principles as a focus for self-assessment and implementation. See Appendix C, which explains the process and expectations.

All CSP projects have worked to include **deeper participation by community partners and residents**, including and compensating people with lived experience as program leaders, on advisory committees, and as speakers and moderators.

For example:

- The Health x Housing Lab Advisory Committee includes five members with lived experience of homelessness. The Lab works to minimize barriers to participation by ensuring that Committee members have the materials and equipment they need to fully engage as Committee members. All of the 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.

One of the Health x Housing Lab’s five values statements, which were written together with the Advisory Committee, focuses on racism explicitly:

“Systemic racism—which has produced inequities in housing and health—must be confronted directly, including in developing, conducting, and disseminating research.”

This values statement reflects our long-term commitment of working toward making sustainable change.

- The Community Health Worker Research and Resource Center (CHW-RRC) is led by the CHW Learning Committee, made up of four to six CHWs, who guide CHW-RRC programming and professional development activities. The quarterly wellness survey for the CHWs, which was prepared collaboratively with the Learning Committee, led to the creation of monthly mental health support groups and other programming and support services. All of the CHW-RRC programs, which are attended by hundreds of frontline workers and health professionals across the country, are moderated by CHWs. The CHW-RRC has also organized a two-session panel for 3rd-year medical students, introducing them to the role of CHWs and exploring how medical students and physicians can work effectively with this workforce. This event has now been incorporated into the medical school’s social determinants of health curriculum.
- Similarly, much of REACH FAR’s pandemic outreach and education has been 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.
- In all of its hiring decisions, ParentChild+ has incorporated community voice, including current and former families. The program is also implementing 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.
- ParentCorps established the Sunset Park ParentCorps Community Advisory Board (CAB) in September 2020, including leaders from six pre-K programs and one elementary school. The CAB also includes a racially, ethnically, linguistically and positionally diverse team of six individuals from NYU’s Center for Early Childhood Health and Development, who are active participants in meetings and collectively assessed the process and progress of the CAB. The CAB members have discussed racism and discrimination in the school system and in the community, sharing their personal stories as well as insights into structural racism. ParentCorps, which has worked on issues of racial equity for many years, has provided assistance to other CSP projects, including the Greenlight program, that are developing community advisory boards, and has shared equity tools and frameworks.

- 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 revised the language in the CBPA principles to make them more youth-friendly, and program youth monitor how effectively the program adheres to the CBPA/equity principles. To ensure that program participants feel safe and supported, Project SAFE created a harassment reporting form and added questions to the quarterly evaluation form to assess how welcome and safe youth feel expressing their racial, gender, or sexual identities in the program.

CSP initiatives are also **educating program leadership, staff and their communities about the historic roots of the inequities** that the programs are intended to address and are developing responsive strategies. For example:

- The Brooklyn Consortium has established a Diversity Equity, Inclusion and Accessibility (DEIA) workgroup with the Bronx Health & Housing Consortium, composed of eight representatives from community-based organizations. The workgroup has helped to develop a Leadership Survey to identify strengths and experiences among Board and Steering Committee leadership and opportunities for bringing new voices to the table. The workgroup is planning a DEIA training and is developing a plan to support policies and practices that address the impact of structural racism on health and housing through research and advocacy, cross-sector relationships, and training.
- ParentChild+ has selected program materials that can spur conversations about race, and has supported and educated staff in understanding biases. The program prioritizes an anti-bias and diverse approach to curricular book choices, including more books that feature people of various races and ethnicities (not just those of program families). Staff are trained and supported to elicit and engage families in the resulting conversations about race. Program leadership is working with staff to recognize and discuss their own biases.
- REACH FAR has worked with imams of two mosques, Assafa Islamic Center and Brooklyn Islamic Center, who delivered two Friday sermons on anti-racism and equality in Islamic belief, reaching about 500 congregants.
- ParentCorp partners with multiple partners to understand the impact of structural racism and to promote anti-racist practices. For example, in its Professional Learning session focused on Culturally Responsive Education, pre-K teachers and leaders are guided to reflect on their own identities and biases, and how they may affect the classroom environment; to navigate conversations about race (using an established framework and tools from [Courageous Conversations about Race](#)); to learn strategies for addressing their discomfort; and to incorporate Culturally Responsive Education into daily classroom practice.

I. Anticipated Impact and Performance Measures

The Coordinating Council will continue to oversee program implementation, work collaboratively to find points of synergy across programs and neighborhoods, and assess progress and make mid-course corrections. In addition, each program collects data about levels of participation, participant

satisfaction, and impact on health and well-being. This is done through attendance records, surveys, and other forms of data collection. Attached as Appendix E is a table summarizing goals and performance measures, together with sources of data to be used to measure outcomes for each CSP project.

Appendices

- A. Data sources and references consulted
- B. Input from persons who represent the broad interests of the community
- C. Guiding principles to increase authentic community engagement, improve health equity, and implement an anti-racist agenda
- D. Evidence base for programs
- E. Anticipated impact and performance measures

Appendix A

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](#) (2015-2019)
- [NYC Department of City Planning – Population Fact Finder](#) (2006-2010; 2015-2019)
- [Census Reporter \(2015-2019\)](#)

Census 2000 - 2020 – US Census Bureau

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

- [US Census Bureau-- \(2000, 2010, 2020\)](#)
- [NYC Department of City Planning – Population Fact Finder \(2020\)](#)

City Health Dashboard – NYU Langone Health

Social and health indicators for large cities, including COVID risk. 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, neighborhood poverty and housing type. Data obtained from:

- [NYC Health Department – EpiQuery](#) (2002-2017)
- [NYU analysis of data obtained from DOHMH \(2015-2016; 2017-2018; 2019-2020\)](#)

Eviction Filings – Eviction Lab

Eviction filings and claim amounts by zip code and race/ethnicity. Data obtained from:

- [Eviction Tracking System \(2020-2021\)](#)

Feeding America – Child Food Insecurity Rate

Impact of COVID-19 on food insecurity, by county. Data obtained from:

- [Feeding America \(2019-2020\)](#)

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 \(2010-2021\)](#)

KIDS 2019 – NYC Department of Health and Mental Hygiene

Health and early childhood development for young children. Data obtained from:

- [NYU analysis of KIDS data \(2019\)](#)

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](#)

NYC Public Housing Residents – NYC Housing Authority

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

- [NYC Housing Authority Official Map \(2021\)](#)

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 \(2017-2018\)](#)

Perinatal Data Profile – NYS Department of Health

Birth data from NYS Vital Statistics. Data obtained from:

- [NYS Vital Statistics \(2016-2018\)](#)

PLACES – Centers for Disease Control and Prevention

Health behaviors and outcomes. Data obtained from:

- [CDC PLACES \(2017-2018\)](#)

Rent Debt in America - National Equity Atlas/ US Census Household Pulse Survey

Population behind on rent and estimated amount owed by race/ethnicity. Data obtained from:

- [National Equity Atlas Rent Debt Dashboard](#)

Rental Subsidies -- NYU Furman Center; US Housing and Urban Development

Housing choice vouchers and rental subsidies. Data obtained from:

- [NYU Furman Center – CoreData.nyc \(2009-2019\)](#)
- [HUD Picture of Subsidized Housing Database \(2020\)](#)

Social Vulnerability Index – CDC/ATSDR

Social factors that impact community's ability to respond and recover to disasters. Data available from:

- [CDC/ATSDR Social Vulnerability Index \(2018\)](#)

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 \(2016-2017\)](#)

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 \(2010-2019\)](#)
- [Citizens Committee for Children \(2016-2018\)](#)

Youth Risk Behavior Survey – NYC Department of Health and Mental Hygiene

Teen health behavior and health outcomes. Data obtained from:

- [NYC Health Department – EpiQuery \(2019\)](#)

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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](#)
 - 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
 - [Public Use Microdata Area \(PUMA\), 2010 boundaries, Community District Approximation](#), 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 \(PUMA\), 2010 boundaries, Community District Approximation](#), for Brooklyn CD 7
 - Zip Codes 11220, 11232

Appendix B

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 <ul style="list-style-type: none"> ▪ Community Health Initiatives and Government Affairs 	Multiple meetings and communication
Health + Hospitals <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ 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 ▪ Bureau of Equitable Health Systems within the Division of Center for Health Equity and Wellness 	Multiple meetings and communication

Agency	Dates
<ul style="list-style-type: none"> ▪ Brooklyn Knows Steering Committee and Youth Subcommittee 	
<p>New York City Department of Health and Mental Hygiene – Brooklyn Community Action Team</p> <ul style="list-style-type: none"> ▪ El Puente ▪ Peer Health Exchange ▪ CAMBA ▪ HEAT ▪ THEO ▪ North Brooklyn Prevention Coalition ▪ New York City Teen Connection ▪ Grand Street Settlement ▪ Bedford YMCA ▪ Bedford Stuyvesant Community Connections ▪ 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
<p>NYS Office of Child and Family Services</p> <ul style="list-style-type: none"> ▪ Division of Child Welfare and Community Services 	Multiple meetings and communication
<p>Public Health Solutions</p> <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ 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) <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ 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 C

Guiding principles to increase authentic community engagement, improve health equity, and implement an anti-racist agenda

Draft: February 12, 2021

To hold ourselves accountable, we will:

- Collaboratively develop a plan for each initiative, and for the CSP as a whole, to increase authentic community engagement, improve health equity, and implement an anti-racist agenda
- Develop mechanisms to review our plans, to measure progress, and to learn from our successes and challenges
- Share what we learn along the way, internally and with other interested collaborations

Suggested process:

Timeframe	Actions
January/February	Program teams (faculty, staff, community partners) meet and collaboratively use this guide to: <ul style="list-style-type: none">▪ Reflect on strengths and opportunities for growth and identify unanswered questions or concerns▪ Select which principles are to be prioritized▪ Set goals for principles that have been prioritized using (to the extent possible) the SMART framework*▪ Develop draft implementation plans
February-April	Each team meets with the CPBA/Anti-Racism workgroup to: <ul style="list-style-type: none">▪ Review SMART goals/plans and get feedback▪ Identify needed assistance to make progress on priorities identified▪ Identify resources/experts across our groups and networks who can provide assistance and guidance
April-May	<ul style="list-style-type: none">▪ Teams finalize plans▪ CSP launches TA programs to support programs' priorities/goals
April-September	Periodic sharing of progress, challenges and questions across programs
October/November	Co-Co meeting to reflect on process, progress and lessons learned

* SMART goals as defined by CDC:

Specific: Concrete, detailed, and well defined so that you know where you are going and what to expect when you arrive

Measureable: Numbers and quantities provide means of measurement and comparison

Achievable: Feasible and easy to put into action

Realistic: Considers constraints such as resources, personnel, cost, and time frame

Time-Bound: A timeframe helps to set boundaries around the objective

See: https://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html

https://www.cdc.gov/dhds/docs/smart_objectives.pdf (pages 3-7)

We commit to:	Guiding discussion questions: to help determine strengths, opportunities for growth, priorities, and assistance needs	Self-evaluation: <ul style="list-style-type: none"> ▪ Strengths ▪ Opportunities for growth ▪ Open questions 	Selected priorities for this year: concrete actions to extend strengths and/or address opportunities for growth	Assistance needed: e.g., capacity building workshops, mentoring, technical assistance
<p>1. Collaboratively defining the community with which we are working, understanding the causes and consequences of health inequities and the impact of structural racism* on community health and well-being, and understanding our roles – as individuals and as members or representatives of organizations</p>	<ul style="list-style-type: none"> ▪ Have we defined the community in such a way that we can assess whether all relevant groups are adequately represented? ▪ Do we understand the power dynamics to ensure that underrepresented people are recognized and engaged? ▪ Do we have a deep and shared understanding of the role of structural racism* as it affects the health and well-being of the community? ▪ Do we understand our role and our organization’s role, and how our organization is perceived? ▪ Does the staffing/leadership of the project reflect the demographics of the intended users/community and offer employment and leadership opportunities to those who have experienced racism and other forms of discrimination? <p>* As defined by Mary Bassett and colleagues, <i>“Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.”</i></p>			

We commit to:	Guiding discussion questions: to help determine strengths, opportunities for growth, priorities, and assistance needs	Self-evaluation: <ul style="list-style-type: none"> ▪ Strengths ▪ Opportunities for growth ▪ Open questions 	Selected priorities for this year: concrete actions to extend strengths and/or address opportunities for growth	Assistance needed: e.g., capacity building workshops, mentoring, technical assistance
2. Building relationships of trust and appreciation, and to taking the time to continually reflect on, evaluate, and strengthen our collaborative processes	<ul style="list-style-type: none"> ▪ Are we assessing/building/sustaining trust and collaboration among stakeholders? ▪ Are our decision-making and implementation processes sufficiently flexible to allow for changes in methods and focus as necessary? ▪ Are our timeframes and expectations realistic? ▪ Are we acknowledging and addressing any inequities in power? ▪ Have we created a venue and process to foster self-reflection and criticism, and a mechanism to address conflict? ▪ Have we developed formal or informal agreements on key procedural matters, e.g., <ul style="list-style-type: none"> ▪ How the partners will work together? ▪ How projects will be managed? ▪ How decisions will be made and differences/ conflicts resolved? ▪ How data are owned and shared? 			
3. Building on and leveraging strengths and resources within the community	<ul style="list-style-type: none"> ▪ Are we applying intended users' knowledge, experiences, or other physical or intellectual resources in the design, implementation, evaluation, dissemination, and action phases? 			

We commit to:	Guiding discussion questions: to help determine strengths, opportunities for growth, priorities, and assistance needs	Self-evaluation: <ul style="list-style-type: none"> ▪ Strengths ▪ Opportunities for growth ▪ Open questions 	Selected priorities for this year: concrete actions to extend strengths and/or address opportunities for growth	Assistance needed: e.g., capacity building workshops, mentoring, technical assistance
<p>4. Collaboratively defining the roles of all partners in all phases of the work in a way that leverages expertise, minimizing barriers to participation, particularly for those who have been underrepresented in the past, and ensuring that the contribution of all participants is recognized and appropriately compensated</p>	<ul style="list-style-type: none"> ▪ Are intended users/community members given the choice regarding how they want to participate and in which program components? ▪ Are we building capacity and working to help secure resources so that intended users/community members are able to participate fully (e.g., as co-researchers, partners, informants)? ▪ Are intended users/community members involved in defining: <ul style="list-style-type: none"> ▪ Need/problem? ▪ Focus/scope? ▪ Research/evaluation questions? ▪ Use of the budget? ▪ Are intended users/community members involved in planning and implementing: <ul style="list-style-type: none"> ▪ Design/methods/ data collection? ▪ Recruitment? ▪ Analysis? ▪ Interpretation, synthesis, and verification of conclusions? ▪ Dissemination? ▪ Action steps? ▪ Have we minimized barriers to participation, generally, and for those who have been underrepresented in the past (e.g., cultural lens; literacy; providing food, childcare, translation; stipends)? 			

We commit to:	Guiding discussion questions: to help determine strengths, opportunities for growth, priorities, and assistance needs	Self-evaluation: <ul style="list-style-type: none"> ▪ Strengths ▪ Opportunities for growth ▪ Open questions 	Selected priorities for this year: concrete actions to extend strengths and/or address opportunities for growth	Assistance needed: e.g., capacity building workshops, mentoring, technical assistance
5. Learning from each other and building our capacities and skills	<ul style="list-style-type: none"> ▪ Does the research/evaluation/ program provide mutual learning among different stakeholder groups? ▪ Will the knowledge produced build the capacity of intended users to address individual or broader determinants of health? 			
6. Ensuring that all partners have the opportunity and resources to participate in the communication of findings and knowledge gained, recognizing the need for privacy and protecting participants and the community from inadvertent harm	<ul style="list-style-type: none"> ▪ Do we have a plan for collective ownership of data as well as for how data and findings will be disseminated? With academic audiences? With community audiences? With policymakers? ▪ Have we explicitly addressed how to avoid contributing to possible stigma or bias? 			
7. Making a long-term commitment and working to make sustainable change	<ul style="list-style-type: none"> ▪ Have we planned for sustainability? ▪ Have we identified a pathway to advocate for changes within our own organization based on what we are learning from the community? 			

Resources:

This website offers a great array of resources, many of which are available by clicking on the link provided.

<https://hslguides.med.nyu.edu/raceandracism>

Defining R

This talk provides a foundation for thinking about race and racism. It is part of a series offered by the NYULH Office of Diversity Affairs:

[Defining Race and Racism](#): Joseph Ravenell, MD & Richard Greene, MD, MHPE

https://nyulangone.hosted.panopto.com/Panopto/Pages/Viewer.aspx?id=2243f9c2-2572-48ed-be54-acc5015d9ef5&mc_cid=7a6176b10b&mc_eid=0f6d054453

Appendix D

Evidence Base for Community Service Plan Projects

Intervention	Evidence	Citations
Preventing Chronic Disease		
Healthy Food Initiative	<p>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:</p> <ul style="list-style-type: none"> • Connecting emergency food programs with local urban agriculture projects <ul style="list-style-type: none"> ○ 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: 	<ul style="list-style-type: none"> • McCullum, C., Desjardins, E., Kraak, V. I., Ladipo, P., & Costello, H. (2005). Evidence-based strategies to build community food security. <i>Journal of the American Dietetic Association</i>, 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. <i>Public Health Nutrition</i>. 2019;22(9):1704-1716. • Grabow KN, Schumacher J, Banning J, Barnes JL. Highlighting healthy options in a food pantry setting: A pilot study. <i>Family and Consumer Sciences Research Journal</i>. 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. <i>Cochrane Database of Systematic Reviews</i>. 2018;(3):CD009728. • Mabli J, Ohls J, Dragoset L, Castner L, Santos B. <i>Measuring the Effect of SNAP Participation on Food Security</i>. 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.pdf • J. Kim, “Are Older Adults Who Participate in the Supplemental Nutrition Assistance Program Healthier Than Eligible Nonparticipants? Evidence from the Health and Retirement Study,” <i>The Gerontologist</i>, 55 (Supplement Issue 2):672, November 1, 2015, https://academic.oup.com/gerontologist/article/55/Suppl_2/672/2489

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> ▪ 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. <ul style="list-style-type: none"> • Counselling clients to maximize access to existing programs providing food and nutrition assistance, social services, and job training; <ul style="list-style-type: none"> ○ 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. 	<ul style="list-style-type: none"> • 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.

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> • Creating multi-sector partnerships and networks. <ul style="list-style-type: none"> ○ Our model includes networks for food access, community counseling, education, and food system coordination across Sunset Park providers. 	
Greenlight	<ul style="list-style-type: none"> • As part of the NIH-funded multi-site cluster randomized study, children who received Greenlight had a lower BMI z-score at 4, 6, 12, 15 and 18 months of age. • There were also reductions in obesogenic behaviors, including less juice consumption by children, among families who received Greenlight. • The Greenlight intervention incorporates evidence-based messages related to child obesity based on comprehensive review of evidence. 	<ul style="list-style-type: none"> • Sanders LM, Perrin EM, Yin HS, et al. A Health-Literacy Intervention for Early Childhood Obesity Prevention: A Cluster-Randomized Controlled Trial. <i>Pediatrics</i>. 2021;147(5):e2020049866. doi:10.1542/peds.2020-049866. PMID: PMC8086006. • Wood CT, Witt WP, Skinner AC, et al. Effects of Breastfeeding, Formula Feeding, and Complementary Feeding on Rapid Weight Gain in the First Year of Life. <i>Acad Pediatr</i>. 2021;21(2):288-296. doi:10.1016/j.acap.2020.09.009 • Sanders LM, Perrin EM, Yin HS, Bronaugh A, Rothman RL, Greenlight Study Team. "Greenlight study": a controlled trial of low-literacy, early childhood obesity prevention. <i>Pediatrics</i>. 2014;133(6):e1724-1737. PMID: PMC4035594. • Ciampa PJ, Kumar D, Barkin SL, et al. Interventions aimed at decreasing obesity in children younger than 2 years: a systematic review. <i>Arch Pediatr Adolesc Med</i>. 2010;164(12):1098-104. PMID:PMC3369272.
REACH FAR	<ul style="list-style-type: none"> • Culturally tailored community health worker programs have been shown to be effective in reaching and engaging populations that experience health disparities. • Faith-based outreach programs have been shown to be effective in engaging populations and fostering behavior change. 	<ul style="list-style-type: none"> • Islam NS, Wyatt LC, Taher M, et al. A culturally tailored community health worker intervention leads to improvement in patient-centered outcomes for immigrant patients with type 2 diabetes. <i>Clinical Diabetes</i>. 2018:cd170068. • Islam NS, Zanowiak JM, Wyatt LC, et al. Diabetes prevention in the New York City Sikh Asian Indian community: a pilot study. <i>International journal of environmental research and public health</i>. 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

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> • 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. 	<p>to Reduce Blood Pressure in Underserved Metropolitan New York Immigrant Communities. Preventing Chronic Disease. 2019 Aug 8;16:E106. doi: 10.5888/pcd16.180618.</p> <ul style="list-style-type: none"> • 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] • 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.

Intervention	Evidence	Citations
		<p>Opens in a new tab. Public Health Reports. 2021 Dec 30; 333549211061313</p> <ul style="list-style-type: none"> ▪ Ursua RA, Aguilar DE, Wyatt LC, et al. A community health worker intervention to improve blood pressure among Filipino Americans with hypertension: A randomized controlled trial. <i>Preventive Medicine Reports</i>. 2018;11:42-48. ▪ Kwon S, Patel S, Choy C, et al. Implementing health promotion activities using community-engaged approaches in Asian American faith-based organizations in New York City and New Jersey. <i>Translational behavioral medicine</i>. 2017;7(3):444-466. ▪ Berra K, Franklin B, Jennings C. Community-based healthy living interventions. <i>Progress in cardiovascular diseases</i>. 2017;59(5):430-439. ▪ Walton JW, Snead CA, Collinsworth AW, Schmidt KL. Reducing diabetes disparities through the implementation of a community health worker–led diabetes self-management education program. <i>Family & community health</i>. 2012;35(2):161-171. ▪ Dallo, F. J., et al. (2019). "Diabetes management among Arab Americans who sought care at a large metropolitan hospital system in Michigan." <i>Journal of immigrant and minority health</i> 21(3): 490-496. ▪ Zayed, L., et al. (2020). "Health Assessment of the Arab American Community in Southwest Chicago." <i>Journal of community health</i>: 1-7. ▪ Abuelezam, N. N., et al. (2018). "The Health of Arab Americans in the United States: An Updated Comprehensive Literature Review." <i>Frontiers in Public Health</i> 6(262). ▪ Hammoud MM, White CB, Fetters MD. Opening cultural doors: Providing culturally sensitive healthcare to Arab American and American Muslim patients. <i>American journal of obstetrics and gynecology</i>. 2005;193(4):1307-1311.
Tobacco Free Community	<ul style="list-style-type: none"> ▪ Quitline interventions, particularly proactive quitlines (i.e. those that offer follow-up counseling calls) have been shown to be effective. 	<ul style="list-style-type: none"> ▪ Kuiper N, Zhang L, Lee J, et al. A national Asian-language smokers' quitline — United States, 2012-2014. <i>Prev Chronic Dis</i>. 2015;12:E99.

Intervention	Evidence	Citations
	<p>For example, telephone counseling found to be effective for Chinese-, Korean-, and Vietnamese-speaking smokers measuring 6-month prolonged abstinence rates.</p> <ul style="list-style-type: none"> • 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 cessation interventions are effective in promoting quit outcomes. 	<ul style="list-style-type: none"> • Zhu SH, Wong S, Stevens C, Nakashima D, Gamst A. Use of a smokers' quitline by Asian language speakers: results from 15 years of operation in California. <i>American Journal of Public Health</i>. 2010;100(5):846-852. • Fiore, M. Treating tobacco use and dependence: 2008 update: Clinical practice guideline. DIANE Publishing, 2008. • Esparza, A. Patient Navigation and the American Cancer Society. <i>Seminars in Oncology Nursing</i>. May 2013;29(2):91-96 • Your online guide of what works to promote healthy communities. The Guide to Community Preventive Services (The Community Guide). http://www.thecommunityguide.org/tobacco/RRquitlines.html. Published December 1, 2016. Accessed March 12, 2019. • Kong, G., Ells, D. M., Camenga, D. R., & Krishnan-Sarin, S. (2014). Text messaging-based smoking cessation intervention: a narrative review. <i>Addictive behaviors</i>, 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. <i>JMIR mHealth and uHealth</i>, 4(2), e49. • Whittaker, R., McRobbie, H., Bullen, C., Rodgers, A., & Gu, Y. (2016). Mobile phone-based interventions for smoking cessation. <i>The Cochrane database of systematic reviews</i>, 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. <i>Addictive behaviors</i>, 73, 81–93.
Stanford Chronic Disease Self-Management program	There is strong evidence from peer-reviewed publications and program evaluations that participation in chronic disease self-management workshops can improve physical and psychosocial outcomes and quality of life for people	<ul style="list-style-type: none"> • Lorig KR, Sobel DS, Ritter PL, et al. Effect of a self-management program on patients with chronic disease. <i>Effective Clinical Practice</i>. 2001;4(6):256–262. PMID: 11769298. • Lorig KR, Ritter P, Stewart AL, et al. Chronic Disease Self-Management Program: 2-year health status and health care utilization outcomes. <i>Medical Care</i>. 2001;39(11):1217–1223. PMID: 11606875.

Intervention	Evidence	Citations
	<p>with chronic health conditions. Benefits include:</p> <ul style="list-style-type: none"> • Decreased pain and health distress • Increased energy and less fatigue • Increased physical activity • Decreased depression • Better communication with physicians • Decreased social role limitations • Increased confidence in managing chronic disease 	<ul style="list-style-type: none"> • Barlow JH, Wright CC, Turner AP, et al. A 12-month follow-up study of self-management training for people with chronic disease: are changes maintained over time? <i>British Journal of Health Psychology</i>. 2005;10(Pt. 4):589–599. PMID: 16238867. • Kennedy A, Reeves D, Power P, et al. The effectiveness and cost effectiveness of a national lay-led self-care support programme for patients with long-term conditions: a pragmatic randomized controlled trial. <i>Journal of Epidemiology and Community Health</i>. 2007;61(3):254–261. PMID: 17325
Red Hook Community Health Network	<p>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 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 Dankwa-Mullan et al. The community-priority network work groups will consult evidence to inform strategies.</p>	<ul style="list-style-type: none"> • Holden, Kisha et al. “Community Engaged Leadership to Advance Health Equity and Build Healthier Communities.” <i>Social sciences (Basel, Switzerland)</i> 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. <i>Cult Med Psychiatry</i>. 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. <i>American journal of public health, 106</i>(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.” <i>American journal of public health</i> vol. 107,10 (2017): 1660-1667. doi:10.2105/AJPH.2017.303985 • 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.” <i>Health services research</i> vol. 55 Suppl 2, Suppl 2 (2020): 894-901. doi:10.1111/1475-6773.13321

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	<p>Evidence suggests Community Health Worker interventions can improve health outcomes and address social needs including, but not limited to:</p> <ul style="list-style-type: none"> • 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 activation scores, primary care utilization, and high-quality quality discharge communication with providers. 	<ul style="list-style-type: none"> • 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
<p>CHW Research and Resource Center</p>	<ul style="list-style-type: none"> • There is strong evidence for the value of community health workers in addressing health equity issues across populations. Evidence base exists for: <ul style="list-style-type: none"> ○ CHW intervention effectiveness for addressing chronic diseases and social determinants of health; 	<ul style="list-style-type: none"> • Peretz, Patricia J., et al. “Community Health Workers and Covid-19 — Addressing Social Determinants of Health in Times of Crisis and Beyond.” New England Journal of Medicine, vol. 383, no. 19, 2020, https://doi.org/10.1056/nejmp2022641. https://www.nejm.org/doi/full/10.1056/NEJMp2022641 • 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

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	<ul style="list-style-type: none"> ○ The value of building capacity of CHWs and front line staff; and ○ Need for advocacy for CHW workforce sustainability and equity through funding for programs and building a CHW career trajectory. 	<ul style="list-style-type: none"> ▪ Allen CG, Brownstein N, Satsangi A, Escoffery C (2016) Capacity Building and Training Needs for Community Health Workers Working in Health Care Organizations. J Community Med Health 6:403. doi:10.4172/2161-0711.1000403 https://www.omicsonline.org/open-access/capacity-building-and-training-needs-for-community-health-workers-working-in-health-care-organizations-2161-0711-1000403.php?aid=69048 ▪ 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/ ▪ Critical Inputs for Successful CHW Programs. https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs_White-Paper_November2021-2.pdf ▪ Jeannette M. Beasley, Megha Shah, Laura C. Wyatt, Jennifer Zanowiak, Chau Trinh-Shevrin, Nadia S. Islam, “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”, American Journal of Public Health 111, no. 6 (June 1, 2021): pp. 1040-1044. https://doi.org/10.2105/AJPH.2021.306216 ▪ Lapidos, Adrienne, et al. “Realizing the Value of Community Health Workers — New Opportunities for Sustainable Financing.” New England Journal of Medicine, vol. 380, no. 21, 2019, pp. 1990–1992., https://doi.org/10.1056/nejmp1815382. ▪ Advancing and Sustaining the Community Health Worker Workforce in Baltimore The Abell Foundation - Working To Enhance The Quality Of Life In Baltimore And In Maryland. https://abell.org/publications/advancing-and-sustaining-community-health-worker-workforce-baltimore. ▪ “Developing Sustainable Community Health Worker Career Paths.” Milbank Memorial Fund, https://www.milbank.org/publications/developing-sustainable-community-health-worker-career-paths/.

Intervention	Evidence	Citations
Brooklyn Health and Housing Consortium	<ul style="list-style-type: none"> • Evidence showing how health system and housing partnerships can impact health outcomes. <ul style="list-style-type: none"> ○ Cross-sector collaboration; ○ Coordinated care and referral programs; ○ Medical respite; ○ Hospital screening for housing insecurity and data sharing; and ○ Investment and advocacy in housing, SDOH, and community health 	<ul style="list-style-type: none"> • 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 Bronx Health & Housing Consortium 2022. http://www.bxconsortium.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. • 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

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		2017. https://www.urban.org/sites/default/files/publication/89586/housing_makingitreal_final.pdf .
Health x Housing Lab	<ul style="list-style-type: none"> • Evidence demonstrates the multifaceted negative health effects of housing insecurity and homelessness; • While there is heterogeneity in study findings, some evidence shows that housing interventions are associated with improved health outcomes and reduced health care costs; • Partnerships with multiple stakeholders and individuals with lived experience perspectives can lead to innovative solutions; • There is increasing interest in health care systems addressing patients’ housing as well as in broader investments in housing; • More research is needed regarding what types of health system interventions and investments related to housing are most impactful; and • There is a need for improved dissemination of high-quality evidence related to health and housing to guide programs and policies. 	<ul style="list-style-type: none"> • Taylor L. Housing And Health: An Overview Of The Literature. (2018). Health Affairs. https://doi.org/10.1377/hpb20180313.396577 • American Hospital Association. (2019). Making the Case for Hospitals to Invest in Housing. https://www.aha.org/issue-brief/2019-04-24-making-case-hospitals-invest-housing • Bailey, P. (2020, January). Housing and Health Partners Can Work Together to Close the Housing Affordability Gap. Center on Budget and Policy Priorities. • Bovell-Ammon, A., Mansilla, C., Poblacion, A., Rateau, L., Heeren, T., Cook, J. T., Zhang, T., de Cuba, S. E., & Sandel, M. T. (2020). Housing Intervention For Medically Complex Families Associated With Improved Family Health: Pilot Randomized Trial. Health Affairs, 39(4), 613–621. https://doi.org/10.1377/hlthaff.2019.01569 • 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 • 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

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		<ul style="list-style-type: none"> ▪ Lucas, S. (2018). Connecting Fragmented Systems: Public Housing Authority Partnerships With the Health Sector. <i>Cityscape</i>, 20(2), 85–106. https://www.jstor.org/stable/26472169 ▪ Scally, C., Waxman, E., Gourevitch, R., & Adeeyo, S. (2017, July). Emerging Strategies for Integrating Health and Housing. https://www.urban.org/research/publication/emerging-strategies-integrating-health-and-housing/view/full_report
Promoting Healthy Women, Infants and Children		
ParentChild+	<ul style="list-style-type: none"> ▪ ParentChild+ (PC+) is a national model that has been shown to reduce the achievement gap between low-and middle-income children. PC+ is a cost-effective approach that impacts school readiness, long-term school success, and strengths-based parenting, as demonstrated in many studies, including matched comparison group and randomized control group studies. The model is replicated with high fidelity in Sunset Park. ▪ Compared to control groups, PC+ child graduates have: <ul style="list-style-type: none"> ○ stronger social emotional and language skills(core school readiness indicators); ○ higher levels of English proficiency in kindergarten; ○ higher third-grade reading and math scores; 	<ul style="list-style-type: none"> ▪ ORS Impact (2015), Long-Term Academic Outcomes of Participation in the Parent-Child Home Program (PCHP) in King County, WA. Seattle, WA. ▪ Astuto J. Playful learning, school readiness, and urban children: Results from two rcts. PCHP Annual Meeting. Uniondale, NY. May 2014. New York University ▪ Lazar I, Darlington R. Lasting effects of early education: A report from the Consortium of Longitudinal Studies. <i>Monographs of the Society for Research in Child Development</i>. 1982;47(195). ▪ Levenstein P, Levenstein S, Shiminski JA, Stolzberg JE. Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the Mother-Child Home Program. <i>Journal of Applied Developmental Psychology</i>. 1998;19:267-285. ▪ Madden J, O’Hara JM, Levenstein P. Home again. <i>Child Development</i>. 1984;55:636-647. ▪ Rafoth M, Knickelbein B. Cohort One Final Report: Assessment Summary for the <i>Parent Child Home Program</i>. An evaluation of the Armstrong Indiana County Intermediate Unit PCHP program, Center for Educational and Program Evaluation located at Indiana University of Pennsylvania. 2005. ▪ Kamerman SB, Kahn, AJ. <i>Starting Right</i>, 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

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> ○ a significant reduction in need for special education by third grade; and ○ higher high school graduation rates. ▪ Compared to control groups, PC+ parent graduates have: <ul style="list-style-type: none"> ○ higher pro-social competence (such as fewer problem behaviors); and, sustained higher-frequency and quality interactions two years after the program that correlates with children’s first grade cognitive and emotional skills. 	<ul style="list-style-type: none"> Parent-Child home program. <i>Journal of Applied Developmental Psychology</i>, 23, 331-353. (S.C. Study) ▪ Smith, Charles & Peck, Stephen. (2020). Impact Evaluation for the Parent Child Plus Program, Newark Trust for Education.
ParentCorps	<ul style="list-style-type: none"> ▪ 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 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, through second grade, with a 24% lower risk of reading below grade level; were 50% less likely to develop mental health problems, 	<ul style="list-style-type: none"> ▪ 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. <i>Early Education and Development</i> 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 ethnically diverse families from underserved, urban communities. <i>Child Development</i>. 2011;82(1):258-276. PMID: 1291441. ▪ Brotman LM, Dawson-McClure S, Huang KY, et al. Early childhood family intervention and long-term obesity prevention among high-risk minority youth. <i>Pediatrics</i>.2012; 129:621-628. PMCID: PMC3289522 ▪ Brotman LM, Dawson-McClure S, Calzada EJ, et al. randomized controlled trial of <i>ParentCorps</i>: Impact on kindergarten academic achievement. <i>Pediatrics</i>. 2013;131: e1521-1529. PMCID: PMC39641414

Intervention	Evidence	Citations
	<p>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 (e.g. more than 10% of days in the school year), from second grade through sixth grade.</p> <ul style="list-style-type: none"> • ParentCorps has meaningful impacts on parenting and teacher practices, strengthening teachers and parents' capacities to create safe, nurturing and predictable environments both in the classroom and at home. • 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. • Teachers demonstrated more nurturing teacher-student 	<ul style="list-style-type: none"> • 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. <i>Trials</i>. 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. <i>Prevention Science</i>.2015;16(2):279-290. PMID: 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. <i>JAMA Pediatrics</i>. 2016;170(12):1149-1155. PMID: PMC5642293. • Dawson-McClure S, Calzada E, Huang KY, et al. A population-level approach to promoting healthy development and school success in low-income, urban neighborhoods: Impact on parenting and child conduct problems. <i>Prevention Science</i>. 2015;16(2):279-290. PMID: PMC4156570. • Hajizadeh N, Stevens ER, Applegate M, et al. Potential return on investment of a family-centered early childhood intervention: A cost-effectiveness analysis. <i>BMC: Public Health</i>. 2017;17(1):796. PMID: 29017527. PMC: 5635549. • Huang K, Nakigudde J, Rhule D, Gumikiriza-Onoria L, Abura G, Kolawole B, Brotman L. Transportability of an evidence-based early childhood intervention in a low-income African country: Results of a cluster randomized controlled study. <i>Prevention Science</i>. 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

Intervention	Evidence	Citations
	<p>interactions and effective behavior management in the classroom.</p> <ul style="list-style-type: none"> • 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 suggests 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. • In NYC, early results from a randomized controlled trial in 74 pre-K programs in high poverty areas show that ParentCorps Professional Development, relative to standard NYC DOE Professional Development leads to: greater pre-K teachers’ use of evidence-based social-emotional learning practices (e.g. emotional modeling, social awareness, social problem-solving) based on standardized observations of teachers-student interactions. 	<p>Development. <i>Research on Family-School Partnerships</i>. 2021; 53–72. https://doi.org/10.1007/978-3-030-74617-9_4</p>

Intervention	Evidence	Citations
Video Interaction Project	<p>Multiple randomized control trials have demonstrated VIP’s impacts including:</p> <ul style="list-style-type: none"> • Large impacts on positive parenting activities <ul style="list-style-type: none"> ○ reading aloud; ○ teaching; ○ talking & back-and-forth conversation; and ○ playing together. • Reduced harsh discipline • Enhanced coping with parenting <ul style="list-style-type: none"> ○ reduced parenting stress; ○ fewer depressive symptoms. • Enhanced parent-child relationships • Enhanced child development across domains <ul style="list-style-type: none"> ○ most strongly for social-emotional development; ○ reductions in hyperactivity and attention problems sustained into school entry; 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 	<ul style="list-style-type: none"> • Cates CB, Weisleder A, Johnson SB, et al. Enhancing parent talk, reading, and play in primary care: sustained impacts of the Video Interaction Project. <i>The Journal of pediatrics</i>.2018. • Canfield C, Weisleder A, Cates CB, et al. Primary care parenting intervention effects on use of corporal punishment among low-income parents of toddlers. <i>Journal of Developmental and Behavioral Pediatrics</i>. 2015;36(8):586-593. • Berkule SB, Cates CB, Dreyer BP, et al. Reducing Maternal Depressive Symptoms Through Promotion of Parenting in Pediatric Primary Care. <i>Clinical Pediatrics</i>. 2014; 460-469. PMID: 24707022. • Cates CB, Weisleder A, Johnson SB, Seery, et al. Enhancing parent talk, reading, and play in primary care: sustained impacts of the Video Interaction Project. <i>The Journal of pediatrics</i>.2018. • Mendelsohn A, Cates CB, Weisleder A, et al. Reading aloud, play, and social-emotional development. <i>Pediatrics</i>. 2018. • Weisleder A, Cates CB, Dreyer B, et al. Promotion of positive parenting and prevention of socioemotional disparities. <i>Pediatrics</i>. 2016;137(2). • Canfield CF, Seery A, Weisleder A, et al. Encouraging parent–child book sharing: Potential additive benefits of literacy promotion in health care and the community. <i>Early Childhood Research Quarterly</i>. 2018. • Roby E, Miller EB, Shaw DS, et al. Improving Parent-Child Interactions in Pediatric Health Care: A Two-Site Randomized Controlled Trial. <i>Pediatrics</i>. 2021. • Shaw DS, Mendelsohn AL, Morris PA. Reducing poverty-related disparities in child development and school readiness: The Smart Beginnings tiered prevention strategy that combines pediatric primary care with home visiting. <i>Clinical Child and Family Psychology Review</i>. 2021.

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> • 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 	
Project SAFE	<ul style="list-style-type: none"> • The program uses two evidence-based sexual health curricula in the multi-session workshop series that have been shown to increase knowledge and eliminate or reduce risky sexual behaviors: Making Proud Choices! (MPC) and Project AIM. • 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, 	<ul style="list-style-type: none"> • Jemmott JB III, Jemmott LS, Fong, GT. Reductions in HIV risk-associated sexual behaviors among Black male adolescents: Effects of an AIDS prevention intervention. <i>American Journal of Public Health</i>. 1992;82(3):372–377. • Jemmott JB III, Jemmott LS, Fong GT, McCaffree K. Reducing HIV risk-associated sexual behavior among African American adolescents: Testing the generality of intervention effects. <i>American Journal of Community Psychology</i>.1999;27(2):161-87. • Jemmott JB III, Jemmott LS, Fong, GT. Abstinence and safer sex HIV risk-reduction interventions for African American adolescents: A randomized controlled trial. <i>JAMA</i>.1998;279 (19):1529-1536. • Clark LF, Miller KS, Nagy SS, Avery J, Roth DL, Liddon N, Mukherjee S. Adult identity mentoring: reducing sexual risk for African-American seventh grade students. <i>J Adolesc Health</i>. 2005 Oct;37(4):337. • Tiffany, Jennifer & Exner-Cortens, Deineria & Eckenrode, John & Henderson, Sara & Zhang, Sherry. (2014). The Influence of Program Settings on Sexual Risk Reduction and Health Promotion Among Adolescents.

Intervention	Evidence	Citations
	<p>which have been shown to be protective factors against HIV infection.</p>	
<p>Family support services: screening and referral and Reach Out and Read</p>	<p>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 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%).</p> <p>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.</p>	<ul style="list-style-type: none"> ▪ 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.
Promoting a Healthy and Safe Environment		
<p>Falls prevention programs</p>	<p>A Matter of Balance: 8-session workshop to reduce fear of falling and increase activity among older adults in the community</p>	<p>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/</p>

Intervention	Evidence	Citations
	<ul style="list-style-type: none"> • 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 <p>Tai Chi for Arthritis for Falls Prevention: Balance and gait training program of controlled movements for older adults and people with balance disorders</p> <ul style="list-style-type: none"> • 55% reduction in falls rate • \$530 net benefit per participant • 509% ROI 	

Appendix E

Anticipated Impact and Performance Measures

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
PREVENTING CHRONIC DISEASES						
<p>Program: Healthy Food Initiative Prevention Agenda Focus Area(s): 1. Healthy Eating and Food Security Prevention Agenda Goal(s): 1.3 Increase food security Objective: By August 2025, 4,860 people served will have improved food or financial security Reach: 37,000 in more than 13,500 households</p>						
Emergency food pantry	<ul style="list-style-type: none"> ▪ 5,000 households ▪ 45 services ▪ 9,000 food packages distributed 	<ul style="list-style-type: none"> ▪ 5,000 households ▪ 45 services ▪ 9,000 food packages distributed 	<ul style="list-style-type: none"> ▪ 5,000 households ▪ 45 services ▪ 9,000 food packages distributed 	<ul style="list-style-type: none"> ▪ The emergency food pantry is focused on short-term outcomes: addressing emergency food needs, increasing awareness of food, financial, and health community resources 	<ul style="list-style-type: none"> ▪ 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) 	<ul style="list-style-type: none"> ▪ Program administrative/ operations records
Screening, Case Management and Nutrition Education	<ul style="list-style-type: none"> ▪ ~2,920 people ▪ 1,800 of benefits applications supported or submitted ▪ 20 workshops ▪ 5 locations/ orgs sessions took place at/ through 	<ul style="list-style-type: none"> ▪ ~2,920 people ▪ 1,800 of benefits applications supported or submitted ▪ 20 workshops ▪ 5 locations/ orgs sessions took place at/ through 	<ul style="list-style-type: none"> ▪ ~2,920 people ▪ 1,800 of benefits applications supported or submitted ▪ 20 workshops ▪ 5 locations/ orgs sessions took place at/ through 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Improved community resiliency and emergency preparedness (more timely detection, cross-sector coordination of response activities, continuity of services during emergencies) 	<ul style="list-style-type: none"> ▪ Program administrative/ operations records ▪ Hunger Vital Signs and similar validated food insecurity screeners ▪ Pre/post workshop survey

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
				<ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ Coalition members, number and type ▪ Meeting structure and frequency ▪ Member retention ▪ Other outputs aligned with activities and goals 	Targets to be finalized in Year 1: <ul style="list-style-type: none"> ▪ Coalition members, number and type ▪ Meeting structure and frequency ▪ Member retention ▪ Other outputs aligned with activities and goals 	Targets to be finalized in Year 1: <ul style="list-style-type: none"> ▪ Coalition members, number and type ▪ Meeting structure and frequency ▪ Member retention ▪ Other outputs aligned with activities and goals 	<ul style="list-style-type: none"> ▪ Improved coordination and integration of food security services between Sunset Park stakeholders 		

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Greenlight Prevention Agenda Focus Area(s): Focus Area 1: Healthy Eating and Food Security Prevention Agenda Goal(s): Goal 1.0 Reduce obesity and the risk of chronic disease Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices Objective: Decrease the percentage of 2–3-year-old children who are overweight / obese at sites served by August 2025. Reach: 2000 children and their families (in 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 Hospital – Long Island Pediatric Center</p>						
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)	<ul style="list-style-type: none"> ▪ Greenlight used at 2000+ well-child visits ▪ Program reach of 80% of 0-2y children (main site) ▪ 800 families reached ▪ 2500+ booklets distributed ▪ 1500+ tangible tools (e.g. portion size snack cups) distributed ▪ 40 providers (physicians, nursing staff, health ed.) engaged ▪ 4 sites 	<ul style="list-style-type: none"> ▪ Greenlight used at 2500+ well-child visits ▪ Program reach of 80% of 0-2y children (main site) ▪ 1000 families reached ▪ 3000+ booklets distributed ▪ 1500+ tangible tools ▪ 50 providers engaged ▪ 5 sites 	<ul style="list-style-type: none"> ▪ Greenlight used at 2500+ well-child visits ▪ Program reach of 80% of 0-2y children (main site) ▪ 1000 families reached ▪ 3000+ booklets distributed ▪ 1500+ tangible tools ▪ 50 providers engaged ▪ 5 sites 	Children/Families <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Increased provider delivery of evidence-based healthy eating/activity recommendations ▪ Increased provider use of evidence-based health communication strategies 	Children/Families <ul style="list-style-type: none"> ▪ Intermediate outcomes plus ▪ Families with greater self-efficacy related to healthy eating and activity-related behaviors ▪ Reduction in obesity Clinical sites / Providers <ul style="list-style-type: none"> ▪ Intermediate outcomes plus ▪ Increased site capacity to support families in engaging in healthy eating / activity-related behaviors 	<ul style="list-style-type: none"> ▪ 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) ▪ Notes from meetings of parent advisory group/community advisory board
Greenlight waiting room program	<ul style="list-style-type: none"> ▪ Maintain delivery to 50% eligible children (main site) <ul style="list-style-type: none"> ○ 300 families reached ▪ Peer training of new staff, including at new site ▪ Dev. workflow for health educator (HE) collection of feeding/activity data (in EHR) 	<ul style="list-style-type: none"> ▪ Maintain delivery to 50% eligible children (main site) <ul style="list-style-type: none"> ○ 300 families reached ▪ Peer training of new staff ▪ HE collection of feeding/activity data; reach of 25% sessions (75 patients) (main site) 	<ul style="list-style-type: none"> ▪ Maintain delivery to 50% of eligible children (main site) <ul style="list-style-type: none"> ○ 300 families reached ▪ Peer training of new staff ▪ HE collection of feeding/activity data; reach of 50% sessions (150 patients) (main site) 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
Technology enhancement of Greenlight	<ul style="list-style-type: none"> ▪ Digital online Greenlight flipbooks (Eng, Span, Chinese) ▪ Explore remote delivery / telehealth use of Greenlight at main site <ul style="list-style-type: none"> ○ 25 families reached ▪ Explore social media platforms to promote Greenlight 	<ul style="list-style-type: none"> ▪ Digital online Greenlight flipbooks (Eng, Span, Chinese) ▪ Remote delivery at main site <ul style="list-style-type: none"> ○ 50 families reached ▪ Greenlight flipbooks used in waiting room ▪ Promote Greenlight via social media platforms ▪ Pilot remote delivery at 2nd site 	<ul style="list-style-type: none"> ▪ Digital online Greenlight flipbooks (Eng, Span, Chinese) ▪ Remote delivery at main site & 2nd site <ul style="list-style-type: none"> ○ 100 families reached ▪ Greenlight flipbooks used in waiting room ▪ Promote Greenlight via social media networks ▪ Pilot remote delivery at 3rd site 			
Partnership with parents and community leaders	<ul style="list-style-type: none"> ▪ Analyze feedback survey results (25-30 families) ▪ Quarterly meetings of community advisory board (4-5 participants) 	<ul style="list-style-type: none"> ▪ Expand community advisory board (CAB) (10 participants) ▪ Quarterly meetings 	<ul style="list-style-type: none"> ▪ Maintain community advisory board (CAB) ▪ Quarterly meetings 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: REACH FAR Brooklyn: Preventing Chronic Disease through Engagement with Community and Faith-Based Organizations in Brooklyn</p> <p>Prevention Agenda Focus Area(s): Focus Area 1: Healthy Eating and Food Security Focus Area 4: Chronic Disease Preventive Care and Management</p> <p>Prevention Agenda Goal(s): Goal 1.0: Reduce obesity and the risk of chronic disease Goal 1.1: Increase access to healthy and affordable foods and beverages Goal 1.3: Increase food security Goal 4.3: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity</p> <p>Objective:</p> <ul style="list-style-type: none"> Objective for Goal 1.0: By August 2025, the percentage of program participants who demonstrate weight-loss will increase by 5 to 10% Objective for Goal 1.1: By August 2025, 100% of the participating mosque sites will have increased access to healthy and affordable foods and beverages for mosque congregants at communal meals Objective for Goal 1.3: By August 2025, approximately 2,000 community members will be referred/connected to community-based free food pantries/tables Objective for Goal 4.3: from baseline to 1 year follow up, among the participants with uncontrolled hypertension, improvement in their systolic and/or diastolic blood pressure control (systolic BP<140, diastolic BP<90) will increase by 5 to 10%. <p>Reach: Over 4,000 community residents</p>						
Implement nutritional policy in faith-based settings (FBO)	<ul style="list-style-type: none"> Identify champion or health committee at Brooklyn Islamic Center and Masjid Nur Al Islam Engage with FBO leadership and host implementation planning meetings Conduct baseline nutrition survey with 150 congregants Conduct baseline organizational assessment Implement nutritional change reaching all congregants Organize 5 food table to serve free food to 500-600 community members 	<ul style="list-style-type: none"> Identify champion or health committee at 2 additional mosques in Brooklyn: Darul Jannah Masjid and Masjid Al Rahman Engage with FBO leadership and host implementation planning meetings Conduct baseline nutrition survey with 150 congregants Conduct baseline organizational assessment Implement nutritional change reaching all congregants Conduct 1-year follow-up surveys on 	<ul style="list-style-type: none"> Conduct quarterly monitoring of nutritional policy change at Brooklyn Islamic Center and Masjid Nur Al Islam One year follow up surveys on Nutrition and organizational assessment at Darul Jannah and Masjid Al Rahman Organize 5 food table to serve free food to 500-600 	<ul style="list-style-type: none"> Increased percentage of people reporting healthy change in diet in the past 3 months 300 community residents will be reached through the food table in the first 5 months. 	<ul style="list-style-type: none"> Increased frequency of those reporting having tried healthy options at communal meals Increased access to healthy foods and beverages at communal meals. Improved food security 	<ul style="list-style-type: none"> Baseline and follow-up nutritional survey Organizational assessment survey Tracking the number of individuals receiving service from each food table

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
		nutrition and organizational assessment <ul style="list-style-type: none"> Organize 5 food table to serve free food to 500-600 community members 	community members			
Implement blood pressure screening program in FBO and CBO setting	<ul style="list-style-type: none"> Provide KOT refresher training to volunteers from Brooklyn Islamic Center (BIC) and Masjid Nur Al Islam (MNI) Launch KOT program at BIC and MNI and enroll 75 congregants from each site Conduct monthly blood pressure screening with 50 congregants at each site Identify health champion at Arab American Association of New York (AAANY) and Arab American Family Support Center (AAFSC) Train volunteers on KOT from AAANY and AAFSC Planning implementation of KOT, develop protocol and referral process 	<ul style="list-style-type: none"> Collect 1 year follow up surveys from BIC and MNI congregants Launch KOT at AAANY and AAFSC and enroll 50 participants from each site Conduct monthly blood pressure screening with 50 community members at AAANY and 50 members at AAFSC Continue monthly blood pressure screening at MNI and BIC Identify champion or health committee at Masjid Al Rahman (MAR) and Darul Jannah (DJ) Train 10 volunteers from MAR and DJ on KOT Planning implementation of KOT, develop protocol 	<ul style="list-style-type: none"> Launch KOT at MAR and DJ and enroll 75 participants from each site Conduct monthly blood pressure screening with 50 congregants at each site Collect 1 year follow up surveys from AAANY and AAFSC participants Continue monthly blood pressure screening at all sites Collect 1 year follow up surveys from MAR and DJ 	<ul style="list-style-type: none"> Increased prevalence of self-reported blood pressure screening 	<ul style="list-style-type: none"> Increased percentage of controlled hypertension (systolic BP<140, diastolic BP<90) among those with hypertension 	<ul style="list-style-type: none"> Baseline and follow-up survey among participants enrolled in the program Participant tracking cards
Diabetes prevention and management	<ul style="list-style-type: none"> Develop culturally tailored hand book on diabetes prevention and management Planning for conducting workshops and 	<ul style="list-style-type: none"> Conduct 4 in-person or live on-line seminars on diabetes prevention and management to reach 200 community members 	<ul style="list-style-type: none"> Conduct 4 in-person or live on-line seminars on diabetes prevention and management 	<ul style="list-style-type: none"> Availability of culturally tailored hand book on diabetes management for community members 	<ul style="list-style-type: none"> 1200-1500 community residents will have tools available to enhance skills on diabetes management and prevention 	<ul style="list-style-type: none"> Tracking the number of community members receiving the hand book and knowledge on diabetes related skills from seminars

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	dissemination of hand book	<ul style="list-style-type: none"> Distribute 500 copies of hand book to mosque members, ethnic doctors' offices, and CBO members 	<ul style="list-style-type: none"> to reach 200 community members Distribute 500 copies of hand book to mosque members, ethnic doctors' offices, and CBO members 			
Referral to Mediators of Atherosclerosis in South Asians Living in America (MASALA) Study	<ul style="list-style-type: none"> Refer 50 Bangladeshi and Pakistani community members into MASALA Study 	<ul style="list-style-type: none"> Refer 50 Bangladeshi and Pakistani community members into MASALA Study 	<ul style="list-style-type: none"> Refer 50 Bangladeshi and Pakistani community members into MASALA Study 	<ul style="list-style-type: none"> At year one, 50 Bangladeshis will be referred to MASALA Study 	<ul style="list-style-type: none"> 150 Bangladeshis and Pakistani community members will contribute to understand the risk factors of cardiovascular disease among the South Asian Americans 	<ul style="list-style-type: none"> Tracking the number referrals made to MASALA study.
Health Insurance Enrollment	<ul style="list-style-type: none"> 50 community members will receive assistance on health insurance information and enrollment 	<ul style="list-style-type: none"> 50 community members will receive assistance on health insurance information and enrollment 	<ul style="list-style-type: none"> 50 community members will receive assistance on health insurance information and enrollment 	<ul style="list-style-type: none"> Increased enrollment into health insurance 	<ul style="list-style-type: none"> Increased access to healthcare system for chronic disease prevention and management 	<ul style="list-style-type: none"> Tracking the number of individuals receiving assistance on health insurance

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Tobacco Free Community: Smoker Navigator Program</p> <p>Prevention Agenda Focus Area(s):</p> <p>Goal 1. Promote tobacco use cessation</p> <p>Goal 2. Eliminate exposure to secondhand smoke</p> <p>Prevention Agenda Goal(s): Reduce tobacco use disparities and exposure to tobacco smoke among Asian Americans and other immigrant populations in New York City</p> <p>Objective: Reduce tobacco use and exposure to environmental tobacco smoke in immigrant communities through prevention, advocacy, and cessation support. By August 31, 2025, enroll a minimum of 255 smokers, with 58% of participants utilizing NRT and 40% referring to the Asian Smokers' Quitline</p> <p>By August 31, 2025, the program will reach a total of 3,750 community members, the initial target of 1,000 community members each year, with an additional increment of 25% annually.</p> <ul style="list-style-type: none"> • Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among all adults) • Increased referrals to the Asian Smokers' Quitline • Increased use and access to evidence-based smoking cessation programs • Increased quitting rates among those interacting with navigators and coaches • Increased awareness of attendees at workshop about exposed to secondhand smoke in their homes <p>Reach: ~3,750 community members in the Lower East Side, Chinatown, Sunset Park, and Red Hook</p>						
Recruit and refer smokers to smoking and lung cancer screening resources	▪ Enroll at least 85 smokers (including at least 5 NYCHA residents)	▪ Enroll 85 smokers (including at least 5 NYCHA residents)	▪ Enroll 85 smokers (including at least 5 NYCHA residents)	<ul style="list-style-type: none"> ▪ Increased self-reported use of smoking cessation treatment services and medications ▪ Increased quit attempts and quit rates among those interacting with navigators and coaches ▪ Increased satisfaction with the Smoker Navigator Program ▪ Increased awareness about the Smoker Navigator Program ▪ Increased knowledge about the harms of 	<ul style="list-style-type: none"> ▪ Increased smoking cessation rate among Chinese Americans and NYCHA residents ▪ Increased utilization of existing smoking cessation treatment resources ▪ Increased public support for smoke-free housing ▪ Increase support for smoke-free housing in AAFE developments ▪ 	<ul style="list-style-type: none"> ▪ AAFE tracking document for enrollment in Navigator Program ▪ Survey data collected by CSP and AAFE ▪ Community outreach tracking document (AAFE completes)
	▪ Dispense nicotine replacement therapy patches/gums to at least 50 smokers	▪ Dispense nicotine replacement therapy patches/gums to at least 50 smokers	▪ Dispense nicotine replacement therapy patches/gums to at least 50 smokers			
	▪ Complete 35 two-week follow-up interviews	▪ Complete 35 two-week follow-up interviews	▪ Complete 35 two-week follow-up interviews			
	▪ Complete 35 referrals to Asian Smokers Quitline (for smokers who speak Chinese) or New York	▪ Complete 35 referrals to Asian Smokers Quitline (for smokers who speak Chinese)	▪ Complete 35 referrals to Asian Smokers Quitline (for			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	State Smokers' Quitline (for smokers who speak English)	or New York State Smokers' Quitline (for smokers who speak English)	smokers who speak Chinese) or New York State Smokers' Quitline (for smokers who speak English)	secondhand smoke exposure and existing smoking cessation treatment resources <ul style="list-style-type: none"> ▪ Increase use of Navigator Program ▪ Increase participation of the NYU Lung Cancer screening program ▪ Incorporate the Smoking Cessation program to AAFE's residence service ▪ Expand the network of the physician referral program 		
	<ul style="list-style-type: none"> ▪ Refer 5 smokers to Smokefree Text Messaging Programs 	<ul style="list-style-type: none"> ▪ Refer 5 smokers to Smokefree Text Messaging Programs 	<ul style="list-style-type: none"> ▪ Refer 5 smokers to Smokefree Text Messaging Programs 			
	<ul style="list-style-type: none"> ▪ Develop a Lung Cancer Screening and Smoking Cessation Referral Pathway between the Program and NYU's Lung Cancer Screening Program 	<ul style="list-style-type: none"> ▪ Launch the Lung Cancer Screening and Smoking Cessation Referral Project ▪ Educate at least 35 smokers about lung cancer screening 	<ul style="list-style-type: none"> ▪ Implement the Lung Cancer Screening and Smoking Cessation Referral Project ▪ Educate at least 35 smokers about lung cancer screening 			
	<ul style="list-style-type: none"> ▪ Develop a survey to assess NRT use from previous participants – Recruit at least 50 smokers 	<ul style="list-style-type: none"> ▪ Analyze the data 				
Community outreach activities to increase access to smoking cessation and lung cancer screening resources	<ul style="list-style-type: none"> ▪ Reach out to 1000 people ▪ Deliver 6 workshops to community and senior centers (in-person or virtual) - reaching 120 community members 	<ul style="list-style-type: none"> ▪ Reach out to 1250 people ▪ Deliver 7 workshops to community and senior centers (in-person or virtual) – reaching 140 community members 	<ul style="list-style-type: none"> ▪ Reach out to 1500 people ▪ Deliver 8 workshops to community and senior centers (in-person or virtual)– - 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
			reaching 160 community members			
	<ul style="list-style-type: none"> Collaborate with 5 community-based organizations to increase the reach of Smoker Navigator Program and educational outreach activities 	<ul style="list-style-type: none"> Collaborate with 6 community-based organizations to increase the reach of Smoker Navigator Program and educational outreach activities 	<ul style="list-style-type: none"> Collaborate with 7 community-based organizations to increase the reach of Smoker Navigator Program and educational outreach activities 			
	<ul style="list-style-type: none"> Collaborate with Chinese American Medical Society to sustain and expand the physician referral system 	<ul style="list-style-type: none"> Collaborate with Chinese American Medical Society to sustain and expand the physician referral system 	<ul style="list-style-type: none"> Collaborate with Chinese American Medical Society to sustain and expand the physician referral system 			
	<ul style="list-style-type: none"> Provide support to help promote NYU's Lung Cancer Screening Program 	<ul style="list-style-type: none"> Provide support to help promote NYU's Lung Cancer Screening Program 	<ul style="list-style-type: none"> Provide support to help promote NYU's Lung Cancer Screening Program 			
	<ul style="list-style-type: none"> Collaborate with Jacob Riis NYCHA development to promote the program 	<ul style="list-style-type: none"> Collaborate with Jacob Riis NYCHA development to promote the program 	<ul style="list-style-type: none"> Collaborate with Jacob Riis NYCHA development to promote the program 			
	<ul style="list-style-type: none"> Implement Smoking Cessation program to AAFE's residence service 	<ul style="list-style-type: none"> Implement Smoking Cessation program to AAFE's residence service 	<ul style="list-style-type: none"> Implement Smoking Cessation program to 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
			AAFE's residence service			
	<ul style="list-style-type: none"> Pilot a acupuncture and smoking cessation service at AAFE's Community Resource Center Develop evaluation tool 	<ul style="list-style-type: none"> Evaluate the pilot project 				
<p>Program: Tobacco Free Community – Asian American Tobacco Free Community Initiative (AATFCI)</p> <p>Prevention Agenda Focus Area(s):</p> <p>Goal 1. Prevent initiation of tobacco use</p> <p>Goal 2. Promote tobacco use cessation</p> <p>Goal 3. Eliminate exposure to secondhand smoke</p> <p>Objectives:</p> <ul style="list-style-type: none"> Establish and maintain a platform for reducing tobacco use and exposure to environmental tobacco smoke in immigrant communities through prevention, advocacy, and cessation support Increase knowledge about the barriers to accessing smoking cessation resources among Chinese American smokers <p>Reach: Engage and collaborate with at least 20 community-based organizations, health care providers, policymakers, researchers, and government agencies</p>						
	<ul style="list-style-type: none"> Organize 4 AATFCI (Smoking Partnership meetings with partners (on a quarterly basis) 	<ul style="list-style-type: none"> Organize 4 AATFCI (Smoking Partnership meetings with partners (on a quarterly basis) 	<ul style="list-style-type: none"> Organize 4 AATFCI (Smoking Partnership meetings with partners (on a quarterly basis) 	<ul style="list-style-type: none"> Increased awareness of and access to linguistically- and culturally competent tobacco use cessation and prevention resources. 	<ul style="list-style-type: none"> Reduced tobacco use disparities experienced by immigrant populations 	<ul style="list-style-type: none"> AATFCI program documentation (meeting minutes, agendas) Evaluation data Resource repository
	<ul style="list-style-type: none"> Reach and engage 3 new organizations who work with immigrant populations experienced high smoking rates to join AATFCI/Smoking Partnership 	<ul style="list-style-type: none"> Reach and engage 2 new organizations who work with immigrant populations experienced high smoking rates to join AATFCI/Smoking Partnership 	<ul style="list-style-type: none"> Reach and engage 1 new organization who work with immigrant populations experienced high smoking rates to join AATFCI/Smoking Partnership 	<ul style="list-style-type: none"> Increased number of members, diversity of membership and engagement of AATFCI/Smoking Partnership members 		
	<ul style="list-style-type: none"> Organize and convene a Resource Repository Workgroup, which will meet at least 6 times 	<ul style="list-style-type: none"> Organize and convene a Resource Repository Workgroup, which will meet at least 6 times 	<ul style="list-style-type: none"> Organize and convene a Resource Repository 	<ul style="list-style-type: none"> Reduced tobacco use disparities experienced by immigrant populations 		

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
			Workgroup, which will meet at least 6 times			
	<ul style="list-style-type: none"> Support the Resource Repository Workgroup with identifying an online platform for the resource repository 	<ul style="list-style-type: none"> Support the Resource Repository Workgroup with uploading and organizing the resources to the online repository and piloting ease of access to the resources 	<ul style="list-style-type: none"> Repository Workgroup finalize, maintaining and promoting the online repository 			
	<ul style="list-style-type: none"> Support the Resource Repository Workgroup with creating sub-committees to identify and curate content for the 3 categories of resources housed in the repository 	<ul style="list-style-type: none"> Support the Resource Workgroup content sub-committees as needed 	<ul style="list-style-type: none"> Support the Resource Workgroup content sub-committees as needed 			
	<ul style="list-style-type: none"> Organize and convene a CBOA Anti-Racism Principles Workgroup, which will meet at least 6 times during the year 	<ul style="list-style-type: none"> Organize and convene a CBOA Anti-Racism Principles Workgroup, which will meet at least 6 times during the year 	<ul style="list-style-type: none"> Organize and convene a CBOA Anti-Racism Principles Workgroup, which will meet at least 6 times during the year 			
	<ul style="list-style-type: none"> Support the CBPA Anti-Racism Principles Workgroup in the development and implementation of an AATFCI/Smoking Partnership evaluation plan 	<ul style="list-style-type: none"> Support the CBPA Anti-Racism Principles Workgroup in the implementation of Year 2 AATFCI/Smoking Partnership evaluation activities 	<ul style="list-style-type: none"> Support the CBPA Anti-Racism Principles Workgroup in implementing Year 3 AATFCI/Smoking Partnership evaluation activities 			
	<ul style="list-style-type: none"> Organize and host 1 meeting focused on smoking-related policy 	<ul style="list-style-type: none"> Organize and host 1 meeting focused on smoking-related policy 	<ul style="list-style-type: none"> Organize and host 1 meeting focused on 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	agenda development and advocacy at the local level	agenda development and advocacy at the local level	smoking-related policy agenda development and advocacy at the local level			
	<ul style="list-style-type: none"> Support any follow-up activities that result from the smoking-related policy and advocacy meeting 	<ul style="list-style-type: none"> Support any follow-up activities that result from the smoking-related policy and advocacy meeting 	<ul style="list-style-type: none"> Organize and host 1 meeting focused on smoking-related policy agenda development and advocacy at the local level 			
<p>Program: Stanford Chronic Disease Self-Management Program</p> <p>Prevention Agenda Focus Area(s): Focus Area 4: Chronic Disease Preventive Care and Management</p> <p>Prevention Agenda Goal(s): Goal 4.4 In the community setting, improve self-management skills for individuals with chronic disease, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity</p> <p>Objective: By August 2025, 125 adults will have learned how to manage their condition</p> <p>Reach: 125 adults</p>						
Weekly 2.5 hour classes for 6 weeks with adults and instructors	<ul style="list-style-type: none"> Recruit and train 2 new staff Conduct baseline survey Retain 80% of registered adults for each class Distribute 43 educational workbooks to each participant 	<ul style="list-style-type: none"> Conduct baseline survey Retain 80% of registered adults for each class Distribute 43 educational workbooks to each participant 	<ul style="list-style-type: none"> Conduct baseline survey Retain 80% of registered adults for each class Distribute 44 educational workbooks to each participant 	<ul style="list-style-type: none"> Increased confidence in managing chronic disease Better communications with physicians Increased physical activity Make better food choices 	<ul style="list-style-type: none"> Participants will gain control of their chronic disease symptoms and live their daily life Manage challenges associated with chronic disease 	<ul style="list-style-type: none"> Attendance data Baseline Survey Post-program and six-month survey Documentation of the number of sessions

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Red Hook Community Health Network (RHCHN) Prevention Agenda Focus Area(s): 4. Chronic Disease Preventive Care and Management Prevention Agenda Goal(s): 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity Objective: By August 2025, the RHCHN will be a sustained network with at least 8 community organizations and 6 residents actively engaged By August 2025, 80% of Red Hook residents who received CHW services have improved access to health and wellbeing resources. Reach: 8 organizations; 750 Red Hook residents</p>						
Community Health Worker Program	<ul style="list-style-type: none"> 20 Red Hook residents are referred to the CHW by RHCHN organizations each month 80% of residents referred to the CHW receive requested support 	<ul style="list-style-type: none"> 30 Red Hook residents are referred to the CHW by RHCHN organizations each month 80% of residents referred to the CHW receive requested support 	<ul style="list-style-type: none"> 30 Red Hook residents are referred to the CHW by RHCHN organizations each month 80% of residents referred to the CHW receive requested support 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Administrative and operations records Participant assessment and self-reporting Network member assessment
Red Hook Community Health Network Workgroups	<ul style="list-style-type: none"> 3 workgroups active 6 organizations represented and active within the Network 4 residents active within the Network 90% of workgroups meeting at least once a month 100% of workgroups completed a gaps and resource inventory 	<ul style="list-style-type: none"> 3 workgroups running 8 organizations represented and active within the Network 6 residents active within the Network 95% of workgroups meeting at least once a month 1-3 strategies identified across all three workgroups 	<ul style="list-style-type: none"> 3 workgroups running 8 organizations represented and active within the Network 6 residents active within the Network 95% of workgroups meeting at least once a month 1-3 strategies identified across all three workgroups 	<ul style="list-style-type: none"> Red Hook residents have improved access to community-identified needed health and SDOH services Greater coordination of existing resources and clear understanding of existing gaps in health care resources in Red Hook New resources in Red Hook related to community-identified needs 	<ul style="list-style-type: none"> Quality care to prevent and manage chronic diseases is equitably accessible in Red Hook Sustained or improved cohesion and collaboration among participating RHCHN organizations 	<ul style="list-style-type: none"> Administrative and operations records Gaps, resources, and strategy inventory Network member assessment

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Community Health Worker Research and Resource (CHW-RRC) Prevention Agenda Focus Area(s): Chronic Disease Preventive Care and Management Prevention Agenda Goal(s): Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity Objective: By August 2025, the CHW-RRC will be recognized as a go-to center for CHW resources, training, and research within NYULH, across NYC, and nationally. Reach: 250 attendees per training; 60 CHW Learning Community members; 2200 listserv subscribers.</p>						
<p>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.</p>	<p>Programming planning</p> <ul style="list-style-type: none"> Hold 6 CHW Stakeholder Group meetings Hold 12 CHW Learning Committee meetings Recruit 4-6 CHW Learning Committee members at the end of each 18-month cycle Conduct CHW Wellness Surveys every quarter or as needed Review registration and attendance data <p>Development & implementation</p> <ul style="list-style-type: none"> Publish 4 CHW Learning Community Newsletters Host an annual CHW Summit on a timely theme Organize regular COVID-19, community health, and professional development webinars of interest for CHWs and frontline workers Maintain weekly CHW Learning Community resource emails Provide technical support and take on research and evaluation projects aimed at strengthening and better understanding the role of CHWs in 	<p>Continue with Year 1 programming planning and development & implementation activities</p> <p>Tracking measures</p> <ul style="list-style-type: none"> # CHW Stakeholder Group meetings # CHW Learning Committee meetings # events and attendees # evaluation surveys collected # partner organizations # CHW Newsletters published # CHW Learning Community resource emails sent # of technical assistance and research partnerships 	<p>Continue with Year 1 programming planning and development & implementation activities</p>	<ul style="list-style-type: none"> Through webinars, increase interest in and understanding of the topics assessed through evaluations Develop and streamline onboarding trainings for new CHW hires at NYULH Continue to advocate for CHW equity by ensuring that new titles and transparent promotion criteria are implemented across the institution Complete development of a Repository of documents and resources in partnership with NYULH digital communications and an external consultant Continue to build CHW Learning Community capacity through 	<ul style="list-style-type: none"> Educate future physicians on the role and importance of community health workers Increase awareness of the importance of CHWs at the institutional level Advocate for more sustainable funding options to support CHW programs Expand the reach and impact of the CHW-RRC, continuing to grow our network Synthesize best practices for CHW program implementation and create standardized protocols for supervision, training, outreach, and case management, and assist with adaptation to specific programs 	<ul style="list-style-type: none"> Mailchimp reach Meeting minutes Webinar event recordings Registration and attendance data for events Event polling data Evaluation reports for research projects Feedback from CHW Stakeholder Group, CHW Learning Community and CHW Learning Committee CHW Wellness Survey CHW Learning Community Newsletter Available data on CHW workforce and CHW impact

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	promoting the health of vulnerable communities			targeted professional development activities, mentoring, and involvement in CHW-RRC committees and webinars <ul style="list-style-type: none"> ▪ Engage external partners in NYC to establish a centralized website for posting CHW job opportunities ▪ Integrate CHW-RRC activities within the newly-funded Beyond Bridges Initiative, which seeks to implement a long-term, integrated community-clinical linkage model to improve health and wellness outcomes in Sunset Park, Brooklyn ▪ Expand webinar reach to more non-English speaking communities by offering simultaneous interpretation during webinar events 		

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Brooklyn Health & Housing Consortium (Brooklyn Consortium) Prevention Agenda Focus Area(s): Chronic Disease Prevention Care and Management Prevention Agenda Goal(s): Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity Objective: By August 31, 2025, make progress towards improving coordination have a formalized data sharing between health care and housing sectors Reach: An average of 250 registrants per training, 10 steering committee organizations/partners annually, and 4000 Mailchimp subscribers across NYC-based healthcare, homeless and social services organizations, and government partners</p>						
<p>The Brooklyn Consortium works at the intersection of health and housing with the goal of improving health equity and housing stability by fostering cross-sector relationships, informing policy, and building capacity of frontline workers to support Brooklyn residents with unmet health and housing needs.</p>	<p>Programming planning/needs assessment</p> <ul style="list-style-type: none"> Convene 4 workgroup meetings/year on priority areas Hold 6 Steering Committee meetings/year Recruit 3 steering committee members from organizations not currently represented Review attendance/evaluation data <p>Development & implementation</p> <ul style="list-style-type: none"> Organize 12 events of interest, including 4 case conferences/year Seek and incorporate expertise from advocates and those with lived experience of health and housing insecurity Facilitate meetings on medical respite Host 2 convenings (1 annual, 1 medical respite) Maintain biweekly newsletter Analyze pre-/ post-learning objective evaluation feedback 	<p>Continue with Year 1 program planning, needs assessment and implementation activities</p> <ul style="list-style-type: none"> Facilitate medical respite partnerships between MCOs and health systems with respite providers (as part of NYS Medicaid pilot) <p>Tracking measures</p> <ul style="list-style-type: none"> # steering committee meetings # workgroup meetings # events # attendees # event evaluations collected # collaborating organizations # convenings - # advocacy efforts supported 	<p>Continue with Year 1 program planning, needs assessment and implementation activities</p> <ul style="list-style-type: none"> Collaborate with hospitals and CBOs to develop a housing insecurity screener 	<ul style="list-style-type: none"> Gain citywide support for formalizing effective and timely communication process between homeless shelters, supportive housing and hospitals Lend support to successful siting of medical respite program in Brooklyn Assist with implementation of housing insecurity screener with incoming hospital patients and improved referrals to CBOs - Communicate between city, borough and local stakeholders on issues pertaining to health and housing 	<ul style="list-style-type: none"> Increased resources for housing insecure residents Increased political and leadership support for systems that follow the <i>Housing is Healthcare</i> model Standardized housing insecurity screener used at all NYC hospitals with appropriate referral process in place 	<ul style="list-style-type: none"> Mailchimp reach Registration and attendance data Evaluation data Open feedback Meeting minutes Workgroup feedback/recommendations Newsletters Available data on housing status of patients in NYC hospitals - Available data on health status of NYC residents by housing status

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	<ul style="list-style-type: none"> Monitor progress in priority areas Collaborate on sign-on letters, help coordinate policy recommendations Engage hospitals on collecting patient housing status at intake 					
<p>Program: Health x Housing Lab</p> <p>Prevention Agenda Focus Area(s): Focus Area 4: Chronic Disease Preventive Care and Management</p> <p>Prevention Agenda Goal(s): Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity</p> <p>Objective: By August 25, 2025, make progress toward influencing stakeholders to invest in affordable housing to reduce homelessness</p> <p>Reach: Anticipated broad reach across NYC and nationally to policy leaders, advocates, housing and healthcare providers and other stakeholders.</p>						
<p>The Health x Housing Lab provides evidence-based guidance for initiatives sitting at the intersection of health and housing. We aim to advance health and health equity by contributing toward a future in which all people have safe, stable, and affordable housing.</p>	<ul style="list-style-type: none"> Hold Advisory Committee meetings 6 times a year Host 3–4 seminars to share evidence on health and housing with diverse stakeholders Host 3–4 Flipping the Script events for healthcare workers to learn from people with lived experience of homelessness Host 2 summer scholar interns Align lab activities with value statements Plan for Op-Ed Project trainings Plan for Health x Housing Lab Speakers Bureau Complete evaluation of cash assistance project in partnership with NYC Health + Hospitals 	<ul style="list-style-type: none"> Hold Advisory Committee meetings 6 times a year Host 3–4 seminars to share evidence on health and housing with diverse stakeholders Host 3–4 Flipping the Script events for healthcare workers to learn from people with lived experience of homelessness Host 2 summer scholar interns Hire new postdoctoral scholar for a 2 year term Implement Op-Ed project trainings Implement Health x Housing Lab Speakers Bureau Complete evaluation of a nurse triage hotline implemented 	<ul style="list-style-type: none"> Hold Advisory Committee meetings 6 times a year Host 3–4 seminars to share evidence on health and housing with diverse stakeholders Host 3–4 Flipping the Script events for healthcare workers to learn from people with lived experience of homelessness Host 2 summer scholar interns Continue Op-Ed project Continue Health x Housing Lab 	<ul style="list-style-type: none"> Increase the influence of people with lived experience of homelessness in relevant policy and programmatic discussions Increase the knowledge of policy makers and practitioners around evidence-based initiatives around health and housing Increase the number of health care workers and trainees who have received education that will enable them to provide better care for patients experiencing homelessness 	<ul style="list-style-type: none"> Work towards a homeless services system that better fosters people’s broadly defined health and wellness Leverage health care and housing collaborations to reduce the toll of homelessness Improve health care sector treatment of people experiencing homelessness Develop new faculty leaders in policy-relevant research related to housing and homelessness as they intersect with health 	<ul style="list-style-type: none"> Meeting minutes Feedback from Advisory Committee members Webinar event recordings Attendance data for events Assessment of impact of trainees Evaluation reports for research projects

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
		in NYC homeless shelters	Speakers Bureau			
PROMOTING HEALTHY WOMEN, INFANTS, AND CHILDREN						
<p>Program: ParentChild+</p> <p>Prevention Agenda Focus Area(s): 3. Child and Adolescent Health, including children with special health care needs (CSHCN)</p> <p>Prevention Agenda Goal(s): 3.1 Support and enhance children and adolescents’ social-emotional development and relationships</p> <p>Objective: By August 2025, 90% of enrolled young children will demonstrate on-target social emotional development at the end of the program.</p> <p>Reach: 120 children (and parent(s))</p>						
Twice-weekly home visits with parent(s), child, and ParentChild+ Early Learning Specialist	<ul style="list-style-type: none"> Provide home visiting services for 60 families Conduct a total of 2760 home visits Retain 90% of enrolled families for duration of program year Distribute 660 educational toys and 720 books to participating families 	<ul style="list-style-type: none"> Provide home visiting services for 60 families Conduct a total of 2760 home visits Retain 90% of enrolled families for duration of program year Distribute 660 educational toys and 720 books to participating families 	<ul style="list-style-type: none"> Provide home visiting services for 60 families Conduct a total of 2760 home visits Retain 90% of enrolled families for duration of program year Distribute 660 educational toys and 720 books to participating families 	<ul style="list-style-type: none"> Parents: Increased (or sustained frequent) use of positive parenting techniques Children: Improved (or sustained on-target) social and emotional development and early literacy skills essential for school readiness 	<ul style="list-style-type: none"> Children will outperform the statewide average on their third grade state math achievement test Children will graduate from high school at the same rate as their middle class peers, eliminating disparities in education attainment based on income 	<ul style="list-style-type: none"> Program administrative data Parent and Child Together (PACT) assessment administered to parents at beginning and end of each program year Child Behavior Traits (CBT) assessment administered to children at beginning and end of each program year
<p>Program: ParentCorps</p> <p>Prevention Agenda Focus Area(s): Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)</p> <p>Prevention Agenda Goal(s): Goal 3.1 Support and enhance children and adolescents’ social-emotional development and relationships</p> <p>Objective: By August 2025, support 12 pre-K programs serving 660 pre-K families in Sunset Park, Brooklyn (37%) to adopt the full ParentCorps model (Professional Learning, Parenting Program & Friends School).</p> <p>Reach: 660 families annually</p>						
Support 12 pre-K programs to adopt the full	<ul style="list-style-type: none"> Add two new pre-K programs to our existing Community Advisory Board and core group of 	<ul style="list-style-type: none"> Add one new pre-K program to our existing Community Advisory Board and 	<ul style="list-style-type: none"> Add one new program, for a total of four new pre-K 	Pre-K Programs <ul style="list-style-type: none"> Increased use of evidence-based and culturally 	Pre-K Programs <ul style="list-style-type: none"> Same as Intermediate outcomes 	<ul style="list-style-type: none"> Attendance and Feedback Forms for all activities (Teacher and Leader Professional Learning,

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
ParentCorps model (Professional Learning, Parenting Program & Friends School)	partner programs, a total of 10 programs.	core group of partner programs, a total of 11 programs.	programs joining our existing Community Advisory Board and core group of partner programs, a total of 12 programs.	relevant policies and practices in support of Family Engagement and Social Emotional Development. <ul style="list-style-type: none"> Positive ratings on the annual NYC School Survey (e.g., family-school connection). 	Families <ul style="list-style-type: none"> 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. 	ParentCorps Program Facilitator Training, Community Advisory Board Meetings, Parenting Program) <ul style="list-style-type: none"> Facilitator Self-Reflection Forms (Parenting Program) Process Notes (Community Advisory Meetings; Teacher Coaching) Focus Groups for Teachers and Families DOE Administrative Data
	<ul style="list-style-type: none"> Facilitate Parenting Program alongside program staff to build their capacity for facilitation (in languages spoken by families).* Develop program materials in Arabic. 	<ul style="list-style-type: none"> Train and coach veteran program staff to directly facilitate Parenting Program (in languages spoken by families). Build capacity of staff at new sites to facilitate.* Pilot program in Arabic at one site. 	<ul style="list-style-type: none"> Coach veteran staff to directly facilitate the Parenting Program with continued coaching. Train new staff to facilitate.* Offer Parenting Program in Arabic. 	Families <ul style="list-style-type: none"> 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. 		
	<ul style="list-style-type: none"> Train and coach site staff to implement Friends School, our classroom-based social-emotional learning program. *All programming contingent on site interest and capacity. 	<ul style="list-style-type: none"> Train new staff and coach all staff to implement Friends School, our classroom-based social-emotional learning program. *All programming contingent on site interest and capacity. 	<ul style="list-style-type: none"> Train new staff and coach all staff to implement Friends School, our classroom-based social-emotional learning program. *All programming contingent on site interest and capacity. 	<ul style="list-style-type: none"> Children build foundational skills for learning and healthful development. Increased use of evidence-based and culturally relevant practice to promote Social Emotional Development at home. 		
	<ul style="list-style-type: none"> Offer both facilitated and self-guided Professional Learning to all teachers and leaders from 32 pre-K programs in Sunset Park, 	<ul style="list-style-type: none"> Offer both facilitated and self-guided Professional Learning to all teachers and leaders from 32 pre-K programs in Sunset 	<ul style="list-style-type: none"> Offer both facilitated and self-guided Professional Learning to all teachers and 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	targeting 90 classrooms serving 1800 families.	Park, targeting 90 classrooms serving 1800 families.	leaders from 32 pre-K programs in Sunset Park, targeting 90 classrooms serving 1800 families.			
	<ul style="list-style-type: none"> ▪ Build ParentCorps Sunset Park ParentCorps Portal for leaders and educators of all 32 Sunset Park Pre-K sites (serving ~1,800 families) to provide ParentCorps tools (social-emotional learning and family engagement). ▪ Plan to extend the virtual community on the ParentCorps Portal from core program partner leaders to core program partner teachers in Sunset Park, Brooklyn. 	<ul style="list-style-type: none"> ▪ Provide ParentCorps tools (social-emotional learning and family engagement) to leaders and educators of all 32 Sunset Park Pre-K sites serving ~1,800 families, via the ParentCorps Portal ▪ Extend the virtual community on the ParentCorps Portal from core program partner leaders to core program partner teachers in Sunset Park, Brooklyn. 	<ul style="list-style-type: none"> ▪ Provide ParentCorps tools (social-emotional learning and family engagement) to leaders and educators of all 32 Sunset Park Pre-K sites serving ~1,800 families, via the ParentCorps Portal. ▪ Extend the virtual community on the ParentCorps Portal from core program partner leaders to core program partner teachers in Sunset Park, Brooklyn. 			

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Video Interaction Project (VIP)</p> <p>Prevention Agenda Focus Area(s): Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN) <i>Also: Focus Area 4: Cross Cutting Health Women, Infants, & Children</i></p> <p>Prevention Agenda Goal(s): Goal 3.1 Support and enhance children and adolescents’ social-emotional development and relationships <i>Also: Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations</i></p> <p>Objective: By August 2025, increase use of positive parenting activities (e.g., reading aloud, playing together) by at least 25%, resulting in long-term enhancement of child social-emotional development.</p> <p>Reach: 600 – 800 families</p>						
Delivery of VIP program	<ul style="list-style-type: none"> Provide one-on-one VIP visits to 300-400 families Complete 700-1,000 one-on-one VIP visits 	<ul style="list-style-type: none"> Provide one-on-one VIP visits to 300-400 families Complete 700-1,000 one-on-one VIP visits 	<ul style="list-style-type: none"> Provide one-on-one VIP visits to 300-400 families Complete 700-1,000 one-on-one VIP visits 	<p>Parents:</p> <ul style="list-style-type: none"> Increased positive parenting activities (reading aloud, playing together, etc.) Increased learning materials in the home (toys and book) that support positive parenting activities Enhanced capacity for coping with stressors (e.g., reduced parenting stress, reduced depressive symptoms) <p>Child:</p> <ul style="list-style-type: none"> Enhanced early child development Enhanced social-emotional development 	<p>Parents:</p> <ul style="list-style-type: none"> Increased positive parenting activities (reading aloud, playing together, etc.) Increased learning materials in the home (toys and book) that support positive parenting activities Enhanced capacity for coping with stressors (e.g., reduced parenting stress, reduced depressive symptoms) <p>Child:</p> <ul style="list-style-type: none"> Enhanced school readiness (as a result of enhanced social-emotional development) 	<ul style="list-style-type: none"> Attendance and visit documentation notes Parent surveys Research findings from previous randomized controlled trials
Linkages with other early childhood programs and organizations	<ul style="list-style-type: none"> Continue to refine linkages between VIP and other co-located or local programs (e.g., Reach Out and Read, HealthySteps, 	<ul style="list-style-type: none"> Continue to refine linkages between VIP and other co-located or local programs (e.g., Reach Out and Read, HealthySteps, 	<ul style="list-style-type: none"> Continue to refine linkages between VIP and other co-located or local programs (e.g., 	<ul style="list-style-type: none"> Strengthened impact of messaging across programs, resulting in increased reading 	<ul style="list-style-type: none"> Enhanced school readiness 	<ul style="list-style-type: none"> Documentation of refinement processes

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
	ParentChild+, VROOM, Brooklyn Public Library)	ParentChild+, VROOM, Brooklyn Public Library)	Reach Out and Read, HealthySteps, ParentChild+, VROOM, Brooklyn Public Library)	aloud and access to learning materials in the home		
<p>Program: Project SAFE</p> <p>Prevention Agenda Focus Area(s): 4. Cross Cutting Health Women, Infants, & Children</p> <p>Prevention Agenda Goal(s): 4.1 Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations</p> <p>Objective: By August 2025, 65% of Peer Educators will improve in at least two pregnancy-prevention behavior areas by the end of the program.</p> <p>Reach: Over 5,000 youth 11-24 years old</p>						
Multi-Session Workshop Series	<ul style="list-style-type: none"> Conduct 26 cycles of Making Proud Choices! (MPC) and Project AIM Curricula administered with high fidelity Reach 650 youth 75 youth referred to social and health services Expand to 1 new site 75% of workshop participants will complete 75% of workshops 	<ul style="list-style-type: none"> Conduct 28 cycles of Making Proud Choices! (MPC) and Project AIM Curricula administered with high fidelity Reach 700 youth 90 youth referred to social and health services Expand to 1 new sites 75% of workshop participants will complete 75% of workshops 	<ul style="list-style-type: none"> Conduct 30 cycles of Making Proud Choices! (MPC) and Project AIM Curricula administered with high fidelity Reach 750 youth 105 youth referred to social and health services Expand to 1 new sites 75% of workshop participants will complete 75% of workshops 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Pre/post survey Referral sheets, including documentation confirming first visit Implementation data
Single-Session Workshops	<ul style="list-style-type: none"> Peer Educators and staff facilitate 8 single-session workshops Reach 120 teen participants 	<ul style="list-style-type: none"> Peer Educators and staff facilitate 10 single-session workshops 	<ul style="list-style-type: none"> Peer Educators and staff facilitate 12 single-session workshops 	<ul style="list-style-type: none"> Single-session workshops are focused on short-term outcomes: increased 		<ul style="list-style-type: none"> Post workshop survey Implementation data

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
		<ul style="list-style-type: none"> Reach 150 teen participants 	<ul style="list-style-type: none"> Reach 180 teen participants 	<ul style="list-style-type: none"> knowledge and awareness of STD, HIV, and pregnancy prevention; increased knowledge of prevention and intervention resources 		
Peer Education Groups	<ul style="list-style-type: none"> Recruit and train 40 youth 33 youth serve as Peer Leaders Retain ≥ 70% of enrolled youth 	<ul style="list-style-type: none"> Recruit and train 56 youth 42 youth serve as Peer Leaders Retain ≥ 70% of enrolled youth 	<ul style="list-style-type: none"> Recruit and train 56 youth 42 youth serve as Peer Leaders Retain ≥ 70% of enrolled youth 	<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> Complementary Strengths Survey – baseline assessment, re-administered every six months of participation in the program Implementation data
Community Events	<ul style="list-style-type: none"> Host or perform at 5 community events Reach 200 youth 20 youth receive HIV screening at Project Reach Youth (PRY) hosted events Additional 75 tested at cohosted events 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Host or perform at 6 community events Reach 240 youth 35 youth receive HIV screening at 	<ul style="list-style-type: none"> Community events are focused on short-term outcomes: increased knowledge and awareness of STD, HIV, and pregnancy prevention; 		<ul style="list-style-type: none"> Post-event survey Screening records

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
			PRY hosted events <ul style="list-style-type: none"> Additional 100 tested at cohosted events 	increased knowledge of prevention and intervention resources		
Teen Health Clinic	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 350 youth receive screenings and other services at the Teen Health Clinic and SBHCs 700 youth receive PrEP and PEP screenings and services 	<ul style="list-style-type: none"> 350 youth receive screenings and other services at the Teen Health Clinic and SBHCs 700 youth receive PrEP and PEP screenings and services 	<ul style="list-style-type: none"> Increased number of sexually active youth using contraception to prevent unintended pregnancy Increased number of sexually active youth screened for STIs and HIV 		<ul style="list-style-type: none"> Appointment records
Staff and Parent Workshops	<ul style="list-style-type: none"> Staff facilitate 6 single-session workshops for staff and parents Reach 32 adult participants 	<ul style="list-style-type: none"> Staff facilitate 6 single-session workshops for staff and parents Reach 34 adult participants 	<ul style="list-style-type: none"> Staff facilitate 6 single-session workshops for staff and parents Reach 34 adult participants 	<ul style="list-style-type: none"> Improved communication with youth about sexual health 		<ul style="list-style-type: none"> Post workshop survey Implementation data

ACTIVITY	OUTPUTS (Number of People Participating/ Exposed, etc.)			OUTCOMES (Health and Wellness Targets)		DATA SOURCES
	Year 1	Year 2	Year 3	Intermediate	Long-Term	
<p>Program: Family Support Services Prevention Agenda Focus Area(s): Focus Area 4: Cross Cutting Healthy Women, Infants, and Children Prevention Agenda Goal(s): Goal 4.1 Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations Objective: By August 2025, 75% of families screened will have improved access to social and economic community services Reach: 500 families</p>						
<p>Implement Family Support Counselors in the pediatric practice at Hempstead Pediatric Primary Center</p> <p>Implement Reach out and Read (ROR) Program</p>	<ul style="list-style-type: none"> Recruit and train 2 new staff members Screen 500 families for social needs and ROR. Connect/refer each family to services Follow up with each family to make services were rendered Distribute 10 books per family by the child's fifth birthday Distribute 3000 books to participants in the ROR program 	<ul style="list-style-type: none"> Screen 500 families for social needs and ROR. Connect/refer each family to services Follow up with each family to make services were rendered Distribute 10 books per family by the child's fifth birthday. Distribute 3000 books to participants in the ROR program. 	<ul style="list-style-type: none"> Screen 500 families for social needs and ROR. Connect/refer each family to services Follow up with each family to make services were rendered Distribute 10 books per family by the child's fifth birthday. Distribute 3000 books to participants in the ROR program 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Improve health equity by addressing social determinants of health Nurturing young minds through reading and storytelling 	<ul style="list-style-type: none"> Attendance data Social Service Needs Screening Form Literacy Screening Form Documentation of the number of sessions
PROMOTING A HEALTHY AND SAFE ENVIRONMENT						
<p>Program: Tai Chi for Arthritis Prevention Agenda Focus Area(s): 1: Injuries, Violence and Occupational Health Prevention Agenda Goal(s): 1.1. Reduce falls among vulnerable populations Objective: By August 2025, decrease falls hospitalizations 5% for program participants aged 65 and older Reach: 250 adults</p>						
Twice-weekly classes for 8 weeks with	<ul style="list-style-type: none"> Recruit and train 2 new staff members 	<ul style="list-style-type: none"> Conduct pre and post balance assessments for 84 adults. 	<ul style="list-style-type: none"> Conduct pre and post balance 	<ul style="list-style-type: none"> Educate participants on proper body mechanics 	<ul style="list-style-type: none"> Adults will enhance their balance both mentally and physically 	<ul style="list-style-type: none"> Attendance data Participant information Form

adults and Tai Chi instructor	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Retain 80% of registered adults for each class Distribute 84 Tai-Chi educational materials to each participant 	<ul style="list-style-type: none"> assessments for 82 adults. Retain 80% of registered adults for each class Distribute 82 Tai-Chi educational materials to each participant 	<ul style="list-style-type: none"> Reducing falls among the adult population Improve the health of adults without exacerbating existing impairments 	<ul style="list-style-type: none"> Improving muscle strength, flexibility, confidence and endurance via weight transference 	<ul style="list-style-type: none"> Pre/Post Balance Assessments Participant Post Program Survey 1- and 3-month post survey Documentation of the number of sessions
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Program: A Matter of Balance

Prevention Agenda Focus Area(s): Focus Area 1: Injuries, Violence and Occupational Health

Prevention Agenda Goal(s): Goal 1.1 Reduce falls among vulnerable populations

Objective: By August 2025, 80% of program participants will have increased activity levels and reduced fear of falling

Reach: 200 adults

Once a week two-hour class for 8 weeks with adults and a trained coach	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Distribute 67 PAR-Q and Participant Agreements Retain 80% of registered adults for each class Distribute 67 A Matter of Balance Participant Workbooks 	<ul style="list-style-type: none"> Distribute 66 PAR-Q and Participant Agreements Retain 80% of registered adults for each class Distribute 66 A Matter of Balance Participant Workbooks 	<ul style="list-style-type: none"> Increased knowledge on how to reduce fall risk at home Increased activity/exercise levels Reducing falls among the adult population 	<ul style="list-style-type: none"> Participants will view falls and fear of falling as controllable Participants will reduce fall risk hazards in the home and community 	<ul style="list-style-type: none"> Attendance data Participant information Form Participant Agreement Form Participant Post Program Survey 1- and 3-month post survey Documentation of the number of sessions
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