NYU Hospitals Center

Community Health Needs Assessment
and
Community Service Plan
2017-2019

Adopted June 2016

Copies of this document can be downloaded from the NYU Langone Medical Center website at: http://www.nyulangone.org/our-story/community-health-needs-assessment-service-plan and http://www.lutheranhealthcare.org/Main/CommunityServicePlan.aspx.

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Overview:

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

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

Through its Community Service Plan, NYUHC brings to bear a wide range of expertise: in obesity prevention, health literacy, parenting, family and community engagement, smoking cessation, prevention science, and population health. The programs and priorities remain consistent with both NYUHC's and the former Lutheran Medical Center's prior years' Community Service Plans, but under the 2017-2019 Plan, existing programs have been extended and new ones added, and its geographic scope now spans the Lower East Side/Chinatown and Sunset Park. Although these communities are not geographically contiguous, they share important similarities, including the diversity of their populations (large Chinese American and Hispanic communities) and pockets of poverty amidst gentrification. The 2017-2019 Community Service Plan is designed to create inter-disciplinary and inter-institutional synergies across programs, and to build on the strength of our community partnerships.

NYU Hospitals Center ("NYUHC" or the "Hospitals Center") is a tertiary care teaching hospital with campuses located in Manhattan and Brooklyn and is the principal teaching hospital of New York University School of Medicine ("NYUSM"). Following the January 1, 2016 merger of NYU Lutheran Medical Center into NYUHC, NYUHC's operations now include three inpatient facilities and over thirty off-campus hospital extension clinics in Manhattan and Brooklyn. In addition, the Sunset Park Health Council, Inc., a federally qualified health center network, is an NYUHC affiliate, operating nine primary care sites in Brooklyn and over forty school- and shelter-based extension clinics under the name of NYU Lutheran Family Health Centers.

NYUHC and NYUSM operate as an integrated academic medical center known as NYU Langone Medical Center.

The programs span multiple sectors:

Community-based early childhood education settings and schools

- ParentCorps, an evidence-based family-centered early childhood intervention to improve child health, behavior and learning, is being implemented in collaboration with University Settlement Society of New York and with the Earth School, a public elementary school in Manhattan Community District 3 (CD 3), and will expand to other public schools, including a school in the NYU Lutheran service area. State Prevention Agenda Priority: *Prevent Chronic Diseases*; *Promote Healthy Women, Infants and Children*

Primary care

- Healthy Families Program/Programa de Familias Saludables, an intervention to address obesity for pre-adolescent children using a shared medical appointment model with one-on-one medical evaluation and group education and activities for the entire family, will be expanded and implemented in four NYU Lutheran Family Health Centers sites. State Prevention Agenda Priority: *Prevent Chronic Diseases*

- Greenlight, a program to improve health literacy and foster healthful behavior, is being adapted and implemented in partnership with the Charles B. Wang Community Health Center to lower rates of childhood obesity in the Chinese American community and will be extended to the NYU Lutheran Family Health Centers Brooklyn-Chinese site in Sunset Park. State Prevention Agenda Priority: *Prevent Chronic Disease*s

- Two Generations, a new program that seeks to reduce the negative health impact of perinatal depression and adverse childhood events on maternal and child physical and mental health, is being piloted in CD 3 in partnership with Gouverneur Health and in Sunset Park with NYU Lutheran Family Health Centers. State Prevention Agenda Priority: *Promote Healthy Women, Infants and Children*

Housing

- The Health+Housing Project, a Community Health Worker program to address social, environmental, behavioral, and structural determinants of health, is being implemented initially in two low-income buildings in CD 3 in partnership with Henry Street Settlement, the NYU Furman Center for Real Estate and Urban Policy, the New York City Housing Authority, the NYC Department of Housing Preservation and Development, Hester Street Collaborative, the Chinatown YMCA, the Two Bridges Neighborhood Council, and with additional support from the Robin Hood Foundation. State Prevention Agenda Priority: *Prevent Chronic Diseases*

Community

- Tobacco Free Community, a community navigator program to facilitate access to smoking cessation treatment and reduce children's exposure to secondhand smoke, is being adapted and implemented in CD 3 in partnership with Asian Americans for Equality and will expand to serve residents of Sunset Park. State Prevention Agenda Priority: *Prevent Chronic Diseases*

- Project SAFE, a peer education program employing an evidence-based youth development approach to prevent teen pregnancy and HIV/AIDS, is being expanded in Sunset Park and other Brooklyn communities. State Prevention Agenda Priority: *Promote Healthy Women, Infants and Children*

- REACH FAR, a program designed to prevent cardiovascular disease by increasing access to healthy foods and providing culturally tailored health coaching, is being launched initially in two mosques in CD 3 and then will be expanded to two mosques in Sunset Park. State Prevention Agenda Priority: *Prevent Chronic Diseases*

Community Health Needs Assessment

I. Hospitals Center's Mission Statement

NYU Langone Medical Center, a world-class, patient-centered, integrated academic medical center, is one of the nation's premier centers for excellence in clinical care, biomedical research, and medical education. Located in the City of New York, NYU Langone is composed of five hospitals - **Tisch Hospital**, *its flagship acute care inpatient facility*; **Rusk Institute for Rehabilitation Medicine**, *the world's first university-affiliated facility devoted entirely to patient rehabilitation*; the **Hospital for Joint Diseases**, *an inpatient hospital dedicated to orthopaedics and rheumatology*; **NYU Lutheran Medical Center**, *a full-service, 450-bed teaching and community hospital located in Brooklyn;* and **Hassenfeld Children's Hospital**, *a comprehensive pediatric hospital supporting a full array of children's health services across the Medical Center*. These hospitals operate as a singled licensed hospital facility: NYU Hospitals Center. An integral component of NYU Langone is the **NYU School of Medicine**, which since 1841 has trained thousands of physicians and scientists who have helped to shape the course of medical history, and the **Laura and Isaac Perlmutter Cancer Center**, a National Cancer Institute - designated cancer center. The Medical Center's trifold mission to serve, teach, and discover is achieved 365 days a year through the seamless integration of a culture devoted to excellence in patient care, education, and research. For information about the NYUHC financial assistance program go to: http://nyulangone.org/files/financial-assistance-summary-6-2016.pdf and http://www.lutheranhealthcare.org/Main/LutheranMedicalCentersFinancialAssistancePolicy.aspx

With the recent merger of NYU Langone and NYU Lutheran, the expanded healthcare delivery system will provide better care to more New Yorkers in more locations than ever before.

NYU Lutheran's Mission:
NYU Lutheran exists to serve its neighbors. Lutheran serves a rich diversity of people through an entire continuum of community-based health and education services. NYU Lutheran is dedicated to caring for whole persons throughout whole communities. As a stabilizing foundation for these communities, Lutheran is committed to meeting our neighbors' changing physical, emotional, spiritual, intellectual and social needs.

Through impact-oriented research and front-line partnerships, the Department of Population Health at NYU Langone Medical Center is bridging the worlds of medical care and public health to improve peoples' lives and the health of populations in New York City and around the globe. As part of carrying out this mission, the Department helped shape NYUHC's 2013-2016 Community Health Needs Assessment (CHNA) and has overseen the implementation of the Community Service Plan (CSP). NYU Lutheran's 2013-2016 Community Health Needs Assessment was conducted by **NYU Lutheran Family Health Centers** (NYU LFHC). With roots stretching back to 1967, NYU LFHC remains dedicated to its core principle: the innovative delivery of quality, culturally competent health care and human services to underserved people in diverse Brooklyn communities. Now, joined together, we have undertaken the 2017-2019 Community Health Needs Assessment and developed the Community Service Plan. The new CSP is 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.

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

II. Definition and Brief Description of Communities Served

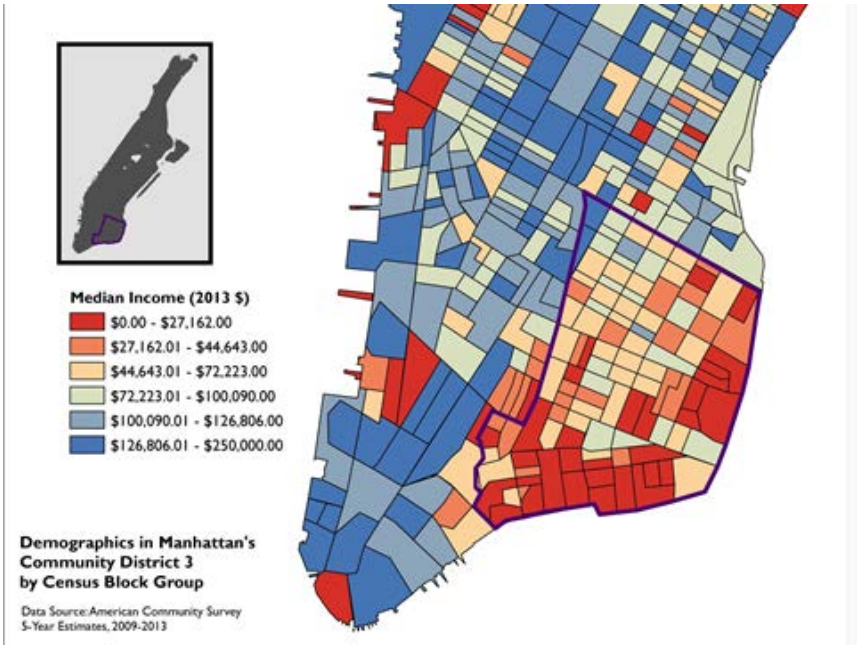
As a major academic medical center, NYUHC serves a broad community of diverse populations with a wide range of health care needs. Its primary service area includes 45 zip codes in Manhattan, Brooklyn and Queens; its secondary service area extends into Staten Island, Long Island, Westchester, and New Jersey. NYUHC's 2015 discharge data depicts a broad geographic area from which the hospitals draw patients.

To understand the needs of our primary service areas, we reviewed all of the Community Health Profiles for New York City provided by the NYC Department of Health and Mental Hygiene, as well as other health and demographic data (see Appendix A). Based on that review, the 2017-2019 Community Service Plan focuses on the communities served through NYU Langone and NYU Lutheran's previous Plans: the Lower East Side and Chinatown in Manhattan, and Sunset Park in Brooklyn. In addition, in Year 1 of the Plan we will assess health priorities and needs in Red Hook, Brooklyn – an under-resourced and medically underserved community. These communities were selected based on the need for service as evidenced by social determinants, health disparities, risk factors, and utilization data.

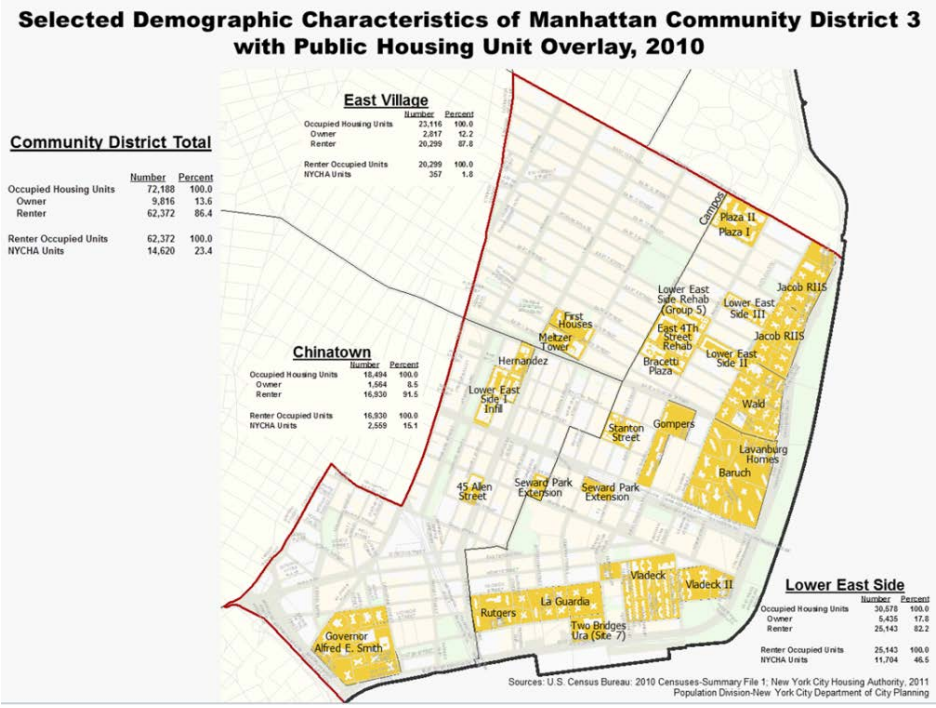
The Lower East Side and Chinatown

To increase our impact and create opportunities for synergy across programs, starting with the 2013-2016 CHNA, NYUHC focused on the closest area of greatest need: the Lower East Side and Chinatown (Manhattan CD 3), a community with concentrated pockets of poverty and a high percentage of Latinos and Asians – groups that experience disparities in many health outcomes.

Secondary data analysis:
Although lower Manhattan as a whole has relatively low (18%) poverty rates, 28% of residents in the Lower East Side/Chinatown live below the Federal Poverty Level. Forty-seven percent of the residents of the Lower East Side/Chinatown receive income support. Within CD 3, there are areas of

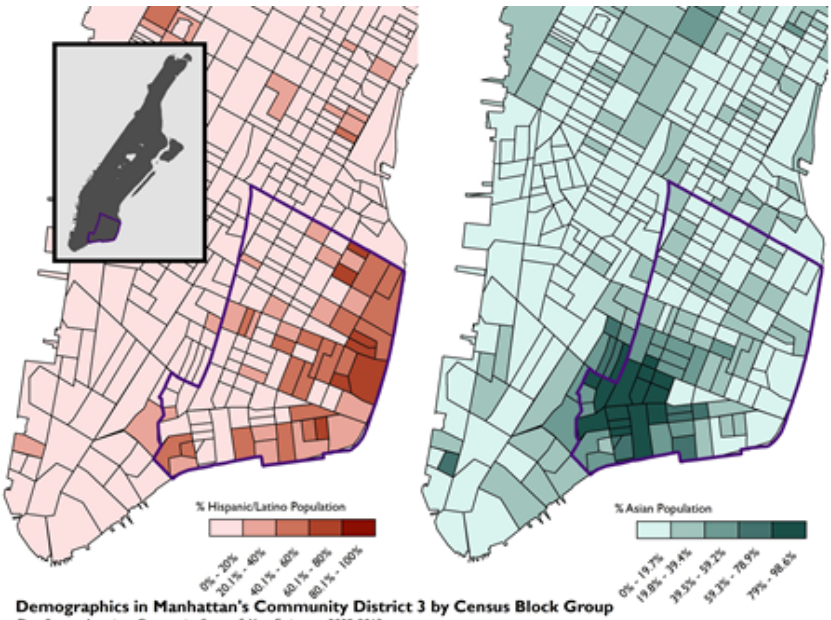


concentrated poverty and disparities in income are stark, with 29% of residents making less than $19,000 annually, and approximately 18% having incomes of $110,000 or more.
Nearly 27% of all public housing units in Manhattan are located in Community District 3 (about 8% of the total for NYC), yet the community continues to gentrify, making it increasingly unaffordable to low-income residents.



A historic stop for immigrants in the 19th and early 20th centuries, immigrants still comprise 36% of CD 3's population. Of the 163,000 residents in Manhattan CD 3, 33% are Asian and 25% are Latino. Census tracts in which Latinos and Asians live are more likely to be poor and to have residents with limited English proficiency.

Overall, 37% of the population in CD 3 have limited English proficiency. Among the Chinese language speakers, 77% speak English "less than very well" compared with 60% for Chinese language speakers in Manhattan as a whole. In its most recent Need Statement, the Community Board has highlighted this issue, particularly for seniors (who comprise almost 15% of the population).



To understand more about community need and to help policymakers, providers and community groups access data, target resources, tailor interventions and evaluate impact, with additional support from the NY Community Trust, we are developing an *iAtlas* – a sector bridging map that will use a wide array of secondary data to illuminate variations in health determinants and health outcomes, starting in Manhattan CD 3 and then expanding to Sunset Park and eventually developing into a citywide resource. A list of data sources accessed is set forth in Appendix A.

Primary data collection and analysis:
In conjunction with our development of the *iAtlas*, we held three focus groups with a total of 20 community leaders. Participants noted that because of the diversity of CD 3, Community District level data mask large pockets of vulnerability associated with poverty and with racial and ethnic disparities in health. The focus group participants identified a wide range of health concerns including smoking; mental health and addiction; and access to healthy, affordable food. More broadly, there was a strong consensus in all three groups that health was affected by the stress of poverty; the challenges of finding stable, affordable and well-maintained housing; language barriers; and issues with the built environment (food access, places for physical activity, traffic safety). Seniors, immigrants, people with mental illness and low-income children were identified as particularly vulnerable populations.

As part of our Health+Housing Project, a Community Health Worker program described below, we held community workshops in two low-income buildings on the Lower East Side. Simultaneous Spanish and Cantonese translation was provided for the 45 adult residents who attended. Participants were asked about factors that affect people's health and then to map health determinants in the neighborhood. Issues identified include: social isolation for non-English speakers; prevention and management of obesity and cardiovascular disease,

including education about and access to healthy, affordable food; management of dementia and access to mental health services; exposure to second hand smoke; asthma; traffic safety; and pest control (inside and outside of buildings).

As part of that needs assessment, we also surveyed the adult residents of those buildings. Our findings from the survey are summarized in the description of the Health+Housing Project below.

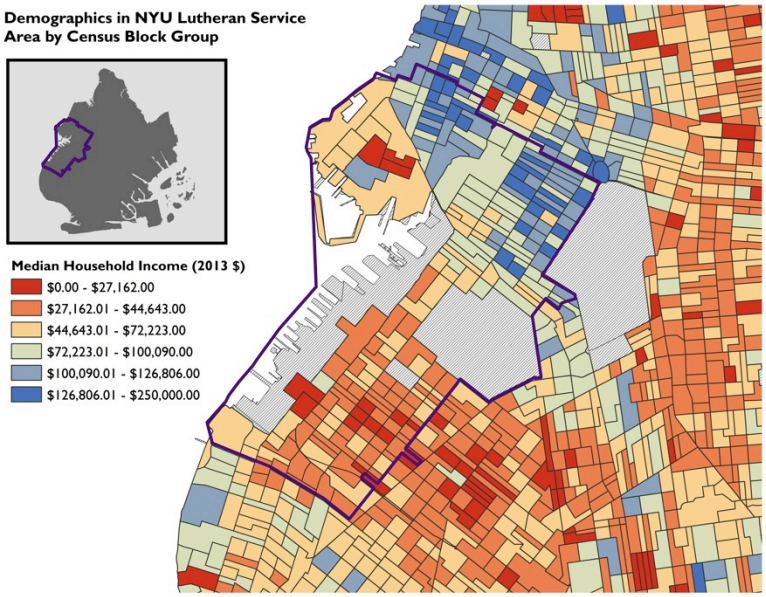
Sunset Park

NYU Lutheran initiated the development of its Community Service Plan by reviewing existing federal, State, City, and hospital data and comparing neighborhoods that comprise the NYU Lutheran Medical Center primary service area: the four contiguous neighborhoods of Sunset Park, Bay Ridge, Borough Park, and Bensonhurst. Based on our assessment of the social determinants of health and other risk factors, health disparities, and data on health care utilization, we have focused our efforts on Sunset Park, including Northern Bay Ridge (zip codes 11220 and 11232).

Secondary data analysis:
Sunset Park is defined as zip codes 11220 and 11232 and is located in the geographic boundaries of Brooklyn Community District 7 in Southwest Brooklyn, New York. A mixed residential, industrial, and commercial area located on Brooklyn's waterfront, its population is 151,077 people. More than one-quarter of its residents (26%) are under the age of 20.

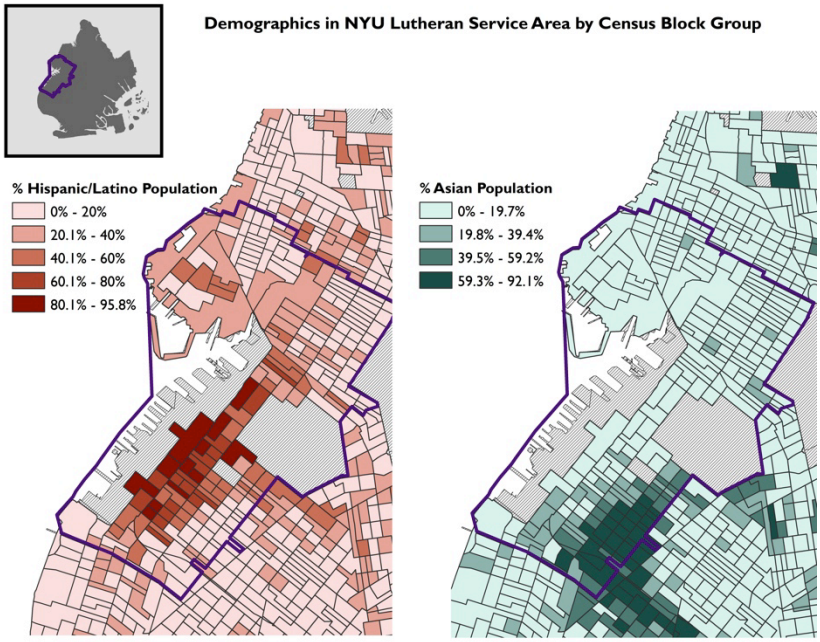
For nearly 200 years, Sunset Park has served as a first destination for immigrants – today, 48% of residents are foreign born. Two crowded and vibrant commercial corridors of shops, restaurants, and small businesses serve the large Latino (42%) and Asian (32%) communities. With a network of community- and faith-based organizations and local industries that provide entry level service and factory jobs, the neighborhood has supported and provided a foothold for many new immigrants.

Like Manhattan's CD 3, Sunset Park is a community that grapples with high levels of poverty, low educational attainment, and health disparities. Twenty-nine percent of residents live below the Federal Poverty level compared to 21% of families in New York City as a whole. Poverty is particularly acute among families with children – 33% of families with children under 18 live below the poverty level. The median household income is $42,630. Levels of educational attainment fall below Brooklyn and New York City as a whole. Forty-one percent of residents lack a high school credential from the U.S. or their home country – 24% have less than a 9th grade education.



English language proficiency is a major barrier for Sunset Park residents: 75% of residents speak a primary language other than English at home. Forty-eight percent of residents have limited English proficiency.

In addition, Sunset Park has the second oldest housing stock in New York City and residents often have no choice but to rent units in poor condition. One-third of residents live in severely rent-burdened households. Sunset Park ranks 3rd in the City for severe overcrowding (9%).



Primary data collection and analysis:
For the 2013-2016 Community Service Plan, NYU Lutheran undertook a comprehensive community engagement effort to ensure that the needs assessment included authentic community voice. This framework informed the planning and development of the current CSP. In addition, in the fall of 2014, the New York Academy of Medicine conducted a Brooklyn-wide community needs assessment (CNA) on behalf of NYU Lutheran and other hospital systems as part of New York

State's Medicaid Delivery System Reform Incentive Payment (DSRIP) program. The data collected through that process have helped inform the Community Health Needs Assessment and the 2017-2019 Community Service Plan. The CNA included a survey, interviews, and focus groups, reaching a wide range of residents and community leaders. Participants were recruited through community-based partners, as well as canvassing in targeted neighborhoods. The survey questions focused on individual and community-wide health concerns, health care utilization, barriers to care, and use of community and other services. Thirty-five community and issue area experts were interviewed and 24 focus groups were conducted.

Given the high percentage of Sunset Park residents who are Latino or Chinese American, the CNA took a deeper look at health status, behaviors, and knowledge and barriers to care within those communities. Latino residents, like many other populations across the City, reported concerns about the prevalence of obesity (including among children), diabetes, and depression. Residents reported concerted efforts to eat a healthy diet and to engage in physical activity—for themselves and for their children. However, lack of time, budget constraints, as well as ingrained habits, serve as barriers to healthy choices. Lack of insurance was more common in the Latino community than among other groups, and resulted in high out-of-pocket costs, lower use of primary care and preventive services, and use of emergency care for non-urgent problems.

The CNA found that smoking is a major concern, with higher rates in the Chinese American community, resulting in high rates of asthma, lung cancer, and other respiratory problems. Cultural beliefs – including stigma and preference for traditional Chinese medicine – and lack of knowledge about preventive services and access to health information affected utilization of health care services within the Chinese American community, particularly among older adults and recent immigrants.

Prior needs assessments have consistently identified access to affordable, quality early childcare as an ongoing need for the Sunset Park community. In response, in 2013, NYU Lutheran established the Parent-Child Home Program, an evidence-based early literacy program for isolated and high-risk families. For the current CHNA, we collaborated with an NYU Wagner Graduate School of Public Service Capstone Team to conduct an in-depth needs assessment, which included a research review; a parent survey in English, Spanish, and Chinese administered at two Sunset Park locations; and six expert interviews. The assessment highlighted potential partnerships that would facilitate the expansion of early childhood services.

To assure that the views of community youth were reflected in the Community Service Plan, teen peer educators in collaboration with youth service staff, developed a Teen Sexual Healthcare Access Survey, which was administered though street outreach to 275 youth ages 13-19 to learn more about perceived barriers to accessing sexual health services. The survey asked respondents about their personal access to sexual health services and their thoughts on

what makes a teen health clinic appealing and accessible to young people. Data from the surveys indicated a need for effective outreach: 60% of respondents could not identify a sexual health clinic in their neighborhood that they felt safe visiting, and 49% had never visited a clinic for sexual health services.

A list of data sources accessed is set forth in Appendix A.

Red Hook

In Year 1 of the 2017-2019 Community Service Plan, we will conduct a Community Health Needs Assessment and collaboratively develop a plan to prioritize and address pressing health concerns and issues in Red Hook, Brooklyn. This assessment is particularly important because readily available data for Red Hook – such as the NYC Department of Health and Mental Hygiene Community District Profile – includes more affluent neighboring communities, thereby masking pockets of poverty and need. We anticipate presenting a community overview in the 2017 CSP progress report.

III. Public Participation

Public participation in assessing community need and setting priorities has been a continuous process over the past three years. We have engaged a range of stakeholders – with a particular focus on medically underserved residents – to assess community needs; set priorities; develop, design, and implement programs; and share and celebrate progress and results. We employ diverse, often multi-pronged, strategies and rely on our extensive network of community partners and advisory boards and committees to provide ongoing outreach and program development. NYU Lutheran's 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 NYUHC CSP Coordinating Council, described below, meets quarterly with a large group community organizations, local leaders, policymakers, and partners.

In addition, over the past year, we have consulted on multiple occasions with numerous public health experts in the City and State Health Departments, the City and State Office of Mental Health, the City Department of Education, and other agencies and organizations with expertise on the needs of low-income populations and children, including community leaders, resident associations, community-based organizations, advocacy groups, and members of Community Boards. A list of people and organizations consulted is attached as Appendix B.

We have solicited written comments from the public on our previous CHNA and implementation plans both through our website and at public meetings. Although no written comments were received, comments and discussion followed public presentations at community meetings. Public notification about the assessment and plan development and implementation was provided through meetings with the *Human Services, Health, Disability, & Seniors/Youth & Education Committee* of Manhattan Community Board 3 and with the *Health, Seniors & Disabilities Subcommittee* of Manhattan Community Board 6, which covers the area in which Tisch Hospital, the Rusk Institute of Rehabilitation Medicine, and the Hospital for Joint Diseases are located. NYU Lutheran obtained input and notified the public through the advisory structure

described above, as well as through Brooklyn Community Board 7 and our extensive network of community partners.

Through these meetings and interviews, as well as through an extensive review of secondary sources of data (see Appendix A), we have compiled and updated our profile of the health needs and strengths of the Lower East Side/Chinatown and Sunset Park. This analysis has, in turn, informed the priorities and partnerships that comprise our Community Service Plan.

IV. Assessment and Selection of Public Health Priorities

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

As described below, these are key concerns in our communities and the evidence-based programs we are adapting and implementing to address these issues allow us to bring to bear the substantial scientific and clinical expertise of NYUHC and NYU LFHC in obesity prevention, health literacy, parenting, family engagement, smoking cessation, prevention science, implementation science, community-based participatory research, and population health.

A. Priority Area: Preventing Chronic Disease

→ Preventing and addressing obesity

Although recent New York City FitnessGram data (provided by the NYC Department of Education and used with permission from NYU's Institute for Education and Social Policy) show an encouraging decrease in the prevalence of obesity among elementary school children in NYC, obesity continues to be epidemic: more than half of adult New Yorkers are overweight (34%) or obese (22%). Obesity begins early in life. Two out of every five NYC elementary school children are overweight or obese, putting these children at immediate risk for hypertension, elevated lipid levels and diabetes – referred to as "adult onset" prior to the obesity epidemic. These risks escalate as obese children become adults, when they also become at risk for heart disease, stroke, arthritis, and cancer.

Disadvantaged urban communities are disproportionately affected by obesity, in part due to lack of neighborhood resources, such as the availability of healthy food and safe places for physical activity. In New York City, as in the rest of the country, there are clear income and racial disparities with regard to obesity. The lowest-income New Yorkers have a rate of obesity 45% higher than that of the highest earners. Adult Latino and African American New Yorkers are more than 1.5 times more likely to be obese than Whites. Latino residents of Brooklyn have the highest rate of obesity in the borough (36.3%). Obesity rates among NYC's children also vary dramatically. For example, as of 2013, the obesity rate among Latino children in the City's public schools is 71% higher than that of White children. An estimated 19% of Sunset Park children between the ages of 5 and 14 are obese. In 2014, NYU Lutheran Family Health Centers Women and Children Health Center served 935 children aged 10-11 years with a BMI $\geq 95^{th}$ percentile, 190 (20%) of whom were Hispanic.

Although the rates of overweight and obesity are lower among most Asian American groups, given emerging evidence that Asian populations are more vulnerable to insulin resistance at lower weights, preventing obesity is a high priority. A study by researchers at the Charles B. Wang Community Health Center found that 24.6% of the children in the pediatric practice (drawn largely from the Chinatown area) were overweight or obese. Among U.S. born boys ages 6-12, the combined prevalence of overweight and obesity was 40%.

Although the prevalence of obesity in CD 3 (14%) and Sunset Park (19%) is lower than the City overall (25%), low-income children in both communities remain vulnerable, and preventing obesity is a concern among community residents and leaders. Obesity and the need for physical activity were ranked among the top five health priorities by participants in the Chinatown Community Consultation held in December 2015 by the NYC Department of Health and Mental Hygiene (DOHMH). Similarly, Sunset Park residents ranked obesity and the consumption of sugary drinks among the top five concerns in the Sunset Park DOHMH Community Consultation in December 2015. Sunset Park residents report among the lowest levels of physical activity in New York City (81.2% of adults report not engaging in any sports or recreational activities that raised their breathing rate in the past 7 days, and 33% report not getting any physical activity other than what is required for work in the past 30 days).

NYC DOHMH Take Care New York 2020 Community Meetings Top Five Health Concerns

LOWER EAST SIDE/ CHINATOWN	SUNSET PARK
Obesity	Obesity
Smoking	Smoking
Physical Activity	Sugary Drinks
High Blood Pressure	High School Graduation
Air Quality	Unmet Medical Need

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

The pre-teen years are also a critical moment for stabilizing and reducing obese children's weight and Body Mass Index (BMI) scores. This period marks a time when children are beginning to develop better abstract reasoning ability, are better able to consider the consequences of their actions, have more control over what they eat and how they spend their time, and begin making their own decisions. Overweight adolescents with metabolic syndrome have a sevenfold greater risk for developing diabetes and twice the risk for developing

cardiovascular disease. The cluster of metabolic syndrome risk factors is generally silent and remains undetected until medical testing or presentation of overt disease. Adolescents are low users of preventive health care services and are unlikely to come to medical attention until symptomatic, by which time their health problems are more difficult to reverse. Multidisciplinary programs that include nutrition education, behavior modification, and promotion of physical activity have been shown to be the most effective in addressing the needs of children who are already struggling with overweight or obesity.

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

→ Reducing tobacco use

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

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

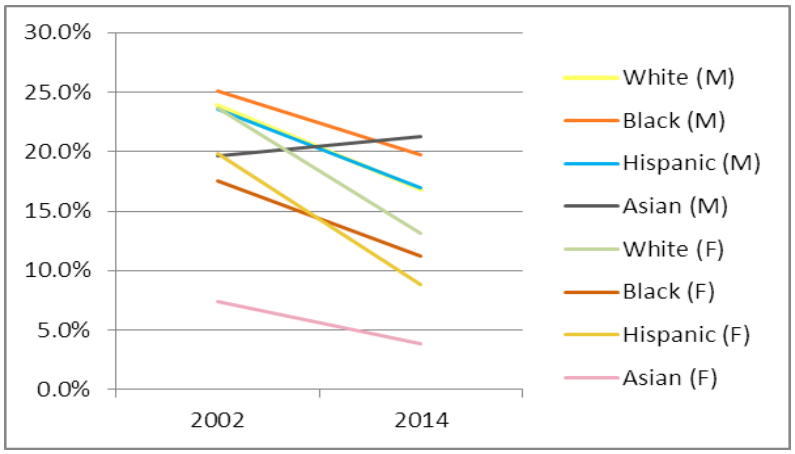
In New York State, 25,500 people die each year from a smoking-related disease and 3,040 non-smokers die each year from exposure to others' smoking. Annual smoking-related health care costs and lost productivity in New York total $14.2 billion and the annual health care expenditure in the State directly caused by tobacco use amounts to $8.17 billion. The economic burden extends to smokers, who are now paying over $11 per pack. Given that the smoking prevalence is highest among those with the lowest incomes, there is an even more compelling reason to implement strategies to ensure that smoking cessation resources reach this population.

In response to the heavy toll of tobacco use, New York State and New York City have implemented aggressive tobacco control agendas. Included in this comprehensive package of policies and programs are efforts to increase access to evidence-based treatment for smokers and an emphasis on developing strategies to reduce the toll of secondhand smoke exposure, particularly among children. A recent study underscores the urgent need to address smoking in housing in New York City. Even among children who did not live with someone who smoked in the home, cotinine levels (a measure of exposure to secondhand smoke) of children living in

apartments were 45% higher than among those living in detached houses. Living in multi-unit housing is placing many children at risk of secondhand smoke related health consequences.

New York City has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 13.9% in 2014. But the rates of reduction across populations have been uneven and income-related and racial and ethnic disparities persist. Despite the high cost of cigarettes, the smoking prevalence among low-income New Yorkers is 16%. Of particular concern is the smoking rate among Asian men in NYC (21.3%), which, by contrast with other populations, is higher now than it was in 2002. Asian smokers are more likely to be heavy smokers than other racial and ethnic groups. Asian men have the highest rates of heavy daily smoking in New York City (6.6% compared to 2.7% overall).

Smoking rates – NYC, 2002 - 2014



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

Not surprisingly, although the data vary from year-to-year, overall, the rates of smoking in the Lower East Side/ Chinatown and Sunset Park, communities with large and relatively poor Asian populations, remain higher than in much of the rest of the City. In addition, Asian American non-smokers are less likely to prohibit smoking in the home than are other non-smokers. Thus, the rates of exposure to secondhand smoke among many families and children living in these communities are likely to be dangerously high.

At recent Community Consultations sponsored by the NYC Department of Health and Mental Hygiene, smoking ranked among the top five health concerns among community residents in both the Lower East Side/Chinatown and Sunset Park.

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

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

The New York State *Prevention Agenda 2013-2018* notes that "[t]he health and well-being of mothers and children are fundamental to overall population health. … Of great concern, New York's key population indicators of maternal and child health have been stagnant or worsened during the last decade. Even for measures with improving trends, there are striking racial, ethnic and economic disparities." Similarly, the NYC DOHMH *Take Care New York 2020* highlights the need to reduce rates of teen pregnancy, noting the higher rate among low-income

populations. Sunset Park has the twelfth highest birth rate among the 59 community districts in the City, with 33.2 births per 1000 girls ages 15-19 – over 40% higher than the City as a whole.

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

Maternal stressors during the prenatal period increase the risk of pre- and postnatal depression, the likelihood of pregnancy complications and adverse birth outcomes, and decreased responsiveness in the newborn, lower initiation of breastfeeding, over feeding, and increased emergency department visits. Fetal exposure to maternal stress in pregnancy negatively affects a child's neuro-development and increases the likelihood of poor health outcomes, such as delays in communication, social-emotional competence, cognitive functioning, behavioral problems, and chronic conditions. These adverse early influences in turn set the stage for subsequent impaired scholastic achievement, conduct disorder, criminal justice system involvement, and a trajectory of disadvantage.

In both Lower East Side/Chinatown and Sunset Park, the impact on families of the stress of poverty and poor quality or unstable housing – particularly amidst gentrification – is of grave concern in the community. Community residents and members of the Community Boards have highlighted the need to prevent and address mental health issues early.

C. Community needs not addressed and why

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

Selecting priority areas for NYUHC's Community Service Plan and using resources efficiently and effectively necessarily means concentrating on some specific challenges and affording less attention to others. For example, in meetings with members of Manhattan Community Board 3 and in the Community Board's *District Needs Statement 2017*, the need for senior services, programs to prevent heavy and binge drinking, services for the growing LGBTQ population, and for culturally and linguistically competent mental health services, were all identified as pressing concerns. Similarly, in Sunset Park, asthma prevention and management, and adult weight management interventions have been identified as important needs and priorities. While some of these needs are being met by other NYUHC and NYU LFHC programs, others are being addressed by the many valuable community organizations and health care providers in the community.

Over the duration of the CSP, we will coordinate our efforts with community organizations so that we continue to have a comprehensive and up-to-date understanding of community needs

and resources so that we can maximize our collective impact to improve the community's health.

D. Information gaps that limit NYUHC's ability to assess the community's health needs

As noted above, although the New York City DOHMH provides a wide array of data about the health of the City and its neighborhoods, the diversity of the Lower East Side/Chinatown and Sunset Park – economically and in terms of race and ethnicity – necessitates a more granular, on-the-ground approach to understanding community needs and assets. Our engagement with community partners and meetings with community residents and organizations have greatly enhanced our understanding of the community's needs and priorities. As described below, this process will continue throughout the next three years of the Community Service Plan.

In addition, our *iAtlas*, which will use secondary data to illuminate variations in health determinants and health outcomes, will help fill some of the gaps in our understanding of health status and need in these neighborhoods.

E. Existing facilities and resources

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

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

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

Community Health Needs Assessment and we will continue this outreach over the course of the Plan.

NYU Lutheran has a long history of strong collaborative relationships with community partners to create integrated service delivery systems that empower individuals and families and provide them with the skills they need to improve their health and effect change within the community. Many of these organizations, like NYU Lutheran, developed from faith-based organizations. The Center for Family Life and Good Shepherd Services are multi-service, child-welfare organizations with deep roots in southwest Brooklyn. Turning Point was established as a faith-based outreach ministry focused on substance abuse and now has evolved into a comprehensive multi-service organization focused on special populations, including youth and homeless New Yorkers. Southwest Brooklyn Industrial Development Corporation works in partnership with the local Community Board to drive the economic empowerment of Sunset Park's waterfront industry. Workforce development providers such as Opportunities for a Better Tomorrow and Brooklyn Workforce Innovations focus on building the work readiness and skills of local residents.

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

Community Service Plan/Implementation Strategy

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

New York State and City public health priorities:

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

Addressing health disparities:

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

The programs and priorities of the 2017-2019 CSP remain consistent with both NYUHC's and the former Lutheran Medical Center's prior years' Community Service Plans, but existing programs have been expanded and new ones added, and the geographic scope of the programs has been

expanded. Although the Lower East Side/Chinatown and Sunset Park are not geographically contiguous, they share important similarities, including the diversity of their populations (large Chinese American and Hispanic communities) and pockets of poverty amidst gentrification. Spanning both neighborhoods, the 2017-2019 Community Service Plan is designed to create inter-disciplinary and inter-institutional synergies, and to build on the strength of our community partnerships.

Although the programs described below target specific risk factors that that align with City and State Health Department priorities, we also recognize the importance of understanding and addressing context: in the words of the State Prevention Agenda, "the impact of social, economic, environmental, biological, behavioral and psychological factors on individuals and families throughout their lives." For this reason, all of the Community Service Plan programs take a holistic approach. For example, our programs that address obesity do so in the context of child and family mental health and self-efficacy; our housing-based health initiative connects residents to a wide range of social, medical and mental health services; our smoking cessation program reaches smokers and their families by providing other community-based services; and our pregnancy prevention program focuses on educating and empowering teens.

The programs span multiple sectors:

Community-based early childhood education settings and schools

- ParentCorps, an evidence-based family-centered early childhood intervention to improve child health, behavior and learning, is being implemented in collaboration with University Settlement Society of New York and with the Earth School, a public elementary school in Manhattan Community District 3 (CD 3), and will expand to other public schools, including a school in the NYU Lutheran service area. State Prevention Agenda Priority: *Prevent Chronic Diseases; Promote Healthy Women, Infants and Children*

Primary care

- Healthy Families Program/Programa de Familias Saludables, an intervention to address obesity for pre-adolescent children using a shared medical appointment model with one-on-one medical evaluation and group education and activities for the entire family, will be expanded and implemented in four NYU Lutheran Family Health Centers sites. State Prevention Agenda Priority: *Prevent Chronic Diseases*

- Greenlight, a program to improve health literacy and foster healthful behavior, is being adapted and implemented in partnership with the Charles B. Wang Community Health Center to lower rates of childhood obesity in the Chinese American community and will be

extended to the NYU Lutheran Family Health Centers Brooklyn-Chinese site in Sunset Park. State Prevention Agenda Priority: *Prevent Chronic Disease*s

- Two Generations, a new program that seeks to reduce the negative health impact of perinatal depression and adverse childhood events on maternal and child physical and mental health, is being piloted in CD 3 in partnership with Gouverneur Health and in Sunset Park with NYU Lutheran Family Health Centers. State Prevention Agenda Priority: *Promote Healthy Women, Infants and Children*

Housing

- The Health+Housing Project, a Community Health Worker program to address social, environmental, behavioral, and structural determinants of health, is being implemented initially in two low-income buildings in CD 3 in partnership with Henry Street Settlement, the NYU Furman Center for Real Estate and Urban Policy, the New York City Housing Authority, the NYC Department of Housing Preservation and Development, Hester Street Collaborative, the Chinatown YMCA, the Two Bridges Neighborhood Council, and with additional support from the Robin Hood Foundation. State Prevention Agenda Priority: *Prevent Chronic Diseases*

Community

- Tobacco Free Community, a community navigator program to facilitate access to smoking cessation treatment and reduce children's exposure to secondhand smoke, is being adapted and implemented in CD 3 in partnership with Asian Americans for Equality and will expand to serve residents of Sunset Park. State Prevention Agenda Priority: *Prevent Chronic Diseases*

- Project SAFE, a peer education program employing an evidence-based youth development approach to prevent teen pregnancy and HIV/AIDS, is being expanded in Sunset Park and other Brooklyn communities. State Prevention Agenda Priority: *Promote Healthy Women, Infants and Children*

- REACH FAR, a program designed to prevent cardiovascular disease by increasing access to healthy foods and providing culturally tailored health coaching, is being launched initially in two mosques in CD 3 and then will be expanded to two mosques in Sunset Park. State Prevention Agenda Priority: *Prevent Chronic Diseases*

In the sections that follow, we briefly describe our programs, our progress to date, and our goals under the 2017-2019 Plan. See Appendix C for a table that summarizes project components.

Our Programs

Sector: community-based early childhood education settings and schools

ParentCorps:

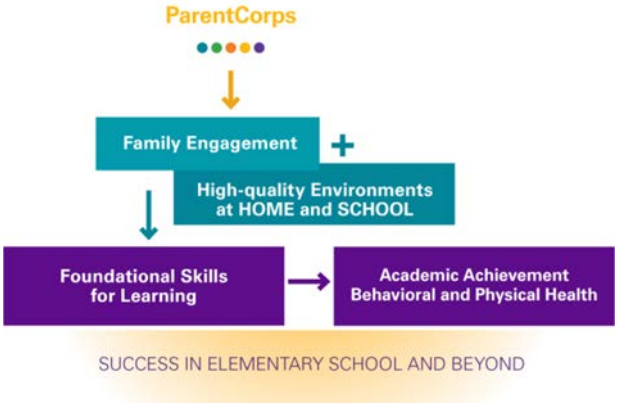
Preventing Chronic Disease; Promoting Healthy Women, Infants and Children

ParentCorps is an evidence-based program developed by NYU Langone Medical Center's Center for Early Childhood Health and Development (CEHD), which is designed to buffer the adverse effects of poverty and related stressors on early child development by engaging and supporting both parents and teachers at children's transition to school.

A family-centered intervention, ParentCorps promotes foundational skills in pre-kindergarten and improves achievement test scores and behavioral and physical health in elementary school. ParentCorps works by strengthening family engagement and helping parents and teachers provide high-quality environments. ParentCorps builds adults' capacity to use evidence-based practices to create safe, nurturing and predictable environments in which children thrive. ParentCorps:

- Promotes foundational skills for students as they make the critical transition to school.
- Engages diverse parents as partners and creates networks of knowledgeable, empowered and capable parents throughout the school community.
- Builds on the strengths of culturally-diverse students and families and includes tailored proactive strategies to address the needs of students with challenging behavior.
- Incorporates "best practices" from mental health, education and professional learning to provide supportive, safe and inspiring spaces for educators and parents to work together on their shared goal of helping young children to succeed.
- Supports sustainable changes in the early childhood workforce to strengthen program quality, ensure that Pre-K and related services are culturally relevant, and promote racial equity and equal opportunities for every student to succeed.

Two federally-funded, randomized controlled trials with more than 1,200 poor, minority NYC children have found that ParentCorps results in more supportive and nurturing home and early childhood classroom environments, higher kindergarten achievement scores (reading, writing, and math) and, among the highest-risk children, lower rates of obesity and mental health problems. A benefit-cost analysis



indicates that ParentCorps has the potential to yield cost savings of more than $2,500 per student. In sum, ParentCorps impact on school readiness, achievement, mental health and physical health suggests the potential to improve on current efforts to reduce the achievement gap and health disparities for NYC's children.

Progress and Impact

During the first three years of the Community Service Plan, CEHD partnered with University Settlement Society, a large social service agency with three early childhood sites (including one in CD3); and with the Earth School, an elementary school located on East 6th Street (CD3).

University Settlement Society

In partnership with University Settlement Society, in the first two years of the Community Service Plan, ParentCorps provided professional development to 56 University Settlement staff, including a four-day series called ParentCorps FUNdamentals. In addition, 21 teachers, teaching assistants and school aides received training and coaching on implementation of the ParentCorps Program for Students ("Friends School") in Pre-K classrooms and six social workers, family service workers and school aides received training and coaching on the ParentCorps Parenting Program.

University Settlement Society

University Settlement is one of New York's most dynamic social service institutions with deep roots on the Lower East Side. Each year University Settlement's diverse programs help over 30,000 low-income and at-risk people build better lives for themselves and their families. With an impressive legacy as the first settlement house in the United States, University Settlement has been an incubator for progressive ideas for over 125 years, offering pioneering programs in early childhood education, literacy, mental health, arts education, and adolescent development that set the standard.

From its earliest days, University Settlement has invested in a robust range of early childhood services, including education, mental health care, early intervention, childcare and arts and recreation. Today, University Settlement's early childhood programs directly support nearly 1,600 New York City children each year.

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

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

The Earth School

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

Leaders and staff from University Settlement and the Earth School are committed to providing evidence-based ParentCorps programs to the children and families served throughout their early education programs. By providing ParentCorps as an enhancement to high-quality early childhood education, children are much more likely to develop the foundational self-regulation and social-emotional skills necessary for school success and healthy development.

Here's what parents said about ParentCorps programs:

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

The Earth School

In 1992, teachers in Manhattan's East Village founded the Earth School to create a peaceful, nurturing place to stimulate learning in all realms of child development intellectual, social, emotional and physical. Today it is a thriving community of over 300 children in pre-kindergarten through grade 5 with a teaching staff dedicated to the founding values of hands-on exploration, an arts-rich curriculum, responsible stewardship of the Earth's resources, harmonious resolution of conflict, and parent-teacher partnership.

Earth School children come from diverse cultural, ethnic and economic backgrounds. Most classrooms combine two grades so that older students can thrive as guides and mentors while younger ones gain confidence in being part of a caring community of learners.

Plans

Over the next three years, ParentCorps will fully support high-quality implementation and continuous quality improvement within all three University Settlement sites (Lower East Side, Manhattan; East New York, Brooklyn; and Park Slope, Brooklyn) and the Earth School (CD3). This includes providing ParentCorps Fundamentals, training, ParentCorps 101 and coaching to program staff who have not been previously exposed. In addition, we will bring ParentCorps to at least two new public schools with Pre-K programs in CD 3 and/or in the NYU Lutheran catchment area. In total, we expect to reach over 1200 children and 660 families.

Sector: primary care

Healthy Families Program/Programa de Familias Saludables:

Preventing Chronic Disease

Stemming from the 2013 CHNA, the NYU LFHC 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. An estimated 19% of Sunset Park residents between the ages of 5 and 14 are obese, increasing their risk for diabetes, heart disease, high blood pressure, cancer and asthma. Sunset Park also has a high concentration of children living in poverty and a large Hispanic population (42%), who are particularly vulnerable to obesity. The program design team – consisting of a medical doctor, nutritionists, community planners, and social workers – used the National Initiative for Children's Healthcare Quality 2007 child and obesity prevention recommendations as a guideline for the intervention and adopted concepts from evidence-based, multi-component programs and curricula including 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.

Healthy Families/ Familias Saludables participants on a local supermarket trip. Nutritionist, Juan Batista (RD, CDN), is highlighting ways to achieve the principles of 5-2-1-0 and portion size (using My Plate guides, as seen in one mother's hands) within the local and Hispanic cultural contexts.

In 2015, NYU LFHC piloted the Healthy Families Program/Programa de Familias Saludables, a 12-session multi-disciplinary program for 10- to 11-year-old obese Hispanic children and their parent(s). 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 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.

The program is designed to:

- Stabilize BMI and BMI z-scores;
- Improve the following behaviors based on 5-2-1-0, a nationally recognized childhood obesity prevention program:

- Consumption of fruit and vegetables (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);
- Sugar-sweetened beverages (0 sugary drinks).

The curriculum is culturally relevant to the local Hispanic population and sessions are conducted in English and Spanish. Each session consists of:

- Customized nutrition education focusing on the 5-2-1-0 model facilitated by a nutritionist ;
- Separate support groups for parents and children that address questions, help them adopt strategies for setting limits and promoting healthy behaviors, and build peer support;
- Physical fitness focused on low- or no cost activities that can be done at home or through local community resources. These sessions are led by NYU Lutheran rehabilitation staff together with local partners, which have provided pro bono programming such as martial arts and dance. A primary care physician consults on participants' health and makes referrals to social supports and specialists as needed.

Local Partners Providing Pro Bono Services

Sunset Park Martial Arts, Inc.
Sunset Park Martial Arts is a family-oriented school working to keep youth off the streets while teaching them respect, humility, discipline, responsibility, self-defense, and most of all, a way to a healthier lifestyle. Kar-Do-Jitsu-Ryu (KDJR) – the mixed martial art form practiced at Sunset Park Martial Arts – was founded by John F. Manniel III out of a deep commitment to the neighborhood's young people.

Young Dancers in Repertory
Young Dancers In Repertory (YDR), a community-based nonprofit arts organization, has provided professional dance training to the Brooklyn community for more than 30 years. YDR fosters growth and communication through creative educational arts programming and performances for youth and the general public.

Brooklyn Health
Brooklyn Health and Performance has been providing research-based, best practice fitness training and coaching to Sunset Park and surrounding neighborhoods since 2015. The team provides customized fitness services to ensure individuals, sports teams, and corporate groups have the tools to reach their goals.

Progress and Impact

We began recruitment for the program in fall 2014, and a pilot cycle was launched in early 2015. The target program size is 12 children (and one parent or caregiver). Twenty children were recruited for the pilot, nine enrolled and six completed nine or more sessions. Measurements at the end of the 12-week intervention and at the three-month, post-program follow- up indicated stabilization of BMI percentiles. Self-reports indicated behavior change in target areas. Children reported increased intake of fruits (affirmed by parent reports), and, according to parents, children's exercise regimens also increased. Data from follow-up measurements at 6 and 12 months post-intervention are being analyzed to determine the program's longer-term impact on weight and BMI. During the second half of 2015, we used process and outcome data as a guide to make further adaptions to the program. Adjustments included extending the age range to include nine-year olds; implementing electronic pediatrician referrals to the program; refining program elements to encourage changes in screen time and beverage consumption; and adding a nutritionist home-visit to reinforce and individualize healthy shopping and cooking practices.

Healthy Families/ Familias Saludables participants (children, parents, and siblings) doing yoga, one of a variety of family-friendly physical activities participants engage in during the program.

In fall 2015, NYU Langone Department of Population Health Center for Healthcare Innovation and Delivery Science (CHIDS) awarded a grant to support the implementation and study of the Healthy Families Program. Three cycles will be completed by September 2016 and we are anticipating the results in fall 2016. The team has presented at the Community Health Centers Association of New York State Annual Conference, National Hispanic Medical Association Annual Conference, and the NYU Lutheran Annual Research Fair, where the program was recognized as one of the "Projects of Distinction," as demonstrated by exceptional impact, quality, and congruence with Evangelical Lutheran Church in America (ELCA) Social Statement, "Caring for Health: Our Shared Endeavor."

Plans

During the 2017-2019 Community Service Plan, we plan to implement the program in school-based health centers and expand from one site to four sites, with two cycles per year at each site. School-based health centers offer medical and mental health services on-site at local schools and offer a unique opportunity to base the program directly where children spend their day. We will continue to use process and outcome data gathered during and after the program to monitor our progress and inform program design and implementation.

Greenlight:

Preventing Chronic Disease

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

The Greenlight program, which was developed as part of an NIH-funded grant in settings that serve predominantly low-income black and

The Charles B. Wang Community Health Center

For more than 40 years, the Charles B. Wang Community Health Center has been a leader in providing high quality, affordable, and culturally competent primary care and support services to medically underserved Asian Americans and other disadvantaged populations in the New York metropolitan area. The Pediatric Clinic at the CBWCHC Chinatown site serves close to 8,500 patients, through over 30,000 visits annually to their primary care and subspecialty clinics.

Hispanic families, trains pediatricians how to communicate with families using toolkits that contain culturally-tailored educational materials for people with low literacy. Approximately 90 million Americans—or 45 percent of the population—have basic or below basic literacy skills, and 110 million have basic or below basic quantitative skills. Minority, immigrant families are at increased risk. Low health literacy and numeracy is associated with lower rates of breastfeeding, difficulty understanding food labels and portion sizes, and higher rates of obesity.

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

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

Early intervention for Chinese American immigrants is critically important in preventing obesity and its health consequences later in life. A study several years ago by CBWCHC found that 25% of the children in the pediatric practice (drawn largely from the Chinatown area) were overweight or obese. Among U.S. born boys ages 6-12, the combined prevalence of overweight and obesity was 40%. This problem is magnified by the fact that Asian populations appear to be more vulnerable to the onset of Type II diabetes at lower weights.

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

Progress and Impact

In adapting the Greenlight program for Chinese American immigrant families, the team strove to go beyond translating language and changing ethnicity in photographs. As one community member observed, "Translation is necessary, complicated *and* insufficient." Greenlight materials reflect deeper cultural values, norms and lifestyle differences. (For specific examples, view the Greenlight team's poster, which they recently presented at National

Association of Community Health Centers annual conference, where it won 2nd prize: http://bit.ly/24wXUci)

The cultural adaptation process has been complex, and included outreach to over 160 parents. Three focus groups were conducted with parents (two in Mandarin and one in Cantonese), and two focus groups were conducted with 17 providers/health educators. In addition, providers (physicians, nurses, nutritionists) and health educators have given individual feedback on the materials throughout the translation and adaptation process. The materials – some of which are shown here – reflect the judgment and care of many participants.

Over the past year, we have rolled out a full set of Greenlight materials at CBWCHC (core and supplemental booklets translated into Traditional and Simplified Chinese, along with 'tangible' tools), trained pediatric providers, and begun to enroll families into the Greenlight program.

To date, we have trained 19 providers (4 health educators, 11 pediatricians, 2 nurses, 2 nutritionists); completed baseline surveys of 285 parent/child-dyads to assess baseline behaviors, attitudes, and practices, and child weight; and recruited 78 parent/child-dyads who will be followed as they receive the program from 2 months through 2 years of age. Based on tracking data from CBWCHC's EMR system, after rollout of the Greenlight program, 193 sessions of provider counseling have involved provision of Greenlight messages, and 154 health education sessions have taken place. An additional 81 parents have received the waiting room program as part the piloting and development stage of the program.

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

Plans

Over the next three years, we plan to continue to implement the Greenlight program at CBWCHC. We will examine the impact of the culturally adapted Greenlight program on parent/family knowledge, attitudes, and practices related to their child's diet and physical activity.

We will also begin to explore strategies for expanding the program through:

- Dissemination of Greenlight materials to the CBWCHC Flushing site;

- Expansion of the Greenlight program to NYU Lutheran Family Health Centers' Brooklyn Chinese site in Sunset Park, Brooklyn;
- Adaptation of Greenlight into an online web resource, with Greenlight booklets available as digital flipbooks;
- Dissemination of the culturally adapted and translated Greenlight materials to other health facilities in the rest of NYC and across the country by making materials available for providers on-line, and leveraging existing relationships with groups like the Community Health Care Association of New York, Chinese American Medical Society (CAMS), Coalition of Asian-American Independent Practice Association (CAIPA)), the American Academy of Pediatrics and the Academic Pediatric Association; and
- Adaptation of Greenlight to other settings, such as daycare centers and schools, including other partners in the Community Service Plan.

Over the course of the next three years of the Community Service Plan, we expect Greenlight to reach over 1,500 children and families.

Two Generations:

Promoting Healthy Women, Infants and Children

Two Generations, a new program that seeks to reduce the negative health impact of perinatal depression and adverse childhood events on maternal and child physical and mental health, is being launched in CD 3 in partnership with Gouverneur Health and in Sunset Park in the NYU Lutheran Family Health Centers.

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

In the first year of this Community Service Plan, we will lay the groundwork for implementing a cross-site intervention that would seamlessly implement effective tools to mitigate these life-long impacts in perinatal and pediatric care in the NYU Lutheran Family Health Centers and in partnership with NYC Health + Hospitals' Gouverneur Health. In this exploratory phase, we will develop and refine a program model that will integrate a comprehensive set of evidence-based

interventions that cross the birth-line and thus have the potential to simultaneously improve outcomes for two generations. These include: Healthy Steps, Starting Early (StEP), Reach Out Stay Strong Essentials (ROSE), STRONG Moms, and the Video Interaction Project.

The goal is to develop a project model that will:

- Address maternal stressors, improve maternal mental health, and facilitate maternal engagement in positive interactions and behaviors with the child;
- Facilitate positive and responsive parent-child interactions to enhance the parent-child relationship and child outcomes, and simultaneously reduce stress and enhance coping for mothers with depressive symptoms; and
- Transform the coordination of care across the prenatal and pediatric settings through training and supporting staff in the delivery of continuous, comprehensive, and culturally effective care to increase family engagement, deliver more timely and effective screening and interventions, facilitate referral to behavioral care, and enhance maternal and child outcomes.

Sector: housing

Health+Housing Project:

Preventing Chronic Disease

Poor health is often concentrated within the same neighborhoods that face concentrated poverty and other social ills. People living in such neighborhoods have high levels of chronic disease, mental illness, and exposure to environmental risks such as injury and violence. Not surprisingly, they concomitantly have high use of costly health care services, including frequent emergency department visits and hospitalizations.

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

Henry Street Settlement
Founded in 1893 by Lillian Wald, Henry Street Settlement opens doors of opportunity to enrich lives and enhance human progress for Lower East Side residents and other New Yorkers through social services, arts, and health care programs.
Each year, Henry Street Settlement serves 60,000 individuals through social services, arts and health care programs. Through these programs, seniors received nutrition, case management and other vital services; youth received educational, recreational and employment services; members of our community received primary and mental health care, free legal and financial counseling and help accessing benefits including low-cost health insurance; homeless individuals and families received shelter and supportive services; the unemployed or underemployed were connected to jobs, and thousands of individuals of all ages were provided access to the arts, including dance, music, theater and visual arts.

social, environmental, and structural determinants of health in addition to promoting healthy behaviors and effective use of the healthcare system; and is tailored to the specific needs of building residents.

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

Progress

Thus far, we have held four workshops to understand more about residents' needs and priorities, and community surveyors completed a total of 374 baseline surveys in the two buildings with adults 18 years and older, representing a participation rate of about 45%. Of the residents who completed a baseline survey, 73% expressed an interest in meeting with a CHW and participating in the program. Bilingual CHWs (Chinese/English and Spanish/English) have been hired and trained, and are now working in both buildings. They are using motivational interviewing techniques to guide residents through a goal-setting activity, and then together they develop an action plan for the resident to achieve those goals. CHWs provide coaching on health behaviors, help residents navigate environmental and structural issues in their apartments, and connect residents to health and social services. As part of an evaluation of the program, we plan to measure changes in residents' emergency department use, hospital days, insurance coverage, and overall physical and mental health.

Summary of survey results: Among the 374 survey respondents, 50% expressed having one or more food security concerns, and nearly 40% described their general health as fair or poor. Building residents suffer from higher rates of chronic disease than NYC adults overall: 33% have been diagnosed with hypertension, 16% with diabetes, and 21% with asthma; this compares to city-wide rates of 28%, 11%, and 11%, respectively. Surveyed residents are also more likely to be current smokers than New Yorkers overall (18%, compared with 14%). The vast majority of respondents have health insurance (95%) and have seen a doctor in the past 6 months (84%). Despite this, their use of emergency departments remains high, with nearly 35% of respondents reporting that they had one or more visit to an emergency department in the past year. This supports a growing body of research indicating that social determinants of health are critical, and that

access to health insurance and regular medical care alone are insufficient for producing optimal health, particularly in lower-income patients.

Plans

Over the 15-month intervention, we expect to provide services to 150-200 residents. The pilot stage of the Health+Housing Project will be completed by October 2017 and evaluation results will be available by early 2018. We will then explore replication of the model in Brooklyn and with our partners – DOHMH, NYCHA, HPD, the Archdiocese of New York and Wavecrest Management – all of whom are interested in the Health+Housing Project as a potentially replicable model for other low-income housing developments across the City.

Sector: community

Tobacco Free Community:

Preventing Chronic Disease

In partnership with Asian Americans for Equality (AAFE) and the Asian Smokers' Quitline, experts from the Section on Tobacco, Alcohol, and Drug Use in NYUHC's Department of Population Health are implementing a community navigator model, which mirrors the patient navigator model that has been well studied and implemented by the American Cancer Society. This model provides lay workers or resident/ community volunteers the skills to educate and motivate people in the community to address modifiable health risks, like tobacco use, and link community members to evidence based smoking cessation resources. Despite the availability of safe and effective treatment for tobacco dependence, only a small proportion of smokers who try to quit each year use cessation therapies. This is particularly true among low-income adults and for non-English language speakers, contributing to growing disparities in smoking prevalence. The Community Service Plan navigator program is designed to address this gap.

Asian Americans for Equality

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

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

Progress and Impact

Training: In our first year of the Community Service Plan, NYULMC experts on tobacco cessation provided comprehensive training to 14 staff from community based organizations and separately trained 11 members of the AAFE staff. Our approach is comprehensive, raising awareness about the often hidden threat of SHS in multiunit housing and ensuring that smokers have access to evidence-based treatment. Training focused on the use of Motivational Interviewing techniques to: (a) assess readiness to change smoking

behavior; (b) employ strategies to increase motivation; (c) inform smokers about free evidence based smoking cessation resources (e.g., Medicaid covers cessation medication with a prescription and free counseling and nicotine replacement therapy available through the New York State and Asian Smokers' Quitline); and (d) for those ready to quit, link smokers to services including arranging doctor appointments and connecting smokers to the New York State or Asian Smokers Quitline.

The program was extremely well-received, with all participants reporting significant increases in knowledge and confidence. Responding to requests from our partners and other community groups and agencies, we have continued to provide tobacco cessation trainings to our community partners, including two separate trainings with staff members from AAFE (3) and health educators at CBWCHC (9). In 2016, we provided a lecture/training for 60 attendees at the annual Chinese American Medical Society (CAMS) meeting and we continue to provide training for physician members of the Chinese American Independent Practice Association (CAIPA).

Outreach: Since the inception of the Community Service Plan, building on AAFE's existing programs and relationships in the community, we have reached over 970 smokers, many of whom had never previously tried to quit or cut down. Of the 183 that completed the baseline interview, 146 (80%) were given nicotine replacement therapy. Of the 126 smokers that were followed-up at two weeks, 105 (83%) reported using the nicotine replacement therapy, 78 (62%) reported cutting back on smoking, and 29 (23%) quit altogether. We are also tracking calls to the Asian Smokers Quitline, which provides smoking cessation counseling. Since implementation of outreach, 76 calls were completed.

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

In addition, growing out of this partnership, the Charles B. Wang Community Health Center was awarded a grant from the RCHN Community Health Foundation to address the high rates of smoking among Chinese American men. Activities include:

- Developing a bi-lingual smoking cessation coaching program;

- Providing smoking cessation counseling and personalized follow-up to support changes in smoking behaviors;
- Developing communication strategies to deliver key anti-smoking messages through print, broadcast and digital media platforms (first press conference for Chinese language media held on November 18, 2015);
- Training and encouraging private practice physicians to adopt tobacco screening, counseling, and referral protocols; and
- Establishing multi-sector partnerships to deliver key messages and services.

Through this new initiative, beginning in November 2015, Charles B. Wang Community Health Center internal medicine providers have referred 72 smokers, 60 of whom received counseling by a health educator; 40% (24/60) quit smoking for at least one day and 72% (43/60) reduced their smoking.

Plans

Outreach: Over the next three years, in collaboration with AAFE, we plan to reach out to 2-5 community-based organizations annually, including senior centers and Family Associations. Our goal is to work with these organizations to raise awareness about the dangers of smoking and secondhand smoke, to provide smoking cessation counseling and referrals to clients and members, and to help Family Associations adopt smoke-free policies. We also plan to continue our community-based outreach to smokers with the goal of reaching at least 100 each year – continuing our work on the Lower East Side/Chinatown and expanding into Sunset Park.

Training: We also plan to offer additional training on tobacco cessation to the more than 2,000 members of the Chinese American Medical Society and the Chinese American Independent Practice Association. Our goal is to help raise their awareness of the importance of incorporating smoking cessation into everyday practice and of the resources that are available to help smokers quit.

Policy: We plan to work with the New York City DOHMH and with New York City Housing Authority leadership to explore strategies to educate and engage the community about smoking cessation and the dangers of secondhand smoke in order to support the implementation of the US Department of Housing and Urban Development's landmark new policy on smoke free public housing.

Finally, to inform our strategies and to raise the visibility of the prevalence of smoking among Asian American men, we plan to conduct a cross sectional survey of 200 Asian Americans in Chinatown and Sunset Park to:

- Assess knowledge, attitudes and beliefs about smoking and the dangers of secondhand smoke among Asian Americans living in Chinatown and Sunset Park;
- Explore the cigarette purchasing patterns among Asian American smokers; and
- Assess exposure to tobacco and counter tobacco media messaging.

Project SAFE:

Promoting Healthy Women, Infants and Children

There are substantial disparities in teen birth rates by ethnicity and poverty in New York City. Sunset Park has the 12th highest teen birth rate in NYC (33.2 births per 1,000 girls ages 15-19, compared to 24.0 in Brooklyn, and 23.6 citywide). Findings from our Teen Sexual Healthcare Access Survey indicate that the primary teen pregnancy risk factors for Sunset Park are poverty and low educational attainment, high rates of intimate partner violence, large numbers of disconnected youth, adolescents having limited knowledge of family planning and discomfort speaking to partners and adults, and fears about breach of confidentiality. 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 14 to 19 with the support and the opportunities to avoid risky behaviors and to develop to their full potential and become agents of change in their communities.

Here's what teens said about Project SAFE programs:

"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."

"I had stay[ed] in Project SAFE this long because it had provide[d] a sense of home. In PRY [Project Reach Youth] I had been able to be myself and not be judged."

"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."

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

Progress and Impact

Multi-Session Workshop Series: Project SAFE works with partners to provide pregnancy prevention workshops to youth in underserved communities in Brooklyn. The program utilizes two, six-session evidence-based sexual health curricula – Be Proud! Be Responsible (BPBR) and

4Me! (part of the Teen Health Project evidence-based intervention). Topics covered include pregnancy and STD/HIV prevention, as well as confidence, pride, and respect-building activities. From 2014 to the present, Project SAFE facilitated 58 cycles of BPBR and 53 cycles of the 4Me! curricula, reaching a total of 2,857 youth in high schools, community-based organizations, and high school equivalency programs. Post-workshop evaluations reveal an increase in self-reported awareness and knowledge, and positive intended behaviors:

- 84% of workshop participants reported that they are more likely to either wait to have sex, or use condoms;
- 89% know more about how to protect themselves from pregnancy and STIs;
- 75% said that they feel more comfortable talking to a partner about safer sex;
- 78% know where they can get tested for STIs because of the workshop series.

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

Awards
Project SAFE social media peer educators recently were honored for winning the 2016 "Echo your Healthy Choice" award for a video they created about healthy teen relationships. The award was presented to the group at this year's NYC Teen Dating Violence Awareness Walk.

- 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;
- The Lab: Peer educators use social media, such as Instagram, Snapchat, Facebook, and YouTube, to reach high-risk youth and provide sexual health education;
- Dance: The dance group trains participants in various dance styles and prepares them to develop performances that celebrate wellness and healthy relationships;
- Ambassadors: Youth are trained to facilitate sexual health workshops for their peers at schools and community events.

Participants have statistically significant increases in: frequency of condom use; HIV knowledge; knowledge of HIV status; and knowledge of STD status. In addition, participants demonstrate increases in school connectedness and self-efficacy, which have been shown to be protective factors against HIV.

Community Events and Single-Session Workshops: Throughout the year, peer educators and Project SAFE staff work collaboratively to produce a series of community events to promote teen sexual health. The events typically include performances from the arts-based groups and an open mic session in which guests and community members can perform. Most of these community events also offer on-site HIV testing and promote teen health services available through Project SAFE and other community organizations. From 2014 to the present, Project SAFE hosted or performed at 26 community events reaching 1,829 youth, of whom 237 received HIV testing. The events received overwhelmingly positive feedback and young people reported

increased knowledge about healthy relationships (61%); feeling more comfortable encouraging others to get tested for HIV (57%); and feeling more comfortable using a condom (60%).

Project SAFE also offers single-session sexual health workshops facilitated by trained peer educators with program staff. We have reached 921 young people through 41 single-session sexual health workshops from 2014 to the present. Project SAFE works with community partners such as Turning Point to reach at-risk youth and young adults.
As a result of the workshops, most participants know more about how to prevent HIV and are more likely to practice safer sex or abstain from sex (91% and 76%% respectively, as self-reported on a post-workshop survey).

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

Plans

Over the next two years, Project SAFE plans to broaden the reach of our evidence-based workshop series and serve an additional 200 students annually by working with high schools connected to NYU LFHC school-based health center sites. The program also plans to more explicitly incorporate reproductive justice, which addresses the complete physical, mental, spiritual, political, social, and economic well-being of women and girls based on the full achievement and protection of women's human rights. Project SAFE has been working with the New York City Department of Health and Mental Hygiene to train staff to facilitate reproductive justice-focused community gatherings for youth. These sessions will gather information about how young people view the link between reproductive rights and social justice. Building on these efforts, Project SAFE plans to establish a new peer education group focusing on reproductive justice. It will be designed to provide youth with skills and resources to enhance their leadership abilities and to support them in embodying their role as social change agents. In this group, youth will select a reproductive justice issue that is important to them and, with the guidance of the facilitator, initiate a project (such as a workshop, social media campaign, or public demonstration) to address the issue.

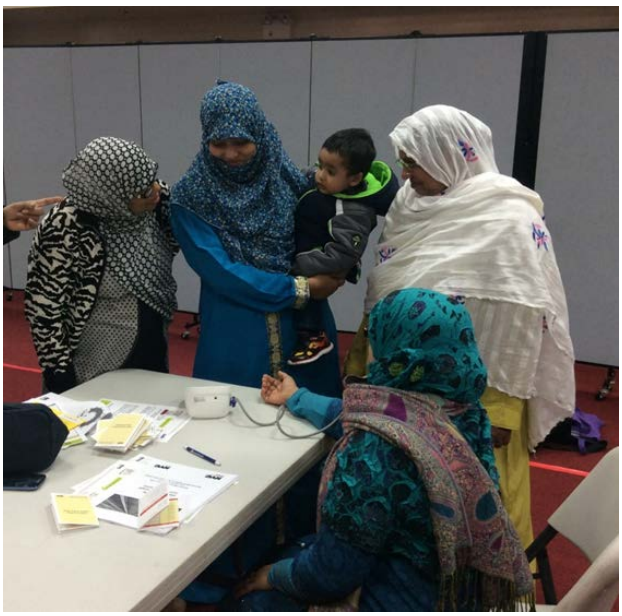
REACH FAR:

Preventing Chronic Disease

Building on the important role that faith-based organizations can play in affecting the health of immigrants and racial and ethnic minority populations, the Racial and Ethnic Approaches to Community Health for Asian AmeRicans (REACH FAR) program will partner with mosques on the Lower East Side and in Sunset Park to improve blood pressure control and promote healthy eating using a three-pronged approach: (1) nutritional strategies, including education and changes to communal food practices; (2) blood pressure control training and monitoring; and (3) culturally tailored communications and education.

Progress and Impact

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.

Plans

Building on these efforts and the materials and strategies that have been developed, in Year 1 REACH FAR will work with the two mosques in the Lower East Side: Assafa Islamic Center and Madina Masjid. Assafa has a total of 1500 congregants and average weekly attendance at Friday Jummah prayers of 250 congregants. Madina Masjid has a congregation size of 2000 and average weekly attendance at Friday Jummah prayers of 400 congregants. In Years 2 and 3, we plan to extend the reach of the program by engaging a two additional mosques serving the South Asian and Middle Eastern community in the Sunset Park area.

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.

Other

Apart from the programs outlined above, which are supported directly by NYUHC as part of the Community Service Plan, NYUHC has numerous community programs that address unmet community need. See Appendix D.

Dissemination

The Community Health Needs Assessment and Community Service Plan, together with our Progress Reports, are conspicuously posted on the NYUHC 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 and http://www.lutheranhealthcare.org/Main/CommunityServicePlan.aspx). An individual seeking access to these materials is not required to create an account or provide any personally identifiable information.

Hard copies of the Community Health Needs Assessment, Community Service Plan and Progress Reports are available without charge to anyone upon request and are regularly distributed to Community Board members, policymakers, local health centers, community based organizations, community members, and other interested stakeholders. Through our outreach and engagement activities, we continually seek to keep the community informed about our activities and to get feedback and input. This year we also sent out an electronic newsletter to nearly 400 people, including policymakers, partners, community groups and colleagues (see: http://eepurl.com/bDaEgv).

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 (the Population Health Summit of 2015, the Community Health Association of NY State Statewide Conference 2015), and the National Hispanic Medical Association Annual Conference and in presentations to Primary Care Residents, medical students and undergraduate students. We plan to conduct similar internal and external presentations for the 2017-2019 Community Service Plan.

Community Engagement

An overarching goal of the Community Service Plan is to help improve the health of the populations of the Lower East Side/Chinatown and Sunset Park. We have continued to engage our partners and the broader community through a variety of mechanisms with the objective of creating an infrastructure for the ongoing exchange of information and ideas and a platform for continued cross-sector work at the neighborhood level to address high priority public health issues.

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

In addition to its regular meetings, in the first year, the Coordinating Council also sponsored a community forum on the changing demographics of CD 3, with presentations by Joseph Salvo, PhD, and Peter Lobo, PhD, Director and Deputy Director respectively of the Demography Division of the NYC Office of City Planning. This event was attended by over 50 people, including staff and leadership from all of our partner organizations, the District Manager and staff of Manhattan Community Board 3, and central Medical Center administrators. We also periodically invite outside speakers to the meetings of the Coordinating Council. In 2015-2016, we heard presentations from representatives from the Mayor's Office of Immigrant Affairs Direct Access Program and from a collective impact program in Astoria and Long Island City, Zone 126. Members of the Coordinating Council also attend presentations of interest at the Medical Center. Over a dozen leaders and staff from our community partners attended the Department of Population Health's inaugural ***Health and…*** conference, which brought together leading investigators, policymakers, practitioners, and community leaders to better leverage the intersection between ***Health and…*** its many determinants.

Over the course of our Plan, our relationships with our partners, as well as with other groups in the community, have grown. For example, the Charles B. Wang Community Health Center has repeatedly welcomed a group of medical students, and is working with other NYUHC faculty on a variety of initiatives. We partnered with Asian Americans for Equality and CBWCHC to develop a grant proposal that was funded by the RCHN Community Health Foundation to support and expand their tobacco-related work. And we work with other organizations, including the Two Bridges Neighborhood Council, in their efforts to increase access to healthy food and to support physical activity on the Lower East Side. http://www.twobridges.org/press-publications/what-s-new/213-two-bridges-neighborhood-council-receives-healthy-neighborhoods-funds-grant-from-the-new-york-state-foundation

Finally, we continue to meet with advocates, service providers, and community groups, including committees of Manhattan Community Board 3 as well as Manhattan Community Board 6 to provide regular updates and opportunities for input.

NYU Lutheran has historically embraced collaboration as the foundation of successful service development and implementation, actively seeking community involvement in its programs as part of its management philosophy. Supporting the Community Service Plan over the past three years, these relationships have provided ongoing opportunities for interaction, including the joint development of programming.

Our commitment to pediatric obesity focused on, but was not limited to, the development and implementation of the Healthy Families program. Working in collaboration with a network of early childhood centers and family child care providers, NYU LFHC secured a grant from the Aetna Foundation to focus on obesity prevention in the youngest ages, providing parent education and staff development for teachers and kitchen staff.

Of particular note is our long history and strong relationships with schools. Our collaborative programming has included the development and operation of an extensive network of over 30 school-based health centers, participation in the City and State's Community Schools initiatives, and extensive youth development programming in elementary and high schools. Capitalizing on these relationships, we plan to increase the reach of the Healthy Families program by expanding to additional sites through school-based health centers and after-school programs.

School-based and high school equivalency programs also serve as expansion opportunities for Project SAFE, the peer education program selected as a new priority focus for 2017-2019. While not a focus of our CSP in the prior three years, adolescent-focused prevention services have been expanded through funding from the New York City Department of Youth and Community Development. We have also successfully expanded opportunities available to participating youth in partnership with the Pinkerton Foundation, which enabled us to offer college access services as part of our overall youth development strategy.

Anticipated Impact and Performance Measures

The Coordinating Council, currently composed of the community partners and NYUHC program leaders, will expand to include colleagues from NYU Lutheran and partners from Sunset Park. The 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 preliminary goals and performance measures, together with sources of data to be used to measure outcomes.

Appendix A

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Appendix B

Input from Persons Who Represent the Broad Interests of the Community

Meetings with public health experts:

Agency	Attendees	Dates
Greater New York Hospitals Association	▪ Lloyd Bishop, Senior Vice President, Community Health Initiatives and Government Affairs & Executive Director, Center on Community Health Policy and Services ▪ Amy Osorio, Assistant Director, Community Health Initiatives ▪ Dwayne Robertson, Senior Project Manager, Policy Analysis	Multiple meetings and communication from January 2013 to present
New York City Department of Health and Mental Hygiene	▪ Ogonnaya Dotson-Newman, Assistant Director of Public Housing and Health ▪ Shannon Farley, Bureau of Chronic Disease Prevention and Tobacco Control ▪ Pauline Ferrante, Community Liasion ▪ Victoria Grimshaw, Policy Analyst/Community Benefits Coordinator ▪ Jacqueline Kennedy, Partnerships for a Healthier NY ▪ Natalia Linos, Science Advisor ▪ Javier Lopez, Assistant Commissioner, Center for Health Equity ▪ Sarah Perl, Senior Advisor/Writer to the Commissioner ▪ Sean Robins, smoke-free housing and physical activity ▪ Rishi Sood, Deputy Director of Policy, Bureau of Primary Care Access and Planning ▪ Cassiopeia Toner, Director for New Initiatives	Multiple meetings and communication from September 2013 to present
New York City Department of Health and Mental Hygiene – Brooklyn Community Action Team	▪ Molly Berman, Brooklyn Community Engagement Coordinator ▪ Staff representatives from: ▪ 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	Monthly meetings from March 2016 to present

Agency	Attendees	Dates
	Connections	
New York City Department of Health and Mental Hygiene – Brooklyn Knows Steering Committee	▪ Patrick Pagen *New York Knows* Project Officer ▪ Brooklyn Knows partners	Monthly meetings from March 2016 to present
New York City Department of Health and Mental Hygiene – Brooklyn Knows Youth Subcommittee "Brooklyn United"	▪ Patrick Pagen *New York Knows* Project Officer ▪ Youth and staff representatives from Community Healthcare Network, SUNY Downstate, Diaspora, Ali Forney	Monthly meetings from November 2015 to present
NY State Department of Health	▪ Sylvia Pirani, MPH, Director Office of Public Health Practice	Meetings and communication from September 2013 to present, including events sponsored by the Greater New York Hospital Association
NYS Office of Mental Health	▪ Mary McHugh, Director, Strategic Clinical Solutions ▪ Presentation to Division (30 stakeholders)	Multiple meetings and 2013 to present; presentation on 5/4/2016
NYS Early Childhood Advisory Council	▪ Council members	Multiple meetings and communication from September 2013 to present; presentation in June 2014.
NYC Division of Early Childhood	▪ Sophia Pappas, Executive Director, Office of Early Childhood Education ▪ Jill Resnick, Executive Director, Family and Community Engagement ▪ Yvonne Delbanco, Deputy Executive Director ▪ Jeff Kotrosser, Family Engagement	Multiple meetings in 2015-2016 about strategic planning, shared decision making and to present
NYC Mayor's Office of Immigrant Affairs, Direct Access Program	▪ Leadership and outreach staff	Multiple meetings and communication from January 2013 to present
Lower East Side Health Advisory Committee	Committee members (19)	Presentation and discussion on December 9, 2015

Agency	Attendees	Dates
Charles B. Wang Community Health Center	▪ Regina Lee, Chief Development Officer ▪ Loretta Au, Chief of Pediatrics ▪ Perry Pong, Chief Medical Officer ▪ Maggie Wong, Coordinator of Marketing Programs ▪ Jin Lu, Nurse Practitioner ▪ Rachelle Ocampo, Associate Director of Health Education ▪ Michelle Chen, Health Educator ▪ Lucas Lao, Health Coach	Multiple meetings and communication from September 2013 to present
Gouverneur Health	▪ Mary McCord, Director of Pediatrics ▪ Peter Davidson, Director of Medicine ▪ Karyn Singer, ACO Lead Physician ▪ Primary Care Residents ▪ Public Health Advocates	Multiple meetings and communication from September 2013 to present
Asian Smokers Quitline (ASQ)	▪ Shu-Hong Zhu, Principal Investigator ▪ Caroline Chen, Project Manager	Multiple meetings and communication from September 2014 to present
Brooklyn Perinatal Network	▪ Ngozi Moses, Executive Director ▪ Denise West, Deputy Executive Director ▪ Network members	Monthly meetings from January 2013 to present

Meetings with community groups and community leaders:

Organizations	Attendees	Dates
ArchCare	▪ Mashi Blech, Director, TimeBank ▪ Omayra Torres, Supervisor	Multiple meetings and communication from January 2013 to present
Asian Americans for Equality	▪ Chris Kui, Executive Director ▪ Flora Ferng, Director of Programs ▪ Ken Ho, Program Coordinator ▪ Kenny Chen, Staff ▪ Ivy Au, Staff	Multiple meetings and communication from September 2013 to present
Brooklyn Family Justice Center	▪ Center leadership and direct service staff	Multiple meetings and communication from January 2013 to present
Brooklyn Pride	▪ Leadership and staff	Multiple meetings and communication from January 2013 to present
CAAAV Organizing Asian Communities	▪ Cathy Dang, Executive Director	November 2016
CAMBA, Inc.	▪ Joanne Oplustil, Executive Director ▪ Valerie Barton-Richardson, Executive Vice President	Multiple meetings and communication from January 2013 to present

Organizations	Attendees	Dates
	▪ Kevin Muir, Vice President	
Caribbean Women's Health Association	▪ Cheryl Hall, Executive Director	Multiple meetings and communication from January 2013 to present
Center for Family Life, part of SCO Family of Services	▪ Julia Jean-Francois, Co-Director ▪ Julie Brockway, Co-Director ▪ Shira Sameroff Community School Program Supervisor	Multiple meetings and communication from January 2013 to present
CMP (Chinatown Manpower Project)	▪ Board leadership and staff	Monthly meetings from January 2013 to present
Chinatown Partnership	▪ Wellington Chen, Executive Director	Multiple meetings and communication from September 2013 to present
Chinatown YMCA Cornerstone @ Two Bridges Community Center	▪ Chi Yung, Center Director ▪ Kingsley Boafo, Associate Director	May 2015 to present
Chinese American Medical Society (CAMS)	▪ Jamie Love, Administrator	Multiple meetings from September 2015; presentation at Annual Scientific Conference November 2015
Coalition of Asian American Independent Practice Association (CAIPA)	▪ Peggy Sheng, Chief Operations Officer	Multiple meetings and communication from January 2013 to present
Community Board 3 (Manhattan)	▪ Susan Stetzer, District Manager ▪ Juliana Dubovsky, Assistant District Manager ▪ Presentation to Human Services, Health, Disability and Seniors/Youth and Education Committee	Multiple meetings and communication from September 2013 to present; most recent presentation: March 3, 2016
Community Board 6 (Manhattan)	▪ Presentation to Health, Senior and Disability Issues Committee	Annual meetings; most recent presentation: April 19, 2016
Community Board 7 (Brooklyn)	▪ Jeremy Laufer, District Manager ▪ Community members and organizations	Multiple meetings and communication from January 2013 to present
Council of Peoples Organization (COPO)	▪ Mohammed Razvi, Executive Director	Multiple meetings and communication from January 2013 to present
Diaspora Community Services	▪ Carine Jocelyn, Chief Executive Officer	Multiple meetings and communication from January 2013 to present

Organizations	Attendees	Dates
Earth School	▪ Abbe Futterman, Principal ▪ Shirley Suarez, mental health professional ▪ Jocelyn Walsh, Parent Coordinator	Monthly Meetings from September 2015 to March 2016
Emblem Health	▪ Peter Chang, Lead Project Specialist	Multiple meetings from 2015
Empire BlueCross BlueShield HealthPlus	▪ Osiris Marte, Health Promotion Manager	Multiple meetings and communication from January 2014 to present
Federation of Italian American (FIAO)	▪ Nancy Sottile, Executive Director	Multiple meetings and communication from January 2013 to present
Fifth Avenue Committee	▪ Michelle De La Uz, Executive Director ▪ Jay Marcus, Director of Housing & Community Facility Development ▪ Aaron Shiffman, Executive Director, Brooklyn Workforce Innovations ▪ Marcela Mitaynes,Tenant Organizing & Advocacy Program Coordinator, Neighbors Helping Neighbors	Multiple meetings and communication from January 2013 to present
Good Old Lower East Side	▪ Demaris Reyes, Executive Director	June 26, 2015
Good Shepherd Services	▪ Kathy Gordon, Associate Executive Director	Multiple meetings and communication from September 2013 to present
Grand Street Guild Resident Association	▪ Daisy Paez, President ▪ Members and residents	Multiple meetings and communication from September 2015 to present
Grand Street Settlement	▪ Willing Irene Chin-Ma, Associate Executive Director ▪ Leslie Capello, Early Head Start Director	Multiple meetings and communication from September 2014 to present
Guild for Exceptional Children	▪ Paul Cassone, Executive Director	Multiple meetings and communications from January 2013 to present
Hamilton-Madison House	▪ Mark Handelman, Executive Director/CEO ▪ Robert Wolf, Consultant ▪ Isabel Ching, Assistant Executive Director, Senior Services ▪ Peter Yee, Assistant Executive Director, Behavioral Health Services	Meetings in 2015-2016
HeartShare Human Services of NY	▪ William Guarinello, Chief Executive Officer	Multiple meetings and communications from January 2013 to present
Henry Street Settlement	▪ Diane Rubin, Chief Program Officer ▪ Ashley Young, Program Director of Henry Street Settlement's	Multiple meetings and communication from 2014 to present

Organizations	Attendees	Dates
	Neighborhood Resource Center ▪ Kristin Hertel, Deputy Program Officer of Health and Wellness	
HER Justice	▪ Amy Barasch, Executive Director ▪ Jennifer DeCarli, Director of Legal Services	Multiple meetings and communication from 2015 to present
Hester Street Collaborative	▪ Betsy MacLean, Executive Director ▪ Yakima E. Peña, Senior Project Manager	Multiple meetings and communication 2015 to present
Interfaith Coalition for Health and Healing	▪ Coalition Members	Multiple meetings and communication from January 2013 to present
Jewish Board of Family and Children Services, Inc.	▪ John Kastan, Chief Program Officer	Multiple meetings and communication from January 2013 to present
Local Initiatives Support Corporation (LISC) New York City	▪ Colleen Flynn, Director of Programs ▪ Amy Gillman, Director of Early Childhood and Health Initiatives	Multiple meetings and communication from January 2013 to present
Low Income Investment Fund	▪ Kirsten Shaw, Director, Eastern Region ▪ Matthew Singh, Pre-K Program Officer	Multiple meetings and communication from September 2015 to present
MetroPlus Health Plan	▪ Luna Liu, Event Specialist/Assistant Director, Marketing Department	
Mixteca Community Organization	▪ Eduardo Peñaloza, Executive Director	Multiple meetings and communication from 2013 to present
New York City Housing Authority	▪ Kirmani-Frye, Rasmia, Director of Public/Private Partnerships ▪ Andrea Mata, Senior Manager for Community Initiatives ▪ Lauren Gray, Deputy Director Research Management & Analysis ▪ Karina Totah, Senior Advisor	Multiple meetings and communication from September 2013 to present
NYC Department of Housing, Preservation and Development	▪ Vicki Been, Commissioner ▪ Elyzabeth Gaumer, Housing Policy Research ▪ Elizabeth Greenstein, Director of External Affairs ▪ Jessica Katz, Assistant Commissioner, Special Needs Housing	Multiple meetings and communication from 2014 to present
NYC Smoke Free	▪ Patrick Kwan, Director ▪ Deidre Sully, Deputy Director ▪ Ayodele Alli, Engagement Coordinator	Multiple meetings from August 2015 to present

Organizations	Attendees	Dates
New York Foundling	▪ Dr. Sylvia Rowlands, Senior Vice President for Evidence Based Programs	Multiple meetings and communication from January 2013 to present
New York Immigration Coalition	▪ Claudia Calhoon, Director of Health Advocacy ▪ Max Hadler, Health Advocacy Specialist	Multiple meetings and communication from 2015 to present
NYU Lutheran Arab Community Advisory Council	Board members, executive leadership, and staff from: ▪ Arab American Association of NY ▪ Arab American Cancer Education & Referral Program (AMBER) ▪ Arab American Family Support Center ▪ Arab Muslim American Federation ▪ Beit Al Maqdis Islamic Center ▪ Egyptian American Alliance ▪ Empire Blue Cross Blue Shield ▪ Islamic Society of Bay Ridge ▪ MAS Youth Center ▪ Moroccan American House Association ▪ National Arab American Medical Association ▪ Network of Arab-American Professionals of NY ▪ New Life Day Care ▪ Salaam Club ▪ Salam Arabic Lutheran Church ▪ Yemen American Association of Greater NY	Quarterly meetings January 2013 to present
NYU Lutheran Chinese Community Advisory Council	Board members, executive leadership, and staff from: ▪ Asian Community United Society ▪ Asian Health and Social Service Council ▪ Brooklyn Chinese-American Association ▪ Chinese American Independent Practice Association ▪ Chinese-American Planning Council ▪ Chinese Promise Baptist Church ▪ Chinese American Social Services Center ▪ CaringKind ▪ Health First ▪ Homecrest Community Services ▪ ElderServe Health Inc. ▪ Mannings 8th Ave Pharmacy, ▪ Visiting Nurse Service of New York	Multiple meetings from January 2013 to present
Opportunities for a Better Tomorrow	▪ Randy Peers, Executive Director	Multiple meetings and communication from September 2013 to present
Red Hook Community Justice	▪ Sabrina Carter, Coordinator of Youth and Community Programs	Multiple meetings and communication from

Organizations	Attendees	Dates
Center		September 2014 to present
Red Hook Initiative	▪ Jill Eisenhard, Executive Director	Multiple meetings and communications from 2015 to present
Ridgewood Bushwick Senior Citizens Council	▪ James Cameron, Chief Executive Officer	
Safe Horizons	▪ Michael Polenberg, Vice President for Government Affairs	Multiple meetings and communications from January 2013 to present
72nd Precinct Community Affairs	▪ Community members and organizations	Multiple meetings from January 2013 to present
Southwest Brooklyn Industrial Development Corporation	▪ David Meade, Executive Director ▪ Justin Collins, Director of Workforce Development	Multiple meetings and communications from January 2013 to present
SUNY Downstate THEO Program BATES Planning Committee	▪ Marian Searchwell, CAPP Coordinator ▪ Youth and staff representatives from CAMBA, HEAT, Project Ally	Bi monthly meetings 2013 to present (February – June only)
Sunset Park Promise Neighborhood Early Learning Network	▪ 14th Street Preschool ▪ Little People Big Dreams ▪ Magical Years Early Childhood Center ▪ St. Andrews Community Day Care ▪ Healthy Families Sunset Park ▪ Parent-Child Home Program ▪ Christ United Methodist Day Care ▪ Warren St. Center for Children ▪ Sunset Park Play House ▪ NYC Department of Education ▪ NYC Administration for Children's Services	Monthly meetings from January 2013 to present
The Door	▪ Various staff	Multiple meetings and communications from January 2013 to present
Turning Point	▪ Tata Traore-Rogers, Executive Director ▪ Margaret Pemberton, Director of Career Pathways and Job Placement ▪ Josh Willis, Education Center Director	Multiple meetings and communications from January 2013 to present
Two Bridges Neighborhood Council	▪ Victor J. Papa, President, ▪ Kerri Culhane, Associate Director ▪ Elisa Rae Espiritu, Director, Development & Communications ▪ E. Francine Gorres, Director of Community Programs ▪ Dan Ping He, Project Manager ▪ Wilson Soo, Director of Administration	Multiple meetings and communication from September 2013 to present

Organizations	Attendees	Dates
	▪ Michael Tsang, Project Manager	
Two Bridges NYCHA Resident Association	▪ Kenneth McIntosh, President ▪ Members and residents	Multiple meetings and communication from September 2015 to present
University Settlement	▪ Bonnie Cohen, Director of Family and Clinical Services ▪ Early childhood staff ▪ Mary Adams Managing Director of Mental Health Programs	Multiple meetings and communication from September 2013 to present
UPROSE	▪ Elizabeth Yeampierre, Executive Director ▪ Ana Orozco, Climate Justice Policy and Programs Coordinator ▪ Ryan Chavez, Infrastructure Coordinator	Multiple meetings and communications from January 2013 to present
Wavecrest Management Grand Street Guild	▪ Leadership team and building board and management	Multiple meetings and communication from September 2015 to present
Zone 126	▪ Anju Rupchandani, Director of Collective Impact ▪ School leaders and administrators	Quarterly meetings 2015-2016

Other health organization partners:

AIDS Service Center NYC	Hamilton Park Nursing & Rehabilitation Center
Arthur Ashe Institute	Hatzolah of Boro Park
Be Well Primary Health Care Center	L'Refuah Health and Rehabilitation Center / Ezra Medical Center
Boropark Care Center for Rehabilitation and Health Care	Maimonides Medical Center
Bowery Residents Committee	Memorial Sloan-Kettering Center for Immigrant Health
Bridge Back to Life Center	Menorah MercyFirst
Brooklyn AIDS Task Force	Metropolitan Jewish Health System (Hospice)
Buena Vida Nursing Home & Rehabilitation Center	New Dimensions
Callen Lorde	Norwegian Christian Home and Health Center
Care for the Homeless	ODA Primary Health Care Network
Cerebral Palsy Association of NYS	Park Slope Center for Mental Health
Charles B. Wang Health Center	Pharmacy on Fifth
Coalition of Asian American IPAs	Premium Health Inc.
Cobble Hill Health Center	Ridgewood Bushwick Senior Citizens Council
Crown Nursing & Rehabilitation Center	Sephardic Nursing & Rehabilitation
Duane Reade Pharmacy	South Beach Psychiatric Services
Ezra Medical Center	SUNY Downstate Medical Center
Gay Men's Health Crisis (GMHC), Inc.	Visiting Nurse Service of NY
Guild for Exceptional Children	White Glove Community Care

School Partners:

PS 1	PS 282
PS 10	PS 288
PS 15	PS 307
PS 18	PS 329
PS 24	PS 369
PS 28	PS 503
PS 31	PS 506
PS 38	PS 971
PS 50	JHS 220
PS 59	MS 88
PS 90	MS 136
PS 94	MS 313
PS 96	Boys & Girls High School
PS 124	Erasmus Academies
PS 153	Juan Morel Campos
PS 164	Sunset Park High School
PS 169	Wingate Educational Campus
PS 172	School District 15
PS 179	School District 20
PS 188	

Shelter partners:

CAMBA
Bowery Residents Committee
Volunteers of America
HELP USA
Grand Central Neighborhood Social Services
Center for Urban Community Services
Project Hospitality
Women in Need
Project Find
NYC Department of Homeless Services

Appendix C

Components

ParentCorps	
Goal	**Prevent Chronic Disease/Promote Healthy Women, Infants and Children through an evidence-based family-centered early childhood intervention to improve child health, behavior and learning**
Outcome objectives	Intermediate: <u>School/Agency</u> ▪ Organizational change in support of policies and practices for Pre-K students and parents ▪ Increased parent/family engagement <u>Professional Development</u> ▪ Participation ▪ Satisfaction ▪ Knowledge gained ▪ Beliefs ▪ Intent to use and actual use of skills <u>Program for Parents</u> ▪ Rates of participation in the program by parents ▪ Parent satisfaction ▪ Parent use of strategies and tools ▪ Fidelity to manuals by teachers and mental health professionals ▪ Staff self-evaluation on implementation and quality of coaching <u>Classroom & Home</u> ▪ Parent knowledge, beliefs and skills ▪ Parent report of child behavior ▪ Parent report of child self-regulation ▪ Parent involvement in education ▪ Support of health-related behaviors for teachers and parents ▪ Healthier eating for children and families ▪ Increased physical activity for children ▪ Decreased sedentary time for children Long-Term: ▪ Organizational change in support of family engagement and early childhood policies ▪ Increase in % of parents engaged in school ▪ Decrease in % of children with behavior problems ▪ Decrease in % of children who are dysregulated ▪ Decrease in % of children in program who are overweight / obese ▪ Sustainable ParentCorps program in 2 sites of University Settlement and schools in CD 3 and Brooklyn

ParentCorps	
Overview	ParentCorps is an evidence-based program developed by NYU Langone Medical Center's Center for Early Childhood Health and Development (CEHD), which is designed to buffer the adverse effects of poverty and related stressors on early child development by engaging and supporting both parents and teachers at children's transition to school. A family-centered intervention, ParentCorps promotes foundational skills in pre-kindergarten and improves achievement test scores and behavioral and physical health in elementary school. ParentCorps works by strengthening family engagement and helping parents and teachers provide high-quality environments. ParentCorps builds adults' capacity to use evidence-based practices to create safe, nurturing and predictable environments in which children thrive. ParentCorps' approach includes the following elements considered essential for achieving positive impact. ParentCorps: • Promotes foundational skills for students as they make the critical transition to school. • Engages diverse parents as partners and creates networks of knowledgeable, empowered and capable parents throughout the school community. • Builds on the strengths of culturally-diverse students and families and includes tailored proactive strategies to address the needs of students with challenging behavior. • Incorporates "best practices" from mental health, education and professional learning to provide supportive, safe and inspiring spaces for educators and parents to work together on their shared goal of helping young children to succeed. • Supports sustainable changes in the early childhood workforce to strengthen program quality, ensure that pre-k and related services are culturally relevant, and promote racial equity and equal opportunities for every student to succeed.
Evidence base	Two federally-funded, randomized controlled trials with more than 1,200 poor, minority NYC children have found that ParentCorps results in more supportive and nurturing home and early childhood classroom environments, higher kindergarten achievement test scores (reading, writing and math) and, among the highest-risk children, lower rates of obesity and mental health problems. A benefit-cost analysis indicates that ParentCorps has the potential to yield cost savings of more than $2,500 per student. [Citations available.]
Where intervention will take place	2 sites of University Settlement and schools in Manhattan CD 3 and Brooklyn sites TBD.
Process measures	Each year has numerical goals attached to the following program activities: <u>Professional development for early childhood staff</u> ▪ classrooms participating ▪ staff members and administrators trained and coached ▪ mental health professionals trained and coached <u>ParentCorps Program for Pre-K Students</u> ▪ students served <u>ParentCorps Program for Parents</u> ▪ parents served <u>Professional development for early childhood staff</u> ▪ Pre-K teachers, Pre-K teaching assistants and Parent Coordinator trained and coached across schools ▪ Pre-K teachers trained across 3 schools ▪ mental health professionals trained and coached across schools ▪ administrators (Principal, Assistant Principal) trained and coached across schools
Partner role	The program confers extensively with policy makers and City and State officials. It also works intensively with University Settlement and several schools, which participate in the program, provide advice about and support for implementation, and provide access to staff, parents,

ParentCorps	
	and students.
Partner resources	Partner provide advice about and support for implementation, and provide access to staff, parents, and students.
By when	Intervention continues for the next three-year cycle with intermediate outcomes in 2/3 years and longer term outcomes in 5 years.
Will action address disparity	Yes. Program addresses needs of low income populations, particularly Latino and Asian American families

Greenlight	
Goal	**Prevent Chronic Disease by lowering rates of childhood obesity in the Chinese American community**
Outcome objectives	Intermediate ▪ Improved parent/family knowledge, attitudes, and practices related to their child's diet and physical activity ▪ Increased parent/family engagement in children's health ▪ Increased parent confidence / empowerment ▪ Increased staff knowledge and awareness ▪ Improved provider engagement and satisfaction ▪ Greater provider use of recommended health communication strategies Long-Term ▪ Healthier eating behaviors / practices for children/ families ▪ Increased physical activity / decreased sedentary time for children ▪ Reduced media exposure ▪ Exploratory goal: 20% relative reduction in rate of obesity from ~25% to ~20% among 3-5 year olds
Overview	Taking advantage of the frequency of primary care pediatric visits in the early years of life, the Department of Pediatrics at NYUHC, in partnership with the Charles B. Wang Community Health Center, has adapted an evidence-based program that teaches families about healthy eating and activity in order to prevent early childhood obesity in the Chinese American community. The Greenlight program, which was developed as part of an NIH-funded grant in settings that serve predominantly low-income black and Hispanic families, trains pediatricians how to communicate with families using toolkits that contain culturally-tailored educational materials for people with low literacy. Greenlight focuses on improving health literacy and fostering family engagement through three core components: ▪ Low literacy toolkits to support physician counseling around diet and activity-related behaviors at well-child visits starting at 2 months of age, which include booklets containing age-specific recommendations and 'tangible tools' to support evidence-based obesity prevention messages (e.g. portion size snack cups); ▪ Training of providers in health communication strategies (use of plain language, supplementing counseling with written information, along with teachback and goal setting); ▪ Waiting room program where health educators promote family engagement in care as they introduce and support Greenlight messages; ▪ New initiative to enhance reach of Greenlight through technology enhancements.
Evidence base	From a preliminary analyses of the NIH study, at 4 months, children whose parents received the GREENLIGHT intervention were more likely to be breastfeeding (49 vs 38%, p=0.05), less likely to drink juice (5 vs 8%, p=0.02), less likely to receive cereal in the bottle (21 vs 30%, p=0.001), and had less television exposure (p=0.004). Intervention parents were also less likely to make a child finish a bottle (p=0.004), prop a bottle for feeding (p=0.014), or feed to stop crying (p=0.014). Similar results were seen at 6-months. The results suggest the intervention positively impacts parent behaviors related to infant feeding and screen time. Future results will examine the impact of the intervention on these outcomes and weight status through 2 years. [Citations available.]
Where intervention will take place	Charles B. Wang Community Health Center and the NYU Lutheran Family Health Centers Brooklyn-Chinese site in Sunset Park.

Greenlight	
Process measures	Process measures are gathered for each of the three years, including the following for each year: ▪ Provide Greenlight materials to CBWCHC families at well-child visits (2, 4, 6, 9, 12, 15-18m check-ups) o Core booklets o Supp. booklets o Tangible tools (e.g. portion size snack cups) ▪ Continue to provide Greenlight materials to cohort of enrolled families o Continue assessments at 6, 12 months ▪ Conduct training with ~20 current providers (physicians, nursing staff, nutritionists, health educators) on Greenlight program / health literacy (HL)-informed counseling ▪ Program reaches 80% of 0-2 year old children seen at CBWCHC, representing ~450 participants ▪ 1000+ booklets ▪ Greenlight waiting room program delivered to 50% of eligible children ▪ 300 families reached ▪ Peer training of new staff ▪ Digital Greenlight flipbooks available on line for staff to send to parents and for parents to email share with family members ▪ Use of Greenlight booklets tracked via web tools ▪ Explore promotion of Greenlight materials via social media networks
Partner role	Charles B. Wang Community Health Center and the NYU Lutheran Family Health Centers Brooklyn-Chinese site in Sunset Park both provide leadership, staff support and access.
Partner resources	Partners provide personnel and access as well as program leadership.
By when	Intervention continues for the next three-year cycle with intermediate outcomes in 2/3 years and longer term outcomes in 5 years.
Will action address disparity?	Yes. Project addresses need of low-income Chinese American families

Healthy Families Program/ Programa Familias Saludables	
Goal	**Prevent Chronic Disease by reducing obesity in children**
Outcome objectives	<u>Intermediate</u> ▪ Increase knowledge and awareness of nutrition, physical activity, and other healthy lifestyle concepts ▪ Improve compliance with 5-2-1-0 daily guidelines – increase fruit and vegetable consumption (to 5 or more); decreased screen time (to 2 hours or less of recreational screen time); increase activity (to 1 or more hours per day); decrease sugar sweetened beverage consumption (to 0 per day, more water) ▪ Stabilize or reduce BMI scores <u>Long-Term</u> ▪ Reduce the percentage of children and adolescents who are obese
Overview	NYU Lutheran Family Health Centers' Healthy Families Program combines preventive programming with research-based interventions designed to equip children to develop healthier behaviors and attitudes around healthy living. The 12-session, multi-disciplinary program for 9- to 11- year-old Hispanic children with high body-mass index (BMI) scores aims to stabilize or slowly decrease weight (1 pound per month) and BMI scores. We focus on children aged 9-11, as this is a time when children begin to become independent from their parents and are able to evaluate and alter their dietary habits and attitudes. The curriculum is culturally relevant to the local Hispanic population and sessions are conducted in English and Spanish. Each session consists of: ▪ Nutrition education facilitated by a nutritionist focusing on the 5-2-1-0 model in the local and cultural contexts of the participating

Healthy Families Program/ Programa Familias Saludables	
	families. ▪ Separate support groups for parents and children that address questions, help them adopt strategies for setting limits and promoting healthy behaviors, and build peer support. ▪ Physical fitness focused on low- or no cost activities that can be done at home or through local community resources, are led by a NYU Lutheran rehabilitation staff, and local businesses (pro-bono), such as martial arts and dance. A primary care physician consults on participants' health and makes referrals to social supports and specialists as needed.
Evidence base	▪ The National Initiative for Children's Healthcare Quality 2007 child and obesity prevention and treatment recommendations were used as a guideline. ▪ Concepts from the following evidence-based, multi-component programs and curricula were used: Media Smart Youth; We Can! Energize Our Families; Nutrition to Grow On; and, Eat Healthy, Be Active. ▪ New York State Department of Health's Prevention Agenda recommends that parents and caregivers work together to prevent childhood obesity by providing healthy meals and snacks, promoting physical activity, and discussing nutrition that will promote healthy eating behavior. ▪ Multi-disciplinary programs that include behavioral counseling, promotion of physical activity, parent training, and dietary counseling provide the most effective treatment for obesity in children and adolescents. ▪ Programs that include family members have significant effects on stabilizing or reducing percentage BMI-for-age. ▪ Principles from the Shared Medical Appointment (SMA) framework were used to inform the program. SMAs are often multi-disciplinary and family based, include group sessions as well as individual contact with a physician, and often lead to greater patient satisfaction and compliance, and better outcomes. SMAs can be cost-effective, help patients get answers to questions they would not other ask, create a sense of empowerment, and provide community support. [Citations available.]
Where intervention will take place	The program currently takes place in Sunset Park, Brooklyn at NYU Lutheran facilities. We plan to expand the program to include school-based health centers and expand from one site to four sites, with two cycles per year at each site. School-based health centers offer medical and mental health services on-site at local schools and offer a unique opportunity to base the program directly where children spend their day.
Process measures	▪ Conduct a total of 2 cycles in four sites per year ▪ Reach 80 children and families per year ▪ Retain ≥ 75% of enrolled families for 9 or more sessions
Partner Role	The program partners with organizations and businesses to support participant recruitment and program implementation (fitness instructors, participant incentives, field trips; etc.). Several partners include: ▪ Center for Family Life ▪ Sunset Park Martial Arts ▪ Young Dancers in Repertory ▪ Brooklyn Health ▪ Empire Blue Cross Blue Shield
Partner resources	Staff time to support recruitment and program implementation. Food and/or material donations for recruitment, program implementation and participant incentives.
By when	▪ Intermediate outcome measures are projected to be achieved by the end of each program cycle ▪ Sustained BMI score stabilization or decrease is projected for 1-year post-program ▪ Long-term goal is projected to be achieved in/by 2022 ▪ Process measures are projected in/by 2019
Will action address disparity?	Yes. The Healthy Families Program/ Programa Familias Saludables addresses racial and income disparities with regard to obesity. There are

Healthy Families Program/ Programa Familias Saludables	
	disparities in obesity rates by ethnicity and poverty in New York City. Hispanic and African American residents are disproportionately represented.

Two Generations	
Goal	**Promote Healthy Women, Infants and Children, through a program that seeks to reduce the negative health impact of perinatal depression and adverse childhood events on maternal and child physical and mental health**
Outcome objectives	Develop a project model that will: ▪ Address maternal stressors, improve maternal mental health, and facilitate maternal engagement in positive interactions and behaviors with the child; ▪ Facilitate positive and responsive parent-child interactions to enhance the parent-child relationship and child outcomes, and simultaneously reduce stress and enhance coping for mothers with depressive symptoms; and ▪ Transform the coordination of care across the prenatal and pediatric settings through training and supporting staff in the delivery of continuous, comprehensive, and culturally effective care to increase family engagement, deliver more timely and effective screening and interventions, facilitate referral to behavioral care, and enhance maternal and child outcomes.
Overview	Maternal stressors during the prenatal period increase the risk of pre- and postnatal depression, the likelihood of pregnancy complications and adverse birth outcomes, and decreased responsiveness in the newborn, as well as reduced mother-child interactions, harsh discipline, lower initiation of breastfeeding, over feeding, and increased Emergency Department visits. Fetal exposure to maternal stress in pregnancy negatively impacts a child's neuro-development and increases the likelihood of poor health outcomes, such as delays in communication, socioemotional competence, cognitive functioning, behavioral problems, and chronic conditions. These adverse early influences in turn set the stage for subsequent impaired scholastic achievement, conduct disorder, criminal justice system involvement, and a trajectory of disadvantage. In the first year of this Community Service Plan, we will lay the groundwork for implementing a cross-site intervention that would comprehensively implement effective tools to mitigate these life-long impacts in perinatal and pediatric care in the NYU Lutheran Family Health Centers and in partnership with NYC Health + Hospitals' Gouverneur Health. In this exploratory phase, we will develop and refine a program model that will integrate a comprehensive set of evidence-based interventions that cross the birth-line and thus have the potential to simultaneously improve outcomes for two generations.
Evidence base	The initiative seeks to integrate several evidenced-based programs into a single, comprehensive program: ▪ Healthy Steps ▪ Starting Early (StEP) ▪ Reach Out Stay Strong Essentials (ROSE) ▪ STRONG Moms ▪ Video Interaction Project [Citations for evidence base of program components are available.]
Where intervention will take place	NYU Lutheran Family Health Centers and in partnership with NYC Health + Hospitals' Gouverneur Health
Process measures	Model development; additional funding support (pending)
Partner role	Gouverneur Health and NYU Lutheran Family Health Centers are playing key roles in program development and will design and implement the model.
Partner resources	Staffing, resource development, design and implementation.
By when	Program planning and model development in year one; program implementation and outcome measurement in years two and three.
Will action address disparity?	Yes. Poverty is a key risk factor. This program is designed to address the needs of low-income, primarily immigrant populations.

Housing + Health	
Goal	**Prevent Chronic Disease by addressing social determinants of health in affordable housing**
Outcome objectives	<u>Intermediate</u> ▪ Lifestyle changes (diet/exercise) ▪ Increased use of tobacco cessation resources ▪ Resolution of apartment/ structural issues ▪ Improved coordination of health care and social services ▪ Resident satisfaction with and acceptance of CHW program ▪ Increased resident engagement in improving health status and overall well being ▪ Improved management of chronic illnesses ▪ Reduced utilization of emergency departments ▪ Reduced inpatient hospital stays <u>Long-Term</u> ▪ Reduced utilization of emergency departments ▪ Reduced inpatient hospital stays ▪ Improved self-reported health status ▪ Improved management of chronic illnesses ▪ Improved healthful behaviors ▪ Increased self-efficacy ▪ Decrease in smoking prevalence ▪ Reduced costs
Overview	The Health+Housing Project, a Community Health Worker program to address social, environmental, behavioral, and structural determinants of health, is being implemented initially in two low-income buildings in CD 3 in partnership with Henry Street Settlement, the NYU Furman Center for Real Estate and Urban Policy, the New York City Housing Authority, the NYC Department of Housing Preservation and Development, Hester Street Collaborative, the Chinatown Y, the Two Bridges Neighborhood Council, and with support from the Robin Hood Foundation.
Evidence base	Poor health is often concentrated within the same neighborhoods that face concentrated poverty and other social ills. People living in such neighborhoods have high levels of chronic disease, mental illness, and exposure to environmental risks such as injury and violence. Not surprisingly, they concomitantly have high use of costly health care services, including frequent emergency department visits and hospitalizations. Studies have found that CHW interventions can result in improved health outcomes. Published reports suggest that CHW interventions that address multilevel structural and environmental determinants of health, in addition to traditional "health care" factors, may be particularly effective. As recently noted, there is growing interest in CHW interventions that address upstream factors of health, and current policies and programs in the U.S. are poised to further increase this trend. [Citations available.]
Where intervention will take place	Two buildings on the Lower East Side and in later in Brooklyn, location TBD.
Process measures	<u>Program implementation and tracking</u> ▪ Ongoing training of CHWs ▪ CHWs implement program to all interested residents (150-200) ▪ Track: o # and type of referrals o # and type of appointments set o # and type of navigation activities o # and type of events sponsored <u>Assess program implementation</u> ▪ Develop and translate follow- up survey

Two Generations	
	▪ Hire and train 4 bilingual community surveyors ▪ Track CHW activities ▪ Track resident participation in CHW program (those reached vs. not reached) ▪ Conduct and analyze follow up survey ▪ Conduct focus groups and exit survey with CHWs to assess strengths and weaknesses of program implementation
Partner role	The project partners with Henry Street Settlement, which hires and supervises the CHWs; the NYU Furman Center for Real Estate and Urban Policy, the New York City Housing Authority (NYCHA), the NYC Department of Housing Preservation and Development (HPD), Hester Street Collaborative, the Chinatown Y and with support from the Robin Hood Foundation.
Partner resources	Partners provide personnel and access as well as program leadership. Robin Hood provides funding support.
By when	Current intervention continues for one additional year and outcomes will be measured thereafter. Expansion in years two and three.
Will action address disparity?	Yes. Project addresses need of low-income residents of the Lower East Side and eventually in Brooklyn, location TBD

Tobacco Free Community	
Goal	**Prevent Chronic Disease by lowering rates of smoking and reducing exposure to secondhand smoke**
Outcome objectives	<u>Intermediate</u> ▪ Satisfaction with tobacco cessation training by navigators, health educators and providers ▪ Retention of smokers (attempt to quit, permanently quit) ▪ Increased use and access to evidence-based smoking cessation program (ecological and behavioral) ▪ Increased Self-reported use of services/ medications ▪ Decreased Smoking rates in past 7, 14, and 45 days among those interacting with navigators and coaches ▪ Increased attendance ▪ Satisfaction with program (outreach activities and quality of navigators and health educators) ▪ Increased knowledge on smoking ▪ Changes in attitudes toward smoke-free housing ▪ Changes in smoking policies in 3-5buildings <u>Long-Term</u> ▪ Increase capacity among community partners and physicians to address smoking through screening, counseling, and referral to evidenced-based smoking cessation program ▪ Increased self-reported use of services/ medications ▪ Decreased smoking rates in past 7, 14, and 45 days ▪ Increased support for smoke-free housing and NYCDOH proposed regulations ▪ Decreased levels of CO (exploratory)
Overview	In partnership with Asian Americans for Equality (AAFE), experts from the Section on Tobacco, Alcohol, and Drug Use in NYUHC's Department of Population Health are implementing a community navigator model, which mirrors the patient navigator model that has been well studied and implemented by the American Cancer Society. This model provides lay workers or resident/ community volunteers the skills to educate and motivate people in the community to address modifiable health risks, like tobacco use, and link community members to evidence based smoking cessation resources. Despite the availability of safe and effective treatment for tobacco dependence, only a small proportion of smokers who try to quit each year use cessation therapies. This is particularly true among low-income adults and for non-English language speakers, contributing to growing disparities in smoking prevalence. The Community Service Plan navigator program is designed to address this gap. Program also includes a growing group of health care centers and individual providers.
Evidence base	The Community Preventive Services Task Force recommends quitline interventions, particularly proactive quitlines (i.e. those that offer follow-

Tobacco Free Community	
	up counseling calls), based on strong evidence of effectiveness in increasing tobacco cessation among clients interested in quitting. Evidence was considered strong based on findings from 60 trials of proactive telephone counseling when provided alone or in combination with additional interventions. [Citations available.]
Where intervention will take place	Manhattan CD 3 and Sunset Park
Process measures	Process measures are gathered for each of the three years, including the following for each year: ▪ Develop and refine curriculum ▪ 2 navigators trained and become certified tobacco treatment specialist ▪ 3 trainings conducted for members (health care providers) of Chinese American Independent Practice Association (CAIPA) and Chinese American Medical Society (CAMS) ▪ 100 smokers completed baseline interview ▪ 75 received Nicotine Replacement Therapy (NRT) ▪ 50 completed two week follow-up interview ▪ 50 online referrals to Asian Smokers Quitline ▪ Collaborate with 3-5 community based organizations to raise awareness about the dangers of smoking and secondhand smoke, to provide smoking cessation counseling and referrals to clients and members, and to help adopt smoke-free policies ▪ Conduct street intercept survey with 100 Asian Americans residents of NYC to understand attitudes towards smoking, knowledge of second hand smoke, and availability of low-price cigarettes ▪ Develop housing-based organizing strategy ▪ Select buildings for smoke-free initiatives and develop strategies
Partner role	Partnership with Asian Americans for Equality (AAFE) and Charles B. Wang Community Health Center (CBWCHC), NYCHA, NYU Lutheran Family Health Centers Brooklyn-Chinese site in Sunset Park. All provide advice, access, and leadership. AAFE hires and supervises navigators.
Partner resources	Partners provide personnel and access as well as program leadership. CBWCHC also received a grant from the RCHN Foundation to support tobacco cessation efforts.
By when	Intervention continues for the next three-year cycle with intermediate outcomes in 2/3 years and longer term outcomes in 5 years.
Will action address disparity?	Yes. Project focuses on Chinese American men, who have among the highest rates of smoking in NYC.

Project SAFE	
Goal	**Promote Healthy Women, Infants, and Children through an evidence-based youth development program that addresses reproductive, preconception and Inter-conception health**
Outcome objectives	<u>Intermediate</u> ▪ Increase knowledge and awareness of STD, HIV, and pregnancy prevention ▪ Increase knowledge of prevention and intervention resources ▪ Increase knowledge and skills – facilitation, community event planning, and outreach ▪ Increase knowledge of HIV and STI status ▪ Increase knowledge of contraceptive options ▪ Behavior change – intent to use and actual use of skills, practices, and resources ▪ Increase the number of sexually active youth that consistently use condoms ▪ Increase the number of youth that delay sexual activity ▪ Increase the number of sexually active youth that use contraception to prevent unintended pregnancy <u>Long-Term</u>

Project SAFE	
	▪ Reduce teen pregnancy ▪ Reduce disparities in teen pregnancy rate for Hispanic and African American teens in relation to white teens ▪ Reduce teen birth rate ▪ Reduce disparities in teen birth rate for Hispanic and African American teens in relation to white teens ▪ Reduce disparities in teen birth rate for teens with Medicaid in relation to teens not on Medicaid ▪ Reduce STI and HIV rates among male and female adolescents
Overview	NYU Lutheran Family Health Centers' 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. The program empowers an inclusive network of individuals and communities to increase teens' access to culturally-appropriate sexual health information and services. Project SAFE has been providing teen leadership and HIV peer education programming since 1989 at the Project Reach Youth (PRY) site in Brooklyn. Project SAFE trains youth ages 14 - 19 to provide life-saving information to their peers through workshops, performances, and community outreach. Project SAFE provides young people with the support and the opportunities they need to not only avoid risky behaviors, but to develop to their full potential and become agents of change in their communities. The program includes: ▪ Multi-session evidence-based sexual health workshop series ▪ Peer-led health education groups ▪ Community events and single-session workshops ▪ Sexual health services designed to meet the unique needs of adolescents provided at our Teen Health Clinics.
Evidence base	4Me! (part of the Teen Health Project) curriculum: culturally appropriate and has been shown to postpone sexual activity and increase condom usage. The Be Proud! Be Responsible! (BPBR) curriculum: aligned with community needs, has been found to be effective with a similar population to our target population, and has a format that is a good fit for both the population and our settings, particularly out of school groups. In four high-quality randomized trials, it was found to delay sexual activity, increase use of condoms, and decrease sexual activity when used in urban settings in high schools and community settings. [Citations available.]
Where intervention will take place	▪ Schools and events in Sunset Park and other underserved Brooklyn communities ▪ Project Reach Youth center in Park Slope, Brooklyn ▪ Teen Health Clinic in Park Slope, Brooklyn
Process measures	▪ Conduct a total of 65 cycles of BPBR and 4Me! ▪ Curricula administered with high fidelity ▪ Reach 1600 teens ▪ 450 teens referred to social and health services ▪ 300 teens access youth development services ▪ Expand to 2 new sites ▪ 75% of workshop participants will complete 75% of workshops
Partner role	Project SAFE partners with schools and community organizations for program recruitment and implementation.
Partner resources	Staff collaboration on joint community programming
By when	▪ Increased knowledge and awareness, behavior intent, and certain behavior change outcomes are projected to be achieved at the end of each program element ▪ Long-term outcomes are projected to be achieved in/by 2022 ▪ Process measures are projected to be achieved in/by 2019
Will action address disparity?	Yes. Project SAFE addresses racial and income disparities in teen birth rates. There are substantial disparities in teen birth rates by ethnicity

Project SAFE	
	and poverty in New York City. Hispanic and African American teens are disproportionately represented in teen birth rates, as are teens on Medicaid.

REACH FAR	
Goal	**Prevent chronic disease by providing access to healthy foods and beverage and promoting hypertension management**
Outcome objectives	Intermediate ▪ Increased percentage of people reporting healthy change in diet in the past 3 months ▪ Increased prevalence of self-reported blood pressure screening ▪ Increased access to messages regarding CVD prevention and management Long-Term ▪ Increased frequency of those reporting having tried healthy options at communal meals ▪ Increased percentage of controlled hypertension (systolic BP<140, diastolic BP<90) among those with hypertension ▪ Increased access to messages regarding CVD prevention and management
Overview	Building on the important role that faith-based organizations can play in affecting the health of immigrants and racial and ethnic minority populations, the Racial and Ethnic Approaches to Community Health for Asian AmeRicans (REACH FAR) program will partner with mosques on the Lower East Side and in Sunset Park to improve blood pressure control and promote healthy eating using a three-pronged approach: (1) nutritional strategies, including education and changes to communal food practices; (2) blood pressure control training and monitoring; and (3) culturally tailored communications and education.
Evidence base	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. [Citations available.]
Where intervention will take place	Manhattan CD 3 and Sunset Park
Process measures	Implement nutritional policy in faith-based settings (FBO) ▪ Identify champion or health committee at Assafa and Madina Masjids ▪ 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 ▪ Identify champion or health committee at 2 additional mosques in Sunset Park ▪ 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 quarterly monitoring of nutritional policy change at Assafa and Madina Implement blood pressure screening program in FBO setting

REACH FAR	
	▪ Identify champion or health committee at Assafa and Madina ▪ Train 5 volunteers at FBO site on Keep on Track (KOT) manual ▪ Implementation planning – training of key personnel, development of implementation protocol ▪ Launch KOT program, enrolling 75 congregants at each site ▪ Conduct monthly blood pressure screening with 50 congregants at each site ▪ Identify champion or health committee at 2 additional Sunset Park mosques ▪ Train 5 volunteers at FBO site on KOT manual ▪ Implementation planning – training of key personnel, development of implementation protocol ▪ Launch KOT program, enrolling 75 congregants at each site ▪ Conduct monthly blood pressure screening with 50 congregants at each site (4 sites total Conduct communication activities ▪ Conduct quarterly dissemination to ethnic media/social media regarding program ▪ Conduct quarterly mosque-wide educational session on HTN management at Assafa and Madina ▪ Conduct quarterly dissemination to ethnic media/social media regarding program ▪ Host community forum in Sunset Park to share results of the program
Partner role	Partnership with 4 mosques which will provide access and volunteer staff, as well as leadership and advice.
Partner resources	Partners provide personnel and access as well as program leadership.
By when	Intervention continues for the next three-year cycle with intermediate outcomes in 2/3 years and longer term outcomes in 5 years.
Will action address disparity?	Yes. Project focuses on South Asians, who are vulnerable to insulin resistance at lower weight levels and who are not reached by many health campaigns

Appendix D

Selection of Other Community Programs

NYUHC Program	Intervention/Program Model	Partners	NYS Prevention Agenda - Primary Priority Area(s)
AmeriCorps	• National Service placements • Training and workforce experience • Stipend • Child care expenses paid if eligible • Higher education scholarship upon completion • Focus on community health, early childhood education, and financial literacy	• ArchCare Time Bank • Brooklyn Workforce Innovation/ Fifth Ave Committee • Turning Point • Financial Clinic	• Other: Promote Voluntarism
Community Empowerment Program	Community Adult Education and Workforce Development: • English Language skill building classes • Career pathway workforce development • Emergent Curriculum: project-and inquiry-based learning, Community Language Learning	• ArchCare Time Bank • Center for Family Life	• Other: Promote Economic Opportunity
Center for Healthful Behavior Change	• Blood pressure screening and other interventions in over 130 faith-based organizations and over 100 barbershops, as well as 64 other community based organizations, reaching over 12,000 adults, primarily African American, who are particularly vulnerable to hypertension • Screening and education, including online interactive resources, to increase awareness and knowledge about sleep health, assessment for sleep problems, and adherence to recommended treatment for Obstructive Sleep Apnea in over 115 community based organizations, barbershops, beauty salons and faith-based organizations	• Over 130 faith-based organizations • Over 100 barbershops/beauty salons • Over 200 community-based organizations • Arthur Ashe Institute for Urban Health • Senior centers • Federally Qualified Health Centers	• Prevent Chronic Diseases
Center for Corporate Wellness	• Screenings, health fairs, and workshops on cardiovascular health, diabetes, nutrition, physical activity, smoking cessation, stress management and other programs at worksites across the City to help employees make sound and informed health choices • Directly engaged over 19,000 employees in worksite programs		• Prevent Chronic Diseases

NYUHC Program	Intervention/Program Model	Partners	NYS Prevention Agenda - Primary Priority Area(s)
Center for the Study of Asian American Health	• Screened over 9,000 Asian Americans for hepatitis B; over 2,000 Asian Americans for diabetes and diabetes risk; and nearly 1,000 for hypertension • Conducted hypertension prevention outreach and dissemination of information reaching close to 4,000 individuals through Asian-serving faith-based organizations and over one million individuals via dissemination strategies and information through Asian-serving grocery stores, restaurants and communication channels in New York and New Jersey • Enrolled 700 Asian Americans into community health worker programs to address diabetes and hypertension prevention and management • Enrolled over 280 individuals into the NY State of Health Insurance Marketplace	• 48 faith-based organizations • 33 social service providers/ community-based organizations • 3 senior centers	• Prevent Chronic Diseases
Connections to Care	Increase access to mental health care and build partner capacity through Mental Health First Aid Training for front line staff	• Arab American Association of New York • Red Hook Initiative	• Promote Mental Health and Prevent Substance Abuse
Early Childhood Centers: • 14th Street Preschool • Magical Years Early Childhood Center • St. Andrews Community Day Care • Warren Street Center for Children and Families	Infant/Toddler, Preschool, UPK, and after-school programming, family support, Creative Curriculum	• Cool Culture • Sunset Park Library • Touro College • Brooklyn College • Guild for Exceptional Children • Work, Grow, and Learn • Center for Family Life	• Promote Healthy Women, Infant, and Children
Faith-Health Partnership	Partnerships with Faith Based Organizations to provide: • Screenings / Individual consultation with nurse • NYCDOHMH Keep on Track • Health Education • Access to a medical home	• Faith-based Organizations • Food Bank of New York City • ArchCare Time Bank • NYC DOHMH • Medical Reserve Corps • NYC College of Technology (CUNY)	• Prevent Chronic Diseases
Family Support Services	• Short Term Crisis Counseling (including Intimate Partner Violence) • Case Management/Referral (Motivational Interviewing) • Supportive counseling	• Center for Antiviolence Education • Center for Family Life • American Immigration Lawyers Association - New York Chapter • Her Justice	• Promote a Health and Safe Environment; • Promote Healthy Women, Infants and Children; • Promote Mental Health and Prevent Substance Abuse • Other: Economic Opportunity

NYUHC Program	Intervention/Program Model	Partners	NYS Prevention Agenda - Primary Priority Area(s)
Healthy Families Sunset Park	Healthy Families National: Home Visiting, positive parent-child bonding, optimal child development, family self-sufficiency, prevention of child abuse and neglect	• Healthy Families New York	• Promote Healthy Women, Infant, and Children
HIV High Intervention Program (CDC)	• Education/Linkage to urgent medical appointment for PEP • Linkage navigation from early identification to PrEP services • Targeted HIV Testing • Integration of two evidence-based programs: Prevention with Positives= Health Relationship; and Prevention with Negatives= Community Promise	• Mixteca • Caribbean Women's Health Association • Turning Point • Bridging Access to Care • CAMBA	• Prevent HIV, STD, Vaccine-Preventable Diseases and Healthcare- Associated Infections
Laura and Isaac Perlmutter Cancer Center	Community outreach and screening programs. For example: • Partnered with the Center for Elimination of Cancer Disparities at NYU Langone to host *Community Voices,* a Town Hall Discussion regarding challenges various communities face that may contribute to cancer disparities • Hosted *The Link Between Cancer and Nutrition,* a community program that highlighted lifestyle factors, including your diet, that can make a difference in cancer prevention and treatment	• Charles B. Wang Community Center • Woodhull Medical Center • Bellevue Hospital Center • Cancer Care • American Academy of Dermatology • Head and Neck Cancer Alliance • Foundation for Women's Cancers • The Creative Center: Arts in Healthcare • Metastatic Breast Cancer Network • SHARE • Kidney Cancer Association • Lung Cancer Alliance • Mollie Biggane Melanoma Foundation • Leukemia and Lymphoma Society	• Prevent Chronic Diseases
Beatrice W. Welters Breast Cancer Program	Improve outcomes for underserved women with breast cancer by reducing barriers to quality care and advancing pioneering treatments for breast cancer. The program has three goals: • To advance an effective and scalable community-based navigation model for reducing disparities in screening and diagnostic follow-up care in medically underserved women • To improve access to and use of high quality breast cancer care and supportive services at Bellevue, Tisch, and NYU Lutheran hospitals among underserved woman utilizing patient navigation • To increase access to and participation in clinical	• Faith-based organizations • Salons • Bellevue Hospital • NYU Silver School of Social Work • American Cancer Society • Arthur Ashe Institute for Urban Health • Cancer Care • SHARE • NY State Department of Health Cancer Services Program • Sisters Network • Susan G. Komen	• Prevent Chronic Diseases

NYUHC Program	Intervention/Program Model	Partners	NYS Prevention Agenda - Primary Priority Area(s)
	trials for the most promising and innovative therapies for breast cancers among underserved women Initially targets the neighborhoods of Bedford-Stuyvesant and Brownsville in Brooklyn, and East and Central Harlem in Manhattan		
Neighborhood Centers for Older Adults • Sunset Park • Shore Road	• Free/Low-Cost meals for low-income seniors • Social, educational, and recreational activities • Friendly visiting for home-bound seniors • Assistance in applying for SNAP benefits • Emergency food distribution	• Guild for Exceptional Children • NY Common Pantry • SUNY Downstate College of Nursing • NYU College of Nursing • MAZii Learning Center • The Healing Center • AARP • Senior Whole Health • Lighthouse Guild • Visions • American Diabetes Association • LiveOn NY • American Italian Cancer Foundation • NYC Board of Education – Adult Learning • ArchCare TimeBank • Brooklyn Arts Council	• Prevent Chronic Diseases; • Promote a Healthy and Safe Environment
Parent Child Home Program	Parent Child Home Program: • Intensive home visiting • Parenting education • Early literacy and school readiness	• Dedalus Foundation • Advocates for Children • New York Center for Child Development	• Promote Healthy Women, Infant, and Children
Programa de Familias Saludables/ Healthy Families Childhood Obesity Program	Shared Medical Appointments Framework: Multi-disciplinary approach including • Nutrition education, • Physical fitness • Support groups over 12-week cycles	• Sunset Park Martial Arts • Center for Family Life • Brooklyn Health and Performance	• Prevent Chronic Diseases

NYUHC Program	Intervention/Program Model	Partners	NYS Prevention Agenda - Primary Priority Area(s)
Project Reach Youth – Education and Career Services • High School Drop-out Prevention • Next Step College and Career Access, • Male Empowerment Program	Youth Development Approach to support skill development, educational attainment, job readiness: • Primary Person Model • Positive Youth Development • College access/dropout prevention • SAT and Regents Prep • Tutoring • Student centered HSE/PRE-HSE curriculum • Job readiness and internship placement • Conflict resolution	• Turning Point • Brooklyn Zen Meditation Center • Red Hook Initiative • Red Hook Community Justice Center	• Promote Healthy Women, Infants, and Children
Project Reach Youth - Project SAFE	Youth Peer Education Model: • Utilizes the Teen Health Project and Be Proud! Be Responsible! • Pregnancy, STD/HIV prevention • HIV Counseling and Testing	• Diaspora Community Services • Youth Organizing to Save Our Streets (Y.O.S.O.S.) • Day One • Teens Helping Each Other (THEO) • Red Hook Community Justice Center	• Promote Healthy Women, Infants and Children; • Prevent HIV, STD, Vaccine-Preventable Diseases and Healthcare- Associated Infections
Reach Out and Read	Pediatric Literacy Intervention: • Book distribution in well-child visits 0-5yrs of age • Anticipatory guidance for caregivers • Model reading in waiting areas	• ArchCare Time Bank	• Promote Healthy Women, Infant, and Children
Seniors in Touch	Social Adult Day Program: • Program focus on Alzheimer's Disease and other dementias • Creative arts activities focused on cognitive acuity • Service coordination • Transportation • Caregiver respite/resources	• Brooklyn Conservatory of Music • JASA Caregiver and Respite Program • Brooklyn Museum • Alzheimer's Poetry Project • CaringKind NYC • Rhythm Breaks • DFTA • Materials for the Arts	• Prevent Chronic Disease; • Promote Mental Health and Substance Abuse
Services for Older Adults • Bay Ridge on the Move • Service Coordination in Senior Housing • Health and Wellness	• Housing and supportive services • Access to medical and rehabilitative care • Service coordination • Health educational and recreational activities • Transportation services • Fall prevention assessment and education • Memory screening • Flu vaccines	• Bay Ridge Council on Aging • NYC Board of Education – Adult Learning • ArchCare Time Bank • Walgreens (flu shots) • NYS Department of Transportation	• Prevent Chronic Diseases; • Promote a Healthy and Safe Environment

NYUHC Program	Intervention/Program Model	Partners	NYS Prevention Agenda - Primary Priority Area(s)
Sunset Park Promise Neighborhood Early Learning Network	Collective Impact Model: • Coordinated professional development • Coaching and mentoring • Advocacy to increase capacity and quality of early childhood services in Sunset Park, Brooklyn	• Committee for Hispanic Children and Families • Christ United Day Care • Sunset Park Playhouse Family Daycare Center • Little People, Big Dreams Family Daycare Center • NY Center for Child Development • NYU Play Lab	• Promote Healthy Women, Infant, and Children
Transitions in Care	Community case management services to high-risk community residents with the goal of improving health outcomes and reducing unnecessary emergency room and hospital admissions • Transition from care at emergency department to a Medical Home and other community services • Supports to bolster patients' ability to self-manage their conditions, including improving their understanding of their condition and ability to recognize and respond to red flags associated with worsening health • Connections to community-based resources to address housing, public benefits, food access, and other social determinants of health • Outreach to patients in crisis to reconnect them to services and supports • Use of Motivational Interviewing	• Center for Family Life • Other community-based organizations	• Prevent Chronic Diseases
Women Infant and Children Program	• Supplemental food packages for pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five • Participant-Centered Nutrition Education and Counseling • Breast-Feeding Support and promotion through peers counselors • Community wellness and outreach activities • Referrals	• Mixteca • Food Bank of NYC • Grow NYC • Toys R Us	• Promote Healthy Women, Infants and Children

New York State Medicaid Delivery System Reform Incentive Payment (DSRIP) Projects			
NYUHC Program	**Intervention/Program Model**	**Partners**	**NYS Prevention Agenda - Primary Priority Area(s)**
DSRIP Project 2.b.iii ED Care Triage for At-Risk Populations	• Evidence-based triage protocols • Patient education and Behavioral health support • Enroll all eligible patients into Health Home	N/A	Other: Promote Primary Care Access
DSRIP Project 2.c.i Development of Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently	• High risk case management • Care transitions &patient navigation • Community resource guide	In development	Other: Promote Primary Care Access
DSRIP Project 3.a.i Integration of Primary Care and Behavioral Health Services	• Colocation of social workers in primary care settings with 'warm transfers' • IMPACT model (Improving Mood - Providing Access to Collaborative Treatment) • Tele-psychiatry services to sites that cannot collocate behavioral health providers	• ODA Primary Health Care Network • EZRA Medical Center • Metro Community Health Centers • Training Resource Center • Jewish Child Care Association • Turning Point	Promote Mental Health and Prevent Substance Abuse
DSRIP Project 3.c.i Evidence based strategies for disease management in high risk/affected populations (Diabetes)	• Evidence-Based Practice Clinical Guidelines for Diabetes management • Enroll all eligible patients into Health Home • Coordinate Care via Patient Navigation Center • Care Coordination Teams • Support Programs Consistent with the Stanford Model for Chronic Disease Management	• ODA Primary Health Care Network • EZRA Medical Center • Metro Community Health Centers • Care for the Homeless • Visiting Nurse Service of New York	Prevent Chronic Diseases
DSRIP Project 3.d.ii Expansion of Asthma Home-Based Self-Management Program	• Evidence-Based Practice Clinical Guidelines • Home-Based Assessment and Self-Management • Care Coordination Teams • Patient education • Coordinated care via Patient Navigation Center • Patient monitoring system to measure/monitor usage levels	• ODA Primary Health Care Network • Good Shepherd Services	Prevent Chronic Diseases
DSRIP Project 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health	• Standardized Clinician Training Program for the 5 A's (Ask, Assess, Advise, Assist And Arrange) • Tobacco Cessation Patient Registry • Culturally Competent Outreach/Education Campaign in Partnership with cbos	• Arab-American Family Support Centers • Chinese-American Planning Council • Turning Point	Prevent Chronic Diseases
DSRIP Project 4.c.ii Increase early access to, and retention in, HIV care	• Viral Load Suppression (VLS) Initiative • Pre-Exposure Prophylaxis (PrEP) for high risk negatives • Track population outcomes via an HIV registry	• CAMBA • Village Care • Caribbean Women's Health Assoc. • Arthur Ashe Institute for Urban Health • Upper Room AIDS Ministry	Prevent HIV, STD, Vaccine-Preventable Diseases and Healthcare- Associated Infections

Appendix E

Anticipated Impact and Performance Measures

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Sector: Community-based early childhood education settings and schools **Prevention Agenda Priority**: Promoting Healthy Women, Infants and Children/Preventing Chronic Disease **Program:** ParentCorps **Reach:** over 1,200 children and 660 parents/families						
Adapt and implement ParentCorps in 3 sites of University Settlement early childhood programs	<u>Professional development for early childhood staff</u> ▪ 12 classrooms participating ▪ 28 staff members trained and coached ▪ 5 mental health professionals trained and coached ▪ 3 administrators trained and coached	<u>Professional development for early childhood staff</u> ▪ 12 classrooms participating ▪ 28 new and returning staff members trained and coached ▪ 5 mental health administrators coached ▪ 3 administrators coached	<u>Professional development for early childhood staff</u> ▪ 12 classrooms participating ▪ 28 new and returning staff members trained and coached ▪ 5 mental health administrators coached ▪ 3 administrators coached	<u>School/Agency</u> ▪ Organizational change in support of policies and practices for Pre-K students and parents ▪ Increased parent/family engagement <u>Professional development</u> ▪ Participation ▪ Satisfaction ▪ Knowledge gained ▪ Beliefs ▪ Intent to use and actual use of skills <u>Program for parents</u> ▪ Rates of participation in the program by parents ▪ Parent satisfaction ▪ Parent use of	▪ Organizational change in support of family engagement and early childhood policies ▪ Increase in % of parents engaged in school ▪ Decrease in % of children with behavior problems ▪ Decrease in % of children who are dysregulated ▪ Decrease in % of overweight /obese children in program ▪ Sustainable ParentCorps program in 3 sites of University Settlement, 3 schools in CD 3 and Lutheran catchment area	▪ Site visits ▪ Surveys from school leadership, Pre-K teachers, social workers and parents ▪ Implementation data using electronic data capturing system
	<u>ParentCorps Program for Pre-K Students</u> ▪ 240 students served <u>ParentCorps Program for Parents</u> ▪ 120 families served (6 Programs)	<u>ParentCorps Program for Pre-K Students</u> ▪ 240 additional students served <u>ParentCorps Program for Parents</u> ▪ 120 additional families served (6 Programs	<u>ParentCorps Program for Pre-K Students</u> ▪ 240 additional students served <u>ParentCorps Program for Parents</u> ▪ 120 additional families served (6 Programs			

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Implement ParentCorps in 3 schools with Universal Pre-K programs in Manhattan Community District 3 and Lutheran catchment area; ParentCorps for Pre-K teachers, students and families	ParentCorps fully implemented in 1 school ▪ 1 school (PS 188) ▪ 2 Pre-K & 1 K classrooms	ParentCorps fully implemented in 5 schools ▪ 1 school (PS 188) ▪ 4 additional schools ▪ 9 Pre-K & 9 K classrooms	ParentCorps fully implemented in 5 same schools ▪ 5 same schools ▪ 9 Pre-K & 9 K classrooms	strategies and tools ▪ Fidelity to manuals by teachers and mental health professionals ▪ Staff self-evaluation on implementation and quality of coaching <u>Classroom and home</u> ▪ Parent knowledge, beliefs and skills ▪ Parent report of child behavior ▪ Parent report of child self-regulation ▪ Parent involvement in education ▪ Support of health-related behaviors for teachers and parents ▪ Healthier eating for children and families ▪ Physical activity for children ▪ Sedentary time for children		
	<u>Professional development for early childhood staff</u> ▪ 9 Pre-K teachers, 9 Pre-K teaching assistants trained and coached across 3 schools ▪ 1 Parent Coordinator trained and coached across 3 schools ▪ 3 mental health professionals trained and coached across 3 schools ▪ 6 administrators (Principal, Assistant Principal) trained and coached across 3 schools	<u>Professional development for early childhood staff</u> ▪ 9 Pre-K teachers, 9 Pre-K teaching assistants coached across 3 schools ▪ 1 Parent Coordinator trained and coached across 3 schools ▪ 3 mental health professionals coached across 3 schools ▪ 6 administrators (Principal, Assistant Principal) coached across 3 schools	<u>Professional development for early childhood staff</u> ▪ 9 Pre-K teachers, 9 Pre-K teaching assistants coached across 3 schools ▪ 1 Parent Coordinator coached across 3 schools ▪ 3 mental health professionals coached across 3 schools ▪ 6 administrators (Principal, Assistant Principal) coached across 3 schools			
	<u>ParentCorps Program for Pre-K Students</u> ▪ 162 students served <u>ParentCorps for Parents</u> 60 parents served (3 Programs)	<u>ParentCorps Program for Pre-K Students</u> ▪ 162 students served <u>ParentCorps for Parents</u> 120 parents served (6 Programs)	<u>ParentCorps Program for Pre-K Students</u> ▪ 162 students served <u>ParentCorps for Parents</u> 120 parents served (6 Programs)			

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Sector: Primary care **Prevention Agenda Priority:** Preventing Chronic Disease **Program:** Greenlight **Reach:** over 1,500 children and parents/families						
Implement Greenlight health literacy/ parent engagement program in pediatric clinic at Charles B. Wang Community Health Center [component of program delivered by physician / provider during well-child visits]	▪ Provide Greenlight materials to CBWCHC families at well-child visits (2, 4, 6, 9, 12, 15-18m check-ups) o Core booklets o Supp. booklets o Tangible tools (e.g. portion size snack cups) ▪ Continue assessments at 6, 12 months visits for cohort families ▪ Conduct training with 20 current providers (physicians, nursing staff, nutritionists, health educators) on Greenlight program / health literacy (HL)-informed counseling ▪ Program reaches 80% of 0-2 year old children seen at CBWCHC, representing 450 participants ▪ 1000 booklets distributed	▪ Provide Greenlight materials to eligible CBWCHC families at well-child visits o Core booklets o Supp booklets o Tangible tools (e.g. portion size snack cups) ▪ Continue assessments at 12, 24 month visits for research cohort families ▪ Conduct training with 20 current and new providers on Greenlight program / HL- informed counseling ▪ Maintain program reach of 80% of 0-2 year old children, representing 450 participants ▪ 1000 booklets distributed	▪ Provide Greenlight materials to eligible CBWCHC families at well-child visits o Core booklets Supp. booklets o Tangible tools (e.g. portion size snack cups) ▪ Continue assessments at 24 and 36 month visits for research cohort families ▪ Conduct training with 20 current and new providers on Greenlight program / HL- informed counseling ▪ Maintain program reach of 80% of 0-2 year old children, representing 450 participants ▪ 1000 booklets distributed	▪ Improved parent/family knowledge, attitudes, and practices related to their child's diet and physical activity ▪ Increased parent/family engagement in children's health ▪ Increased parent confidence / empowerment ▪ Increased staff knowledge and awareness ▪ Improved provider engagement and satisfaction ▪ Greater provider use of recommended health communication strategies	▪ Healthier eating behaviors / practices for children/ families ▪ Increased physical activity / decreased sedentary time for children ▪ Reduced screen time ▪ Exploratory goal: 20% relative reduction in rate of obesity from 25% to 20% among 3-5 year olds	Program data, including surveys of: ▪ 300 parent/ child dyads (baseline assessment for use in analyses of change of health and wellness outcomes, including 75 at each of 4 time points – 6 mos, 12 mos, 24 mos and 36 mos); ▪ 100 parent/ child dyads enrolled as cohort in Years 3-4 to perform exploratory assessment of intervention impacts; ▪ 10-15 providers (physicians, nurses, nutritionists, health educators) assessed via pre- and post- surveys

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Implement Greenlight waiting room program at Charles B. Wang Community Health Center [component delivered by health educator in waiting room]	▪ Greenlight waiting room program delivered to 50% of eligible children ▪ 300 families reached ▪ Peer training of new staff	▪ Maintain Greenlight waiting room program delivery to 50% of eligible children ▪ 300 families reached ▪ Peer training of new staff	▪ Maintain Greenlight waiting room program delivery to 50% of eligible children ▪ 300 families reached			
New initiative to enhance reach of Greenlight through technology enhancements	▪ Adaptation of Greenlight into an online web resource, with Greenlight booklets available as digital flipbooks ▪ Explore best practices for making web tools accessible to families served at CBWCHC	▪ Digital Greenlight flipbooks available on line for staff to send to parents and for parents to email share with family members ▪ Use of Greenlight booklets tracked via web tools ▪ Explore promotion of Greenlight materials via social media networks	▪ Digital Greenlight flipbooks available on line for staff to send to parents and for parents to email share with family members ▪ Further refine and adapt Greenlight web app to optimize utilization			
Dissemination of Greenlight program to additional practices	▪ Start discussion at CBWCHC Flushing site to spread Greenlight materials ▪ Start discussion to disseminate Greenlight program to NYU Lutheran Family Health Centers Brooklyn	▪ Provision of Greenlight materials to families served at CBWCHC Flushing site ▪ 100 families / patients reached at CBWCHC Flushing site ▪ Make Greenlight	▪ Continue to make Greenlight materials available to CBWCHC Flushing site ▪ 100 families / patients reached at CBWCHC Flushing site ▪ Continue to make Greenlight materials			

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	Chinese site, including feasibility of implementing waiting room program	materials available to Lutheran Brooklyn site ▪ 100 families / patients reached at Lutheran site	available to Lutheran Brooklyn site ▪ 150 of families / patients reached at Lutheran site ▪ Explore strategies to engage community physicians (e.g. via Chinese American Medical Society (CAMS)/ Coalition of Asian-American Independent Practice Association (CAIPA))			
Sector: Primary care **Prevention Agenda Priority:** Preventing Chronic Disease **Program:** Healthy Families/Programa de Familias Saludables **Reach:** 180 families						
Implement Healthy Families/ Programa de Familias Saludables, a Pediatric Obesity Intervention (12-session cycle) consisting of: ▪ Nutrition education ▪ Support groups ▪ Physical fitness	<u>Staff and Materials</u> ▪ Adapt program materials and content based on insight from previous cycles ▪ Recruit and train new staff <u>Outreach and Collaboration</u> ▪ Develop program outreach materials for NYU LFHC pediatricians and families ▪ Conduct outreach to NYU LFHC pediatricians ▪ Increase percentage of referrals from	<u>Staff and Materials</u> ▪ Adapt program materials and content based on insight from previous cycles ▪ Recruit and train new staff <u>Outreach and Collaboration</u> ▪ Conduct outreach to NYU LFHC pediatricians ▪ Sustain percentage of referrals from pediatricians ▪ Conduct outreach to local partners for in-kind physical fitness	<u>Staff and Materials</u> ▪ Adapt program materials and content based on insight from previous cycles ▪ Recruit and train new staff <u>Outreach and Collaboration</u> ▪ Conduct outreach to NYU LFHC pediatricians ▪ Sustain percentage of referrals from pediatricians ▪ Conduct outreach to local partners for in-kind physical fitness	▪ Increased knowledge and awareness of nutrition, physical activity, and other healthy lifestyle concepts ▪ Improved compliance with 5-2-1-0 daily guidelines – increase fruit and vegetable consumption (to 5 or more); decreased screen time (to 2 hours or less of recreational screen time); increase activity (to 1 or more hours per day); decreased sugar	▪ Reduce the percentage of children and adolescents who are obese	▪ Pre/post 5-2-1-0 survey administered to children ▪ Pre/post PHQ2 screening (and PHQ9 if indicated) to children ▪ Pre/post PSC 17 survey administered to parents ▪ Attendance data and height/weight measurements in eClinical Works/

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	pediatricians ▪ Conduct outreach to local partners for in-kind physical fitness instruction ▪ Organize and host recruitment events <u>Implementation</u> ▪ Expand to 1 new site ▪ Conduct a total of 4 cycles ▪ Reach 40 children and families ▪ Retain ≥ 75% of enrolled families for 9 or more sessions	instruction ▪ Organize and host recruitment events <u>Implementation</u> ▪ Expand to 1 new site ▪ Conduct a total of 2 cycles in 3 sites (6 cycles total) ▪ Reach 60 children and families ▪ Retain ≥ 75% of enrolled families for 9 or more sessions	instruction ▪ Organize and host recruitment events <u>Implementation</u> ▪ Expand to 1 new site ▪ Conduct a total of 2 cycles in 4 sites ▪ Reach 80 children and families ▪ Retain ≥ 75% of enrolled families for 9 or more sessions	sweetened beverage consumption (to 0 sugar sweetened beverages, and more water). ▪ Stabilize or reduce BMI scores		Epic (baseline, each session, and 1-year follow up) ▪ Family Support Services referral sheets, including documentation confirming consult/ visit ▪ Evaluation survey
Sector: Primary care **Prevention Agenda Priority:** Promoting Healthy Women, Infants and Children **Program:** Two Generations						
Develop a Two Generations model program that integrates several evidenced-based interventions into a single, comprehensive program to address maternal/child health for high risk families	Work with NYU Lutheran Family Health Centers and Gouverneur Health and experts in child development to integrate the evidence-based programs into a single cross-generation system of care			Program model with funding to: ▪ Address maternal stressors, improve maternal mental health, and facilitate maternal engagement in positive interactions and behaviors with the child ▪ Facilitate positive and responsive parent-child interactions to enhance the parent-child relationship and child outcomes, and simultaneously reduce stress and enhance coping for mothers with depressive symptoms ▪ Transform the coordination of care across the prenatal and pediatric settings to increase family engagement, deliver screening and interventions, facilitate referral to behavioral care, and enhance maternal and child outcomes		

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Sector: Housing **Prevention Agenda Priority:** Preventing Chronic Disease **Program:** Health+Housing Project **Reach:** 150-200 individuals/families						
Develop and implement a community health worker (CHW) pilot program in two low-income apartment buildings in CD 3 and explore expansion to other locations in Brooklyn	<u>Program planning and needs assessment</u> ▪ Establish partnerships and MOUs with key stakeholders and community service providers in the neighborhood ▪ Select intervention buildings and conduct preliminary analyses on ED use and hospitalizations using SPARCS data ▪ Conduct focus groups with building residents ▪ Develop and translate baseline survey ▪ Hire and train 8 bilingual (Spanish and Chinese) community surveyors ▪ Collect and analyze baseline/needs assessment data on residents' health status, health behaviors, and social	<u>Continue program implementation and tracking</u> ▪ Ongoing training of CHWs ▪ CHWs implement program to all interested residents (150-200) ▪ Track: o # and type of referrals o # and type of appointments set o # and type of navigation activities o # and type of events sponsored <u>Assess program implementation</u> ▪ Develop and translate follow- up survey ▪ Hire and train 4 bilingual community surveyors ▪ Track CHW activities ▪ Track resident participation in CHW program (those	<u>Assess program effectiveness</u> ▪ Pre-post analysis comparing outcomes within intervention buildings before and after intervention period ▪ Analysis of SPARCS data comparing outcomes for intervention buildings with those of a matched control group ▪ Assess community activation through CHW program activities ▪ Assess cost-effectiveness and ROI ▪ Work with insurers and City and State initiatives (e.g., Medicaid Redesign Teams) to develop sustainability strategy <u>Explore expansion to other buildings in Brooklyn</u>	▪ Lifestyle changes (diet/exercise) ▪ Increased use of tobacco cessation resources ▪ Resolution of apartment/ structural issues ▪ Improved coordination of health care and social services ▪ Resident satisfaction with and acceptance of CHW program ▪ Increased resident engagement in improving health status and overall well being ▪ Improved management of chronic illnesses ▪ Reduced utilization of emergency departments ▪ Reduced inpatient hospital stays	▪ Reduced utilization of emergency departments ▪ Reduced inpatient hospital stays ▪ Improved self-reported health status ▪ Improved management of chronic illnesses ▪ Improved healthful behaviors ▪ Increased self-efficacy ▪ Decrease in smoking prevalence ▪ Reduced costs	▪ SPARCS/ Medicaid claims data ▪ Focus groups ▪ Baseline and follow-up surveys of adult residents ▪ CHW intake and encounter data ▪ Qualitative interviews with building residents and key stakeholders to assess impact of program, participant satisfaction, and community activation

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	service needs <u>Program development and implementation</u> ▪ Develop protocol for CHW program ▪ Create and translate program material and data collection instruments ▪ Hire and train 4 bilingual CHWs ▪ CHWs implement program to all interested residents (150-200) ▪ Work with community partner for supervision of CHWs by licensed social worker ▪ Develop/provide group workshops or activities for CHWs to bring to building residents	reached vs. not reached) ▪ Conduct and analyze follow up survey ▪ Conduct focus groups and exit survey with CHWs to assess strengths and weaknesses of program implementation				
Sector: Community **Prevention Agenda Priority:** Preventing Chronic Disease **Program:** Tobacco Free Community **Reach:** over 2000 community residents in the Lower East Side/Chinatown and Sunset Park						
Train community navigators and health care providers on smoking and tobacco prevention,	▪ Develop and refine curriculum ▪ 2 navigators trained and certified as tobacco treatment specialist	▪ 4 additional navigators trained ▪ 2 navigators retrained ▪ 3 additional trainings held for CAMS and	▪ 6 new navigators trained ▪ 4 navigators retrained ▪ 3 additional trainings held for CAMS and	▪ Satisfaction with tobacco cessation training by navigators, health educators and providers	▪ Increase capacity among community partners and physicians to address smoking through screening,	▪ Program data ▪ Surveys

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
as well as, evidenced based smoking cessation programs/ resources	▪ 3 trainings conducted for members (health care providers) of Chinese American Independent Practice Association (CAIPA) and Chinese American Medical Society (CAMS)	CAIPA health care providers	CAIPA health care providers	▪ Retention of smokers (attempt to quit, permanently quit) ▪ Increased use and access to evidence-based smoking cessation program	counseling, and referral to evidenced-based smoking cessation program	
Provide outreach and assistance to smokers via health navigators and health coaches	▪ 100 smokers completed baseline interview ▪ 75 received Nicotine Replacement Therapy (NRT) ▪ 50 completed two week follow-up interview ▪ 50 online referrals to Asian Smokers Quitline	▪ 100 smokers completed baseline interview ▪ 75 received Nicotine Replacement Therapy (NRT) ▪ 50 completed two week follow-up interview ▪ 50 online referrals to Asian Smokers Quitline	▪ 100 smokers completed baseline interview ▪ 75 received Nicotine Replacement Therapy (NRT) ▪ 50 completed two week follow-up interview ▪ 50 online referrals to Asian Smokers Quitline	▪ Increased self-reported use of services/ medications ▪ Decreased smoking rates in past 7, 14, and 45 days among those interacting with navigators and coaches	▪ Increased self-reported use of services/ medications ▪ Decreased smoking rates in past 7, 14, and 45 days	▪ Surveys ▪ Program data ▪ Quitline data
Provide community outreach to raise awareness and knowledge about smoke-free policies and increase knowledge about smoking cessation resources	▪ Collaborate with 3-5 community based organizations to raise awareness about the dangers of smoking/ SHS, provide smoking cessation counseling and referrals to clients and members, and help adopt smoke-free policies ▪ Conduct street	▪ Identify and collaborate with 2-3 new community based organizations ▪ Maintain partnerships with past community based organizations ▪ Attend community meetings ▪ Work with 2 -3 buildings to develop	▪ Identify and collaborate with 2-3 new community based organizations ▪ Maintain partnerships with past community based organizations Attend community meetings ▪ Continue to work with 2 - 3 buildings to	▪ Increased attendance ▪ Satisfaction with program (outreach activities and quality of navigators and health educators) ▪ Increased knowledge about smoking and treatment options ▪ Changes in attitudes toward smoke-free housing	▪ Increased support for smoke-free housing ▪ Exploratory: decreased levels of CO	▪ Surveys ▪ Exploratory: Aerosol Monitors

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	intercept survey with 200 Asian Americans residents of NYC to understand attitudes towards smoking, knowledge of SHS, and availability of low-price cigarettes ▪ Develop housing-based organizing strategy ▪ Select buildings for smoke-free initiatives and develop strategies	and implement smoke-free policies	implement and monitor smoke-free policies	▪ Changes in smoking policies in 3-5 buildings		
Sector: Community **Prevention Agenda Priority**: Promoting Healthy Women, Infants and Children **Program:** Project SAFE **Reach:** over 4,700 teens						
Multi-Session Workshop Series	▪ Conduct a total of 60 cycles of BPBR and 4Me! ▪ Curricula administered with high fidelity ▪ Reach 1500 teens ▪ 400 teens referred to social and health services ▪ 250 teens access youth development services ▪ Expand to 2 new sites ▪ 75% of workshop	▪ Conduct a total of 65 cycles of BPBR and 4Me! ▪ Curricula administered with high fidelity ▪ Reach 1600 teens ▪ 450 teens referred to social and health services ▪ 300 teens access youth development services ▪ Expand to 2 new sites ▪ 75% of workshop	▪ Conduct a total of 65 cycles of BPBR and 4Me! ▪ Curricula administered with high fidelity ▪ Reach 1600 teens ▪ 450 teens referred to social and health services ▪ 300 teens access youth development services ▪ Expand to 2 new sites ▪ 75% of workshop	▪ Increased knowledge and awareness of STD, HIV, and pregnancy prevention ▪ Increased knowledge of resources ▪ Improved behavior change - intent to use and actual use of skills, practices, and resources	▪ Reduced teen pregnancy ▪ Reduced disparities in teen pregnancy rate for Hispanic and African American teens in relation to white teens ▪ Reduced teen birth rate ▪ Reduced disparities in teen birth rate for Hispanic and African American teens in relation to white teens	▪ Pre/post survey ▪ Referral sheets, including documentation confirming first visit ▪ Implementation data

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	participants will complete 75% of workshops	participants will complete 75% of workshops	participants will complete 75% of workshops		▪ Reduced disparities in teen birth rate for teens with Medicaid in relation to teens not on Medicaid ▪ Reduce STI and HIV rates among male and female adolescents	
Single-Session Workshops	▪ Peer Educators and staff facilitate 30 single-session workshops ▪ Reach 600 teen participants	▪ Peer Educators and staff facilitate 35 single-session workshops ▪ Reach 650 teen participants	▪ Peer Educators and staff facilitate 35 single-session workshops ▪ Reach 650 teen participants	▪ Increased knowledge and awareness of STD, HIV, and pregnancy prevention ▪ Increased knowledge of prevention and intervention resources		▪ Post workshop survey ▪ Implementation data using the ETO database
Peer Education Groups	▪ Recruit and train 60 teens ▪ 55 teens serve as Peer Leaders ▪ Retain ≥ 70% of enrolled teens ▪ 6 staff are trained in reproductive justice ▪ Planning and development for the launch of reproductive justice group – listening sessions with teens re: reproductive justice issues are	▪ Recruit and train 60 teens ▪ 55 teens serve as Peer Leaders ▪ Retain ≥ 70% of enrolled teens ▪ New reproductive justice peer education group is launched	▪ Recruit and train 60 teens ▪ 55 teens serve as Peer Leaders ▪ Retain ≥ 70% of enrolled teens	▪ Increased knowledge and skills – facilitation, community event planning/outreach ▪ Increased knowledge and awareness of STD, HIV, and pregnancy prevention ▪ Increased knowledge of resources ▪ Behavior change – increased intent to use and actual use of skills, practices, and		▪ Complementary Strengths Survey – baseline assessment, re-administered every six months of participation in the program ▪ Implementation data using the ETO database

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	held, and guidelines/ curriculum for new group is developed			resources ▪ Increased number of sexually active youth who consistently use condoms ▪ Increased number of youth that delay sexual activity ▪ Increased number of sexually active youth using contraception to prevent unintended pregnancy		
Community Events	▪ Host or perform at 6 community events ▪ Reach 300 youth (50% unduplicated) ▪ 60 youth receive HIV screening at PRY hosted events ▪ Additional 150 tested at cohosted events	▪ Host or perform at 6 community events ▪ Reach 300 youth (50% unduplicated) ▪ 60 youth receive HIV screening at PRY hosted events ▪ Additional 150 tested at cohosted events	▪ Host or perform at 6 community events ▪ Reach 300 youth (50% unduplicated) ▪ 60 youth receive HIV screening at PRY hosted events ▪ Additional 150 tested at cohosted events	▪ Increased knowledge and awareness of STI, HIV, and pregnancy prevention ▪ Increased knowledge of prevention and intervention resources		▪ Post-event survey ▪ Screening records
Teen Health Clinic	▪ 300 teens receive screenings and other services at the Teen Health Clinic ▪ PrEP and PEP services expanded – 1500 teens receive screenings	▪ 350 teens receive screenings and other services at the Teen Health Clinic ▪ PrEP and PEP services expanded – 1600 teens receive screenings and connection to services	▪ 350 teens receive screenings and other services at the Teen Health Clinic ▪ PrEP and PEP services expanded – 1600 teens receive screenings and connection to services	▪ Increased knowledge of HIV and STI status ▪ Increased knowledge of contraceptive options		▪ Appointment records through eClinical Works/Epic
Sector: Community						

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
Prevention Agenda Priority: Preventing Chronic Disease **Program:** REACH FAR: Access to Healthy Foods and Beverage and Hypertension Management **Reach:** over 3,500 community residents						
Implement nutritional policy in faith-based settings (FBO)	▪ Identify champion or health committee at Assafa and Madina Masjids ▪ 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	▪ Identify champion or health committee at 2 additional mosques in Sunset Park ▪ 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 quarterly monitoring of nutritional policy change at Assafa and Madina	▪ Conduct quarterly monitoring of nutritional policy change at Assafa, Madina, and 2 additional Sunset Park mosques	▪ Increased percentage of people reporting healthy change in diet in the past 3 months	▪ Increased frequency of those reporting having tried healthy options at communal meals	▪ Baseline and follow-up nutritional survey
Implement blood pressure screening program in FBO setting	▪ Identify champion or health committee at Assafa and Madina ▪ Train 5 volunteers at FBO site on Keep on Track (KOT) manual ▪ Implementation planning – training of	▪ Identify champion or health committee at 2 additional Sunset Park mosques ▪ Train 5 volunteers at FBO site on KOT manual ▪ Implementation	▪ Conduct monthly blood pressure screening with 50 congregants at each site (4 sites total)	▪ Increased prevalence of self-reported blood pressure screening	▪ Increased percentage of controlled hypertension (systolic BP<140, diastolic BP<90) among those with hypertension	▪ Baseline and follow-up survey among participants enrolled in the program ▪ Participant tracking cards

Program	Number of People Participating/Exposed (Process outcome targets)			Health and Wellness Outcomes (Targets)		Data Sources
	Year 1	Year 2	Year 3	Intermediate (years 2/3)	Long-Term (year 5)	
	key personnel, development of implementation protocol ▪ Launch KOT program, enrolling 75 congregants at each site ▪ Conduct monthly blood pressure screening with 50 congregants at each site	planning – training of key personnel, development of implementation protocol ▪ Launch KOT program, enrolling 75 congregants at each site ▪ Conduct monthly blood pressure screening with 50 congregants at each site (4 sites total)				
Conduct communication activities	▪ Conduct quarterly dissemination to ethnic media/social media regarding program ▪ Conduct quarterly mosque-wide educational session on HTN management at Assafa and Madina	▪ Conduct quarterly dissemination to ethnic media/social media regarding program ▪ Host community forum in LES to share results of the program ▪ Conduct quarterly mosque-wide educational session on HTN management at two additional Sunset Park sites	▪ Conduct quarterly dissemination to ethnic media/social media regarding program ▪ Host community forum in Sunset Park to share results of the program	▪ Increased access to messages regarding CVD prevention and management	▪ Increased access to messages regarding CVD prevention and management	▪ Attendance at educational seminars and forums ▪ Circulation of ethnic and social media