



Division of Community and Population Health 2017 Annual Report



**Weill Cornell
Medicine**

**NewYork-
Presbyterian**



COLUMBIA



Table of Contents

Setting the Stage for the Future of Community Health	1
Ambulatory Care Network Leadership	2
About NewYork-Presbyterian	3
Division of Community and Population Health: Our Mission	4
Clinical Services	6
Community Health Programs	11
ANCHOR (Addressing the Needs of the Community Through Holistic, Organizational Relationships)	12
Building Bridges, Knowledge and Health	13
Behavioral Health Clinical Services (Outpatient)	14
Center for Community Health and Education	16
CCHE: Family Planning Program and Young Men’s Clinic	17
CCHE: School-Based Health Center Program	18
Centering Pregnancy Program and the Carnegie Hall Lullaby Project	19
Center for Community Health Navigation	20
Choosing Healthy & Active Lifestyles for Kids™ (CHALK)	22
Child Advocacy Center	24
Collaborator Network Workforce Development and Training	25
Comprehensive Health Program	26
Comprehensive Health Program: Project STAY	28
Division and Community Collaborator Cultural Competency and Health Literacy	30
Health for Life	31
Health Homes	32
Healthy City Kids	33
Lang Youth Medical Program	34
Outreach Program	36
Manhattan Cancer Services Program	38
Reach Out and Read	39
The Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center	40
The Uptown Hub	41
Turn 2 Us (T2U)	42
Waiting Room As a Literacy & Learning Environment (WALLE)	44
Women, Infants, and Children Program	45
Education and Training	46
Health Reform	48
Healthcare Networks	50

Setting the Stage for the Future of Community Health

It was Helen Keller who said, “Alone we can do so little; together we can do so much.” In the Division of Community and Population Health at NewYork-Presbyterian, we share the same philosophy. We would not be able to improve community health without our numerous and varied collaborators. The hospital works closely with community and educational organizations and providers, sharing a passion and commitment to our neighbors that ultimately result in better health for people of all ages. This 2017 report is a testament to that success.

Our programs build on a long history of dedication to the community. Today we offer a myriad of programs and services to residents of Washington Heights and Inwood, the Upper East Side, East Harlem, and northwest Queens. Moreover, we are accomplishing this at a time when the United States is going through significant changes in healthcare reimbursement and delivery, making collaboration all the more important in achieving our shared goals. Thanks to these community connections and generous philanthropic support, we are moving ahead.

As you can read in this report, NewYork-Presbyterian’s Division of Community and Population Health connects community residents with medical and behavioral health care as well as community programs through a number of avenues, including:

- Skilled nursing and behavioral health referral networks
- The NewYork-Presbyterian Health Home
- A wide range of primary care services offered through the Ambulatory Care Network
- Community health programs for children, adolescents, and adults, including those that connect NewYork-Presbyterian’s expertise and programs with schools, faith-based organizations, and community organizations
- Programs aimed at increasing literacy and decreasing domestic violence

The ultimate goal of these programs is not only to connect residents of our communities with high-quality health care, but to encourage them to become advocates for their own health and their family members’ health – so that good health behaviors become a longstanding part of their lives.

This report also outlines our educational programs: the comprehensive Pediatrics, Adult Medicine, and Family Medicine residency programs for physicians early in their careers, as well as the Lang Youth Medical Program for underserved middle school and high school students interested in the health professions. These programs set the stage for the future of community health by training tomorrow’s leaders today.

In the pages to follow, you can read about the success we achieved in 2017 to connect more people in our community with New York’s best health care. We thank the individuals, families, foundations, and other organizations that have supported our work over the last year. We welcome your interest in learning about NewYork-Presbyterian’s Division of Community and Population Health and our efforts to partner with others who believe in our mission and our goals.

Sincerely,



David Alge
Senior Vice President
NewYork-Presbyterian Community and Population Health





Community and Population Health Leadership



David Alge
Senior Vice President
Community & Population Health



Isaac Kastenbaum
Director
DSRIP Programs



Davina V. Prabhu
Vice President
Ambulatory Care Network



Mark Krugman, RN
Director of Nursing
Ambulatory Care Network



Elaine Fleck, MD
Associate Chief Medical Officer
Ambulatory Care Network - NYP
Associate Clinical Professor
Columbia University Irving Medical Center



Andres Nieto
Director
Community Health Outreach & Marketing



Taroon Amin
Director
Population Health Strategy



Jennie Overell
Director
Ambulatory Care Network
NewYork-Presbyterian/Columbia



Lester Govia
Director
Ambulatory Care Network
NewYork-Presbyterian/Weill Cornell



Alpa Prashar
Director of Operations

About NewYork-Presbyterian

NewYork-Presbyterian is one of the nation's most comprehensive, integrated academic healthcare systems, dedicated to providing the highest quality, most compassionate care to patients in the New York area, nationally, and across the globe. In collaboration with two renowned medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons, NewYork-Presbyterian is consistently recognized as a leader in medical education, groundbreaking research, and innovative, patient-centered clinical care.

NewYork-Presbyterian has four major divisions:

- NewYork-Presbyterian Hospital**
 Ranked #1 in the New York metropolitan area by *U.S. News and World Report* and repeatedly named to the Honor Roll
- NewYork-Presbyterian Regional Hospital Network**
 Comprised of leading hospitals in and around New York and delivers high-quality care to patients throughout the region
- NewYork-Presbyterian Physician Services**
 Connects medical experts with patients in their communities to expand coordinated healthcare delivery across the region
- NewYork-Presbyterian Community and Population Health**
 Encompasses ambulatory care network sites and community healthcare initiatives, including NewYork Quality Care, an Accountable Care Organization



THE SEVEN-CAMPUS ACADEMIC MEDICAL CENTER

NewYork-Presbyterian/Weill Cornell Medical Center
 525 East 68th Street
 New York, NY 10065
 212-746-5454

NewYork-Presbyterian Morgan Stanley Children's Hospital
 3959 Broadway
 New York, NY 10032
 800-245-KIDS

NewYork-Presbyterian Lawrence Hospital
 55 Palmer Avenue
 Bronxville, NY 10708
 914-787-1000

NewYork-Presbyterian/Columbia University Irving Medical Center
 622 West 168th Street
 New York, NY 10032
 212-305-2500

NewYork-Presbyterian The Allen Hospital
 5141 Broadway
 New York, NY 10034
 212-932-4000

NewYork-Presbyterian Westchester Division
 21 Bloomingdale Road
 White Plains, NY 10605
 914-682-9100

NewYork-Presbyterian Lower Manhattan Hospital
 170 William Street
 New York, NY 10038
 212-312-5000

REGIONAL HOSPITAL NETWORK

NewYork-Presbyterian Brooklyn Methodist Hospital
 525 East 68th Street
 New York, NY 10065
 212-746-5454

NewYork-Presbyterian Hudson Valley Hospital
 1980 Crompond Road
 Cortlandt Manor, NY 10567
 914-737-9000

NewYork-Presbyterian Queens
 56-45 Main Street
 Flushing, NY 11355
 718-670-1065

For more information, visit www.nyp.org and find us on Facebook, Twitter, Instagram, YouTube and Healthmatters.nyp.org

2017 FACTS AND FIGURES

Leadership

Steven J. Corwin, MD
President and Chief Executive Officer

Laura L. Forese, MD
Executive Vice President and Chief Operating Officer

Employees

Full Time Equivalent Employees **46,942**

Residents and Fellows **2,512**

Attending Physicians **8,252**

Total Physicians **10,764**

Inpatient Statistics

Total Beds **4,069**

Inpatient Days **1,248,685**

Discharges **221,797**

Deliveries **26,144**

Outpatient Statistics

Total Outpatient Visits **3,350,517**

Ambulatory Surgeries **147,559**

Emergency Department Visits **681,000**
(includes ED admissions)

Payor Mix

Medicare **35.7%**

Medicaid **30.1%**

Commercial **33.1%**

Self Pay **1.1%**

Find a Doctor Referral Call Center
877-NYP-WELL
www.nyp.org

Division of Community and Population Health: Our Mission



The mission of NewYork-Presbyterian's Division of Community and Population Health is to collaborate across the community, hospital, and academic organizations to impact the health and well-being of children, adolescents, and adults in the communities we serve.

Every three years the Division conducts a comprehensive community needs assessment to better understand the health and social needs of the communities we reach. Using this understanding, we develop a community service plan delineating the health priorities we will focus on and our approach to each. NewYork-Presbyterian (NYP) and community resources are leveraged to reduce local health disparities through innovative population health initiatives, care provider training, scholarship, and research. These initiatives are collaboratively developed, implemented, evaluated, and sustained. Only by combining the skills and resources of NYP with the energy, immense talents, and resources of our community partners can we achieve these goals. Through these measures, we also hope to reduce length of stay, avoidable ED visits, inpatient admissions, and readmissions within 30 days. Further, these efforts support initiatives that:

- Empower individuals and families to promote health and wellness
- Better navigate local systems of care and local resources
- Improve school readiness and academic achievement
- Ultimately improve quality of life.

As one of the largest academic medical centers in the United States, we leverage our patient care, research, and educational resources to address health inequities at the local level.

A History of Commitment to Our Communities

NYP has always worked to improve the health of individuals in our surrounding communities. As one of the largest academic medical centers in the United States, we leverage our patient care, research, and educational resources to address health inequities at the local level. For over three decades in the Washington Heights and Inwood (WHI) communities, we and our community collaborators have come together to create the infrastructure needed to support and sustain these important population health efforts.

Our Communities

The WHI communities are home to a diverse population. Nearly 70.9% of the residents identify as Hispanic and have faced social, cultural, and language barriers to care. In addition, WHI experiences a disproportionate health burden compared to the rest of New York City. One in three residents lives below the poverty line. Major health concerns for the community include diabetes, asthma, heart failure, depression, and childhood obesity. WHI is a federally designated “empowerment zone,” meaning that it has one of the highest concentrations of poverty in the United States and is eligible for special grants, loans, and investments to improve the lives of people in these communities.

Some 524,000 people live in the NewYork-Presbyterian/Weill Cornell Medical Center (WCMC) region, which includes communities of the Upper East Side of Manhattan, East Harlem, and northwest Queens. Twenty-five percent of the WCMC region is of Hispanic descent, with an additional 11% African American and 11% Asian/Pacific Islander. Moreover, 31% of the population in the WCMC region is foreign born. While English is the predominant language, 22% report Spanish as their primary language. There are more than 125,000 people on Medicaid living in the WCMC area, and approximately 13% of the population does not have health insurance.





Clinical Services: Ambulatory Care Network



NewYork-Presbyterian’s Division of Community and Population Health provides clinical services through its Ambulatory Care Network (ACN). The ACN is comprised of 14 primary care sites, seven school-based health centers, 13 mental health school-based programs, and over 60 specialty practices. We serve families from across New York City that span generations and who represent a wide array of nationalities, and ethnic and religious backgrounds.

The ACN reaches into all of our communities, making it easier for everyone to access high-quality, affordable, patient-friendly care in their own neighborhoods. We provide a broad range of services. When specialized care or hospitalization is required, our compassionate and helpful staff coordinate patient needs with the extraordinary range of specialty programs and resources available at NewYork-Presbyterian.

All of our ACN primary care practices are Patient-Centered Medical Homes. This means that patients receive care from a team of dedicated healthcare providers, led by their primary doctor. With patient participation, the medical team coordinates and manages treatment plans so that patients and their families receive the best care. Thanks to State funding and generous donors, we have continued to enhance our clinical care through the implementation of innovative programs that target specific health needs in the communities we serve. These programs have been seamlessly embedded into our practice operations and function in collaboration with our clinical staff to ensure our patients are receiving the care they need. Following, is a description of some of our new clinical offerings.

Ambulatory Care Network Primary Care Improvement

Craig Blinderman, MD, Medical Director
 cdb21@cumc.columbia.edu

Connie H. Kostacos, MD, Medical Director
 chk11@cumc.columbia.edu

Elaine Fleck, MD, Medical Director
 emf12@cumc.columbia.edu

Adriana Matiz, MD, Medical Director
 lam2048@columbia.edu

Maura D. Frank, MD, Medical Director
 mdfrank@med.cornell.edu

Felicia Blaise, MPH, MA, Manager,
 feb9021@nyp.org

Allison Gorman, MD, Medical Director
 agg9003@med.cornell.edu

Maria Burke, MBA, Manager
 mam7045@nyp.org

Through DSRIP, there have been a number of targeted efforts to improve the quality of care and health outcomes for high-risk and high-cost adult and pediatric populations with complex care needs in the Ambulatory Care Network’s primary care practices. Culturally competent and family-centered nurse care managers, social workers, psychiatric nurse practitioners, and community health workers (CHWs) have been augmented and embedded in practices to coordinate care. There is increased collaboration among providers and community-based organizations to meet the needs of the population. Palliative care screening, risk assessment, and dedicated staffing have been integrated within practices to address unmet palliative care needs. More than 16,000 adults and 10,000 patients have been reached, and over 1,600 have received palliative care.

The NYP PPS has numerous programs across the Hospital and collaborator network to connect patients and families with the care they need.

PRIMARY CARE LOCATIONS

**NewYork-Presbyterian/
 Weill Cornell Medical Center**

**Weill Cornell Internal
 Medicine Associates
 Wright Center**
 1484 First Avenue, 1st Floor
 New York, NY 10075

**Irving Sherwood Wright Center
 on Aging**
 1484 First Avenue, 1st Floor
 New York, NY 10075

**Weill Cornell Internal Medicine
 Associates**
 505 East 70th Street
 Helmsley Tower, 4th Floor
 New York, NY 10021

Pediatric Practice
 505 East 70th Street
 Helmsley Tower, 5th Floor
 New York, NY 10021

Women’s Health Practice
 505 East 70th Street
 Helmsley Tower, 5th Floor
 New York, NY 10021

The Center for Special Studies
 Glenn Bernbaum Unit
 525 East 68th Street, Baker 24
 New York, NY 10065

The Judith Peabody Wellness Center
 David E. Rogers Unit
 53 West 23rd Street, 6th Floor
 New York, NY 10010

Behavioral Health Crisis Program

Warren Y.K. Ng, MD, MPH, Clinical Lead
ywn9001@nyp.org

Brian Youngblood, LCSW, Manager
bjy9001@nyp.org

Supported by DSRIP funding and project management support, the Division launched a Behavioral Health Crisis (BH Crisis) Program featuring a telephonic screening and triage system known as the “HUB”; the Treat-Link-Connect (TLC) Brief Crisis Treatment program; a community-based Critical Time Intervention (CTI) team focusing on the most vulnerable patients with complicated medical, behavioral health, and social determinant needs; and embedded staff from community-based organizations, ACMH Inc., and The Bridge. The BH Crisis Program quickly identifies, assesses, and connects patients to a richer variety of wraparound services tailored to patients’ needs to reduce emergency department and inpatient admissions and increase community access to rapid mental health care, substance use services, “warm handoffs,” case management, and home-based and community care. The HUB provided services to nearly 500 patients in 2017, with nearly 100 receiving CTI services and 30% graduating with a strong system of care.

Tobacco Cessation Services

David Albert, MD, Clinical Lead
daa1@cumc.columbia.edu

Julie Chipman, Program Manager
chipmaj@nyp.org

Ambulatory Care Network’s Tobacco Cessation Services (TCS) facilitates clinician adoption of tobacco cessation. TCS staff members include patient navigators and nurse practitioners who are solely dedicated to TCS or are content experts who integrate TCS into their primary care roles. The TCS program also engaged in provider and community education activities in 2017, including in-person and online learning modules and webinars for NYP employees and NYP PPS members; participation in community health fairs; smoking cessation outreach for adult ACN patients and TCS counseling for providers; and sponsorship of an annual Certified Tobacco Treatment Specialist training for hospitals and community-based organizations. Nearly 3,000 patients have visited with or been engaged by TCS nurse practitioners.

PRIMARY CARE LOCATIONS

NewYork-Presbyterian/ Columbia University Irving Medical Center

**Associates in Internal Medicine
(AIM)**
622 West 168th Street, 2nd Floor
New York, NY 10032

**Audubon Practice
Obstetrics and Gynecology/Pediatrics**
21 Audubon Avenue
New York, NY 10032

Broadway Practice
4781-83 Broadway
New York, NY 10034

**Comprehensive Health Program
Infectious Disease Clinic (IDC)**
180 Fort Washington, 6th Floor
New York, NY 10032

**Charles B. Rangel
Community Health Center**
534 West 135th Street
New York, NY 10031

**Herman “Denny” Farrell, Jr.
Community Health Center**
610 West 158th Street
New York, NY 10032

**The Washington Heights
Family Health Center**
575 West 181st Street
New York, NY 10033



Health Information Exchange Expansion

Patricia Hernandez, LCSW, Manager
pah9051@nyp.org

The Division of Community and Population Health has expanded its use of Health Information Exchange to support team-based care across the Hospital and the network of community-based collaborators. The Division has rolled out Healthix — a New York State-sponsored information exchange platform — to support the flow of information and patients across providers in New York City. Healthix utilization enhances access to patient records across health providers; improves receipt of clinical event notifications (targeted messages on patients' use of emergency departments, inpatient facilities, and so forth); and improves community provider access to a patient's health data from across New York State.

Transitions of Care Program

Lisa McIntyre, Clinical Lead
lim9139@nyp.org

The Transitions of Care (ToC) program was implemented to strengthen continuity of care between NewYork-Presbyterian inpatient units and subsequent settings to reduce the risk of avoidable 30-day readmissions to the hospital and/or emergency department. The ToC model is currently operating at the NYP Allen Hospital, Milstein Hospital at NYP/Columbia Irving Medical Center, NYP/Weill Cornell, and NYP Lower Manhattan Hospital. The program aims to identify and engage Medicaid patients at increased risk for readmission to provide education on disease and self-management, facilitate timely follow-up with primary care provider(s), and coordinate medical and social service needs to overcome barriers to safe transitions. The ToC program partners with the Center for Community Health Navigation Community Health Worker (CHW) program to reinforce education in a linguistically and culturally appropriate manner, and to provide home visits and accompaniment to follow-up appointments. More than 1,100 patient discharges were reached in 2017.



SPECIALTY PRACTICES

Urgicare Center

21 Audubon Avenue
at West 166th Street, 1st Floor
New York, NY 10032
212-342-4700

NewYork-Presbyterian/ Weill Cornell Medical Center

525 East 68th Street
New York, NY 10065

Cardiology	646-962-5558
Dentistry (adult)	212-746-5190
Dentistry (pediatric)	212-746-5119
Endocrinology	212-746-6285
Neurology	212-746-2323
Orthopedics	212-746-4500

NewYork-Presbyterian/Columbia University Irving Medical Center

622 West 168th Street
New York, NY 10032
866-463-2778

Allergy, Audiology, Dermatology, ENT (adult and pediatric), Neurology (adult and pediatric), Nutrition, Ophthalmology, Orthopedics (adult and pediatric), Urology (adult and pediatric), Pulmonary Medicine, Rehabilitation Medicine, Speech Pathology

Grants Received

Total Grant Awards in 2017:
\$34.0 million
Includes both government and foundation grant support

Ambulatory Care Network Community Practices

COLUMBIA UNIVERSITY VOLUME BY PRACTICE – 2017 VISITS			
PRIMARY CARE	VISITS	VC3 CLINICS	VISITS
AIM Group	68,279	VC3 - Allergy	749
Audubon	35,790	VC3 - Ortho	6,576
Broadway	43,822	VC3 - Pediatric Neuro	1,567
Farrell	25,366	VC3 - Pediatric Ortho	1,292
Rangel	21,162	VC3 - Psychiatry	1,627
Urgicare Center	10,802	SUBTOTAL VC3	11,811
Washington Heights	35,693		
SUBTOTAL PRIMARY CARE	240,914	VC10 CLINICS	VISITS
		VC10 - Chest	2,064
		VC10 - Neurology	3,582
		VC10 - Neurosurgery	448
		VC10 - Newborn	1,753
		VC10 - Newborn Nutrition	560
		VC10 - Nutrition	827
		VC10 - Otolaryngology	5,231
		VC10 - Special Gyn	1,227
		SUBTOTAL VC10	15,692
		PSYCH CLINICS	VISITS
		Adult Psych	23,960
		Pediatric Psych	27,785
		SUBTOTAL PSYCH	51,745
		TOTAL SPECIALTY CARE	184,146
		TOTAL COLUMBIA UNIVERSITY ACN	425,060

WEILL CORNELL VOLUME BY PRACTICE 2017 VISITS	
PRIMARY CARE	VISITS
Pediatrics	17,443
OB/GYN	17,393
WCIMA	51,360
WCIMA at Wright	6,379
Wright Center on Aging	9,812
SUBTOTAL PRIMARY CARE	102,387
SPECIALTY CARE	VISITS
Adult Dental	8,742
Baker CSS	14,379
Cardiology	2,181
Chelsea CSS	14,706
CSS Dental	1,816
Endocrinology	854
Fracture	445
Hand Surgery	316
Neurology	2,403
Pediatric Dental	3,414
PFT Lab	1,131
SUBTOTAL SPECIALTY CARE	50,387
TOTAL WEILL CORNELL ACN	152,774
METHADONE	VISITS
Adult HIV SVC.	1,252
Adult	25,335
TOTAL METHADONE	26,587
TOTAL NUTRITION	1,370



ACN-Payor Mix 2017	Sum of Cases
Medicaid Managed	51%
Medicare Managed	14%
Medicare FFS	12%
Commercial	12%
Medicaid FFS	8%
Self-Pay	3%
Other	1%



Community Health Programs



ANCHOR (Addressing the Needs of the Community through Holistic, Organizational Relationships)

DODI MEYER, MD • Clinical Lead • ddm11@cumc.columbia.edu
EVA LERNER, MSW, MPA • Program Manager • evl9023@nyp.org

Mission and Goals



In 2017, the Division of Community and Population Health received a five-year grant from the Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities (AHC) program to systematically identify the health-related social needs of Northern Manhattan/South Bronx Medicare and Medicaid beneficiaries and address their identified needs through referrals to local community-based social service organizations. The Division is leveraging this grant's resources to standardize and expand its existing Ambulatory Care Network pre-visit screening efforts. By systematically screening for health-related social needs and clinical risk factors, ANCHOR seeks to identify the most vulnerable patients and improve their access to preventative services through a combination of social and clinical interventions in the community.



By systematically screening for health-related social needs and clinical risk factors, ANCHOR seeks to identify the most vulnerable patients and improve their access to preventative services through a combination of social and clinical interventions in the community.

Building Bridges, Knowledge and Health

MONICA HIDALGO • Manager • moh9017@nyp.org
DEBORAH ACEVEDO, RN • Nurse Coordinator • acevedd@nyp.org

Mission and Goals



Building Bridges, Knowledge and Health (BBKH) is a coalition of faith and community-based organizations that work together to reduce racial/ethnic health disparities and improve the health of residents of Northern Manhattan, Harlem, and the South Bronx. The BBKH coalition utilizes church members as conduits of good health to address community health needs, implementing interventions that produce meaningful and lasting results.

Number of People Reached



4,000

Key Accomplishments



In 2017, NewYork-Presbyterian — in partnership with BBKH program members — supported New York City First Lady Chirlane McCray's Thrive NYC initiative by offering Mental Health First Aid trainings to over 200 community members. We hosted our first Annual Clergy Summit, where nearly 100 clergy members heard First Lady McCray and doctors from NYP psychiatric practices talk about mental health and the faith-based community.

To complement the Mental Health First Aid curriculum, NYP developed a

Mental Health Resource Directory that includes an extensive list of mental health resources, including faith-based providers, throughout New York City.

BBKH also teams up each year with the NYP Outreach Program to host:

- The **Day of Hope** Community Health Event in East Harlem, which draws as many as 1,000 city residents who access free health screenings, information, counseling, resources, medical referrals, and health insurance information. Telephone follow-up is a critical component that connects participants to primary care. We also participate in Hope Day in the Bronx, where we collaborate with a dozen churches that host a health fair for the community in two locations.
- Two health luncheons in the Bowery Mission Women and Men's Residency Centers, as well as their Homeless Outreach **Don't Walk By** events (held

every Saturday in February) — in partnership with the Salvation Army, New York City Rescue Mission, and the Bowery Mission.

- **Health education and screenings** in the community in partnership with local churches and community organizations. One example includes the partnership in 2017 with the Church of the Epiphany to provide monthly blood pressure screening, HIV/STD screenings, and counseling to dinner guests of their soup kitchen. In December, we provided free reading glasses, thermals, and toiletries to dinner guests. We also contributed toiletries to homeless youth who participate in the Drop-In Program at the Dominican Women's Development Center and collaborated with member churches — such as the Narrow Door Church, where we provided free screenings at their yearly block party.



Behavioral Health Clinical Services (Outpatient)

WARREN Y.K. NG, MD, MPH • Medical Director • ywn9001@nyp.org

The NewYork-Presbyterian Ambulatory Care Network and the Division of Community and Population Health at Columbia University Irving Medical Center have developed comprehensive Behavioral Health Outpatient Clinical Services for children, adolescents, and adults to meet the needs of our community. Many services are provided in partnership with community-based programs and/or within community primary care clinics or schools. The Criminal Justice Investment Initiative's Youth Opportunity HUB and Family Youth Development grants in 2017 further expanded behavioral health services for children, youth, and families. DSRIP initiatives have focused on expanding access, targeting high utilizers, and decreasing avoidable emergency department and psychiatric inpatient admissions across our behavioral health services.

Behavioral Health Clinical Services are comprised of two comprehensive clinical components: Adult and Child/Adolescent clinical services.

Mission and Goals



Adult Behavioral Health Services

The mission of our Adult Outpatient Clinic is to serve the community by providing exceptional patient-centered mental health care, by ensuring that every patient and employee is treated with the utmost respect and empathy, and by offering the highest quality of training to the next generation of clinicians.

Number of People Reached



1,597 Number of adults reached

23,975 Number of adult mental health visits

2,100 Number of adult primary care visits

Key Accomplishments



Adult behavioral health services are provided through:

- The **Adult Outpatient Psychiatry Clinic**, which offers comprehensive mental health treatment for patients age 18 and older. The clinic had

23,960 visits in 2017 and served approximately 1,597 adults, most of whom are Hispanic and insured by Medicaid, reflective of community characteristics.

- Housed within the New York-Presbyterian Ambulatory Care Network, the **Integrated Mental Health-Primary Care Program (IMP)** aims to improve patient outcomes and experiences by addressing behavioral healthcare needs within the primary care practice setting. In 2017, the IMP grew to include Psychiatry Residents and expanded its Collaborative Care model of depression treatment in primary care. There are approximately 2,100 visits annually within the primary care sites provided by IMP staff.



Mission and Goals



Child/Adolescent Behavioral Health Services

The mission of our Child/Adolescent Psychiatric Services is to enrich our community by providing the highest quality mental health care to our youth and their families. These services are comprehensive and create a spectrum of mental health services from homes and schools within the community into primary care and hospital-based clinic programs. There are mental health services within 13 schools, including 13 primary care licensed clinics, and 13 Office of Mental Health (OMH)-licensed programs, offering a comprehensive array of mental health services.

Number of People Reached



2,164 Number of children and adolescents reached

28,296 Number of child and adolescent mental health visits

2,100 Number of child and adolescent primary care visits

Key Accomplishments



Child and adolescent behavioral health services are provided through:

- The **Child and Adolescent Community Clinic** at NYP Morgan Stanley Children's Hospital, which serves as the primary outpatient clinic for children and adolescents with a wide range of mental health concerns and disorders, including disruptive behavior disorders, anxiety, depression, ADHD, Tourette's disorder, and developmental disorders. Services are provided to children and adolescents from birth through age 21. In 2017, 2,164 patients were served through 11,802 visits.
- The **Home-Based Crisis Intervention Program**, a unique acute care program providing mental health services to those in crisis in the home and community. In 2017, there were 532 clinic visits.
- The **NYP Youth Anxiety Center** in Washington Heights, a culturally specific mental health program targeting youth and young adults with anxiety disorders.
- **Promise Project** at Columbia (for Learning Disorders), which offers comprehensive evaluations for underserved children and adolescents with learning disorders. The program had over 873 visits.
- Collaborating with the Department of Education and partner schools, the **School-Based Mental Health clinics** provide psychological evaluation, treatment, consultation, and workshops to children (ages 4–13, grades pre-K through 8), families, and school staff. A total of 430 children and their families received mental health clinical services, and 2,161 children and their families received preventive services. Additional indirect prevention through training of teachers and staff engaged an additional 1,545 students. These preventive resources equipped 93 teachers, school staff, and para professionals who focused on using trauma-informed strategies in their classroom. There were 10,183 visits in 2017.
- The **Special Needs Clinic**, a family-based mental health program that serves children and youth with chronic medical conditions and their families. In 2017, there were over 4,906 visits and more than 250 patients.
- **Integrated Mental Health Program (IMP): Pediatrics**, an innovative program that provides psychiatric and psychological services at four community pediatric primary care sites that are part of the ACN. The team includes psychiatric nurse practitioners, social workers, and psychologists who work side by side with the multidisciplinary teams at these primary care sites. There are approximately 2,100 visits annually within the primary care sites provided by the IMP pediatric staff.

Center for Community Health and Education

JANET GARTH, MPH • Manager • jag9007@nyp.org

Mission and Goals



The Center for Community Health and Education (CCHE), in partnership with Columbia University Medical Irving Center, has provided comprehensive medical, mental health, and health education services to adolescents and adults in Northern Manhattan and the Bronx for over 40 years. We advance service innovations through community partnerships, research, and teaching. The CCHE is comprised of:

- The Family Planning Practice and its co-located Young Men's Clinic
- Seven School-Based Health Centers serving 23 New York City intermediate and high schools
- The Uptown Hub (launched in 2017)
- Truthe (Teens Remaining United Through Health Education), a teen peer education and leadership program
- Community and classroom-based health education and adolescent pregnancy prevention programming

Our goals are to:

- Provide comprehensive women's and young men's healthcare services
- Provide primary healthcare services to adolescents that include medical, mental health, and health education
- Prevent early childbearing and delay initiation of first intercourse

- Increase the use of effective contraception among sexually active men and women who are not seeking pregnancy
- Reduce the transmission of sexually transmitted infections, including HIV
- Support the healthy transition from adolescence to adulthood

CCHE collaborates with local New York City public schools, the Columbia University Irving Medical Center Departments of Population and Family Health, Pediatrics, Obstetrics and Gynecology, Family Medicine, Psychiatry, and Ophthalmology, and the Columbia University College of Dental Medicine, as well as many community-based organizations.



CCHE: Family Planning Program and Young Men's Clinic

DANIEL BURNETT • Practice Administrator • burnett@nyp.org | DAVID BELL, MD • Medical Director, Young Men's Clinic • dlb54@cumc.columbia.edu | ANA CEPIN, MD • Medical Director, Family Planning Program • ac272@cumc.columbia.edu

Mission and Goals



The Family Planning Program provides confidential and comprehensive medical, sexual health, mental health, and health education services to:

- Assist individuals in determining the number and spacing of their children
- Increase use of effective contraception among sexually active men and women who are not seeking pregnancy
- Prevent teen pregnancy and early childbearing
- Reduce the transmission of sexually transmitted infections and HIV
- Facilitate entry into early prenatal care for pregnant women
- Provide preventative, preconception health services, such as breast and cervical cancer screening

The Family Planning Center (FPC) and Young Men's Clinic have provided family planning and adolescent pregnancy prevention services to the Washington Heights/Inwood community since 1976.

Number of People Reached



- 15,000** Total patients annually
- 1,700** Adolescent patients
- 800** Community health education workshops
- 2,000** Teen health education workshops
- 2,600** Benefits and supportive services enrollment

Key Accomplishments



- **Contraceptive Best Practices:** The FPC has been a national leader in service-based research for women's reproductive health, and several contraceptive best practices pioneered at the FPC have significantly improved contraceptive initiation and compliance nationally. Nearly 80% of our female patients who are not seeking pregnancy use a highly effective contraceptive; 30.4% of patients who are not seeking pregnancy use a long-acting reversible contraceptive (LARC), compared to the national average of 15%.
- **Male Involvement and CDC-Funded Research:** Co-located at the FPC, the Young Men's Clinic (YMC) is nationally recognized for its efforts to promote male involvement in family planning. Twenty-two percent of the Family Planning Program's clients are male. A grant from the CDC supports the implementation and evaluation of a computer tablet-assisted intervention, designed for young males, to prevent teen pregnancy.
- **Adolescent Services:** Adolescents can access confidential sexual and reproductive health services. Health educators and social workers work with adolescents to develop decision-making skills, support the adoption of preventive health practices, encourage family involvement, and prevent unplanned pregnancies and sexually transmitted infections (STI), including HIV.
- **Integration of HIV Prevention Services:** HIV prevention education and rapid testing services are fully integrated within the FPC/YMC. We provide HIV testing to over 7,000 patients a year, helping to identify patients who are not aware of their status and linking them to care. In addition, we provide PrEP and PEP (post-exposure prophylaxis) treatment.
- **Community Health Education & Outreach:** The FPC/YMC conducts community-based outreach and activities to impact public awareness around family planning, STI and HIV prevention, and male health, with a special focus on adolescents, immigrants, and the uninsured.
- **Co-located Benefits Enrollment and Access to Supportive Services:** We also provide onsite screening and enrollment for health insurance; screening and enrollment in food stamps (SNAP); referrals to GED and English as a Second Language (ESL) programs; referrals to job training and placement programs; and referrals to free legal assistance.
- **Recipient of NYC Council Funding for Services to Immigrants:** The YMC has received grant funding from the New York City Council for Services to Immigrants to help focus on decreasing health disparities among foreign-born New Yorkers by improving access to health care and addressing cultural and language barriers.

CCHE: School-Based Health Center Program

LEON SMART • Practice Administrator • lds9005@nyp.org

MELANIE GOLD, DO, DABMA, DMQ, FAAP, FACOP • Medical Director • mag2295@columbia.edu

Mission and Goals



The School-Based Health Center (SBHC) Program is a network of primary care practice sites located within seven New York City Department of Education school campuses, housing 23 middle schools and high schools. SBHCs provide primary health care, immunizations, chronic illness management, sexual and reproductive health services, and care for acute illness and injury to all students on campus — facilitating access to care and preventing lost academic time. In addition, mental health care is fully integrated in the provision of care and provided onsite by psychologists, clinical social workers, and a psychiatrist. Dental services are available at select sites. Health educators provide individual counseling, conduct classroom education sessions — including evidence-based teen pregnancy prevention curricula — and train and lead peer educators who conduct educational sessions on a range of youth health promotion topics.

Number of People Reached



6,000 Total number of patients annually

2,000 Students receiving evidence-based classroom education

Key Accomplishments



- **Community Schools Mental Health Intervention:** Via an evidence-based framework, a broad range of school-based mental health support services promote the emotional well-being and healthy functioning of all students on the George Washington Educational High School Campus. The three tiers encompass “universal” mental health services, which provide school-wide resources to impart knowledge and promote a nurturing environment for all students; “selective” services, which support a subset of students at risk of developing mental health or substance use conditions; and “targeted” mental health services,

which support students who have diagnosable mental health conditions.

- **The Truth Peer Education and Youth Development:** Annual cohorts of youth leaders are identified to receive evidence-based training and conduct peer education on a host of health promotion topics. In addition, youth leaders spend a summer interning at the Hospital and gain professional skills and exposure to health career paths.
- **Integrative Health in SBHCs:** Mindfulness, self-hypnosis, acupuncture, acupressure, aromatherapy, and yoga are integrative health modalities offered at SBHCs.



Centering Pregnancy Program and the Carnegie Hall Lullaby Project

SARAH H. KELLY, MD • Medical Director • shk1@cumc.columbia.edu

Mission and Goals



Through the NYP Ambulatory Care Network, we offer a special program called Centering Pregnancy, which has been available at the Broadway Practice and the Washington Heights Family Health Center (WHFHC). With this program, we deliver prenatal care and education to a group of eight to 12 women — typically young mothers-to-be having their first or second child. Each group meets for a total of ten two-hour sessions throughout pregnancy and during the early period after the child's birth. The goal of this unique model of care is to empower women to choose healthy behaviors.

The Carnegie Hall Lullaby Project pairs pregnant women and new mothers with professional artists to write and sing personal lullabies for their babies — supporting maternal health, aiding child development, and strengthening the bond between parent and child. Lullaby Project musicians create beautiful lullabies with our Centering patients. The lullabies are presented at the group's postpartum session and often bring tears to the eyes of listeners. Some of our patients' lullabies were also performed and recorded at Carnegie Hall assemblies by the professional vocalists and musicians. The Lullaby Project expanded to the Broadway Practice this year.

Number of People Reached



- 104** Patients in Centering program (April 2016-April 2017)
- 83** Patients who have written lullabies since 2013 (the project's inception)

Key Accomplishments



Prior studies have reported that among women who participated in Centering programs, there are fewer preterm births, a lower rate of STDs, and a direct correlation between better medical outcomes and the number of Centering sessions attended. At NYP, our Centering patients' medical outcomes were impressive:

- Preterm (<37 weeks) delivery = 4%, compared to 11.4 % in the U.S. and 10.5 in NY State in 2014. Each preterm delivery prevented reduces long-term disabilities and saves well over \$100,000 in healthcare costs.
- Babies born with birthweight less than 2500 grams = 2%
- Babies admitted to the NICU = 5%
- Primary Cesarean rate = 21%, compared to 33.9% in the U.S. in 2014
- Vaginal delivery = 74%
- Mothers who were breastfeeding at hospital discharge = 100%, compared to 79% in U.S. in 2011



- Mothers who were breastfeeding at their postpartum visit = 87%
- Mothers who attended postpartum visit = 93%
- Mothers who were using contraception at the time of the postpartum visit = 98%

The Centering Pregnancy program at the WHFHC was once again certified as an official Centering Pregnancy site by the Centering Healthcare Institute in Boston. In addition, our Centering Pregnancy team was recognized with an NYP Patient Care Award at the April 2016 leadership meeting of the Ambulatory Care Network.



Presentations

- Sarah H. Kelly participated in a New York City Department of Health forum about Centering, held at Brookdale Hospital in Brooklyn, June 2017.
- Sarah H. Kelly and Suzette Garcia made a presentation about the Centering program at a gathering for Harlem Hospital staff, January 2018.

Center for Community Health Navigation

PATRICIA PERETZ • Manager • pap9046@nyp.org
ADRIANA MATIZ, MD • Medical Director • lam2048@columbia.edu

Mission and Goals



The Center for Community Health Navigation (CCHN) at NewYork-Presbyterian is dedicated to supporting the health and well-being of patients through the delivery of culturally sensitive, peer-based support in the emergency department, inpatient, outpatient, and community settings. The overall aim is to promote healthcare self-management, to connect patients to care, and to decrease preventable system utilization.

CCHN aims to achieve its mission through five key activities:

1. Improve patient access to care at NewYork-Presbyterian Hospital and in the community
2. Deepen connections between Hospital and community resources
3. Develop and sustain innovative patient-centered initiatives
4. Advance the Community Health Worker role and workforce
5. Enhance the Community Health Worker knowledge base and inform best practice

Number of People Reached



34,653

Key Accomplishments



In 2017, the CCHN nearly doubled the number of people reached through new initiatives.

- **32,093** people were supported by emergency department-based patient navigators located at Columbia, Weill Cornell, and Lower Manhattan Hospital.
- **2,560** adults and children were reached through community health workers based in the communities surrounding Columbia, Weill Cornell, and Lower Manhattan hospitals.

The CCHN also received a new grant in 2017, the Oberkötter Foundation Grant: Community Hearing Health Collaborative to Meet the Needs of Children with Hearing Impairment. \$875,000 over three years.

The patients, staff, and physicians of NewYork-Presbyterian's Ambulatory Care Network are grateful to Pilar Crespi Robert, Stephen Robert, and the Source of Hope Foundation for enabling us to begin providing the Center for Community Health Navigation's life-changing support to the patients of NewYork-Presbyterian Brooklyn Methodist Hospital and NewYork-Presbyterian Queens.





Publications

- 1 Tiasse, VL, Peretz, P, Biernacki, et al. *Computers, Informatics, Nursing*. 2017;9:447-451.
- 2 Garbers, S, Peretz P, Greca, E, et al. *J Community Med Health Educ*. 2016;6:440.
- 3 Matiz LA, Robbins-Milne, L, Krause MC, et al. *Clin Pediatr*. 2016;55(2):165-70.
- 4 Matiz LA, Peretz PJ, Jacotin P, et al. *J Prim Care Community Health*. 2014;5(4):271-274.
- 5 Peretz P, Matiz A, Findley S, et al. *American Journal of Public Health*. 2012;102(8):1443-1446.
- 6 Findley, S, Rosenthal, M, Bryant Stephens, T, et al. *Health Promotion Practice*. 2012;12(1):52S-62S.



Presentations

- *Expanding and Evolving a Proven Community Health Worker Partnership Model to Bridge Gaps in Care for Underserved Patients and Their Caregivers*. American Public Health Association Annual Meeting. Atlanta, GA, 2017.
- *The Implementation of a CHW-Driven Tool to Improve Chronic Disease Self-Management in the PCMH*. International

Conference on Communication in Healthcare and Health Literacy Annual Research Conference. Baltimore, MD, 2017.

- *A Partnership Model to Bridge Gaps in Care for the Underserved Patients*. Reimagining Health in Cities: From Local to Global Urban Health Symposium. Philadelphia, PA, 2017.
- *Creation of a Center for Community Health Navigation: Preparation for the Post-DSRIP Era*. New York Academy of Medicine Fourth Annual Population Health Summit: Working Across Sectors to Address Social Determinants of Health. New York, NY, 2016.
- *The Center for Community Health Navigation of New York Presbyterian Hospital*. Komen Greater NYC Patient Navigation Conference. New York, NY, 2016.
- *A Nationally Recognized Hospital-Community Model Bridging Gaps in Care for Patients in Lower Manhattan*. Planetree International Conference on Patient-Centered Care. Chicago, IL, 2016.
- *Evolution of a Proven Community Health Worker Model Bridging Gaps in Care for Patients and Their Caregivers*. American Public Health Association Annual Meeting and Exposition. Denver, CO, 2016.
- *Evolution of an Emergency Department-Based Community Health Workers Bridging Gaps in Care for Vulnerable Patients*. American Public Health Association Annual Meeting and Exposition. Denver, CO, 2016.
- *A CHW-Led Initiative to Reduce the Burden of Chronic Illness in a Low-Income, Urban Community*. American Public Health Association Annual Meeting and Exposition. Denver, CO, 2016.
- *Improving Care Transitions to Reduce Readmissions*. Institute for Health Improvement Expedition Series. Virtual presentation, 2016
- *Integrating a Community Health Worker into the Emergency Department*. Institute of Education for the Care of Chronic Diseases. Participatory Healthcare Practice and Education Conference. New York, NY, 2016.
- *CHW-Led Program to Reduce the Burden of Chronic Disease in Northern Manhattan*. 2nd Annual Patient and Family Education – National Health Education Week Conference at NYU Langone Medical Center. New York, NY, 2015.
- *An Emergency Department Based Patient Navigator Program*. Second Annual Patient and Family Education – National Health Education Week Conference at NYU Langone Medical Center. New York, NY, 2015.

The overall aim of the CCHN is to promote healthcare self-management, to connect patients to care, and to decrease preventable system utilization.

Choosing Healthy & Active Lifestyles for Kids (CHALK)

EMMA HULSE • Program Manager • emh9022@nyp.org

DODI MEYER, MD • Medical Director • ddm11@cumc.columbia.edu

Mission and Goals



CHALK — NewYork-Presbyterian's obesity prevention program — is a collaboration with NYP/Columbia University Irving Medical Center and the Northern Manhattan community. The program developed from a need to serve the high-risk, predominantly Latino community of Washington Heights/Inwood. The goal of CHALK is to reduce the prevalence of childhood obesity in Northern Manhattan by creating an environment that promotes healthy lifestyles for children and their families. CHALK serves clients through community organizations and programs, public elementary schools, faith-based organizations, early childhood centers, and NewYork-Presbyterian Hospital's outpatient pediatric practices.

CHALK in the schools is a four-year model which focuses on sustainable and systemic changes, utilizing a wellness council to transfer ownership of projects and wellness goals throughout the intervention. In the community, we focus on changing the food environment and fostering physical activity through work with the greenmarkets of Upper Manhattan, the distribution of mini-grants to community agencies, and work with faith-based organizations (in which we focus on food insecurity through the establishment of food pantries). In the outpatient clinics of the NYP Ambulatory Care Network, residents learn how to provide resources to patients in the waiting room.



The non-prescriptive approach and fluidity of CHALK make the program model easily adaptable into a variety of settings, while enhancing the wellness environment specific to that organization.

CHALK maintains a non-prescriptive approach to implement systemic changes that are sustainable and require minimal resources. The program model builds upon an academic-community partnership framework that is asset-based, where there is joint decision-making. Capacity-building is central to the success of the partnership. CHALK partners are teamed with a full-time staff member to assess and create wellness goals

with the organization's leadership and wellness champions; this approach enables an organization to feel empowered and create ownership of their wellness goals and projects. The non-prescriptive approach and fluidity of CHALK make the program model easily adaptable into a variety of settings, while enhancing the wellness environment specific to that organization.



CHOOSING HEALTHY & ACTIVE LIFESTYLES FOR KIDS™



Number of People Reached



5,000

Key Accomplishments



- **La Puerta Estrecha Food Pantry**
CHALK initiated our first faith-based partnership with La Puerta Estrecha, a longstanding, Spanish-speaking church in Inwood. We assembled a wellness ministry that started numerous programs for church congregants as well as the surrounding community, including cooking classes, training of Sunday school teachers to lead physical activity programming for their students, farmers market tours, and the construction of an edible garden. The church also wanted to target food insecurity, since the WHI communities have a high need and lack of reliable

sources of emergency food assistance. With CHALK's help, La Puerta Estrecha received \$35,000 to build an infrastructure for a sustainable food pantry operation. Opening its doors in April 2017, the pantry has distributed 40,000 pounds of food per month to 700 families each pantry day and has served as many as 7,000 individuals so far.

- **The Fruit and Vegetable Prescription Program** is a collaboration between the NYP Ambulatory Care Network's Nutrition Department, Grow NYC, and CHALK, and is funded by NYP Community Relations. Registered dietitians from the five outpatient clinics of the ACN "prescribe" their patients fruits and vegetables. These prescriptions are redeemable for \$10 in fruit and vegetable coupons ("Greenmarket Bucks") at the Grow NYC tents of the 168th Street and 175th Street greenmarkets. In 2017, in only three and a half months and 28 market days, 320 prescriptions were redeemed.

- **CHALK Jr.**
CHALK received funding from Healthy Tomorrows, a partnership between the American Academy of Pediatrics and the Health Resources and Services Administration of the U.S. Department of Health and Human Services, to (1) merge the school-based program with the community-based program, and then (2) to adapt the CHALK model into the early childhood setting. CHALK Jr. plans to partner with eight early childhood centers throughout Northern Manhattan to focus on systemic, sustainable changes in a preschool setting targeting underserved children and their families. This initiative started at the first early childhood center in fall 2017.

Child Advocacy Center

MIRIAM TORRES, RN • Manager • torresi@nyp.org
 JOCELYN BROWN, MD • Medical Director • jb58@columbia.edu

Mission and Goals



The Child Advocacy Center (CAC) is a medically based child abuse assessment and intervention center that offers services to children 0-21 years of age. Children are referred to the CAC due to allegations of abuse and/or maltreatment. The CAC is a specialized program that conducts comprehensive evaluations to determine or make recommendations as to whether abuse has occurred.

An integral component of the program involves the care and coordination offered to children and families. By taking a victim-centered approach, the CAC aims to reduce further victimization and ease the emotional trauma experienced by children during the investigation by offering a coordinated response in a safe, child-friendly environment. A multidisciplinary team of experts who specialize in child abuse conducts assessments. The evaluation may include a psychosocial assessment, a child interview by trained social workers, and a medical examination by physicians who are highly trained in this specialized area of medical evaluation.

The goal is to advocate for and support children to achieve positive outcomes which result in regaining control, power, and healing in their lives. Health promotion and child abuse prevention are achieved through relationships with community partners and government agencies.

Number of People Reached

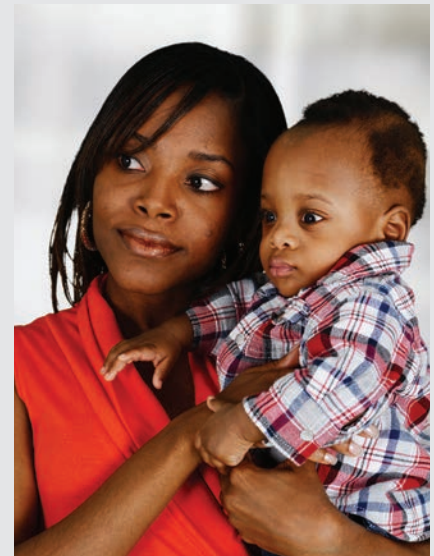


300

Key Accomplishments



Program members presented Hospital-wide Child Abuse training called “Recognizing and Reporting Child Abuse” to social workers, nurses, physicians, residents, interns, students, community health workers, and others. The CAC was also a Supporting Member of the National Children’s Alliance.



Publications

- 1 Chang E, Brown J. *Ann Intern Med.* 2017; 166:854.
- 2 Cardenas, TM et al. *Annals of Emergency Medicine.* 2017;70:72-79.
- 3 Tiyyagura G, Beucher M, Bechtel K. *Pediatric Emergency Medicine Practice.* July 2017.



Presentations

- J. Brown. *American Public Health Association Meeting. National Trends In Emergency Department For Suspicion Of Child Maltreatment.*
- J. Brown. *ISPCAN European Regional Meeting. The Role of School in the Child Protection System in New York City.*
- J. Brown. *Child Health Delegation to Cuba. Understand how the medical system works at the community level and explore how child abuse prevention can be implemented within that system of care, using “Safe Community” model.*
- M. O’Hara. *Ray Helfer Society 2017 Annual Meeting. Presentation: “A Closer Look at Bully Victimization of Maltreated Youth: Distinct Risk for Physically Abused versus Neglected Children.”*
- M. O’Hara. *International Veterinary Forensic Sciences Association 2017 International Meeting. Invited lecturer: “The Human Approach to Non-Accidental Trauma.”*
- T. Cardenas. *Violencia en las Poblaciones Diversas. XXIV Congreso Colombiano de Prevención y Atención del Maltrato Infantil. Bogota, Colombia.*
- T. Cardenas. *Escuela Forense de Abuso Infantil. XXIV Congreso Colombiano de Prevención y Atención del Maltrato Infantil. Bogota, Colombia.*

Collaborator Network Workforce Development and Training

ANGELA WARD, EDD, RDH, CHES, NCTTP • Clinical Lead • aw527@cumc.columbia.edu
RACHEL A. NAIUKOW, MS, MPH • Program Coordinator • ran9031@nyp.org

Mission and Goals



As part of DSRIP, the Division has expanded its efforts to develop and enhance the Hospital and its community collaborators' workforce competencies and capabilities. Focus groups were held across all provider types in early 2017 to identify the training needs of collaborator organizations, in addition to focus groups with DSRIP clinical project teams. Trainings covered various topics, including quality improvement and data analytics, cultural competency and health literacy, LGBTQ+ inclusive service delivery, tobacco cessation, collaborative care, health home serving children policy, and motivational interviewing. Over the past year, nearly 200 people have attended webinar trainings and more than 120 people attended in-person trainings.



Trainings covered various topics, including quality improvement and data analytics, cultural competency and health literacy, LGBTQ+ inclusive service delivery, tobacco cessation, collaborative care, health home serving children policy, and motivational interviewing.

Comprehensive Health Program

MARIA V. ESPINAL, MPH • Practice Administrator • mrd9075@nyp.org
 PETER GORDON, MD • Medical Director • pgg2@columbia.edu

Mission and Goals



The Comprehensive Health Program (CHP) provides medical, gynecological, psychosocial, and case management services to people with HIV and those at risk for HIV, sexually transmitted infections, and hepatitis C. Care coordinators, physicians, nurses, social workers, and navigators facilitate a patient-centered model of care. The young adults' component, Project STAY (Services to Assist Youth), serves young people between the ages of 13-24 onsite and in the community. One of the major goals of the program is to increase access to and the capacity for pre-exposure prophylaxis (PrEP) services.

Key Accomplishments



The CHP received three End the Epidemic (ETE) grants, specifically for Post Exposure Prophylaxis, PEP Center of Excellence (PCE), Adolescent Pre-Exposure Prophylaxis PrEP Center of Excellence (ADL), and Status Neutral Care (SNC). The PCE is a cross-campus collaboration with the Center for Special Studies to provide screening, testing, and treatment to patients of all ages. As a result of these grants, the NYP PrEP program is the second largest prevention program in New York City.

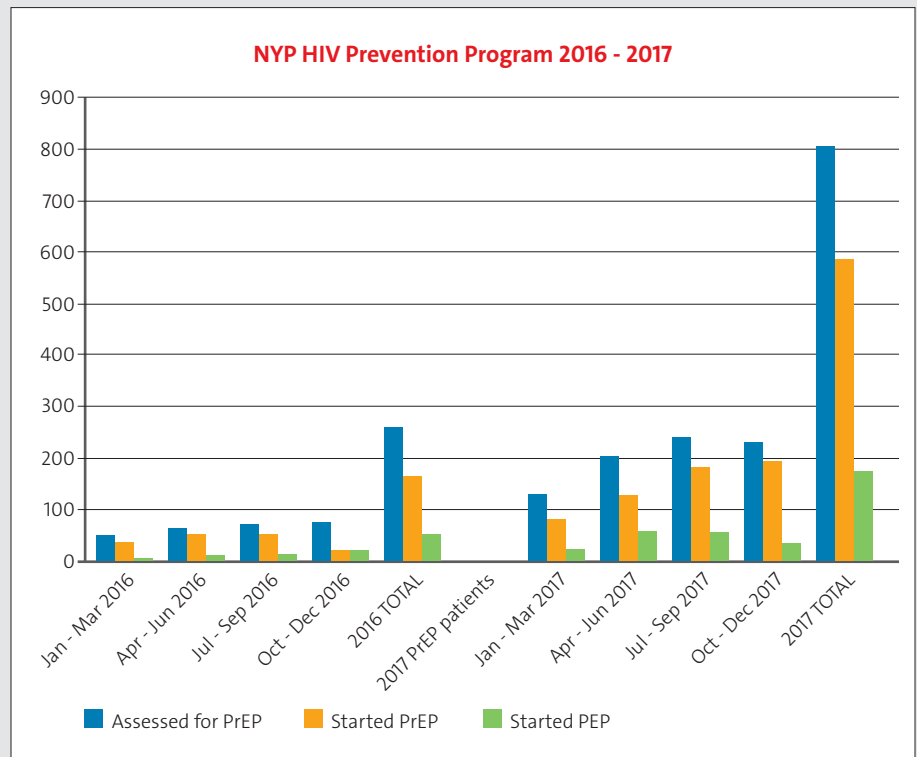
Services delivered through our MCM, YAP, REACH Collaborative, and Washington Heights CORNER Project (WHCP) hepatitis C programs — such as screenings, treatment, and psychosocial assessments in the community — improve community health outcomes and public health. In addition, our collaborations with community-based organizations (CBO) and other local organizations have increased the capacity to serve more areas in New York City.

Number of People Reached



- 1,200** PrEP patients assessed; 72% started PrEP
- 200** Patients served by Medical Case Management (MCM)
- 650** Ready to End AIDS & Cure Hepatitis C (REACH) Collaborative
- 950** Clients served by the Youth Access Program (YAP) services

NYP HIV Prevention Program 2016 - 2017



The Comprehensive Health Program (CHP) provides medical, gynecological, psychosocial, and case management services to people with HIV and those at risk for HIV, sexually transmitted infections, and hepatitis C.

REACH Collaborative (Ready to End AIDS & Cure Hepatitis C)

With the support of DSRIP funding, NewYork-Presbyterian identified Performing Provider System partners to form the REACH Collaborative.

- Current members include the Alliance for Positive Change, WHCP, Argus Community Inc., Dominican Women's Development Center, Village Care, and Harlem United. Subcontracts with all six CBO core partners support a team of eleven Community Health Workers (CHW) and peers, and extended outreach efforts through a mobile medical van.
- Together, the CHWs and peers form a community-based health navigation team to coordinate care and linkage to the full range of support services offered across the REACH Collaborative, such as care

management, housing support, needle exchange, harm reduction and substance use treatment, mental health, food access, money management/vocational training, and domestic violence support and child care services.

- As psychosocial needs are addressed, the REACH Collaborative team aims to achieve patient-centered sexual health goals and to link clients directly to one of three NYP HIV Centers of Excellence or to Harlem United's Federally Qualified Health Center ("The Nest").

Medical Case Management Program

In collaboration with the Alliance for Positive Change, the MCM Program is a holistic and comprehensive client-centered approach to meeting medical, support, and social needs. Two Care Coordinators and eight Patient

Navigators use a chronic care model across the care continuum (such as inpatient, emergency room, ambulatory clinic, home-based, and community-based) to help clients living with HIV achieve and maintain independence in their health care, as well as prevent deterioration, reduce the risk of complications, prevent related illnesses, and improve quality of life. The active caseload is currently 130-145.



Publications

- 1 *Suglia SF, Shen S, Cohall A, et al. J Interpers Violence. 2016 Jul 31.*
- 2 *Armstrong BJ, Kalmuss D, Cushman LF, et al. Prog Community Health Partnersh. 2016;10(2):225-33.*
- 3 *Cohall AT. Am J Public Health. 2016;106(6):972-3.*
- 4 *Smith M, Mateo KF, Morita H, et al. Health Promot Pract. 2015;16(4):480-91.*



Presentations

- UNICEF September 12, 2017
- NYP School-Based Health PrEP Bootcamp September 21 and October 12, 2017
- NYP Family Planning and YMC December 7, 2017
- NYC Department of Education Condom Availability Program, December 12, 2017
- Youth Commissioner of the Philippines December 20, 2017
- ANAC Presentations: RN as a Care Change Agent/Practice Transformation

Comprehensive Health Program: Project STAY

MARIA V. ESPINAL • Practice Administrator • mrd9075@nyp.org | ALWYN COHALL, MD • Director • atc1@cumc.columbia.edu
PETER GORDON, MD • Medical Director • pgg2@columbia.edu

Mission and Goals



Project STAY (Services to Assist Youth) is part of the NYP Comprehensive Health Program. Program members work with community leaders, academic scholars, and public health professionals to serve Harlem and other New York City communities through two major programs:

- The Specialized Care Center, providing care for young people who are HIV-positive or are at risk for HIV infection.
- The Youth Access Program, which conducts community outreach, screening, and linkage to care for young people engaging in risk-taking behaviors. A youth-friendly primary care clinic provides medical and mental health services for these young people as well.

The Project STAY team includes physicians, outreach specialists, social workers, nurses and nurse practitioners, and others dedicated to ensuring that the young people of New York have ready access to the healthcare services they need. We care for young people between the ages of 14 and 24 who are:

- Living with or at high risk for HIV
- Justice-involved youth
- Lesbian, gay, bisexual, transgender, queer, questioning, or pansexual
- Men who have sex with men

Number of People Reached



- 1,400** Sexual health education workshops
- 1,200** Community-based STI/HIV screenings
- 600** Clinic visits for high-risk youth
- 300** Clinic visits for HIV+ youth

Key Accomplishments



The New York City STD Prevention Training Center (PTC) is a CDC-funded program of Columbia University Mailman School of Public Health and one of eight regional training centers of the National Network of STD Clinical Prevention Training Centers. The PTC is dedicated to increasing the sexual health knowledge and skills of medical health professionals in the prevention, diagnosis, screening, and management of sexually transmitted diseases, with the goal of reducing the community burden of sexually transmitted infections and HIV— one of the key areas of focus for DSRIP. Several faculty members from NYP/Columbia Irving Medical Center are involved in the PTC. Additionally, the PTC provides support for two fellows from Infectious Disease and Adolescent Medicine. Furthermore, the PTC collaborates with the Comprehensive Health Center and its Sexual Health Service for NYP's Ambulatory Care Network.

On October 17, 2017, the PTC offered a one-day clinical Continuing Medical and Nursing Education-accredited Adolescent Health symposium for primary care providers. The PTC partnered with the New York City Department of Health and Mental Hygiene, Physicians for Reproductive Health, and Callen Lorde Community Health Center, and attracted 120 providers.

The program aimed to describe best practices for providing comprehensive adolescent healthcare, the local epidemiology of STDs in adolescents, current STD screening strategies for these patients, and the use of pre-exposure prophylaxis (PrEP). Participants had the opportunity to attend different breakout sessions on a variety of topics. The conference closed with a panel which reviewed the use of PrEP in adolescents.





We care for young people between the ages of 14 and 24 who are living with or at high risk for HIV; justice-involved youth; lesbian, gay, bisexual, transgender, queer, questioning, or pansexual; and men who have sex with men.



Publications

- 1 *Suglia SF, Shen S, Cohall A, et al. J Interpers Violence. 2016; Jul 31.*
- 2 *Armstrong BJ, Kalmuss D, Cushman LF, et al. Prog Community Health Partnerships. 2016;10(2):225-33.*
- 3 *Cohall AT. Am J Public Health. 2016;106(6):972-3.*
- 4 *Smith M, Mateo KF, Morita H, et al. Health Promot Pract. 2015;16(4):480-91.*



Presentations

- *CDC STD Training Center Adolescent Health Symposium October 17, 2017*
- *“Trauma Informed Care – Strategies to Improve Care Delivery for High Risk Youth and Youth Living with HIV/AIDS” (multiple conferences: US Conference on AIDS; Association of Nurses in Aids Care; NAESM).*
- *“STD Treatment Guidelines” – multiple conferences sponsored by New York City Department of Health for providers in the Bronx, Manhattan, and Brooklyn.*
- *Adolescent Trials Network: Strategies to improve linkages and retention in care for HIV+ youth.*
- *Year UP National Conference (organization which provides workforce development services for high-risk young adults): “Impact of Stress on Health and Work Performance.”*
- *Multiple workshops provided to community providers on (1) PEP and PrEP, and (2) Linking Justice Involved Youth to Clinical Services.*

Division and Community Collaborator Cultural Competency and Health Literacy

DODI MEYER, MD • Clinical Lead • ddm11@cumc.columbia.edu
RACHEL A. NAIUKOW, MS, MPH • Program Coordinator • ran9031@nyp.org

Mission and Goals



The goal of the Division's Cultural Competency and Health Literacy strategy is to develop a Hospital and community collaborator-focused approach that respects diversity, focuses on clear communication, emphasizes the importance of understanding differences, and engages the individual. The first annual Cultural Competency & Health Literacy in-person training event was held in the fall of 2017. "Instituting Agency Transformation for LGBTQ+ Inclusion" was well attended by Hospital and community agency representatives. There was also a bilingual community health talk for parents of young children. Webinars and tip sheets have been co-developed with collaborators and distributed across the Hospital and community-based organizations with which the Division usually partners.



Health for Life

ROBYN TURETSKY • Program Coordinator • rkt9001@nyp.org
MAURA FRANK, MD • Medical Director • mdfrank@med.cornell.edu

Mission and Goals



Health for Life (H4L) is a comprehensive weight management program whose mission is to provide a safe and supportive environment for 4-to-18-year-olds and their families who are interested in improving their health through a better diet and increased physical activity. Through individual clinic visits as well as group programming, H4L empowers participants to make healthier lifestyle choices for themselves and the whole family.

H4L staff work with patients identified as overweight or obese by their primary care doctors, based on BMI percentile. At clinic visits, patients meet with doctors, dietitians, social workers, and an exercise specialist. Eight-week group programs are offered to patients age 7 and older and consist of one hour of nutrition education and one hour of physical activity.

Number of People Reached



250

Key Accomplishments



H4L staff conducted community outreach initiatives such as:

- Participating in the ACS East Harlem resource fair to provide education on the importance of decreasing consumption of sugary beverages
- Providing two movement classes for young children at the Children's Museum of Manhattan to encourage fitness and physical activity for all ages



Presentations

- *Foundations in Lifestyle Medicine* course presentation to Weill Cornell Medical College students, 2017.
- *Presentation of Health for Life research results to the Weil Cornell Medical College Atkins Journal Club.*



Health Homes

TIFFANY STURDIVANT-MORRISON, MPH • Lead • tis9034@nyp.org

Mission and Goals



The Division is the lead of the NewYork-Presbyterian Health Home — a New York State Medicaid program that reimburses community-based organizations to provide high-quality care management services to at-risk Medicaid beneficiaries. As the lead, the Division provides the financial, analytical, clinical, and information technology backbone for a network of agencies that work together to improve the health of the Medicaid population.

As part of the Health Home, Medicaid members with complex medical and behavioral healthcare needs are assigned a designated care manager — at the Hospital or at a community-based organization — to help coordinate their care. The role of the care manager includes but is not limited

to health promotion, provision of individual and family support, and care coordination and referral management to community and support resources. By providing these services, the NYP Health Home hopes to reduce avoidable emergency room visits and inpatient stays and improve health outcomes for its members and their community.

Number of People Reached



The Health Home network consists of ten care management agencies who provide services to **1,231** patients:

- ACMH
- Argus Community, Inc.
- Alliance for Positive Change
- CREATE Inc.

- The Bridge
- Isabella Geriatric Center
- NYP Ambulatory Care Management
- Riverstone Senior Life Services
- Upper Manhattan Mental Health Center
- Village Care

Our care management agencies also provide outreach services to 312 beneficiaries. These agencies provide a broad portfolio of services, including behavioral health, housing, complex medical care, substance use treatment, and geriatrics care. Services are available in all New York City boroughs except Staten Island.

Key Accomplishments



Throughout the past year, the NYP Health Home has:

- Expanded the central office to support the Health Home's day-to-day operations
- Improved workflows and patient care with both Hospital and community-based stakeholders
- Successfully passed the NYS DOH re-designation process, allowing the NYP Health Home to operate for three more years
- Generated \$4.4 million dollars in revenue across the network of collaborators



Healthy City Kids

ROBYN TURETSKY • Program Coordinator • rkt9001@nyp.org
MAURA FRANK, MD • Medical Director • mdfrank@med.cornell.edu

Mission and Goals



Healthy City Kids is a healthy lifestyle promotion and obesity prevention program for families of preschool children. It is currently delivered in partnership with the Lenox Hill Neighborhood House Head Start program. The program consists of six weekly interactive sessions for parents of enrolled preschoolers and runs two to three times a year. It is overseen by a pediatrician and dietitian, with each lesson taught by a pediatric resident.

Key Accomplishments



Participating families have reported making multiple changes in their homes, including purchasing healthier foods and encouraging children to try new foods.



Lang Youth Medical Program

MARIA MOLINA • Program Manager • mam9452@nyp.org
MARA MINGUEZ, MD • Medical Director • mm2060@cumc.columbia.edu

Mission and Goals



The Lang Youth Medical Program (Lang Youth) is a six-year, science enrichment and medical pipeline program for undeserved youth who represent the diversity of the WHI communities. Lang Youth's mission is to inspire and motivate young people from the community to realize their college and career aspirations in the health sciences. Lang Scholars develop academic, professional, and social skills by participating in a hands-on health sciences curriculum and receiving mentorship from graduate students, medical trainees, and professionals from various Hospital departments.

Number of People Reached



306	Total
83	Current scholars (7th-12th grades)
135	Parents of current scholars
88	Alumni (Class of 2009-2017)

Key Accomplishments

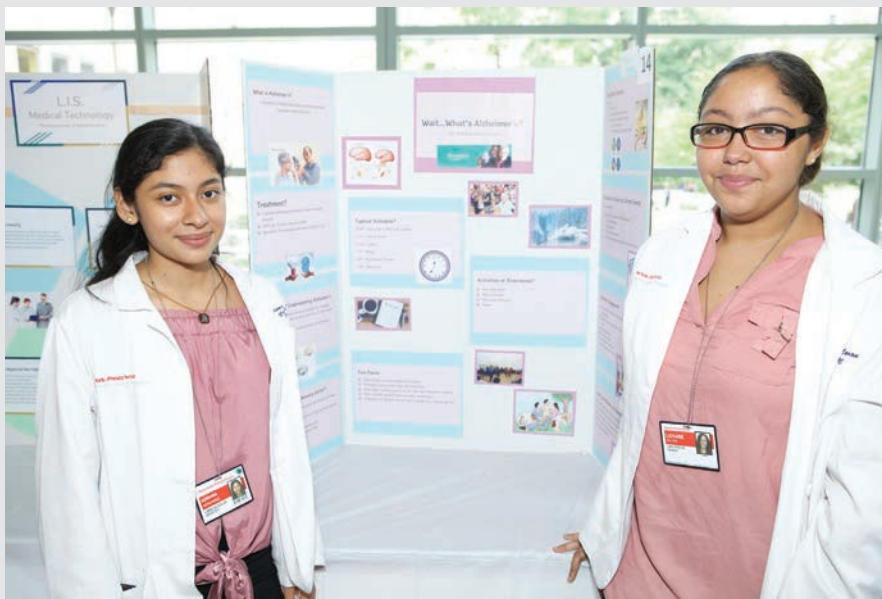


Lang Youth aims to increase high school and college graduation rates, with the goal of improving health outcomes in the future. The program also helps to reduce the deficit of minority healthcare workers in the United States.

- In 2017, the program held its ninth annual graduation ceremony, celebrating 13 graduates. This cohort of Lang Scholars had a 92% retention rate over the past six years, and all are attending four-year universities.
- Lang Youth welcomed its first Alumni Relations Coordinator, Jose Ramos-Muñiz, who is leading the expansion of the program's academic and professional support to its 88 alumni.
- The program has partnered with Columbia University Teachers College's Instructional Media and Technology program to redesign the six-year Lang curriculum.

- The Lang Youth, CHALK, and TRUThe Peer Education programs hosted the third annual teen health conference, which was attended by approximately 200 youths from across New York City and various community-based organizations. This teen-led health conference included educational stations and workshops focusing on topics such as physical fitness and nutrition, emotional wellness, and sexual health. Over 75 youths utilized HIV testing facilities offered by the NYP Ambulatory Care Network Comprehensive Health Program during the conference.
- The newest member of the Lang team, Virgdant Breton, is the program's first psychometrist. Her role will complement academic programming by addressing the psychosocial needs of Scholars and alumni, while providing support to staff and parents.





Lang Youth's mission is to inspire and motivate young people from the community to realize their college and career aspirations in the health sciences.



Presentations

- Adlparvar F, Molina M, Minguez M. *Teaching Narrative Medicine Methods to Youth and Evaluating its Impact on Empathy, 2017 New York State Public Health Association Annual Conference. Poster Presentation. Lake Placid, NY April 2017.*
- Newman-Walden A, Molina M, Minguez M. *Lang Youth Medical Program Summer Immersion Proposal, Mailman School of Public Health Masters Students' Poster Presentations Day, October 2016.*
- Chang J, Molina M, Minguez M. *Prepping for College: Building a Curriculum for Lang Youth Scholars in Northern Manhattan, Mailman School of Public Health Masters Students' Poster Presentations Day, October 2016.*
- Audi Z, Kim S, Colon M, et al. *Lang scholar community ambassador internship: the impact of a patient-as-teacher module created by adolescents in Washington Heights. Poster presentation at the Pediatric Academic Societies Meeting. San Diego, CA. April 2015.*
- Barela JM, Kolff CA, Colon M, et al. *Lang Youth medical program public health curriculum: empowering youth and expanding their vision of health through the inclusion of a public health curriculum in a science enrichment program. Poster presentation at the Society for Adolescent Health and Medicine Annual Meeting. Los Angeles, CA. March 2015.*

Outreach Program

MONICA HIDALGO • Manager • moh9017@nyp.org | **DEBORAH ACEVEDO, RN** • Nurse Coordinator • acevedd@nyp.org
CARLA MILAN • Program Coordinator • cam9200@nyp.org

Mission and Goals



The Outreach Program aims to promote health and prevent disease through education and screening about early detection and effective interventions. The goal is to connect people in the community with a reliable source of primary medical care. The program evaluates the needs of underserved residents in the communities surrounding NewYork-Presbyterian Hospital campuses. One of our major goals is to reduce health disparities that exist in the community.

Events include free screenings and services, information about health insurance, and educational presentations that are culturally sensitive and relevant to members of the community. Examples include the annual Taxi Drivers' Health Fair, Bodegueros (Grocery Shop) Health events, and the Domestic Worker's Health Fair.

Number of People Reached



1,860 People screened at targeted health events

Key Accomplishments



The results of some of our most popular events underscore the need to continue to provide outreach to the communities surrounding NYP. For example, out of 300 people screened at the Taxi Drivers' Health Fair, 103 had abnormal results (18 of whom were sent to Urgicare or the emergency department). Of 480 individuals screened at the Bodegueros Health Initiative at Jetros Cash and Carry in the South Bronx, 85 had abnormal blood pressure results (13 of whom were advised to visit the emergency department). These individuals received counseling and education about the importance of follow-up care and connecting to primary care services. Each month we returned, we spoke to participants who had changed their eating habits because of the guidance they received at these events.

Last May, we hosted the Domestic Worker's Outreach event at St. Catherine's Park on the Upper East Side, where nannies bring children to play. We were able to screen 100 nannies and connected many of them to primary care. One of the nannies shared with us that she was very grateful for the event and wished that we could return monthly. We learned that six nannies had died of sudden heart attacks and that they lacked resources. In September, we had a second event

at John Jay Park, where we screened 120 nannies. Three of our ACN nurses from NYP/Weill Cornell joined us. We counseled many participants about healthy lifestyle habits and connected them to needed services, such as the Avon Breast Imaging Center.

Spearheaded by the Outreach Program, NewYork-Presbyterian is the only healthcare sponsor of NYC Pride and Harlem Pride events, which celebrate the LGBTQ community and promote inclusivity and equality of community members. We provide information and promote STI testing, PrEP and PEP services, and access to primary health care through our ACN clinics. We engage some 10,000 people throughout Pride weekend each June.

Every fall, we host flu vaccination events, in collaboration with elected officials and local senior centers. In 2017, we vaccinated 310 participants. Our nurse intervened when one older gentleman presented with an irregular heartbeat. We sent him to the nearest hospital (NYP/Weill Cornell), and he was admitted and hospitalized for almost a week.

In addition to these events, we also partnered with the Avon Breast Imaging Center in 2017 to support their Komen Tissue Bank donation event, and we supported the Domestic Violence Coalition women's health and wellness event, which was hosted by the ACN's Family Peace program.



One of the nannies shared with us that she was very grateful for the event and wished that we could return monthly.



Manhattan Cancer Services Program

KAREN SCHMITT, MA, RN • Director • schmitt@nyp.org

Mission and Goals



The goal of the Manhattan Cancer Services Program (MCSP) is to decrease cancer outcome disparities among underserved adults in New York State. The program targets uninsured individuals in difficult-to-reach communities of Manhattan, as well as people who receive primary care through the ACN who are outside of guidance concordant screening. This is accomplished through:

- Community-based education, outreach, and recruitment
- Provision of no-cost screening and diagnostic services
- Referral to treatment
- Enrollment in the Medicaid Cancer Treatment Program
- Case Management Services
- Support services in English and Spanish
- Provision of Navigation Services to patients with government insurance who are outside of guidance concordant screening, to assure adherence to screening and all diagnostic testing

Number of People Reached



- 4,261** Received cancer education through community outreach
- 13,662** Uninsured individuals were screened

- 134** People were diagnosed with cancer
- 1,116** Insured individuals were navigated to screening
- 592** Community members received Precision Medicine/ Cancer Genetics Education

Key Accomplishments



MCSP provides multiple points of access through eight service providers (Charles B. Wang Community Health Center, Bellevue Hospital, Callen-Lorde CHC, Ryan/Chelsea-Clinton CHC, Breast Examination Center of Harlem, Project Renewal, Multi-Diagnostic Services Inc, and NewYork-Presbyterian/ Columbia Irving Medical Center). MCSP engages community partners such as community-based organizations, faith-based organizations, small businesses, social service agencies, government

agencies, legislators, and small media to help identify and refer uninsured individuals to services.

Grants

- New York State Department of Health Integrated Cancer Services Program (2013-2018) — Manhattan Cancer Services Program/Cancer Navigation Program
- Avon Foundation Breast Cancer Center of Excellence (2016)
- Davida T. Deutsch Breast Cancer Support Program (2016)
- Grace B. Lamb Trust (2017) — Treatment Support for Uninsured
- P30 Herbert Irving Comprehensive Cancer Center (2013-2018) — Community and Ambulatory Research Share Resource
- NCI National Outreach Network Community Health Education Program (2015-2018) — Precision Medicine and Cancer Genetics Education Program



Publications

- 1 Hillyer, GC, Schmitt, KM, Lizardo, M. *Journal of Community Health*. 2017;42(2):349-357.

(ASPO), March 11-14, 2017.

- Schmitt, KM. *Manhattan Cancer Services Program. Komen Greater NYC Patient Navigation Initiative*. New York, November 3, 2016.



Presentations

- Schmitt KM, Reyes A, Bazan M et al. *Pilot test of a genetics curriculum tailored to Hispanics in Northern Manhattan*. *American Society of Preventive Oncology*

- Clarke Hillyer G, Schmitt KM, Lizardo M et al. "Examination of e-communication and health information preferences among Hispanics in Northern Manhattan: Prelude to delivering a public-centered precision medicine curriculum." *Abstract: 40th Annual Meeting of ASPO, March 12-15, 2016*.

Reach Out and Read Program

EMELIN MARTINEZ • Program Manager • emm9016@nyp.org
DODI MEYER, MD • Medical Director • ddm11@cumc.columbia.edu

Mission and Goals



Reach Out and Read (ROR) is a national hospital-based pre-literacy program that links reading aloud with giving books to children aged 6 months to 5 years during their primary healthcare visits. The NYP/Columbia Irving Medical Center program is one of the largest in New York State. Foster grandparents read to children in waiting rooms at all sites, and volunteers model reading techniques to children in the waiting room.

Number of People Reached



- More than **10,000** patients throughout **15,000** well-child visits among five Ambulatory Care Network sites
- **12,183** books were disseminated by medical providers to patients during well-child visits

Key Accomplishments



The 20th Anniversary of Reach Out & Read was celebrated on May 20, 2017 in the Wintergarden of NewYork-Presbyterian Morgan Stanley Children's Hospital. Community members and families with young children from WHI were invited to participate in a fun-filled day of literacy-centered activities. Nearly 200 children attended the event with their parents. Most of them had the opportunity to meet and receive autographed books by renowned children's book authors, such as Elizabeth Balaguer, Frida Larios, and Tish Rabe. In addition:

- Twenty-nine first-year Medical Residents were trained in the ROR Model
- New York Public Library staff visited the Audubon Clinic and Washington Heights Family Health Center for story time in the clinics' waiting rooms, and also provided library cards to children and their parents

Foster grandparents read to children in waiting rooms at all sites, and volunteers model reading techniques to children in the waiting room.



The Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center

CYNTHIA ARREOLA • Program Manager • cya9006@nyp.org
ERICA WILLHEIM, PHD • Clinical Director • erw9011@nyp.org

Mission and Goals



The Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center (FPTTC) works to help very young children and their families heal from experiences of family violence, abuse, and other forms of trauma. With the goal of ending intergenerational cycles of violence, the Center offers services to young children (ages birth to 5 years), their primary caregivers, and siblings (ages 6-10 years). Services include:

- Dyadic treatment for very young children and their caregivers
- Individual therapy for school age siblings and caregivers
- Art therapy and case management when needed

The FPTTC strives to offer culturally and linguistically appropriate programming, which is essential to engaging and serving the needs of the community. To that end, the Center employs staff that is bilingual/bicultural, and all services are offered in both English and Spanish.

Number of People Reached



- 1,519** Visits with 144 patients
- 64** Medical residents/interns trained on how to screen for domestic violence in the primary care setting
- 13** Medical residents trained on Trauma Informed Care
- 17** Medical attendings trained on Trauma Informed Care
- 1,400+** Number of medical professionals trained since inception

Key Accomplishments



Thanks to a grant from the State Office of Victim Services (OVS), Family PEACE was able to expand its treatment services to victims of child abuse ages 0-6 years and their siblings when clinically indicated. This service facilitates access to care, minimizes barriers/challenges to services at outside agencies, and improves care coordination among service providers, thus increasing the likelihood that victims and their families will engage in treatment.

The Family PEACE Trauma Treatment Center is a federally funded National Child Traumatic Stress Network Category III Direct Service site. The Center received a five-year SAMHSA/NCTSN grant for “Increasing Community Access to Early Childhood Evidence-Based Trauma Services,” which allowed for the co-location of FPTTC psychologists into the pediatric care clinics to screen for trauma and streamline access to treatment.

Number of Patients Screened in the Pediatric Setting

- 191** Children
- 182** Caregivers

The FPTTC is also very active in the community’s grassroots and advocacy efforts against domestic violence and is a member of the Washington Heights/Inwood Coalition Against Interpersonal and Domestic Violence and the Upper Manhattan Collaborative. In 2013, the FPTTC was endorsed as an off-site partner for the Manhattan Family Justice Center, which is run by the Mayor’s Office to Combat Domestic Violence. These community groups are comprised of various public and private agencies — all working together with the goal of ending domestic violence in our communities.

The Uptown Hub

SHARON KIM, LMSW • Program Manager • shk9051@nyp.org | ERICA CHIN, PHD • Project Co-Principal Investigator • erc9027@nyp.org | ALWYN T. COHALL, MD • Project Co-Principal Investigator • atc1@cumc.columbia.edu

Mission and Goals



In 2017, NewYork-Presbyterian, in collaboration with Columbia University Irving Medical Center, received a four-year, \$10.3 million grant from the Manhattan District Attorney's Office Criminal Justice Investment Initiative ("CJII") to establish a Youth Opportunity Hub in WHI. The grant will allow NewYork-Presbyterian/Columbia University Irving Medical Center, along with other community collaborators, to serve over 250 youths aged 14 to 24 years each year who have been or are at risk for involvement with the juvenile or adult judicial systems.

Recognizing that young people utilize supportive services at higher rates when such services are easily accessible, this "neighborhood Hub" approach coordinates family, community, school, and city resources in attractive and convenient locations within underserved neighborhoods. The new center will provide access to a wide range of community programs, including services for medical care, reproductive health and HIV/STI prevention, trauma-informed mental health treatment, and substance use counseling. In addition, the Hub will offer services for the assessment of and advocacy for learning disabilities, afterschool tutoring and educational attainment, and employment readiness and placement. Other planned offerings include neighborhood community service and youth development groups, as well as recreation and arts activities.

The Uptown Hub seeks to improve the well-being of young adults in Washington Heights/Inwood by:

- Increasing the collective impact of youth-serving agencies through enhanced collaboration
- Facilitating the engagement and retention of young adults in work and education opportunities
- Improving mental and physical health, supporting psychological development, and enhancing resilience and acquisition of coping skills
- Supporting increased pro-social connections to peers, adults, and mentors and reducing idle time, risky behaviors, and initial justice system involvement

Key Accomplishments



The Uptown Hub's collaborators include the Ambulatory Care Network's CCHE, Project STAY, and Pediatric Psychiatry programs; the Dominican Women's Development Center; Fundacion Dominicana de Deportes; Northern Manhattan Improvement Corporation; People's Theatre Project; and Police Athletic League at the Armory. Together these agencies have established an Uptown Hub Steering Committee to plan and coordinate community-informed programming. The new physical site is scheduled to open in 2018. The Hub also plans to launch a Youth Advisory Council in 2018 to give community youth voice and leadership opportunities.



Turn 2 Us (T2U)

EVELYN MONTAÑEZ, PH.D., LCSW • Program Manager • montae@nyp.org
DODI MEYER, MD • Medical Director • ddm11@cumc.columbia.edu

Mission and Goals



Turn 2 Us (T2U) is a mental health promotion and prevention program serving local elementary schools in northern Manhattan. The program strives to:

- Promote mental health and academic success in children at risk for a mental health disorder
- Empower the entire school community (students, parents, and school staff) to engage in healthy lifestyle practices that promote well-being

- Enhance the mental health literacy of school personnel and caretakers so they are better equipped to ensure that youth progress emotionally, socially, and academically
- Reduce the stigma that impedes individuals from seeking mental health-related services

Number of People Reached



Since its inception, T2U has reached over **10,000** students, caregivers, and school personnel.

Key Accomplishments



- Staff submitted a manuscript to the *Journal of School Health* on the program's effectiveness for reducing mental health symptoms (such as anxiety and disruptive behaviors), especially among students reported on teachers' measures to be most symptomatic
- A Turn 2 Us Training Manual was developed to expand and sustain similar programming throughout New York City schools





Publications

- 1 Montanez E, Berger-Jenkins E, Rodriguez J, et al. "Turn 2 Us: Outcomes of an Urban Elementary School-based Mental Health Promotion and Prevention Program Serving Ethnic Minority Youths." *National Association of Social Workers*. 2015;1-8.
- 2 Raval G, Montañez E, Meyer D, Berger-Jenkins E. (Pending publication). *School-based mental health promotion and prevention program "Turn 2 Us" reduces mental health risk behaviors in urban, minority youth*
- 3 Montanez E. (Pending Publication) *Turn 2 Us: School-Based Mental Health Promotion and Prevention Training Manual*.
- 4 Montañez E, Finkel M, Haley C, Berger-Jenkins E. (Work in Progress) *Turn 2 Us: Building Mental Health Literacy of School Personnel to Reduce Barriers for Success in Latino Youth..*
- 5 Zhang P, Montañez E. (Work in Progress) *Elementary School Teachers Report on the Major Problems and Barriers in Managing Students Mental Health Issues*.



Trainings & Webinars

- Montañez E, & Rodriguez, J. "Turn 2 Us: How to implement and evaluate an evidenced-informed comprehensive mental health promotion and prevention program in elementary schools." *Half-day trainer for the 22nd Annual Advancing School Mental Health Conference in Washington, D.C.* October 2017.
- Montañez E, & Rodriguez, J. "Turn 2 Us: Methods for implementing an evidenced-informed comprehensive mental health promotion and prevention program in urban elementary schools." *Half-day trainer for the 21st Annual Advancing School Mental Health Conference in San Diego, CA.* October 2016.
- Montañez, E & Battino, B. "How to Develop and Implement Interventions that Promote Mental Health Literacy and Foster Academic and Social Achievement in Urban Elementary Schools. *Half-Day Trainer for the 20th Annual Conference on Advancing School Mental Health.* New Orleans, LA (November 2015).

- Montañez, E. *Common School-Age Disorders, Symptoms and Strategies to Manage Symptoms in the Classrooms School Staff Professional Development PS4, PS128, PS115, & PS8.* New York, NY (Fall 2007-Present).
- Montañez, E. *Understanding the Implication of Trauma on Students Academic and Social Performance and Heightening Sensitivity and Strategies to Mitigate Such Stressors. Staff Development for all School Personnel at PS4, PS128 PS115 & PS8, New York, NY (Fall 2007-Present).*
- Montañez, E. *In-Class Mindfulness Exercises (ICME): Reducing Student Stressors and Promoting Positive Coping Skills. Staff Development for all School Personnel PS4, PS128, PS115 & PS8. New York, NY (Fall 2005-Present).*

Grant

- Derek Jeter's Turn 2 Foundation – Recipient - \$75,000 (2009-present)

The program strives to enhance the mental health literacy of school personnel and caretakers so they are better equipped to ensure that youth progress emotionally, socially, and academically.

Waiting Room As a Literacy & Learning Environment (WALLE)

EMELIN MARTINEZ • Program Manager • emm9016@nyp.org

Mission and Goals



The Waiting Room As a Literacy & Learning Environment (WALLE) is a pediatrics initiative of the NewYork-Presbyterian Ambulatory Care Network. WALLE seeks to address the social determinants of health through a unique two-fold approach: improving health literacy by providing targeted health education, and empowering patients to seek out resource referrals to help their social needs. WALLE serves medically underserved patients who are predominantly from Washington Heights, Inwood, and the Bronx, most of whom are native Spanish speakers. Bilingual volunteers are trained in the tenets of health literacy and cultural competency to approach caregivers in a non-didactic manner.

The goals of the program are to:

- Provide patient-centered approaches that will improve quality of care, patient satisfaction, and health education
- Support clinical staff by providing supplemental counseling and resources to patients
- Maximize provider-patient interaction and time spent in the waiting room by increasing patient engagement

WALLE staff aim to achieve these goals by:

- Connecting patients to free/low cost community resources
- Providing patients with relevant health education and improving their health literacy
- Informing medical providers of patients' needs as identified by caregivers
- Supporting medical providers in the provision of health education
- Helping patients complete medical forms, as necessary

During a medical visit, healthcare providers identify and discuss with caregivers any social need(s) that may be interfering with their patients' health. They may refer caregivers to the WALLE Help Desk, where they can continue their conversation with a trained volunteer and receive information about available community resources.



Key Accomplishments



Twenty-five WALLE volunteers from various learning institutions (such as Columbia University, CUNY School of Medicine/The Sophie Davis Biomedical Education Program, Hunter College, and Lehman College) were recruited and trained. WALLE expanded its services and is now offered in the waiting rooms at the Audubon Clinic and the Washington Heights Family Health Center, serving 1,076 patients' caregivers in these clinics in 2017. Since the inception of WALLE, 79% of caregivers served through the program reported awareness of community resources. Through follow-up calls, 35% of caregivers with resource needs were reached, of whom 20% accessed a WALLE-referred resource. Among those previously not using a service, resource utilization increased by 17% due to WALLE. Caregivers reported very high satisfaction with the WALLE experience.



Presentations

- Srinivasulu S, Kannan N, Martinez E et al. "Sparking the light": leveraging patients' time in the waiting room to address health education and social needs. New York State Population Health Summit 2017.

Women Infant and Children Program

NALINI CHARLES • Program Manager • nac9026@nyp.org

Mission and Goals



Women, Infants, and Children (WIC) of the NewYork-Presbyterian Ambulatory Care Network is a federally and state-funded nutrition education and supplemental foods program. WIC provides nutrition, health, fitness, and breastfeeding information as well as monthly vouchers for nutritious foods to eligible participants.

Number of People Reached



WIC serves approximately **10,500** participants each month.

Key Accomplishments



Our Breastfeeding Help & Referral Center provides one-on-one breastfeeding support plus breastfeeding aids such as breast pumps, breast shells, and nipple shields to our WIC participants. WIC works with mothers to increase the rates of breastfeeding initiation and duration. We continue to strive for higher rates of breastfeeding through education and support provided by our nutrition and peer counseling staff.

Our Breastfeeding Help & Referral Center provides one-on-one breastfeeding support plus breastfeeding aids to our WIC participants.



Education and Training

NewYork-Presbyterian's community healthcare practices and programs provide rich educational opportunities for residents, fellows, and other trainees with a passion and commitment to improving health at the community level. Specialized residency programs for pediatrics, adult medicine, and family medicine offer instruction, mentorship, and exposure to a wide range of healthcare issues and challenges, providing unparalleled experience for physicians early in their careers.

Community Pediatric Residents' Training Program

Anne Armstrong-Coben, MD: aha2@columbia.edu
Assistant Professor of Pediatrics, CUMC
Dodi Meyer, MD: ddm11@columbia.edu
Professor of Pediatrics, CUMC

With one-to-one faculty mentorship, residents in the Community Pediatric Track have the opportunity to work on a project, in collaboration with a community health initiative, which spans three years of training that integrates three core concepts — community health, cultural competency, and advocacy. All trainees are exposed to the strong community-academic partnerships that exist between NewYork-Presbyterian, Columbia University Irving Medical Center, and the surrounding community. Future pediatricians work collaboratively with the community to address healthcare disparities. Residents from this program have presented their work at national meetings.

Quality Improvement Initiatives in the Pediatric Residency Program

Mariellen M. Lane, MD: mmL2@columbia.edu
Assistant Professor of Pediatrics at CUMC
Assistant Program Director for Ambulatory Education, Pediatric Residency Program

Quality Improvement (QI) is one of the focus areas of the Clinical Learning Environment Review (CLER) program of the ACGME. Through the Pediatric Residency experiential learning QI program at NewYork-Presbyterian Morgan Stanley Children's Hospital (NYP MSCH), residents develop and lead projects in their ambulatory practices that impact patient care, emphasize inter-professional collaborative teamwork, and use formal QI methodology. Each project is presented annually at NYP MSCH Chief of Service. Well over half of the projects have been sustained and spread, resulting in workflow changes in the ambulatory setting and support of Hospital QI priorities.

Pediatric and Adolescent Resident Training at NewYork-Presbyterian/Weill Cornell

Maura D. Frank, MD: mdfrank@med.cornell.edu
Assistant Professor of Clinical Pediatrics, Weill Cornell Medical College

The Ambulatory Care Network Pediatric and Adolescent Practice at Weill Cornell Medicine is the major training site for pediatric resident and medical student training in primary care. Residents are trained in preventive care from the newborn period through adolescence. Additionally, there is a focus on training in the care of the medically complex child, with the residents participating in a team approach that includes social workers, a care manager, community health workers, and psychiatric practitioners.



Residents are also trained in the care of other special populations. The TAPP program trains residents and students in the care of adolescent mothers and their children. The Health for Life Program teaches the approach to caring for children and adolescents who are overweight or obese.

Adult Medicine Resident Training Program

Associates in Internal Medicine (AIM)

Maria H. De Miguel, MD: mh2634@cumc.columbia.edu
Assistant Professor of Medicine

Steven Shea, MD, MS: ss35@cumc.columbia.edu
Hamilton Southworth Professor of Medicine and Professor of Epidemiology
Senior Vice Dean, College of Physicians and Surgeons

Washington Heights Family Health Center

Elaine Fleck, MD: fleckel@nyp.org
Associate Professor of Medicine
Associate Chief Medical Officer

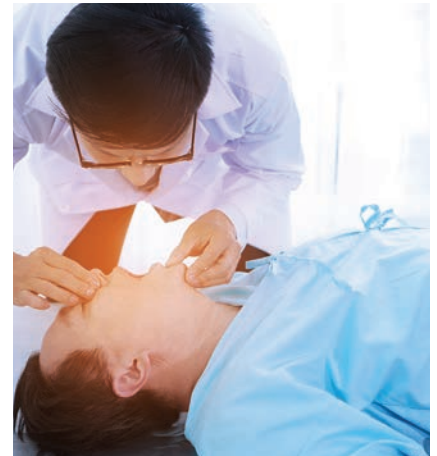
Monica Suarez, MD: mis2140@cumc.columbia.edu
Assistant Professor of Medicine
Director of Internal Medicine at Washington Heights Family Health Center

Residents in the Columbia University Internal Medicine Residency Program master the skills needed to care for a culturally diverse medically complex adult patient population at the Washington Heights Family Health Center (the training site for 15 residents) and the AIM Practice at NewYork-Presbyterian/Columbia University Irving Medical Center. At the Washington Heights Family Health Center — a multidisciplinary community health center with predominantly internal medicine, pediatrics, and ob/gyn on site, as well as social work, psychiatry, podiatry, and gastroenterology — residents have a unique opportunity to learn evidence-based, ambulatory care medicine in a Level 3, patient-centered medical home. The AIM Clinic (Associates in Internal Medicine) — the largest provider of adult primary care in Northern Manhattan, serving over 15,500 adult patients from the surrounding community and the primary referral site for those discharged from the hospital and emergency room — is the primary training site for 120 residents who interact closely with faculty in small-group didactic sessions and one-on-one patient care teaching.

Family Medicine Residency Program

Heather Paladine, MD: hlp11@cumc.columbia.edu
Family Medicine Residency Program Director
Assistant Professor of Medicine CFCM at CUMC

The goal of the Family Medicine Residency Program is to recruit and train tomorrow's community healthcare leaders. The program is committed to training physicians who wish to care for patients and their families, particularly those with problems unique to underserved urban communities, and strives to teach residents how to develop systems that can improve the health of whole communities. We encourage the education of fellow practitioners on the impact and influence of family medicine and aspire to create change. Nearly 100% of graduates go on to practice primary care, with more than half practicing in low-income communities that have a shortage of primary care doctors.



Health Reform

The United States is going through an unprecedented transformation in how health care is reimbursed and delivered to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

Since the passage of the 2009 American Recovery and Reinvestment Act (ARRA) and the 2010 Patient Protection and Affordable Care Act ("Obamacare"), governmental payors have been piloting and rolling out numerous programs to encourage better care for individuals, better health for populations, and lower costs. (Source: Center for Medicare and Medicaid Services Three-Part Aim.) The NewYork-Presbyterian Division of Community and Population Health has been the primary department responsible for participating in and responding to these policy reforms. The following are three examples of delivery and reimbursement system changes that the Division is participating in:

Medicare Shared Savings Program/Accountable Care Organization (ACO)

As part of the Affordable Care Act, Medicare made it possible for groups of unrelated providers to form ACOs. These new organizations will be assigned responsibility for improving the quality of care and reducing the total cost of care delivered to a specific population of Medicare beneficiaries. Beneficiaries are assigned to ACOs based on their historic relationships with primary care and other outpatient providers. ACOs that show demonstrable improvements in 33 quality measures are eligible to partake in shared savings achieved through the program. The federal government also relieves certain non-competitive and compensation regulations that are required for disparate providers to work together more easily.



NewYork-Presbyterian Hospital, Weill Cornell Medicine, and ColumbiaDoctors have jointly formed an ACO — NewYork Quality Care — and are responsible for approximately 35,000 Medicare beneficiaries. The ACO is currently focused on reducing use of inpatient and emergency department services, improving the quality of care delivered, and enhancing the use of data to drive change. As part of this program, the NYP Ambulatory Care Network is actively engaged in improving the outcomes of Medicare beneficiaries.

New York State Delivery System Reform Incentive Payment (DSRIP) Program

New York State is in the process of implementing a five-year, approximately \$8 billion initiative to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Through DSRIP, organizations work together to form Performing Provider Systems (PPSs) — either coming together under a single new entity or forming a tighter collaborative — to accept responsibility for the health of a Medicaid population in their service area. These PPSs are then responsible for selecting five to ten projects based on a Community Needs Assessment, which includes feedback from community leaders, collaborators, and beneficiaries.

Through DSRIP, the NewYork-Presbyterian Performing Provider System (NYP PPS) was developed to align the quality improvement efforts of 85 organizations, ranging from independent community physician practices to community health centers and community-based organizations, to larger, post-acute providers to improve the health of approximately 85,000 Medicaid beneficiaries across New York City. The NYP PPS has the potential to receive up to \$97 million in funding over five years, if it successfully meets its pay-for-performance goals. The Division has leveraged these resources to add frontline and community-based staff to reach the most vulnerable patients, and additional project management, IT, and analytics staff to build new clinical and community programs. The Division has also leveraged information technology to ensure patients have a seamless care experience across the 85 participating organizations.

Medicare Comprehensive Joint Replacement (CJR)

As part of the Affordable Care Act, the U.S. Department of Health and Human Services (HHS) was granted the ability to develop novel reimbursement mechanisms that encouraged greater coordination across disparate programs. In November 2015, HHS announced the Comprehensive Joint Replacement (CJR) program, which bundled the reimbursement for Medicare beneficiaries' hospital-based total hip or knee replacement with services (post-acute, rehabilitation, outpatient care, etc.) provided in the 90-day period after the procedure. If providers are able to reduce the total cost of services provided in each 90-day period, they are eligible to participate in the shared savings with Medicare. Specific geographies across the country were chosen to participate in this program.

The Division is also responsible for the Hospital's participation (across the Regional Health Network) in this program; as such, the Division has made significant strides in improving pre-procedure efforts, improving coordination post-procedure, and reducing the use of costly post-acute providers (i.e., skilled nursing facility). Procedural physicians from across the Hospital have been actively participating in initiatives to reduce the variation in patients' experiences for total hip and knee procedures.



Healthcare Networks

NewYork-Presbyterian strives to deliver an integrated, high-quality continuum of care for the patients we serve. Our goal is to ensure that patients requiring post-acute care services or outpatient behavioral health services receive the same premier quality of care and patient experience that they know and trust in NYP, regardless of whether the provider is an NYP entity. This requires a referral network of quality providers, seamless access, communications, and transitions of care amongst emergency department (ED), acute, post-acute, specialty, and primary care providers. To this end, the Division of Community and Population Health has developed the following referral networks:

Skilled Nursing Facility (SNF) Referral Network

In close collaboration with the NYP Department of Care Coordination and care coordination leads at the Regional Hospitals, a comprehensive evaluation of all SNFs across the NYP and Regional Hospital Network service region was performed and a set of high quality partners identified. This evaluation consisted of a review of Center for Medicare & Medicaid Services (CMS) Nursing Home Compare star ratings, reportable CMS measures, volume and acceptance rate of referrals, specialty services offered, and locations. Ongoing communication with facilities in the NYP Referral Network is focused on opportunities for joint collaboration of program development, patient flow, and quality improvements.

Behavioral Health Referral Network

There continues to be significant behavioral health provider shortages and limited behavioral health physician coverage in the NYP Regional Hospital Network, and the NYP psychiatric EDs are at or above capacity. In order to improve transitions from inpatient to outpatient community providers, NYP identified a set of high-quality behavioral health providers across the NewYork-Presbyterian Hospital and Regional Hospital service region. This referral network will help to ensure that complex and vulnerable patients can seek a behavioral healthcare transition to high-quality ambulatory care services.

The Division of Community and Population Health is working closely with NYP Care Coordination to evaluate other post-acute care settings where an enhanced relationship through referral network development may be beneficial for the patients we serve. Plans to expand the Referral Network include Pediatric Post-Acute Care, Home Health, and Hospice. These important sites of post-acute care will help to facilitate high-quality care transitions for the patients we serve every day.

For more information about the Ambulatory Care Network and community health programs at NewYork-Presbyterian, please visit us online at nyp.org/acn.



**Weill Cornell
Medicine**

**NewYork-
Presbyterian**



COLUMBIA

**AMAZING
THINGS
ARE
HAPPENING
HERE**