AMBULATORY CARE NETWORK
2016 ANNUAL REPORT
New York City’s diverse communities are home to people of all backgrounds and walks of life. Some trace their roots to local neighborhoods, while many come here from across the country and around the world. Each comes out of a unique culture, bringing a mix of healthcare needs, behaviors, and access patterns that require special attention.

At NewYork-Presbyterian (NYP), we have a long-standing commitment to understanding the healthcare needs of the communities we serve and adapting our programs to meet those needs. Our ultimate goal: to reduce, and ultimately erase, health disparities by linking our neighbors with the world’s best healthcare services.

We understand that good health behaviors begin early in life. Toward that goal, many of our programs focus on improving the health of very young children, school-age children, and adolescents — and often by extension, they improve the health of their families. Examples of those programs, described in this report, include CHALK (Choosing Healthy & Active Lifestyles for Kids™), Health for Life and Healthy City Kids (which promote weight management and a healthy lifestyle), our school-based health centers, and Turn 2 Us (which advocates for mental health promotion). We also pay close attention to the unique needs of children and families affected by domestic abuse and trauma through the Child Advocacy Center and the Family PEACE Trauma Treatment Center.

HIV, hepatitis C, and sexually transmitted infections (STIs) remain healthcare challenges for residents throughout New York City. Through the Comprehensive Health Program, the Center for Special Studies, Family Planning Practice and Young Men’s Clinic, Project K.I.S.S., and Project STAY, NYP offers prevention, screening, counseling, and treatment services to people of all ages, including youth. We’ve made excellent progress in the treatment of these infections, and through these programs, we are able to link our clients with these advances in ways that benefit their health. We also remain steadfastly committed to ending the HIV epidemic.

Other programs, such as the Lang Youth Medical Program, focus on educating the future leaders and providers of health care. We also have special literacy programs — Reach Out & Read and Heal — for both children and adults. And patients from the very young to the very old have access to primary care and specialty services at the many locations of our Ambulatory Care Network.

In the pages to follow, you’ll see that 2016 was one of tremendous success for our community programs, empowering our neighbors to take charge of their health. We invite you to learn more about our commitment to the community and look forward to partnering with you to improve the health of New York City.

Sincerely,

David Alge
Senior Vice President
NewYork-Presbyterian Community and Population Health
NewYork-Presbyterian is one of the nation’s most comprehensive healthcare delivery networks, focused on providing innovative and compassionate care to patients in the New York metropolitan area and throughout the globe. In collaboration with two renowned medical school partners, Weill Cornell Medicine and Columbia University College of Physicians & Surgeons, NewYork-Presbyterian is consistently recognized as a leader in medical education, groundbreaking research, and clinical innovation.

NewYork-Presbyterian has four major divisions:

- **NewYork-Presbyterian** is ranked #1 in the New York metropolitan area by U.S. News and World Report and repeatedly named to the magazine’s Honor Roll of best hospitals in the nation.
- **NewYork-Presbyterian Regional Hospital Network** is 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.
- **NewYork-Presbyterian Community and Population Health** features the Hospital’s Ambulatory Care Network sites and operations, community care initiatives, and healthcare quality programs, including NewYork Quality Care, established by NewYork-Presbyterian, Weill Cornell and Columbia.

NewYork-Presbyterian is one of the largest healthcare providers in the U.S. Each year, some 40,000 NewYork-Presbyterian professionals deliver exceptional care to more than 4 million patients.

**CONTACT US**

**NewYork-Presbyterian/ Columbia University**

Irving Medical Center
622 West 168th Street
New York, NY 10032
212-305-2500

NewYork-Presbyterian/ Phyllis and David Komansky Center for Children’s Health
525 East 68th Street
New York, NY 10065
212-748-5454

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

The Allen Hospital
541 Broadway
New York, NY 10014
212-932-4000

**NewYork-Presbyterian**

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

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

**NewYork-Presbyterian**

Community Health Outreach & Marketing

David Alge
Senior Vice President
Community & Population Health

Irina Extenbaum
Director
DSRIP Programs

Jennie Overall
Director
Ambulatory Care Network
NewYork-Presbyterian/Columbia

Isaac Kastenbaum
Director
DSRIP Programs

Jennie Overall
Director
Ambulatory Care Network
NewYork-Presbyterian/Weill Cornell

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

Mark Krugman, RN
Director of Nursing
Ambulatory Care Network

Alpa Prashar
Director
Finance & Compliance

Andres Nieto
Director
Community Health Outreach & Marketing

**Ambulatory Care Network Leadership**

**FACTS & FINANCIALS**

**Leadership**

Steven J. Corwin, MD
President and Chief Executive Officer

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

**Full Time Equivalent Employees**

39,943
(includes residents, fellows & attendings)

**Residents and Fellows**

2,555

**Attending Physicians**

7,022

**Total Physicians**

9,380

**Inpatient Statistics**

Certified Beds
4,057

Bassinets
294

Total Beds
4,351

Discharges
217,400

Inpatient Days
1,251,929

Deliveries
27,112

**Outpatient Statistics**

Total Outpatient Visits
4,970,794

Ambulatory Surgeries
( includes cardiac catheterization)
146,202

Discharges
937,400

Inpatient Days
27,112

**Payor Mix**

Medicare
30%

Medicaid
35%

Commercial
34%

Self Pay and Other
1%

**Total number of visits and surgeries comprises statistics from NewYork-Presbyterian’s six campuses and the NewYork-Presbyterian Regional Hospital Network’s four sites. All statistics are the most recent available.**

Find a Doctor Referral Call Center 877-NYP-WELL www.nyp.org
The mission of NewYork-Presbyterian’s Ambulatory Care Network is to utilize partnerships between community, hospital, and academic organizations to impact the health and well-being of children, adolescents, and adults in the communities we serve.

NewYork-Presbyterian 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. These partnerships 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.

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. Over three decades, 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 Washington Heights and Inwood communities (WHI) are home to a diverse population. Some 70.6% 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.

THE REGIONAL HEALTH COLLABORATIVE

In 2007, NYP embarked on an evidence-based population health initiative designed to measurably improve the health of the WHI community. This effort began with a comprehensive community needs assessment, completed in collaboration with healthcare providers and community-based organizations aimed at identifying the most pressing needs of the neighborhood. The needs assessment — coupled with the vast portfolio of public health and training programs embedded within a community partnership framework — led NYP and our collaborators to form the Washington Heights-Inwood Regional Health Collaborative, an evidence-based collaboration of NYP, community-based organizations, and providers. The Regional Health Collaborative evolved in four phases:

- Phase 1 (1995-present): Development of population health initiatives addressing the root causes of disease, including programs focused on improving health literacy, screening for cancer, reducing obesity, and preventing mental health disorders.
- Phase 2 (2008): Creation of patient-centered medical homes through NYP’s Ambulatory Care Network.
- Phase 3 (2010): Embedding of new care team members in medical practices to address the needs of patients at risk for poor health outcomes.
- Phase 4 (2012): Engagement of community collaborators to address social determinants of health, including development of the NewYork-Presbyterian Health Home — a model that leverages community-based organization care management to address patients’ needs in their residences and communities.

Impact: By 2014, the impact of the Regional Health Collaborative became apparent. NYP emergency department visits for patients cared for in the Collaborative decreased by 29.7% and inpatient hospitalizations fell by 28.5%. Thirty-day readmissions and average length-of-stay were reduced by 36.7% and 4.9%, respectively, concurrent with improved patient satisfaction scores.

DIVISION OF COMMUNITY AND POPULATION HEALTH

NYP leveraged a number of funding mechanisms, including private philanthropy, state and federal grants, and participation in state and federal reform initiatives to expand and sustain the Regional Health Collaborative. In 2015, NYP organized the various efforts of the ACN and community programs under the Division of Community and Population Health. This reorganization allows our programs to continually address the needs of our community, while ensuring the programs are optimally aligned for maximum impact.

The Regional Health Collaborative expanded, through participation in New York State’s Delivery System Reform Incentive Payment (DSRIP) Program, to include new collaborators across New York City — including substance use treatment, housing providers, and federally qualified health centers. This expanded group spreads community programs, information technology resources, and collaborative approaches across the various communities and populations that we serve.

In the pages to follow, we describe the NYP Ambulatory Care Network and its community programs in addition to new initiatives, some funded by the New York State DSRIP Program, that together aim to reduce health disparities over a person’s lifespan.
NewYork-Presbyterian’s Ambulatory Care Network is composed of 14 primary care practices and more than 50 specialty care clinics. Our patients, from newborns to older adults, come from across New York City. We serve families 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.

In addition, the ACN sponsors numerous community events and programs throughout the year — such as health fairs and screenings, annual flu vaccinations, and educational programs.

<table>
<thead>
<tr>
<th>PRIMARY CARE LOCATIONS</th>
<th>NewYork-Presbyterian/Weill Cornell Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weill Cornell Internal Medicine Associates Wright Center</td>
<td>1484 First Avenue, 1st Floor New York, NY 10075</td>
</tr>
<tr>
<td>Irving Sherwood Wright Center on Aging</td>
<td>1484 First Avenue, 1st Floor New York, NY 10075</td>
</tr>
<tr>
<td>Weill Cornell Internal Medicine Associates</td>
<td>505 East 70th Street Helmsley Tower, 5th Floor New York, NY 10021</td>
</tr>
<tr>
<td>Pediatric Practice</td>
<td>505 East 70th Street Helmsley Tower, 5th Floor New York, NY 10021</td>
</tr>
<tr>
<td>Women’s Health Practice</td>
<td>505 East 70th Street Helmsley Tower, 5th Floor New York, NY 10021</td>
</tr>
<tr>
<td>The Center for Special Studies Glenn Bernbaum Unit</td>
<td>525 East 68th Street, Baker 24 New York, NY 10065</td>
</tr>
<tr>
<td>The Judith Peabody Wellness Center</td>
<td>David E. Rogers Unit 53 West 23rd Street, 6th Floor New York, NY 10010</td>
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2016 PRIMARY CARE NUMBER OF UNIQUE PATIENTS

<table>
<thead>
<tr>
<th>Ambulatory Care Network</th>
<th>Adult Patients</th>
<th>Pediatric Patients</th>
<th>Total</th>
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<tbody>
<tr>
<td>NYP/COLUMBIA</td>
<td>42,516</td>
<td>21,247</td>
<td>63,758</td>
</tr>
<tr>
<td>AIM Group</td>
<td>15,608</td>
<td>200</td>
<td>15,808</td>
</tr>
<tr>
<td>Broadway</td>
<td>6,339</td>
<td>4,831</td>
<td>11,170</td>
</tr>
<tr>
<td>Washington Heights</td>
<td>4,918</td>
<td>5,316</td>
<td>10,232</td>
</tr>
<tr>
<td>Audubon</td>
<td>3,896</td>
<td>6,258</td>
<td>10,154</td>
</tr>
<tr>
<td>Farrell</td>
<td>5,243</td>
<td>1,723</td>
<td>6,966</td>
</tr>
<tr>
<td>Rangel</td>
<td>2,829</td>
<td>3,233</td>
<td>6,062</td>
</tr>
<tr>
<td>Comprehensive Health</td>
<td>2,730</td>
<td>290</td>
<td>3,020</td>
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<tr>
<td>Urgicare Center</td>
<td>8,101</td>
<td>368</td>
<td>8,468</td>
</tr>
<tr>
<td>NYP/WEILL CORNELL</td>
<td>31,934</td>
<td>6,008</td>
<td>37,942</td>
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<tr>
<td>WC/MA</td>
<td>19,702</td>
<td>286</td>
<td>19,988</td>
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<tr>
<td>Pediatrics</td>
<td>19</td>
<td>5,540</td>
<td>5,559</td>
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<tr>
<td>OB/GYN</td>
<td>4,211</td>
<td>247</td>
<td>4,458</td>
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<tr>
<td>Wright Center on Aging</td>
<td>2,748</td>
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<td>2,748</td>
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<tr>
<td>WC/MA at Wright</td>
<td>2,682</td>
<td>30</td>
<td>2,712</td>
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<td>TOTAL</td>
<td>69,640</td>
<td>27,253</td>
<td>96,602</td>
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2016 PRIMARY CARE TOTAL VISITS BY AGE GROUP

<table>
<thead>
<tr>
<th>Ambulatory Care Network</th>
<th>Adult Patients</th>
<th>Pediatric Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYP/COLUMBIA</td>
<td>198,403</td>
<td>63,838</td>
<td>262,241</td>
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<tr>
<td>AIM Group</td>
<td>70,685</td>
<td>366</td>
<td>71,051</td>
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<tr>
<td>Broadway</td>
<td>28,116</td>
<td>16,526</td>
<td>44,642</td>
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<tr>
<td>Washington Heights</td>
<td>21,903</td>
<td>15,037</td>
<td>36,940</td>
</tr>
<tr>
<td>Audubon</td>
<td>15,447</td>
<td>20,301</td>
<td>35,748</td>
</tr>
<tr>
<td>Farrell</td>
<td>20,708</td>
<td>4,704</td>
<td>25,412</td>
</tr>
<tr>
<td>Rangel</td>
<td>12,007</td>
<td>9,261</td>
<td>21,268</td>
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<tr>
<td>Comprehensive Health</td>
<td>17,557</td>
<td>1,174</td>
<td>18,731</td>
</tr>
<tr>
<td>Urgicare Center</td>
<td>11,800</td>
<td>461</td>
<td>12,261</td>
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<tr>
<td>NYP/WEILL CORNELL</td>
<td>49,679</td>
<td>460</td>
<td>50,139</td>
</tr>
<tr>
<td>WC/MA</td>
<td>49,679</td>
<td>460</td>
<td>50,139</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>19,093</td>
<td>18,093</td>
<td>37,186</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>15,888</td>
<td>1,004</td>
<td>16,892</td>
</tr>
<tr>
<td>Wright Center on Aging</td>
<td>9,503</td>
<td>–</td>
<td>9,503</td>
</tr>
<tr>
<td>WC/MA at Wright</td>
<td>3,968</td>
<td>39</td>
<td>4,007</td>
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<tr>
<td>TOTAL</td>
<td>279,498</td>
<td>81,436</td>
<td>360,934</td>
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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

NewYork-Presbyterian/Weill Cornell Medical Center

Cardiology 646-962-5558
Dentistry (adult) 212-342-4700
Dentistry (pediatric) 212-342-5719
Endocrinology 212-342-6285
Neurology 212-342-2523
Orthopedics 212-342-4500

SPECIALTY PRACTICES

Urgicare Center
21 Audubon Avenue at West 166th Street, 1st Floor
New York, NY 10032

NewYork-Presbyterian/Columbia University Irving Medical Center

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 2015-2016: $37.0 million
Includes both government and foundation grant support

ACN PAYOR MIX 2016

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Medicaid Managed Care</td>
<td>52%</td>
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<tr>
<td>Medicare FFS</td>
<td>12%</td>
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<tr>
<td>Medicare Managed Care</td>
<td>12%</td>
</tr>
<tr>
<td>Medicaid FFS</td>
<td>11%</td>
</tr>
<tr>
<td>Commercial</td>
<td>9%</td>
</tr>
<tr>
<td>Grant</td>
<td>4%</td>
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<tr>
<td>Self-Pay</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>0.03%</td>
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</table>
In April 2015, NewYork-Presbyterian was accepted as a lead entity in the New York State Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP’s purpose is 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. Up to $7.4 billion dollars are allocated to this program, with payouts based on achieving predefined results in system transformation, clinical management, and population health.

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 the 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 NYP PPS engages its collaborators through a governance structure, including Finance, Clinical, IT/Data, and Executive Committees. There are also two workgroups to address the Cultural Competency, Health Literacy, and Workforce Development needs of the collaborator network. These Committees are co-chaired by division leadership and collaborator leadership.
In 2016, the NYP PPS focused on implementing new programs across the Hospital and collaborator network. These include:

- **INTEGRATED DELIVERY SYSTEM**
  This effort built the foundation and infrastructure necessary to support the development of the collaborator network. Specific initiatives have included supporting non-NYP community providers to achieve Patient-Centered Medical Home designation, and rolling out a web-based community resource directory, care management, and healthcare information exchange to the collaborators.
  Lead: Isaac Kastenbaum • Manager: Maria Moreno

- **AMBULATORY ICU**
  This program focused on strengthening the interdisciplinary approach to care within the adult and pediatric Ambulatory Care Network practices. The program introduced new resources and processes to the practices to ensure that the most vulnerable patients received additional support.
  Leads: Elaine Fleck, MD, Maura Frank, MD, Connie Kostacos, MD, Allison Garman, MD, Adriana Matiz, MD • Managers: Felicia Blaise, Maria Moreno

- **EMERGENCY DEPARTMENT CARE TRIAGE**
  This program has spread the Patient Navigator intervention across the Hospital’s emergency departments, in order to improve patients’ connectivity with outpatient primary and specialty care.
  Leads: Adriana Matiz, MD, Patricia Peretz, Jordan Faster, MD, Peter Steel, MD • Manager: Leslie Chiu

- **TRANSITIONS OF CARE**
  This intervention introduced Nurse Care Managers and Community Health Workers into the inpatient units and processes to the practices to ensure that the most vulnerable patients received additional support back to the Hospital after discharge.
  Lead: Claudia Beck • Manager: Leslie Chiu

- **PRIMARY CARE – BEHAVIORAL HEALTH INTEGRATION**
  This program introduced additional mental health and substance use treatment services to the Ambulatory Care Network. It also brought primary care to the New York State Psychiatric Institute’s two Washington Heights outpatient psychiatric practices. The goal is to improve patients’ connectivity to services where they normally receive care.
  Leads: Mary Hannahahan, Warren Ng, MD • Manager: Julie Chipman

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.

- **BEHAVIORAL HEALTH COMMUNITY CRISIS STABILIZATION**
  This program expanded psychiatric resources for the highest need patients. The program includes (a) a HUB to conduct rapid telephonic triage by identifying non-emergent, emergent, and chronic users, and connecting these patients with clinical services; (b) clinical and psychopharmacological interventions for patients who are likely to return to the ED when services would otherwise not be provided; and (c) a community-focused treatment team to assist patients in potentially destabilizing periods of transition as well as intensive, wrap-around behavioral health services for a period of three to nine months.
  Leads: Mary Hannahahan, Warren Ng, MD • Manager: Brian Youngblood

- **HIV CENTER OF EXCELLENCE**
  This effort develops a network of collaborators that engage into clinical services those who are at risk for HIV or living with HIV and/or HCV but are not engaged in care, and links them to community-based services to address social determinants of health and psychosocial needs that may impact on engagement and/or retention in clinical care. The program also expands the clinical and mental health services at NYP’s HIV practices.
  Leads: Peter Gordon, MD, Sam Merrick, MD • Manager: Steve Chang, NP

- **INTEGRATION OF PALLIATIVE CARE INTO THE MEDICAL HOME**
  This initiative focuses on improving Primary Care Physicians’ competencies to integrate generalist-level palliative care in the Ambulatory Care Network and community-based practices as standard of care.
  Leads: Craig Blinderman, MD, Veronica Lestelle • Manager: Felicia Blaise

- **TOBACCO CESSATION**
  This program focuses on integrating sustainable tobacco use treatment into health services across the Hospital and the collaborators. The intervention introduces new staff and patient education resources, as well as clinical services.
  Lead: David Albert, DDS • Manager: Julie Chipman

The DSRIP team is now focused on achieving 44 pay-for-performance (utilization, quality, and patient experience) outcomes for its Ambulatory Care Network and community-based partners. This work will continue through 2020.

DSRIP’s purpose is 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.
The NewYork-Presbyterian Health Home is a group of health and community agencies who collaborate to provide comprehensive care coordination services to Medicaid members. Medicaid members with complex medical and behavioral healthcare needs are assigned a designated care manager to help them coordinate services that include, but are not limited to, health promotion, individual and family support, care coordination, and referral management to community and support resources. By providing these services, the NYP Health Home aims to reduce avoidable emergency room/inpatient stays and improve health outcomes for its members and the communities in which they live.

The Health Home network currently consists of ten care management agencies that provide care management services to 974 patients. These agencies include:

- ACMH
- Argus
- Alliance for Positive Change
- CREATE Inc.
- The Bridge
- Isabella
- NYP Care Management
- Riverstone
- Upper Manhattan
- Village Care

Our care management agencies also provide outreach services to 742 patients and deliver other types of services, such as those related to behavioral health, housing, complex medical care, substance use treatment, and geriatrics to patients in all boroughs except Staten Island.

This year, the NYP Health Home will focus on solidifying its foundation by:

- Completing a comprehensive review of our policies and procedures to ensure compliance with New York State Department of Health standards and opportunities to implement best practices.
- Working with our internal care coordination and DSRIP collaborators to ensure integrated workflows and identify opportunities to work together.
- Adding one to two new care management agencies to the network to increase the Health Home’s capacity.
- Hiring one to two additional staff members to support the NYP Health Home’s day-to-day operations.
Building Bridges, Knowledge and Health

**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, as well as develop interventions that produce meaningful and lasting results.

**KEY ACCOMPLISHMENTS**

In 2016, NYP — in partnership with BBKH program members — supported First Lady McCray’s Thrive NYC initiative by offering Mental Health First Aid trainings to over 200 community members. 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. For a copy of this directory, please contact Deborah Acevedo (acevedd@nyp.org).

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.
- Two health luncheons in the Bowery Mission Women and Men’s Residency Centers, as well as their Homeless Outreach Events (Saturdays in February) — in partnership with the Salvation Army, New York City Rescue Mission, and New York City Rescue Alliance.
- Health education and screenings in the community, in partnership with local churches and community organizations. An example is the partnership in May 2016 with the senior program at Bethel Gospel Assembly in Harlem to provide a heart health education class, including free blood pressure screenings.

**NUMBER OF PEOPLE REACHED**

1,300

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.

**PUBLICATIONS**

- Community Mental Health Resource Directory (Spring 2016)

**PRESENTATIONS**

- Acevedo D and Olivo K, Adult Mental Health First Aid Training, April 16 and June 10, 2016
- Acevedo D and Milan C, Youth Mental Health First Aid Training, February 22, June 8 and 20, and September 17, 2016
- Acevedo D and Chapman C, Mental Health and the Church, Convent Baptist Church, New York, June 6, 2016
Center for Community Health Navigation

The program’s ultimate goals are to promote healthcare self-management and to decrease avoidable system utilization.

**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 competent, peer-based support in the emergency department, inpatient, outpatient, and community settings. The program’s ultimate goals are to promote healthcare self-management and to decrease avoidable system utilization.

CCHN aims to achieve this mission through four key activities:
- Connecting patients to the healthcare system and to local community resources
- Supporting innovative patient-centered care initiatives
- Advancing the community health worker role and workforce
- Enhancing the knowledge base and informing local practice

**NUMBER OF PEOPLE REACHED**

16,000

**KEY ACCOMPLISHMENTS**

The CCHN received a number of awards and grants in recent years:

**Awards**
- AAMC: 2014 Community Service Award
- Healthcare Association of New York State: 2014 Community Health Improvement Award
- Community Campus Partnership for Health: 2012 Annual Award
- EPA: 2010 Environmental Leadership Award in Asthma Management

**Grants**
- Altman Foundation Grant: to integrate and enhance collaboration between three distinct, high-functioning programs as a model to ensure continuity of care for patients across community, hospital, and primary care settings. Received in 2011: $124,722 over 18 months.
- New York State Health Department Grant: to improve quality of life for individuals with asthma. Received in 2012: initial awards of $180,000 for a 12-month period, and may qualify for additional awards — up to a maximum of $900,000 over five years.

**PRESENTATIONS**


**PUBLICATIONS**

CHALK (Choosing Healthy & Active Lifestyles for Kids™)

**MISSION AND GOALS**

CHALK (Choosing Healthy & Active Lifestyles for Kids) is an integrated obesity prevention program whose purpose is to reduce the prevalence of childhood obesity in Northern Manhattan and to create environments in which healthy lifestyles are integral to the lives of all children.

**NUMBER OF PEOPLE REACHED**

7,000

**KEY ACCOMPLISHMENTS**

- CHALK’s three areas of focus are schools, NewYork-Presbyterian/Columbia University Medical Center, and the community of Northern Manhattan.
- **CHALK in the schools** is a four-year model focusing on sustainable and systemic changes. We offer wellness initiatives for schools to choose from, based on their interest, capacity, and priorities. It is not a prescriptive program, but rather one that offers a menu of options — such as “Just Move,” which serves as a source for in-class physical activity.
- **In the community,** CHALK focuses on changing the food environment through our work with the greenmarkets of Northern Manhattan. Through our partnership with GrowNYC, we started the West 168th Greenmarket. We continue to provide nutrition education at this market during the season. We now have a presence at the Greenmarket on 175th Street as well; staff members from NYP/Columbia speak about diabetes and stroke prevention as well as dental health, providing health education to the market’s customers.

**SUSTAINABLE AND SYSTEMIC WELLNESS CHANGES**

Though this initiative is in its infancy, we have started to focus on increasing food accessibility through the establishment of food pantries in low-resource areas.

CHALK also supports the development and growth of small nonprofits through mini-grants. This year, we have selected five recipients to receive $5,000 each to implement a health-related project. Our hope is to prepare and support “mini-grantees” in developing programs that are evidence-based and sustainable, enabling them to find additional funding for future project development.

This year, CHALK started partnerships with two faith-based organizations in Northern Manhattan.


**PRESENTATIONS**


**PUBLICATIONS**

4. CHALK toolkit – available for free download at http://www.nyp.org/CHALK.
7. Food Guidelines for Pediatric Events at NewYork-Presbyterian (March 2011)

**CHALK toolkit – available for free download at**

http://www.nyp.org/CHALK

**Vive tu Vida/Live your Life Guide to Healthy Living (Winter 2010)**

**Food Guidelines for Pediatric Events at NewYork-Presbyterian (March 2011)**

**Guide to Healthier Shopping at Discount Stores (January 2010)**


**MARKETING TO TACKLE CHILDHOOD OBESITY IN NORTHERN MANHATTAN**

- **Storytelling Presentation:** ECLExpo2013: Community-University Partnerships: Bringing global perspectives to local action. Waterloo, Ontario. May 2011.

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**ACTIVESCHOOLASAP.ORG/CHALK**

**CHALK ®**

**CHOOSING HEALTHY & ACTIVE LIFESTYLES FOR KIDS ™**

**PUBLICATIONS**


**CHALK toolkit – available for free download at**

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**MARKETING TO TACKLE CHILDHOOD OBESITY IN NORTHERN MANHATTAN**

- **Storytelling Presentation:** ECLExpo2013: Community-University Partnerships: Bringing global perspectives to local action. Waterloo, Ontario. May 2011.
**Community Pediatrics Residents’ Training Program**

**MISSION AND GOALS**

All pediatric trainees are exposed to the strong community-academic partnerships that exist between NewYork-Presbyterian and the surrounding community. These core concepts — community health, cultural competency, and advocacy — are integrated into all three years of residency training. We use service-learning in our partnerships as our teaching methodology — a strategy that integrates meaningful community service with instruction and reflection to enrich residents’ learning experience and teach civic responsibility, while strengthening the community. These future pediatricians learn the skills required to understand community health and to work collaboratively with the community to address disparities in health care.

For residents with a particular interest in community pediatrics, the track offers an enhanced experience that fosters the development of future leaders in the field. Residents work on a project, in collaboration with a community health initiative, which spans their three years of training, with one-to-one faculty mentorship.

**NUMBER OF PEOPLE REACHED**

- Each year, all 75 pediatric residents receive training in Community Pediatrics.
- Currently, 19 residents participate in the Community Pediatrics Track.
- All second-year residents participate in a two-week Community Pediatrics Elective.
- We have more than 20 community-academic partnerships which impact different populations (such as the Head Start Program, where residents read to children; the Lang Youth Program, where residents teach youth; and Food Insecurity, where residents work in a food bank).

**KEY ACCOMPLISHMENTS**

- Our residents have presented their work at national meetings, such as the Pediatric Academic Societies’ Annual Meeting. Residents have received CATCH grants from the American Academy of Pediatrics to support their work. Community Pediatrics residents have leadership roles in regional pediatric organizations, such as the American Academy of Pediatrics and the New York State Pediatric Advocacy Coalition. Community Pediatrics residents have also become involved in legislative advocacy, travelling to Albany and Washington to advocate for patients and families. In 2017, residents created the Community Pediatrics Advocacy Project (CPAP) to advance advocacy efforts for patients.

Residents work on a project, in collaboration with a community health initiative, which spans their three years of training, with one-to-one faculty mentorship.

**PRESENTATIONS**

- “Is There Anything to Learn From the Cuban Child Abuse Protection System?”

**NUMBER OF PEOPLE REACHED**

- 300

**KEY ACCOMPLISHMENTS**

- Residents present at national meetings (such as Pediatric Academic Societies’ Annual Meeting)
- residents have also become involved in legislative advocacy, travelling to Albany and Washington to advocate for patients and families.
- 20 residents present at national meetings, such as the Pediatric Academic Societies’ Annual Meeting.
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.

NUMBER OF PEOPLE REACHED

220 PrEP patients assessed; 72% started PrEP
200 patients Medical Case Management (MCM)
500 Ready to End AIDS & Cure Hepatitis C (REACH) Collaborative
800 clients Hepatitis C and Youth Access Program (YAP) services

KEY ACCOMPLISHMENTS

Services delivered through our MCM, YAP, REACH Collaborative, and Washington Heights CORNER Project (WHCPC) 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.

REACH Collaborative

(Ready to End AIDS & Cure Hepatitis C)

With the support of DSRIP funding, NewYork-Presbyterian identified a core group of 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, as well as 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 works to achieve patient-centered sexual health goals and to link clients directly to one of three NYP HIV Centers of Excellence and Harlem United’s Federally Qualified Health Center (“The Nest”).

PUBLICATIONS


PRESENTATIONS


• Hanson E, Klein M, Dyer B et al. “Developing a National Child Poverty Curriculum: The process and initial products of the APAC Task Force on Childhood Poverty Education Subcommittee (CPEG).”


• Hanson E, Klein M, Dyer B et al. “Developing a National Child Poverty Curriculum: The process and initial products of the APAC Task Force on Childhood Poverty Education Subcommittee (CPEG).”


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One of the major goals of the program is to increase access to and the capacity for pre-exposure prophylaxis (PrEP) services.

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.
- A team of two Care Coordinators and eight Patient Navigators uses a chronic care model across the care continuum (e.g., inpatient, emergency room, ambulatory clinic, in the home, and in the community) to help clients living with HIV gain and maintain independence in their health care, as well as to prevent deterioration, reduce the risk of complications, prevent associated illnesses, and improve their quality of life. The active caseload is currently 130-145.
- A 2014 study across all 28 grantees showed that among newly diagnosed clients, 90.5% were engaged in care (EiC) and 66.2% achieved viral load suppression (VLS). Among previously diagnosed clients, EiC increased from 32.3% to 50.9%, and VLS increased from 73.7% to 91.3%, and VLS increased from 73.7% to 91.3%, and VLS increased from 73.7% to 91.3%. Clients without associated illnesses, and improve their quality of life. The active caseload is currently 130-145.

PUBLICATIONS

PRESENTATIONS
- RW All Grantees Meeting in Washington DC.
- Multiple presentations on HIV Cascade for NYP, Abnormal PAR and Practice Transformation, NY.
- Presentation to AIDS Institute Quality Committee —— REACH.
Family Planning Program and Young Men’s Clinic

The Family Planning Program provides confidential and comprehensive medical, sexual health, mental health, and health education services to adolescents, women, and men to assist individuals in determining the number and spacing of their children; to increase use of effective contraception among sexually active men and women who are not seeking pregnancy; to prevent teen pregnancy and early childbearing; to reduce the transmission of sexually transmitted infections and HIV; to facilitate entry into early prenatal care for pregnant women; and to 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. The Family Planning Center and Young Men’s Clinic

MISSION AND GOALS

- 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; 30-40% 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 five-year grant from the CDC supports the implementation and evaluation of a computer tablet-assisted intervention, designed for young males, to prevent unplanned pregnancies and sexually transmitted infections (STI), including HIV.

- 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.

KEY ACCOMPLISHMENTS

NUMBER OF PEOPLE REACHED

- 15,000 Total patients annually
- 1,742 Adolescent patients
- 872 Community health education workshops
- 2,074 Teen health education workshops
- 2,600 Benefits and supportive services enrollment

PRESENTATIONS

- Presented an “Adolescent Trials Network: Strategies to improve Adolescents’ Engagement and Retention in care for HIV+ youth.”
- Presented an “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 Adolescents’ Engagement and Retention in care for HIV+ youth.
- Year UP National Conference (organization which provides workforce development services for high-risk young adults): “Impact of Clinics 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.
- Several regional webinars conducted for NY PATH and CHACNY on “Strategies to Improve HIV/STI screening for High Risk Youth” and “Management of HIV among Youth living with HIV.”

PUBLICATIONS


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

continued

NewYork-Presbyterian • COMMUNITY PROGRAMS

• Receipt of special recognition award on World AIDS Day in 2013 from the New York State Department of Health
• Obtaining successful competitive renewal application for Project STAY: $750,000 annually for five years
• Obtaining additional funding from the New York City Department of Health to expand PrEP services for adolescents
• Negotiating an arrangement with Harlem United to utilize their mobile medical van (a “health clinic on wheels”), and securing access to the van 10 hours per week to enhance STI/HIV screening for high-risk youth and adults in community settings
• Ramping up PEP and PrEP services within NYP and obtaining a PEP Center of Excellence grant to coordinate services with NYP/Weill Cornell. Kerri Carnevale, NP, has played a leading role in establishing NYP as one of the leading institutions in New York City providing these services.

PRESENTATIONS

- Presented an “Trauma Informed Care – Strategies to Improve Care Delivery for High Risk Youth” and “Management of HIV among Youth living with HIV.”
- Involved Youth to Clinical Services.
- Adolescent Trials Network: Strategies to improve linkages and retention in care for HIV+ youth.
- Presented on “STD Treatment Guidelines” – multiple conferences sponsored by New York City Department of Health for providers in the Bronx, Manhattan, and Brooklyn.
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PUBLICATIONS


The Family Planning Center and Young Men’s Clinic have provided family planning and adolescent pregnancy prevention services to the Washington Heights/Inwood community since 1976.
Family Planning Program and Young Men’s Clinic continued

- 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.

- Recipient of NYC Council Funding for Services to Immigrants: The YMC received a grant 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.

- Co-located Benefits Enrollment and Access to Supportive Services: We also provide on-site 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.

- HEAL (Health Education and Adult Literacy) is a health literacy program which aims to improve the health literacy of pediatric patients’ caregivers, with an emphasis on medication administration and adherence. The program aims to:
  - Improve health knowledge and promote healthy behaviors among patients’ caregivers who possess low health literacy skills.
  - Foster opportunities to engage caregivers in their children’s health and wellbeing.
  - Narrow the communication gap that may exist between healthcare providers and patients’ caregivers.

- Since the initiation of the program in July 2007, 2,890 patients and caregivers of pediatric patients’ caregivers reported English as their preferred language, 43% Spanish, and 3% other languages, with the remainder reporting no preference between their first language and English.

- The HEAL program utilizes culturally responsive health education materials taught in waiting rooms throughout the NewYork-Presbyterian Ambulatory Care Network. Families are not solely given the information, but also the opportunity to share their views regarding health topics that impact their wellbeing — with proper antibacterial usage, understanding colds and the flu, and CHALK Healthy Habits being common topics of interest.

- In 2016, HEAL initiated the WALLE (Waiting room As a Literacy Learning Environment) pilot project, in collaboration with CHALK (Choosing Healthy Active Lifestyles for Kids). WALLE is a volunteer-based program that leverages patients’ caregivers’ wait time by providing health information and community resources. The HEAL program has fostered partnerships between providers and communities by reaching out to families with low health literacy and sharing knowledge and tools to empower them, implementing the curriculum in a variety of venues not limited to average healthcare settings. The curriculum was informed by focus groups of community members representing the population served, and is used to train pediatric providers, community workers, and volunteers.

- In 2016, HEAL also established collaborations with three educational institutions (Albert Einstein College of Medicine, Hunter College, and Monroe College) to recruit bilingual volunteers pursuing a career in public health.

- In 2016, HEAL also presented at the NYAPRS (New York Association of Psychiatric Rehabilitation Services) Annual Conference in Albany, New York.

- Since the initiation of the program in July 2007, 2,890 patients were approached in NYP Ambulatory Care Network pediatric waiting rooms, and 83% were interested in the curriculum, 46% of caregivers reported English as their preferred language, 43% Spanish, and 3% other languages, with the remainder reporting no preference between their first language and English.

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Healthy City Kids

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.

NUMBER OF PEOPLE REACHED

90

KEY ACCOMPLISHMENTS

Participating families have reported making multiple changes in their homes, including purchasing healthier foods and encouraging children to try new foods. In addition, Healthy City Kids participated in the 2016 Lenox Hill Neighborhood House annual health fair, where we discussed the hidden sugars in beverages and where we reached many more families.

PRESENTATIONS

- Advocates for Pediatric Nutrition Symposium, 2015 (held at NYP)
- Foundations in Lifestyle Medicine course presentation to Weill Cornell Medical College students, 2016

Health for Life

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 improved health through 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.

NUMBER OF PEOPLE REACHED

200

KEY ACCOMPLISHMENTS

H4L staff conducted community outreach initiatives such as:
- The “Groove With Me” dance program to provide three weekly nutrition education sessions to parents.
- Healthy cooking instruction and nutrition education provided for four weeks to summer students of the Liberty Partnership Program.
- Health for Life parent and child cooking classes offered once a week for 10 weeks, run by a NewYork-Presbyterian chef.

PRESENTATIONS

- Advocates for Pediatric Nutrition Symposium, 2015 (held at NYP)
- Foundations in Lifestyle Medicine course presentation to Weill Cornell Medical College students, 2016
Project K. I. S. S.

MISSION AND GOALS
Project K.I.S.S. is an adolescent HIV prevention program which provides services to youth ages 13-24. Staff engage youth through innovative health education, HIV/AIDS awareness, safer sex products and prevention counseling, and rapid HIV testing. Services are accessible to all youth, regardless of race, class, sexual orientation, gender identity, or ability to pay. Education about HIV/AIDS is provided to young people through conversations, role-play, written material, educational workshops, and events.

NUMBER OF PEOPLE REACHED
500

KEY ACCOMPLISHMENTS
In 2016, Project K.I.S.S. collaborated with The New School to put on the 8th Annual Project K.I.S.S. Health Education Fashion Show. The show reached about 200 individuals and featured a night of entertainment and sexual health education. Throughout 2016, Project K.I.S.S. also had the honor of collaborating with more than 20 different community-based organizations and agencies throughout the city on events to educate and support diverse communities of young people.

Services are accessible to all youth, regardless of race, class, sexual orientation, gender identity, or ability to pay.

Lang Youth Medical Program

MISSION AND GOALS
The Lang Youth Medical Program (Lang Youth) is a six-year science enrichment and medical pipeline program for talented youth who represent the diversity of the Washington Heights and Inwood communities. Lang Youth’s mission is to use the resources of NewYork-Presbyterian and Columbia University Irving Medical Center to inspire and motivate young people from the community to realize their college and career aspirations, especially in the health sciences. The program fosters an environment where scholars can develop social and academic skills while participating in a challenging, hands-on science curriculum — working alongside graduate students, medical trainees, and professionals from various Hospital departments.

KEY ACCOMPLISHMENTS
Lang Youth promotes high school and college graduation rates, with the aim of improving health outcomes in the future. The program also helps to reduce the deficit of minority physicians and other healthcare workers in the United States.

In 2016, a partnership was formed with the Boy Scouts of America’s Exploring Program. Lang Youth facilitated the creation of a “post” at NYP to give New York City teens the opportunity to explore healthcare professions during a weekly after-school program from mid-May to mid-June. Approximately 50 high school youth from across the city attended the post and participated in activities such as clinical rotations and career panels.

NUMBER OF PARTICIPANTS
274 Total
79 Current scholars (7th-12th grades)
120 Parents of current scholars
75 Alumni (Class of 2009-2016)

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PROJECT K. I. S. S.

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In addition, new partnerships within NYP/Columbia have helped strengthen the services offered to Lang Youth scholars. These include a collaboration with CARING at Columbia to introduce students to the expressive arts to promote the learning of self-discovery and coping skills, the development of a college preparatory mentorship program with Columbia’s Physical Therapy students, and a partnership with a Teacher’s College graduate student for the creation of a personal wellness curriculum.

Finally, Lang Youth has strengthened its partnership with scholars’ parents through the creation of a monthly didactic workshops.


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### Outreach Program

**MISSION AND GOALS**
The mission of the Outreach Program is to promote health and disease prevention through education and screening supporting early detection and intervention, and to ensure that people in the community have a reliable source of primary medical care. The program assesses the needs of underserved residents in communities surrounding the Hospital campuses. One of our major goals is to reduce health disparities that exist in the community.

Events include free screenings, services, health insurance information, and education that are culturally sensitive and relevant. Examples include the yearly Taxi Drivers’ health fair, Bodegueros (Grocery Shop) health events, Domestic Worker’s health fair, and Day of Hope (in partnership with Building Bridges, Knowledge and Health).

**NUMBER OF PEOPLE REACHED**
1,770 People screened at targeted health events

**KEY ACCOMPLISHMENTS**
The results of some of our signature events underscore the need to continue to provide outreach to the communities surrounding NYP. For example, out of 125 people screened at the Taxi Drivers’ health fair, 105 had abnormal results. Out of 480 individuals screened at the Bodegueros Health Initiative at Jetros Cash and Carry in the South Bronx, 115 had abnormal blood pressure results. These individuals received counseling and education about the importance of follow-up care and connecting to primary care services.

Last May, our Domestic Worker’s Outreach venue was held at St. Catherine’s Park in the Upper East Side, where nannies bring children to play. We were able to screen almost 100 nannies and connected many to primary care.

Every fall, we host community flu vaccine initiatives, in collaboration with elected officials and local senior centers. Last year, we vaccinated nearly 270 participants. We also offered a healthy cooking class to the Bowery Mission women’s shelter guests and to ACN patients, in partnership with NYP Senior Executive Chef Pnina L. Peled and in collaboration with ACN nurses via an NYP patient and family experience grant.

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### Reach Out and Read

**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 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**
21,038 Well child visit encounters with over 10,000 patients

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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.
School-Based Health Center Program

### 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 provided 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 prevention curricula — and train and lead peer educators who conduct educational classroom education sessions — on a range of youth health promotion topics. In addition, youth leaders spend a summer interning at the Hospital and gaining professional skills and exposure to career paths in the health field.

### KEY ACCOMPLISHMENTS

- Community Schools Mental Health Intervention: Via an evidence-based framework, a broad range of school 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.

- Peer Education and Youth Development: Annual cohorts of youth leaders are trained and conduct peer education on a host of health promotion topics. In addition, youth leaders spend a summer interning at the Hospital and gaining professional skills and exposure to career paths in the health field.

### PUBLICATIONS


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

### MISSION AND GOALS

The Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center (FPTTC) at NewYork-Presbyterian provides mental health services to children (ages birth to 5 years) and their primary caregivers who have been exposed to various forms of trauma, including violence and abuse. The FPTTC is dedicated to improving the safety and well-being of children and caregivers by addressing the psychological impact of trauma exposure, re-building safety for the family, improving the quality of parent-child attachment, providing age-appropriate developmental guidance, and improving both parents’ and children’s capacity for positive self-regulation and conflict resolution — all in an effort to interrupt the intergenerational transmission of violence and trauma. The FPTTC is staffed by early childhood mental health psychologists who provide evidence-based trauma and attachment-informed dyadic treatment to young children and their caregivers. The FPTTC is a federally funded National Child Traumatic Stress Network Category III Direct Service site.

### KEY ACCOMPLISHMENTS

- In September 2014, the program received a three-year grant from the State Office of Victim Services (OVS) to expand its treatment services to victims of child abuse ages 0-5 — with the goal of increasing early identification and improving access to developmentally appropriate, culturally competent, linguistically competent evidence-based trauma treatment. The project will also serve as a model for improving urban community capacity in Spanish-language Evidence-Based Practices for bicultural Latino families affected by traumatic events. The grant will co-locate trauma and CPP trained, Spanish-speaking, early childhood psychologists within the Hospital’s pediatric primary care clinics and at a local community-based organization.

### NUMBER OF PEOPLE REACHED

- 1,920 Visits with 196 patients
- 65 Medical residents trained on how to screen for domestic violence in the primary care setting
- 1,300+ Number of medical professionals trained since inception

### PRESENTATIONS

- Presentation on Batterer’s Intervention Program (BIP) Group Curriculum developed in collaboration with the Children’s Aid Society. Batterer’s group intervention as preparation for engaging abusive fathers in CPP. The International Society of Traumatic Stress Studies (TSST) Conference. Miami, FL November 2014.
- Presentation to Wayne State University’s Infant Mental Health monthly colloquium to discuss BIP Group Curriculum in preparation for engaging abusive fathers in CPP Detroit, MI: March 2015.
**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 9,000 students, caregivers, and school personnel.

**KEY ACCOMPLISHMENTS**

As published in the February 2015 issue of Children & Schools Journal, T2U continues to improve students’ classroom compliance/social performance, as well as attendance and state exam scores; decrease unscheduled guidance counselor visits and suspensions; and reduce mental health symptoms (i.e., anxiety and disruptive behaviors, especially those most symptomatic, as reported on teachers’ measures).

Preliminary findings of our most recent study (2015-16) examining school personnel’s Mental Health Literacy pre- and post-intervention, when compared to our wait-list school, show an increase in:

- Knowledge of school-age mental health conditions
- Familiarity with early identification and referral of students presenting with mental health needs
- Self-efficacy in addressing challenging behaviors in the classroom

In addition, stigma related to school-age mental health conditions decreased.

In 2016, T2U was selected as a Pioneer in Children’s Wellbeing by the Ashoka Changemakers and Robert Wood Johnson Foundation. T2U was also recognized by the American Hospital Association for “Meeting the community’s social and basic needs, promoting community health, improving access and coverage, and enhancing quality of life.”

**Grant:**

Derek Jeter’s Turn 2 Foundation – Recipient – $50,000 (2007-08) $25,000 (2009-2010)

**PUBLICATIONS**


- Montañez E, & Battino, B. Effective Mental Health Interventions in At-Risk Elementary Schools. Presentation at the 11th Annual Conference on Advancing School Mental Health. Salt Lake City, UT. October 2012.


- Montañez, E. Turn 2 Us School-Based Mental Health Promotion and Prevention. Presentation at the quarterly meeting for Community Board 12: Mental Health Initiatives in Washington Heights, New York, NY May 2011.


- Montañez, E. & Battino, B. It takes a village to raise a child: Learn how to incorporate preventive mental health interventions through partnerships that foster academic and social achievement in urban elementary schools. Presentation at the National Association of Social Workers Florida Chapter 2010 Conference. Orlando, FL. June 2010.

Women, Infants, and Children Program

Mission and Goals
The NewYork-Presbyterian Ambulatory Care Network’s Women, Infants, and Children (WIC) 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 9,800 participants on a monthly basis.

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

WIC provides nutrition, health, fitness, and breastfeeding information as well as monthly vouchers for nutritious foods to eligible participants.

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