NewYork-Presbyterian

NewYork-Presbyterian

DIVISION OF COMMUNITY & POPULATION HEALTH REPORT

THANK YOU

To Community-Based Organizations

NewYork-Presbyterian extends our deepest gratitude to all of our community collaborators throughout New York City and Westchester County. Without you, none of our work would be possible!

To Our Donors

Thank you to the generous and visionary donors who support our community and population health programs. In partnership with you, we are increasing access to care and improving the health of adults and children throughout the neighborhoods of New York City and Westchester County.

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Letter From Our Chief Operating Officer

Addressing Equity in a Post-Pandemic World

As we navigate the complexities of a post-pandemic world, the commitment to addressing social determinants of health remains at the forefront of our mission at NewYork-Presbyterian. Our dedicated efforts have centered around reengaging with our communities in a safe and positive manner, forging true partnerships that redefine equitable access to care.

Our approach involves turning to our community members and fostering true partnerships. Collaborating closely with clinical and community partners, we have co-developed and implemented programs aligned with community-informed domains of focus. Simultaneously, we have tackled crucial issues like access to health care, navigation, and social determinants of health.

While the concept of social determinants of health is not new, our communities' support, knowledge, and resilience have enabled us to redefine what equitable access to care means in this post-pandemic era. The achievements under this new norm have been truly remarkable, showcasing the strength and adaptability of our collective efforts.

The programs operating under Maternal and Child Health, Chronic Disease Prevention and Management, Behavioral Health, Youth Development, and Sexual and Reproductive Health have been nothing short of phenomenal in addressing the unique needs of their respective populations. Each program has consistently strived for excellence, both within our hospital walls and beyond, ensuring the provision of the best possible care to our community members.

This report stands as a testament to the outstanding model we have collectively created—an innovative framework that facilitates high-quality care within and outside our hospital walls. It is a foundation that propels us forward in our unwavering commitment to pioneering health justice.

To the members of the Division of Community & Population Health, I extend my heartfelt gratitude. Thank you for another year of remarkable accomplishments and milestones. Your dedication has been instrumental in shaping our success, and I look forward to continuing this transformative journey together.

Sincerely,

Tiffany Sullivan, MPH
Senior Vice President & Chief Operating Officer
NewYork-Presbyterian Physician Services

Our Mission

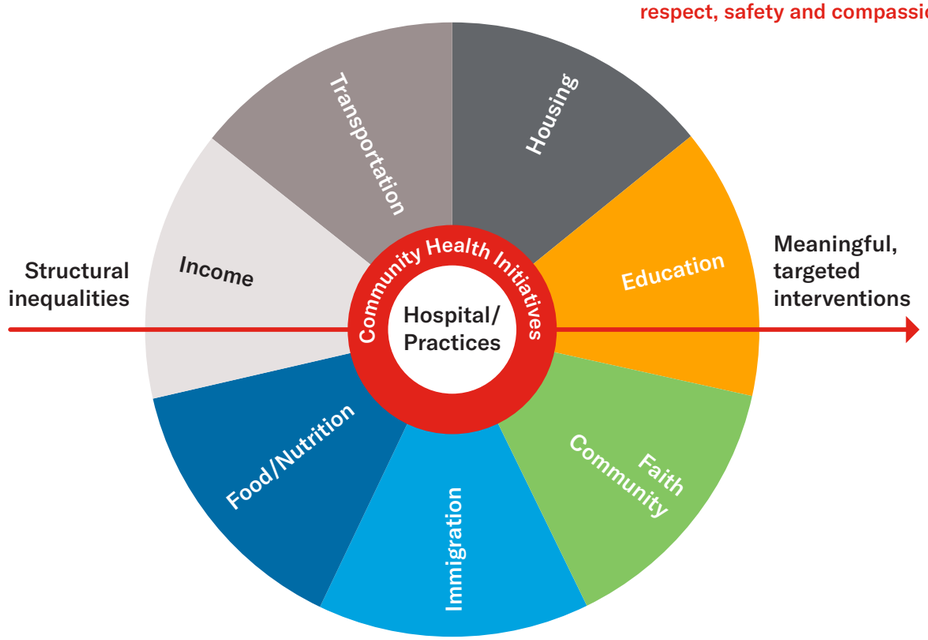
NewYork-Presbyterian Hospital's Division of Community & Population Health collaborates with community partners across New York City and Westchester County to improve the health and well-being of the communities we serve, with the goal of achieving health equity for all.

We connect community members and patients with medical, social, and behavioral health care through a wide range of community health programs and practices for children, adolescents, and adults.

The Division of Community & Population Health Includes: Ambulatory Care Network (ACN), Community Health, Care Coordination, Accountable Care Organization (ACO), Access, and Quality.

Guiding Principles:

- Collaborate with **community partners** to address shared **health priorities**
- Provide the **highest quality, evidence-based care**, regardless of ability to pay
- **Support continuity of care by enhancing access** to appointments for all patients who would like to be seen at NewYork-Presbyterian
- Train the next generation of **health professionals**
- Advance **best practices** through **community-engaged research**
- Actively contribute to a culture of **teamwork, respect, safety and compassion**



Community & Population Health Leadership

Tiffany Sullivan, MPH
Senior Vice President &
Chief Operating Officer,
NewYork-Presbyterian Physician Services

Davina V. Prabhu
Vice President
Ambulatory Care Network

Elaine Fleck, MD
Vice President
Regional Executive Medical Director

Diego Arias
Director, Ambulatory Care Network
NewYork-Presbyterian/Cornell

Mark Krugman, RN
Director of Nursing,
Ambulatory Care Network

Nelson Mesa
Director, Quality Improvement
Ambulatory Care Network

Dodi Meyer, MD
Medical Director, Community Health

Andres Nieto
Senior Director
Community & Population Health

Jennie Overell
Director, Ambulatory Care Network
NewYork-Presbyterian/Columbia

Patricia Peretz
Director, Community and Population
Health Strategy & Center for
Community Health Navigation

NYP AT A GLANCE

3.2M
hospital and clinic visits

2.1M
medical group visits

#1
ranked as the top hospital in New York and among the best in the nation

38.5k
employees

10.3k
affiliated physicians, residents and fellows

759k
telehealth visits

Quality of Care

#2
in the nation for rheumatology*

#3
in the nation for diabetes and endocrinology*

#6
in the nation for cardiology and heart surgery*

#3
in the nation for neurology and neurosurgery*

#5
in the nation for orthopedics*

#3
in the nation for psychiatry*

*According to *U.S. News & World Report's "Best Hospitals" Survey 2023-2024*

Caring for the Community Impact in 2023

$6M
distributed to 879 small businesses

2.2M
pounds of healthy food distributed across New York region

9.9k
visits to the Center on Aging

107.5k
visits to women, infants, and children locations (WIC)

171k+
people vaccinated in the community

461.8k
ambulatory care network visits

Investment in Community Youth

750
community-based jobs created for youth

2.6k
children served at school-based mental health centers

$1.5m
invested in summer youth experiences

141
alumni of Lang Youth Medical Program

9k
children served at school-based health centers

900
children served through Northern Manhattan Youth Hub

COMMUNITY HEALTH NEEDS ASSESSMENT & SERVICE PLAN

In partnership with the New York Academy of Medicine, NewYork-Presbyterian conducts a comprehensive Community Health Needs Assessment (CHNA) every three years to gain an updated understanding of the health and social needs of the communities we serve. The findings of the CHNA help inform the development of the Community Service Plan (CSP) which, in alignment with New York State's Prevention Agenda, outlines the health priorities NewYork-Presbyterian will address and the approach to each one. In addition, the data are utilized to identify priority communities of high need where the CSP interventions are implemented.

The Division develops and implements the CSP programs across the health system by leveraging resources from both the community and within NewYork-Presbyterian. CSP programs address local health disparities through evidenced-based population health initiatives, care provider training, funding opportunities, and research. These activities are collaboratively developed, executed, and maintained in partnership with community-based organizations and departments within NewYork-Presbyterian. The combination of NewYork-Presbyterian's skills and resources with the talents, energy, and resources of our community partners enables us to achieve our goals. These efforts also 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

In 2022, the hospital selected the following Prevention Agenda priorities for its focus during the 2022-2024 Community Service Plan period.

- Prevention of Communicable Diseases
- Mental Health and Substance Use
- Women, Infants, and Children
- Prevention of Chronic Diseases

High-Need Areas include:

- Washington Heights
- Mount Vernon
- Chinatown & Lower East Side
- Crown Heights
- Corona
- Peekskill

DOMAINS OF HEALTH

MATERNAL & CHILD HEALTH

Women, Infants, and Children Program

The Women, Infants, and Children Program (WIC) safeguards the health of low-income women, infants, and children through age 5 who are at nutritional risk by providing nutritious foods, education about healthy eating, and referrals to health care.

During the infant formula shortages of 2022, WIC staff connected our clients with vendors who had supplies of formula. The U.S. Department of Agriculture and New York State Department of Health allowed formula substitutions to provide participants with more formula choices. The pandemic escalated housing shortages and unemployment among the population we serve. WIC staff provided referrals to organizations that address housing.

Key Accomplishments & Outcomes for 2022

9,711
average number of participants reached monthly—an increase of over 600 participants per month since 2020

Received a
MULTIMILLION DOLLAR CONTRACT
for psychotherapy visits through telehealth

Maternal and Child Integrated Mental Health Program

The Maternal and Child Integrated Mental Health Program (MAC-IMP) aligns target health metrics, care approaches, and dyadic interventions across obstetric, pediatric, and behavioral health services in Northern Manhattan community-based practices. MAC-IMP promotes community-wide health initiatives and strengthens support networks for young families. The shared goal is to improve the quality of care throughout the continuum of a mother's and child's life, including new caregivers at different stages of the perinatal and early childhood periods.

MAC-IMP successfully provides its services through the following programs:

— **Postpartum Doula Program** For patients at NewYork-Presbyterian/Columbia University Irving Medical Center and in collaboration with the Northern Manhattan Perinatal Partnership, a certified postpartum doula provides medical and psychosocial support and infant care education to new caregivers. The program is set to expand to NewYork-Presbyterian/Weill Cornell Medical Center and Brooklyn Methodist Hospital.

— **HealthySteps** This national evidence-based prevention model builds a foundation of health and strong social-emotional development for children. NewYork-Presbyterian expanded this model to begin in the prenatal period, offering behavioral health support in the obstetric and pediatric care environments.

— **Northern Manhattan Early Childhood Collaborative (NMECC)** This shared partnership between NewYork-Presbyterian/Columbia and local organizations ensures all families with young children in Northern Manhattan can embark upon lifelong trajectories of physical, social-emotional, and educational well-being. In 2022, NMECC hosted monthly stakeholder meetings and hosted eight parent group meetings.

— **Obstetric & Early Childhood Community Health Work Programs** These programs support caregivers of children with special healthcare needs to understand and manage their child's condition. Bilingual community health workers are anchored in community-based organizations and hospitals, where they provide education and support to expectant and new parents.

— **Reach Out and Read (ROR)** A national program, returned to an in-person format. Volunteers in waiting rooms model reading techniques to children in the presence of caregivers and distribute books to families. Services are provided at each well-child visit up through age 6. NewYork-Presbyterian/Columbia's ROR program is one of the largest in the state.

Challenges & Successes

Expectant caregivers and young families continue to feel the effects of the COVID-19 pandemic, with impacts on psychosocial health, financial stability, housing needs, and childhood growth. MAC-IMP social workers and community health workers help patients locate public and community psychosocial support resources. HealthySteps specialists and MAC-IMP case managers promote developmental screening, prevention, and linkages with early intervention services. They also work with patients to navigate affordable and public housing resources and employment services.

Support, guidance, and reassurance are essential for caregiver and infant well-being. Through an integrative, primary care model, MAC-IMP staff help caregivers manage the many structural, hormonal, and physical changes that occur during and after pregnancy to ensure optimal maternal and infant well-being.

Key Accomplishments & Outcomes for 2022

MAC-IMP received

$1.3M

in grant funding from the Robin Hood foundation to substantially expand our staff and our mental health, social work, and case management services for caregivers and young children

The American Academy for Pediatrics highlighted MAC-IMP as a

"PROMISING PRACTICE" INITIATIVE

spotlighting the program's focus on social determinants of health, integrative approaches, and community care

4,906

books were distributed to young families through the Reach Out and Read program

420+

families engaged in dyadic behavioral health interventions through HealthySteps

356+

families have been reached through the Postpartum Doula program since 2020

YOUTH DEVELOPMENT

The Uptown Hub

Serving youth and young adults ages 14-24 who are primarily from the Washington Heights and Inwood neighborhoods of New York City, the Uptown Hub empowers young people by providing access to holistic and culturally affirming services and building self-advocacy and self-sufficiency.

The Uptown Hub aims to:

- Cultivate a community that facilitates employment readiness, educational support, wellness, creative youth development, and recreational activities
- Reduce idle time, risky behaviors, and justice system involvement
- Improve mental and physical health
- Increase the collective impact of youth-serving agencies and expand community awareness of available services

Key Accomplishments & Outcomes for 2022

1,000
youth enrolled since program began

1,163
psychotherapy visits through telehealth

Return to fully
IN-PERSON PROGRAMS

OFFICIALLY LICENSED
to provide in-person psychotherapy visits

Challenges & Successes

The mental health crisis that worsened during the pandemic is still present. The Uptown Hub leveraged resources at NewYork-Presbyterian Hospital to limit waiting time for our population to receive mental health care. Today, many young people also have severe deficiencies in socializing due to being confined indoors during the pandemic. We are giving our participants a safe space to practice social skills and more programming to teach these skills. In addition, the Uptown Hub bolstered employment readiness programming as well as internship and job opportunities through connection with the 1199 union and the support of NewYork-Presbyterian's Human Resources department.

Rose's Story

"Rose" was a young person who moved to New York from Arizona after her mother died. Her father was absent, so she was taken in by her grandmother. Rose had severe traumas in her past, was not able to complete high school, and did not know anyone in New York. Her grandmother's friend recommended the Uptown Hub. Rose joined and started working with her Hub Advocate. She was connected with therapy, received her high school diploma, is part of the Hub's Youth Council, participated in a summer hospital internship at NewYork-Presbyterian, and has started college.

Youth Development

Compass Program

The Compass Program serves transgender and gender-diverse children and adolescents.

The Compass team provides:

- Patient care in a safe and welcoming environment
- Family support by listening to parents' concerns and fears and helping them understand their child's experience
- Education of clinical staff, fellows, residents, and medical students
- Advocacy within NewYork-Presbyterian and in the community

Key Accomplishments & Outcomes for 2022

EXPANSION OF THE COMPASS PROGRAM

to include Compass West, a new clinic at 21 Audubon Ave for Medicaid transgender and gender-diverse patients

Challenges & Successes

During the height of the pandemic, some of our patients were living in places where their gender was not being affirmed, and they were unable to access affirming spaces. In addition, the pandemic negatively affected the mental health of many adolescents, including the patients we serve. The Compass team has been working to remedy both situations.

Youth Development

Lang Youth Medical Program

The Lang Youth Medical Program is a six-year enrichment program designed to inspire and motivate underserved youth from the Washington Heights and Inwood communities who are interested in the health sciences. From grades 7-12, students receive hands-on learning and mentorship at a world-class academic medical center, as well as college preparation support. They meet on Saturdays during the school year and in July during the summers.

Key Accomplishments & Outcomes for 2022

In partnership with the Washington Heights Armory, Isabella Senior Center, Nido De Esperanza, and PS173, the program launched a

SERVICE-LEARNING CURRICULUM

where students participate in intergenerational tutoring and volunteering opportunities

A record

92

6th-graders applied from 22 schools in Community District 6

In partnership with the Dalio Center for Health Justice, the program awarded three graduating seniors with the

DALIO SCHOLARSHIP

The program's first

COMMUNITY HEALTH SYMPOSIUM

featured students presenting their research about health issues in Northern Manhattan and Bronx communities

At the first

INTERNSHIP MATCH DAY

students received letters about their summer internship placements

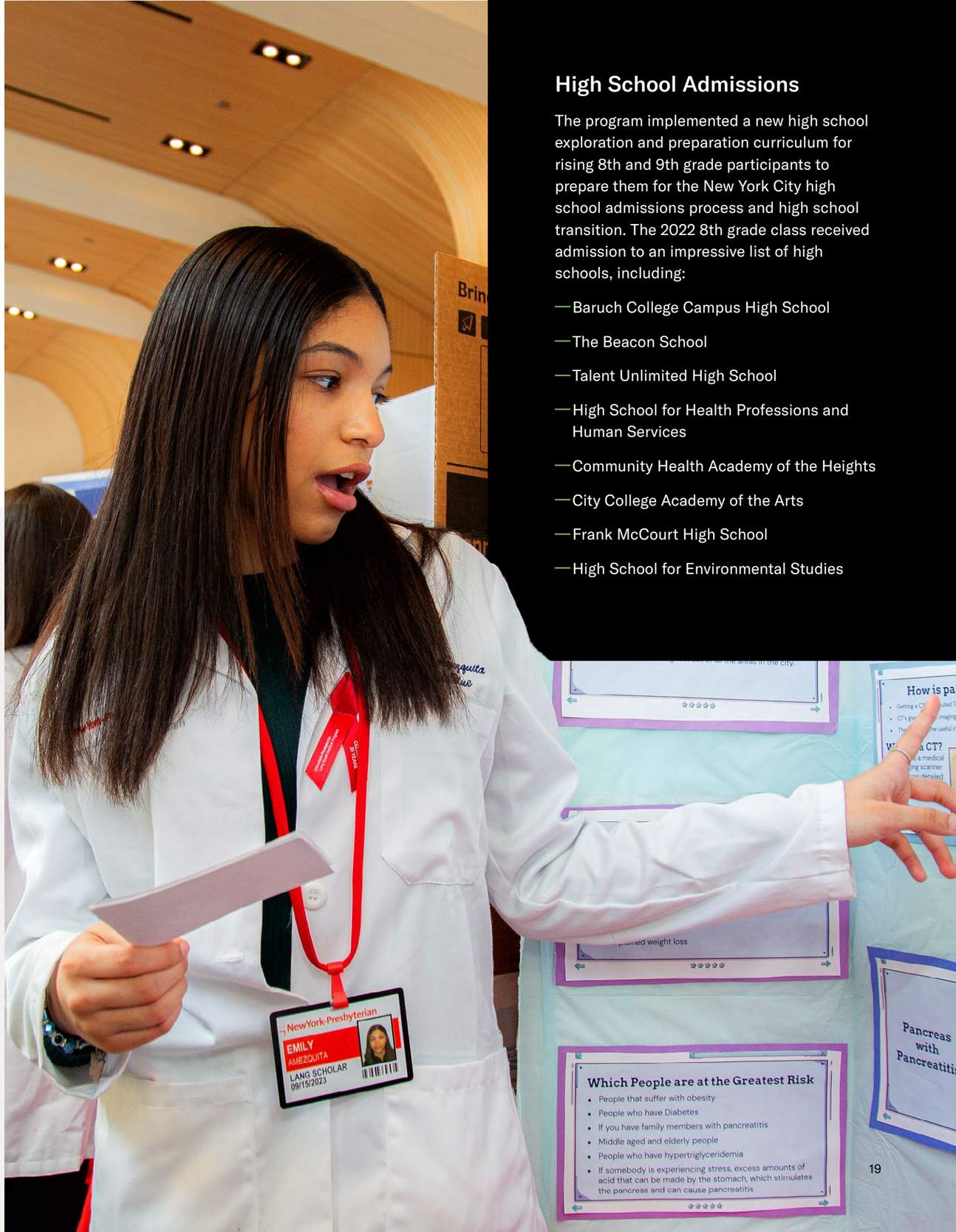
14

students graduated from the program in 2022

High School Admissions

The program implemented a new high school exploration and preparation curriculum for rising 8th and 9th grade participants to prepare them for the New York City high school admissions process and high school transition. The 2022 8th grade class received admission to an impressive list of high schools, including:

- Baruch College Campus High School
- The Beacon School
- Talent Unlimited High School
- High School for Health Professions and Human Services
- Community Health Academy of the Heights
- City College Academy of the Arts
- Frank McCourt High School
- High School for Environmental Studies



Youth Development

School-Based Health Center Program

Our School-Based Health Center (SBHC) Program supports the healthy transition from adolescence to adulthood through targeted health education and school-based access to preventive physical and mental health care. By providing services to students within their schools, the program facilitates access to care and prevents lost academic time.

Components include:

- **School-Based Health Centers** providing urgent and primary care; reproductive health services and family planning; universal, selective, and targeted mental health care services; and dental care
- **Healthy Bodies, Healthy Minds, Healthy Relationships**, a comprehensive health promotion, teen pregnancy prevention, and mental health program
- **NYPeers Wellness Educator Program** to empower high school students identified from the student body to learn about adolescent health topics and serve as leaders, advisors, and ambassadors to care
- **Integrative health education and promotion**, including mindfulness, sleep hygiene, acupressure, and aromatherapy offered at SBHCs.

Key Accomplishments & Outcomes for 2022

7,200
students reached at 21 public schools on seven campuses in Northern Manhattan and the Bronx

15,300
medical, mental health, health education, and dental visits

More than
75%
of students enroll in SBHCs

The 2022-23 cohort of the NYPeers Wellness Educator Program trained
26
peers from 11 schools across five campuses in Northern Manhattan and the Bronx

Peers engaged about
2,000
teens throughout the year

NYPeers worked closely with program staff to design and deliver virtual campaigns which engaged students from
19
schools across six campuses

Challenges & Successes

During the 2021-2022 school year, medical providers in SBHCs triaged suspected COVID-19 cases to determine appropriate intervention. The program collaborated with school partners to facilitate vaccine distribution, provide vaccine information, and educate students about COVID-19 prevention. The return to in-person instruction involved significant challenges and adjustments for students and families and spotlighted educational gaps and mental health declines that occurred during the pandemic. SBHCs conducted mental health-focused outreach and engagement activities that prioritized access to care.

In 2022, the SBHC program promoted preventive care through educational campaigns, reminders, and increased access to ensure students receive necessary vaccinations and screenings. We also integrated resilience-building activities into our services, including stress management workshops, mindfulness exercises, and social-emotional learning programs.

From Depression to Success

The parent of a 15-year-old sophomore reached out to the family's SBHC with a concern: her usually high-achieving son seemed depressed, was losing weight, and felt burdened by school. An evaluation by a psychologist diagnosed a major depressive disorder, anxiety, and the beginning of an eating disorder. He began weekly individual psychotherapy sessions at the SBHC and was referred to the program's nurse practitioner and registered dietitian, continuing with services via telehealth over the summer. He has made significant progress, is thriving socially and academically, and has achieved his personal goal: becoming the top student in his grade.

Youth Development

Summer Youth Experience

The Summer Youth Experience Program provides young people ages 14-24 with enriching summer employment opportunities throughout the NewYork-Presbyterian enterprise and/or the community.

Over the course of six weeks in 2022, participants learned about the breadths and depths of health care while developing their interpersonal skills. In addition, they were able to take part in a comprehensive professional development series focusing on topics such as resume writing, networking, and communication etiquette.

Summer Youth Experience employees provided support to the following community-based organizations in 2022:

- Community League of the Heights (CLOTH)
- Prospect Park Alliance
- Westchester Youth Bureau

Key Accomplishments & Outcomes for 2022

Proudly hosted more than

200

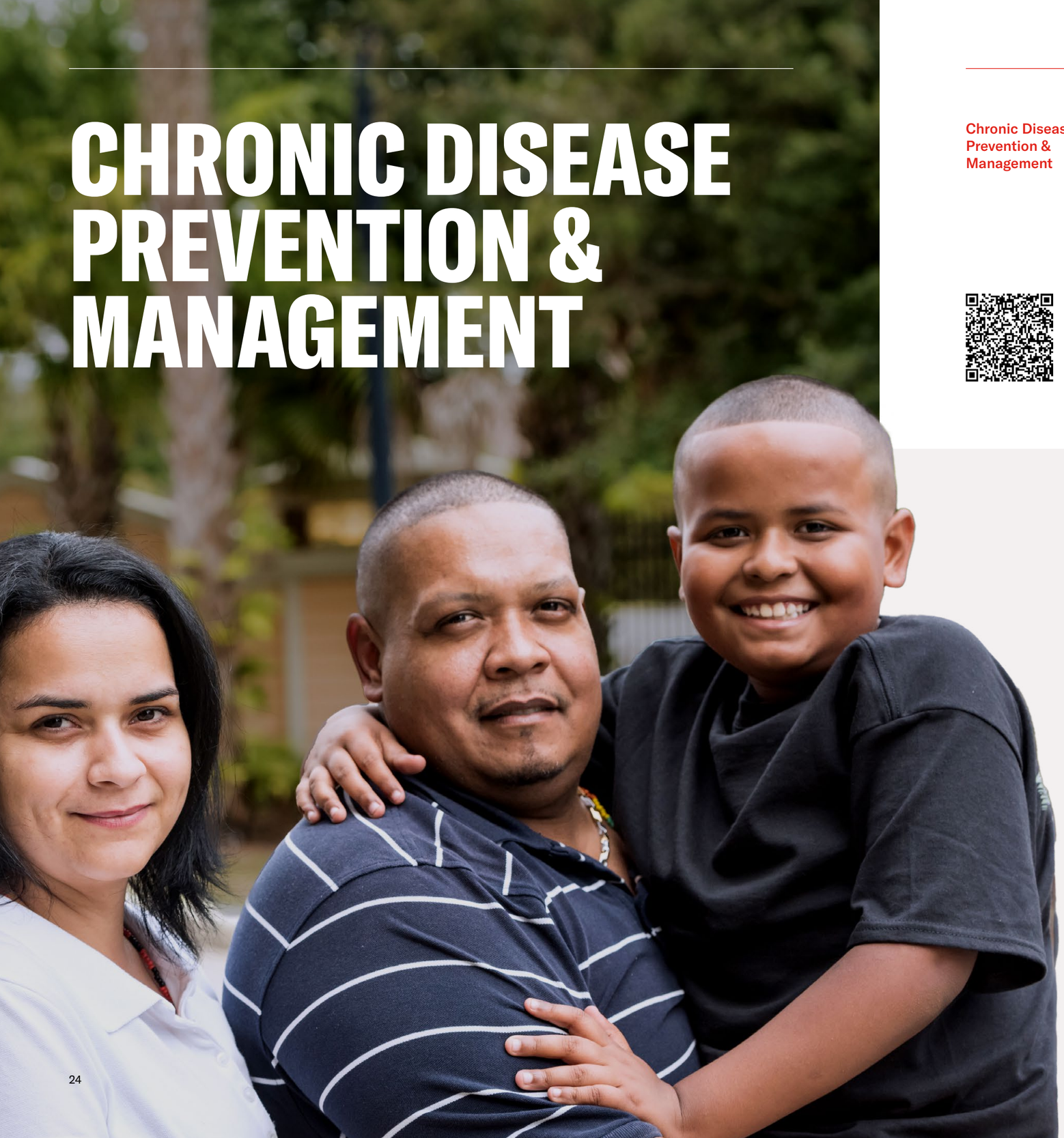
participants during the summer of 2022

60

adolescents from the Uptown Hub and Lang Youth Medical Program,

153

relatives of NYP employees, and other young people from community partnerships participated.



CHRONIC DISEASE PREVENTION & MANAGEMENT

Chronic Disease Prevention & Management

Health for Life

Health4Life (H4L) is a family-centered lifestyle intervention program for overweight children and adolescents ages 2-18 and their families. The program provides a safe and supportive environment for patients and families and empowers them to make healthier lifestyle choices through dietary changes and increased physical activity. Children aged 7-18 may join weekly virtual exercise classes. Parents can engage in a 10-week nutrition education and support group program.

Key Accomplishments & Outcomes for 2022

500+
referrals to the clinical program

18
interactions in four in-person summer activity programs

30
families attended nutrition education classes

30
caregiver nutrition education classes for caregivers were offered with 89% attendance. Every family received free fruit and vegetable deliveries to their homes for six months through the Tangelo program.

71%
attendance at clinical visits; families now prefer virtual visits

NYP Hudson Valley Hospital Teaching Kitchen provided
COOKING DEMONSTRATIONS

141
interactions in 33 virtual exercise classes

Challenges and Successes

To address continuing COVID-related challenges such as declining mental health, food and financial insecurity, sedentary behavior, screen usage, and housing and employment problems, we use a team approach. The licensed social worker connects families with community mental health resources or food banks and food delivery services. The registered dietitian provides advice regarding better nutrition, and the exercise physiologist offers guidance about incorporating more physical activity and reducing screen time.

To adjust to the post-pandemic world, we now offer virtual clinic appointments, weekly virtual exercise and in-person summer exercise classes for kids, and virtual nutrition parent groups held in English and Spanish. Attendance rates have increased as we have implemented more community assistance initiatives and online options.

Eating Better, Living Better

“

I failed so many times trying to make my daughter eat new foods. After just one Zoom visit with you, I was fascinated by the possibility of finally getting her to eat better. I felt overjoyed when I saw her eating vegetables and other types of food. The way your entire team worked with her and helped us try different kinds of food, vegetables, and exercise was amazing. Seeing my baby enjoying broccoli, I cried with happiness. Thank you for not only changing my daughter’s life, but the lives of my entire family.

”

Health4Life parent

Chronic Disease Prevention & Management

Building Bridges, Knowledge & Health Coalition

The Building Bridges, Knowledge and Health (BBKH) coalition works with faith and community-based organizations to reduce racial and ethnic health disparities and enhance the well-being of residents in Northern Manhattan, Harlem, and the Bronx. Church members are valuable conduits of good health, responding to community health needs and implementing interventions to achieve meaningful results.

Key Accomplishments & Outcomes for 2022

5,000
members reached through BBKH coalition initiatives

20%
increase in coalition membership

100+
Mental Health First Aid (MHFA) trainings for adults who work with adults and youth

SCHOLARSHIP FUNDS
for a BBKH faith leader to become an MHFA trainer

More than
80
participants attended the Sixth Annual Clergy Summit entitled “Mental Health Equity and Advocacy for a Healing Community,” held virtually in November 2022

MONTHLY MEETINGS
with faith leaders to provide education and resources identified by the member-driven planning committee

Provided
IN-PERSON SAFETY TRAININGS
in hands-only CPR, active shooter, de-escalation, EpiPen use, Stop the Bleed, and transportation

HEALTH FAIRS, IN-HOUSE TRAININGS, AND POP-UP CLINICS
led by coalition members

Challenges & Successes

COVID-19-related illnesses remain a challenge. The BBKH coalition provided virtual health education, in-person vaccinations, free screenings, and connections to primary care. The Bowery Mission, Church of the Epiphany, and Young Lives program address the needs of the homeless community. We support them with educational workshops, connection to resources, and donations of essential needs.

To address rising mental health challenges since the pandemic, we provide education and Mental Health First Aid (MHFA) trainings. One of our leaders became an MHFA trainer and created a faith-based mental health practitioners’ directory, increasing access and improving equity for the community.

One Pastor’s Story

I am the pastor of St. Helena Catholic Church in the Bronx and our parish is a member of the BBKH coalition. I believe that BBKH’s move to virtual meetings has significantly increased member participation and greatly expanded the list of potential partners. The meetings are always informative. Last September, St. Helena hosted a BBKH in-person presentation focusing on what to do in an active shooter situation, a segment on Stop the Bleed, and another on hands-only CPR. Each topic could easily have been a full workshop in itself. Participants were interested, engaged, and asked many relevant questions. I look forward to actively participating in future BBKH meetings and events.

Rev. David Powers, Sch.P., Pastor,
St. Helena’s Church

Chronic Disease Prevention & Management

Center for Community Health Navigation

Since 2005, the Center for Community Health Navigation (CCHN) works to support 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.

Emergency Department-Based Patient Navigator Program

NewYork-Presbyterian has an emergency-department (ED)-based Patient Navigator Program to support, educate, and empower patients to effectively navigate the healthcare system. Located in seven EDs, bilingual patient navigators offer peer-based, culturally sensitive education and support, connect patients with health insurance and financial assistance, schedule primary care and specialty appointments, and provide appointment reminders and follow-up calls.

Outcomes

From December 2008 to December 2022, ED-based patient navigators supported

339,440

patients

76%

of the 178,553 patients for whom an appointment was scheduled attended it

93%

of the 88,583 patients without a primary care provider had an appointment with a new provider upon discharge

CCHN Adult CHW Program

The Adult CHW Program empowers rising-risk patients in New York City who have diabetes by providing education, support, and resources to manage their health and well-being. Bilingual community health workers (CHWs) deliver education and support to help patients access care, manage their medications, and deal with social determinants of health such as housing, food insecurity, transportation, and immigration support.

Outcomes

Between June 2017 and December 2022, CHWs supported

1,317

participants enrolled in the Adult CHW Program

Among graduates

89%

met their medication management goal

90%

met their patient navigation goal

89%

met their social determinants goal

CCHN Pediatric CHW Program

The Pediatric CHW Program empowers caregivers of children with asthma and other special healthcare needs with education, tools, and resources to manage their child's health condition and address their social needs. Bilingual CHWs in community-based organizations (CBOs) serve as the single point of contact for caregivers. Participating caregivers receive comprehensive information to understand their child's condition, learn how to access health care for the child, and keep the child's condition under control. CHWs serve as a bridge between the hospital and community.

Outcomes

Between September 2006 and December 2022, CHWs enrolled

1,565

caregivers of children with poorly managed asthma

Among graduates of the program, hospitalizations decreased by

76%

ED visits declined by 68%, and

97%

of caregivers felt able to manage their child's asthma

Between July 2018 and December 2022, nearly

84%

of caregivers of children with special healthcare needs reported reduced or similar levels of stress upon discharge compared to intake, 95% reported that they knew how to access care for their children, and 91% felt in control of their child's condition

A Fresh Start

During an interaction between a CHW and the mother of an 11-year-old child and a newborn, the CHW learned that the mother was unable to afford a crib, car seat, and clothes for her newborn. The CHW referred the mother to various community programs so she could receive the resources and support she needed. Through this program, the mother obtained a car seat and a crib. She also received resources for diapers and clothing for the newborn. All of this was possible thanks to the help of the CHW and teamwork. The mother was very grateful.

Challenges & Successes

The COVID-19 pandemic worsened poverty and healthcare access and further marginalized Black and Latino communities throughout New York City. Bilingual CHWs helped patients complete housing applications through web portals, connected them with food resources, and provided educational support to caregivers of newborns. The ED-Based Patient Navigator program began screening patients for social determinants of health in September 2022 in the NewYork-Presbyterian/Weill Cornell ED and expanded to the remaining six NewYork-Presbyterian EDs by mid-October 2022. Our programs have enhanced patient care for those with unmet social needs who struggle to navigate the healthcare system.

Chronic Disease Prevention & Management

Choosing Healthy & Active Lifestyles for Kids

NewYork-Presbyterian's Choosing Healthy & Active Lifestyles for Kids (CHALK) increases access to healthy lifestyles for children and families by focusing on nutrition and physical activity and collaborating with community-based organizations, early childhood centers, public schools, emergency food providers, and healthcare teams. The CHALK model was developed as an obesity prevention program in Northern Manhattan and has expanded to other New York City communities and Westchester County.

CHALK initiatives include:

— **Food FARMacy**, a free healthy grocery program for households experiencing food insecurity. Children ages 0-5 participating in the program have demonstrated improved weight gain trajectories.

— **Youth Market**, a paid internship opportunity for 16-22-year-olds exploring food insecurity, social justice, and public health/healthcare careers, which expanded to a second site and extended to Brooklyn and Queens in 2023. Graduates have entered the workforce in public health and nutrition jobs.

— **CHALK School Partnerships** and **CHALK Jr focus** on improving the school wellness environment through bilingual weekly virtual workshops featuring interactive cooking demos, diabetes education, yoga, and dance.

— **The Capacity Building Initiative** and **CBO Mini-Grant Program** invest in community leaders on the frontlines of increasing access to healthy lifestyles.

— Other programs include Pediatric Resident Training, the Fruit and Vegetable Prescription Program, and CHALK Built Environment.

Key Accomplishments & Outcomes for 2022

17,528
individuals participated in Food FARMacy programs

915
patients received Fruit and Vegetable Prescriptions

800
Youth Market customers at farm stands were served by 20 interns

3,190
students and parents/caregivers were reached through CHALK schools and CHALK Jr

4,518
community members were reached through mini-grant projects

$35,500
in mini-grants were awarded to 11 community-based organizations

284
community leaders attended capacity-building events: five webinars, seven consulting opportunities, four affinity group meetings, and a conference

1,073
interactions took place at open streets and health fairs

1,453
people attended 83 nutrition and physical activity workshops

68
pediatric medical residents attended community health and obesity prevention workshops

Challenges & Successes

The communities CHALK serves continue to feel the shadow of the COVID-19 pandemic. Both food and housing insecurity continue to affect more than 1 in 4 families screened for social determinants of health in NewYork-Presbyterian pediatric and OB/GYN practices in Washington Heights and Inwood. Our pediatrician mentors are seeing increased cases of overweight and obesity among children who had fewer opportunities to play outside or at school during the pandemic years. In response to these challenges, CHALK has continued collaborating with community-based organizations, schools, and early childhood centers to provide emergency food support while investing in increased opportunities for physical activity and social connection through programming for youth and families.

From Participant to Employee

“

I transitioned from being a Nido participant to an employee. Being part of the distribution team has been a positive and wonderful experience. I enjoy being one of the friendly faces the families get to see every time they pick up their pantry boxes. It makes my soul happy to see them receive the fresh produce that they need.

”

Mobile market coordinator at Nido de Esperanza, a CHALK partner committed to supporting the first 1,000 days of a child’s life

Chronic Disease Prevention & Management

Manhattan Cancer Services Program

The aim of the Manhattan Cancer Services Program is to reduce cancer outcome disparities in at-risk, uninsured community residents. Program staff identify communities at high risk for cancer mortality who are under or uninsured and have low cancer screening rates. In collaboration with community and faith-based organizations, key stakeholders and decision makers provide community-based education and enrollment. Staff screen individuals using the New York State Department of Health assessment to identify and overcome barriers to care and provide no-cost screening and diagnostic services in Manhattan.

Key Accomplishments & Outcomes for 2022

EXPANDED PROVIDER SITES
with a special focus on federally qualified health centers

Provided
52
educational events attended by 1,690 community members

2,808
people screened for breast, cervical, or colorectal cancer

Diagnosed
11
breast cancers
46
cervical cancers
1
colorectal cancer

Challenges & Successes

Despite low cancer screening rates during the pandemic, people who avoided screening are now returning. We also continue to help them access COVID testing and vaccination. Unaffordable substandard housing and underemployment are constant challenges for the population we serve. We provide referrals for housing, legal assistance, and advocacy, as well as education and career services.

Most populations we serve are immigrants and migrants. We also help them enroll in food pantries, access immigration legal services, and connect with citizen preparation classes. People diagnosed with cancer can receive no-cost treatment through New York City Health + Hospitals providers.

Accessing Breast Cancer Care

An uninsured woman diagnosed with breast cancer was living in temporary housing, was food insecure, and was unable to use the subway or bus to get to her treatments. She was overwhelmed by her diagnosis. She applied for and was accepted for housing at Hope Lodge, but there was no available room when she needed it. Her daughter arrived from the Dominican Republic and engaged extended family members to help with housing in Queens and support for activities of daily living. We helped her apply for no-cost food delivery from a local food pantry and connected her with transportation through Access-a-Ride. She has been receiving treatment and has been supported by a nurse case manager, who continues to provide her with emotional support and helps her navigate barriers.

Chronic Disease Prevention & Management

Community Outreach Program

The Community Outreach Program promotes overall wellness and disease prevention through educational and screening activities that facilitate early detection and intervention, with the ultimate goal of reducing health disparities. Staff connect people to primary and specialty care as well as other supportive resources. Community members have access to free screenings, vaccinations, and counseling and are empowered through a myriad of educational workshops.

Challenges & Successes

Mental health challenges increased dramatically after the pandemic. The Outreach Program supports the Bowery Mission, HelpUSA, and the Church of the Epiphany, which provide people who are experiencing homelessness with housing, unemployment, and other basic needs. To help people stay on top of their primary care, vaccinations, and screening exams, the Outreach Program provided health education, pediatric and adult COVID-19 and flu vaccinations, health screenings, and counseling and connected community members with primary and specialty care. We also donated items such as clothing, medication, diapers, and infant formula to homeless shelters.

Key Accomplishments & Outcomes for 2022

Bimonthly virtual and in-person

EDUCATIONAL PROGRAMS

for the Bowery Mission and HELP USA women's shelter

POP-UP CLINICS

for asylum seekers in New York City, homeless outreach events, and PCR testing for the Washington Heights community

Relaunch of

IN-PERSON HEALTH FAIRS & TARGETED EVENTS

such as the Domestic Workers Health Fair and Harlem Pride event

133+

people received Mental Health First Aid (MHFA) training

3,000+

community members impacted at targeted health screening events, community health fairs, and pop-up clinics

1,100+

flu and COVID-19 vaccinations administered

Supporting Health at the Church of the Epiphany

At the Church of the Epiphany on the Upper East Side, the Outreach Program staff ran monthly health screening events for dinner guests before the pandemic. We collaborated with NewYork-Presbyterian/Weill Cornell nursing staff to provide blood pressure screenings, reading glasses, hands-only CPR training, and counseling on healthy lifestyle choices. We counseled one gentleman on how to lower his blood pressure and stay compliant with his medications and his doctor visits. Over time, his blood pressure improved, he lost weight, and he felt better about his well-being. We rewarded him with a portable machine to monitor his blood pressure at home. His entire disposition changed as he moved toward improved health. Throughout the pandemic, Outreach Program staff continued to support the church by providing temperature screenings for their pick-up meal service. The team was happy to provide assistance during the church's "new normal."

Chronic Disease Prevention & Management

Waiting Room as a Literacy & Learning Environment

The Waiting Room As a Literacy & Learning Environment (WALLE), an initiative of the NewYork-Presbyterian Ambulatory Care Network (ACN), addresses the social determinants of health through a twofold approach: improving health literacy through targeted health education and empowering patients to connect with resource referrals to meet their social needs. WALLE helps medically underserved patients who are primarily from Washington Heights, Inwood, and the Bronx, most of whom are native Spanish speakers. Bilingual volunteers are trained in motivational interviewing skills, the tenets of health literacy, and the Transtheoretical Model. WALLE staff members link patients with free or low-cost community resources, assist patients with the completion of medical forms, and recruit interns to serve ACN patients.

Key Accomplishments & Outcomes for 2022

Successfully concluded the

CMMI ACCOUNTABLE HEALTH COMMUNITIES GRANT

and expanded New York State Department of Health (NYSDOH) screening and closed loop navigation for low- and rising-risk patients

Reached out to 21,747 patients and connected with

13,862

of them

Administered

11,392

NYSDOH screenings across ACN sites

Challenges & Successes

For many patients, clinical care is a small piece of the puzzle when it comes to addressing health equity. Social determinants of health are important to identify and address, since there are increasing gaps in social access. As many patients continue to experience financial insecurity, unemployment, and housing instability, more of them screen as rising risk with increased need. The WALLE program identifies patients with social needs and provides resources to address those needs.

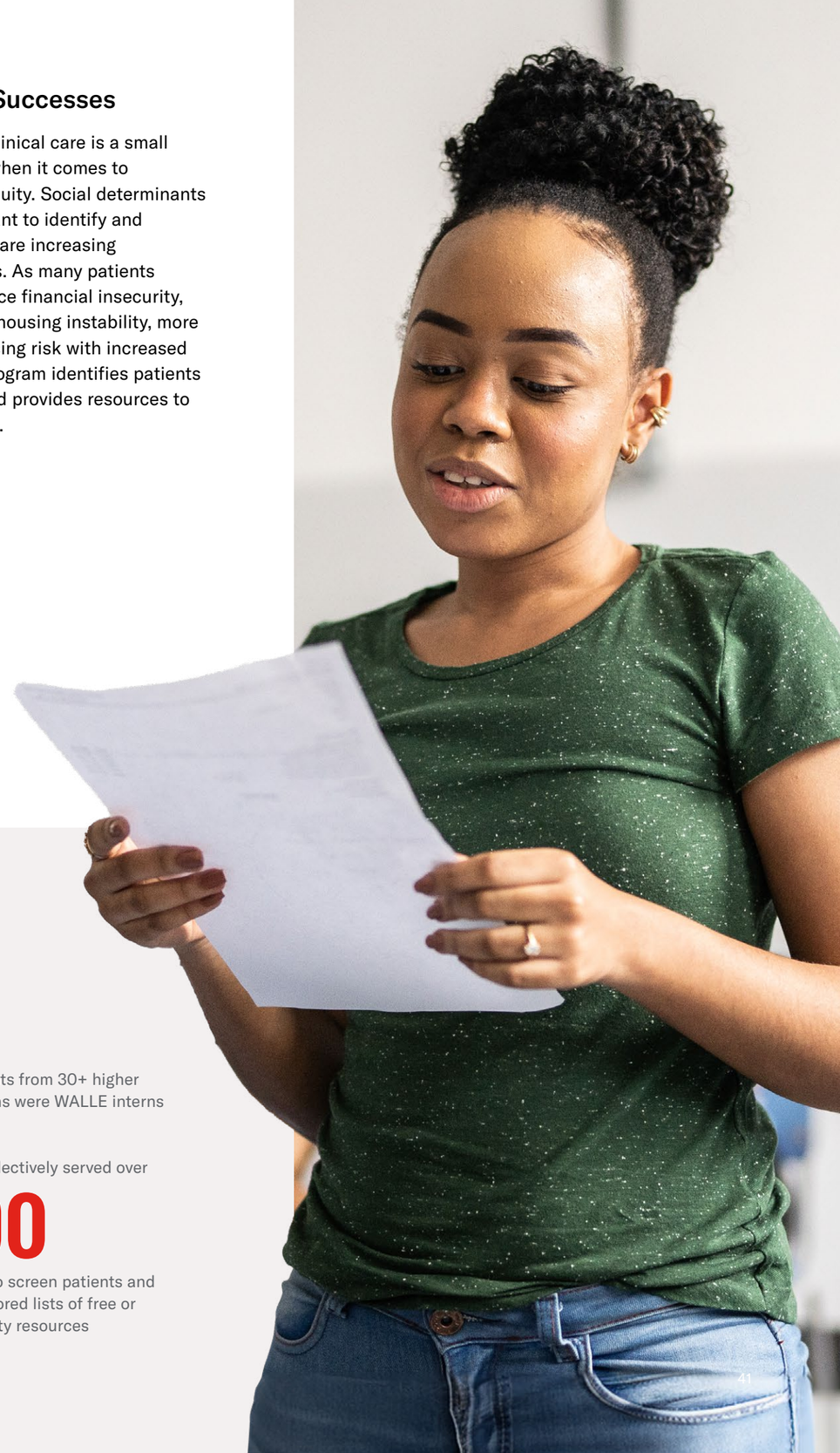
41

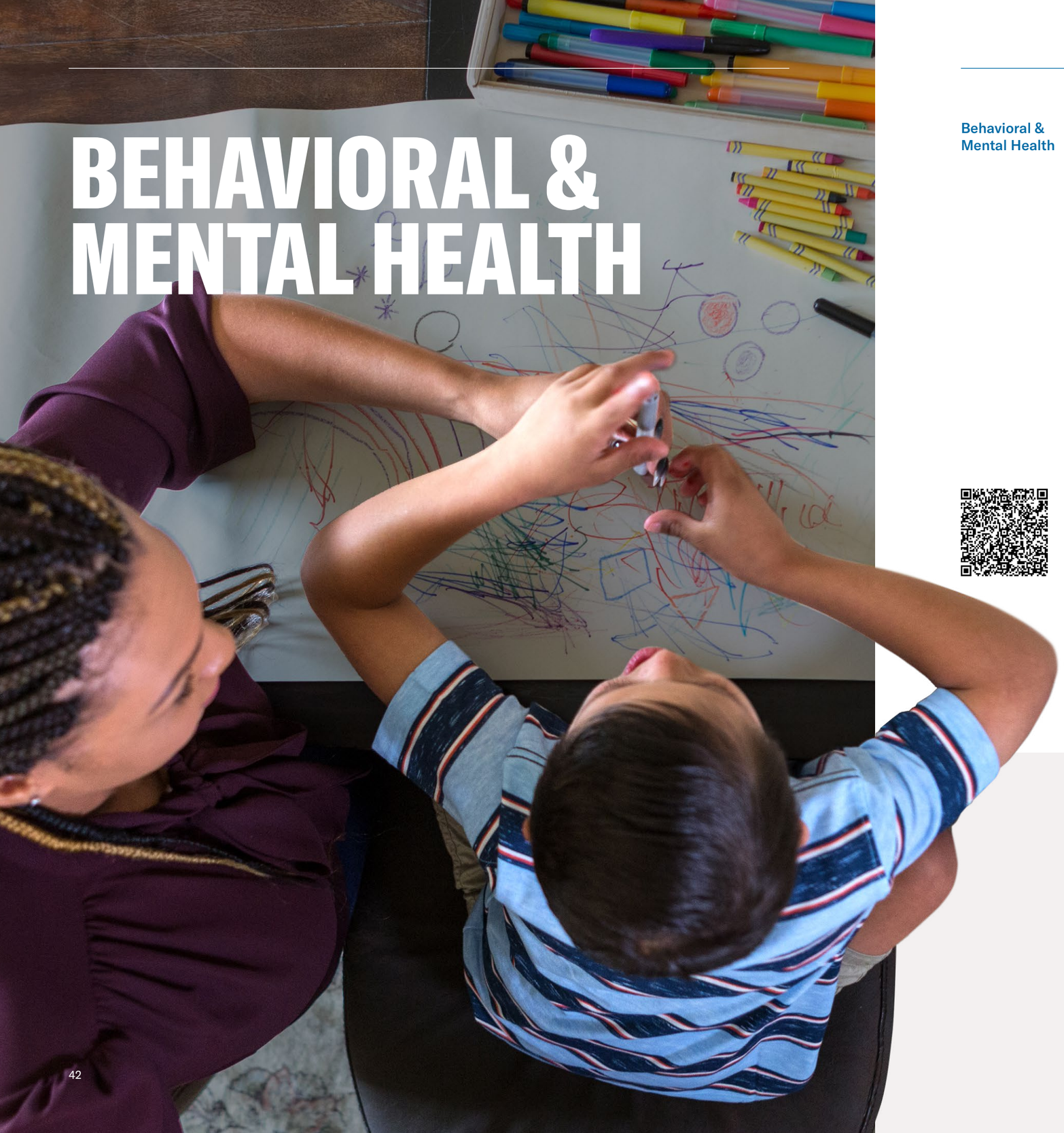
health field students from 30+ higher learning institutions were WALLE interns

WALLE interns collectively served over

5,600

hours by helping to screen patients and providing 7,811 tailored lists of free or low-cost community resources





BEHAVIORAL & MENTAL HEALTH

Behavioral & Mental Health

The Family PEACE Trauma Treatment Center

Family Preventing Early Adverse Childhood Experiences (Family PEACE) supports the mental health of very young children and their families after traumatic experiences such as violence and abuse. The goal is to end intergenerational cycles of violence. Services are available for children up to age 5, their caregivers, and siblings ages 6-12 who may have also been impacted by family trauma. The program creates a safe, empowered community for individuals and families to feel seen, heard, and valued through self-awareness, cultural attunement, and spiritual sensitivity.

Family PEACE takes a holistic approach that incorporates:

- Traditional and child-parent psychotherapy (CPP)
- Creative arts and integrative therapies
- Spirituality, parenting, and healthy relationship groups
- Nutritional services
- Case management and assistance for crime victims
- On-site trauma-informed legal services, chaplaincy, and psychiatry

Key Accomplishments & Outcomes for 2022

3,806

mental health contacts delivered via telehealth, phone, or in person to 216 unique clients

Challenges & Successes

Family PEACE has addressed food insecurity, financial struggles, and housing instability with short-term solutions, such as having a dedicated case manager to bridge our clients with resources to meet their concrete needs, referring patients to food FARMacy with our partners at CHALK, and connecting patients with food pantries. We assisted our clients with needs such as food, clothing, rent arrears assistance, and utilities through the help we received from the Pandemic Emergency Assistance Fund (PEAF). We have also collaborated with local HomeBase agencies to connect our patients with qualifying vouchers.

Our families also reported high levels of substance misuse after the pandemic. We have connected patients with substance misuse treatment, psychotherapy, and case coordination services.

Recovery & Renewal

One Family PEACE client had experienced difficulty with employment. After connecting with our services, she opened her own daycare center and engaged in an English as a Second Language course. Another patient who had experienced intimate partner violence and utilized substance as a coping mechanism has successfully entered and completed a rehabilitation program.

Behavioral & Mental Health

Substance Use Disorder (SUD) Peer Navigation Program

The Substance Use Disorder (SUD) Peer Navigation Program is a collaboration between NewYork-Presbyterian and Services for the Underserved. The program's mission is to embed staff in all NewYork-Presbyterian emergency departments to identify, engage, link, and provide continuity of care and treatment for patients with opioid and other drug-related conditions, in collaboration with social work and care coordination teams and other providers.

When encountering a patient, SUD peer navigators:

- Perform a needs assessment
- Provide peer support and navigation services
- Place patients in desired treatment settings

More than 3,000 patients have been referred to the SUD Peer Navigation Program since its inception in 2019. The program has expanded to NewYork-Presbyterian/Weill Cornell, NewYork-Presbyterian/Columbia, the Comprehensive Psychiatric Emergency Program, NewYork-Presbyterian Allen Hospital, and NewYork-Presbyterian Lower Manhattan Hospital. Future plans include embedding SUD peer navigators at NewYork-Presbyterian Brooklyn Methodist Hospital and NewYork-Presbyterian Queens.

Challenges & Successes

The population we serve faced many challenges before as well as after the pandemic. If a patient tests positive for COVID-19 and is referred to the SUD Program, our staff cannot place the patient in the treatment facility of their choice due to restrictions. Once medically cleared, peer navigators collaborate with each patient, care coordination, and social work teams to secure placement in a sub-acute facility or hospital that will accept them with their chronic conditions while receiving treatment for substance use.

Most of our patients struggle with substance use and housing instability, and it is difficult to manage their housing and employment needs. This is one reason why this program is so vital for this vulnerable population.

Patients may visit the ED early in the morning or stay in the evening, and the program does not have the ability to cover these shifts. To address this problem, we provide an SUD team flyer for providers to hand to patients seen on the weekend or after hours. The flyer contains detailed contact information for the SUD team as well as Services for the Underserved.

From Patient to Nurse

A 26-year-old nursing student was persuaded by a friend to try a substance that landed her in the emergency department. The Comprehensive Psychiatric Emergency Program (CPEP) Unit referred the patient to an SUD peer navigator, who assessed the patient's needs and connected her with services. She subsequently had another psychiatric encounter and, upon arrival back at CPEP, requested the navigator she had seen before. The navigator shared his experiences with substance use and how he overcame them to stay healthy. He linked the patient to services to address her mental health, substance use, and other challenges, and the patient stayed in touch with him for support and resources. She actively participates in her treatment and is managing her mental health well with medications and regular psychotherapy. Happily, she achieved her dream of becoming a nurse, passed her R.N. license exam, and now works in a New York City hospital. She has expressed her gratitude to her peer navigator and acknowledged his support in her recovery.

Key Accomplishments & Outcomes for 2022

592
referrals were received from NewYork-Presbyterian clinicians for peer navigation services and placement in community opiate programming

525
patients were reached and engaged in a conversation about treatment options

365
patients accepted treatments for their condition

Behavioral & Mental Health

Turn 2 Us

Turn 2 Us (T2U) is a school-based mental health promotion and prevention program at NewYork-Presbyterian in partnership with Columbia University Irving Medical Center, public elementary schools in Washington Heights/Inwood, and Derek Jeter, the CEO and Founder of the Turn 2 Foundation.

T2U promotes mental health and academic success in at-risk children by:

- Mitigating and/or preventing mental health conditions
- Fostering healthy lifestyle practices
- Enhancing the mental health literacy of school personnel and parents
- Promoting social-emotional development for youth
- Reducing the stigma associated with mental health

Challenges & Successes

Since the pandemic, students have been behind academically, socially, and emotionally. Housing and unemployment issues also affect our population in a number of ways. To meet their needs, T2U adapted program materials and initiatives. We created new workshops and also provide on-site consultations for students and staff.

There was a 40% decrease in depression/anxiety symptoms and a 21% reduction in disruptive symptoms in high-risk students, a 20% decrease in mental health stigma in school staff, a 17% increase in school staff confidence, a 15% reduction in absences, and a 15% improvement in standardized test scores in English/language arts and 7% in math.

Back at the Plate

In 2022, one student was identified by his teachers as being at risk. He wasn't completing his homework, wouldn't pay attention, and was disrespectful in class. When the baseball league started in March, his two teachers were hesitant to allow him to play, but decided it would be best for him to be on the team. Once the baseball season began, his behavior and academics improved drastically. He demonstrated leadership in the classroom, completed his homework, and was motivated to stay on top of his work so he could play in each game. At the start of the season, students create goal cards. Each week, we check in with teachers to discuss each student's goals, progress, and barriers to determine if they can play. The league motivates students to work toward their goals, provides a healthy way to cope with stressors, and helps launch students on a path to success.

Key Accomplishments & Outcomes for 2022

Primary/Universal Services at PS48M, PS115M, PS4M, PS189M, PS306M, and PS8M

Delivered

MENTAL HEALTH PROMOTION INITIATIVES

for 3rd through 5th graders, teachers, and parents, and trained school-designated "key champions" to replicate and sustain initiatives

Mental Health Literacy (MHL) for School Personnel at PS48

40

staff members completed an MHL baseline and a post intervention survey; 5 mental health professional development workshops were delivered, with 40 staff attending each

MHL for Parents/Caregivers

56

parents/caregivers attended bilingual workshops

In-Class Mindfulness Exercises

149

students and 11 teachers at PS48M

Healthy Lifestyle Campaign

363

students and 21 teachers at PS48M attended assemblies and in-class workshops

Self-Care is Essential

595

students and 32 teachers attended stress reduction and self-care workshops

Targeted Outreach & Support

55

people attended six sessions of Open Streets—Community League of the Heights (CLOTH)

The Real Impact of Social Media on Youth

1,019

students and 60 teachers attended in-class workshops to discuss how social media can increase and decrease stress

Anti-Bullying Campaign

851

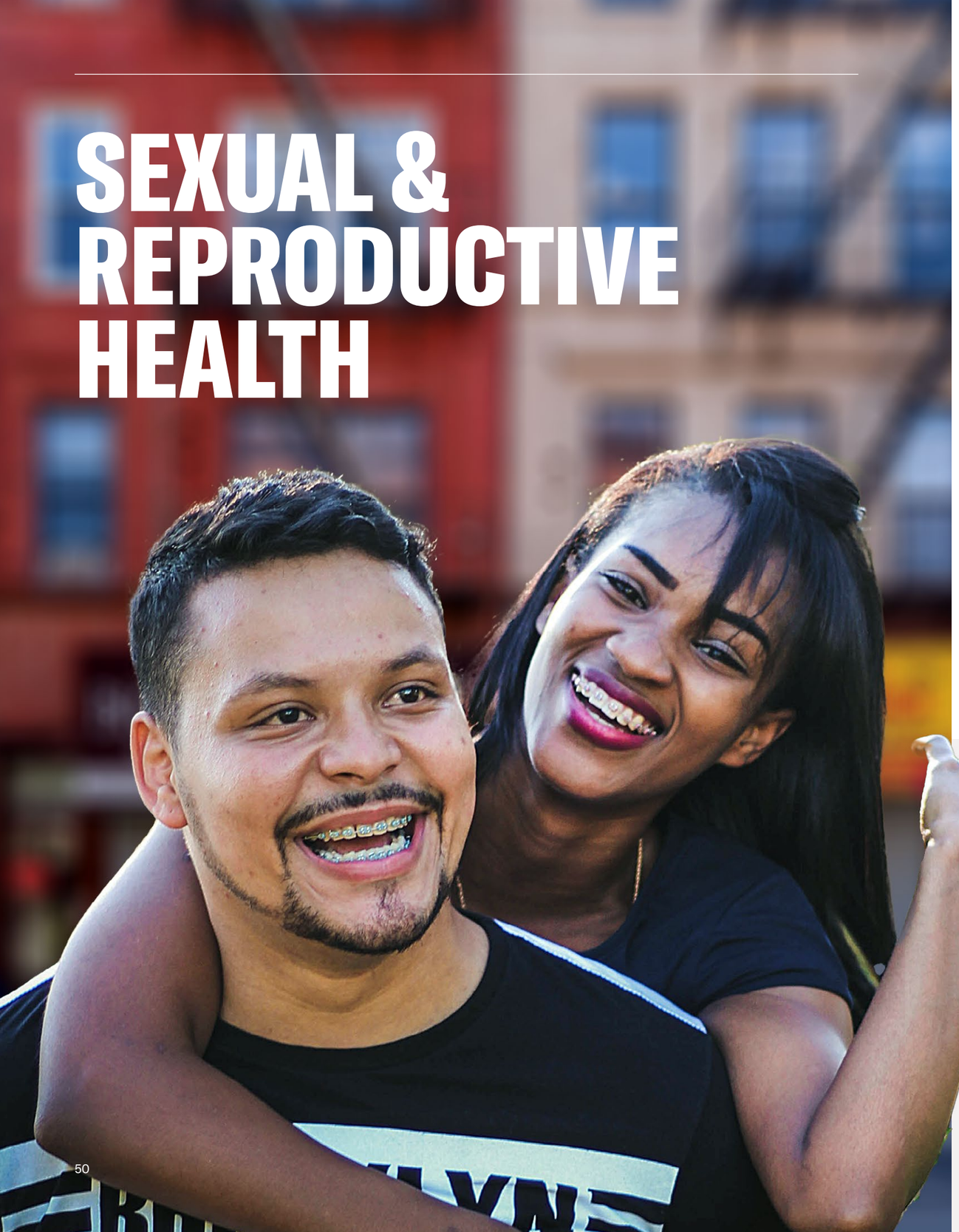
students and 61 teachers participated in workshops aimed to raise awareness about the types of bullying and how to protect yourself and others

Mental Health Workshops

99

people attended four sessions hosted by the AmeriCorps VISTA Program, Turn 2 Foundation, Jeter's Leaders, or the Bella Abzug Leadership Institute

SEXUAL & REPRODUCTIVE HEALTH



Sexual & Reproductive Health

Family Planning Program & Young Men's Clinic

The Family Planning Practice (FPP) and Young Men's Clinic (YMC) support pre-conception health and improved birth outcomes, prevent unintended pregnancy, reduce the transmission of sexually transmitted infections (STIs), and promote overall well-being through care and education.

FPP

YMC

- The FPP delivers comprehensive women's health/gynecologic and teen pregnancy prevention services
- The YMC delivers sexual health services and encourages male involvement in family planning and STI prevention
- Targeted outreach and comprehensive sexual/reproductive health education are tailored for teens and adults

Outcomes for 2022

9,500
females and 1,500 males served annually through 18,000 visits

1,700
patients received early pregnancy management and prenatal care enrollment

1,000
adolescent patients

Estimated
1,000
unplanned pregnancies averted

Challenges & Successes

In 2022, FPP/YMC continued to provide access to telehealth services for birth control counseling, reproductive health education, and follow-up care. The on-site availability of integrated mental health support services remained key for our patients. We increased outreach efforts to ensure that patients are aware of our services, as well as changes in clinic procedures due to the pandemic. FPP/YMC also offers workshops, support groups, and information to empower individuals to make informed health decisions.

Factors such as housing stability, food insecurity, access to education, and employment opportunities are integrated into our health screenings. We collaborate with community organizations through NewYork-Presbyterian's WALLE and community health worker programs to connect our patients with resources. The pandemic led to a disruptions in STI prevention efforts and education. FPP/YMC has addressed this challenge by conducting wide-ranging outreach activities, implementing targeted community engagement initiatives, and partnering with local community organizations to promote regular STI screenings to prevent the spread of infections.

TJ's Story

TJ was a patient in our Family Planning Practice/Young Men's Clinic when they were referred to our social workers for bereavement counseling after the sudden passing of their mother. The patient was having a difficult time grieving. TJ felt hopeless and unable to process the trauma. Having been trained in the trauma treatment eye movement desensitization and reprocessing (EMDR), our clinician used this method to help TJ process their trauma. After several EMDR sessions, TJ was able reprocess their loss and move forward.

Key Accomplishments

- **Contraception** The FPP pioneered best practices to enhance contraceptive initiation and compliance
- **Adolescent Services** Health educators and social workers helped teens learn how to make good decisions, adopt preventive health practices, become better involved with their families, and prevent sexually transmitted infections (STIs) and unplanned pregnancies
- **HIV Prevention Services** FPP provided integrated HIV prevention education, rapid testing services, linkage with care, and PrEP and PEP (pre- and post-exposure prophylaxis)
- **Services to Immigrants** The YMC received grant funding from the New York City Council for services for immigrants
- **Expanded Access to Abortion** Received state funding to expand access to safe and supportive abortion services

Sexual & Reproductive Health

Comprehensive Health Program

The Comprehensive Health Program (CHP), one of New York State's Designated AIDS Centers (DAC), has provided innovative services to complex patients since the beginning of the HIV epidemic. CHP serves patients from infants to seniors and provides HIV prevention and treatment as well as screening and treatment of STIs and hepatitis C.

There are two components of the CHP:

Project STAY

Project STAY (Services to Assist Youth) serves young people ages 14-29 living with or at risk for HIV, with a special emphasis on carceral legal system-involved youth, and lesbian, gay, bisexual, transgender, queer, questioning, or pansexual adolescents and young adults. The Project STAY team makes sure that young people in New York have access to healthcare services, including gender-affirming care. New York City communities benefit from two major programs:

- The Specialized Care Center, a regional center which provides care for young people living with HIV.
- The Youth Access Program, a citywide initiative providing targeted outreach, sexual health education, venue-based screening for STIs and HIV, and linkage to care for young people engaging in risk-taking behaviors, regardless of insurance status.

The HIV Prevention/Sexual Health Program offers comprehensive, barrier-free care to individuals of all ages, genders, documentation, and insurance statuses, engaging patients primarily from communities of color and gender-diverse communities. Services include PEP, pre-PrEP, STI testing and treatment, transgender care, family planning, HIV testing, and referrals to primary care.

Challenges & Successes

Before the pandemic, New York City witnessed a 35% decline in new HIV infections. During the pandemic, most city-run sexual health clinics closed and many other sexual health programs had reduced services. Notably, there has been a 14% increase in new HIV cases in New York City.

Project STAY and the CHP have redoubled efforts to engage Individuals needing sexual health services in a timely fashion and are often able to provide these services within 24 to 48 hours of the patient contacting us. We provide culturally appropriate, trauma-Informed, low-threshold, gender-affirming sexual health services at our clinics. In 2022, we also became a hub to administer the monkeypox vaccine.

There is a concerted need to provide comprehensive sexual health services to formerly incarcerated individuals. Coordinated care can reduce emergency room visits, hospitalizations, and recidivism among this population.

The model providing this type of care is called a Transitions Clinic. In 2022, we received support from the Dalio Center for Health Justice to establish a Transitions Clinic for the Northern Manhattan community.

Accessing Care for Health & Well-Being

JD, a 22-year-old gay, Hispanic, cisgender male, stopped by Project STAY's pop-up HIV/STI testing booth during New York City's Pridefest in June 2022. A rapid HIV test was positive. We connected him with services at our Specialized Care Center clinic the next day, and he started taking anti-retroviral therapy.

KH, 21-year-old gay, Hispanic, cisgender male, was seen by the Youth Access Program during outreach at a community college. After screening positive for gonorrhea and chlamydia, he came to the HIV Prevention/ Sexual Health Program for treatment and brought in his partner as well. Both of them started PrEP treatment.

Key Accomplishments & Outcomes for 2022

Specialized Care Center

88
youth living with HIV received comprehensive services during 264 visits

Youth Access Program

858
clients were engaged during 1,812 visits

192
testing events were held at 28 community events

891
HIV tests and 937 STI tests were distributed

215
people were tested for HIV and STIs at Pride events

96
community-based sexual health workshops

HIV Prevention/Sexual Health Program

2,923
patient visits; of 388 new patients, 206 began PrEP

AMBULATORY CARE NETWORK NURSING

Nurses in NewYork-Presbyterian's Ambulatory Care Network (ACN) are committed to ensuring that patients receive the best care possible. Working to the highest level of their licenses, they follow the Professional Practice Model, which is characterized by advocacy, autonomy, collaboration, evidence-based practice, and professional development.

ACN nurses meet their mission by:

- Participating in various committees and in decision-making, collaborating with various disciplines to enhance care, and contributing their input regarding practice and policy changes, evidenced-based projects, and standardization of care.
- Expediting primary care and triaging patients by taking calls from primary care sites through the Centralized Clinical Telephone Center.
- Providing comprehensive care, vaccinations, and other services to children and adolescents at seven school-based health centers.

Key Accomplishments

Collaborated with

NEWBORN CLINIC CERTIFIED LACTATION CONSULTANTS

to develop and implement monthly virtual breastfeeding education classes for Spanish and English-Speaking patients, in alignment with Baby Friendly mandatory education topics

Leveraged IT resources to implement the scheduling of

MONTHLY BREASTFEEDING CLASSES

and prenatal breastfeeding education via Epic, in alignment with mandates for Baby Friendly Hospital designation

Presented at the

GERIATRIC FALL SYMPOSIUM

and other professional nursing forums

Formulated staff and patient

EDUCATION TEACHING CURRICULA

in collaboration with Certified Nurse Educators

Challenges & Successes

ACN nurses and the communities they serve continue to face challenges with economic recovery, healthcare access, drug abuse, and disruption of children's education due to the COVID-19 pandemic. To address these challenges, ACN West nurses hosted six young people from the NYP Summer Youth Experience Program to provide adolescents from the community with an opportunity, mentor youth working in professional settings, and keep them from engaging with negative influences in their communities. To enhance healthcare access, nurses supported extended evening operating hours on Tuesdays and Wednesdays at the Farrell Family Health Clinic. They have also led efforts to support same-day and telehealth triage and walk-in appointments. They continue to collaborate on interdisciplinary teams to address patients' psychosocial needs.

ACN East nurses expanded access to COVID vaccinations and testing by providing appointments with nurses and collaborating with pharmacists and other healthcare providers. Nurses received in-service training on the use of Narcan for opioid overdoses and how to educate the community about Narcan use.

ACN nurses have also been addressing the extraordinary influx of newly arrived immigrant and undocumented patients. ACN West nurses are supporting clinics for undocumented, underserved, and uninsured patients by ordering and administering vaccines. They also volunteer to screen and triage newly arrived undocumented and uninsured patients.

TELEHEALTH

Throughout 2022, as the severe threat of the COVID-19 pandemic waned and patients could resume in-person appointments, we created a hybrid care model which gives patients the option of choosing the mode of care that best meets their needs. Even with this shift, we witnessed a 29% increase in video visits in 2022 compared to 2020. The Centralized Clinical Triage Center (CCTC) and Tele-lactation also became embedded in our daily operations.

Centralized Clinical Triage Center

The CCTC supports all Columbia University Ambulatory Care Network primary care practices and continues to be a part of care coordination. CCTC assists with prescription refills, forms management, remote blood pressure monitoring, patient questions about their care, and urgent care for COVID, flu, and other conditions. Sick patients who call the triage center or send MyChart messages are fast-tracked for timely provider visits in their medical homes or connected with telehealth visits when no medical home appointment is available.

On-Demand Tele-Lactation

Through the Connect patient portal, new mothers can schedule video visits with lactation consultants who provide education and support and address breastfeeding challenges. The program is available for parents of babies born at NewYork-Presbyterian Morgan Stanley Children's and Allen Hospitals, as well as for pediatric patients of the ACN and ColumbiaDoctors. In 2022, 1,568 unique patients engaged in 2,015 tele-lactation visits.

Remote Patient Monitoring (RPM)

The RPM Program offers a safe, convenient solution to monitor patients with chronic conditions at home. Since 2019, the program has offered care to more than 2,100 patients, helping prevent readmissions and providing a continuum of care as they transition from hospital to home. We are exploring the use of RPM for obstetric patients with hypertension and people undergoing cardiac rehabilitation.

Virtual Centering Pregnancy

Centering Pregnancy is prenatal care that unites pregnant patients with similar due dates together in a group setting. In 2022, 40% of group sessions took place virtually. Patients can borrow an iPad if needed.

Addressing the Digital Divide

NewYork-Presbyterian patients have access to technical support to assist them with navigating the Connect platform, completing pre-appointment steps, and facilitating video visits. Our community health workers and patient navigators have enrolled more than 13,000 patients on the patient portal and also provide referrals to low-cost mobile phone programs.

Comprehensive Health Program's Be InTo Health (BITH)

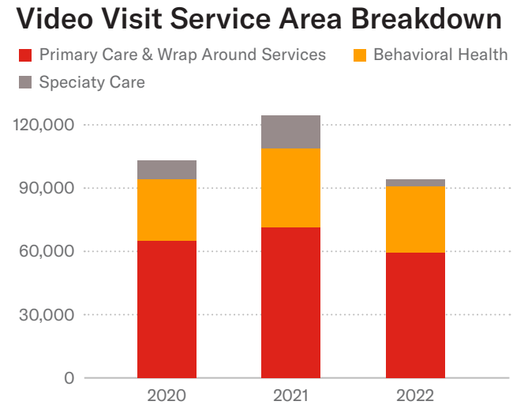
This multidisciplinary care coordination model integrates geriatric services and social and community building activities for Black and Hispanic/Latino patients age 50+ with HIV, with an emphasis on wellness, quality of life, and personal transformations. The program offers comprehensive screenings for health literacy and IT assessment; iPad loaners and technical education; and in-person and virtual wellness support groups. To date, 100 patients are enrolled in the wellness program and 25 have received an iPad and technical education.

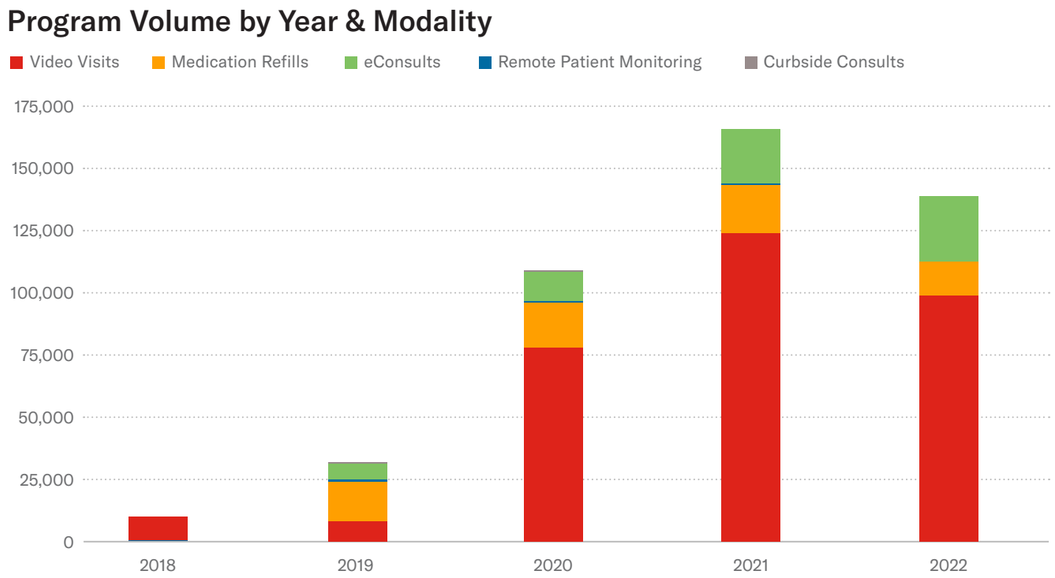
58%
of ACN patients send messages in Connect

46%
of ACN patients review lab results in Connect

96,005
ACN patients have an active Connect account (Florida Health Shands study)

82%
of ACN Patients have an active MyChart account





HEALTHCARE NETWORKS

NewYork-Presbyterian endeavors to provide multidisciplinary, exceptional care to our patients. We are committed to ensuring that patients who need post-acute care and outpatient behavioral health care receive the same high-quality services and experience they have come to know and trust from NewYork-Presbyterian, regardless of whether the care provider is a NewYork-Presbyterian entity. To achieve this goal, we have established a referral network of quality providers as well as seamless access, effective communications, and transitions of care among emergency department, acute, post-acute, specialty, and primary care providers.

Referral networks developed by the Division of Community & Population Health include:

Skilled Nursing Facility (SNF) and Home Health Agency (HHA) Referral Network

Collaborating with the NewYork-Presbyterian Department of Care Coordination and care coordination leads at NYP's regional hospitals, the Division performed a full assessment of facilities and home health agencies throughout the NewYork-Presbyterian and Regional Hospital Network to identify high-quality collaborators. We reviewed the Center for Medicare & Medicaid Services (CMS) Nursing Home and Home Health Agency Compare star ratings, reportable CMS measures, volume and acceptance rate of referrals, specialty services offered, and locations. Through continuous communication with agencies and facilities in the NewYork-Presbyterian Referral Network, we are focusing on new opportunities for joint collaboration of program development, patient flow, and quality improvements.

Behavioral Health and Substance Use Disorder (SUD) Referral Networks

To improve the transition from inpatient to outpatient community providers, NewYork-Presbyterian identified high-quality providers of mental health care, SUD treatment, and care management across the NewYork-Presbyterian and Regional Hospital Network region—with the goal of ensuring that vulnerable patients requiring complex care can transition to high-quality ambulatory behavioral health care. These networks have been active and include representation from community agencies, NewYork-Presbyterian Psychiatry ambulatory care clinics, inpatient care providers, and emergency department leadership.

The Division of Community & Population Health is working closely with NewYork-Presbyterian 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.

The SUD network group coordinated targeted trainings for NewYork-Presbyterian and community providers, such as Medication-Assisted Treatment, the use of Narcan to treat opioid overdoses, a film series addressing bias and stigma, and collaboration with OnPoint NYC, to pilot a referral process for the Weill Cornell and Columbia University Emergency Departments. The Division also funded two collaborators to expand access to programming for patients with opioid and serious substance abuse disorders: Services for the

What's Next?

The Division of Community & Population Health at NewYork-Presbyterian Hospital is dedicated to achieving health equity for everyone. In line with this commitment, we are set to broaden the scope of our community health programs, extending our influence to additional neighborhoods in New York City.

Our initiatives include the launch of Mobile Medical Health Units, providing a gateway to equitable healthcare for residents of Brooklyn and Queens. We are also expanding our food insecurity initiatives to reach communities in Brooklyn and Queens, and extending the Summer Youth Experience program citywide. Furthermore, our Mental Health First Aid trainings will now be available in Westchester, Brooklyn, and Queens, while our housing programs are expanding to cover Lower Manhattan.

Through these expansions, our goal is to target priority neighborhoods identified in the Community Health Needs Assessment and advance the pursuit of health equity for all, championing the cause of health justice.

NewYork-Presbyterian

WITH WORLD-CLASS DOCTORS FROM

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