Northwell Health
2019 Workplan

Planning Report Liaison Name of liaison — Edward Fraser
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	By December 31, 2021, increase the number of employees pledging to complete health risk assessments and viewing wellness videos by 10%. By December 31, 2021, increase the number of healthy food and beverage vending items by 10%. By December 31, 2021, increase the number of fresh produce access sites for patients, visitors and employees by 15%.	low income populations with health disparities	Adopt policies and implement practices to reduce (over)consumption of sugary drinks by implementing worksite wellness programs including nutrition and physical activity interventions as part of a comprehensive worksite wellness program. Components include: Educating and informing through classes, distributing written information or utilizing educational software; Conducting activities that target thoughts and social factors to influence behavior change. Examples include individual or group behavioral counseling, skill-building activities, providing rewards, and building support systems among co-workers and family members; and changing physical or organizational structures that reach the entire workforce and make the healthy choice the easy choice. Examples include changing the options in cafeterias or vending machines; providing more opportunities for physical activity; modifying health insurance benefits; or offering memberships to health clubs.	HR Employee Wellness Pledge data; employee wellness program engagement; vending audits; fresh produce access; policy and built environment changes	Employee Wellness Initiatives (i.e. Healthy Choice ,Vending, Wellness Programs)	Expand Employee Wellness Initiatives (i.e. Healthy Choice ,Vending, Wellness Programs)	Employee Wellness Initiatives (i.e. Healthy Choice , CSA/Farmers Markets, Vending, Wellness Programs)	Business	Partner with business vendors for procurement, program development and program delivery both in person and online. Partner with agricultural businesses for CSA and Farmers market programs
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	By December 31, 2021, increase inpatient food security screening by 25% through EMR integration of screens into provider workflows. By December 31, 2021, increase Food As Health Program to 3 sites.	focus on low income populations with health disparities	Integrate one of the Hunger Vital Sign Screening questions into system inpatient enterprise EMR as part of admission workflows, identify food insecure patients and refer to appropriate health system staff and facilitate and actively support referral to community food resources. Launch Food As Health Programs which are a hospital-community partnership among LI Harvest and Gods Love We Deliver that screens inpatients for food security and provides on site emergency food, nutrition counseling, SNAP enrollment and community social service navigation in addition to home-based interventions for non-ambulatory patients with nutrition related diagnosis (i.e. diabetes, hypertension, unintended weight loss).	EMR Screening: Food Security Screening rates ; Food Insecurity Prevalence; Referrals to providers and Community Resources. Food As Health(FAH): Food Security Screening rates ; Food Insecurity Prevalence; Referrals to hospital providers, On-site FAH CBO Registered Dietitian, Community CBO (i.e. Local Food Bank Home Delivery Partner) and referrals to Medically Tailored Home Delivery Partner (i.e. God's Love We Deliver) and Community Food Resources (i.e. local food pantries); Pounds of fresh produce and non-perishables distributed at FAH Center; SNAP applications completed; referrals to non-food related community social services; Post FAH Engagement Food Security Status, food procurement and eating behavior changes.	EMR Food Security question integrated into enterprise inpatient EMR and screening has been implemented. LIJ Valley Stream FAH Program operating for 16 months. Plans for expansion to Southside Hospital in December 2019.	Expand EMR screening as additional Northwell facilities are migrated to enterprise EMR; Expand FAH Centers to 2 Centers focusing on facilities with low income populations. Expand the use of online community referral electronic platforms.	Expand EMR screening as additional Northwell facilities are migrated to enterprise EMR; Expand FAH Centers to 3 Centers focusing on facilities with low income populations.	Community-based organizations	Community Food CBO (Island Harvest) - FAH onsite service provider and program team member - Registered Dietitian , nutritional counseling, SNAP entitlement application, community food and non-food resource navigation, FAH inventory management and distribution. Additional Community Food CBO (LI Cares) - Home Emergency Food and nutrition education. Additional Community CBO (God's Love We Deliver) - provision of Medically Tailored Meals Home Delivery. Food Business Partner - Corporate Social Responsibility fresh produce and non-perishable donations.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	By December 31, 2021, increase hospital food donations and rescue by 25% in partnership with local food community based organizations	focus on low income populations with health disparities	Cohen Children's Medical Center Kohl's Kares Program support of Island Harvest's Kids Weekend Backpack Feeding Program. Suffolk and Nassau County schools in areas with increased prevalence of food insecurity partner with Island Harvest and Cohen's Children's Medical Center to implement the program at their school. Children are assessed and referred to the program by the school social worker and each Friday afternoon, students receive our special food packs, free of charge, to take home during the weekend.	number of school districts, schools and children enrolled; number of meals and snacks distributed; impact on local Island Harvest Feeding America Child Hunger Statistics	In Nassau and Suffolk Counties 17 school districts; 28 schools and 1700 students participated in the program; 3,750 meals/snacks including health information and location of area community food resources were distributed per school year.	Continue program related to evaluation	Continue program related to evaluation	Community-based organizations	Island Harvest - Manages the School Weekend Food Backpack Program; Schools- identify students and provide distribution sites
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	By December 31, 2021, increase by 20% the number of engaged in the Phelps Food Pharmacy Program.	focus on low income populations with health disparities	In an effort to address food insecurities, Phelps Hospital's Food Pharmacy Program which includes 3 community gardens, provides patients who are screened for food insecurity a supply of fresh fruits & vegetables to take home upon discharge.	number of people engaged in community gardens; # patients screened;# patients distributed produce	Maintain 3 community gardens; expand referral of food insecure patients	Continue program related to evaluation	Continue program related to evaluation	Community-based organizations	provide sites and volunteers
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	By December 31, 2021, increase access by 10% to healthy affordable fresh produce and nutrition/health education and screenings through mobile farmers markets sites.	focus on low income populations with health disparities	City Harvest Mobile Market offers access to healthy, food by providing free fruits and vegetables through their Mobile Markets to residents in Mariner's Harbor and Stapleton. SIUH provides health information and programs in support of living and eating healthy on a monthly basis at both locations. Information on behavioral health, smoking cessation, cancer services cholesterol, diabetes, stroke, blood pressure and asthma and offers health screenings each month	Farmers Market visitors; SNAP/Farmers Market Nutrition Program Checks; health screening numbers; # and type of health conditions identified; # referrals to providers; residence zip codes of participants	Staten Island University Hospital and City Harvest enjoy a long term partnership. City Harvest Mobile Market offers access to healthy, food by providing free fruits and vegetables through their Mobile Markets to residents in Mariner's Harbor and Stapleton. SIUH provides health information and programs in support of living and eating healthy on a monthly basis at both locations. Information on behavioral health, smoking cessation, cancer services cholesterol, diabetes, stroke, blood pressure and asthma and offers health screenings each month. SIUH participation their strategic planning in December and are on numerous committees together. I.e. The Hunger Taskforce and the Childhood Wellness Iniative, SIPCW. Staten Island University Hospital have partnered to provide community education at the SIUH Maria Regina Center, with City Harvest as the lead.	Continue program related to evaluation	Continue program related to evaluation	Community-based organizations	City Harvest - Manages the Mobile Farmers Market and partners with Staten Island University Hospital to provide health education and screenings at sites in addition to assistance with partnership strategic planning.

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Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	By December 31, 2021, the Northern Westchester Hospital Food Care Program targets to close the gap by 3% between the Community Center of Northern Westchester Food Rescue program food inventory and community need.	focus on low income populations with health disparities	The Food Care Program provides 60 meals/week (Tuesday-Friday) of Register Dietician planned freshly prepared medically tailored meals for clients requiring nutritionally modified diets to the Community Center of Northern Westchester Food Rescue Program. The majority of the CCNW clients live in Ossing and Mt. Kisco.	# therapeutic meals provided, % of meals provided and community need for the meals	The Food Care Program provides 60 meals/week (Tuesday-Friday) of Register Dietician planned freshly prepared medically tailored meals for clients requiring nutritionally modified diets to the Community Center of Northern Westchester Food Rescue Program.	Continue program related to evaluation	Continue program related to evaluation	Community-based organizations	Community Center of Northern Westchester Food Rescue program - Manages a food hub for the receipt and distribution of rescued food from organizations such as Northern Westchester Hospital
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	By December 31, 2021, Harlem Grown and Lenox Hill Hospital targets to increase youth participation in urban farming, nutrition and sustainability through mentorship and leadership development by raising support to increase the physical renovation of abandoned Harlem lots and transforming them into thriving urban farms by 10%.	focus on low income populations with health disparities	Lenox Hill Hospital will support Harlem Grown with hospital resources to increase participation of at risk youth in urban farming, nutrition, food justice, mentoring and leadership programs through the maintenance and expansion of their agricultural sites and program.	# youth engaged; # lessons; change in nutrition, physical activity and social emotional related behaviors; produce grown/eggs harvested and distributed to Harlem Community; # of lbs. compost made	Lenox Hill provides organizational resources including staff time for farm infrastructure improvements, nutrition education, produce recipe development and health education	Continue program related to evaluation	Continue program related to evaluation	Community-based organizations	Harlem Grown- a non-profit organization whose mission is to inspire youth to lead healthy and ambitious lives through mentorship and hands-on education in urban farming, sustainability, and nutrition.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	By December 31, 2021, increase employee food drives by 10%.	focus on low income populations with health disparities	Establish a partnership with food banks to organize Northwell Health Healthy Food Drives to supply foods needed for client modified diets utilizing an online CBO portal to improve efficiency, access and evaluation of program.	Track # food drives, sites and pounds of food donated; track CBO food partner food insecurity/hunger measures	Track completed food drives with Island Harvest Portal	Promote and track food drives	Promote and track food drives	Community-based organizations	Island Harvest provides online platform, operation support in organizing through food drive toolkits, pick - up of donated goods and tracking of donations.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	By December 32, 2021 support existing and increase Healthy Corner Stores in communities with health disparities and lack of access to affordable health foods by 33%.	focus on low income populations with health disparities	Cohen Children's Medical Center Kohl's Kares Program in partnership with Cornell Cooperative Extension of Suffolk County will support of existing Healthy Corner Stores in Roosevelt and expand initiave to Suffolk County.	Healthy Corner Store Initiatives Measures	Established 2 Health Corner Stores in partnership with Cornell Cooperative Extension in Roosevelt, NY	Expand Health Corner Stores to Nassau/Suffolk Counties	Continue program related to evaluation	Other (please describe partner and role(s) in column D)	Bodegas and corner stores provide site for HCS ; Cornell Cooperative Extension of Suffolk County provides HCS technical assistance
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	By December 31, 2021, partner with Queens Farm Museum to provide "Farm to Table " evidence based elementary school curriculum taught at the Queens County Museum Farm to Queens elementary students improve awareness of agriculture, nutrition and intent to increase fruit and vegetable consumption.	focus on low income populations with health disparities	Cohen Children's Medical Center Kohl's Kares Program in partnership with Queens Farm Museum to provide "Farm to Table " evidence based elementary school curriculum taught at the Queens County Museum Farm to Queens elementary students	# program;# students: knowledge and behavioral outcomes	Launch partnership and joint program in 2020	expand reach of program	Continue program related to evaluation	Local governmental unit	Queens County Farm Museum part of the NYC Parks Department will provide assistance in program strategic planning, learning site, educators and curriculum.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.1 Prevent initiation of tobacco use	To Increase by 10% the educational activities regarding the dangers of tobacco use and vaping in the community to prevent youth tobacco use.	focus on low income populations with health disparities	Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms. Decrease youth use and availability of flavored tobacco products including menthol flavors used in combustible and non-combustible tobacco products and flavored liquids including menthol used in electronic vapor products through community education.	amount and type of earned media; amount and type of Northwell community awareness events and media; change in participant knowledge/behaviors; policy/legislation created	SIUH Tackling Youth Substance Abuse Steering Committee activities, Northern Westchester We Can Resist: Know the Facts about Vaping ; Phelps Vaping Presentations; Northwell Center for Tobacco Control activities	Continue program related to evaluation	Continue program related to evaluation	Other (please describe partner and role(s) in column D)	Partners such as : schools; health care providers; government agencies; community based organizations
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.2 Promote school, child care and worksite environments that increase physical activity	By December 31, 2021, increase the number of Northwell employees engaged in worksite wellness physical activity initiatives by 10%	focus on low income populations with health disparities	Northwell Health system-wide Walking Challenges	# teams; # individuals;# steps/miles; participant platform engagement metrics	Walk to Rome, Northwell Health enterprise walking challenge	Continue program related to evaluation	Continue program related to evaluation	Hospital	Northwell Health supports program
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.2 Promote school, child care and worksite environments that increase physical activity	By December 31, 2021, to promote childhood physical activity and increase access to school-based physical activity program, Northwell Peconic Bay Medical Center and Cohen Children's Medical in collaboration with area organizations will increase by 10% the number of Nassau and/or Suffolk County schools participating in the national Project Fit America (PFA) Program.	focus on low income populations with health disparities	To promote childhood physical activity and increase access to school-based physical activity program, Northwell Peconic Bay Medical Center and Cohen Children's Medical Center in collaboration with area organizations provides the national Project Fit America (PFA) Program to schools in Suffolk County providing grants to install PFA equipment and curriculum in elementary schools on the East End of Long Island. Because of PFA, the students at these schools have shown a significant increase in physical fitness and the schools built physical education environment has been modified.	# school participating, # students participating, student participant physical fitness improvements; # school physical education built environments modified	PFA is currently in 10 schools in the eastern end of Suffolk County.	Projected expansion of program	Projected expansion of program	Other (please describe partner and role(s) in column D)	PFA is supported by a coalition of Peconic Bay Medical Center, Cohen Children's Medical Center Suffolk County Lions Diabetes Education Foundation and the Mattituck Lions.
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.	By December 31, 2021, increase Tai Chi for Arthritis and Balance Program participation by 10%.	focus on low income populations with health disparities	Phelps Hospital will deliver Tai Chi for Arthritis and Balance Program to community members.	# programs; # participants;	Delivering Tai Chi programs	Continue program based on evaluation	Continue program based on evaluation	Other (please describe partner and role(s) in column D)	Recruit participants
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.	By December 31, 2021, increase in participation in Phelps Senior Steps Fall Prevention Program focusing on daily strength and balance exercises delivered by Phelps Hospital participation by 10%.	focus on low income populations with health disparities	Phelps will deliver a Fall Prevention Program, Phelps Senior Steps, to Seniors	# programs; # participants;	Continue program related to evaluation	Continue program related to evaluation	Continue program related to evaluation	Other (please describe partner and role(s) in column D)	partner with organizations to recruit participants
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.	By December 31, 2021, increase in Stepping On falls prevention program focusing on daily strength and balance exercises delivered by Northwell Health STARS Rehabilitation and Northwell Trauma Centers participation by 10%.	focus on low income populations with health disparities	Deliver community Stepping On Programs	# programs; # participants;	Continue program related to evaluation	Continue program related to evaluation	Continue program related to evaluation	Community-based organizations	provide sites and recruit particiants includes libraries
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	By December 31, 2021 increase community access to community chronic disease screening rates especially in areas with increased prevalence of health disparities by 5% .	focus on low income populations with health disparities	Evidence-based guideline chronic disease community screenings, health education and referrals to care.	# screenings; types of screenings; # screenings in communities with health disparities; # referrals to care	Northwell health Evidence-based guideline chronic disease community screenings, health education and referrals to care throughout service area	Continue related to program evaluation	Continue program related to evaluation	Other (please describe partner and role(s) in column D)	Cross sector partnerships that provide recruitment and screening sites

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Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.	By December 31, 2021, increase Long Island Health Collaborative Ready Feet Platform activity by 10%.	focus on low income populations with health disparities	Are You Ready, Feet?™ walking program.	School based Challenges: Number of schools and children participating; number of total steps walked; Community Participation: # community member accounts, # miles logged; total logs (activity)	Continue to promote and expand program with Walk with a Doc initiative	School-based challenges completed by January 2020; Community member portal and promotion continues in partnership with Long Island Health Collaborative for Nassau and Suffolk Counties	Community member portal and promotion continues in partnership with Long Island Health Collaborative for Nassau and Suffolk Counties	Other (please describe partner and role(s) in column D)	Long Island Health Collaborative - The Long Island Health Collaborative is a partnership of Long Island's hospitals, county health departments, health providers, community-based social and human service organizations, academic institutions, health plans, local government, and the business sector, all engaged in improving the health of Long Islanders.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	By December 31, 2021, increase provider compliance with 5A's (chart December review) tobacco cessation counseling by 10%. By December 31, 2021, increase in volume of electronic medical record for tobacco counseling by 10%. By December 31, 2021, increase in number of tobacco cessation trained providers especially behavioral health providers by 10%.	focus on low income populations with health disparities	Assist medical and behavioral health care organizations and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on primary care providers providing care to low income populations and behavioral health providers. Promote Medicaid and other health plan coverage benefits for tobacco dependence counseling and medications. Provide improved access to cessation resources through online programs with Eventbrite registration and reminders, telehealth, phone coaching and EMR cessation referrals.	Track # of trainings, sites, participants and policy changes. Track Grand Rounds increase in knowledge & intent to change behavior. Track # Protocols integrated into provider practice. Track annual provider practice specific EMR tobacco use screening, counseling and referral data. Survey of participants' satisfaction with program, knowledge, and intent to change practice behavior. Track # of trainings. Track telehealth, online and eventbrite usage. Track # planning meetings scheduled to discuss curriculum.	tobacco cessation programs for the community and employees. For 20 years, nurses and nurse practitioners at the Center for Tobacco Control (CTC) have been offering tobacco cessation services to the community. The programs are provided in-person in Great Neck and at Southside Hospital. The CTC facilitates group programs as well as individual coaching sessions to accommodate the needs of the patient. The CTC also provides treatment by phone or through Telehealth services. A weekly support is available to assist patients in remaining tobacco-free. In addition, individuals can enroll in our program via Eventbrite. The newest aspect of our CTC program is the addition of Telehealth services for individuals who cannot receive in-person services. This year, nearly 700 individuals who use tobacco were treated for tobacco dependence at the CTC through the group and individual cessation programs. With an increasing focus on the health of Northwell employees we have educated approximately 5,000 Northwell employees about the benefits of quitting and about the services available through the CTC. We have also educated over 4,000 health care providers and health care students (nursing, PA and medical students) about how to assist their patients to quit their tobacco use. In 2019, 46 Provider Tobacco Cessation Group Trainings (9,075 of health care providers) were delivered to health care staff (primary care and specialty care practices), behavioral health providers, allied health students and care management	Continued expansion of programs and use of technology.	Continued expansion of programs and use of technology.	Other (please describe partner and role(s) in column D)	Cross sector partnerships
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.1 Prevent initiation of tobacco use	By December 31, 2021 prevent the increase in youth combustible tobacco and vaping rates and promote a reduction in vaping by community awareness campaigns and education of decisionmakers.	focus on low income populations with health disparities	Community awareness and education campaigns by the Northwell Center for Tobacco Control (CTC), Staten Island University Hospital, Northern Westchester Hospital, Phelps Hospital and Cohen's Children Medical Center.	# programs; # participants; tobacco and vaping policy changes ; NYS Quitline usage; earned media stats	The CTC provided tobacco prevention education to about 2,000 local school students. The CTC also provided tobacco prevention and cessation information as well resources to nearly 18,000 community members. Nassau and Suffolk residents who received counseling and medications through the quitline from 1/31/19 through 11/21/19 include : Nassau County: 2,526;Suffolk County: 4,112 residents. In 2019, Northwell Health lead by the Center for Tobacco Control had over 55 tobacco related earned media spots. These included social media posts, online interviews, radio interviews, television interviews and print interviews. Northern Westchester Hospital's We Can Resist: Know the Facts about Vaping community education program has reached over 5,000 community members.	Continued expansion of programs and use of technology.	Continued expansion of programs and use of technology.	Other (please describe partner and role(s) in column D)	Cross sector partnerships
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	By December 31, 2021 increase the Northwell Health enterprise social determinant of health screening and community resource navigation using EMRs and community social service resource bi-directional referrals by 25%.	focus on low income populations with health disparities	Integrate 15 social determinant of health questions into system inpatient enterprise EMR as part of admission workflows, identify patients with needs and refer to appropriate health system staff and facilitate and actively support referral to community resources. Pilot NOWPOW community social determinants of health resource platform with bi-directional health system and CBO referrals.	# screenings; # unique individuals screened; #/% individuals 1> positive needs; types and prevalence of needs; types and providers of service referrals	Integrated SDH screening in enterprise inpatient EMR, clinical workflows created and screening and data analysis begun. Over 48,000 patients screened. NOWPOW community resource bi-directional referral platform pilot begun.	Continue SDH screening expansion to sites and evaluate NOW POW pilot for expansion	Continue program related to evaluation	other (please describe partner and role(s) in column D)- CBOs provide social determinant of health related services	Other (please describe partner and role(s) in column D)
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	By December 31, 2021 increase Northwell Health cancer screening by 5% through the utilization of technology and community and mobile screenings.	focus on low income populations with health disparities	Plainview, Syosset, Southside and Huntington Hospitals offer skin cancer prevention/free sunscreen dispensers/ skin cancer screening in non-clinical settings in partnership with local parks and recreation departments and other organizations.	# sites; # dispensers; # participants; number of screenings; # positive screenings; # referrals	Hospitals partnered with Towns of Oyster Bay, Islip, Babylon and Huntington to provide program. Over 100 dispensers placed and over 110 screenings given.	Continue program related to evaluation	Continue program related to evaluation	City government	Provide site locations and awareness for program
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	By December 31, 2021 increase Northwell Health cancer screening and community education by 5% through the utilization of technology and community and mobile screenings.	focus on low income populations with health disparities	Staten Island University Hospital, Long Island Jewish Medical Center and Peconic Bay Medical Center provide cancer services program in 3 locations covering 3 Counties (Richmond, Queens and Suffolk) to provide breast, cervical and colorectal cancer screenings and diagnostic services at no charge to uninsured or underinsured women and men. Bilingual outreach and education is also performed.	3 and types of screenings; 3 positive screenings; # referrals for care; sites of screening; # screenings providing access to at risk populations	The Cancer Service Program is operational.	Continue program related to evaluation	Continue program related to evaluation	Other (please describe partner and role(s) in column D)	Cross sector partnerships
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase program engagement of African American women and underserved women for education, cancer screening and access to care by December 31, 2021	focus on low income populations with health disparities	LIJ's Cancer Community Connection Program works to remove barriers to screening and treatment in African American and Hispanic women in Queens and Nassau County through the Susan G. Komen Foundation.	# women engaged; # screenings, positive screens, education activities and referrals; # of women engaged from areas with health disparities	Program is operational in Nassau and Queens Counties	Continue program expansion to emphasize recruitment of Asian American, Foreign Born and Undocumented related to evaluation	Continue program related to evaluation	Community-based organizations	Recruit participants

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Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Increase program engagement by 10% by December 31, 2021	focus on low income populations with health disparities	unnecessary suffering of patients who have recently been hospitalized, Northwell Health has deployed Conversa ,a technological solution that is an automatic texting application that empowers patients to manage their post-discharge care. The application enhances patient experience and extends the reach of our transitional care team outside of the hospital. Since the launch in April 2018, Conversa has been utilized in Health Solutions' nine transitional care programs which include Medicare, Medicaid, and commercial payer populations. Patients are provided an opportunity to enroll in six diagnosis or procedure specific modules, Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PNA), Chronic Obstructive Pulmonary Disease (COPD), Stroke, and Coronary Artery Bypass Graft (CABG) with the choice between two languages, English or Spanish. Patients who are not discharged with any of these specific measures, with exception to patients who have received joint replacements, can receive a Generic conversation. Health Solutions has enrolled a total of 3,900 patients on Conversa,	program adoption of technology, enrollment, patient usage data (i.e. number of meaningful patient interactions) and future measure of health impact	The application enhances patient experience and extends the reach of our transitional care team outside of the hospital. Since the launch in April 2018, Conversa has been utilized in Health Solutions' nine transitional care programs which include Medicare, Medicaid, and commercial payer populations. Patients are provided an opportunity to enroll in six diagnosis or procedure specific modules, Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PNA), Chronic Obstructive Pulmonary Disease (COPD), Stroke, and Coronary Artery Bypass Graft (CABG) with the choice between two languages, English or Spanish. Patients who are not discharged with any of these specific measures, with exception to patients who have received joint replacements, can receive a Generic conversation. Health Solutions has enrolled a total of 3,900 patients on Conversa, increasing the number of meaningful patient interactions from 5.3 to 10.8. Compared to 2018, there has been a 158% increase in total enrollments in 2019 YTD, averaging 275 new enrollments every month. Northwell Health is aiming to expand Conversa for Medicare & Medicaid joint patients in the first quarter of 2020.	Northwell Health is aiming to expand Conversa for Medicare & Medicaid joint patients in the first quarter of 2020.	Continue program related to evaluation	Business	technology vendor
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Improve self-management skills for individuals with Chronic Disease	By December 31, 2021, increase the number of participants that enroll and complete in the National Diabetes Prevention Program by 5%.	focus on low income populations with health disparities	The National Diabetes Prevention Program delivered by Northwell Health Solutions and Peconic Bay Medical Center	# participants enrolled; # participants completed; aggregate health outcomes: weight loss, HgbA1C,	National Diabetes Prevention Program delivered by Northwell Health Solutions and Peconic Bay Medical Center	Continuance based on Year 1 Outcomes	Continuance based on Year 2 Outcomes	Primary Care Practices	refer participants
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Improve self-management skills for individuals with Chronic Disease	By December 31, 2021, increase the number of participants that enroll and complete the Stanford Chronic Disease Self-Management Programs by 5%.	focus on low income populations with health disparities	The Stanford Chronic Disease Self-Management Program delivered by the Northwell Ryan White Center, Southside Hospital and Mather Hospital Community - based Organizations and in collaboration with the Long Island Health Collaborative	# participants enrolled; # participants completed;	Programs currently delivered in Nassau, Queens and Suffolk Counties in English, Spanish, Korean and Chinese.	Continuance based on Year 1 Outcomes	Continuance based on Year 2 Outcomes	Community-based organizations	CBO- recruits participants and delivers programs
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Use media such as social media, videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand.	Increase media awareness channels and community reach by 10% by December 31, 2021.	focus on low income populations with health disparities	provide health information on chronic disease management and prevention: Northwell News: Newsroom: https://www.northwell.edu/about/news The Well: https://thewell.northwell.edu/ Careers Blog: http://jobs.northwell.edu/blog/ Publication Channels // Look North Community Newsletters: https://www.northwell.edu/about/news/publications Glen Cove Hospital Huntington Hospital Lenox Hill Hospital Long Island Jewish Forest Hills Long Island Jewish Valley Stream North Shore University Hospital and Long Island Jewish Medical Center Plainview Hospital and Syosset Hospital Southside Hospital Staten Island University Hospital Publication Channels // Specialty Newsletters: During Gratitude	Northwell Health media tracking : articles; potential reach. Northwell Health Newsroom traffic: Avg. Page Views per month. Northwell Publications: circulation. Northwell Social Followers: Facebook; LinkedIn; Twitter; Instagram; YouTube.	Continued expansion of media awareness programs	Continued expansion of media awareness programs	Continued expansion of media awareness programs	media outlets	provide media channels for awareness program

Name of County - Organization(s)
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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	By December 31, 2021, Develop and begin to implement Northwell Health anchor institution strategies.	focus on low income populations with health disparities	Democracy Collaborative Healthcare Anchor Network and ACEND Partnership -Build community wealth: Approaches include creating and supporting inclusive, healthy public spaces, using the power of anchor institutions such as hospitals to revitalize neighborhoods, supporting democratically operated worker cooperatives, reemployment and supported employment.	Establishment of Anchor Strategy Plan ; ACEND Metrics:Gross Revenue 2018 Gross Revenues 2019 (Projected) Net Revenues 2018 Net Revenues 2019 (Projected) Profitability in 2018 Profitability in 2019 # of Full Time Employees (FTE) in 2018 # of FTE Retained in 2019 # of Jobs Created in 2019 Debt/Equity Pending Debt/Equity Secured # of RFPs submitted in 2019 # of contracts secured in 2019	Democracy Collaborative Healthcare Anchor Network Membership pursuing local hire, local procurement and local investment strategies Partnership with ACEND. A partnership was formed between Northwell Health and the ACEND Long Island program at Hofstra University that will focus on local procurement. The program serves as the suburban model for the national ACEND 2020 initiative. The goal of Ascend Long Island is to provide vital resources in the areas of procurement, access to capital and access to markets to small business owners within a cluster of underserved communities within Nassau County known as "The Corridor" – Hempstead Village, Freeport Village, Roosevelt, and Uniondale.	Continue programs	Continue programs based on evaluation	Other (please describe partner and role(s) in column D)	local vendors, financial institutions, ACEND partners participate in anchor strategies, ac
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	By December 31, 2021, increase by 10% the employees participating in enterprise local hiring initiatives.	focus on low income populations with health disparities	"From the Community For the Community"- a healthcare workforce development program. Committed to improving an individual's total health, this program trains job seekers from communities with health disparities and connects them with entry-level healthcare and social service positions as Community Health Workers (CHW). ABLE BERG - Northwell local hiring initiative for people with Autism Spectrum Disorders; Veteran's Hiring Initiative - Northwell initiative to recruit and hire veterans	# applicants,# participants enrolled, # participants completed program, # participants hired, # and type of training and employment sites; participant career progression	CHW and HR Local Hire	Continue programs	Continue programs based on evaluation	Community-based organizations	Provide apprentice and employment sites
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	By December 31,2021 increase participants in Northwell Health Home Visits Program by 10%.	focus on low income populations with health disparities	Northwell Health Home Visits Program/Family Connects LI a licensee of the Family Connects evidence-based Home visiting program for mothers and newborn infants. The program is a universal screening program launched at Long Island Jewish Medical Center and provide structured visits by trained professionals and paraprofessionals to pregnant women and families and necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.	Families Consented and Enrolled into Program; Activity Totals to Date: Completed Initial Home Visit; Families Completed 6 month Follow-Up Visit, Cancellations/Withdrawals; Referrals made in-home by Nurse Practitioner; Selections of Referral Type; Significant Needs/Risk – Trends; Challenges Identified through Home Visiting; Patient Experience, Quality Assurance Findings.	Activity Totals to Date: Completed Initial Home Visit: 212 Families Completed 6 month Follow-Up Visit: 107 Cancellations/Withdrawals: 69 Referrals made in-home by Nurse Practitioner: 220 Selections of Referral Type: ▪IMIC/SNAP: 48 ▪Primary Care Provider /1-888-321-DOCS: 42 ▪Lactation Consultation/Breast pump/Baby Café/ Breastfeeding assistance: 42 ▪Perinatal Psychiatry at Zucker Hillside: 20 ▪Women's Heart Health Program: 16 ▪Help Me Grow- LI : 13 ▪Pediatrician/Pediatric Specialist: 7 ▪OBGYN: 6 Significant Needs/Risk - Trends: Greatest areas of need/risk requiring intervention: 1.▪Household/Material Supports ▪Pack and Plays (support for safe sleep) ▪Car seats ▪Baby clothes ▪Diapers ▪Food (WIC/SNAP) ▪Formula 2.▪Infant Health ▪Weight concerns ▪Feeding	Continue programs	Continue programs based on evaluation	Other (please describe partner and role(s) in column D)	Help Me Grow LI -HMG-LI is a coalition of regional cross sector organizations that provide early childhood services. It also provides resources for community members and providers and is coordinated by Docs for Tots, housed at the Child Care Council of Nassau, and is connected to United Way of Long Island's 2-1-1 phone system.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	By December 31,2021 increase participants in Northwell Health Mental First Aid Program by 10%.	focus on low income populations with health disparities	Lennox Hill Hospital and partner Thrive NY will provide the Mental Health First Aid Certificate Course to staff and community stakeholders.	# courses;# participants trained; types of settings with trained participants	Lenox Hill Hospital will partner with ThriveNYC to deliver Mental Health First Aid Certification Course	Continue programs based on evaluation	Continue programs based on evaluation	City government	Thrive NYC - provides training
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	By December 31,2021 increase number of caregiving center by 33% and form enterprise Caregiver Business Employee Resource Group.	focus on low income populations with health disparities	The nationally recognized Northern Westchester Hospital Ken Hamilton Caregivers Center is open to all community members regardless of where they receive care and is staffed by social workers and caregiver coaches. The Center provides counseling for caregivers, navigation to community resources, workspace, nourishment and a space for caregiver respite. The Center also assists other organizations outside of Northwell Health to establish similar models. The Northwell Peconic Bay Medical Center Caregivers Center and Huntington Hospital Caregivers Center modeled after the Ken Hamilton Center in Suffolk County opened in 2019. Northwell Caregivers Business Employee Resource Group is an enterprise network for employees who have an interest in promoting supports for Caregiving both within Northwell and in the community.	Caregiver Centers: # visitors, # and type of resources accessed or navigated to; visitor feedback of center	Northern Westchester Hospital Ken Hamilton, Huntington Hospital and Peconic Bay Medical Center Caregivers Centers are operational. The Northwell Caregivers Business Employee Resource Group is in the planning stage.	continue programs and expand sites	continue programs and expand sites	Other (please describe partner and role(s) in column D)	cross sector of organizations that provide caregiver supports such as day care, respite, wellness programs, transportation, legal guidance, and entitlement guidance.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	By December 31, 2021 increase by 25% the access to and appropriate use of NAL-SAT and MAT in the ED for patients.	focus on low income populations with health disparities	Naloxone Saturation Campaign (NAL-SAT) is available in all 18 Northwell emergency departments and 5 primary care practices, NAL-SAT is an Opioid Overdose Program which provides an education on prevention, recognition, response and a Naloxone rescue kits free to patients, family friends and staff. Medication for Addiction Treatment (MAT) is currently offered to patients in 1 of the 6 learning laboratories in the health system- 4 emergency departments, 1 primary care practice, and 1 inpatient unit. Medications include those such as Buprenorphine in combination with psychosocial support provided by one of our Northwell Health treatment facilities.	# trainings; # participants; participant evaluations	To date, 4,155 individual received Opioid Overdose education and naloxone rescue kits including patients, family, friends, community members, staff and students; 60 Buprenorphine inductions in 4 emergency depts and 60 direct referrals to next day induction and/or treatment.	Continue to expand programs based on evaluation	Continue to programs based on evaluation	Other (please describe partner and role(s) in column D)	CBO substance use providers that provide community treatment and support resources.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	By December 31,2021 increase the number of provider opioid and alternative pain management trainings by 10%	focus on low income populations with health disparities	Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations through Northwell Opioid Task Force.	# trainings; # participants; participant evaluations; system opioid prescription data	Northwell Opioid Task Force; Staten Island University Hospital Tackling Youth Substance Abuse Steering Committee;	Continue program related to evaluation	Continue program related to evaluation	Other (please describe partner and role(s) in column D)	Cross sector of organizations including behavioral heath and substance use providers, local health departments, and government agencies

Name of County - Organization(s)
2019 Workplan

Planning Report Liaison Name of liaison
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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	By December 31, 2021 increase provider SBIRT screening and community based care substance use referrals by 50%.	focus on low income populations with health disparities	SBIRT screening and referral process integrated into Northwell enterprise inpatient, emergency department and ambulatory EMRs and healthcare provider workflows in 14 hospitals, 16 emergency departments, and 5 primary care practices spanning Northwell's 6 county service area. Project Connect is a complementary program developed in collaboration with the Central Nassau Guidance & Counseling (CBO) to provide external navigation for patients struggling with substance use. Patients are provided with support and assistance for 120 days following enrollment during an emergency department visit. These programs are part of a 4 layer framework that also includes the SBIRT screening process (foundation) Naloxone Saturation Campaign (NAL-SAT)(layer 2), Medication for Addiction Treatment MAT in ED (layer 3) and Project Connect (layer 4).	# screenings ; # and type of referrals; # pts coached by SBIRT Coach; Aggregate screening results for substance use types; # patients enrolled in Project Connect and f-up outcomes;	As of 2019, 1,000,000 pts received SBIRT screens in ED and primary care practices; 31,000 have had SBIRT Coaching; 365 pts were enrolled in Project Connect.	Continue to expand program layers reach	Continue to expand program layers reach	Community-based organizations	Cross sector of organizations including behavioral heath and substance use providers, local health departments, and government agencies
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.4 Reduce the prevalence of major depressive disorders	By December 31, 2021 increase participation in programs which meet the need of patients, their families and community members as related to program outcome measures.	focus on low income populations with health disparities	Strengthening resources for families and caregivers through Northwell support programs including The Center for Attention and Learning (CAL) at Lenox Hill Hospital; Staten Island University Hospital SIPPS Behavioral Health Infrastructure Project and Partnership for Community Wellness ;Northern Westchester Reframe Your Perspective Program, Center for Healthy Living and Community Care Team; Phelps Hospital Vitality Program; Northern Westchester Hospital's Center for Healthy Living and Reflect, Respect Rekindle Your Relationships Programs; Phelps Hospital Functional Medicine Program/ Holistic Pain Support Program; Northwell at Home Aging in Place and Senior Navigator Programs; Zucker Hillside Hospital NAMI Programming Partnership and Patient & Family Partnership Council; Southside Hospital's Wellness from Within Series and Long Island Against Domestic Violence Workshops; Mather Hospital's Healthy U Program; Lenox Hill Hospital/MEETH Accessibility Resources for People with Visual Impairments Series; Huntington Hospital YMCA as well as other Northwell support groups.	# programs;# participants; participant knowledge and behavioral outcomes	Northwell support programs including The Center for Attention and Learning (CAL) at Lenox Hill Hospital; Staten Island University Hospital SIPPS Behavioral Health Infrastructure Project and Partnership for Community Wellness ;Northern Westchester Reframe Your Perspective Program, Center for Healthy Living and Community Care Team; Phelps Hospital Vitality Program; Northern Westchester Hospital's Center for Healthy Living and Reflect, Respect Rekindle Your Relationships Programs; Phelps Hospital Functional Medicine Program/ Holistic Pain Support Program; Northwell at Home Aging in Place and Senior Navigator Programs; Zucker Hillside Hospital NAMI Programming Partnership and Patient & Family Partnership Council; Southside Hospital's Wellness from Within Series and Long Island Against Domestic Violence Workshops; Mather Hospital's Healthy U Program; Lenox Hill Hospital/MEETH Accessibility Resources for People with Visual Impairments Series; Huntington Hospital YMCA as well as other Northwell support groups continue.	Continue as related to program evaluation	Continue as related to program evaluation	Other (please describe partner and role(s) in column D)	cross sector partners including CBOs, government, schools, business, faith-based, etc.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	By December 31, 2021, launch Northwell Health High School Prescription Drug Safety Network Program in Suffolk County increase knowledge, awareness and attitudes, perceptions of social norms and promote behavior change regarding drug use.	focus on low income communities with health disparities	Launch in Suffolk County high schools an evidence-based digital prescription drug safety course that is tailored to individual user learning and contains interactive modules and outcome assessments.	knowledge, awareness and attitudes, perceptions of social norms, behavior change regarding drug use participant and educator engagement and assessments	Launch in pilot school in 2020	Continue program related to evaluation	Continue program related to evaluation	K-12 School	partner in integrating into health curriculum

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Promote a Healthy and Safe Environment											

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Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health	Goal 2.2: Increase breastfeeding	By December 31, 2021, increase the percentage of newborns being discharged on breastfeeding by 10%.	focus on low income populations with health disparities	Breastfeeding Friendly Hospital Initiative at Staten Island University Hospital, Lenox Hill Hospital, Forest Hills Hospital, Long Island Jewish Medical Center, North Shore University Hospital, Southside Hospital, Peconic Bay Medical Center, Phelps Hospital and Northern Westchester	Track Baby-Friendly USA Evaluation Criteria Track # of families provided prenatal breastfeeding education	Continue program progression related to evaluation	Continue program progression related to evaluation	Continue program progression related to evaluation	Other (please describe partner and role(s) in column D)	Local community breast feeding support resources
Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health	Goal 2.2: Increase breastfeeding	By December 31, 2021, increase the utilization of Baby Cafes by 15%, increase the number of breast feeding friendly pediatric practices, worksites, community and daycare sites by 15%	focus on low income populations with health disparities	Expand the NYSDOH Pediatric Obesity Prevention: Creating Breastfeeding Friendly Communities that increases pediatric primary care provider, worksite, daycare and community promotion and support of breastfeeding to prevent pediatric obesity.	NYSDOH Pediatric Obesity Prevention: Creating Breastfeeding Friendly Communities tracking data	OB/GYN & Pediatric Practices: Steps - 1. Engaged staff and developed working relationships 2. Provided trainings and technical assistance 3. Developed Policy 4. Achieved NYS Breastfeeding Friendly Practice Designation - Family Medicine Center at Glen Cove Hospital (1,2,3,4), Pediatric Healthcare Solutions (1,3), West Islip Pediatrics (1,2,3,4), HRHCare Brentwood &	Continue program progression related to evaluation	Continue program progression related to evaluation	Other (please describe partner and role(s) in column D)	cross sector partners such as worksites, government, breast feeding support CBOs, Childcare organizations.

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Prevent Communicable Diseases											