Northwell Health -CHIP/ CSP
CHIP/ CSP Workplan: 2022-2024 CYCLE

Planning Report Liaison: Sabrina Lutchman
E-mail: slutchman1@northwell.edu

Priority	Focus Area	Goal	Interventions	Family of Measures	Annual Update	Partnerships
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	**Nutrition Pathways Program:** The purpose of the Nutrition Pathways program is to improve the health and well-being of the poor, underserved, vulnerable, and disadvantaged patients in the communities served by the Dolan Family Health Center, through the identification and addressing of health-related social needs, most notably food insecurity. The program deployed at the Dolan Center, in partnership with Island Harvest, Long Island's largest food bank, provides food insecure individuals and their families, with nutrition counseling and education, healthy food packages and support, and referrals for other community-based programs and resources, as needed. The program also provides weekly community food distribution. The Nutrition Pathways Program has implemented use of the NowPow referral platform, enabling us to link clients with appropriate services, as well as ensure referred services are received, resulting in an improved ability to sustainably address participants' food insecurity and other related social needs. Dolan Family Health Center staff routinely screen patients for food insecurity. Those who screen positive are referred to the Nutrition Pathways Program, where they meet with an Island Harvest registered dietician (RDN) who is embedded on-site. The patients meet with the RDN weekly or bi-weekly for up to 12 visits. At each session, the RDN provides personalized education and advice on diet and health priorities set by the patient. After each session, patients are guided, by the RDN, as they "shop" for food in the program's on-site Pantry/Nutrition Center. Participants also receive practical cooking tips, shopping guides, kitchen tools, and other essential items to encourage and support healthy home meal preparation. While the Nutrition Pathways Program focuses on addressing food insecurity, participants are also screened for needs beyond food assistance and are connected with other community resources to address a full range of social determinants of health. To best serve the needs of the largely LatinX community served at the Dolan Center, the nutritionists who are embedded are competent in communicating to the Spanish-speaking community. In addition to providing nutritionally appropriate food items and recipes, the staff also tries to ensure that food and other materials provided are culturally appropriate and that recipes are palatable, from a cultural lens. Materials are available in both English and Spanish.	• Number of individuals enrolled in the full program and received counseling sessions. • Number of individuals who participated in the weekly Friday community box food distribution. • Number of meals provided • Number of individuals who have been assisted with SNAP benefits enrollment. • Number of individuals with other health-related social needs connect with services/resources.	The Nutrition Pathways Program launched in May 2021 and in April 2022 we conducted our one-year assessment. In this one-year period, Nutrition Pathways achieved the following: • 134 people were enrolled in the full program and received (as of April 30th) a total of 981 counseling sessions. As this program is designed to improve food security for entire households, the program's true impact is significantly higher. With Census data showing an average household size of 3.5 members in the target communities, the true impact is closer to 469 individuals. • Approximately 250 people participated in the weekly Friday community food box distribution at the Dolan Center. Using the Census estimates of household size above, the true reach of the weekly food distribution was approximately 875 individuals. • A total of 29,052 meals were provided (11,772 meals through the one-on-one RDN sessions, and an additional 17,280 meals through the on-site community food box distributions). • 86 individuals have been assisted with Supplemental Nutrition Assistance Program (SNAP) benefits enrollment. • 125 individuals with other health-related social needs were connected with more than 793 services/resources. Common referral needs, other than food insecurity, included immigration assistance, assistance with utilities, assistance with rent/housing, baby care needs, mental health needs, COVID-related assistance (testing and vaccinations), and transportation. Finally, the following outcomes metrics have been tracked since the program inception for 61 patients who have completed at least 12 sessions as of April 30, 2022: • 86 individuals have been assisted with Supplemental Nutrition Assistance Program (SNAP) benefits enrollment. • 125 individuals with other health-related social needs were connected with more than 793 services/resources. Common referral needs, other than food insecurity, included immigration assistance, assistance with utilities, assistance with rent/housing, baby care needs, mental health needs, COVID-related assistance (testing and vaccinations), and transportation. • Significant improvement in healthful behaviors was achieved: o 54% of participants reported increased consumption of healthy foods. o 67% reported a dietary reduction in unhealthy foods. o 26% reported a reduction in meals eaten away from home. o 44% reported increased physical activity. • Significant improvement in health outcomes was achieved: o 50 of participants have achieved reduced BMI (as per medical records). o 36% have achieved reduced blood pressure. o 55% have achieved reduced A1C.	Close collaboration with the Island Harvest team that staffs the registered dietician on-site at Dolan. Financial support of the Mother Cabrini Health Foundation.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Food as Health Program (FAH):** The Food As Health Program was created to help connect the patients health and nutrition to improve their overall wellness. Patients who screen positive for food insecurity, receive personalized nutrition counseling sessions, access to nutritious foods from the on site health food pantry, referrals to community resources, and assistance with SNAP. Island Harvest distributes	# of meals provided, # of days served, # people served	In 2021: - At least 500 bags were distributed (one insulated bag with cold products such as milk and cheese, and one bag of fruits and vegetables per recipient). - 11,018 meals were delivered to 62 community members through 5,509 deliveries. - 75 people estimated to be served. - 103 clicks onto food drive link in emails sent for virtual food drive.	Island Harvest, National Grid grant, Town wide Fund of Huntington, Suffolk County Women's Alliance to End Food Insecurity, Three Village Meals on Wheels
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1: Increase access to healthy and affordable foods and beverages	**City Harvest Mobile Market:** offers access to healthy food by providing free fruits and vegetables through their mobile markets to residents in Oakwood and Stapleton in Staten Island. SIUH provides health information and programs in support of living and eating healthy on a monthly basis at both locations. Information is provided on behavioral health, smoking cessation, cancer services, cholesterol, diabetes, stroke, blood pressure , asthma. Our team has created a food resource rack card, this car identifies all the food pantries throughout Staten Island, the cards are in English and Spanish. We have reached out to the Northwell translation team to translate into other languages.	Pounds of food distributed	Mobile Market program will run from January 2022-December 2022. City Harvest has 9 mobile markets across the 5 boroughs and 2 pantry sites in Staten Island. Oakwood Shopping center and Stapleton NYCHA houses. The zip codes that food have been distributed in are 10304, 10306 and 10301. As of July 2022 the Mariners Harbor NYCHA houses in 10301 no longer exists as a direct affiliate of the City Harvest program due to low turn out. 341,954 pounds of produce have been distributed to Staten Island residents from January 2022-August 2022.	SIUH partners with many community based organizations that focus on food insecurities. The Hunger Taskforce, The Childhood Wellness Initiative through the Staten Island Partnership for Community Wellness, Health for Youth. Health for Youth/SIPCW are our partners in the Clementine Collective.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1: Increase access to healthy and affordable foods and beverages	**Clementine Collective:** an initiative started by Columbia University Graduate students. This program was based on food deserts in certain areas where community residents don't have access to fresh fruits and vegetables. The students goal was to introduce 50 clementines daily to a local bodega for two reasons, to see the response from the community to the introduction of the clementines to the stores and the second goal was to get the storeowner to understand the importance of stocking these fruits for the community residents. This was a program started through Health for Youth, SIUH partnered with this organization to bring clementines to 3 local bodegas. October 5 2021 was the kickoff at Columbia Meat Market in Staten Island.	The goal of the Clementine Collective was to operate in each store for up to 8 weeks, however with the success of the initiative we continued to stay in Columbia meat market. We are now in two other bodega's on Staten Island, Curtis Deli and Midway Deli. Our goal is to have this initiative within two other zip codes by December 2022.	H.E.A.L.T.H for Youths, Inc. is doing mapping to locate other stores on Staten Island within the 5 neighborhoods on Staten Island's North Shore. These neighborhoods face a significant negative impact on the Social Determinants of Health. Along with the fresh fruits and vegetables we are educating the community with Northwell's healthy choices at home recipes and Northwell health eating tips. A total of 4400 pounds of clementines, sweet potatoes, onions and tomatoes have been given to community residents in zip codes 10301 and 10304. A total of 132 surveys were completed at Columbia Meat Market. The community residents that shopped were asked questions regarding (the program and its impact, what other fruits and vegetables the would like in the store, If they wanted other recipes, and ways we could improve the program.	We have partnered with Health For Youth, SIPCW gave a $2000 grant and the SIPPS is in the process of giving a grant of $5000 towards this important initiative.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**NYC Public Schools Pop up Pantry:** The Community Health team has developed a relationship with the NYC Department of Education and the Private Schools on Staten Island to connect with the parent coordinators and guidance counselors to identify the families in need of food items. Program began in April 2022.	Number of bags and total weight of each bag. We give each school 15 bags with a total weight of 16 pounds. In the bags are clementines, potatoes, onions, green beans, pasta, Cheerios.	From April 2022- June 2022 we gave out a total of 720 pounds of food that feed 180 community members. Our goal for 2023 will be to give 30 bags monthly and to also give to programs over the summer. In each bag we put the Northwell Start Simple with My plate Wellness on wheels recipe book. The book consists of 24 recipes in English/ Spanish. Our team has also created a food resource rack card this card identifies food pantries throughout Staten Island, the cards are in English and Spanish. We place these cards in the bags, we have reached out to the Northwell translation team to translate into other languages.	The support from leadership and the relationship with the parent coordinators guidance counselor and Principals in Staten Island. We also received a $4000 donation from Ralph's Sports Bar on Staten Island to fund this initiative.
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	**Wellness on Wheels (WOW):** WOW is mobile nutrition education program that serves high needs communities and economically disadvantaged students. The programs encourages building healthy habits focusing on nutrition while guiding those families that have been identified as food insecure to resources to help gain them food access; Increase food security through Island Harvest's Weekend Backpack Program; and Increase food security and access to food by distributing Fresh Produce bags at Greater Springfield Community Church and The Interfaith Nutrition Network	Number of families that apply for SNAP benefits; Number of programs and students that receive WOW programing, Knowledge and behavioral outcomes; Number of school districts, schools and children enrolled; Number of meals and snacks distributed; Number of people receiving fresh produce bags	Expand programs to new districts and communities; 350 food insecure children will participate in the Weekend Backpack program during the 2022 school year in Brentwood and Riverhead schools. This collaboration with Rite Aid Wellness on wheels funding will provide a minimum of 10,140 healthy meal and snacks to these children for 30 weeks. 130 food insecure children will participate in the Weekend Backpack program during the 2022 school year in Brentwood schools. This collaboration with Mother Cabrini Wellness on wheels funding will provide a minimum of 5,070 healthy meal and snacks to these children for 30 weeks; 125 fresh produce bags distributed for 8 weeks during the summer, total bags distributed 1,000 350 fresh produce bags distributed 4 weeks over the summer, total bags distributed 1,400 Total bags 2,400, which equates to 24,000 pounds of food distributed.	Funding provided by Mother Cabrini and Rite Aid has aided in the programs expansion. Partnering with Northwell Health Home Solutions team enabled us to facilitate SNAP benefits on site. Northwell partners with Island Harvest, who manages the School Weekend Food Backpack Program and schools in Nassau and Suffolk counties to help identify students and provide distribution sites. The Weekend Food Backpack Program is also in collaboration with schools in the following school districts: Brentwood, Central Islip, Copiague, Riverhead, South Country, Westbury and Wyandanch. The INN provides services to individuals and families in Nassau county suffering from housing and food insecurity. GSCC serves a community in Jamaica/Southeast Queens that has high rates of food insecurity and other health-related social vulnerabilities.

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**	**Health and Wellness Program:** The Health and Wellness Program is an opportunity for elementary school students (Kindergarten-6th grades) to learn about introducing healthy behaviors into their everyday life. Students have the opportunity to speak with clinical and non-clinical healthcare professionals from various service lines and specialties including: nutrition and healthy eating, dental hygiene, bike and helmet safety, pedestrian safety, hygiene and hand washing, sun safety, stress reduction and stretching, staying active and fit, bullying prevention, recycling, and more. In addition, our team is committed to taking an active role to address obesity and food insecurity as top priorities for our community through the G.R.O.W. (Growing Real Opportunities through Wellness) program. G.R.O.W. focuses on the unique health benefits that come from growing plants and impacts the students by helping shift and change unhealthy behaviors that are ingrained in our society while satisfying Northwell Health's commitment to social responsibility. The students are engaged by planting their own seedling and then nurturing the seedlings to learn the skills needed to grow and harvest.	Number of students	By the end of 2021, there was a total of 8 events and 2,394 students reached	School districts and internal
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**	**POWER Kids**: More than one-third of all children in this country have difficulty achieving a healthy weight, putting them at risk for health problems now and in the future. Cohen Children's is committed to helping children and adolescents get healthy and stay that way through the POWER Kids Weight Management Program. The POWER Kids Weight Management Program takes a multidisciplinary approach to managing overweight and obesity in children using medical, nutritional and support services. The patients we treat and come to us from many different backgrounds. Our trained specialists in pediatric and adolescent medicine welcome this diversity and the opportunity to impact future health through positive change and supportive guidance.	Number of participants enrolled	By the end of 2021, there was a total of 1,587 patients	Internal clinicians
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**	**Junior Leadership Council:** The Junior Leadership Council is a youth leadership program whose mission is to improve the health, safety, and well-being of adolescents and young adults in Nassau, Suffolk, and Westchester Counties. This development and leadership opportunity is exclusive to students in select schools. JLC members act as liaisons between community youth, their schools, and partnering hospitals within the Northwell system. JLC members are given the opportunity to: help identify and prioritize key health issues affecting young people; develop and implement programs to address these key health issues; support, advise, and assist partnering hospitals in efforts to promote health and wellness in the community; and explore career possibilities in health and medicine. Each year, JLC members are expected to develop, disseminate, and implement a final outreach project that targets the identified health issue within their communities.	Number of students enrolled	By the end of 2021, there was a total of 27 students	The program partnered with various high schools from Westchester, Nassau, and Suffolk Counties (Bay Shore, Brentwood, Amityville, Central Islip, Mineola, Roosevelt, Westbury, Ossining, Sleepy Hollow, and Briarcliff) as well as multiple Northwell hospitals (South Shore University Hospital, South Oaks Hospital, Phelps Hospital, and Zucker Hillside 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**	**School and Community Based Educational Programs:** Cohen Children's Medical Center provides various educational workshops to support the healthy growth and development of students grades K-12 and to provide the latest information on topics relevant to school administrators and teachers, school nurses, sports teams, parents groups, and community organizations. Each workshop can be tailored directly to the specific needs of the audience.	Number of students	By the end of 2021, there was a total of 70,000 students reached	partnerships with local schools
Prevent Chronic Diseases	**Focus Area 1: Healthy eating and food security**	**Goal 1.3: Increase food security**	**Food As Health (FAH) Program:** A food distribution event was held at Comsewogue High School in Port Jefferson Station. Recipients were provided with bags of dairy products, fresh fruits and vegetables, a healthy meal kit, and information on local food pantries and soup kitchens. A collaboration with Northwell's Community and Population Health, Mather Hospital provided staff and supplies for the event, which provided families in an underserved area with nutritious food items that are more difficult for those impacted by food insecurity to obtain. **One off event**	# of bags distributed	At least 500 bags were distributed (one insulated bag with cold products such as milk and cheese, and one bag of fruits and vegetables per recipient).	Suffolk County Women's Alliance to End Food Insecurity partnered in holding the event. Internal Northwell's Community and Population Health and Mather team
Prevent Chronic Diseases	**Focus Area 1: Healthy eating and food security**	**Goal 1.3: Increase food security**	**Food As Health (FAH) Program:** Mather Hospital provides discounted meals to Meals on Wheels, which delivers to homebound, handicapped, chronically ill, or convalescent persons in our community who are unable to prepare their own food. Mather Hospital's dietary department collaborates with Meals on Wheels each year to ensure homebound individuals receive two nutritious meals/day. Ongoing activity that happens throughout the year. **One off event**	# of meals provided, # of days served, # people served	In 2021, 11,018 meals were delivered to 62 community members through 5,509 deliveries. 2022 data not yet available.	This is a partnership with Three Village Meals on Wheels.
Prevent Chronic Diseases	**Focus Area 1: Healthy eating and food security**	**Goal 1.3: Increase food security**	**Food As Health (FAH) Program:** Mather Hospital held a Thanksgiving Food Drive benefitting local food pantries. Food collection and distribution is coordinated by Social Work and assists organizations serving community members affected by food insecurity. In addition, Mather has promoted the Northwell virtual food drive. Event held every year at Thanksgiving. **One off event**	Estimated # of people served (receiving multiple food items), click throughs for emails promoting virtual food drive	75 people estimated to be served in 2021 with food items. 103 clicks onto food drive link in emails sent for virtual food drive.	Social Work runs the drive. Food is donated to local church pantries. The virtual food drive in 2021 that Mather promoted was a collaboration of Northwell and Island Harvest.
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**	**Food as Health Program (FAH):** The Food As Health Program was created to help connect the patients health and nutrition to improve their overall wellness. This program offers the qualifying patients access to these onsite food pantry and community resources while they are in the hospital. The program's registered dietitian guides each patient to find the best food for their specific health needs, as well as provides them with healthy recipes and nutrition education based on their comorbid health condition (i.e. diabetes, hypertension, obesity, etc.). These patients are seen by the RD before discharge where an initial nutrition screening, nutrition education, healthy recipes, groceries, as well as assistance with governmental and community resources are provided. After discharge the RD will check-in two additional times over the next couple of months for questions about nutrition, community resources, and coordination of another grocery pick up.	Ethnicity Age Gender Town of Residence Comorbid Health Conditions(i.e. diabetes, hypertension, obesity, etc.) Community Resources Provided	• 708 SDoH screenings for food insecurity • 14% positive screens (14%) • 30% of screened patients newly enrolled this year	Hospital Team: Dietetic Interns Registered Dietitians Head Chef Social Workers/Case Management Interpreters Clinical Team Community Partners: Baldor- Donations of Fresh Produce US Foods- Donations of Non-Perishable Foods Stop & Shop Local Food Pantries Pronto Open Exchange Long Island Cares Mom's Meals NowPow Governmental and Health Agencies: SNAP Offices American Diabetes Association American Heart Association Stonybrook WIC Offices
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**	**Teaching Kitchens: Postponed due to COVID- Will resume 2022 Q4** Classes are an opportunity to learn how to shop for, utilize, and prepare healthy and delicious meals. Each class focuses on a different topic that includes a nutrition lesson provided by a dietitian followed by a live cooking demonstration with a SSUH professional chef. Food sampling and recipes are provided.	Number of classes held	Goal to restart the classes in 3/1/23	Partner with Pronto of Long Island and other local food pantries
Prevent Chronic Diseases	**Focus Area 1: Healthy eating and food security**	**Goal 1.3: Increase food security**	**Jammin for the Community:** Northwell employees' partner with our community members to volunteer making Peanut Butter and Jelly sandwiches for those in need. At the close of 2019 the group was able to proudly share that they have made over 160,000 sandwiches.	Number of sandwiches given	2020-2022: Postponed due to Covid Estimated 3/1/23	Local Pantries

Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Garden in Northern Westchester:** founded in 2021 is located on the grounds of Northern Westchester Hospital and cultivated by volunteer staff. The fruits and vegetables cultivated in the garden are donated to patients at discharge who are 1. identified upon assessment as food insecure 2. to new parents. 100% of patients are given cards with recipe ideas and nutrition FAQs to aid in increased knowledge of nutrition and exposure to new recipes. These cards are offered in multiple languages.	Number of bags distributed	In our first harvest, 2022 50 bags of fresh grown food was donated to patients.	Partnerships with our employees has been our biggest driver of success. We have also partnered with the Community Center of Northern Westchester when we have additional food to donate. We donate food on a weekly basis to the Community Center of Northern Westchester as part of the Food Rescue program which provides 60 meals a week in donations (this was submitted on a previous form).
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	**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 Community Center of Northwell Westchester clients live in Ossining and Mt. Kisco.	Pounds of food distributed	In 2021, due to increased food insecurity in the community, CCNW distributed 808,933 lbs. of food serving over 3,000 households - 3,160 lbs. (0.34%) of this food was from NWH Meal donations from NWH to CCNW increased since the pandemic began - going from 50 meals per week in 2020 to 60 items per day, Tuesday-Friday.	CCNW and NWH have a strong community partnership through our Community Health department foundation and board of directors. Because of this multifaceted close relationship, CCNW shared with NWH that more clients were seeking food services through their organization, suggesting heightening food insecurity in the community. Due to our close communications, NWH was able to respond swiftly increasing donations in a timely manner to help CCNW meet this need.
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	**B.E.S.T. Informational Table:** Informational Tabling at B.E.S.T. to share upcoming programs and the Northwell Garden**. One off event**	Number of attendees	A total of 35 people were interacted with during this tabling event	LIJ Valley Stream, Community and Population Health, Nutrition
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Food Donation to Our Lady of Good Counsel:** Food donation from LIJVS Kitchen - 49 cases of lunch time tuna kits**. One off event**	Number of cases distributed	49 cases of tuna (12 packs in each). out of those 49 cases of tuna, a total of 294 people received tuna kits	LIJ Valley Stream Nutrition Department
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1: Increase access to healthy and affordable foods and beverages	**Community Garden - Prevent Chronic Diseases**: 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; Number of patients screened; Number of patients distributed produce.	Phelps FARMacy garden vegetable produce continues to promote health and wellness. Through the summer and early fall of 2021, 18 vegetable bags were assembled and provided to patients identified in need, or identified at risk for food insecurity. The initiatives are coordinated by a team of social workers, case managers, dietitians, call-center coordinator, dining assistants, as well as food-service, kitchen staff and quality management. All patients are screened during their stay to identify if they are appropriate candidates to receive produce (i.e.: new moms, patients at risk for food insecurity). The overall number of patients distributed produce thus far has been 50 - 60 in 2021. 2022 is currently in process and has already distributed ~10 bags to identified patients at risk for food insecurity as well as new mothers. We have also partnered with CDI/reporting to create a more efficient way to screen and identify patients triggering "Yes" at risk for food insecurity so we can better identify at risk patients both upon admission as well as discharge. We have also created beautiful garden produce bags which are packaged with signage and include informational handouts that explain recipe utilization of produce as well as the nutritional benefits and properties.	Dietitians, case management, dining assistants, IT partnerships and volunteers worked together with FARMacy to promote wellness and community building through education and access to healthy foods and healing spaces. The growing FARMacy Garden Series includes the Employee Health Garden (Phelps "Peas & Quiet Garden") and the Intergenerational Garden serving children from the Robin's Nest Daycare along with their parents and grandparents, Kendal residents and the others in the community.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3: Increase food security	**Trinity Lutheran Food Pantry/GCH Partnership:** Trinity Lutheran Church is directly behind our Emergency Room and easily accessible to our Family Medicine clinic patients. The pantry serves the resident of the City of Glen Cove, but also serves as a source of support for our own patients. In order to ensure that the pantry is supplied with enough food, Glen Cove Hospital Nursing Admin and Family Medicine have partnered for a year round food drive that is delivered to the church every Wednesday. In addition to providing food, members of the Glen Cove Nursing team partner with residents to volunteer at the pantry on Wednesday nights where there are able to provide nutritional information as well as help with creating healthy menus for those individuals and families that make use of the pantry.	Pounds of food distributed	This is an ongoing initiative that was started in October of 2021 and has been in effect since that time. Since the inception of this partnership, the number of families served by the pantry has gone from 28 to 123. Trinity Lutheran has also served as a respite for some of the homeless population in Glen Cove. In addition to serving the City, the pantry has been able to expand its reach to help the communities of Locust Valley, Sea Cliff , Glen Head and Bayville	Glen Cove Hospital partners with a multitude of community organizations including Assisted Living facilities in the area. As part of our ongoing drive, we have been supported by the local IAC (Inter Agency Council) which is comprised of all local not for profit agencies, school districts and elected officials.
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	**Harlem Grown** is an independent, 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. They operate local urban farms, increase access to and knowledge of healthy food for Harlem residents, and provide garden-based development programs to Harlem youth. Lenox Hill Hospital/ Northwell supports Harlem Grown as a corporate partner. LHH aims to provide 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.	Number of participants	On 5/20/22, a team of 30 hospital leaders and employees participated in a corporate day of service on the farm. The team is currently working with Harlem Grown leadership to develop programming such as medical career days, nutrition talks and other educational events with the youth.	Lenox Hill Hospital/ Northwell supports Harlem Grown as a corporate partner.
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**The Well by Northwell:** The Well is Northwell's health and wellness online publication. Our goal is to educate and support the healthcare wellness journey.	Engagements with our content 3 million	We have reached 2.1M content engagements as of August 2022	Katz Institute for Women's Health, GoHealth, The Cooking Lab, Patient experience
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Northwell Health HR Employee Wellness: Physical Activity** Northwell's 2021 annual system-wide step-based physical activity campaign was entitled "Walk Across Asia." Employees participated by forming teams of six and participated in a virtual journey of over 2 million steps across six destinations. All members of 6 who reached the final destination qualified to win a cash prize of $5,000 and my Recognition points. Additionally, Northwell promotes: -Site-specific walking challenges established -myHealthyBody workshops offered to increase movement -Employee Wellness YouTube channel with videos for exercise/movement -promotion of the Center for Wellness + Integrative Medicine services - partners with Benefits to promote Gympass	Walk Across Asia, Northwell Health enterprise walking challenge	Program is currently active. Results are not yet finalized.	The partnerships for this series of initiatives were: Virgin Pulse, myHealthyBody, Center for Wellness + Integrative Medicine, Benefits
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Tai Chi for Arthritis and Balance Program**: is an ancient art form which has many proven therapeutic health benefits. This evidence-based program has been designed to help participants improve muscular strength and endurance, enhance flexibility and balance, and reduce falls.	Number of people who attended the events	16 classes completed at Riverhead Library	Riverhead Free Library and Suffolk County Department of Health.

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.	**The Arthritis Foundation Walk with Ease Program:** is an exercise program that is proven to reduce pain and improve overall health. If you can be on your feet for 10 minutes without increased pain, you can have success with Walk with Ease. Benefits: - Motivate yourself to get in great shape - Walk safely and comfortably - Improve your flexibility, strength and stamina - Reduce pain and feel great	Number of participants enrolled	Numbers are low due to COVID 18 Sessions- 10 participants	Arthritis Foundation
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Tai Chi for Arthritis:** This program meets twice weekly for 8 weeks, with class sizes ranging from 10-20 for in-person and 25 for virtual. Tai Chi is a gentle exercise focusing on balance and gait. It has been proven to reduce the rate of recurring falls by 70%. https://taichiforhealthinstitute.org/programs/tai-chi-for-fall-prevention/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	5 events held: 1/4; 1/8; 2/3; 6/14 and 7/1. Total of 123 people in attendance	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**1-Hour Fall Prevention Lecture:** This is a lecture that covers many aspects of fall prevention. This is not an evidence-based fall prevention program. This lecture is held in libraries, senior centers, or other venues. No min or max for attendees.	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	3 events held: 6/22; 9/22; and 9/29. Total of 63 people in attendance	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Falls Talk:** FallsTalk is a one to six-month personalized behavior change intervention for individuals at risk for falls. The intervention program requires: a) evidence-based fall risk screening and a standardized FallsTalk interview which creates various customized intervention components and reports; b) daily log training; c) telephone check-ins; d) follow-up interview and log review. http://fallscape.org/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	3 events held: 1/5; 11/23; 12/15. Total of 78 people in attendance	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**BingoCIZE: Fall Prevention and Nutrition:** Bingocize® strategically combines the game of bingo, exercise, and/or health education. Trained lay leaders may select between three separate 10-week units that focus on exercise-only, exercise and falls prevention, or exercise and nutrition. https://www.ncoa.org/article/evidence-based-program-bingocize	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	Currently, Bingocize is only offered at Staten Island University Hospital. Bingocize class # 1 Exercise and falls prevention at Seview Site C: 5/26/22-7/28/22. 16 participants/13 "completers" (attended at least 16/20 classes) Bingocize class # 2 Exercise and nutrition at Seaview Cite C: 8/30/22-11/29/22. 15 participants/13 completers. Bingocize class # 3 at Exercise and falls prevention JCC-Bernikow: 11/7/22-ongoing	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Chair Yoga:** This program is for older adults who may not have the ability to participate in other exercise-based fall prevention programs. This program is 45 minutes in length and meets once per week. This program is held both virtually and in-person. NOT A EBE PROGRAM	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	total of 58 events held; total of 3207 people in attendance	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Impact Teen Drivers:** This EBE program targets teen driving behaviors, to reduce the rate of risk-taking behaviors while in the car. This program is 1 session and is approximately 1 hour in length. There is no maximum class size, however classes should be no smaller that 15 people. https://www.impactteendrivers.org/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	total of 8 sessions held in 2021. total of 984 people in attendance	Northwell Community Relations Dept., Local schools, community programs-
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Car-Fit:** Offered in conjunction with AAA. This program's design is intended to ensure that older adults are properly fit into their cars to help prevent crashes and injuries if a crash occurs. This is held in community parking lots. Min and Max are flexible depending on the length of the event. https://www.car-fit.org/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	A total of 5 events: 3 held on 1/6/2022; 3/10/2022; 5/12/2022; a total 300 participants	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Multisport helmet initiative w/MAP Peds Clinic:** IFK grant for $500 was used to purchase 30 multisport helmets currently being distributed through the clinic. $1,000 ATS grant received in 1/22, will be used to purchase 62 multisport helmets for the clinic as well. SIUH	Number of events and participants	A total of 3 events: 1/8/2021; 5/12/2022; 6/14/2022 - a total of 319.	Northwell Community Relations Dept., Local schools, community programs, parent groups
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.2: Promote school, child care and worksite environments that increase physical activity	**Think First:** National Injury Prevention Program (K-12)Traumatic brain injuries, like most injuries, can be prevented by making safe decisions. Think First is a program geared to reducing injuries amongst children, teens and young adults. https://www.thinkfirst.org./	Number of attendees each year	4 events held: 2/4; 3/19; 4/30; and 5/3. Total of 742 people in attendance	Northwell Community Relations Dept., Local schools, community programs, parent groups
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Bike and Helmet Safety (K-5):** Cohen Children's Medical Center's bike safety education and helmet fittings help reduce the risk of head injuries by 85%.	Number of attendees each year	1 event held on 1/8. Total of 69 people in attendance	Northwell Community Relations Dept., Local schools, community programs, parent groups

Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Pedestrian Safety (K-4):** Safety Street is an interactive activity where students practice crossing the street with our simulated street model as well as safe pedestrian behavior.	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	14 events held. Total of 2549 people in attendance	Northwell Community Relations Dept., Local schools, community programs-
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Decision Making (Middle school):** Live virtual or in person education for students in Middle School on decision making and how it relates to future outcomes. Decision making process is defined and outlined with examples geared towards being a safe passenger and proper seat belt use.	Number of attendees each year	7 events held. Total of 985 attendees	Northwell Community Relations Dept., Local schools, community programs-
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Child Passenger Safety:** This workshop will provide participants with the basics of proper car seat selection, installation and use. Car seat check events are held monthly at our hospital from March through November	Number of attendees each year	1 event held on 1/5/22. Total of 30 people in attendance	Northwell Community Relations Dept., Local community programs, community physicians, parent groups
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.	**Glen Cove Age Friendly/Walk with The Doc:** The Age-Friendly Glen Cove initiative in the City of Glen Cove, New York, seeks to enhance the lives of people of all ages by developing policies and programs that will make our city more livable. By redesigning our community and prioritizing all eight domains of livability, we will improve access to important information, services and events, a variety of transportation options, and affordable housing opportunities. We will create a community where people can thrive as they grow up and grow older. As a member of the Age Friendly Board, Glen Cove Hospital has provided ongoing educational opportunities to multiple city organizations as well as the schools. One ongoing initiative in particular that has been an important component of the program is the Walk with The Doc program which provides education for members of the community while also providing an opportunity make exercise a part of the program. Every month a new topic is discussed while community members are invited to walk on the esplanade on the water front of Glen Cove. The program ends with a Q & A. As part of our ongoing partnership with the Age Friendly Initiative, Glen Cove Hospital has also developed a community outreach process for our Caregiver Center that provides resources and contacts for anyone in need of advisement.	Number of participants on a monthly basis. Referrals to the Caregiver Center and the number served.	This program has just been approved by Nassau County and the City of Glen Cove to continue for the next two years. As part of the ongoing outreach, our intention is to grow the Walk with The Doc program to reach more communities served by Glen Cove Hospital, including the Life Enrichment Center in Oyster Bay as well as the school districts in the area.	This partnership came to be as a result of our robust relationship with the City of Glen Cove as well as the multiple stake holders that are part of Glen Cove Age Friendly. They consist of the mayor of the city, Glen Cove School superintendent, as well as multiple elected officials for Nassau county.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 2.2: Promote tobacco use cessation	**Tobacco Cessation Program:** The goal of our program is to decrease tobacco use rate among community members and employees of the health system. Although we have been providing free tobacco cessation in-person services for several years, for the last 2 1/2 years we have been providing our coaching and counseling services via phone or telehealth. Patients are provided information about the evidence-based treatment of tobacco dependence, relapse prevention strategies, and methods to address cravings. We conduct follow-up with patients and also offer a weekly virtual support group. Prescriptions for some of the FDA approved cessation medications will be submitted for patients with insurance coverage. If a patient does not have insurance coverage, the program will provide the cessation medications as needed. The program is facilitated by nurses and nurse practitioners.	Number of patients referred to our program through the electronic health record; Number of patients who enroll in the program from the referrals; Number of patients who attend the virtual support group; Amount spent on free medications for those without coverage; Number of virtual or phone encounters the staff has with the patients as follow-up to the initial enrollment.	**January to June 2022:** - Number of patients referred by NHPP- 1,196. - Number of patients who enrolled in the program from the referrals- 468. - Number of patients who attend the virtual support group- 266. - Amount spent on free medications for those without coverage- $39,500. - Number of virtual or phone encounters the staff has with the patients as follow up to the initial enrollment- 4.929.	Northwell Health Physician Partners who make patient referrals through the Ambulatory EHR; Northwell Health Solutions for also making patient referrals to the program; the IT and EHR team for setting up the referral system in the EHR.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 2.1: Prevent initiation of tobacco use	**Tobacco Education Program:** Educate healthcare providers and healthcare students about the evidence-based practice of Treating Tobacco Use and Dependence as well the issues of vaping and method.	The number of healthcare providers and students who were educated about Tobacco Dependence Treatment.	From January-June 2022, 50 Molloy nursing students, 325 medical students at the Zucker School of Medicine, 125 Physician Assistant students, and 50 practitioners with the Baitul Jaamat House of Community were educated about best practice regarding tobacco cessation.	Faculty members at Molloy College and Hofstra University for the nursing, PA and medical students. Also partnered with the Northwell Community Health team to collaborate with the medical director at the Baitul Jaamat House of Community.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 2.2: Promote tobacco use cessation	**Tobacco Cessation Program:** Mather Hospital hosts a Smoking Cessation course run by the Suffolk County Department of Health. The seven week course covers stress management techniques, behavior modification, relaxation, techniques. Cessation medication is provided for a nominal fee. In addition to providing space, Mather promotes the program to the community. Referrals to the program are also made from the hospital's lung cancer screening program.	# of attendees	Course took place July-September 2022. Estimated # of attendees based on past course: 10	Suffolk County Department of Health
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Cancer Service Program:** The Cancer Services Program (CSP) provides no-cost screening for Breast, Colon, and Cervical Cancer for uninsured or underinsured New York State residents. The program covers screenings and diagnostics up to the time of a proven cancer diagnosis funded by the New York State Department of Health. Patient Navigation, case Management and Social Work support are also highly integrated into the program to support and assist patients at all stages of the screening and diagnostic process.	The NYS DOH holds the program to specific standards, or Performance Measures (PM), to measure success of each individual program. Each PM is defined according CDC and USPTF cancer screening guidelines. Each program receives a report on the PM of the program, how that individual program is performing as well as compared to DOH guidelines and other contractors.	Year 1 was completed from October 1, 2018 to September 30th, 2019. During this time, the new contract at Long Island Jewish Medical Center was establishing the program through known and new partnerships. The program began to foster new community relationships and build a network of available screening sites for any all uninsured residents. During Year 2, which began October 1, 2019 the Nassau CSP was well on it's way of meeting and exceeding program standards as far as enrollment, Community Outreach and Strategic partnerships. During year 2, COVID began in March of 2020 and the CSP quickly and easily pivoted to a virtual format for community engagement. During the height of COVID, the CSP remained open and available to screen and assess clients. The CSP of Nassau was only a handful of contractors that remained open during COVID and met and exceeded program deliverables. Year 3 began October 1, 2020 and the CSP of Nassau continued to increase patient enrollment, foster further community contacts and become experts at a virtual forum for community education sessions. Year 4 began on October 1, 2021 as a stable program, again meeting and well exceeding program deliverables. The goal for this upcoming year is to establish more community connections, collaborate with more elected officials and become a site that is strategically sound in order to apply for renewal for the next 5 year cycle.	Community groups which have a mutual goals in assisting as many at-risk individuals as possible. We have established relationships with elected officials, including NY State Senators, Assembly women, Nassau County Legislators, and the Nassau County Department of Health.
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Lung Cancer Screening Program:** Educate patients referred to the tobacco cessation program about the criteria for eligibility in the lung cancer screening program and its role in early detection of lung cancer.	Number of referred patients who met the eligibility requirements for lung cancer screening and were educated about the lung cancer screening program.	From January-June 2022, 902 patients who were referred by physicians for tobacco cessation and met the eligibility requirement for lung cancer screening were provided education about the importance of lung cancer screening as an early detection measure and preventive health check.	Advanced practice providers at Northwell's Lung Cancer Screening Program
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**NowPow, which in September 2021 was acquired by UniteUs: i**s a social referral platform to connect patients who screen positive for social determinants of health with needed resources. NowPow contains listings of approximately 20,000 community-based organizations in Northwell's service area that are available to curate tailored referral lists for patients to self- refer. Northwell currently on a limited basis also has built tracked referral networks, specifically for the Health Home Health and Recovery Plan patients and for the Nutrition Pathways Program.	Number of users, utilization, referrals made.	There are currently nearly 1,500 users of the NowPow referral platform. We are looking to increase this by 10% by the end of the year. We are currently working on evaluating use cases and utilization rates.	Strong partnership with the NowPow client success team has facilitated our success. It is hoped that a similar relationship and related outcome will continue with the transition to UniteUs.
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	**Cancer Service Program:** The Dolan Family Health Center became a NYSDOH Cancer Services Program provider in October 2021. The Cancer Services Program (CSP) provides breast, cervical and colorectal cancer screenings and diagnostic services at NO COST to people who: live in New York State, do not have health insurance, have health insurance with a cost share that may prevent a person from obtaining screening and/or diagnostic services, meet income eligibility requirements and meet age requirements.	Number of patients screened	50 eligible Dolan patients were enrolled in CSP in 2021 for cervical and breast cancer screening.	Suffolk County CSP Program, American Cancer Society, Northwell Rechert Imaging Center

Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Faith Based Screenings:** The Faith based screening initiative was a call to action after the second annual North Shore Summit held at the Fellow Baptist church on Staten Island. Parishioners/Community residents inquired about screenings and health education. The goal is to provide screenings on worship day(s) after services. Thereby, screening and educating the maximum amount of community residents present in the house of worship. On June 26, 2022 the first FBS took place at Mt Sinai United Christian Church, 149 parishioners were in attendance. Blood pressure , lipid profiles and a Cardiology presentation was given. Since then two additional worship houses were also provided with screenings.	To improve health and wellness in faith based organizations the following health measures will be performed; Blood Pressure screenings , Lipid profile, and A1C screening will be conducted at each event. Results will be mailed out with physician referrals. Health education and SIUH clinicians will provide presentations, followed by Q&A sessions. Two houses of worship screening events will be scheduled monthly till December 2022.	June 2022 - 1 event July 2022 - 1 event August 2022 - 1 event	The Faith based Leadership Council as been instrumental in identifying the houses of Worship. Staten Island has houses of worship for every Christian denomination and branch of Judaism, Muslim, Hindu and Buddhist congregations. Our interdepartmental collaboration with the lab department, Clinicians and Physician have made screening and education events successful. Utilizing surveys after events ensures success at the next event. Community Health Department has also partnered with health insurance companies such as Metro Plus to provide information for community residents. We have also partnered with Flexjob where residents can obtain employment opportunities.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Breast Cancer Screening for Underserved Women:** A Pink Aid Grant for Breast Cancer Screening funding was obtained for the 7th cycle in 2021. The Pink Aid Grant funding period is from March to February. The nursing department coordinated Dolan's self-pay patients to receive no-cost breast screening services by offering free screening mammograms and other breast imaging services utilizing Pink Aid funds. Due to challenges with COVID-19, Pink Aid funding was decreased in 2021-2022 from previous years. In order to reach patients for the entire 12 months of the grant cycle, Dolan Administration was able to use over $8,000 to supplement the program from a Temporary Restricted Account (donor support) for Breast Cancer Services. Keeping the program running without interruption was so critical for patients during the final months of the grant cycle. Removing the financial barrier by offering no-cost screening services continued for these self-pay women.	Number of patients screened	Dolan Family Health Center mammograms completed by self-pay patients increased in 2021 which was hopeful following many women postponing this important health screening during the pandemic. 87% of the self-pay women who had mammograms ordered during the 2021 completed this imaging. This reflected an increase in compliance from 79% in 2020.	Pink Aid LI
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Diabetes Tele-Enrichment Program:** Dolan Family health Center's Diabetes Tele-enrichment Program began in May of 2017 by the registered dietician targeting the highest risk diabetic patients. This alternative visit program identifies ten health center patients with HgbA1c levels above 9.0% in need of coaching and support. The RD makes bi-weekly telephone appointments, scheduled phone sessions in which medication adherence, diet, needed services, barriers to self-care are covered. The goal of the program is to simplify access to the RD/Certified Diabetic Educator and expand the patients' nutritional support through the utilization of the organization's existing resources and infrastructure. Once the patient's HgbA1c is below 9.0% they graduate from the program and another patient is added.	Number of patients enrolled	46 patients have graduated successfully from the program and 25 patients have dropped out of the program. At the end of 2021 there were 9 individuals enrolled in the program.	American Diabetes Association
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Health Home:** The Dolan Family Health Center remains the only Northwell Health Home based in a comprehensive primary care setting. This care coordination program is responsible for linking qualified Medicaid patients to supportive services, social services, family supports, specialty appointments, etc. Each member is given careful attention by our care management coordinators and support team to help meet their health care goals. Program goals are to provide coordinated care to reduce avoidable emergency department visits and inpatient stays while connecting members to the community services that are needed for all their medical, behavioral health and social service needs. The social program runs alongside the primary care focus at the health center targeting the most needy and vulnerable of our Medicaid population. Five care management coordinators (including the Health Home Supervisor) enroll and manage qualified Dolan patients in our Pediatric and Adult programs.	Number of patients enrolled	In 2021, the adult program enrollment fluctuated between 212-249 patients and the pediatric program was launched; enrolling a total of 28 patients by years end. Dolan's Health Home is a downstream Care Management Agency of Northwell Health Home. Dolan continues to receive a Tier 1 rating for quality as per Northwell Health Solutions.	Northwell Health Solutions - Health Home
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Conversa for Transitional Care Management:** 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' 9 transitional care programs, which include Medicare, Medicaid, and commercial payer populations. Patients are provided an opportunity to enroll in 6 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. In fall 2021, we also collaborated with the OBGYN and Pediatric Service lines to launch a Pregnancy Chat focused on optimizing health outcomes for pregnant and postpartum women.	Program adoption of technology; Enrollment, patient usage data (i.e. number of meaningful patient interactions); 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 ten diagnosis or procedure specific modules - Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PNA), Chronic Obstructive Pulmonary Disease (COPD), Stroke, Coronary Artery Bypass Graft (CABG), and three which were added in 2021 - Hip and Knee Joint Replacement, Cardiac Valve Repair, and Transcatheter Aortic Valve Replacement (TAVR), with the choice between two languages, English or Spanish. In March of 2020 Northwell worked with Conversa to create a chat for patients who have COVID 19 who are discharged from the Emergency Room or Inpatient discharge. In 2021, a Monoclonal Antibody chat was created and is automatically distributed to patients post infusion. 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 over 21,000 patients on Conversa, doubling the amount of meaningful patient interactions. Since 2021, there has been a 59% increase in total monthly enrollments in 2022 YTD, averaging 1,318 new enrollments every month. Health Solutions is working collaboratively with the OB/GYN and Pediatric Service lines to support chats for patients from inception through the first year of life. The Conversa Pregnancy chat went live in November 2021 and has since enrolled 1,637 moms as of early August 2022 with 766 completing one or more chats.	Specific to our use of Conversa during the COVID-19 Pandemic, the Transitional Care Navigation Team provides 24 hour follow up calls for all COVID-19 patients who receive an outpatient Monoclonal Antibody Infusion. Partnership with Northwell system IT allowed the ability to automate patient follow ups utilizing Conversa Health Chats upon the identification of a documented infusion. Conversa provides complete outreach for patients who respond without worsening symptoms (Conversa green flag) while patients who respond with worsening symptoms (yellow or red flag on Conversa), and patients who do not respond to the chats are provided direct telephonic care from the navigation team. The development of chat automation has resulted in a 18% coverage of manual telephonic calls. Our partnership with the OBGYN and Pediatric Service Lines have been paramount to the successful launch of Conversa Pregnancy chats. The teams have been instrumental in the design of the chat's clinical content as well as creating appropriate escalation pathways.
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Media awareness program:** Use media such as social media, videos, printed materials (letters, brochures, newsletters) & health communications to build public awareness and demand. Focus on low income populations with health disparities.	Northwell Health media tracking: Number of articles; Potential reach Northwell Health Newsroom traffic: Average page views per month Northwell Publications: Circulation Northwell Social: Number of Facebook followers; Number of LinkedIn followers; Number of twitter followers; Number of Instagram followers; Number of YouTube followers	Continued expansion of media awareness programs. Northwell Health media channels that provide health information continue to serve as an important resource to raise community awareness particularly on chronic disease management and prevention. As of 2022, there were 520 pieces of digital content published in the Newsroom — 335% increase since 2021 — with an average of 87,000 pageviews per month and circulation of 880,000. Additionally, Northwell's annual social media stats are as follows: Northwell Social: Number of Facebook followers 93.2 K (3% increase over 2021) Number of LinkedIn followers 153K (325% increase over 2021) Number of twitter followers. 22.4K (7% increase over 2021) Number of Instagram followers 27.8K (10% increase over 2021) Number of YouTube followers 24.9K (8% increase over 2021) [13.3 million views, 565% increase over 2021] Northwell also created the 20 Minute Health Talk podcast: 90 episodes (so far); 92.4K listens/views (we post videos of the podcasts as well), a 25% increase since 2021.	Efforts for Northwell media campaigns and tracking efforts are internal to the organization.
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Northwell Health HR Employee Wellness: Prevent Chronic Diseases** The Northwell Health HR Employee Wellness campaigns have experienced strong engagement across its 80,000+ workforce. A few annual statistics to highlight our engagement: - Health Risk Assessment Completions: 26,628 - Employee Wellness Program Engagement: 50,343 enrolled on Virgin Pulse - Fresh Produce Access: 70% vending machines meets healthy choice criteria system-wide - Healthy Choice Commitment Statement to reinforce policy and environment changes - Healthy choice cook-along - 55 delivered - Healthy choice videos - 37 available to view - 27 Healthy choice assessments of site cafeterias - Employee Wellness YouTube channel over 40k views	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) - Health Risk Assessment Completions: 26,628 - Employee Wellness Program Engagement: 50,343 enrolled on Virgin Pulse - Fresh Produce Access: 70% vending machines meets healthy choice criteria system-wide - Healthy Choice Commitment Statement to reinforce policy and environment changes - Healthy choice cook-along - 55 delivered - Healthy choice videos - 37 available to view - 27 Healthy choice assessments of site cafeterias - Employee Wellness YouTube channel over 40k views	Virgin Pulse, as well as Northwell Benefits, Northwell Caregiver Fund, Northwell Foundations, and the Northwell Office of Patient & Customer Experience.

Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Health Solutions/ Health Home Program:** The CPMA's (previously known as the Community Health Workers) role transitioned to a completely remote workforce protocol since April 2020 due to COVID, where the establishment of trust and professionalism are maintained. We have also seen a year-over-year increase in the productivity of services. We are able to track the services provided by the CMPAs and measure their outcome. CMPAs have proven to be an asset to the organization, have become fully engaged, and are an integral part of the health care delivery model for Health Home members. Health Home is a Medicaid program for patients with 2 or more chronic medical conditions susceptible to poor outcomes. A ´Health Home´ is not a physical place; it is a group of health care and service providers working together to make sure members get the care and services they need to stay healthy. Once enrolled in a Health Home, each member will have a care manager that works with him/her to develop a care plan. A care plan maps out the services needed, to put the member on the road to better health. Some of the services may include: • Connecting to health care providers, • Connecting to mental health and substance abuse providers, • Connecting to needed medications, • Help with housing, • Social services (such as food, benefits, and transportation) or, • Other community programs that can support and assist members. In addition, CMPAs are also engaged in activities specific to relieving the SDOH burden such as: - Connecting members to services post-ED visits as part of the Care Transitions process - Accompanying members home post discharge from mental health admission as part of the ZHH Rapid Transition program - Assisting members in maintaining/reestablishing Medicaid active status	Per 6,000 HH members we have 13 CMPAs, With an increase of 500 members an additional CMPA will be hired.	Number of Medicaid members recertified - 386 Successful graduation out of the Health Home program: 3,225	I-Learn, Partner with ZHH discharge planning team to broadening scope of practice as part of the Behavioral Health Rapid Transition, MCTAC & CTAC, Supervised stretch Assignments,
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	**Community Education- Diabetes Management**: Addresses Prevent Chronic Diseases, Preventive Care and Management by educating community members on managing diabetes and prediabetes including information on the Diabetes Prevention Program and how to access.	# participants, # webinar views, program evaluations	4/5/22 webinar was attended by 18 people and has had 248 views as of 9/8/22.	Internal Clinicians
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	**Community Education- Diabetes Management:** A webinar providing community members with education on the prevention of diabetes and pre-diabetes was held. Presented as part of Mather's HealthyU series of free community health education events, the webinar was recorded and is also available for viewing online. Objectives for the webinar included understanding the risk factors for diabetes, understanding the A1C level and what it means in terms of risk for diabetes, ability to list 2 lifestyle changes that will decrease the risk for diabetes, and ability to read a nutritional label and understand the carbohydrate content of different foods. Information about the Diabetes Prevention Program was presented.	# participants, # webinar views, program evaluations	4/5/22 webinar was attended by 18 people and has had 248 views as of 9/8/22.	RN, Diabetes Nurse Educator.
Prevent Chronic Diseases	Focus Area 4: Preventative 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	**Community Education- Nutrition:** A series of webinars provided community members with education on healthy eating as well as physical activity. As part of Mather's HealthyU series of free community health education events, three healthy eating webinars were held in 2022. The webinars were recorded and are also available for viewing online. Dietitians presented evidence-based information using three themes: nutrition for achieving fitness goals, nutrition strategies for healthy weight management during menopause, and making peace with food. Nutrition for fitness goals addressed metabolism, body composition and nutrients/micronutrients. The weight management in menopause webinar explained the pathophysiology of menopause, explored the connection between menopause and weight gain, and discussed life-style changes that promote healthy outcomes using the principles of the Mediterranean diet. AHA recommendations for physical activity and other evidence-based information and resources were provided. The making peace with food webinar covered the hunger scale and the ten principles of intuitive eating.	# of webinars, # attendees, # of webinar views	1/18/22 Achieving fitness goals with proper nutrition 2/8/22 Is menopause weighing on you? Nutrition and lifestyle strategies for healthy weight management during this lifecycle phase 4/12/22 Making peace with food Attendees (respectively): 46 + 22 + 32= 100 total in 2022 to date. Webinar views: 155 + 133 + through 9/8/22.	Registered Dietitians.
Prevent Chronic Diseases	Focus Area 4: Preventative 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	**Community Education- Nutrition and Physical Activity:** A Weight Loss Matters Blog educates the community on healthy eating and physical activity. Articles written by dietitians or other clinicians are posted weekly on the blog, with occasional healthy recipes. Topics in 2022 have included exercise and physical activity with breast cancer, healthy lunchbox snacks, benefits of outdoor fitness, loss of control eating, exercise and brain health. https://www.matherhospital.org/our-blogs/weight-loss-matters/	# of posts, click analysis	30 posts in 2022 through 9/8/22 2,589 readers in 2021	Registered Dietitian contributors
Prevent Chronic Diseases	Focus Area 4: Preventative 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	**Peer Teen Health Symposium:** began as the Peer HIV/AIDS Education and Prevention pilot program in 1994. It was designed to address the widespread HIV/AIDS epidemic. Under the vision and leadership of Caroland Dr. Mark Kaplan, the Peer Education Program expanded over the years to provide training for thousands of teens. The program has focused on the knowledge and skills needed to develop effective peer programs throughout the metropolitan area. Today, we are proud to forge ahead with a new generation of leaders learning to manage interpersonal relationships, healthy sexual behaviors, and leadership dynamics. The evolution of the Peer Teen Health Leadership program in collaboration with the Cohen Children’s Medical Center at Northwell Health continues to be at the forefront of our ever changing world .	Number of students	By the end of 2021, there was a total of 200 students reached	partnerships with dedicated school districts.
Prevent Chronic Diseases	Focus Area 4: Preventative 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	**Commerce Plaza:** is an immersive field trip experience for 5th grade students across Long Island. Bringing in 7,500 students each year, this is a culminating experience of an intensive business and finance curriculum students have engaged in for 10 weeks prior to attending. Cohen Children’s Medical Center is proud to host a business station within Commerce Plaza, “employing” a Doctor, Nurse, Office Manager, X-Ray Technician, and Medical Biller. Students who rotate through this station learn more than just business and finance skills, but are introduced to handwashing, sun safety, smoking cessation, bullying, and nutrition topics as well.	Number of events completed	By the end of 2021, there was a total of 2,500 students reached.	Commerce Plaza, Yes Community Counseling
Prevent Chronic Diseases	Focus Area 4: Preventative 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	**Social Work Services:** As the largest and most diverse health care provider in the state of New York, we are redefining the way we view, treat, and serve those who have served. We are using our size and reach to do more than any other private organization, to stand side by side with our Veterans and their families, because we know that it’s the right thing to do. We are delivering on our mission — to understand the unique needs of every individual in our communities, to see them fully and to break down the barriers that keep them from exceptional care. We know that our commitment will continue to dramatically improve the lives of Veterans and their families, long after they return from service. The Military Liaison Services Department is organized into three Foundational Pillars, with our Care Coordination team and social work services falling within "Exceptional Care." Within this pillar, we are broadly preparing to expand how we care for Veterans and driving volume back to the service lines. Through a proactive approach to care coordination, licensed social workers connect to service members, Veterans, and their families and offer additional supports post-discharge. The goal is to not only generate an additional 3,000 appointments back into the service lines but reduce the no-show rate across the ambulatory sites.	List App data and Avaya call logs will be reviewed to ensure Care Coordinators are placing the estimated number of phone calls to ensure 30 unique Veteran contacts are achieved weekly. An estimated 100 phone calls placed will result in a 30% conversion rate.	Projected Conversion Rate (Unique Touches) 30% of 4,800 = 1,440 /Per Care Coordinator (2 Care Coordinators). Additionally, filtered List App data to capture unique Veteran touches achieved via outreach and community events. Care Coordinators review Clinical Viewer feature for HIE Veteran Patient Information prior to placing the call. When connection is made, Care Coordinators will build rapport with the Veteran to introduce the Military Liaison Services Department and outline services provided. Care Coordinators will conduct a needs assessment to better understand the needs, wants, and desires of the Veteran patient and/or family members. Care Coordinators create referrals for appointments and/or connect Veteran to Community Based Organizations to address any additional needs identified during the needs assessment. Care Coordinators will discuss the next steps and will send email to Veteran patient or family member detailing Military Liaison Services and any additional resources provided. Care Coordinators will continue to follow-up with the Veteran patient to ensure needs are met and offer additional support.	External partnerships with Northport VAMC, MWR Ft. Hamilton, New York City Department of Veteran Services in addition to internal partnerships with Unified Behavioral Health Center, South Shore University Hospital, North Sore University Hospital, LIJ, Huntington Hospital, Community Engagement, and Patient Access Services.

Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Health Education & Outreach Program**: Various events throughout the year include: -Cancer Survivorship Webinar Series: monthly web series for cancer survivors, caregivers or anyone affected by cancer. Each month is a new topic lead by an expert. July= Nutrition, September: Lymphedema -Building Bridges to the Community: A monthly heart health lecture series with a different topic each month lead by an expert -Life Saving Event - The LHH Emergency Department physicians will host an event in the fall with a local school for students and parents. They will give instruction on hands only CPR, "stop the bleed" training, Narcan training, AED demonstration, etc.	Number of events completed	•Cancer Survivorship Webinar series: Total of 8 attendees; total of 4 events held in 2022 • Building Bridges: Total of 96 attendees and 7 events held in 2022 • Life Saving Event is still in the works • Men's Health Seminar & Girl Scouts event has not occurred yet	Internal clinicians
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity**	**Promote Healthy Environment for our Community Members:** This program encompasses various events throughout the year - 3rd Avenue Street fair 9/10/22: We will offer blood pressure screenings & counseling, flu shots and vision screenings - Free Flu shot event at Esplanade Garden in Harlem - Blood Drives in Partnership with the NY Blood Center x2 in 2022	Number of events completed	• 3rd Avenue Street Fair: We gave away 1,000 free bike helmets, hosted hundreds of kid's ambulance tours (gave away 600 jr. paramedic hats), performed 373 blood pressure screenings, 248 vision screenings, distributed 226 flu vaccines (167 regular and 59 high dose), demonstrated countless rounds of hands-only CPR, answered all kinds of health-related questions • Flu Shots at Esplanade Garden: 43 (34 high dose, 9 Regular dose) • Flu Shots at LHH: 63 (36 high dose, 27 regular dose) • Blood pressure screening at AM Seawright's Event: 25 screened • Breast Cancer Screenings: I am still waiting on the numbers	• 3rd Avenue Street Fair: Internal partners= EMS, Nursing, ACPs, Emergency Department, Department of Orthopedics, NHPP Heart & Lung, Pulmonary & Sleep Medicine, Katz Institute for Women's Health, Lenox Hill House Calls, 85th Street Practice, MEETH, Northwell Health at Home, Talent Acquisition, Pharmacy • Flu shots at LHH: Internal Partners: LHH Pharmacy team. Cohosted with local elected: Manhattan Borough President Mark Levine, City Council Member Julie Menin, Senator Liz Krueger, Congress woman Carolyn Maloney, City Council Member Keith Powers, Assembly member Dan Quart, Assembly member Rebecca Seawright • Breast Cancer Screening – partnered with Northwell Cancer Institute
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Community Education- Preventive Care:** A blog educates community members on screenings for cancer, congestive heart failure management and other chronic disease preventive care and management subjects. Typically posts are made twice/month. A recent post was What you need to know about lung cancer screening. https://www.matherhospital.org/our-blogs/wellness-at-mather-blog/	# of chronic disease prevention/management posts, # clicks	In 2022 to date, posts included Lung Cancer Screening, Congestive Heart Failure, and Radiation Cystitis for Cancer Survivors	Internal
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Community Education- Screening for Cancers:** Community members were provided with education on screening for breast cancer, lung cancer and colorectal cancer. A webinar for each type of cancer screening was presented as part of Mather's HealthyU series of free community health education events. Webinars are recorded and are also available for viewing online. The colorectal cancer screening webinar, presented by a gastroenterologist and associate professor, Zucker School of Medicine, provided an overview of colorectal cancer, early detection/prognosis, risk factors, symptoms, stages, colonoscopy with polypectomy, polyps, screening methods, colonoscopy prep and procedure, U.S. MSTF recommendations. The lung cancer screening webinar, presented by Mather's chief of pulmonary medicine, covered impact on community, survivorship by type and stage, low dose CT scanning, national lung screening trial, screening programs and referral resource. The breast cancer screening webinar focused on COVID's impact and was presented by the medical director of Mather's breast center. It covered the impact of delayed screening, COVID vaccine myths, and risk of COVID exposure/ACR recommended precautions.	# of webinars# of attendees, # of webinar views, program evaluations	1/25/22- What you should know about colorectal cancer screening: 34 attendees, 27 webinar views as of 9/9/22 5/10/22- Should you be screened for lung cancer? 22 attendees, 121 webinar views as of 9/9/22 5/17/22- The impact of COVID-19 on breast cancer screening 13 attendees	Colorectal cancer screening webinar had grant support from the American Cancer Society. Lung cancer screening webinar had grant support from the NYS DOH Community Cancer Prevention initiative. Physicians presented.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Skin cancer screenings:** Free skin cancer screenings are provided to community members. Offered onsite and in the community via a mobile unit, a dermatologist provides registrants with skin cancer screenings. This program complements Mather's provision of free sun screen to community members visiting parks, beaches and other outdoor destinations during the summer months, for prevention and early detection of skin cancer.	# of events, # of participants	4/13/22 Port Jefferson Chamber of Commerce Health & Wellness Fest- Skin Cancer Screenings- 20 participants	Northwell mobile unit, clinicians provided the resources for screening and Port Jefferson Chamber of Commerce the venue, helping to reach community members attending the health fair.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity**	**Blood Pressure Screenings:** Community members are provided with blood pressure screenings at community events, during Go Red! Heart month, and at a library. The screenings help to identify individuals with high blood pressure for whom follow up is needed.	# of times screening offered, # people screened	2/16/22 Mather Hospital Go Red! Heart Month screening: 20 people screened 4/23/22 Port Jefferson Chamber of Commerce Health & Wellness Fest: 50 people screened 5/22/22 Northwell Health Walk at Port Jefferson: 25 people screened 4 more screenings anticipated at Longwood Public Library (monthly screenings beginning 9/29/22), for an estimated 200 people screened in 2022.	Go Red! Heart month is promoted by the American Heart Association. The health fair was held by the Port Jefferson Chamber of Commerce. Longwood Public Library has requested we provide monthly screenings.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Breast Cancer Screening Awareness- Paint Port Pink:** Through Paint Port Pink, Mather provides a month of community awareness activities and education events promoting the importance of breast cancer screening. Held in October, Paint Port Pink brings the community together in the fight against breast cancer by spreading awareness, encouraging annual screenings, and providing information/ education.	# events, # participants, # community partners, # website visits	Paint Port Pink takes place in October. In 2021, 168 community partners joined Mather Hospital in promoting breast cancer screening awareness to the community through pink lights, banners, store/restaurant promotions, etc. A webinar provides community members with education on breast cancer (27 people attended webinars promoted through Paint Port Pink in 2021). In 2022, an in-person event will be held that provides community members with education on healthy eating to prevent cancer (American Cancer Society guidelines) and how to perform breast self-exam/other relevant health topics. We estimate 50 community members will receive preventive education. In addition, the Paint Port Pink website provides community members with information on screening including how to access screening if you are uninsured.	Paint Port Pink engages the Village, non-profits and businesses in the Port Jefferson area in promoting awareness of the importance of breast cancer screening. In 2021, Paint Port Pink had 168 community partners. In addition, community members participate in raising awareness through activities such as a Pink your Pumpkin contest utilizing social media.
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Community Education- Heart health:** Community members were educated on heart health through three webinars: Heart care that can save your life, Reduce stress and save your heart, and Are you walking around with a blood clot in your leg? Presented as part of Mather's HealthyU series of free community health education events, the webinars were recorded and are also available for viewing online. Objectives for the reduce stress webinar included Explore current scientific evidence for the relationship between stress and cardiovascular disease, Explore the impact of stress on cardiac health, Discuss actionable strategies to mitigate stress, Discuss actionable strategies to enhance heart health. The COVID pandemic's impact on increased stress and stress cardiomyopathy was discussed. For the blood clot webinar, content included signs and symptoms of DVT, causes and risk factors, DVT anatomy, treatment.	# webinars, # attendees, program evaluations	2/1/22 Heart Care that can Save your Life: 57 attendees 2/15/22 Reduce Stress and Save your Heart: 46 attendees 6/21/22 Are you walking around with a blood clot in your leg?: 16 attendees	Clinician presenters. Some webinars held during Go Red! month
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Breast Cancer Screening Navigation:** Mather's Breast Cancer Screening Navigation program assists women who are overdue for a mammogram or who never had a mammogram to obtain recommended screening. A patient navigator helps women, including underserved women, to overcome barriers to screening such as language, lack of insurance, or lack of a provider. Through this assistance, breast cancer can be detected earlier when it is more treatable. The program, which collaborates with community partners to addresses disparities, has grant funding from DOH that ends in September 2022; Mather Hospital is working to continue and evolve the program to include navigation for screenings to other cancers such as colorectal and lung.	# women contacted, # women provided navigation, # screenings completed, # positive findings	In 2021, the screening navigator contacted 671 women and provided navigation services for 240 women. 211 screenings were completed and there were 6 positive findings. 2022 data to be completed.	Mather Hospital partners with Elsie Owens Health Center, Nightingale Preventive Care, and the Suffolk County Cancer Services Program to engage underserved women in screening.

Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Cancer Service Program:** Mather Hospital helps to increase access to breast and colorectal cancer screening for underserved community members via participation in the Suffolk County Cancer Services Program. In addition, Mather has a Fund for Uninsured/Underinsured for Breast Center patients for services not eligible for CSP.	# CSP breast cancer screenings at Mather # CSP colorectal cancer screenings at Mather # Women assisted by Fund for Uninsured	9 CSP breast cancer screenings in 2021 (data for 2022 not yet available) 5 CSP colorectal cancer screenings in 2021 (data for 2022 not yet available) 17 women assisted by Fund for Uninsured in 2021 (data for 2022 not yet available)	Suffolk County Cancer Services Program, run out of Peconic Bay Medical Center. Mather also coordinates with its physician practice, Harbor View, to provide colorectal cancer screenings.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Cancer Service Program:** When it comes to cancer, early detection saves lives. At Peconic Bay Medical Center, our Suffolk County Cancer Services Program is regionally acclaimed for its proactive approach to patient care. We are here for you through every step of the process, from initial screening through creating an individualized, state-of-the-art cancer treatment plan.	Screenings facilitated, Financial support provided, Community education events.	2020-21 statistics: 2,914 Screenings facilitated to uninsured men and women. $18,000 in financial support provided to 55 people. Community education events across Suffolk County to more than 1,000 people.	NYS Department of Health.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity**	**Blood Pressure Screenings:** Provide blood pressure screenings in the community to over 15 community partners. For those individuals who are identified as at-risk or high-risk for hypertension we connect them to a telephonic nurse for follow-up lifestyle counseling.	Number of screenings	BP screenings in 2021: total of 423 BP screenings at 31 events	We provide on-site health screenings in our community at the following primary locations: Neighbor's Link, Interfaith Food Pantry, Community Center Northern Westchester
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Sunscreen Dispensers:** Plainview, Syosset, 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.	Number of sites; Number of dispensers; Number of participants; Number of screenings; Number of positive screenings; Number of referrals	Plainview & Syosset Hospitals participated in sponsoring 16 free SPF 30 Sunscreen dispensers across the Town of Oyster Bay's pools, beaches and golf courses.	Town of Oyster Bay (city government)
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity**	**The Diabetes Club:** provides current information and support to the community members living with Diabetes. Topics vary according to participants needs.	Number of participants enrolled	2021: Program was put on hold due to COVID. 2022: Number of participants enrolled; 7	SSUH Pharmacy provides educational lectures on antidiabetic medication.
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Stop the Bleed:** an initiative of the American College of Surgeons, was launched in October 2015 by the White House. It's a national awareness campaign and a call to action intended to educate, train and empower civilian bystanders with the necessary skills and tools to help in a bleeding emergency before professional help arrives. When a response is delayed, massive bleeding from any cause can result in death. Similar to how the general public learns and performs CPR, the public must learn proper bleeding control techniques, including how to use their hands, dressings and tourniquets	Number of participants enrolled	2021-90 participants 2022- 100 participants	American College of Surgeons
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Stepping On:** More than one out of four adults aged 65 or older falls each year, leading to both fatal and non-fatal injuries, and threatening safety and independence. Stepping On is an evidence-based community prevention program that empowers independent, older adults to carry out health behaviors that reduce the risks of falls. In a small group setting, older adults learn balance and strength exercises and develop specific knowledge and skills to prevent falls. Workshops are facilitated by trained leaders.	Number of participants	Postponed due to COVID - goal to restart in late 2022	Internal partners
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Town of Babylon & Islip Sunscreen Program** – SSUH Sunscreen Program is an innovative way to provide preventive measures in the community for Skin Cancer. A total of more than 50 sunscreen dispensaries have been installed at Islip and Babylon Town parks and beaches thanks to a partnership with the Town of Islip & Babylon. The free SPF 30 broad spectrum sunscreen was stocked for all Long Islanders to use throughout the summer.	Number of people attended	2021 & 2022 May through September	Town of Babylon & Islip Creative Concepts
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Community Outreach and Health Education Council :** The Community Outreach and Health Education Council was established in 2015. Its mission is to strengthen partnerships to promote access to the highest quality healthcare, health literacy and wellness to improve the quality of life in all the communities SSUH serves.	Number of events completed	Postponed due to covid 3/2020 Goal to restart: 2022 Q4	Local Faith- Based Organizations and non-profits sit on this committee.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Clinics on Fire Island:** Northwell Health immediate care centers are located in Ocean Beach, Cherry Grove and Saltaire on Fire Island. The facilities are open seven days a week from Memorial Day through Labor Day. The immediate care centers are staffed by a physician, physician's assistant or nurse practitioner. People can receive medical care for non-life threatening illnesses and injuries; for those who might need a higher level of medical care, they can call the emergency numbers and will be taken to South Shore University Hospital. After the summer season, the sites are utilized to provide free flu vaccines to Fire Island residents.	Number of patients visited	Events held: 7/22/2021, 7/23/2021, 7/24/2021, 7/15/2021, 7/16/2021, 7/26/2021, 7/23/2021, 7/24/2021 Total of 599 patients seen in 2021	Internal clinicians
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Blood Pressure Screenings:** SSUH partners with local Faith Based Organizations to provide Blood Pressure Screenings on the Northwell Bus.	Number of patients seen	2021 & 2022 over 100 participants	Internal clinicians
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Skin Cancer Screening:** South Shore University Hospital partners with the local Faith Based Organizations to provide Skin Cancer screening on the Northwell Bus.	Number of referrals and visits	Skin Cancer screenings are offered yearly. 3 events. 72 participants, 6 referred	We partner with local Faith- Based organizations
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Stop The Bleed:** American College of Surgeons (ACS) Bleeding Control Program. This national awareness campaign and call to action educates, trains and empowers civilian bystanders with the necessary skills and tools to help in a bleeding emergency before professional help arrives. https://www.stopthebleed.org/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	303 attendees for 2021 across 5 events (1/20, 6/8, 7/30, 8/26, 10/26)	Northwell Community Relations Dept., Local schools, community programs

Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Stepping On:** Meets for 2 hours for 7 weeks with a 3 month follow up. The program is a multifaceted program that is intended for older adults or those who have a risk of falling. Topics covered include strength, balance, vision, medication, footwear, and community safety. Guest experts including PTs, pharmacists and vision experts attend various classes throughout the program. This program can be both virtual and in-person. Attendance is 10-15. http://www.steppingon.com/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	35 attendees for 2021	Northwell Community Relations Dept. Local libraries and community centers
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Ask the Experts on Covid:** during the years of covid crisis we would do every other month zoom sessions with medical director for community to hear updates on COVID and to ask any questions.	number of sessions	had about 10 sessions and 15 community persons for each sessions	Internal
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**ER101:** We work with community organizations to speak to their members about when should person call an ambulance and how to prepare in case they ever have to go to Emergency Room	number of sessions	Held about 10 sessions	Worked with organization on presentation with Say Ah! They helped translate medical information into communication that can be understood by non-medical people.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Flu Vaccines:** Every year we provide our community with free regular dose and high-dose flu vaccines and specifically target communities with historically lower access to healthcare.	Number of vaccines	In 2021, we provided 800 free flu shots. For 2022, we are on target to do the same (as of 10/12 we have over 600 shots given).	We provide free flu shots at the following community-based organizations: A-Home, Antioch Baptist, Bedford Hills Seniors, Fox Senior Center, Heritage Hills, Interfaith Food Pantry, Lewisboro Seniors, Lexington Center for Recovery, Mt. KIsco Childcare Center, Neighbor's Link, New Castle Seniors, North Salem Seniors, Oak Lane Childcare, Pinecrest Manor, Septemberfest, Yorktown Festival and Street fair, Bedford Tri-Town Health and Wellness Fest
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Go Red Event - What Can I Do Now to Make a Healthier Heart?:** Cardiologist of Valley Stream will present this topic to the Valley Stream Chamber of Commerce at their General Membership Meeting at Pomodorino Rosso. **One off event.**	Number of attendees	25 people were educated on Healthier Heart	Cardiology Dept
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Hempstead Police Department and Fidelis Healthcare Bridging the Gap Unity Community Day:** Partnership between Hempstead Police dept and Fidelis in bridging the gap in the community**. One off event.**	Number of attendees	250 people were interacted with	Hempstead Police Department, Fidelis Health Care
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Indian Nursing Association of New York Health Fair:** Health Fair for the community surrounding Kennedy Park in Hempstead. **One off event.**	Number of people in attendance	This was a health Fair, we interacted with a total of 560 people during this event	LIJ Valley Stream, Cancer, Community and Population Health, Nutrition, Organ Donation, Trauma Institute
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**James A Dever Elementary School Health, Safety and Wellness Fair:** Health Fair concentrating on Dietician and Pharmacy Speakers from LIJVS**. One off event**	Number of attendees	A total of 150 students attended the event	LIJ Valley Stream Nutrition, Pharmacy & Pediatrics
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Arts Below Sunrise - S.T.E.A.M. Festival with Glucose Screening:** Multi Service line event at the Hewlett-Woodmere Community Health Fair and Festival. We will be performing glucose screenings, BMI/BP and Diabetes Education**. One off event**	Number of attendees	150 total people attended the Festival, out of those 150 people served, 35 were screened, the other 115 visited the other informational tables available on site	LIJ VS Diabetes, Nutrition, Orthopedics, Organ Donation & Cancer
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Hope Day Community Fair:** Health Fair consisting of Blood Pressure Screening from Northwell. **One off event**	Number of screenings	350 total of people attended the fair, out of those 350 people, 49 people were BP screened	LIJ Valley Stream Nursing Staff
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Belmont Backstretch Health Fair and Glucose Screening: H**ealth Fair for the Backstretch workers at Belmont Race track includes glucose screening, BP screening, BMI screening along with education provided by an Advanced Care Practitioner. **One off event**	Number of screenings	Total Screenings Performed 21 (Out of 21 screenings 19 did Glucose ; 21 did Height and Weight; 21 did Waist Circumference; 21 did Blood Pressure	B.E.S.T. - Belmont Employee Service Team

Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**The Manna Project:** The First Annual Community Health Fair and Glucose Screening - Inwood. Serving under privilege community members**. One off event**	Number of screenings	250 people attended this event. 27 people were screened for BP & BMI. The rest of the people who attended visited the other tables (Cancer, General Facility Services, Orthopedics, Wound Care)	Northwell Health Community Relations
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.1 Increase cancer screening rates**	**Senator Brooks Skin Cancer Screening/ Health Fair & Glucose Screenings at Jones Beach:** Skin cancer screening by a Northwell Dermatologist on location at Jones Beach Field 6. No appointments needed. LIJVS and Senator Brooks planned this health fair/glucose/BMI and BP screening event for the community at Jones Beach. This will include the mammography mobile unit, and multiple service lines from LIJVS. **2 events held**	Number of screenings	2 different events: Jones Beach Skin cancer screened 25 people. Glucose, BP & BMI Health Fair at Jones beach screened 55 people	LIJ Valley Stream Dermatology, Cancer, Cardiac, Community and Population Health, Orthopedics, Organ Donation
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Senator Brooks Merrick Flu Shot event:** Free flu shot event offered at the Merrick Library**. One off event**	Number of shots distributed	1 day event. 48 people received flu shots (40 RDLIJVS /8 HD CORPH)	Senator Brooks Office, LIJ VS Nursing, Ortho, Cancer services, LiveOnNY
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Senator ThomasHealth Fair:** Health Fair conducting blood pressure and body mass index screenings. **One off event.**	Number of screenings	1 event for underserved community. 61 people were screened	LIJVS & Senator Thomas' office
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and**	At the Hong Kong Dragon Boat Festival, our team of clinicians and non-clinicians, were able to talk to the community about LIJFH's general hospital services, New Life Center, and Bariatrics program. We had a BMI interactive tool where participants were able to calculate their BMI through height, weight, and waist circumference. **One off event**	Estimated number of attendees	Media exposure for various alcohol & drug misuse campaigns.	Hyper-local community stakeholder relationships helped ensure that LIJFH was able to be a partner in the community.
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	At the 112th Precinct National Night Out campaign, LIJFH team members had the opportunity to liaise with community members on the hospital's services. BMI collection tools were available and interacted with community members. **One off event**	Estimated number of attendees	Seminars & webinars related to mental health & substance use/misuse. Arts below Sunrise Community Fair, Police National Night Out	Stakeholder relationship with the 112th NYPD Precinct
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	LIJFH invited Northwell's newly squired Queens Medical Associates (QMA) to speak to the community at the Jamaica Muslim Center about LIJFH's Bariatrics program, halal-friendly healthy eating and weight management, and QMA's language-accessible services. BMI collection was present. **One off event**	Estimated number of attendees	Estimated number of attendees is 200	Local stakeholder relationship and QMA participation.
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	LIVFH staff visited the Forest Hills American Legion Post 1424 to speak to veterans and friends of the Legion about LIJFH and our commitment to serving the medical needs of veterans and those in our catchment area. **One off event**	Estimated number of attendees	Estimated number of attendees is 40	Veterans' outreach
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	LIJFH team members visited the Hillcrest Senior Center and discussed senior volunteer opportunities at LIJFH, LIJFH's stroke support group and resources on stroke, as well as healthy eating. **One off event**	Estimated number of attendees	Estimated number of attendees is 75	Local stakeholder relationship
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	LIJFH team member facilitated a talk on COPD with seniors at the Selfhelp Virtual Senior Center with LIJFH's Director of Respiratory Care, Romy Cayard-Belance. **One off event**	Estimated number of attendees	Estimated number of attendees is 30	Local stakeholder relationship
Prevent Chronic Diseases	**Focus Area 4: Preventative care and management**	**Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**	**Monthly Blood Pressure Screenings at Glen Cove Senior Center:** Glen Cove Family Medicine residents provide screenings for members of the Glen Cove Senior Center one Friday per month. The Senior Center is one of the most well attended centers in Nassau county, with over 2000 members who utilize their services. The residents provide screenings but also serve as a preventive form of medicine for any number of the individuals that they see. By developing trusting relationships with the members of the center, residents are able to provide preventive measures for the seniors.	Monthly blood pressure readings Number of individuals seen	This program will continue through 2023 and will be growing as part of the ENHANCE program which provides residents with an opportunity to work with the seniors to identify a project that they believe with help to enhance their health and quality of life. This year through June 2023, residents will spend an additional half day of every month with seniors in order to help educate them about telehealth, how to use telehealth and how to include their adult children in the process.	Our partners in these endeavors have been the City of Glen Cove, the Family Medicine Service line and the Glen Cove Senior Center's Foundation – SAGE.
Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**The "COVID-19 Conversations Within the Black and Brown Community"** are a free, virtual lecture series hosted two times a month by Northwell team members Dr. Alyson Myers, endocrinologist at North Shore University Hospital & Myia Williams, Post Doctorate Research Associate at Feinstein, who run a healthcare advocacy group, Minority Health. These lectures are open to the general community and hosted on their Zoom account to discuss health-care related topics around COVID-19 and its implications on the Black & Brown community.	Number of participants	This series ran from November of 2020 through December of 2021. Total participants for the 24 sessions: 4,759 Average session attendance ~200	Internal

Prevent Chronic Diseases	**Focus Area 4: Preventative 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**	**Covid-19 Vaccines for Adults and Children** - In December 2021 and January 2022 North Shore University Hospital partnered with Community Relations to provide Covid-19 vaccines along with covid testing and flu shots for community members in Manorhaven, Port Washington. We were contacted by the local Councilwoman Mariann Dalimonte who shared that limited English proficiency and lack of access to transportation was preventing many of her constituents from obtaining covid vaccines for themselves and their families. We hosted vaccine pods starting in December 2021 at Manorhaven Beach Park to provide free vaccines, testing and flu shots for the community. These events continued into January 2022. Nearly 300 people were vaccinated at these pods.	Number of participants	Vaccine pods started in December 2021 at Manorhaven Beach Park to provide free vaccines, testing and flu shots for the community. These events continued into January 2022. Nearly 300 people were vaccinated at these pods.	Internal
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**	**Stress First Aid:** Mather Hospital is partnering with the Northwell Institute for Nursing and the Center for Traumatic Stress Resilience & Recovery to implement Stress First Aide, a peer support and self-care framework for managing stress. A Mather team is training all staff on SFA and otherwise supporting implementation. Employees learn to identify where they or their coworkers are on the stress continuum model, skills for intervening, and resources to draw on. Earlier identification and intervention is expected to prevent or reduce the burden of mental illness among health care workers.	# of employees trained, survey results, resources tapped	In 2022/2023, all employees will be trained in SFA either through in-person or remote sessions.	Mather's Behavioral Health department is leading the implementation of SFA at Mather with the support of Northwell's CTSRR & Institute for Nursing.
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**	**Life After Service, Veteran Hiring:** Military Liaison Services' takes a holistic approach to assist Veterans, Service Members, and their family members. We are committed to assisting veterans, service members and their spouses in gaining employment with Northwell by having one-on-one "Career Planning Sessions." In these sessions, we speak about their goals, review their resume, and explore Northwell's open positions. We are also able to make referrals to our Care Coordination team who will assist the Veteran with medical appointments, and connecting them to Community Based Organizations based on their needs. Our priority and focus is to create opportunities for veterans, service members and spouses by having virtual Career Planning Sessions, to best understand their wants, goals and needs. We then review resumes and make any recommendations that we see, as well as teach the candidate to tailor their resumes to the job they are wanting. We discuss open positions that best fit their wants and qualifications. We then look into those roles to check on availability and then refer the candidate to those roles. Subsequently, we follow up with the recruiters and hiring managers to advocate on behalf of the veteran and answer any questions they may have. Finally, we work with the candidate on interview skills and techniques. All this time we are continually working on expectation management and maintaining the best customer service we can. This process of applying and gaining attention can take time and can be discouraging. We are there to support and manage emotions. We realize that not every veteran, service member and spouse will get hired, but they can become patients and we can always present Northwell in the best light. If the candidate begins to get traction with hiring managers, we are there to request feedback and discuss this feedback, good or bad, with the candidate. Finally, we are able to support the candidate through the onboarding process and with retention moving forward. In order to achieve some of our goals, we need to outreach and network with local, state and community organizations. We are also planning on quarterly veteran interview days; our most recent interview day resulted in 8 out of 15 veterans getting hired.	Within the second pillar of Northwell Health Military Liaison Services, Life After Service reimagines how Veterans thrive when they return home from active duty, Military Talent is assisting Talent Acquisition with an additional 100 veteran, service member and spouse new hires in 2022. Military Talent works side by side to not only prepare the individual for an interview, but guide them with constructive feedback, interview skills, resume assistance, and advocacy for those looking to explore career opportunities within Northwell Health.	Northwell's Military Liaison Services' employment goal is to hire 100 veterans in 2022. To date, we have 40 hires, 15 offers of employment and 8 veterans retained as employees. Considering we do not receive unique candidate leads without outreach or exposure to candidate applications to open job requisitions, we are extremely proud of these numbers and the relationships we have built. Our Career Planning Sessions have created quality candidates and relationships that will continue beyond initial hire. Our communication and relationships within Northwell and other teams has improved tremendously and the awareness that we are helping to create veteran pools of candidates is exciting to hiring managers that use and utilize us as resource for quality candidates. The challenge has been quantity of candidates. The need for outreach has far exceeded expectation, as the candidates coming in are not as plentiful as expected, compared to the reported numbers of veterans that are living in the NY Metro area	Our internal partnerships include Talent Acquisition, Workforce Readiness, Career and Performance Development and veteran hiring managers. We continue to build individual partnerships with hiring managers that understand the value of hiring a veterans, service members and spouses. We have external community partnerships that allow us to table events or present our department's services, such as Fort Hamilton, Hempstead works, Workforce1 Queens, Department of Labor (Nassau/Suffolk/NYC), Department of Veteran Services, agencies that hold the SSVF contract (SUS, EOC of Suffolk) Food banks, etc.
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**	**Behavioral Health School Partnership Program**: This program allows families to get help when they need it and before problems warrant an emergency room visit. It includes: Access to child and adolescent psychiatry evaluations in a community ambulatory crisis center as well as consultations and assessments in schools. Professional help navigating health insurance and community referrals to make sure families find affordable, appropriate care. Timely, short term crisis treatment, including medications and therapy as needed for high-risk students. The Northwell School Mental Health Partnership addresses the whole community. Our subject matter experts offer faculty development, staff support and community education on important behavioral health topics affecting kids. An advisory committee comprised of school district leaders, Northwell administrators and clinicians regularly discusses clinical outcomes and where there may be room for the program to grow. Part of this school-based initiative has included collecting data to see whether the program has been effective. Within the first 12 months of opening our first behavioral health center, we've seen a 60 percent drop in pediatric emergency room visits for behavioral health from our partnering districts. We're in talks with 15 to 20 Suffolk County school districts to replicate this model, first with a few pilot districts, and then hopefully expanding to more to help bring much needed youth mental health services to this community.	Number of participants enrolled	By the end of 2021, there was a total of 1,259 participants	20+ school districts
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**	**Pediatric Behavioral Health Urgent Care Center:** The Cohen Children's Pediatric Behavioral Health Urgent Care Center provides timely access to pediatric mental health services for children and adolescents (age 5-17) presenting in a mental health crisis. The program is designed as an alternative treatment setting for those who need urgent (same day) intervention, but do not necessarily require the services of the emergency room. (If your child does need the emergency room for a mental health issue, they should go straight to the emergency room.)	Number of participants enrolled	By the end of 2021, there was a total of 2,182 participants enrolled	Cohen Children's Pediatric Behavioral Health Urgent Care Center
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**	**Screening, Brief Intervention, Referral to Treatment (SBIRT)**: This new initiative is an age-appropriate adaptation of the health system's existing Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, which promotes the "We Ask Everyone" process. Originally instituted for adult patients presenting to select Northwell Emergency Departments and Primary Care Practices, the protocol is designed to universally screen patients. Evidence-based questions are utilized to determine the patient's level of risk and if they may benefit from support or treatment for their substance use. At Cohen, social workers and front-line Emergency Department nursing and physician teams have been trained to use the SBIRT screening tool. It's important to address this crisis with a team-based approach to better support our patients and their families.	Number of screenings	By the end of 2021, there was a total of 4,785 screenings	social workers and front-line Emergency Department nursing and physician
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**	**Child Life Program:** The Child Life Program at CCMC collaborates with various departments to improve children's and families' understanding of hospitalization, illness, injury, and medical procedures. The Child Life Team utilizes innovative educational strategies to help minimize the psychological trauma illness and injury may cause. They educate children and families as well as pediatric residents who travel to La Romana, Dominican Republic to provide medical care to children. For more information, please call (516) or (718) 470-3005.	Number of patients	By the end of 2021, there was a total of 44,728 patients reached	Internal CCMC team
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**	**Center For Young Adult, Adolescent & Pediatric HIV:** The Center for Young Adult, Adolescent, and Pediatric HIV (CYAAPH) at Cohen's Children's Medical Center of New York provides comprehensive medical care and social support services to individuals under the age of 30, regardless of sex assigned at birth, sexual orientation, gender identity and expression. Our expert team provides compassionate medical and psychosocial care to adolescent and young adults, from infancy to age 30, who are HIV-infected. We help manage HIV with expert medical care and medication therapy; STI screening and treatment; immunizations; supportive mental health services; case management services to assist with various social determinants of health; risk reduction and U=U education; gynecological exams; nutrition services; and primary care services. CYAAPH also provides HIV prevention services such as Prep and PEP for at risk individuals. Housed in CYAAPH is Project inspect - an initiative which offers free rapid HIV testing and Prep screenings all over Nassau and Queens County. Safer sex, LGBTQ 101, and HIV prevention workshops are offered to schools and CBOs to spread awareness of HIV and STI prevention. For more information please call (516) 622-5189	Number of participants enrolled	Total in office for 2021 – 1944 Outreach HIV Test 2021 – 248	Internal
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**	**Trauma Survivor Network:** The Trauma Survivor Network (TSN) is a community of patients & families who are looking to connect with one another and rebuild their life after a serious injury, Recovering patients may become involved in the TSN for many reasons, including the opportunity to share their experiences with other survivors, learn new coping strategies, and support others through the recovery process. The TSN at Cohen Children's Medical Center offers support for patients through: 1. Virtual support groups 2. National NextSteps Program – Managing Life after Trauma 3. National Trauma Survivor Day 4. PTSD Screenings post discharge	Number of programs and participants	By the end of 2021, there was a total of 52 programs and 4,035 participants enrolled.	Internal

Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population	**Behavioral Health Screening:** Mather Hospital offers free online mental health and substance abuse screening to the community as well as in-person screening for eating disorders. Screening participants are referred to resources. Online screening for mental health and substance abuse helps to address stigma and other barriers to care, increasing access for those needing services. Free screening for eating disorders is a vital service due to the scarcity of eating disorders programs in the community, connecting individuals to care who might not otherwise receive treatment.	# of online screenings completed, # of in person eating disorder screenings	Online MH/SA screenings: estimated at 150 based on past data Eating disorder screenings: estimated at 19 based on past data	Subscription with MindWise for online screening. Clinician conducts eating disorders screening.
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	**Emergency Department MAT/Referral for Opioid Disorder:** For individuals with opioid use disorder presenting in the Emergency Department, Mather Hospital offers Buprenorphine induction and referral to outpatient MAT (in conjunction with the Chemical Dependency Clinic's Intensive Outpatient Program). Access to outpatient MAT is a critical aspect of effective treatment for opioid disorder, and access to MAT is extremely limited in the community. This intervention offers an option to individuals recovering from an opioid overdose to engage in treatment that can help them break the cycle of addiction.	Number of Buprenorphine Inductions in ED Number of Referrals to Chemical Dependency in ED Number of Visits with Both Buprenorphine Inductions and a Referral to Chemical Dependency in ED	2021 data was as follows. 2022 data will be reported once complete. Number of Buprenorphine Inductions in ED: 181 Number of Referrals to Chemical Dependency in ED: 27 Number of Visits with Both Buprenorphine Inductions and a Referral to Chemical Dependency in ED: 6	Internal partners are Mather's Chemical Dependency Clinic and also the Emergency Department service line as this is a system initiative.
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	**Outpatient BH Expansion:** Mather Hospital is engaged in a project to expand access to outpatient behavioral health services in the community and initiate evidence-based, patient centered care models. Partially funded by a NYS DOH Statewide Health Care Facilities Transformation II grant, the project will expand the adolescent psychiatric partial hospitalization program and establish a co-occurring disorders track, create a rapid access intake center to better serve individuals currently seeking behavioral health care in the Emergency Department, and increase Medication Assisted Treatment for individuals with opioid use disorder in conjunction with the Chemical Dependency Clinic's Intensive Outpatient Program.	Adolescent partial hospitalization increased by 10 additional program slots allowing 70% more visits annually. Decreased LOS on the adolescent psychiatric unit and Emergency Department. Rapid access intake center: 1,000 visits/year and a reduction in ED behavioral health visits of 25%. Annual MAT visits increased to 6,400 by year 3 and chemical dependency clinic volume increased by a third. Reduction in opioid admissions as a result of patients accessing MAT/IOP services.	N/A	The NYS Department of Health provided a $6.75 million grant towards the project. Foundation partnership is also making this project possible.
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	**Caregivers Center**: Brick and mortar location in hospital and virtual workshops/resources provide family caregivers with information and comfort they need to help support them in their time as a caregiver.	Number of caregivers supported Amount of informational workshops Amount of support group sessions	Over 70 caregiver supported by social workers and caregiver coaches. Monthly "Tuesday Talks" detailing resources available to caregivers in the community. In person Caregivers support group meets 1st Wednesday of every month. Virtual Caregivers support group meets 1st Thursday of every month.	Partnerships with multiple local resources including elder law groups, nursing homes etc. (Peconic).
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	**Ambulatory Psychiatric Rehabilitation Department:** Assisting individuals with disabilities to secure work, school/training and volunteer work.	Number of individuals who successfully transition back to the community in their desired role.	At this time our employment outcomes have surpassed the total of our previous year by 10%. Current data as of October 2022: We have placed 145 people in paid employment, supported 55 people with transitioning to school and placed 17 people in volunteer jobs.	We continued our partnerships with Northwell Health Flexstaff and Workforce Readiness which assisted us with increasing access for people with disabilities into Northwell Health. We received the National Disability Employment Award for 2022.
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	**Jones Beach Clean up:** Group of nurses from LIJVS participating in a beach clean up at Jones Beach field 10 - Trash pick up on land and shore. One off event	Number people in attendance	A total of 8,000 people showed up to assisted with the beach trash clean up event.	ANA - American Nursing Association – LIJ Valley Stream Nursing department
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	**PRIDE Month:** LIJVS Hospital Educational lunch and learn with Dr. Genn Herley and Stephanie Battaglino of Trans New York. LGBTQ+ PRIDE Event tabling in the Lobby for Community Access. Courtyard event to celebrate PRIDE month with Expressions BERG Members	Number of events and number of attendees	3 events were held with a total of 201 people attended the sessions for this year	Trans New York, Expressions BERG.
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	**Addiction Services Consultations:** At Zucker, we do an average of 2 consults per week for patients on the inpatient unit who are identified as having a substance use related issue. The consults are focused on Motivational Interviewing(increasing the patients motivation to address their substance issues) or addiction medication consults(our Addiction Psychiatrists help the Attending Psychiatrists decide if and what addiction medications might be helpful to the patient).	Will perform 2 consults per week	Be the end of 12/21 we had performed over 120 consultations with over 77% of those referred for follow up addiction care keeping their initial appointment	This initiative is in partnership with ZHH in-patient psychiatry team and social workers and the ZHH Addiction Services Ambulatory Programs
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	**Far Rockaway Treatment Center:** The Far Rockaway Treatment Center draws about 65% of its patients from two zip codes (11961, 11962) in which the poverty rate runs between 19 - 24%. Many factors that effect health and subsequently quality of life happen outside of the clinic. This includes access to education, jobs, quality health care, and safe spaces to live in. Residents of high poverty neighborhoods often lack these resources. Included here is a 2018 snap shot of the community. • 29% No HS diploma or GED • 42% Completed HS or equivalent • 25 % Living at poverty level or below • 70% Black • 25 % Hispanic • Recent immigrants • Increased consumption of alcohol, tobacco and other substances. Substance use disorders have been identified as the underlying cause or co-factor for 60% repeat ED and in patient re-admissions at St John's Episcopal Hospital with the rates opioid related ED visits and overdose deaths among residents of the Rockaways higher than for NYC. This coastal community continues to experience residual setbacks from Hurricane Sandy . The Rockaways suffered disproportionally high rates of infection and deaths through-out the pandemic. It is also a community plagued by gun and other means of violence. On a positive note, a transformative revitalization project in downtown Far Rockaway was recently completed that includes 224 units of affordable housing, community spaces, enhancements to street safety, and climate resiliency. The project supports access to transit, jobs , daycare retail and community space Our Program Northwell Health's Far Rockaway Treatment Center provides comprehensive behavioral health care to residents of the Rockaways and neighboring communities. We provide substance use disorder (SUD) services, including medically assisted treatment (MAT), as well as treatment and medication management for those struggling with co-occurring psychiatric disorders. Currently we are running a PICG project connecting patients to economic, educational, employment and housing services. Other projects include, but are not limited to contingency management initiative, improving the health and nutrition of pre-diabetic, hypertensive, and /or obese patients, development of a bereavement group in response to the COVID 19 pandemic , building a Spanish speaking track, and development of a parenting program. We strive to meet the needs of the community in meaningful ways. We have also partnered with the North well Health Home, vocational rehab services, SBIRT and the Liver Transplant team and seek to build a collaborative with Northwell's Firearms Injury and Mortality Prevention program (FIMP) in CY 2023 .	Will admit 15 new patients each Month Will refer 3 patients a month to employment , educational , economic support or housing programs.	Admitted 158 new patients CY 2021. New initiative About our patients 10,112 completed visits thus far CY 2022 Average census runs between 150 -160 patients • 32% No high school diploma or GED • 60% receiving psychiatric services. • 19% on MAT • They score lowest on the Q-LES-Q-SF in the domains of economics and employment • Many with co-morbid medical conditions • Some struggle with Unstable housing • Many undocumented • 47% reported food insecurity pre-pandemic.	In partnership with various community stakeholders; Parole, Probation , ACS , other behavioral health and medical providers, social service organizations and religious institutions. services Non- specific external social support services also in partnership with ZHH Vocational Rehab Services and the , the Northwell Health Home
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	**NAMI:** NAMI-National Alliance on Mental Illness helps those affected by mental health conditions build better lives through support, education and advocacy. ZHH is very aligned with NAMI as we host their monthly meetings, support their annual walk fundraiser as sponsors, actively participate in NAMI Faithnet which is focused on educating & supporting faith leaders to address the mental health issues presented by their congregations.	160 events/classes/groups were offered, serving 260 people	260 people/consumers & families	Partnerships with Northwell Health, Unitarian Church of Manhasset, NAMI NYS, Central Nassau Child & Family Guidance, Nassau County
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	**Saving Lives Five Towns Drug & Alcohol Coalition:** Saving Lives Five Towns Drug and Alcohol Coalition provides critical awareness, prevention and educational programs that address youth mental health, alcohol, and substance misuse – ensuring the Greater Five Towns Communities are safe for our youth and their families. We have meetings every 2 months to discuss issues and plans, host awareness days with tabling opportunities, educational presentations for parents.	15 events /classes/educational programs reaching 500 adolescents, children and family members	15 events that touched 500 people. Media exposure for various alcohol & drug misuse campaigns. Seminars & webinars related to mental health & substance use/misuse. Arts below Sunrise Community Fair, Police National Night Out	Partner with Northwell Health, Nassau County 4th Precinct Police Department, Tempo Group, Newport Health, Acadia Healthcare, Nassau County Heroin Task Force, Faith-based organizations, Rockville Center for Youth, Woodmere Business Association, Village of Cedarhurst, Hatzalah of Rockaways and Nassau, Long Island National Guard Drug Task Force

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	**Living Healthy:** Northwell Health's Chronic Disease Self-Management Program (CDSMP), is a 6-session, evidence-based health education program for people with any type of ongoing health problems. This program is designed to help people gain self-confidence in their ability to control their symptoms and manage how their health condition affects their lives.	Number of participants enrolled	Postponed due to COVID - goal to restart in 2023.	Community Engagement Network
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	**Trauma Survivors Network:** Is a community of patients and survivors looking to connect with one another and rebuild their lives after a serious injury. The underlying goal of our resources and programs is to ensure the survivors of trauma a stable recovery and to connect those who share similar stories.	Number of participants enrolled	No activity in 2021	Internal partners
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	**The Carter Burden Network (CBN)** promotes the well-being of adults 60 and older through a continuum of services, advocacy, arts and culture, health and wellness and volunteer programs, all oriented to individual, family and community needs. As a leader in aging services in NYC, CBN welcomes older adults to participate in programs and attend centers offering vital resources that support the independence of seniors and provide opportunities to form connections. Lenox Hill Hospital is proud to partner with CBN's Health and Wellness Program in support of older adults gaining knowledge about their health and adopting healthy behaviors to support fall prevention, prevent and manage chronic illness, and support long-term wellness. Over the past few years, Lenox Hill has facilitated numerous educational workshops and lectures on health-specific topics pertinent to the senior community. In 2022, CBN identified ear health and mental health as topics of priority, so Lenox Hill focused on coordinating presentations given by clinical leaders within those fields.	Number of participants	3/24/22: Hearing & Ear Health Workshop - total of 20 participants 6/23/22: Mental Health Workshop - total of 20 participants	CBN's Health and Wellness Program
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**A Matter of Balance:** This program is intended for older adults that have a fear of falling. This program offers strength and balance exercises as well as teaching participants how to alter their behavior to mitigate potential fall risks. This class meets for 8 weeks for 2 hours each session and has a class size of 8-12. This program can be offered both virtually and in person. https://www.mainehealth.org/healthy-communities/healthy-aging/matter-of-balance	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	8 attendees for 2021	Northwell Community Relations Dept. Local libraries and community centers
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Stay Active and Independent for Life (SAIL):** EBE fitness program for older adults (65+). In the class, older adults preform various exercises to improve strength, balance, gait, and overall fitness levels of participants to help reduce their chances of falling. Class size varies depending on room size, max 25 participants. Meets 2-3 times per week for 12 weeks. These programs run continuously at 2 locations currently. https://www.sailfitness.org/	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	4 events held: 1/4; 1/8; 6/14; 6/18; total of 75 people in attendance	Northwell Community Relations Dept. Local libraries and community centers
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Walk with Ease:** Walk with Ease is a 6-week program that meets twice per week with 1 additional self-directed walk each week. Class size varies based on space, and instructors. Max 15 people for safety precautions. The program's goals include reducing pain and discomfort from arthritis, increasing balance, strength, and walking pace, build confidence in participant ability to be active and improve overall health. This program targets older adult fall prevention. https://www.arthritis.org/health-wellness/healthy-living/physical-activity/walking/walk-with-ease	Number of attendees each year, injuries seen at trauma centers We target the communities with the highest rates of the related injury for the class	5 events held: 1/4; 1/7; 5/18; 6/15; 6/18. Total of 81 people in attendance	Northwell Community Relations Dept. Local libraries and community centers
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.3: Prevent and address adverse childhood experiences (ACES)	**Center for Attention and Learning:** Center for Attention and Learning (CAL) is a pediatric neuropsychology training program that serves under-resourced families. CAL is grounded in the understanding that well-being is not defined by medical status alone; economic, environmental, and cultural factors all contribute to the complete picture of health. Education is widely recognized as a major social determinant of health outcomes and research has proven that early intervention is key in helping children with attention and learning differences experience academic success. The longer these needs go without proper diagnosis and treatment, the greater the risks that threaten a child's opportunity for success. Children with attention and learning differences experience lower graduation rates and higher rates of future poverty and unemployment than their peers. For children with learning differences from low-income families, these challenges are compounded. An appropriate educational experience is one of the greatest tools available for breaking the cycle of poverty. For this reason, CAL was established in 2001 with the mission of addressing the enormous disparities experienced by children with learning differences from low-income families. CAL provides comprehensive evaluations to help pinpoint areas of strength as well as areas in need of support. Additionally, therapeutic services have been added to our roster to help families move forward with the recommendations from our evaluations in order to enact measurable change. The Emergency Response Program (ERP) service was developed and initiated at the beginning of the pandemic (April 2020) as a temporary offering to address a wide array of challenges facing students and their families. These services included learning and educational access, emotional and behavioral needs, and resources for basic living necessities during the initial months of the pandemic. Under its new name, the Parenting Support Program (PSP) continues to provide short-term, essential therapeutic support and resources to families so that they may better understand and support their child's needs; all families that are referred for an evaluation are offered the services upon completion.	For the Parenting Support Program (PSP), we conduct a two question patient satisfaction survey. **1)** How satisfied were you with the PSP service? rated on a Likert scale 1 to 5 (1-not at all satisfied, 3-somewhat satisfied, and 5-very satisfied); **2)** How likely would you recommend this service to a friend? rated on a Likert scale 1 to 5 (1-not at all likely, 3-somewhat likely, and 5-very likely).	A total of 55 families have been served to date since the program's inception; that represents 61 patients (in some cases multiple children from one family). 36 responded to the recent survey and of those contacted, 100% provided the highest rating (5) to both questions.	Support from leadership and the Northwell Health System as well as partnerships with Advocates for Children (AFC), Legal Aid Society (LAS), charter schools and after-school programs.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**Community Education- Opioid Use Disorder: Addresses prevention agenda priority Prevent Mental and Substance Use Disorders by providing community with education on opioid use disorder.**	# of attendees, # of webinar recording views, webinar evaluations	The 3/1/22 webinar was attended by12 people. The webinar recording had 99 views as of 9/7/22.	Internal Clinicians
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**NARCAN Training & Kit Distribution/to Prevent Opioid Overdoses:** Addresses Prevent Mental and Substance Use Disorders priority by educating community on opioid disorder and the use of naloxone to reverse opioid overdose. Narcan kits are distributed to participants. Trainings were provided both in-person and via webinar.	# of trainings, # of participants/kits distributed, program evaluations	Trainings provided on 2/3/22, 3/17/22, 4/12/22, 5/26/22, 6/9/22, 6/14/22, 6/21/22, 7/2/22, 7/7/22, 7/23/22, 8/23/22. Through August, 63 community members attended and received kits; this does not include trainings to be held in fall/winter 2022.	The June trainings were part of a Recovery, Resiliency and Hope series that included a collaboration with NAACP Brookhaven, and were held at the request of the EMSL Addiction Services Team in conjunction with their NIH grant.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**National Prescription Drug Take Back Day**: The National Prescription Drug Take Back Day aims to provide a safe, convenient, and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications. Lenox Hill Hospital partners with the DEA to serve as a registration "take back" site. There are two dates each year: one in April and one in October. LHH & Northwell are committed to helping keep these drugs from getting in to the wrong hands.	We keep track of the pounds of prescriptions drugs that are collected for safe disposal	April 30th: Lenox Hill Hospital collected 22 lbs. October 29th: LHH collected 32 lbs.	Partnership with the DEA and our local NYPD precinct
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**Community Education- Opioid Use Disorder:** A webinar providing the community with education on opioid use disorder was held. Presented as part of Mather's HealthyU series of free community health education events, the recorded webinar is also available for viewing online. The webinar covered an overview of the opioid epidemic, the source of misused prescription opioids, the role of withdrawal and cravings in escalation, transition to heroin, fentanyl, the three Cs of addiction, signs your loved one is addicted, withdrawal symptoms, components of addiction treatment, finding treatment, overdose prevention, and where to get naloxone.	# of attendees, # of webinar recording views, webinar evaluations	The 3/1/22 webinar was attended by 12 people. The webinar recording had 99 views as of 9/7/22.	MD, Psychiatrists and Psychiatry Residents
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population	**SBIRT:** Mather Hospital screens patients for substance use disorder, ensuring community members receive treatment for SUD. Screening, Brief Intervention and Referral to Treatment (SBIRT) is conducted in inpatient, outpatient and Emergency Department care settings.	SBIRT # Including: SBIRT # Emergency Department SBIRT # Inpatient SBIRT # Outpatient	2021 numbers below. Will update with 2022 data when complete SBIRT # Total: 610 This includes: SBIRT # Emergency Department: 331 SBIRT # Inpatient: 203 SBIRT # Outpatient: 76	This was implemented in conjunction with DSRIP.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**Community Prescription Drug Collection:** Mather Hospital collects unused prescription drugs from community members for safe disposal. This limits access to drugs by community members who may have or develop a substance use disorder. Drugs can be dropped off in the main entrance of the hospital, and drug take back day events are held.	Pounds of drugs collected, # of clicks in email and social media promotions of prescription drug collection	370 pounds of drugs were collected in 2021;	Local law enforcement assists with drug take back days. Pharmacy assists with ongoing collection.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	**International Overdose Awareness Day (IOAD):** Tabling with SBIRT to raise awareness of International Overdose Awareness Day**. One off event**	Number of kits distributed	34 Narcan kits were handed out along with education on how to administer in an overdose emergency	SBRIT
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	**International Overdose Awareness Day**: LIJFH team members distributed over 150 Narcan kits and educational materials to employees and community members in hopes to de-stigmatize the conversation around overdose and help those at risk. **One off event**	Estimated number of attendees	Estimated number of attendees is 200	Internal Clinicians

Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Mental and Substance User Disorders	Goal 2.4: Reduce the prevalence of major depressive disorders	**Perinatal Psychiatry Center:** During the reproductive years, depression and anxiety rates in women are nearly double that in men and are especially elevated during the perimenstrual, perinatal and perimenopausal times of a woman's life. Perinatal depression has been estimated to effect 1 in 7 birthing parents and represents the most common complication of childbirth. Untreated, perinatal psychiatric illness can have major impacts on the patient and her family, including negative neonatal and obstetric outcomes, delayed bonding, psychiatric hospitalization, and increased risk of suicide and substance abuse. Over the past year, our team has provided treatment for over 500 individuals seeking care during this vulnerable period of life. At the Perinatal Psychiatry Center, we work diligently to maintain evidence-based approaches to treatment, provide education to providers in the community and within our training programs, and contribute to furthering the scientific knowledge of reproductive psychiatric illness. People who may benefit from our care include: • Individuals with existing psychiatric disorders and treatment who are: • Planning pregnancy • Seeking one-time medication consultation • Looking for treatment to maintain stability during pregnancy • Individuals struggling with unexpected pregnancy outcomes such as miscarriage • Individuals who develop postpartum depression and/or anxiety • Individuals who develop psychiatric symptoms during pregnancy or postpartum period • Birthing parents with complicated medical or social issues who are experiencing emotional distress during pregnancy or postpartum period • Individuals struggling with the social isolation, role transitions, and identity changes involved in becoming a new parent • New parents struggling to bond with their newborn Our multidisciplinary treatment approach involves physicians, nurse practitioners, psychologists, social workers and licensed mental health counselors. We provide not only medication management but individualized psychotherapy and a wide array of perinatal-specific group therapies. During our work we often collaborate with OB/GYN services, consult-liaison psychiatry, and our women's behavioral health research team.	Approximately 25 intakes/month	4,400 visits by the end of 2021	Partner with many external organizations who refer women in need of perinatal services
Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health	Goal 1.1: Increase use of primary and preventive health care services among women of all ages, with special focus on women of reproductive age	**Restore, Nurture & Empower for Women (ReNew):** Restore, Nurture & Empower for Women (ReNew) offers alternative pain management to women as part of an integrative oncology clinic. Women are an underserved population when it comes to chronic pain. Alternative pain management strategies can prevent the need to prescribe opioids for pain, and thereby prevent opioid use disorder.	# participants, participant completion rate, participant satisfaction health related quality of life & well being HRQOL/WB-1.1 Increase the proportion of adults who self-report good or better physical health - National benchmark 79.8 (healthy people 2020) Defense and Veterans Pain Rating Scale (DVPRS) Functional outcomes for pain, sleep, mood, activity and stress	For the first two quarters of the project there were 30 intake appointments and 77 treatments. On participant surveys, 99.5% experienced enhanced wellbeing and 100% would recommend to someone with an active cancer diagnosis or a survivor, and 100% said they would continue to participate.	This project has grant support from the Katz Institute for Women's Health
Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health	Goal 1.1: Increase use of primary and preventive health care services among women of all ages, with special focus on women of reproductive age	**Go Red - Wear Red Information and Fundraising Table:** Two Go Red AHA fundraising and awareness tables located in the lobby for patient and families and the cafeteria for staff**. One off event**	Number of participants	A total of 40 participants visited the Go Red Table	LIJ Valley Stream Nursing department
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Friendly Hospital Initiative:** The Dolan Family Health Center has been a NYSDOH Breastfeeding Friendly Practice since 2016. This includes: maintaining a breastfeeding-friendly office policy, training all staff to promote, support and protect breastfeeding, discontinuing the distribution of infant formula samples, creating a breastfeeding friendly environment, discussing breastfeeding benefits and management during the prenatal and postpartum periods, encouraging exclusive breastfeeding and providing support, assistance and education to breastfeeding mothers. An RN who provides nursing care in our OB/GYN department is an International Board Certified Lactation Consultant (IBCLC) and a Certified Pediatric NP who provides primary care in our Pediatric department is a Certified Lactation Counselor (CLC). The health center's ability to provide expert breastfeeding guidance and counseling to our patients is a tremendous asset in our continued effort to encourage our patients to exclusively breastfeed, emphasizing the benefits of the first and best nutrition available to babies. Prenatal patients were offered private breastfeeding educational/support sessions with our lactation specialists. Virtual breastfeeding visits via telephone and telehealth have been initiated and offered to our patients in light of COVID-19 practice changes.	# of enrolled patients	2021: All 276 enrolled prenatal patients received breastfeeding education as part of their prenatal care. 71 individualized breastfeeding educational sessions were held and documented in 2021. Providing individualized care is the priority for these women and their babies.	WIC (Suffolk county Dept of Health) program is onsite at Dolan and supports breastfeeding as well.
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Creating Breastfeeding Friendly Communities:** The mission of this program, supported by New York State Department of Health, is to help families meet their infant feeding goals by improving breastfeeding education and support through pregnancy, the postpartum period, and early childhood in four underserved communities on Long Island. Efforts aim to help reduce racial, ethnic and community disparities in rates of breastfeeding	Number of participants enrolled; number of practices/worksites	By the end of 2021, there was a total of 405 mothers; 1 practice designated; 3 worksites recognized	New York State Department of Health
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Friendly Hospital Initiative:** Baby Friendly Hospital Initiative and Designation is an ongoing quality assessment and improvement program focused on adhering to the 10 Steps to Successful Breastfeeding as advised by the WHO, NYS DOH, JCAHO and the accrediting body; Baby Friendly USA.	Number of events completed	11 events completed before end of 2022.	Partnership with Mastic Moriches Shirley Community Library.
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Friendly Hospital Initiative:** Baby Friendly Hospital Initiative and Designation is an ongoing quality assessment and improvement program focused on adhering to the 10 Steps to Successful Breastfeeding as advised by the WHO, NYS DOH, JCAHO and the accrediting body; Baby Friendly USA.	Our department tracks exclusive breastfeeding, skin to skin contact and breastfeeding initiation. Our exclusive breastfeeding rate continues to be one of the highest in the system at 46%.	We have been successfully designated a baby friendly hospital in 2021 and continue to track and monitor our measures for compliance. Our goal this year is to return to in-person postpartum breastfeeding support at our community Baby Cafe. We have been virtual since April of 2020 due to COVID.	We have partnered with SSUH leadership, pediatric and obstetrical physicians as well as our nursing staff for our in-patient measures. We have partnered with BFREE and the grant they received through NYS DOH to work with our community, specifically targeting low-income areas. We also have partnered with our physician partners in the out-patient setting to improve prenatal education and support.
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.1: Reduce infant mortality & morbidity	**Think First For Your Baby (4 module course):** A baby safety class for new and expectant parents & caregivers	Number of attendees each year	A total of 3 events held on 2/9/2022; 2/23/2022/ and 3/2/2022. A total of 45 participants.	Northwell Community Relations Dept., Local community programs, community physicians, parent groups
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.1: Reduce infant mortality & morbidity	**Baby Registry 101:** A child passenger safety and baby product safety hybrid course for new and expecting parents and caregivers.	Number of attendees each year	A total of 5 events held; 3 events held on 1/6/2022; 3/10/2022/ 5/12/2022. A total of 300 participants	Northwell Community Relations Dept., Local community programs, community physicians, parent groups
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.1: Reduce infant mortality & morbidity	**ABCs of Baby Care:** This class for expectant parents is to help prepare for their new baby's arrival. Topics covered include how to diaper and bathe a baby, car seat and crib safety, guidelines for safe sleep, newborn characteristics and appearance, general baby care and more.	Number of support groups held; Number of participants	12 groups held in 2021 with a total of 520 participants.	Internal partnership with maternal child health
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Support Group:** The Breastfeeding Support Group is a free support group for new mothers. Bring your baby to share and learn in a friendly, supportive environment. Meet other new moms, ask questions, and get help with breastfeeding and other new baby challenges. New moms are encouraged to bring a support person if desired. There is no cost to attend. This support group is led by an International Board Certified Lactation Consultant (IBCLC).	Number of support groups held; Number of participants	24 groups held in 2021 with a total of 97 participants.	Internal partnership with Maternal Child Health Department and our lactation consultants. No external partnership.
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal & Infant Health	Goal 2.2: Increase breastfeeding	**Breastfeeding Class:** This class for expectant parents offers information on how to initiate successful breastfeeding. Topics include: benefits of breastfeeding, how milk is made, breastfeeding do and don'ts, latch and positioning, how to tell if your baby is getting enough and more. Due to COVID-19 this class is free.	Number of support groups held; Number of participants	12 groups held in 2021 with a total of 486 participants.	Internal partnership with maternal child health and our lactation consultants
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Reach Out and Read:** The Dolan Family Health Center participates in the Reach-Out-and-Read Program since 2000. This program links literacy with early pediatric visits. Pediatric health care providers provide parents/guardians with information about the importance of reading to their children and age/culturally appropriate books are given to children at well check-ups from six months to five years of age. In 2021, books were given to children of this age group at their 1,847 Complete Physical Exams.	Number of participants enrolled	In 2021, books were given to children of this age group at their 1,847 Complete Physical Exams	Reach-Out-and-Read
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**School Supply Drive:** Dolan Family Health Center's Annual School Supply Drive was a Drive-Thru event on a Saturday morning in August, 2021. Dolan pediatric patients who completed their physical exams within the year were invited to participate in this outreach program. The majority of our patients identify as being in need of basic supplies and this event helps students start the school year prepared and confident. **One off event**	Number of backpacks distributed	452 filled backpacks were distributed during the school supply drive-thru at the end of August and during pediatric health center visits prior to school opening.	Donations from BAE, a local business funded the purchase of supplies. Northwell Health Eastern Region – Community Health supplied 50 of these filled backpacks.

Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**Adopt-A-Family:** The Dolan Family Health Center organized the adoption and support for needy families during the December holiday season. Identified families received brand new warm clothing and winter footwear, supermarket gift cards, small kitchen appliances, toys, electronic devices and baby car items. All gifts were wrapped, labeled and presented to these families. **One off event**	Number of gifts distributed	15 Dolan Family Health Center families received holiday gifts by health center, Huntington Hospital and community members.	Huntington Hospital departments and units, Community physician offices
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**School Nurse Education Program:** Since the 2016-2017 school year, Cohen Children's Medical Center has worked diligently to provide education to school nurses in Nassau, Suffolk, and Westchester Counties and New York City. In partnership with Northwell Health's Institute for Nursing (IFN) and Community Relations, we have established a robust offering of programs. Through our partnership with Northwell Health's Institute for Nursing, we can offer Contact Hours free of charge to nurses who complete our program. Our monthly programs cover topics and trends such as Managing Food Allergies in School; Mental Health in School-Aged Children and Adolescents; Helping LGBTQ+ Students Feel Comfortable in School; Caring for Seizure Disorders; Management of Food Allergy and Allergic Reactions/Anaphylaxis at School; Tech for Tots Through Teens: Social Media and its Effects on Children and Adolescents; and Rashes in School-Aged Children.	Number of attendees	By the end of 2021, there was a total of 2,152 participants	Zoom - This platform allows our school nurse partners in numerous regions join our monthly programs.
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.2: Increase supports for children and youth with special health care needs**	**Safe Sitter®:** Cohen Children's Medical Center is a proud Safe Sitter® registered provider. Safe Sitter® is a national non-profit organization that provides life skills, safety skills and child care training for youth. The Safe Sitter® Essentials Class prepares students in middle school and high school to be safe when they're babysitting, home alone, or even watching younger siblings. The Safe Sitter® Essentials Class covers safety skills, child chare skills, first aid and rescue skills, and life and business skills.	Number of participants	By the end of 2021, there was a total of 31 participants	We are able to host these classes on Zoom when necessary. This enables us to enroll students from Nassau, Suffolk, and Westchester Counties and New York City.
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.2: Increase supports for children and youth with special health care needs**	**ThinkFirst National Injury Prevention Program:** Each year millions of children visit emergency departments for injuries across the United States, most of these injuries can be prevented by making safe decisions. CCMC is the NYC/Long Island Chapter for national Think First, an evidence based educational program with a goal of reducing injuries in children, teens and young adults. Through this curriculum based program, children, teens and young adults learn to reduce their risk for injury, thereby significantly lowering the incidence of injury related death and disability. The Think First curriculum is implemented in schools across Queens, Nassau, & Suffolk, for grades k-12. To schedule a program please call (516) or (718) 470-7178 or visit the website at www.thinkfirst.org.	Number of participants	A total of 7,500 participants reached in 2021	Think First, schools across Queens, Nassau, & Suffolk, for grades k-12.
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.2: Increase supports for children and youth with special health care needs**	**Childhood Injury Prevention:** The Injury Prevention Program at CCMC strives to secure the safety of our youngest population. This requires a multi-faceted approach to identify injury risks, generate action to minimize these risks and provide a means to actively protect children from preventative injuries. Injury prevention programs are available for community organizations, school age children, school staff, community outreach services and for general public and professionals. The success of this program relies heavily on collaborative partnerships and stakeholder support throughout the region. These partnerships assist our program to identify and address the needs of different populations, providing safety education to families and engaging local communities to influence change to protect children from preventative injury. In addition to our educational programs, free car seat check events are held bi-monthly (both virtually and in person) for the community and for our patients. For more information, please contact (516) or (718) 470-7178.	Number of participants	A Total of 10,566 participants in 2021	Internal
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**Prom Program:** The Prom Program is designed to address the conversations and issues which most prominently surround prom night. Our experts provide an interactive and informative overview of these concerns, while addressing the needs of both students and parents. At Northwell Health, we know prom is a special occasion everyone has been waiting for and we are here to help make it as enjoyable and safe as possible. This program Includes: 1. Concepts and Importance Around Decision Making with experts from Cohen Children's Medical Center 2. Understanding Drugs & Alcohol with experts from Zucker Hillside Hospital and South Oaks Hospital 3. Consent Laws & Rights with experts from Cohen Children's Medical Center	Number of students reached	By there end of 2021, there was a total of 300 students reached	Our partnerships with South Oaks Hospital and Zucker Hillside Hospital have helped us facilitate this program.
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.2: Increase supports for children and youth with special health care needs**	**BEE MINDFUL™ Program:** BEE MINDFUL™ is a program for children with special needs in healthcare that individualizes care and provides a safe place for healing and wellness. The program provides: 1. Education to all staff on the unique needs of children with special needs and how we can improve the care we provide. 2. Pediatric Neurobehavioral Assessment tool (PNAT)- An assessment and intervention tool that individualizes care and provides continuity 3. Signage for situational awareness: The BEE MINDFUL™ symbol used to minimize the amount of interruptions to the patient's room through the clustering of care and ensure individual needs are communicated prior to entering into the child's safe place. 4. Sensory BEE MINDFUL™ Cart- Provide sensory support while in the medical environment 5. BEE PASS- Facilitates an expedited, calm and safe entry into the facility.	Number of participants enrolled	The BEE Mindful program has reached 650+ patients in the hospital	Internal patients
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**Cohen Strong:** is a youth leadership group that will successfully strengthen young people's connections to their community through training on leadership skills that will increase their ability to identify and stop bullying in their schools. The members are a liaison between the hospital and their schools and serve as ambassadors to the community conducting outreach, prevention and wellness programs. This select group of teens has the opportunity to meet and interact with hospital personnel and gain skills to help prepare them for the challenges and responsibilities they will face as college students and beyond.	Number of participants enrolled	By there end of 2021, there was a total of 50 participants	The Long Island Crisis Center
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**Annual Superintendent's Day Symposium:** Cohen Children's Medical Center in collaboration with Zucker Hillside Hospital and South Oaks Hospital, hosts an annual symposium on Election Day every year for school professionals to learn about the current trends impacting youth. Previous sessions have included: Child Abuse & Neglect in the Wake of COVID-19; Assisting Youth with Autism Spectrum Disorder Navigate Home and School During COVID-19; Diversity, Equity, and Inclusion in Education & Healthcare; Supporting Adolescents with Anxiety.	Number of participants	By the end of 2021, there was a total of 1,600 participants	Zucker Hillside and South Oaks
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**The Center for HOPE:** The Center for HOPE (Healing, Opportunity, Perseverance, Enlightenment) provides a place where children and families can come together in their journey of grief. We offer programs to meet the needs of the entire family—providing support and help to bereaved children, adolescents and parents through developmentally age-appropriate groups and short term counseling. These groups are facilitated by certified social workers and compassionate trained volunteers and are provided free of charge. For more information, please call the Center for HOPE at (516) 216-5194.	Number of participants enrolled	By the end of 2021, there was a total of 120 participants	Certified social workers and trained volunteers
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.2: Increase supports for children and youth with special health care needs**	**Eating Disorder Center:** The Eating Disorders Center (EDC) at Cohen Children's Medical Center is a nationally recognized program for the treatment of children, adolescents and young adults (up to 21 years old) with anorexia nervosa, bulimia nervosa, avoidant/restrictive food intake disorder (ARFID) and other food related disorders. We are the only program in the New York metropolitan area to treat children under 13 years old. Our caring and experienced staff members understand the complexity of eating disorders and provide a supportive, nurturing environment to foster successful recovery.	Number of participants enrolled	By the end of 2021 there was a total of 540 new patients; over 1000 patients reached in total	Internal clinicians
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**Northwell Community Scholars:** Northwell Community Scholars (NCS) is a new innovative program being launched by Northwell Health in partnership with school districts throughout Long Island. Northwell Community Scholars (NCS) is currently in partnership with Brentwood High School, Bayshore High School, Freeport High School, and Hempstead High Schools. The program offers high school students with opportunities for academic advancement and career exploration, with a focus on healthcare careers, leading to potential employment. Once students are accepted, the program provides services to support continued growth and development, including but not limited to mentorship, college preparation, career advisement, internship/shadowing opportunities, and financial support to pursue an Associate's Degree or certificate program at Nassau or Suffolk Community College. PROGRAM OBJECTIVES • Support students in their academic journey to successfully achieve high school graduation and continue on to pursue higher education. • Help students develop and strengthen their professional skills and competencies for entry into the workforce. • Foster student academic, professional and personal success. The NCS Program has two separate components – the Career Exploration Program and the Senior Scholarship Program. A multidisciplinary Selection Committee comprised of representatives from our partnering school districts and Northwell Health review applications and accept a select number of students each year to participate in the NCS Program.	Number of students	By the end of 2021, there was a total of 11,073 students reached	Bayshore High School, Freeport High School, Brentwood High School, Roosevelt High School, Nassau Community College, Suffolk Community College
Promote Healthy Women, Infants and Children	**Focus Area 3: Child & Adolescent Health**	**Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships**	**Born to Read:** Each year, SSUH partners with the national Born to Read Program, a family literacy promotion program offered to every newborn delivered at the hospital. Designed to empower parents to be their child's first teacher, handmade cloth bags are presented to the family, containing a book to be read to the child, a list of local libraries, a list of recommended reading to toddlers and preschoolers, and an application for English literacy. The program is available in both Spanish and English.	Number of newborns delivered at hospital	To date: 500 newborns	National Born to Read program

Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**My Brother's Keeper (MBK) Program:** Brentwood Union Free School District, (BUFSD), the goal of increasing academic and social outcomes through mentoring, leadership development, college awareness and minimizing the gaps for young men of color. The MBK Community Challenge asks for communities to work with community leaders, educators, business leaders and youth development experts across sectors to design and implement action plans that expand opportunities for All young people; regardless of who they are, where they come from, or the circumstances into which they are born. 2020 & 2021- SSUH donated $4000 to purchase 8 laptops for 8 young men.	Number of participants enrolled	2020 & 2021- SSUH donated $4000 to purchase 8 laptops for 8 young men	My Brother's Keeper Brentwood High School
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Distracted Driving:** Is a national injury prevention program focused on decreasing vehicular death and Injury. Reckless and distracted driving is the number 1 killer of teens in America. 4,000 teens die annually; 400K seriously injured; 100%preventable The program is high-energy and interactive, and they share real stories that connect with teens, empowering them with evidence-based strategies to keep themselves and others safe. We seek to change the culture of driving to one that is distraction-free – thereby saving lives not only in this generation, but in all future generations of drivers.	Number of participants enrolled	Events: Participants 04/06/21 : 41 04/07/21 : 50 04/19/21 : 49 04/22/21 : 38 10/01/21 : 53 Total: 5 events with a total of 231 participants	Hauppauge High School West Babylon High School
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Safe @ Home:** 90 minute program for grades 4-6 on home safety	Number of attendees each year	2 events held: 7/27 and 8/25. Total of 22 people in attendance	Northwell Community Relations Dept., Local schools, community programs, parent groups
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Safe Sitter (Middle and High School):** Cohen Children's Medical Center is a proud Safe Sitter® registered provider. Safe Sitter® is a national nonprofit organization that provides life skills, safety skills and child care training for youth. The Safe Sitter® Essentials class prepares students in middle school and high school to be safe when they're home alone, watching younger siblings, or babysitting.	Number of attendees each year	5 events held: 8/19; 9/25 (2 events this day) ; 11/13; 12/4. Total of 36 people in attendance	Northwell Community Relations Dept., Local schools, community programs-
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Home Safety:** Stemming from the alarming fact that 2,200 children die at home each year from unintentional injuries in the home, we cover how to properly: child proof, identify hazards, poison control and practice safe sleep.	Number of attendees each year	4 events held: 2/11; 10/26; 11/8; 11/17. Total of 143 attendees	Northwell Community Relations Dept., Local schools, community programs-
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Baldwin High Honors Virtual Classroom - Nursing:** LIJVS Presents a live virtual education from various departments to the Baldwin Medical Academy every two weeks during Spring.	Number of session held and number of attendees	A total of 8 virtual sessions were held with a total of 147 attendees	LIJ Valley Stream Departments such as Nursing, Quality, Patient & Family Experience, Engineering, Pharmacy Emergency Management, PACU and Orthopedics.
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**The Book Fairies Book Drive Jan 1 - Jan 31:** Book Drive created in collaboration with The Book Fairies organization for programs across Long Island and NYC. Books from this book drive go to families in disadvantaged communities, directly impacting literacy rates in local neighborhoods.	Number of books distributed	A total of 420 books were distributed	The Book Fairies Organization
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Zoom Webinar Link - Saving Lives Coalition and Northwell Virtual Presentation to Parents: Your Teens Emotional Health - What to Know! What to Do! What to Say!:** Virtual Presentation for parents - collaboration by Saving Lives Five Towns and Northwell on teens emotional health	Number of attendees	A total of 65 people attended the presentation	Saving Lives Five Towns Drug and Alcohol Coalition, Behavioral Health, Pediatrics
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Malverne Modified Medical Career Day:** LIJ Valley Stream partnered with Malverne High School for Career Day - Various presenters gathered at the school gymnasium to speak on medical careers choices. **One off event**	Number of students attended	The school officials arranged for all 561 students to visit the gymnasium for this 1 day event	Malverne High School, Behavioral Health, General Facility Services, Imaging, Labs, Nursing, Radiology, Patient & Family Experience
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Gateway Youth Outreach Access:** Gateway Youth Outreach Access Presentation - Career Presentations from speakers across corporations and healthcare on long Island to students at Elmont and Sewanhaka High School**. One off event**	Number of sessions and number of attendees	A total of 4 sessions were held with a total of 55 total students were able to attend the presentation	General Facility Services, Northwell Health, Nursing, Community and Population Health
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	**Girlz Talk Summit 2022:** Over 500 underserved female students from across Long Island and NYC will be attending workshops to empower and inspire them are attending the Girlz Talk Summit 2022. **One off event**	Number of attendees	Over 500 females attended the workshops Girlz Summit and visited our tables	LIJ Valley Stream Orthopedics & Pharmacy Department
Promote Healthy Women, Infants and Children	Focus Area 3: Child & Adolescent Health	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships	At the Forestdale Back-to-School Event, LIJFH team members spoke to parents and their children about the hospital's services, CCMC's pediatric services, healthy eating and healthy weight, and provide B2SKL LIJFH branded collateral. **One off event**	Estimated number of attendees	Estimated number of attendees is 200	Stakeholder relationships with local group and LIJFH Dietary team's educational materials.
Promote Healthy Women, Infants and Children	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	**Diversity, Equity, and Inclusion:** Our diversity, equity, and inclusion workshops facilitate acceptance, understanding, and awareness among students by immersing them in real-life scenarios that address the topics of race, gender and sexuality, and religion. While focusing on microaggressions, gender stereotypes, and bias, students learn to become allies, promote equality, and respect the uniqueness that each individual embodies.	Number of participants	By the end of 2021, there was a total of 1,706 participants	Internal