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1.

Please complete this survey to report on first year activities related to the Prevention Agenda 2013-2017. The due date for this survey is Tuesday, December 30, 2014.

In 2013, the NYSDOH asked local health departments and hospitals to identify at least two priorities from the Prevention Agenda 2013 and to develop a community health improvement plan or community service plan to address them. Organizations had the choice of selecting two focus areas from one priority, such as tobacco use and obesity within the priority area Prevent Chronic Disease, or two focus areas from two different priorities such as tobacco use from the Prevent Chronic Disease priority and injury from Promote a Healthy and Safe Environment. We want to learn about efforts you are making to implement interventions to address TWO priorities or focus areas. For each of two priorities or focus areas selected, please report on the two interventions that are furthest along in the implementation process.

The survey asks your organization to provide brief, and in most, cases multiple choice answers to questions about the progress made since you submitted your 2013 Plan on two Prevention Agenda priorities or focus areas and the interventions selected for implementation.

The survey also asks you to review and if necessary update summary information about your Prevention Agenda plan. This summary information is available in the attachments labeled: LHD Community Health Improvement Plan Summaries 10-31-2014.docx Hospital Community Service Plan Summaries 10-31-2014.docx

To help you review the questions prior to completing the survey we have provided a "fillable" pdf version of the survey. However, the online survey itself uses skip patterns so it is much shorter than appears in the pdf version. If you would like a word version of the blank or completed survey, please send us an email.

The survey works with all browsers. Please use the survey "next" and "previous" buttons to move between pages rather than the browser buttons. When you click "next", the content filled in automatically gets saved. If you exit before clicking the "next" button, the content may not be saved.

A completed survey will serve as the 2014 Community Service Plan update for hospitals, and as a one year update for Local Health Departments. Most importantly, the responses will assist the NYS Department of Health and its partners on the Ad Hoc Committee to Lead the Prevention Agenda to organize and provide technical assistance to support local Prevention Agenda efforts.

If you have questions about the survey, please send an email to prevention@health.ny.gov or contact the NYS Department of Health Office of Public Health Practice at 518-473-4223.

Thank you for everything you are doing to improve the health of your community and for taking the time to complete this survey.

2. First Prevention Agenda Priority Area

*1. What is the first Prevention Agenda Priority Area you are reporting on?

Select only one

- (●) Prevent Chronic Diseases
- ( ) Promote a Healthy and Safe Environment
- ( ) Promote Healthy Women, Infants and Children
- ( ) Promote Mental Health and Prevent Substance Abuse
- ( ) Prevent HIV/STDs, Vaccine-Preventable Disease, and Healthcare-Associated Infections

3. Preventing Chronic Diseases

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*2. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area

- ( ) Reduce Obesity in Children and Adults.
- ( ) Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.
- (•) Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.

*3. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.

- ( ) Increase the number of public and private employers and service providers in your county to adopt standards for healthy food and beverage procurement.
- ( ) Increase the number of passed municipal complete streets policies.
- ( ) Recruit and encourage hospitals to participate in quality improvement efforts based on geographic location to increase breastfeeding exclusivity at discharge.
- ( ) Encourage and recruit Pediatric, Family Practice, Obstetrics and Gynecology and other primary care provider and clinical offices to become New York State Breastfeeding Friendly Practices.
- ( ) Use the Business Case for Breastfeeding as a tool to assist employers in establishing lactation support programs.
- ( ) Promote the Making it Work: Returning to Work Toolkit to empower women in hourly wage positions to speak with their employers about lactation support needs in the workplace.
- ( ) Increase the number of employers with supports for breastfeeding at the worksite.
- ( ) Promote smoke-free policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-socioeconomic status (SES) residents.
- ( ) Restrict tobacco marketing (including canceling store displays, limiting the density of tobacco vendors and their proximity to schools) in municipalities.
- ( ) Increase participation of adult with arthritis, asthma, cardiovascular disease, or diabetes in a course or class to learn how to manage their condition.
- ( ) Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and increase the number of Baby Friendly Hospitals in NYS.
- ( ) Implement policies that restrict infant formula marketing and distribution of "gifts" through health care providers and hospitals.
- ( ) Implement evidence-based activities that increase public awareness about colorectal cancer.
- ( ) Implement policy, systems or environmental approaches (e.g., paid time off for cancer screening) to increase access to colorectal cancer screening services.
- ( ) Create linkages with local health care systems to connect patients to community preventative resources.
- ( ) Support use of alternative locations to deliver preventive services, including cancer screening.
- ( ) Support training and use of community health workers and patient navigators.
- (•) Other (please specify)

Promote culturally relevant chronic disease self-management education.

*4. What process measures are being used to monitor progress on this intervention?

Choose all that apply.

- [ ] Number of municipalities, community-based organizations, worksites and hospitals that develop and adopt policies to implement nutrition standards (cafeterias, snack bars, vending)
- [ ] Number of individuals (and their demographic data if available) potentially accessing settings that have adopted policies to implement nutrition standards for healthy food and beverage procurement
- [ ] Number of municipalities where new or enhanced policies, plans and practices that promote Complete Streets were proposed
- [ ] Number of municipalities that adopted and implemented policies, plans, and practices that promoted Complete Streets
- [ ] Percent of roads in a jurisdiction that are subject to Complete Streets policies, plans, and practices
- [ ] Number or percentage of residents that reside in a jurisdiction with Complete Streets policies, plans, and practices
- [ ] Number of employers that have implemented lactation support programs
- [ ] Number of hospitals that have joined NYS Breastfeeding Quality Improvement Hospital Initiative, NYC Breastfeeding Hospital Collaborative, Great Beginnings NY, or Latch On NYC
- [ ] Number of primary care practices that are designated as NYS Breastfeeding Friendly
- [ ] Number and demographics of women reached by policies and practices to support breastfeeding
- [ ] Number of public housing authorities, nonprofit community development corporations and market-rate apartment management companies educated about the dangers of secondhand smoke exposure and benefits of smoke-free multi-unit housing
- [ ] Number of municipalities that restrict tobacco marketing in stores
- [ ] Number and type of evidence-based initiatives offered by partners
- [ ] Number of participants in evidence-based initiatives offered by partners
- [x] Percent of adults with one or more chronic diseases who have attended a self-management program
- [ ] Number of referrals to evidence-based initiatives from health care professionals
- [ ] Number and percent of adults among population(s) of focus who have attended EBIs
- [ ] Number of partners, employers and local officials participating in colorectal cancer screening awareness events
- [ ] Number of media alerts related to colorectal cancer awareness event promotions.
- [ ] Number of colorectal cancer awareness events held/promoted/attended
- [ ] Number of cancer screening events held in partnership with community providers
- [ ] Number of county worksites implementing paid time off or flex time policies for cancer screening
- [ ] Number of individuals navigated to and/or through cancer screening
- [ ] No process measures used
- [x] Other (please specify)

Number of attendees at diabetes and cardiovascular disease health screenings.
Number of people screened, number of people counseled on disease self-management.
Number of post-discharge follow-ups with congestive heart failure patients.

4. Promote a Healthy and Safe Environment

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***5. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area**

- ◯ Outdoor Air Quality
- ◯ Water Quality
- ◯ Built Environment
- ◯ Injuries, Violence and Occupational Health

***6. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

- ◯ Incorporate 'Healthy Homes' education and inspections into other (non-health) 'opportunity points', e.g., building inspections, firefighters annual fall fund drives, installation and inspection of CO alarms.
- ◯ Provide communities interested in implementing fluoridation with outreach materials and resources to promote fluoridation as a significant health intervention.
- ◯ Support transportation options that reduce air pollution from mobile sources (e.g., support public transportation, community planning incorporating enhanced walkability or cycling, pricing strategies, greater diversification of transportation fuels).
- ◯ Promote community based programs for fall prevention.
- ◯ Develop multisector violence prevention programs (e.g., LHDs, criminal justice, social services, job training, CBOs) such as SNUG, Cure Violence or CEASEFIRE in highrisk communities.
- ◯ Other (please specify)

*7. What process measures are being used to monitor progress on this intervention?

Choose all that apply.

- [ ] Number of opportunities that incorporate 'Healthy Homes' education and inspections into other (non-health) interactions, e.g., building inspections, firefighters annual fall fund drives, installation and inspection of CO alarms
- [ ] Number of partners that have received fluoridation outreach resources
- [ ] Number of municipalities where new or enhanced policies, plans and practices that promote Complete Streets are proposed
- [ ] Number of municipalities that adopted and implemented policies, plans and practices that promote Complete Streets
- [ ] Percent of roads in a jurisdiction that are subject to Complete Streets policies, plans and practices
- [ ] Number or percent of residents that reside in a jurisdiction with Complete Streets policies, plans and practices
- [ ] Policies enabling reimbursement by health plans for indoor asthma trigger reduction and counseling by healthcare providers about reduction of asthma triggers
- [ ] Number of people surveyed regarding mass transit ridership (from different locations in the county)
- [ ] Number of meetings with the transportation authority regarding better access to bus routes
- [ ] Number of CPT-Codes submitted for falls risk assessment and/or plan of care
- [ ] Number of evidence-based, community fall prevention programs offered
- [ ] Number of practices educated about community fall prevention services/programs
- [ ] Number of people participating in evidence-based, community fall prevention programs
- [ ] Number of partnerships on fall prevention programs for older adults
- [ ] Number of partnerships developed to coordinate services around violence prevention (or number of meetings attended to coordinate services around violence prevention)
- [ ] No process measures used
- [ ] Other (please specify)

5. Promote Healthy Women, Infants and Children

*8. Within this Prevention Agenda priority area, which Focus Area are you reporting on?

Select one Focus Area

- ◯ Maternal and Infant Health
- ◯ Child Health
- ◯ Reproductive, Preconception and Inter-Conception Health

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***9. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

◯ Recruit and encourage hospitals to participate in quality improvement efforts based on geographic location to increase breastfeeding exclusivity at discharge.

◯ Encourage and recruit Pediatric, Family Practice, Obstetrics and Gynecology and other primary care provider and clinical offices to become New York State Breastfeeding Friendly Practices.

◯ Use the Business Case for Breastfeeding as a tool to assist employers in establishing lactation support programs.

◯ Promote the Making it Work: Returning to Work Toolkit to empower women in hourly wage positions to speak with their employers about lactation support needs in the workplace.

◯ Increase the number of employers with supports for breastfeeding at the worksite.

◯ Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and increase the number of Baby Friendly Hospitals in NYS.

◯ Implement policies that restrict infant formula marketing and distribution of "gifts" through health care providers and hospitals.

◯ Implement enhancements to WIC Breastfeeding Food Package.

◯ Recruit and encourage hospitals to participate in quality improvement efforts based on geographic location to increase breastfeeding exclusivity at discharge.

◯ Encourage and recruit Pediatric, Family Practice, Obstetrics and Gynecology and other primary care provider and clinical offices to become New York State Breastfeeding Friendly Practices.

◯ Use the Business Case for Breastfeeding as a tool to assist employers in establishing lactation support programs.

◯ Promote the Making it Work: Returning to Work Toolkit to empower women in hourly wage positions to speak with their employers about lactation support needs in the workplace.

◯ Increase the number of employers with supports for breastfeeding at the worksite.

◯ Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and increase the number of Baby Friendly Hospitals in NYS.

◯ Implement policies that restrict infant formula marketing and distribution of "gifts" through health care providers and hospitals.

◯ Implement enhancements to WIC Breastfeeding Food Package.

◯ Ask all pregnant women about tobacco use and provide augmented, pregnancy tailored counseling for those who smoke

◯ Identify and promote educational messages and formats that have demonstrated to improve knowledge, attitudes, skills and/or behavior related to prenatal care and preterm birth among target populations, including high-risk pregnant women, women of childbearing age and women with disabilities.

◯ Provide timely, continuous and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines

◯ Provide education to health care providers, such as public health detailing, to improve their knowledge, beliefs and skills related to improved use of evidence-based clinical and community-based interventions to reduce preterm birth.

◯ Develop, disseminate, promote and utilize tools for providers to prompt or facilitate well-child visit components, including checklists, registries, data systems and electronic health records.

◯ Link children and families to dental services

◯ Develop effective health marketing campaigns that promote norms of wellness, healthy behavior and regular use of preventive health care services throughout the lifespan

- ◯ Integrate preconception and inter-conception care into routine primary care for women of reproductive age including screening and follow-up for risk factors, management of chronic diseases and contraception.
- ◯ Utilize evidence-based guidelines and tools for health care providers to promote optimal well-being through utilization of preventive health services to providers.
- ◯ Develop and disseminate to providers evidence-based clinical guidelines and tools to promote patients' optimal well-being through use of preventive health services.
- ◯ Train health practitioners on disability literacy regarding women's reproductive health.
- ◯ Conduct public health detailing to improve providers' knowledge, beliefs and skills related to delivery of comprehensive, integrated preconception and inter-conception preventive health care services.
- ◯ Create referral networks and practices to streamline and simplify enrollment and renewal of health insurance for low-income women.
- ◯ Provide comprehensive, evidence-based health education, including health literacy, for children and youth in schools.
- ◯ Other (please specify)

*10. What process measures are being used to monitor progress on this intervention?

Choose all that apply

- [ ] Number of employers that have implemented lactation support programs
- [ ] Number of hospitals that have joined NYS BQIH (Breastfeeding Quality Improvement Hospital Initiative), NYC BHC, Great Beginnings NY, or Latch On NYC
- [ ] Number of primary care practices that are designated as NYS Breastfeeding Friendly
- [ ] Number and demographics of women reached by policies and practices to support breastfeeding
- [ ] WIC local agencies participating in the exclusive Breastfeeding Learning community will increase by 10% the percentage of mothers receiving the fully breastfeeding food package at 30 days.
- [ ] Inclusion of tobacco counselling in prenatal visits
- [ ] Number and percent of women within target population reached by educational campaign addressing the importance of receiving early prenatal care and attending prenatal visits
- [ ] Percentage of total prenatal patients enrolled in program
- [ ] Number and percent of women/families who participate in family education programs (e.g., Lamaze childbirth, pre-natal breastfeeding, sibling classes and a new mom support group)
- [ ] Number and percent of providers that offer the recommended clinical services
- [ ] Number of providers reached
- [ ] Number and percent of active pediatric patients who received reminders about recommended well-child-visits
- [ ] Number of regional school-based dental sealant programs
- [ ] Number of children enrolled in school-based dental sealant programs
- [ ] Number and percent of community residents reached by campaigns
- [ ] Number of primary care providers implementing appropriate screening, management, follow-up for risk factors
- [ ] Number and percent of health care providers using evidence-based guidelines and tools to promote optimal well-being through utilization of health services
- [ ] Number and percent of target provider practices to which guidelines or tools have been disseminated
- [ ] Number of health practitioners trained on disability literacy regarding women's reproductive health
- [ ] Number and percent of targeted provider practices that received a detailing visit
- [ ] Number and percent of targeted provider practices that received a detailing visit and indicated a change in knowledge base on a pre/post questionnaire
- [ ] Number of referral networks established or expanded
- [ ] Number of organizations and agencies that participated in a referral network
- [ ] Percentage of low income women within identified target population who were enrolled in health insurance
- [ ] Number and percent of schools in catchment area that offer evidence-based health education that includes health literacy for children and youth
- [ ] No process measures used
- [ ] Other (please specify)

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6. Promote Mental Health and Prevent Substance Abuse

***11. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area**

- ◯ Promote Mental, Emotional and Behavioral Well-Being in Communities
- ◯ Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
- ◯ Strengthen Infrastructure across Systems

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***12. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

- ◯ Assess community well-being using a standardized survey tool (e.g. BRFSS, WHO (Five) Well-Being Index, Gallup, School climate survey etc.)
- ◯ Identify evidence-based programs or community action activities that promote well-being
- ◯ Pilot or implement evidence-based programs and community action activities
- ◯ Promote smoking cessation among people with mental health disabilities through partnerships with state/local offices of Mental Health.
- ◯ Mobilize community to reduce alcohol use
- ◯ Participate in community trial intervention to reduce high risk drinking
- ◯ Participation by providers in the Internet System for Tracking Over-Prescribing - Prescription Monitoring Program (I-STOP/PMP)
- ◯ Build community coalitions that advance the State's 'Suicide as a Never Event' through promotion and prevention activities
- ◯ Administer screening programs such as SBIRT, Symptom Checklist -90 etc.
- ◯ Educate to increase positive emotions and skills such as engagement, problem-solving, growth mindset, and decrease negative emotions and skills such as feelings of hopelessness, inadequacy.
- ◯ Identify and implement healthy public policies that enhance housing, employment and education opportunities as well as reduce poverty
- ◯ Engage communities in action and create supportive environments with the goal of improving social environment, which is known to impact physical and mental health
- ◯ Implement mental health promotion and anti-stigma campaigns
- ◯ Engage multidisciplinary primary health care teams and community mental health service providers in an integrated approach to prevent, screen and manage depression in people with chronic physical conditions
- ◯ Provide training in prevention and management strategies that are known to be effective with people who report poor mental health
- ◯ Strengthen availability and access to data related to mental health wellbeing and disorder prevention

Other (please specify)

*13. What process measures are being used to monitor progress on this intervention?

- [ ] Community Wellbeing has been assessed using a standardized survey such as the Behavioral Risk Factor Surveillance System (BRFSS) or other standarized well-being surveys.
- [ ] Alcohol outlet density: Number of outlets per geographic unit (e.g. census tract, zip code, etc).
- [ ] Youth and/or perception of harm of underage alcohol use or prescription drugs for non-medical use.
- [ ] Percent of participants who quit smoking three and/or six months after completing the smoking cessation program.
- [ ] Percent of participants with presence of suicide means in the home.
- [ ] Percent of participants with presence of meaningful supportive relationships.
- [ ] Use of systematic tools to screen individuals for mental health and substance abuse problems.
- [ ] Percent of participants who participated in evidence-based program(s) or community action activities being piloted or implemented toward preventing behavioral disorders and/or promoting mental health
- [ ] No process measures

Other (please specify)

7. HIV, STDs, Vaccine-Preventable Diseases and Healthcare Associated Infection...

*14. Within this Prevention Agenda priority area, which Focus Area are you reporting on?

Select one Focus Area

- ◯ Prevent HIV and STDs
- ◯ Prevent Vaccine-Preventable Diseases
- ◯ Prevent Health Care-Associated Infections

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***15. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

- ◯ Include at least two cofactors that drive the HIV virus, such as homelessness, substance use, history of incarceration and mental health, in community interventions
- ◯ Develop STD diagnosis and treatment capacity in settings beyond government clinics
- ◯ Support existing HIV/STD treatment guidelines by establishing computerized algorithms
- ◯ Enhance vaccination of adults with HPV, Tdap, influenza and pneumococcal vaccines.
- ◯ Enhance vaccination of children with HPV, Tdap, influenza and pneumococcal vaccines.
- ◯ Ensure that sinks and alcohol based hand rub are readily available for patients, visitors and health care personnel
- ◯ Other (please specify)

***16. What process measures are being used to monitor progress on this intervention?**

- ☐ Number of co-factors addressed by each community intervention
- ☐ Number of primary care clinicians trained in treatment and diagnosis of STDs
- ☐ Availability of preferred treatment regimens in either hospitals or local pharmacies
- ☐ Protocols and supplies for preferred testing modalities according to current CDC treatment guidelines for syphilis, gonorrhea and chlamydia beyond government clinics
- ☐ Number of treatment scenarios for which there are established algorithms
- ☐ The percentage of 13-year-old children who have received the complete adolescent immunization series as indicated in NYSIS
- ☐ The percentage of children who have received the 4:3:1:3:3:1:4 immunization series between the ages of 19 to 35 months as indicated in NYSIS
- ☐ Immunization rates for health care personnel in hospitals and long-term care facilities.
- ☐ Number of sinks and alcohol based hand rubs available
- ☐ No process measures

Other (please specify)

8. Intervention detail

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***17. Describe the target population (e.g., problem/burden affecting this population, demographics, geographical locations, etc.)**

Populations served by New York Methodist Hospital particularly those from underserved communities, ethnic groups, economic classes and older populations. The single most heavily represented neighborhood in NYM discharges is Crown Heights/Bedford Stuyvesant. A very large

***18. What is the expected number of people to be reached by end of 2014 or the end of the first year of activities?**

100 or more people.

***19. How many people have you actually reached toward this target?**

We met and exceeded the target.

***20. Are you addressing a disparity with this intervention?**

- (●) Yes
- ( ) No

9. Disparities

***21. Which of the following types of disparities are you addressing?**

Check all that apply

- [x] Race/ethnicity
- [x] Income/SES
- [ ] Gender
- [ ] Disability
- [x] Geography
- [x] Age
- [ ] Other (please specify)

***22. How are you working with the target populations addressed by the intervention?**

Check all that apply

- [x] The intervention is focused within specific neighborhoods
- [x] The program screens and offers services to high-need participants
- [x] The program takes into consideration specific cultural needs (please specify)
- [x] Other (please specify)

Culturally relevant diabetes and nutrition education are offered to participants (specifically, the ingredients of a typical dinner in their household or at a holiday meal).
Phone calls are made to patients who are discharged with congestive heart failure.

10. Baseline data

***23. Were baseline data collected for the process measures selected?**

Select only one

- ( ) Yes, for all of them
- (•) Yes, for some of them
- ( ) No

11. Periodicity of data collection

***24. On average, how often are you collecting data for your intervention?**

Check all that apply

- [ ] Monthly
- [ ] Quarterly
- [ ] Twice a year
- [x] Annually
- [ ] Other (please specify)

12. Status of Implementation Effort

***25. What is the current status of your implementation efforts related to this intervention?**

Select only one

- ( ) Ahead of projected implementation schedule
- (•) On track with implementation schedule
- ( ) Behind projected implementation schedule
- ( ) Have not started. If so, describe why

13. Partnership Development

***26. Who are the current partners involved in the implementation of the intervention just described?**

Check all that apply

- [ ] LHD
- [x] Hospital
- [ ] Community health center/Federally Qualified Health Center
- [ ] Health Insurance Plan
- [ ] Business
- [ ] Philanthropy
- [x] College/University
- [ ] Schools (K-12)
- [x] Faith-based organization
- [ ] Media
- [ ] Government or community-based organization - Housing
- [ ] Government or community-based organization - Mental and Behavioral Health (including Substance Abuse)
- [ ] Government or community-based organization - Social Services
- [ ] Government or community- based organization - Transportation
- [ ] Government or community-based organization-Youth Focused
- [ ] Clinical or Community Based Lifestyle Change Program
- [ ] Clinical or Community Based Lifestyle Change Referral Agency
- [x] Local coalition
- [x] Other (please specify)

Health based organizations like American Diabetes Association and American Heart Association.

14. Partner Engagement

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***27. What is the role of partners in this intervention? Check all that apply.**

- [ ] Coordinate intervention
- [ ] Conducts educational activities
- [ ] Provides a health service
- [ ] Funds the intervention
- [x] Allows/sponsors access to the site or population
- [x] Assist with advocacy
- [ ] Other (please specify)

***28. Overall, how would you rate the level of engagement of your partners/members in the implementation of this intervention?**

Select only one

- ( ) Highly engaged
- ( ) Somewhat engaged
- (•) Engaged
- ( ) Disengaged

***29. Describe any successes in engaging partners to actively work on this intervention:**

Check all that apply

- [ ] Focused efforts allowing us to make clear progress on the priority
- [ ] Contributes staff time to help with intervention
- [ ] Helps with training coalition members
- [x] Enables us to offer intervention activities to a target population
- [ ] Provides site for meetings
- [ ] Other (please specify)

***30. Describe any challenges in keeping members of your partnerships engaged and/or actively participating in the implementation of this intervention.**

Check all that apply

- [ ] Some partners are not focused and do not seem to know how to proceed.
- [ ] Few help contribute staff time to help with the program.
- [ ] Partners seem to lack training to help.
- [ ] Challenging to offer programs to target population
- [x] Other (please specify)

No longer provided with interns from the American Diabetes Association who were helping with on-site patient education and workshops.

***31. Do you need help developing or sustaining partnerships with certain sectors?**

- ( ) Yes
- (•) No

15. Strengthening Partnerships

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***32. What types of partnerships do you need help with?**

Check all that apply

- [ ] LHD
- [ ] Hospital
- [ ] Community health center/Federally Qualified Health Center
- [ ] Health Insurance Plan
- [ ] Business
- [ ] Philanthropy
- [ ] College/University
- [ ] Schools (K-12)
- [ ] Faith-based organization
- [ ] Media
- [ ] Government or community-based organization - Housing
- [ ] Government or community-based organization - Mental and Behavioral Health (including Substance Abuse)
- [ ] Government or community-based organization - Social Services
- [ ] Government or community- based organization - Transportation
- [ ] Government or community-based organization - Youth Focused
- [ ] Clinical or Community Based Lifestyle Change Program
- [ ] Clinical or Community Based Lifestyle Change Referral Agency
- [ ] Local coalition
- [ ] Other (please specify)

16. Overall Successes and Challenges of Implementation of Intervention Strategi...

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***33. What have been the successes in implementing the intervention you described?**

Mark all that apply

- [x] Identifying burden/problem to be addressed
- [x] Educating the community about the problem
- [ ] Engaging community leaders to address problem
- [x] Defining target population
- [ ] Establishing clear goals
- [ ] Researching evidence-based interventions to address problem among target population
- [ ] Identifying process and outcome measures to monitor progress toward reaching goals
- [ ] Developing data collection methods
- [ ] Establishing clear implementation timelines/milestones
- [x] Reviewing and monitoring progress with partners
- [ ] Making adjustments to implementation plan/timeline based on progress
- [ ] Disseminating results broadly through a variety of methods
- [ ] Other (please specify)

***34. What challenges are you facing in the implementation of the intervention?**

Mark all that apply

- [ ] Identifying burden/problem to be addressed
- [ ] Educating the community about the problem
- [ ] Engaging community leaders to address problem
- [ ] Defining target population
- [ ] Establishing clear goals
- [ ] Researching evidence-based interventions to address problem among target population
- [ ] Identifying process and outcome measures to monitor progress toward reaching goals
- [x] Developing data collection methods
- [ ] Establishing clear implementation timelines/milestones
- [ ] Reviewing and monitoring progress with partners
- [ ] Making adjustments to implementation plan/timeline based on progress
- [ ] Disseminating results broadly through a variety of methods
- [ ] Other (please specify)

17. Second Prevention Agenda Priority Area

***35. What is the second Prevention Agenda Priority Area you are reporting on?**

Select only one

- (●) Prevent Chronic Diseases
- ( ) Promote a Healthy and Safe Environment
- ( ) Promote Healthy Women, Infants and Children
- ( ) Promote Mental Health and Prevent Substance Abuse
- ( ) Prevent HIV/STDs, Vaccine-Preventable Disease, and Healthcare-Associated Infections

18. Preventing Chronic Diseases

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*36. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area

- (●) Reduce Obesity in Children and Adults
- ( ) Eliminate Exposure to Secondhand Smoke
- ( ) Initiation of Tobacco Use by Youth and Young Adults
- ( ) Promote Evidence-Based Interventions to Prevent or Manage Chronic Disease

*37. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.

- ( ) Increase the number of public and private employers and service providers in your county to adopt standards for healthy food and beverage procurement.
- ( ) Increase the number of passed municipal complete streets policies.
- ( ) Recruit and encourage hospitals to participate in quality improvement efforts based on geographic location to increase breastfeeding exclusivity at discharge.
- ( ) Encourage and recruit Pediatric, Family Practice, Obstetrics and Gynecology and other primary care provider and clinical offices to become New York State Breastfeeding Friendly Practices.
- ( ) Use the Business Case for Breastfeeding as a tool to assist employers in establishing lactation support programs.
- ( ) Promote the Making it Work: Returning to Work Toolkit to empower women in hourly wage positions to speak with their employers about lactation support needs in the workplace.
- ( ) Increase the number of employers with supports for breastfeeding at the worksite.
- ( ) Promote smoke-free policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-socioeconomic status (SES) residents.
- ( ) Restrict tobacco marketing (including canceling store displays, limiting the density of tobacco vendors and their proximity to schools) in municipalities.
- (●) Increase participation of adult with arthritis, asthma, cardiovascular disease, or diabetes in a course or class to learn how to manage their condition.
- ( ) Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and increase the number of Baby Friendly Hospitals in NYS.
- ( ) Implement policies that restrict infant formula marketing and distribution of "gifts" through health care providers and hospitals.
- ( ) Implement evidence-based activities that increase public awareness about colorectal cancer.
- ( ) Implement policy, systems or environmental approaches (e.g., paid time off for cancer screening) to increase access to colorectal cancer screening services.
- ( ) Create linkages with local health care systems to connect patients to community preventative resources.
- ( ) Support use of alternative locations to deliver preventive services, including cancer screening.
- ( ) Support training and use of community health workers and patient navigators.
- ( ) Other (please specify)

*38. What process measures are being used to monitor progress on this intervention?

Choose all that apply.

- [ ] Number of municipalities, community-based organizations, worksites and hospitals that develop and adopt policies to implement nutrition standards (cafeterias, snack bars, vending)
- [ ] Number of individuals (and their demographic data if available) potentially accessing settings that have adopted policies to implement nutrition standards for healthy food and beverage procurement
- [ ] Number of municipalities where new or enhanced policies, plans and practices that promote Complete Streets were proposed
- [ ] Number of municipalities that adopted and implemented policies, plans, and practices that promoted Complete Streets
- [ ] Percent of roads in a jurisdiction that are subject to Complete Streets policies, plans, and practices
- [ ] Number or percentage of residents that reside in a jurisdiction with Complete Streets policies, plans, and practices
- [ ] Number of employers that have implemented lactation support programs
- [ ] Number of hospitals that have joined NYS Breastfeeding Quality Improvement Hospital Initiative, NYC Breastfeeding Hospital Collaborative, Great Beginnings NY, or Latch On NYC
- [ ] Number of primary care practices that are designated as NYS Breastfeeding Friendly
- [ ] Number and demographics of women reached by policies and practices to support breastfeeding
- [ ] Number of public housing authorities, nonprofit community development corporations and market-rate apartment management companies educated about the dangers of secondhand smoke exposure and benefits of smoke-free multi-unit housing
- [ ] Number of municipalities that restrict tobacco marketing in stores
- [ ] Number and type of evidence-based initiatives offered by partners
- [ ] Number of participants in evidence-based initiatives offered by partners
- [ ] Percent of adults with one or more chronic diseases who have attended a self-management program
- [ ] Number of referrals to evidence-based initiatives from health care professionals
- [ ] Number and percent of adults among population(s) of focus who have attended EBIs
- [ ] Number of partners, employers and local officials participating in colorectal cancer screening awareness events
- [ ] Number of media alerts related to colorectal cancer awareness event promotions.
- [ ] Number of colorectal cancer awareness events held/promoted/attended
- [ ] Number of cancer screening events held in partnership with community providers
- [ ] Number of county worksites implementing paid time off or flex time policies for cancer screening
- [ ] Number of individuals navigated to and/or through cancer screening
- [ ] No process measures used
- [x] Other (please specify)

Number of attendees at Dance Your Heart Healthy Sessions.
Number of regular/repeat attendees.
Average weight loss per regular attendee.

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19. Promote a Healthy and Safe Environment

***39. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area**

- ◯ Outdoor Air Quality
- ◯ Water Quality
- ◯ Built Environment
- ◯ Injuries, Violence and Occupational Health

***40. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

- ◯ Incorporate 'Healthy Homes' education and inspections into other (non-health) 'opportunity points', e.g., building inspections, firefighters annual fall fund drives, installation and inspection of CO alarms.
- ◯ Provide communities interested in implementing fluoridation with outreach materials and resources to promote fluoridation as a significant health intervention.
- ◯ Support transportation options that reduce air pollution from mobile sources (e.g., support public transportation, community planning incorporating enhanced walkability or cycling, pricing strategies, greater diversification of transportation fuels).
- ◯ Promote community based programs for fall prevention.
- ◯ Develop multisector violence prevention programs (e.g., LHDs, criminal justice, social services, job training, CBOs) such as SNUG, Cure Violence or CEASEFIRE in highrisk communities.
- ◯ Other (please specify)

***41. What process measures are being used to monitor progress on this intervention?**

Choose all that apply.

- [ ] Number of opportunities that incorporate 'Healthy Homes' education and inspections into other (non-health) interactions, e.g., building inspections, firefighters annual fall fund drives, installation and inspection of CO alarms
- [ ] Number of partners that have received fluoridation outreach resources
- [ ] Number of municipalities where new or enhanced policies, plans and practices that promote Complete Streets are proposed
- [ ] Number of municipalities that adopted and implemented policies, plans and practices that promote Complete Streets
- [ ] Percent of roads in a jurisdiction that are subject to Complete Streets policies, plans and practices
- [ ] Number or percent of residents that reside in a jurisdiction with Complete Streets policies, plans and practices
- [ ] Policies enabling reimbursement by health plans for indoor asthma trigger reduction and counseling by healthcare providers about reduction of asthma triggers
- [ ] Number of people surveyed regarding mass transit ridership (from different locations in the county)
- [ ] Number of meetings with the transportation authority regarding better access to bus routes
- [ ] Number of CPT-Codes submitted for falls risk assessment and/or plan of care
- [ ] Number of evidence-based, community fall prevention programs offered
- [ ] Number of practices educated about community fall prevention services/programs
- [ ] Number of people participating in evidence-based, community fall prevention programs
- [ ] Number of partnerships on fall prevention programs for older adults
- [ ] Number of partnerships developed to coordinate services around violence prevention (or number of meetings attended to coordinate services around violence prevention)
- [ ] No process measures used
- [ ] Other (please specify)

20. Promote Healthy Women, Infants and Children

***42. Within this Prevention Agenda priority area, which Focus Area are you reporting on?**

Select one Focus Area

- ◯ Maternal and Infant Health
- ◯ Child Health
- ◯ Reproductive, Preconception and Inter-Conception Health

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***43. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

◯ Recruit and encourage hospitals to participate in quality improvement efforts based on geographic location to increase breastfeeding exclusivity at discharge.

◯ Encourage and recruit Pediatric, Family Practice, Obstetrics and Gynecology and other primary care provider and clinical offices to become New York State Breastfeeding Friendly Practices.

◯ Use the Business Case for Breastfeeding as a tool to assist employers in establishing lactation support programs.

◯ Promote the Making it Work: Returning to Work Toolkit to empower women in hourly wage positions to speak with their employers about lactation support needs in the workplace.

◯ Increase the number of employers with supports for breastfeeding at the worksite.

◯ Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and increase the number of Baby Friendly Hospitals in NYS.

◯ Implement policies that restrict infant formula marketing and distribution of "gifts" through health care providers and hospitals.

◯ Implement enhancements to WIC Breastfeeding Food Package.

◯ Recruit and encourage hospitals to participate in quality improvement efforts based on geographic location to increase breastfeeding exclusivity at discharge.

◯ Encourage and recruit Pediatric, Family Practice, Obstetrics and Gynecology and other primary care provider and clinical offices to become New York State Breastfeeding Friendly Practices.

◯ Use the Business Case for Breastfeeding as a tool to assist employers in establishing lactation support programs.

◯ Promote the Making it Work: Returning to Work Toolkit to empower women in hourly wage positions to speak with their employers about lactation support needs in the workplace.

◯ Increase the number of employers with supports for breastfeeding at the worksite.

◯ Implement maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding and increase the number of Baby Friendly Hospitals in NYS.

◯ Implement policies that restrict infant formula marketing and distribution of "gifts" through health care providers and hospitals.

◯ Implement enhancements to WIC Breastfeeding Food Package.

◯ Ask all pregnant women about tobacco use and provide augmented, pregnancy tailored counseling for those who smoke

◯ Identify and promote educational messages and formats that have demonstrated to improve knowledge, attitudes, skills and/or behavior related to prenatal care and preterm birth among target populations, including high-risk pregnant women, women of childbearing age and women with disabilities.

◯ Provide timely, continuous and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines

◯ Provide education to health care providers, such as public health detailing, to improve their knowledge, beliefs and skills related to improved use of evidence-based clinical and community-based interventions to reduce preterm birth.

◯ Develop, disseminate, promote and utilize tools for providers to prompt or facilitate well-child visit components, including checklists, registries, data systems and electronic health records.

◯ Link children and families to dental services

◯ Develop effective health marketing campaigns that promote norms of wellness, healthy behavior and regular use of preventive health care services throughout the lifespan

- ◯ Integrate preconception and inter-conception care into routine primary care for women of reproductive age including screening and follow-up for risk factors, management of chronic diseases and contraception.
- ◯ Utilize evidence-based guidelines and tools for health care providers to promote optimal well-being through utilization of preventive health services to providers.
- ◯ Develop and disseminate to providers evidence-based clinical guidelines and tools to promote patients' optimal well-being through use of preventive health services.
- ◯ Train health practitioners on disability literacy regarding women's reproductive health.
- ◯ Conduct public health detailing to improve providers' knowledge, beliefs and skills related to delivery of comprehensive, integrated preconception and inter-conception preventive health care services.
- ◯ Create referral networks and practices to streamline and simplify enrollment and renewal of health insurance for low-income women.
- ◯ Provide comprehensive, evidence-based health education, including health literacy, for children and youth in schools.
- ◯ Other (please specify)

*44. What process measures are being used to monitor progress on this intervention?

Choose all that apply

- [ ] Number of employers that have implemented lactation support programs
- [ ] Number of hospitals that have joined NYS BQIH (Breastfeeding Quality Improvement Hospital Initiative), NYC BHC, Great Beginnings NY, or Latch On NYC
- [ ] Number of primary care practices that are designated as NYS Breastfeeding Friendly
- [ ] Number and demographics of women reached by policies and practices to support breastfeeding
- [ ] WIC local agencies participating in the exclusive Breastfeeding Learning community will increase by 10% the percentage of mothers receiving the fully breastfeeding food package at 30 days.
- [ ] Inclusion of tobacco counselling in prenatal visits
- [ ] Number and percent of women within target population reached by educational campaign addressing the importance of receiving early prenatal care and attending prenatal visits
- [ ] Percentage of total prenatal patients enrolled in program
- [ ] Number and percent of women/ families who participate in family education programs (e.g., Lamaze childbirth, pre-natal breastfeeding, sibling classes and a new mom support group)
- [ ] Number and percent of providers that offer the recommended clinical services
- [ ] Number of providers reached
- [ ] Number and percent of active pediatric patients who received reminders about recommended well-child-visits
- [ ] Number of regional school-based dental sealant programs
- [ ] Number of children enrolled in school-based dental sealant programs
- [ ] Number and percent of community residents reached by campaigns
- [ ] Number of primary care providers implementing appropriate screening, management, follow-up for risk factors
- [ ] Number and percent of health care providers using evidence-based guidelines and tools to promote optimal well-being through utilization of health services
- [ ] Number and percent of target provider practices to which guidelines or tools have been disseminated
- [ ] Number of health practitioners trained on disability literacy regarding women's reproductive health
- [ ] Number and percent of targeted provider practices that received a detailing visit
- [ ] Number and percent of targeted provider practices that received a detailing visit and indicated a change in knowledge base on a pre/post questionnaire
- [ ] Number of referral networks established or expanded
- [ ] Number of organizations and agencies that participated in a referral network
- [ ] Percentage of low income women within identified target population who were enrolled in health insurance
- [ ] Number and percent of schools in catchment area that offer evidence-based health education that includes health literacy for children and youth
- [ ] No process measures used
- [ ]

☐ Other (please specify)

21. Promote Mental Health and Prevent Substance Abuse

***45. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area**

- ◯ Promote Mental, Emotional and Behavioral Well-Being in Communities
- ◯ Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
- ◯ Strengthen Infrastructure across Systems

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***46. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.**

- ◯ Assess community well-being using a standardized survey tool (e.g. BRFSS, WHO (Five) Well-Being Index, Gallup, School climate survey etc.)
- ◯ Identify evidence-based programs or community action activities that promote well-being
- ◯ Pilot or implement evidence-based programs and community action activities
- ◯ Promote smoking cessation among people with mental health disabilities through partnerships with state/local offices of Mental Health.
- ◯ Mobilize community to reduce alcohol use
- ◯ Participate in community trial intervention to reduce high risk drinking
- ◯ Participation by providers in the Internet System for Tracking Over-Prescribing - Prescription Monitoring Program (I-STOP/PMP)
- ◯ Build community coalitions that advance the State's 'Suicide as a Never Event' through promotion and prevention activities
- ◯ Administer screening programs such as SBIRT, Symptom Checklist -90 etc.
- ◯ Educate to increase positive emotions and skills such as engagement, problem-solving, growth mindset, and decrease negative emotions and skills such as feelings of hopelessness, inadequacy.
- ◯ Identify and implement healthy public policies that enhance housing, employment and education opportunities as well as reduce poverty
- ◯ Engage communities in action and create supportive environments with the goal of improving social environment, which is known to impact physical and mental health
- ◯ Implement mental health promotion and anti-stigma campaigns
- ◯ Engage multidisciplinary primary health care teams and community mental health service providers in an integrated approach to prevent, screen and manage depression in people with chronic physical conditions
- ◯ Provide training in prevention and management strategies that are known to be effective with people who report poor mental health
- ◯ Strengthen availability and access to data related to mental health wellbeing and disorder prevention
- ◯ Other (please specify)

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*47. What process measures are being used to monitor progress on this intervention

- [ ] Community Wellbeing has been assessed using a standardized survey such as the Behavioral Risk Factor Surveillance System (BRFSS) or other standardized well-being surveys.
- [ ] Alcohol outlet density: Number of outlets per geographic unit (e.g. census tract, zip code, etc).
- [ ] Youth and/or perception of harm of underage alcohol use or prescription drugs for non-medical use.
- [ ] Percent of participants who quit smoking three and/or six months after completing the smoking cessation program.
- [ ] Percent of participants with presence of suicide means in the home.
- [ ] Percent of participants with presence of meaningful supportive relationships.
- [ ] Use of systematic tools to screen individuals for mental health and substance abuse problems.
- [ ] Percent of participants who participated in evidence-based program(s) or community action activities being piloted or implemented toward preventing behavioral disorders and/or promoting mental health
- [ ] No process measures
- [ ] Other (please specify)

22. HIV, STDs, Vaccine-Preventable Diseases and Healthcare Associated Infection

*48. Within this Prevention Agenda priority area, which Focus Area are you reporting on? Select one Focus Area

- ◯ Prevent HIV and STDs
- ◯ Prevent Vaccine-Preventable Diseases
- ◯ Prevent Health Care-Associated Infections

*49. Please select one intervention from this Focus Area to report on. If there are multiple interventions, select the one that is furthest along in implementation.

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*50. What process measures are being used to monitor progress on this intervention?

- [ ] Number of co-factors addressed by each community intervention
- [ ] Number of primary care clinicians trained in treatment and diagnosis of STDs
- [ ] Availability of preferred treatment regimens in either hospitals or local pharmacies
- [ ] Protocols and supplies for preferred testing modalities according to current CDC treatment guidelines for syphilis, gonorrhea and chlamydia beyond government clinics
- [ ] Number of treatment scenarios for which there are established algorithms
- [ ] The percentage of 13-year-old children who have received the complete adolescent immunization series as indicated in NYSIS
- [ ] The percentage of children who have received the 4:3:1:3:3:1:4 immunization series between the ages of 19 to 35 months as indicated in NYSIS
- [ ] Immunization rates for health care personnel in hospitals and long-term care facilities.
- [ ] Number of sinks and alcohol based hand rubs available
- [ ] No process measures

Other (please specify)

23. Intervention detail

*51. Describe the target population (e.g., problem/burden affecting this population, demographics, geographical locations, etc.)

Populations served by New York Methodist Hospital particularly those from underserved communities, ethnic groups, economic classes

*52. What is the expected number of people to be reached by the end of 2014, or the end of the first year of activities?

40

*53. How many people have you actually reached toward this target?

We met and exceeded the target. (58 total people)

*54. Are you addressing a disparity with this intervention?

- (●) Yes
- ( ) No

24. Disparities

***55. Which of the following types of disparities are you addressing?**

Check all that apply

- [x] Race/ethnicity
- [x] Income/SES
- [ ] Gender
- [ ] Disability
- [x] Geography
- [ ] Age
- [ ] Other (please specify)

***56. How are you working with the target populations addressed by the intervention?**

Check all that apply

- [x] The intervention is focused within specific neighborhoods
- [ ] The program screens and offers services to high-need participants
- [ ] The program takes into consideration specific cultural needs (please specify)
- [ ] Other (please specify)

25. Baseline data

***57. Were baseline data collected for the process measures selected?**

Select only one

- (●) Yes, for all of them
- ( ) Yes, for some of them
- ( ) No

26. Periodicity of data collection

***58. On average, how often are you collecting data on these process measures?**

Check all that apply

- ○ Monthly
- ○ Quarterly
- ○ Twice a year
- ○ Annually
- ◉ Other (please specify)

Weekly

27. Status of Implementation Effort

***59. What is the current status of your implementation efforts related to this intervention?**

Select only one

- ○ Ahead of projected implementation schedule
- ◉ On track with implementation schedule
- ○ Behind projected implementation schedule
- ○ Have not started. If so, describe why

28. Partnership Development

***60. Who are the current partners involved in the implementation of the intervention just described?**

Check all that apply

- [ ] LHD
- [ ] Hospital
- [ ] Community health center/Federally Qualified Health Center
- [ ] Health Insurance Plan
- [ ] Business
- [ ] Philanthropy
- [ ] College/University
- [ ] Schools (K-12)
- [ ] Faith-based organization
- [ ] Media
- [ ] Government or community-based organization - Housing
- [ ] Government or community-based organization - Mental and Behavioral Health (including Substance Abuse)
- [ ] Government or community-based organization - Social Services
- [ ] Government or community- based organization - Transportation
- [ ] Government or community-based organization -Youth Focused
- [ ] Clinical or Community Based Lifestyle Change Program
- [ ] Clinical or Community Based Lifestyle Change Referral Agency
- [x] Local coalition
- [x] Other (please specify)

Community Based Dance Organization

29. Partner Engagement

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***61. What is the role of partners in this intervention? Check all that apply.**

- [x] Coordinate intervention
- [x] Conducts educational activities
- [ ] Provides a health service
- [ ] Funds the intervention
- [x] Allows/sponsors access to the site or population
- [x] Assist with advocacy
- [ ] Other (please specify)

***62. Overall, how would you rate the level of engagement of your partners/members in the implementation of this intervention?**

Select only one

- (●) Highly engaged
- ( ) Somewhat engaged
- ( ) Engaged
- ( ) Disengaged

***63. Describe any successes in engaging partners to actively work on this intervention:**

Check all that apply

- [ ] Focused efforts allowing us to make clear progress on the priority
- [x] Contributes staff time to help with intervention
- [ ] Helps with training coalition members
- [x] Enables us to offer intervention activities to a target population
- [x] Provides site for meetings
- [ ] Other (please specify)

***64. Describe any challenges in keeping members of your partnerships engaged and/or actively participating in the implementation of this intervention.**

Check all that apply

- [ ] Some partners are not focused and do not seem to know how to proceed.
- [ ] Few help contribute staff time to help with the intervention.
- [ ] Partners seem to lack training to help.
- [ ] Challenging to offer programs to target population.
- [x] Other (please specify)

No challenges with partner.

***65. Do you need help developing or sustaining partnerships with certain sectors?**

- ( ) Yes
- (•) No

30. Strengthening Partnerships

***66. What types of partnerships do you need help with?**

Check all that apply

- [ ] LHD
- [ ] Hospital
- [ ] Community health center/Federally Qualified Health Center
- [ ] Health Insurance Plan
- [ ] Business
- [ ] Philanthropy
- [ ] College/University
- [ ] Schools (K-12)
- [ ] Faith-based organization
- [ ] Media
- [ ] Government or community-based organization - Housing
- [ ] Government or community-based organization - Mental and Behavioral Health (including Substance Abuse)
- [ ] Government or community-based organization - Social Services
- [ ] Government or community- based organization - Transportation
- [ ] Government or community-based organization - Youth Focused
- [ ] Clinical or Community Based Lifestyle Change Program
- [ ] Clinical or Community Based Lifestyle Change Referral Agency
- [ ] Local coalition
- [x] Other (please specify)

None.

31. Overall Successes and Challenges of Implementation of Intervention Strategi...

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*67. What have been the successes in implementing the intervention you described?

Mark all that apply

- [x] Identifying burden/problem to be addressed
- [x] Educating the community about the problem
- [ ] Engaging community leaders to address problem
- [x] Defining target population
- [x] Establishing clear goals
- [ ] Researching evidence-based interventions to address problem among target population
- [x] Identifying process and outcome measures to monitor progress toward reaching goals
- [x] Developing data collection methods
- [x] Establishing clear implementation timelines/milestones
- [ ] Reviewing and monitoring progress with partners
- [ ] Making adjustments to implementation plan/timeline based on progress
- [ ] Disseminating results broadly through a variety of methods
- [ ] Other (please specify)

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***68. What challenges are you facing in the implementation of the intervention?**

Mark all that apply

- [ ] Identifying burden/problem to be addressed
- [ ] Educating the community about the problem
- [ ] Engaging community leaders to address problem
- [ ] Defining target population
- [ ] Establishing clear goals
- [ ] Researching evidence-based interventions to address problem among target population
- [ ] Identifying process and outcome measures to monitor progress toward reaching goals
- [ ] Developing data collection methods
- [ ] Establishing clear implementation timelines/milestones
- [ ] Reviewing and monitoring progress with partners
- [ ] Making adjustments to implementation plan/timeline based on progress
- [ ] Disseminating results broadly through a variety of methods
- [x] Other (please specify)

Budget and resources to expand.

32. Location

***69. In what county is your hospital or local health department (LHD) located?**

***70. Are you reporting from a LHD or hospital?**

Select one

- ( ) LHD
- (•) Hospital

33. LHD Contact Information Verification

***71. Please review contact information for your LHD liaison at: http://www.health.ny.gov/prevention/prevention_agenda/contact_list.htm and provide correction if needed.**

- (•) The contact information posted is accurate.
- ( ) Contact information has to be corrected.

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34. LHD Liasion

***72. LHD liaison**

Please provide the name, title, phone (with area code) and email contact of your CHA-CHIP liaison.

Name	
Title	
Phone (with area code)	
Email	

35. Hospital Name

*73. Hospital

Select the hospital you are reporting on:

Choose all that apply

- [ ] Adirondack Medical Center
- [ ] Albany Medical Center Hospital
- [ ] Albany Memorial Hospital – Northeast Health System
- [ ] Alice Hyde Medical Center
- [ ] Arnot Ogden Medical Center
- [ ] Auburn Memorial Hospital
- [ ] Aurelia Osborn Fox Memorial Hospital
- [ ] Bassett Medical Center, Cooperstown
- [ ] Benedictine Hospital – Health Alliance of the Hudson Valley
- [ ] Bertrand Chaffee Hospital
- [ ] Blythedale Childrens Hospital
- [ ] Bon Secours Community Hospital Bronx Lebanon Hospital Center
- [ ] Brookdale Hospital Medical Center
- [ ] Brookhaven Hospital Medical Center
- [ ] Brooks Memorial Hospital
- [ ] Burke (Winifred Masterson) Rehabilitation Hospital
- [ ] Calvary Hospital Inc
- [ ] Canton-Potsdam Hospital
- [ ] Carthage Area Hospital Inc
- [ ] St. Francis Hospital (Roslyn) Catholic Health Services
- [ ] St. Catherine of Siena Catholic Health Services
- [ ] St. Charles Hospital Catholic Health Services
- [ ] Catskill Regional Medical Center
- [ ] Cayuga Medical Center at Ithaca
- [ ] Champlain Valley Physicians Hospital Medical Center
- [ ] Chenango Memorial Hospital Inc
- [ ] Claxton-Hepburn Medical Center
- [ ] Clifton Springs Hospital and Clinic
- [ ] Clifton-Fine Hospital
- [ ]
- [ ] Moses-Ludington Hospital – Inter Lakes Health
- [ ] Mount Sinai Beth Israel
- [ ] Mount Sinai Hospital of Queen
- [ ] Mount St Marys Hospital and Health Center
- [ ] Nassau University Medical Center
- [ ] Nathan Littauer Hospital
- [ ] New Hyde Park Hospital - North Shore LIJ Health System
- [ ] New Island Hospital – Catholic Health Services
- [ ] New York Community Hospital of Brooklyn
- [x] New York Methodist Hospital
- [ ] New York Presbyterian Hospital - Westchester Division
- [ ] New York University Langone Medical Center
- [ ] Newark-Wayne Community Hospital - Rochester General Health System
- [ ] Niagara Falls Memorial Medical Center
- [ ] Nicholas H Noyes Memorial Hospital
- [ ] North Shore University Hospital
- [ ] Northern Dutchess Hospital
- [ ] Northern Westchester Hospital
- [ ] Nyack Hospital
- [ ] NYU Hospital for Joint Diseases
- [ ] NYU Hospitals Center
- [ ] O'Connor Hospital – Bassett Healthcare Network
- [ ] Olean General Hospital
- [ ] Oneida Healthcare Center
- [ ] Orange Regional Medical Center
- [ ] Oswego Hospital
- [ ] Our Lady of Lourdes Memorial Hospital
- [ ] Peconic Bay Medical Center – Peconic Health System
- [ ] Phelps Memorial Hospital Assn
- [ ]

- [ ] Columbia Memorial Hospital
- [ ] Community Memorial Hospital
- [ ] Corning Hospital
- [ ] Cortland Regional Medical Center Inc
- [ ] Crouse Hospital
- [ ] Cuba Memorial Hospital Inc
- [ ] Delaware Valley Hospital Inc (United Health Services)
- [ ] Eastern Long Island Hospital
- [ ] Eastern Niagara Hospital
- [ ] Edward John Noble Hospital of Gouverneur
- [ ] Elizabethtown Community Hospital
- [ ] Ellenville Regional Hospital
- [ ] Ellis Hospital
- [ ] F F Thompson Hospital
- [ ] Flushing Hospital Medical Center
- [ ] Forest Hills Hospital – North Shore LIJ Health System
- [ ] Franklin Hospital – North Shore LIJ System
- [ ] Geneva General Hospital - Finger Lakes Health
- [ ] Glen Cove Hospital – North Shore LIJ Health System
- [ ] Glens Falls Hospital
- [ ] Hospital for Special Surgery
- [ ] Hudson Valley Hospital Center
- [ ] Huntingdon Hospital – North Shore LIJ Health System
- [ ] Ira Davenport Memorial Hospital Inc
- [ ] Jamaica Hospital Medical Center
- [ ] John T Mather Memorial Hospital of Port
- [ ] Buffalo General Medical Hospital Kaleida Health System
- [ ] Kenmore Hospital - Catholic Health System:
- [ ] Kenmore Mercy Hospital
- [ ] Kingsbrook Jewish Medical Center
- [ ] Lake Shore Hospital - TLC Health Network
- [ ] Lawrence Hospital Center
- [ ] Little Falls Hospital
- [ ] Plainview Hospital - North Shore LIJ Health System
- [ ] Putnam Hospital Center – HealthQuest
- [ ] Richmond University Medical Center
- [ ] River Hospital, Inc
- [ ] Rochester General Hospital
- [ ] Rockefeller University Hospital
- [ ] Rome Memorial Hospital, Inc
- [ ] Samaritan Hospital – Northeast Health System
- [ ] Samaritan Medical Center, Watertown
- [ ] Saratoga Hospital
- [ ] Schuyler Hospital
- [ ] Seton Health System-St Mary's – St Peter's Health Partners
- [ ] Sisters of Charity Hospital – Catholic Services
- [ ] Soldiers & Sailors Memorial - Finger Lakes Health
- [ ] South Nassau Communities Hospital
- [ ] Southampton Hospital
- [ ] Southside Hospital - North Shore LIJ Health System
- [ ] St Charles Hospital
- [ ] St Elizabeth Medical Center
- [ ] St John's Episcopal Hospital South Shore
- [ ] St Johns Riverside Hospital - SJRH
- [ ] St Joseph Hospital of Cheektowaga New York
- [ ] St Josephs Hospital Health Center
- [ ] St Josephs Hospital Yonkers
- [ ] St Luke's Healthcare – Faxton Division
- [ ] St Luke's-Cornwall Hospital
- [ ] St Marys Hospital at Amsterdam
- [ ] St Peters Hospital – St Peter's Health Partners
- [ ] St. Catherine of Siena Medical Center - Catholic Health Services
- [ ] St. Charles Hospital
- [ ] St. John's Riverside Hospital – Dobbs Ferry Pavilion
- [ ] Staten Island University Hospital - North Shore LIJ Health System
- [ ] Strong Memorial Hospital

- [ ] Lutheran Medical Center
- [ ] Maimonides Medical Center
- [ ] Margaretville Hospital – Health Alliance of Hudson Valley
- [ ] Mary Imogene Bassett Hospital
- [ ] Massena Memorial Hospital
- [ ] Medina Memorial Hospital
- [ ] Memorial Hosp of Wm F & Gertrude F Jones A/K/A Jones Memorial Hosp
- [ ] Memorial Hospital for Cancer and Allied Diseases
- [ ] Mercy Hospital - Catholic Health System
- [ ] Westchester Medical Center St James Mercy Hospital Mid-Hudson Regional
- [ ] Monroe County Joint CSP (Lakeside, Rochester, Unity, Highland, Strong)
- [ ] Montefiore Medical Center
- [ ] Montefiore Mount Vernon Hospital
- [ ] Montefiore Mount Vernon
- [ ] Montefiore - New Rochelle
- [ ] Sunnyview Rehabilitation – Northeast Health System
- [ ] SUNY Downstate Medical Center
- [ ] SVCMC-St Vincents Westchester
- [ ] Syosett Hospital in Manhasset - North Shore LIJ Health System
- [ ] The Unity Hospital of Rochester
- [ ] Tri-County Memorial - TLC Health Network
- [ ] United Health Services Hospitals Inc (Binghamton General, CS Wilson)
- [ ] United Memorial Medical Center
- [ ] Westchester Medical Center
- [ ] Westchester Square Campus – Montefiore Medical Center
- [ ] Westfield Memorial Hospital Inc
- [ ] White Plains Hospital Center
- [ ] Winthrop-University Hospital
- [ ] Woman's Christian Association

Other (please specify)

*74. Hospital liaison

Please provide the name, title, phone (with area code) and email contact of your CSP liaison.

Name of Hospital CSP Liaison	Lyn Hill
Title	Vice President for Communication and External Affairs
Phone (with area code)	718.780.3301
Email Contact	lyh9001@nyp.org

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***75. If reporting for a hospital, are any of your Prevention Agenda activities incorporated in your DSRIP application?**

Select only one

- ◯ Yes
- ◯ No
- ◉ Unsure
- ◯ No DSRIP application

***76. Are the two interventions you provided detail on this report described as a community benefit in the Schedule H tax form?**

Select only one

- ◯ Yes, only the first intervention is described as a community benefit in the Schedule H tax form
- ◯ Yes, only the second intervention is described as a community benefit in the Schedule H tax form
- ◉ Yes, both interventions are described as a community benefit in the Schedule H tax form
- ◯ No, neither intervention is described as a community benefit
- ◯ Unsure

Comments:

The Community Service Plan which describes the interventions is referred to in the Schedule H form.

36. Review Summary of Plan

***77. Please review the summary of your CHIP/CSP attached. Does this accurately reflect the priorities, focus areas, goals, and interventions from the plan you submitted in 2013? Please note, these documents can also be downloaded off the commerce site. (1) You will need to sign into the commerce site at https://commerce.health.state.ny.us; (2) After you are signed in, paste the url http://tinyurl.com/summary-chip-csp on the address line.**

- ◯ Yes, the priorities, focus areas, goals, and interventions correctly reflect the plan submitted in 2013
- ◉ No, a revised description needs to be submitted. Please send changes to prevention@health.ny.gov with "Progress Report" in the Subject line.

37. Needs and Comments

78. What tools, support, or resources do you need to fully implement your plan?

Additional funding for education and administration of interventions.

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79. Is there anything else you would like us to know or any other information you would like to share?

38. Final Page

***80. Are ready to submit your survey? Changes can no longer be made after you click "done".**

- (●) Yes