Updates

• Status of Prevention Agenda Goals and Objectives
• Health Disparities Activities in Support of Prevention Agenda
• Linking Prevention Agenda with DSRIP
Opportunity to provide Feedback on Process Thus Far and Next Steps

• Intentional discussion about actions taken and what has gone well and not so well, and make improvements as needed.
Prevention Agenda 2013-2017

• Goal is improved health status of New Yorkers and reduction in health disparities through increased emphasis on prevention

• Call to action to broad range of stakeholders to collaborate at the community level to assess local health status and needs; identify local health priorities; and plan, implement and evaluate strategies for local health improvement

• Incorporated into NYS Health Care Reform efforts including DSRIP and SIM and PHIPs
Lessons Learned, Years One and Two

• LHDs and Hospitals are on track with implementation
• LHDs and hospitals are implementing a mix of evidence-based and “other” interventions and strategies
• Identifying and using measures to track process is challenging
• Collaboration in communities is strong, but some partners remain less involved, including health insurance plans, faith based organizations, schools, business and media.
• Health Disparities need attention.
• LHDs, hospitals and their partners taking advantage of many TA sessions sponsored by NYSDOH, NYAM, Hospital Associations, etc.
Percentage Of Local Health Departments, Hospitals Reporting On At least One Intervention\* By Priority Area, December 2014

- Prevent Chronic Diseases: 94.9 LHD, 95.9 Hospitals
- Promote a Health and Safe Environment: 10.3 LHD, 9.8 Hospitals
- Promote Health Women, Infants and Children: 24.1 LHD, 26 Hospitals
- Promote Mental Health And Prevent Substance Abuse: 41.3 LHD, 27.6 Hospitals
- Prevent HIV/STDs, VaccinePreventableDisease, and HealthcareAssociatedInfections: 3.4 LHD, 7.3 Hospitals

LHDs N=58   Hospitals N=123
Other
Increase participation of adult with chronic illness in a class to learn how to manage their condition.
Create linkages with local health care systems to connect patients to community preventative resources.
Increase the number employers and service providers in your county to adopt standards for healthy food and beverage procurement.
Support use of alternative locations to deliver preventive services, including cancer screening.

Chronic Disease Interventions Among Local Health Departments, Hospitals, December 2014

LHDs N=70  Hospitals N=159
Healthy Women, Infants And Children Interventions Among Local Health Departments, Hospitals December 2014

<table>
<thead>
<tr>
<th>Intervention</th>
<th>LHDs N=12</th>
<th>Hospitals N=32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote Breastfeeding</td>
<td>57.1%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Provide timely, continuous and comprehensive prenatal care services to</td>
<td>28.6%</td>
<td>37.5%</td>
</tr>
<tr>
<td>pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide education to health care providers to reduce preterm birth.</td>
<td>9.1%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Integrate preconception and interconception care into routine primary</td>
<td>3.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>care for women</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
Implement mental health promotion and antistigma campaigns

LHDs N=24 Hospitals N=34

Mental Health Interventions

Other
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.
Implement mental health promotion and antistigma campaigns

Percent
Percent Of Interventions Addressing A Disparity Among Local Health Departments, Hospitals, December 2014

LHDs N=116     Hospitals N=246
Number of Interventions Addressing Each Type of Disparity, by Local Health Departments, Hospitals, December 2014

Disparity Type Intervention Addresses

- Income/SES
- Race/ethnicity
- Geography
- Age
- Other
- Disability
- Gender

Number of Interventions Addressing Each Type of Disparity, by Local Health Departments, Hospitals, December 2014

LHDs Hospitals
Top Partnerships Local Health Departments And Hospitals Require Help To Develop, December 2014

- Health Insurance Plan: 22
- Faith-based organization: 21
- Schools (K-12): 18
- Business: 16
- Media: 16
Progress on Prevention Agenda Objectives

**Prevention Agenda Dashboard** measures progress on 96 statewide five-year health outcome indicators, including reductions in health disparities.

As of April 2014:

- 16 of the objectives were met
- 22 indicators show progress (19 with significant improvement)
- 42 not met and staying the same
- 13 not met and going in wrong direction
- Of 29 objectives tracking health disparities, making progress on only 2
New York State - Age-adjusted preventable hospitalization rate per 10,000 - Aged 18+ years

Data Source: SPARCS data as of December 2014
New York State - Prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students

Data Source: NYS Youth Tobacco Survey data as of January 2015
New York State - Percentage of adults who are obese

Data Source: NYS Behavioral Risk Factor Surveillance System data as of January 2015
Next Steps

• Obtain Year 2 data on how LHDs and hospitals are doing in December, 2015
• Prepare for next cycle of local assessment and planning
• Focus attention on health disparities
• Be explicit about connections between Prevention Agenda and Health Care Reform
Next Cycle of Community Health Improvement Planning

- Deadline: December 2016
- Aligning LHD and Hospital requirements into one guidance
- Focuses attention on implementation of interventions and does not require a comprehensive health assessment since many hospitals recently completed CHNA for DSRIP
- Collaboration among partners in identification of priorities and disparity and in development of action plan required
- Recommendation: one plan with contributions from LHDs and hospitals, but separate plans allowed
- Role for PHIPs
CHA/CHP/CSP Template

• Executive Summary
• Brief description of new data on priorities
• Identification of 2 priorities and 1 disparity being addressed collaboratively
• Action plan with goals, objectives, EBIs, and process measures to track progress
• Process for community engagement
Prevention Agenda 2013-2017 Timeline (extend to 2018?)

- **Prevention Agenda 2008-2012**
  - LHD 2014-17 CHA Hospital
  - 2013-15 CSP

- **2013**
  - Prevention Agenda Update Survey (LHDs and Hospitals)
  - Prevention Agenda Update Survey (LHDs and Hospitals)
  - Prevention Agenda Update Survey (LHDs and Hospitals)
  - Prevention Agenda Update Survey (LHDs and Hospitals)
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2014**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2015**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2016**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2017**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2018**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2019**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2020**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2021**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2022**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2023**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

- **2024**
  - Prevention Agenda Update Survey (LHDs and Hospitals)

**DSRIP (April 2014 – April 2020)**

**SIM (2015 – 2019)**

**3 year LHD and Hospital Planning**
Refreshed PA priority action plans

• Refocus our attention on interventions that are evidence based or most promising in making an impact

• Updated charts based on review of first year reports, national literature, and discussion w/ DOH subject matter experts.
# Refreshed PA priority action plan

## Priority: Prevent Chronic Disease

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Goals</th>
<th>Rec’d Interventions for Local Action</th>
<th>Rec’d Process Measures</th>
<th>Resources (web links)</th>
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</thead>
<tbody>
<tr>
<td>Obesity</td>
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<tr>
<td>Tobacco</td>
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<tr>
<td>Preventive Care and</td>
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<tr>
<td>Management</td>
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</tbody>
</table>
Changes in Chart

- **Chronic Disease**: focus attention on fewer EBIs
- **HIV/STD/Vaccine Preventable, Health Care Acquired Infections**: include EBIs that support End of AIDS
- **Mental Health/Substance Abuse**: make focus areas and interventions more specific, include ACEs and EBIs to address trauma
- **Healthy and Safe Environment**: include more specific interventions related to climate change and asthma
- **Healthy Women, Infants and Children**: focus attention on preconception and inter-conception care for women
Discussion and Questions
New York State Department of Health

Office of Minority Health & Health Disparities
Prevention and the Minority Health Council:
Creating Information for Action and
Increasing Access to Care

September 23, 2015
Office of Minority Health and Health Disparities Prevention

- Works across the Department’s programs to advance policies and support programs and initiatives that promote high quality, accessible, patient-centered, and culturally and linguistically appropriate care for all New Yorkers.

- Partners with government systems, public and private agencies, and communities to identify and realize opportunities towards eliminating health disparities and achieving health equity.

- Works with The Minority Health Council (MHC) to develop policies to address the broader social and economic factors that lead to poor health.

- Identifies “Section §240 Minority Areas” (service areas with non-white populations of 40% or more), to facilitate targeting resources to those areas.
Minority Health Council

A 14 member body appointed by the Governor and approved by the Senate, working to:

- Raise awareness about the health of racial, ethnic and underserved populations;
- Increase the engagement of local grassroots communities in public health advocacy and research; and
- Increase the number of racial, ethnic and other underrepresented individuals that work in public health.
Creating Information for Action
Creating Information for Action: Health Equity Report 2015

- Mandated by New York State Public Health Law Title II F §242

- Aligned with the NYSDOH Prevention Agenda – the State Health Improvement Plan; the Affordable Care Act; and the HHS Action Plan to Eliminate Health Disparities.
Creating Information for Action: Health Equity Report 2015 – Progress to Date

- **Section 1. Background** – an overview of health equity including definitions of key terms and concepts. (Done)

- **Section 2. How Differences are Measured: Making Sense of and Using Data** (Done)

- **Section 3. Making Connections: the Causal Chain between Place and Health** (Done)

- **Section 4. The Picture of Health in New York** – a quantitative, geographically-based picture of health equity in New York State. (In progress)
Increasing Access to Care – 2015 Listening Sessions
Voice Your Vision Buffalo – Listening Session
June 6, 2015

Source: GBUAHN Presentation to MHC - July 24, 2015
Voice Your Vision Buffalo: A Listening Session For and By the People!

Goals of Voice Your Vision Buffalo:

- To give Buffalo residents a platform to share their views on health and access to care without judgement or fear of retaliation.

- To provide healthcare professionals and political officials with an opportunity to listen to the concerns of Buffalo residents.
Voice Your Vision Buffalo: Morning Session

- Registration
- Continental Breakfast
- Call to Order – Chalma Warmley
- Welcome by Toni Vasquez, GBUAHN CFO
- Statement of Purpose by Dr. Raul Vasquez, GBUAHN CEO
- Remarks by Dr. Bert Stevenson, Principal of Bennett High School
- Buffalo Needs Assessment Overview by Dr. Henry Taylor of University at Buffalo Department of Public Health
- Community Member Panel Discussion moderated by Lou Santiago, GBUAHN VP of Executive Affairs

Source: GBUAHN Presentation to MHC - July 24, 2015
Voice Your Vision Buffalo: Breakout Sessions

Morning and Afternoon breakout sessions led by members of the community included:

- Controlling Health and Faith
- Mental Health
- Primary Language Barriers
- Over 50
- Action Planning & Goal Setting for Chronic Disease
- Housing
- Men’s Health
- Women’s Health
- LGBT Health
- Teen Health and Living Conditions

Source: GBUAHN Presentation to MHC - July 24, 2015
Voice Your Vision Buffalo: Afternoon Session

- The General Assembly included powerful recaps and testimonies from focus group representatives.

- Closing remarks were given by Dr. Carla Boutin-Foster, NYS Minority Health Council Chair and Dr. John Ruffin, Founding Director of the National Institute of Minority Health Disparities.

187 total registrants and 12 vendors were in attendance at Voice Your Vision Buffalo.

Source: GBUAHN Presentation to MHC - July 24, 2015
“What the People Said” (Key Takeaways)

- Neighborhoods should be used as a platform for promoting wellness and delivery of health care services.
- The culture of physicians and their offices must change.
- Approaches to health education and the promotion of wellness must be changed.
- Unique strategies must be formulated to deal with the unique health challenges of different social groups in the community.

Source: GBUAHN Presentation to MHC - July 24, 2015
On-site Health Initiatives

The following were made available to all participants:

- Gospel Aerobics and Pilates classes were held in the gymnasium;
- Community vendors displayed health information in the foyer; and
- A Wegmans boxed lunch was served to all attendees.

Source: GBUAHN Presentation to MHC - July 24, 2015
Next Steps

- Voice Your Vision Rochester - Saturday, October 3, 2015
- Voice Your Vision Capital District - TBD
- Policy Recommendations Report compiled and submitted to NYSDOH Commissioner
- Release NYS Health Equity Report
Prevention Agenda and DSRIP

Douglas Fish, MD
Medical Director
Office of Health Insurance Programs
Division of Program Development and Management

September 24, 2015
New York State Health Initiatives

**PREVENTION AGENDA**

**Priority Areas:**
- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections

**STATE HEALTH INNOVATION PLAN (SHIP)**

**Pillars and Enablers:**
- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- Performance measurement & evaluation

**ALIGNMENT:**
- Improve Population Health
- Transform Health Care Delivery
- Eliminate Health Disparities

**MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM**

**Key Themes:**
- Integrate delivery – create Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & health system sustainability

**POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)**

**PHIP Regional Contractors:**
- Identify, share, disseminate, and help implement best practices and strategies to promote population health
- Support and advance the Prevention Agenda
- Support and advance the SHIP
- Serve as resources to DSRIP Performing Provider Systems
New Opportunities with NY Health Care Reform

• Local Health Departments (LHDs): lead community health assessment process and lead/participate in community health improvement planning with hospitals locally and with PPSs regionally

• Hospitals: work with LHDs and community partners to conduct assessments and health improvement plans, and connect work where possible with DSRIP projects
Hospitals Reporting Interventions Part Of DSRIP Application, December 2014 (N=123 Hospitals/Groups)

<table>
<thead>
<tr>
<th>Interventions Part of DSRIP Application</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>48.0</td>
</tr>
<tr>
<td>No</td>
<td>13.8</td>
</tr>
<tr>
<td>Unsure</td>
<td>29.3</td>
</tr>
<tr>
<td>No DSRIP application</td>
<td>8.9</td>
</tr>
</tbody>
</table>
Connecting Prevention Agenda (PA) and DSRIP

• Issued Guidance to PPSs for Domain 4 that reflects PA and population health evidence-based interventions
• Reviewed Applications and Implementation Plans from PPSs to assess conformity with PA and provided suggestions for improvement
• Encourage participation of LHDs in PPS networks
• 47 tracking indicators from the PA dashboard are used for tracking population health improvement in DSRIP Domain 4 at PPS, county and state levels
Domain 3: Clinical Improvement Projects
Project 3.b.i: Cardiovascular Health

Map Key
- CVD Project Selected (3.b.i)
- Not Selected

Eight of eleven DSRIP regions selected this project area.

- Related Prevention Agenda Intervention

Region | PPS
--- | ---
New York City | Advocate Community Partners (AW)
Capital District | Albany Medical Center Hospital
Western NY | Catholic Medical Partners
Central NY | Central NY PPS
New York City | HHC Facilities
New York City | Maimonides Medical Center
Western NY | Millennium Collaborative Care (ECMC)
Mid-Hudson | Montefiore Medical Center
New York City | Mount Sinai Hospital Group
Long Island | Nassau County PPS
New York City | NY Hospital Center of Queens
Tug Hill Seaway | Samaritan Medical Center
New York City | St. Barnabas Hospital
Long Island | Stony Brook University Hospital
Southern Tier | United Health Services Hospitals

New York State of Opportunity
Department of Health
Project 3.c.i & Project 3.c.ii: Diabete

Map Key

- Diabetes Project Selected (3.c.i or 3.c.ii)
- Not Selected

Four of eleven DSRIP regions selected this project area.
- Related Prevention Agenda Intervention

<table>
<thead>
<tr>
<th>Region</th>
<th>PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>Advocate Community Partners (AW)</td>
</tr>
<tr>
<td>New York City</td>
<td>Bronx-Lebanon Hospital Center</td>
</tr>
<tr>
<td>New York City</td>
<td>Lutheran Medical Center</td>
</tr>
<tr>
<td>New York City</td>
<td>Mount Sinai Hospital Group</td>
</tr>
<tr>
<td>New York City</td>
<td>Nassau County PPS</td>
</tr>
<tr>
<td>New York City</td>
<td>Richmond Univ. Med Ctr &amp; Staten Island Univ. Hospital</td>
</tr>
<tr>
<td>Tug Hill Seaway</td>
<td>Samaritan Medical Center (both 3.c.i + 3.c.ii)</td>
</tr>
<tr>
<td>New York City</td>
<td>St. Barnabas Hospital</td>
</tr>
<tr>
<td>Long Island</td>
<td>Stony Brook University Hospital</td>
</tr>
<tr>
<td>Mid-Hudson</td>
<td>Westchester Medical Center</td>
</tr>
</tbody>
</table>
Project 3.d.ii & Project 3.d.iii: Asthma

Map Key
- Asthma Project Selected (3.d.ii or 3.d.iii)
- Not Selected

Five of eleven DSRIP regions selected this project area.
- Related Prevention Agenda Intervention

<table>
<thead>
<tr>
<th>Region</th>
<th>PPS</th>
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</thead>
<tbody>
<tr>
<td>New York City</td>
<td>Advocate Community Partners (AW)</td>
</tr>
<tr>
<td>Capital District</td>
<td>Albany Medical Center Hospital</td>
</tr>
<tr>
<td>New York City</td>
<td>Bronx-Lebanon Hospital Center</td>
</tr>
<tr>
<td>Capital District</td>
<td>Ellis Hospital</td>
</tr>
<tr>
<td>New York City</td>
<td>HHC Facilities</td>
</tr>
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<td>New York City</td>
<td>Lutheran Medical Center</td>
</tr>
<tr>
<td>New York City</td>
<td>Maimonides Medical Center</td>
</tr>
<tr>
<td>Mohawk Valley</td>
<td>Mohawk Valley (Bassett)</td>
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<tr>
<td>Mid-Hudson</td>
<td>Montefiore Medical Center</td>
</tr>
<tr>
<td>New York City</td>
<td>St. Barnabas Hospital</td>
</tr>
<tr>
<td>Long Island</td>
<td>Stony Brook University Hospital</td>
</tr>
<tr>
<td>New York City</td>
<td>The NY Hospital of Queens</td>
</tr>
<tr>
<td>Mid-Hudson</td>
<td>Westchester Medical Center</td>
</tr>
</tbody>
</table>
Example: Asthma Collaboration in Schenectady

• iHANY (Ellis & St. Peter’s PPS) project plan
  o Asthma self-management program: home environmental trigger reduction, self-monitoring, medication use, patient follow-up.

• Ellis Hospital and Schenectady County Health Department collaborative Community Service Plan/Community Health Improvement Plan
  o Care coordination, home visits/assessments, and asthma education for patients
  o Implement smoke-free policies at two mental health offices
  o Improve prescribing concordance with NIH guidelines
  o Complement the Better Neighborhood Program that works toward improving the neighborhood (e.g. tobacco, lead poisoning, asthma)

• Participating Community Partners
  o Asthma Coalition of the Capital Region
  o Schenectady Asthma Support Collaborative (intensive case management in high needs areas)
  o Schenectady School-Based Asthma Management Program
  o Capital District Tobacco-Free Coalition (set up tobacco-free housing in three municipal housing developments, and continuing work to increase smoke-free housing in all neighborhoods in the County)
Project 3.d.iii: HIV/AIDS

Map Key
- HIV/AIDS Project Selected (3.e.i)
- Not Selected

One of eleven DSRIP regions selected this project area.
- Related Prevention Agenda Intervention

<table>
<thead>
<tr>
<th>Region</th>
<th>PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>The NY and Presbyterian Hospital</td>
</tr>
</tbody>
</table>
## Project 3.f.i: Perinatal Health

### Map Key
- **Perinatal Health Project Selected (3.f.i)**
- **Not Selected**

Three of eleven DSRIP regions selected this project area.

- Related Prevention Agenda Intervention

### Regions and PPS

<table>
<thead>
<tr>
<th>Region</th>
<th>PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>Bronx-Lebanon Hospital Center</td>
</tr>
<tr>
<td>Western NY</td>
<td>Catholic Medical Partners</td>
</tr>
<tr>
<td>Finger Lakes</td>
<td>Finger Lakes PPS</td>
</tr>
<tr>
<td>Western NY</td>
<td>Millennium Collaborative Care (ECMC)</td>
</tr>
</tbody>
</table>

---

New York City

![New York City Map](image)
Domain 4: Population-wide Projects (Prevention Agenda)
Projects 4.a.i,ii,iii: Mental Health and Substance Abuse

Sixteen PPSs in ten regions selected MH/SA projects

Map Key
- MH/SA Project 4.a.i Selected
- MH/SA Project 4.a.ii Selected
- MH/SA Project 4.a.iii Selected
- No MH/SA Project Selected

Related Prevention Agenda Intervention

<table>
<thead>
<tr>
<th>Region</th>
<th>PPS</th>
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<tbody>
<tr>
<td>Western NY</td>
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<td>Stony Brook University Hospital</td>
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<td>New York City</td>
<td>Richmond Univ. Med Ctr &amp; Staten Island Univ. Hospital</td>
</tr>
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<td>HHC Facilities</td>
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<td>Bronx-Lebanon Hospital Center</td>
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<td>Maimonides Medical Center</td>
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<td>St. Barnabas Hospital</td>
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<td>Tug Hill Seaway</td>
<td>Samaritan Medical Center</td>
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<td>Long Island</td>
<td>Nassau County PPS</td>
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<tr>
<td>Southern Tier</td>
<td>United Health Services Hospitals</td>
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<tr>
<td>North Country</td>
<td>Adirondack Health Institute</td>
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</table>
**Project 4.b.i: Tobacco Cessation**

Map Key
- Chronic Disease 4.b.i Project Selected
- Not Selected
- Six of eleven DSRIP regions selected this project area.

- Related Prevention Agenda Intervention

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<th>Region</th>
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<tr>
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<td>Long Island</td>
<td>Nassau County PPS</td>
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<td>Mid-Hudson</td>
<td>Refuah Health Center</td>
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<td>Montefiore Medical Center</td>
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<td>Westchester Medical Center</td>
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<td>Lutheran Medical Center</td>
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<td>The NY and Presbyterian Hospital</td>
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</table>
Project 4.b.ii: Preventive Care Management

<table>
<thead>
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<th>Focus of 4.b.ii</th>
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<td>Adirondack Health Institute</td>
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<td>Advocate Community Partners (AW)</td>
<td>Cancer and hepatitis screening; HPV vaccines</td>
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<td>Capital District</td>
<td>Albany Medical Center Hospital</td>
<td>Cancer screening</td>
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<td>Finger Lakes</td>
<td>Finger Lakes PPS</td>
<td>Obesity and Tobacco in high risk populations, especially low SES</td>
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<tr>
<td>Mid-Hudson</td>
<td>Montefiore Medical Center</td>
<td>Cancer screening and prevention</td>
</tr>
<tr>
<td>New York City</td>
<td>Mt. Sinai Hospital Group</td>
<td>Cancer, Hep C, Chlamydia screening; increase well child visits</td>
</tr>
<tr>
<td>New York City</td>
<td>Richmond Univ. Med Ctr &amp; Staten Island Univ. Hospital</td>
<td>Cancer, COPD and hypertension</td>
</tr>
<tr>
<td>Tug Hill Seaway</td>
<td>Samaritan Medical Center</td>
<td>COPD and Cancer</td>
</tr>
<tr>
<td>Long Island</td>
<td>Stony Brook University Hospital</td>
<td>Cancer screening; tobacco cessation; obesity</td>
</tr>
<tr>
<td>Southern Tier</td>
<td>United Health Services Hospitals</td>
<td>COPD</td>
</tr>
<tr>
<td>Mid-Hudson</td>
<td>Westchester Medical Center</td>
<td>Cancer screening</td>
</tr>
</tbody>
</table>

Map Key
- Chronic Disease 4.b.ii Project Selected
- Not Selected
- Eight of eleven DSRIP regions selected this project area.
- Related Prevention Agenda Intervention
Project 4.c.i & 4.c.ii: HIV and STDs

Map Key
- HIV/STD Project Selected (4.c.i or 4.c.ii)
- Not Selected

Region | PPS
---|---
New York City | Bronx-Lebanon Medical Center
New York City | HHC Facilities
New York City | Lutheran Medical Center
New York City | Maimonides Medical Center
New York City | Mount Sinai Hospitals Group
New York City | St. Barnabas Hospital
New York City | The NY and Presbyterian Hospital
New York City | The NY Hospital of Queens
Project 4.d.i: Reduce Premature Births

Map Key
- Women, Infants and Children Project Selected (4.d.i)
- Not Selected

Two of eleven DSRIP regions selected this project area.
- Related Prevention Agenda Intervention

<table>
<thead>
<tr>
<th>Region</th>
<th>PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central NY</td>
<td>Central NY PPS</td>
</tr>
<tr>
<td>Western NY</td>
<td>Millennium Collaborative Care (ECMC)</td>
</tr>
</tbody>
</table>
Summary

• Significant alignment between the Prevention Agenda and DSRIP projects
• PPSs embracing Domain 3 and 4 projects and concept of population health
• Ongoing commitment to collaborate and focus on many of the priorities of the Prevention Agenda with DSRIP
Question for Discussion

• What opportunities are there to strengthen linkages between partners and between initiatives to maximize impact?