NYC - Hospital for Special Surgery - CSP
2017 Update

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Priority	2017 Progress to Date	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s)	Strengths	Challenges? How will they be addressed?	Focus Area	Goal	Objectives	Disparities	Interventions/ Strategies/Activities	Family of Measures
Prevent Chronic Diseases	In 2017, SNEAKER: • Developed one new partnership with Public School (PS) 116 to implement the program • Implemented three SNEAKER program in PS116 reaching a total of 72 third grade students **Outcomes Measures:** • Students knowledge scores significantly increased by 54%; p< 0.001 Student who understood the concept/importance of : • Fruits serving consumed each day increased by 480%; p < 0.001 • Adding whole grains to their diet increased by 133%; p < 0.05 • Reduced milk (1%) as a healthier choice increased by 138%; p < 0.05 • Low-fat yogurt as a healthier choice increased by 46%; p < 0.001 • Students that consumed reduced fat significantly increased by 71%	City government	In 2017, SNEAKER partnered with NYCDOE and Public School (PS) 116. Our partners role include: • Providing schools to conduct SNEAKER program (Transactional) • Providing an avenue to recruit potential schools for the SNEAKER program (Leadership). • Providing health educators from the HSS Nutrition and Food Service Department to implement SNEAKER program (Informational)	Our relationship with the NYCDOE has helped to increase awareness of SNEAKER through the NYCDOE School Wellness Weekly Newsletter in order recruit potential schools for the program.	A significant challenge has been scheduling with schools. While the initial interest for the program is high, it is difficult for schools to find time in their schedules to implement the program. To address this challenge, we will continue to explore other ways to engage schools in the program to address obesity. Furthermore, the Train the Trainer model was not implemented as a pilot due to lack of funding. We are currently exploring additional funding opportunities.	Reduce obesity in children and adults	Create community environments that promote and support healthy food and beverage choices and physical activity	1. Increase knowledge on specific nutrition areas keyed to the curriculum 2. Improve healthy behavior and lifestyle on selecting healthier food choices and physical activity	Yes, the SNEAKER program will serve children living in underserved communities who are either obese or at risk for obesity.	Super Nutrition Education for All Kids to Eat Right (SNEAKER©): A 7-week interactive nutrition and physical activity education program is designed to provide children and families with essential knowledge about healthy eating and physical activity. The SNEAKER program was designed based on the following evidence-based interventions: • It's All About Kids - a 6 week program shown effective in improving food choices and increasing physical activity among elementary school students with weekly 30-minute classroom lessons. https://www.ncbi.nlm.nih.gov/pubmed/19328263 • Programs that involve parents have proved to be effective like the Health in Adolescents program. http://www.med.uio.no/imb/english/research/projects/heia . The SNEAKER curriculum is comprised of the following evidenced-based models • Choose MyPlate - https://www.choosemyplate.gov • Team Nutrition – https://www.fns.usda.gov/tn/team-nutrition/	During each of the next three years, the following process measures will be assessed: • The train the trainer curriculum will be developed • Number of educational programs implemented in schools • Number of new partnerships generated for program expansion (CBO's, Train the Trainer pilot); During each of the next three years, the following outcome measures will be assessed: • % of participants who gained knowledge about specific nutrition areas keyed to curriculum • % of participants who increased physical activity • % of participants who increased fruit and vegetable consumption • % of participants who decreased average screen time • Number of participants that complete the program • Number of trainees enrolled in the Train the Trainer pilot program
	In 2017,the Asian Community Bone Health Initiative: • Conducted two educational lectures reaching 138 participants • Conducted four eight-week sessions of Arthritis Foundation Exercise Programs (AFEP) exercise programs reaching reaching 517 participants • Conducted one eight-week session of yoga reaching 67 participants • Developed two new partnerships with a community based organization - Chinese Community Center of Flushing and HSS China Exchange Program **Outcomes Measures:** • Participants that experienced any muscle pain or joint pain decreased by 42%; p < 0.001 • 95% of participants reported decrease in stiffness • 92% of participants reported decrease in their fatigue • 96% of participants reported improvement in their balance • Reduced Health Limitation - Participants that could lift/carry groceries significantly increased by 46%; p < 0.001 - Participants that could climb one flight of stairs significantly increased by 45%; p < 0.001 - Participants that could climb several flights of stairs significantly increased by 55%; p < 0.001 - Participants that could bend, kneel, or stoop significantly increased by 45%; p < 0.001 • Increased physical activity - Participants engaging in moderate intensity for more than 3 times a week significantly increased by 39%; p < 0.001 - Participants engaging in vigorous intensity for more than 3 times a week significantly increased by 42%; p < 0.001 • Participants that felt confident about exercising without making symptoms worse significantly increased by 21%; p < 0.001) • 98% of participants gained knowledge in osteoporosis and/or osteopenia	Community-based organizations	The ACBHI had developed key partnernership with CBOs serving asian communities and the HSS China Exchange program. These partnerships have provided an effective way of overcoming the language and cultural barriers that may exist among the Asian older adult population. Essentially, the roles of our community partners include: • Marketing educational lectures and exercise program (Transactional) • Recruitment participants in the community to participate in educational lectures and exercise programs (Transactional) • Providing location to host educational lectures and exercise programs (Transactional) • Providing education in the spoken language of the participants at the senior centers	The collaboration with the HSS China Exchange Program has enabled ACBHI to allow for an opportunity of learning and engagement with Asian older adults through the educational lectures provided by their expert program staff.	• No Chronic Disease Self-Management Programs (CDSMP) have been offered since Spring 2016. Trainings for staff to implement this program are no longer being offered by the NY state. • Language barrier at Mott Street Senior Center. This has been addressed by identifying a Cantonese speaking HSS nutritionist to provide lectures in Cantonese. • The unexpected closing of the Chinese Community Center of Flushing, our newly acquired partnership; thereby terminating the potential for future collaborations. We will continue to explore partnerships with community centers serving the Asian population in Flushing.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Increase Asian older adults' awareness of musculoskeletal conditions such as Osteoarthritis and Osteoporosis 2. Increase knowledge of chronic disease self-management techniques, the importance of and techniques for improved provider-patient communication and falls prevention 3. Improve musculoskeletal health among Asian seniors by: • decreasing musculoskeletal pain, stiffness, fatigue and falls • improving balance and health status • increasing frequency of physical activity and self-efficacy • decreasing health limitations	Yes, this program serves at-risk older adult members of NYC's Asian community with low socio-economic status, limited English proficiency and cultural barriers.	HSS Asian Community Bone Health Initiative (ACBHI): The overall goal is to help Asian seniors better manage chronic musculoskeletal disorders while also increasing access to care in this medically underserved community. ACBHI's utilize evidence based interventions and promising practice such as • Yoga - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3156498/ • The Arthritis Foundation Exercise Program (AFEP) - https://www.cdc.gov/arthritis/interventions/physical-activity.html • Self-efficacy program to prevent osteoporosis among Chinese immigrants: A randomized controlled trial. https://www.ncbi.nlm.nih.gov/pubmed/22048557	During each of the next three years, the following process measures will be assessed: • Number of education lectures and exercise programs (Yoga, AFEP) implemented • Number of new partnerships and linkages with CBOs • Number of participants that engaged in exercise programs • Number of participants that attended exercise lectures During each of the next three years, the following outcome measures will be assessed: • % of participants who decrease in musculoskeletal pain, stiffness, fatigue, health limitations and falls • % of participants who improve balance, health status and/or self-efficacy • % of participants who increase physical activity • % of participants who gained knowledge
	In 2017, the Musculoskeletal Health Wellness Initiative (MHI): • Implemented 108 educational workshops and lecutures programs reaching 1,115 participants • Implemented 491 exercise classes ; reaching 3,301 participants • Developed one new partnership with the HSS Stamford Health Initiative • Conducted six new on-demand webinars reaching 118 participants • Continued to explore the feasibility of partnering with senior centers and/or faith based agencies to hold live educational webinars **Outcomes Measures:** • 95% of participants demonstrated knowledge/material comprehension about musculoskeletal conditions • 92% of participants demonstrated ability to apply self-management techniques • 96% of participants indicated intent to change health behaviors • The number of participants who reported improved self-efficacy to exercise significantly increased by 29%; p<0.01 • The number of participants who reported lower pain intensity significantly increased by 50%; p<0.05 • 73% of participants reported improved balance ratings • 76% of participants reported decreased stiffness • 57% of participants reported decreased fatigue • 11% of participants reported decreased falls	Other (please describe partner and role(s) in column D)	Our implementation partners include internal multi-disciplinary staff (i.e. RN, SW, MD, PT, etc.) and their roles are: • Providing expertise in programming to address musculoskeletal health needs (Advisory) • Presenting at educational lectures, workshops or forums (Informational)	Securing studio space outside of the HSS main building during the latter part of the year has allowed for more consistent class scheduling	• In evaluating our program, we identified some age related issues among participants that may or may not be attributed to our exercise classes. To address this, we will be conducting informal interviews with participants to get a deeper understanding of our program data. • Space to hold exercise classes continues to be an issue. With a large demand for programming space within the main hospital, exercise classes cannot be scheduled consistently. To address this, we are exploring options outside of the hospital's main building. • Low attendance in our Intermediate Pilates and Yogalates exercise classes. This will be addressed by expanding our marketing strategy and sharing the program flyers with community partners.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	Program objectives include: 1. Increase participants knowledge of musculoskeletal conditions and self-management techniques 2. Improve musculoskeletal health among participants by: • Decreasing musculoskeletal pain, stiffness, fatigue, falls and functional limitations • Improving balance and self-efficacy to manage chronic conditions • Improving self-efficacy around communication with health care providers	Yes, this program serves at-risk adults and older adults by providing free or low-cost chronic disease health education programs and exercise classes.	Musculoskeletal Health Wellness Initiative (MHI): HSS developed the Musculoskeletal Health Initiative (MHI), which is comprised of educational and exercise programs, to raise awareness, educate and reduce the impact of musculoskeletal conditions (such as Osteoarthritis, Osteoporosis, Rheumatoid Arthritis, Gout, Fibromyalgia) in the community. MHI employs various evidence-based/promising practices in bringing the use of exercise and education regarding musculoskeletal health to the general community such as: • Yoga -https://www.ncbi.nlm.nih.gov/pubmed/21168108 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3156498/ • Pilates - http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0100402 • Tai Chi - https://www.ncbi.nlm.nih.gov/pubmed/23620778 https://taichiforhealthinstitute.org/programs/tai-chi-for-arthritis/ https://www.ncoa.org/wp-content/uploads/Tai-Chi-for-Arthritis-Information-and-Guidance.pdf • Dance - https://www.ncbi.nlm.nih.gov/pubmed/28610676 In addition, the program also utlizes principles based on the Adult Learning Theory - https://lincs.ed.gov/sites/default/files/11_%20TEAL_Adult_Learning_Theory.pdf	During each of the next three years, the following process measures will be assessed; • Number of educational lectures/workshops implemented • Number of webinars delivered • Number of exercise classes implemented • Number of participants reached through lectures/workshops, exercise classes and webinars; During each of the next three years, the following outcome measures will be assessed: - % of participants who demonstrate knowledge/material comprehension about musculoskeletal conditions and self-management techniques - % of participants who indicate intent to change health behaviors - % of participants with improved health status and balance ratings - % of participants who report decreased pain, stiffness, fatigue, falls and health limitations - % of participants who report increased self-efficacy to exercise, manage chronic conditions and communicate with health care providers

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	In 2017, the Charla de Lupus/Lupus Chat*: • Implemented a preliminary needs assessment (a pilot survey) with seven males with lupus, analyzed the results and developed a report. • Utilized survey results and feedback from patient and physician partners by forming an Advisory Board of three male lupus patients and three Rheumatologists to develop a comprehensive needs assessment tool. • Recruited participants for the needs assessment • Application for IRB approval is deferred to 2018 • Administration of the needs assessment, analysis of data and development of a report is deferred to 2018 • Share results from needs assessment with clients, clinicians and community partners is deferred to 2018 • Provision of trainings to reproductive health community partners about SLE and reproductive health considerations, with a focus on male SLE patients is deferred to 2018 **Outcomes Measures** • 98% of participants reported knowledge gain • 96% of participants gained self-management skills to manage thier condition	Hospital	Our partners role include: • Providing specific feedback on needs assessment questions, and specific guidance on IRB process (Advisory) • Providing feedback on tools relevance to lived male experience of lupus, with a focus on cultural considerations & health literacy (Advisory). • Sharing survey with male program participants (Transactional).	The following factors have enabled implementation of the program: • Patient Participatory Research laid the framework for our study, as suggested by evidence-based literature for this type of assessment. • The newly developed male advisory board provided information related to their personal experiences with lupus that shaped the tool. • Collaboration and commitment from three specific male Rheumatology physicians who represent 80 years of experience working with the lupus population. • Inclusion of validated measures such as the PHQ9, Multidimensional Health assessment to help facilitate national comparisons to different populations. • Bilingual/Bi-cultural staff & partners allows for attention to cultural specific needs of population allowing us to reach a more diverse population.	• Implementation of the comprehensive needs assessment was deferred until 2018 due to time, resources and scheduling issues, as well as length of time required for the IRB approval process.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Increase overall knowledge of SLE including diagnosis, treatment and self-management goals in the lupus community, with a specific focus on culturally diverse males with lupus, their families and loved ones. 2. Improve culturally relevant knowledge of sexual health among traditionally underserved males with lupus by partnering with rheumatologists, sexual health professionals and CBOs to : • Increase lupus self-management skills • Improve self-efficacy related to negotiating and communicating about lupus and sexual health with providers and partners • Enhance sexual decision making skills between patient and sexual partners • Increase awareness and access to appropriate sexual health care throughout NYC	Yes, this action will address disparity by serving SLE patients from traditionally underserved neighborhoods throughout NYC, with low socio-economic status, limited English proficiency and cultural barriers.	HSS Charla de Lupus/Lupus Chat*: The Charla de Lupus/Lupus Chat ("Charla") is a social work led program that engages and trains peer volunteers to become empowering role models by providing culturally relevant strategies to help increase understanding of this complex illness and its treatment, improve medical adherence, and enhance coping and healthy behaviors. The program's interventions are informed by evidence –based and promising practice models such as: • Planned Parenthood's Fundamental Education on Life, Love and Sexuality (FELLAS) - https://www.plannedparenthood.org/planned-parenthood-new-york-city/stray-pages/fellas • Program and the Young Men's Initiative (YMI) - http://www1.nyc.gov/site/ymi/initiatives/programs.page • Participation Action Research (PAR) - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566051/	During each of the next three years, the following process measures will be assessed: • Number of people who participate in needs assessment • Number of males with SLE who participate in the interventions • Number of new partnerships and linkages with CBOs; During each of the next three years, the following outcome measures will be assessed: • Number of participants who report knowledge gain, increased self-efficacy and intent to change behavior or integrate tools and strategies for self-managing or coping with their or a loved one's lupus • Number of sexual health professionals who report increase in their overall knowledge of male patients with SLE, including diagnosis, treatment, and management goals • Number of male patients with SLE who report knowledge gained and increased self-efficacy; Number of male patients with SLE who report an increased ability to negotiate sexual decisions and who report increased skills on how to communicate with partners and health care professionals about sexual health in order to effectively advocate and optimize their own health
	In 2017, the VOICES 60+ Senior Advocacy Program: • Reviewed the survey results from Year 1 and adjusted its education programs • Conducted five community education programs in English and Spanish reaching 59 older adults • Conducted two service provider programs reaching 22 participants • Presented at ESCOTA meeting to 50 service providers of older adults • Presented a workshop at Aging in America National Conference on Aging reaching 15 participants. • Conducted two programs with new community based organizations • Participated in two senior health fairs providing health education material reaching 250 participants. • Did not conduct the initial Task Force community partnership meetings due to staff changes. • Hosted the annual VOICES 60+ Holiday Event reaching 48 participants. • Developed three new collaborations with community partners. **Outcomes Measures:** • 97% of participants were satisfied with the program • 95% of participants reported knowledge gain and increased understanding • 97% of participants gained self-management skills to manage thier condition	Community-based organizations	Our partners provide: • Target audience/population served (Transactional) • Collaboration and planning meetings to identify mutual goals (Transactional) • Promotion of educational workshops to the target audience (Transactional) • Space and coordinated logistics (Transactional)	The following factors have enabled implementation of the program: • Our partners serve a diverse multicultural population which we wanted to access and target our interventions (older adults who are bilingual- English/Spanish and their service providers). • The evidence based tools provided met mutually agreed upon goals to improve self-management skills and the health literacy of ethnically diverse older adults.	• Competing senior center programming limits program implementation. This will be addressed by improving schedule coordination to identify optimal time for programs. • Leadership changes internally and with partner agencies prevented the launching of the Community Task Force. We anticipate that new staff will establish partnerships with leadership in community agencies in 2018.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Increase awareness about the health literacy needs of ethnically diverse older adults, and its impact on chronic disease self-management and health outcomes. 2. Improve chronic disease/arthritis self-management of ethnically diverse older adults, with a focus on Spanish speakers, through learning specific techniques to enhance health literacy and patient provider communication. 3. Enhance healthcare team's awareness of patient health literacy challenges, assessment and intervention strategies to improve understanding of illness and treatment to enhance communication, adherence, and improved outcomes. 4. Publicize and promote best practices through dissemination at local and national professional conferences and venues.	Yes, this action will address disparities serving at-risk older adult members of NYC's ethnically diverse older adult community with low socio-economic status, limited English proficiency and cultural barriers, which may include differences in health beliefs, values and cultural norms and practices, with a specific focus on Spanish speaking older adults.	HSS VOICES 60+ Senior Advocacy Program: VOICES 60+ is designed to enhance the medical care experience of low income, ethnically diverse (primarily Hispanic) HSS patients 60 and older in these areas. The program utilizes evidence based strategies from the Health Literacy Universal Precautions Toolkit such as • Teach me back - https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-6/index.html • Tell Me - https://npsf.site-ym.com/default.asp?page=askme3 • the SILS (single-item literacy screener)- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1435902/	Number of education programs implemented • Number of new partnerships and linkages with CBOs • Number of participants attending education programs Rate of satisfaction with program • Increase in understanding and knowledge learned • Intended behavior change
	In 2017, the Lantern program: • Reached out to the Asian-led and Asian-servicing organization for provider network expansion: the Chinese American Independent Practice Association (CAIPA) • Implemented two community education programs for lupus patients, families, and community members reaching 78 participants • Hosted the Annual Asian Lupus Community Lunch gathering reaching 39 community members • Facilitated two psychosocial support groups (English only) reaching 10 paticipants • Participated in seven community health events reaching a total of 889 community members • Collaborate with 2-3 community partners to implement 1-2 professional education programs is deferred to 2018 **Outcome Measures** • All (100%) were satisfied with the program • 96% of participants reported increase in knowledge and self-management skills	Community-based organizations	Our partners role include: • Providing meeting venue and facilities (Transactional) • Collaborating on planning and implementation for LANtern's Health Presentation and the Annual Luncheon (Transactional) • Providing resources for promoting LANtern's Health and Wellness Day (Transactional) • Sharing membership directory for promoting LANtern's Health & Wellness Day (Transactional)	The following factors have enabled implementation of the program: • Strong support from LANtern's Community Advisory Board and our community partners who offered helpful resources, expertise and planning input. • Guided by the results of our program needs assessment, LANtern geared its programming towards patients' health-related concerns hence implemented programs that met these needs, including Chinese/English. translation/interpretation. • In consensus with our participants, Advisory Board, and community partners, Lantern was able to create a safe, trusting and welcoming space for patients/loved ones to share their voices. The increase in comfort level and open attitude led them to reach out to LANtern's support network.	• Staffing issues – The program manager has been on extended leave, from 8/17 to 5/18. We are addressing this in the interim with some coverage by Social Work Programs Director, and plan to hire a temporary replacement for the Manager position for this extended leave. • Scheduling issues – People finding the time to attend psychosocial support groups given individuals' work/school schedules; we have had to defer on support group meetings and planning during this time.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Educate professional providers about lupus who serve diverse Asian ethnic groups, to enhance needed care for these underserved communities. 2. Increase awareness and understanding about lupus and its impact among Asian-led and Asian-serving organizations 3. Enhance peer support and connections, emotional wellness, lupus knowledge and disease self-management techniques through culturally tailored, patient-oriented programs	Yes. Lupus is a complex and multi-system life-threatening autoimmune disease that affects Asians 2-3 times as frequently as their white counterparts, with significant health disparities reported in age of onset, severity of symptoms, and mortality.	HSS LANtern* Lupus Asian Network: LANtern is the only hospital-based support and education program designed specifically for Asians/Asian Americans with lupus. Since its inception in 2001, the program has served as a national model for multi-tiered culturally tailored interventions. The program's interventions are informed by evidence –based practices models such as: • Group psychosocial program - https://www.ncbi.nlm.nih.gov/pubmed/?term=ng+p%2C+chanw%2C+group+psychosocial+support+program+for • Psychoeducational intervention - https://www.ncbi.nlm.nih.gov/pubmed/?term=rutter+sj%2C+kiemle+G%2C+exploring+the+social+and+interpersonal+experience+of+south+Asian+women+with+a+diagnosis+of+systemic+lupus+erythematosus • Exploring social and interpersonal experiences - https://www.ncbi.nlm.nih.gov/pubmed/?term=rutter+sj%2C+kiemle+G%2C+exploring+the+social+and+interpersonal+experience+of+south+Asian+women+with+a+diagnosis+of+systemic+lupus+erythematosus	During each of the next three years, the following process measures will be assessed: • Number of educational programs planned and implemented • Number of community partnerships and linkages that are both new and sustained • Number of participants who engaged in patient related programs • Number of participants that attended educational programs for professionals; During each of the next three years, the following outcome measures will be assessed: • Participant satisfaction • Increased knowledge, and self-management skills • Professional education participants who increased their lupus knowledge and intended practice
	In 2017, the Inflammatory Arthritis Support and Education Programs: • Conducted three focus groups reaching 33 participants • Facilitated 16 support and education programs reaching 246 attendees • Initiated multi-level analysis of needs assessment and community partnership input to develop culturally relevant pilot community psycho-educational program, providing disease-specific education to Spanish- speaking Latino people with RA. • Identified four potential community partners • Provided two community education lectures on disease-specific information with focus on Spondyloarthritis and Early RA reaching 90 participants. The content was captured for on-demand webinars. **Outcome Measures:** • 98% of participants were satisfied with the program. • 93% of participants reported knowledge gain. • 93% of participants gained self-management skills to manage thier condition.	Advocates	Our partners role include: • Providing patient education materials in print and digital format (Informational) • Promoting program via email, multiple social media platforms, partner website, e-newsletter (Transactional) • Providing input regarding curriculum of community education lectures (Advisory)	Factors that have enabled program implementation include: • Expertise of internal multi-disciplinary team (eg, RN, MSW, MD, PT), incorporating patient perspective and external partners in planning curriculum • Promotion via social media (internal and community partners)	• Personnel resources: Group coordinator was away on extended leave, which was a barrier to completing our target of four scheduled focus groups. The Group coordinator has since returned from leave.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Provide disease-specific education and psychosocial support to people with longstanding and newly diagnosed rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA) and gout to enhance disease self- management and coping strategies. 2. Provide disease-specific education to Spanish-speaking people with RA to address health disparities in disease outcomes in this population.	Yes. The pilot psychoeducational community program for Latino/Hispanic RA patients will address health disparity regarding poor outcomes in pain and disability in this population.	HSS Inflammatory Arthritis Support and Education Programs: The RA Support and Education programs were developed in 1999 to meet the specific psychoeducational needs of people with long-standing rheumatoid arthritis, and for people newly diagnosed. Based on evidence-based strategies, we have adapted models to develop and implement programs aimed at enhancing self-efficacy, disease self-management and coping strategies such as: • Nurse-led group intervention for RA and PsA patients. Elements of this intervention are used in our programs - https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-016-0150-x • Community-Based Spanish Language Arthritis Education Program - http://www.jstor.org/stable/3767425 • Findings from EULAR recommendations for effective patient education for inflammatory arthritis. Findings are integrated in our intervention approach - http://ard.bmj.com/content/74/6/954.short	During each of the next three years, the following process measures will be assessed: • Number of attendees • Number of new partnerships • Number of support and education group programs • Number of disease-specific community education lecture programs; During each of the next three years, the following outcome measures will be assessed: -Participant satisfaction - Intent to change disease self- management skills/ behaviors - Knowledge

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Priority	2017 Progress to Date	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s)	Strengths	Challenges? How will they be addressed?	Focus Area	Goal	Objectives	Disparities	Interventions/ Strategies/Activities	Family of Measures
	In 2017, the Nursing Community Education Outreach (NCEOP): • Conducted 29 educational sessions reaching approximately 250 individuals. • Deveolped programs three new partnerships: Lenox Hill/St. peter's Church, Gouverneur Court and the Young Women's Leadership School-Astoria. • Collaborated with the United States Bone & Joint Initiative (USBJI) to deliver session on arthritis. • Developed partnerships with one additional interdisciplinary group (Pediatrics) to provide Bone Health lecture to school aged children. • Provided education in Spanish and Cantonese to address a more diverse audience. • Taught middle school and high school classes, and used an audience response system which is an interactive teaching method. **Outcome Measures:** • 90% of participants were satisfied with the program. • 91% of participants reported increase in knowledge. • 90% of participants gained self-management skills to manage thier condition.	Community-based organizations	Our partner roles include: • Partnering with NCEOP program staff to identify educational needs of the community based on results from the HSS Community Health Needs Assessment (CHNA) and program evaluations (Transactional) • Educating the NCEOP staff on needs of the community (Informational) • Marketing educational lectures and workshops (Transactional) • Recruiting participants in the community to participate in educational offering (Transactional) • Providing location to host educational programs (Transactional)	Having one part-time staff member totally dedicated to this program has created continuity and has led to the addition of some new sites	We are training some clinical bedside nurses to provide education. The challenge is identifying nurses who will participate in this on their days off and finding times that work for them and for our community partners. This is addressed by receiving approval for staff to use continuing education annual allotment for community service to increase participation.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Improve health management for seniors by building knowledge, skills and confidence on topics various topics that are relevant to seniors. 2. Increase self-care management on musculoskeletal health conditions for children.	Yes, this action will address disparity serving at-risk members of NYC's community with low socio-economic status.	HSS Nursing Community Education Outreach (NCEOP): HSS' nursing community outreach program (NCEOP) targets underserved older adults living in the community. The program's overall goal is to deliver evidence-based educational content germane to issues appropriate for older adults. Our Nursing community sessions are based which are evidence based models such as: • Self-care management education models - https://www.ncbi.nlm.nih.gov/pubmed/24471229 • The chronic disease self-management program - https://www.ncbi.nlm.nih.gov/pubmed/24113813 https://www.cdc.gov/arthritis/interventions/self_manage.htm	During each of the next three years, the following process measures will be assessed: • Number of education lectures implemented • Number of skills-training workshops implemented • Number of new partnerships and linkages with CBOs • Number of new interdisciplinary collaborations • Number of participants that engaged in programs; During each of the next three years, the following process measures will be assessed: • % of participants who increased knowledge • % of participants who changed behavior related to educational activity • % of participants who increased ability to manage self-care
	In 2017, the Pain and Stress Management Series implemented: • Three educational lectures, reaching 95 community members. • Seven educational workshops, reaching 81 community members. • Nine meditation workshops at the Ambulatory Care Clinic (ACC), reaching 30 physiatry clinic patients. • 50 conference calls on mindful breathing techniques, reaching 23 community members. **Outcomes Measures:** • 97% of participants were satisfied with the program • 93% of participants reported increased knowledge/material comprehension about pain and stress management techniques • 91% of participants reported increased self-efficacy to manage pain and stress	Hospital	Our partner roles include: • Providing participants and location to host meditation workshops (Transactional) • Providing guidance on needs of participants required to implement educational programs and conference calls (Informational and Advisory)	Our internal partnerships with the hopsital's Ambulatory Care Clinic and subject matter experts have enabled succesful implementation of the program. These partnerships have provided expert guidance and information exchange for developing educational programming and location to host meditation workshops, and facilitated for participant recruitment.	Participant attendance is a challenge for the meditation workshops. The clinic patient population tends to have limited access to transportation. To address this challenge, the weekly conference calls offer participants the opportunity to retain knowledge and self-management skills learned from the on-site workshop, but in a location that is convenient for them.	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote culturally relevant chronic disease self-management education	1. Increase participants awareness of pain and stress management techniques 2. Increase knowledge of pain-management and mindfulness based coping techniques such as yoga, meditation and exercise. 3. Increase self-management and coping strategies around managing pain and stress	Yes, this program serves at-risk adults exposed to increased physical, mental and emotional stress from low-income population	Pain and Stress Management Series: HSS developed the pain and stress management series, which is comprised of self-management education and evidence-based stress reduction strategies to raise awareness, educate and improve the ability to cope with pain and stress. These evidence-based strategies include: • Yoga and meditation which are effective methods in reducing stress, pain and anxiety symptoms (NIH, National Center for Complementary and Integrative Health, https://nccih.nih.gov/) • Phone delivered mindfulness training which is effective in improving mindfulness and anxiety levels in patients with cardiac defibrillators (Annals of Behavioral Medicine, https://link.springer.com/article/10.1007/s12160-013-9505-7) In addition, the program also utilizes principles based on the Adult Learning Theory - https://lincs.ed.gov/sites/default/files/11_%20TEAL_Adult_Learning_Theory.pdf	1. Increase participants awareness of pain and stress management techniques 2. Increase knowledge of pain-management and mindfulness based coping techniques such as yoga, meditation and exercise. 3. Increase self-management and coping strategies around managing pain and stress; During each of the next three years, the following outcome measures will be assessed: • % of participants who demonstrate knowledge/material comprehension about pain and stress management techniques • % of participants who report increased self-efficacy to manage pain and stress