



CONNECTING WITH COMMUNITIES

Community Health Initiatives
Across New York State



Healthcare Association
of New York State

2009-2010 Edition

INTRODUCTION

HANYS is proud of its members and the multitude of health care services and other benefits they provide to their communities. In addition to being care providers, they are educators, employers, and advocates for the people who live and work within their communities. They provide acute and continuing health care, and are a critical resource for preventive care, education, and outreach programs.

Increasingly, not-for-profit health care providers are asked to demonstrate that their charitable tradition continues and that their tax-exempt status is deserved. The Internal Revenue Service has made changes to its Form 990 and developed a new Schedule H for hospitals, which outlines how tax-exempt hospitals must report their community benefit policies and activities to assist patients and their communities. In 2010, hospitals will be required to quantify the community benefit they provide to their communities, both in dollars and in programming. Many of the programs included in this publication have demonstrated their ability to quantify their community benefit and can serve as examples for others around the state.

This is the twelfth year that HANYS is presenting its Community Health Improvement Award. This year, HANYS received more than 50 nominations. Every year, these nominations highlight the innovation, collaboration, and great strides members make for their communities in outreach, education, and prevention programming.

This year, the winner of HANYS' Community Health Improvement Award is the University of Rochester Medical Center for its Health-e-Access (HeA) Telemedicine Network. HeA uses information technology to connect children to a clinician in the child's own primary care medical practice. HeA uses both real-time interactive (videoconference) and store-and-forward telemedicine, which is similar to e-mail.

Honorable Mentions were given to Sound Shore Medical Center of Westchester for its Diabetes Outpatient Education Program and to New York City Health and Hospitals Corporation's Woodhull Medical and Mental Health Center for its Geriatric Outreach Program.

HANYS created the Community Health Improvement Award in 1997 to recognize outstanding initiatives aimed at improving the health and well-being of communities. The award is presented to member facilities and programs that target specific community health programs, demonstrate leadership, collaborate among diverse groups, and, most importantly, achieve quantifiable results.

For more information about HANYS' 2009 Community Health Improvement Award or HANYS' advocacy and support for community health initiatives, contact Sue Ellen Wagner, Vice President, Community Health, at (518) 431-7837 or at swagner@hanys.org.

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2009 AWARD WINNER

Health-e-Access Telemedicine Network UNIVERSITY OF ROCHESTER MEDICAL CENTER

Year the Program Started

2001

Program Description and Goals

The mission of the Health-e-Access (HeA) Telemedicine Network is to provide health care for children when and where they need it, by providers they know and trust. Consistent with this mission, HeA has provided telemedicine care and service to children in 23 sites including child-care programs, elementary schools, and a program for severely developmentally disabled children.



Kathleen Parrinello, Chief Operating Officer of Strong Memorial Hospital, accepts the 2009 Community Health Improvement Award on behalf of the University of Rochester Medical Center from David Kruczynski, HANYS' Chairman and President and Chief Executive Officer of Glens Falls Hospital.

Health information technology is used to connect the children at these sites to a clinician in the child's own primary care medical practice. The focus has been care of acute illness episodes. A companion teledentistry program is being conducted in inner-city childcare centers. Since September 2008, two of the participating practices have begun using HeA to provide care for chronic childhood disease management, a focus that is expected to grow. HeA is eager to welcome family and internal medicine clinicians into this program to care for common problems in adults, including frail elderly in assisted living and skilled nursing facilities.

Trained telehealth assistants at the child's site collect information and store and forward the illness history forms, still images, video clips, and audio files directly to clinicians in remote locations through digitized electronic "feeds." The forwarded documents and images are supplemented as required through videoconferencing. Real-time telemedicine is invaluable for clinical observations (e.g., breathing patterns) and in enhancing the quality of interactions among clinicians, children, family, and telehealth assistants. Videoconference interaction adds facial expression and body language to the communication process, substantially enhancing the potential for useful exchange. Newly designed mobile telemedicine units allow HeA to extend telemedicine visits to any elementary school or childcare program in the city.

Partners

- Wilson Commencement Park
- VOA Child Care

-
- ABC North Street Head Start
 - Metro YMCA Child Care
 - Ibero Child Care
 - Lewis Street YMCA Child Care
 - Bates Rich Child Care
 - Kids First Child Care
 - Miss Rita's Small World
 - Rochester City School District
 - Catholic Diocese of Rochester
 - Mary Cariola Children's Center
 - Anthony Jordan Health Center
 - Rochester General Pediatric Associates
 - Pediatric Practice of the Golisano Children's Hospital
 - Lewis Pediatrics
 - Clinton Family Medicine
 - Genesee Pediatrics
 - Wilson-Lifetime Pediatrics
 - Rochester Surround Care

Outcomes

- In city childcare centers, absence due to illness dropped by 63% after the introduction of HeA.
- HeA delivered 7,000 telemedicine visits among children in childcare and schools.
- Of these telemedicine visits, 96% were successfully completed at the child site and did not require a follow-up referral to a primary care practice or emergency department.
- Children are typically seen by their own primary care provider or someone in their practice. This happens 83% of the time, on average, so continuity of care is achieved.
- In a six-year study, emergency department use was 22% less for children with telemedicine access than for matched controls.

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HONORABLE MENTION

Diabetes Outpatient Education Program SOUND SHORE MEDICAL CENTER OF WESTCHESTER

Year the Program Started

1989

Program Description and Goals

The mission of Sound Shore Medical Center's (SSMC) Diabetes Outpatient Education Program is to teach adults with Type 1, Type 2, or gestational diabetes about their disease and the steps necessary to improve their health. Participants are offered information on diet, medications, home blood glucose monitoring, hyper/hypoglycemia management, foot care, exercise, sick day guidelines, and stress management. The program also offers a support group, Sweet Talk, for patients and their families.



Margaret Monahan, R.N., Director of Nursing, accepts an Honorable Mention Award on behalf of Sound Shore Medical Center of Westchester from David Kruczynski, HANYS' Chairman and President and Chief Executive Officer of Glens Falls Hospital.

The program helps patients develop the necessary knowledge and skills for successful self-management; thus delaying or preventing long-term complications associated with uncontrolled diabetes. It also promotes professional education and community and public awareness of diabetes. The significant clinical outcomes and improvement in quality of life for its nearly 300 outpatients and their families—representing 1,200 program visits annually—is a measure of success.

Partners

- The Diabetes Advisory Committee
- New York State Department of Health (DOH)
- Pinnacle Healthcare Diabetes Coalition
- Westchester Department of Senior Programs and Services
- Health and Wellness Coalition
- Mount Vernon Hospital
- American Diabetes Association
- Westchester Chapter of Links, Inc.
- Westchester County Department of Health
- New Rochelle High School
- United Hebrew Geriatric Center

Outcomes

- Of the 197 patients (excluding women with gestational diabetes) who entered the program in 2008, 146 received initial/comprehensive education. Of the 146 patients, 120, or 83.7%, completed their three-month follow-up assessment. Each of these chose one behavior to change. The following percentage of patients met their goal in four categories: 85.7% diet/weight loss; 87.1% exercise; 100% home self-blood glucose monitoring; 100% medication. Patients who completed the program lost 697 pounds, collectively.
- All patients had a reduction in their A1C level post-program and the overall reduction in A1C was 2.33%.
- Forty-seven percent of pre-program patients were performing self-foot inspections at least four times a week. Three months post-program, the rate had increased to 97%.
- Sixty-three women with gestational diabetes were counseled; 35 women delivered at SSMC and 32 were successfully tracked. Of those, 100% of the neonates were born with blood glucose >40 mg/dl, reflecting a positive outcome.
- Fourteen diabetes support group meetings were held, allowing patients to share their feelings, concerns, and experiences about living with diabetes.
- In partnership with DOH and Pinnacle Coalition for Diabetes Presentation and Control, SSMC developed a *Diabetes Resource Nurse* course, offered at SSMC beginning in 2006 and at Mount Vernon Hospital in 2007. The course aims to enhance the education and care of hospitalized patients with newly diagnosed and uncontrolled diabetes through improved health care provider education.

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HONORABLE MENTION

Geriatric Outreach Program WOODHULL MEDICAL AND MENTAL HEALTH CENTER/ NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Year the Program Started

1977

Program Description and Goals

The Geriatric Outreach Program collaborates with community-based senior citizen centers and senior housing developments to provide health education, prevention, and psycho-social support services to the elderly in comfortable and familiar surroundings. The Geriatric Outreach Program includes:

- **Workshops:** A variety of workshops are facilitated in senior centers and housing developments. Topics include hypertension; hepatitis; alcohol and substance abuse; falls prevention; and nutrition and its role in cholesterol management, diabetes, and osteoporosis. Specialized workshops address medication use, memory loss, and chronic care needs of the elderly.
- **Screenings:** Diabetes, blood pressure, cholesterol, cardiac risk, colorectal cancer, hearing, depression, and dental screenings are provided at the centers and housing developments, as well as at health fairs. When screenings reveal a problem (e.g., high blood sugar), the senior is referred to the emergency department or to the appropriate clinic through Woodhull's Open Access System.
- **Mental Health Program:** A social worker facilitates focus groups to initiate a dialogue with seniors on topics such as depression. Social work home assessments are provided within two weeks after a senior has been discharged from the hospital. The provision of this service is to ensure adherence with the post-discharge plan, to improve outpatient follow-up compliance, to mitigate potential falls in the home, and to reduce the incidence of re-hospitalization.

Partners

- Thirty-six senior centers and housing developments



Richard Marin, Chief of Staff, accepts an Honorable Mention Award on behalf of Woodhull Medical and Mental Health Center/ New York City Health and Hospitals Corporation from David Kruczynski, HANYS' Chairman and President and Chief Executive Officer of Glens Falls Hospital.

Outcomes

- In 2008, the Geriatric Outreach Program provided 199 health screenings, reaching 4,852 seniors, and resulted in 802 referrals to the hospital.
- The program provided 133 educational events reaching 5,129 seniors, resulting in 422 referrals.
- Behavioral health focus groups in 2008 reached 443 seniors in 50 separate events.
- More than 1,500 seniors received home assessments. A five-year analysis of home assessment showed an increase in first post-discharge outpatient visits of 13% following intervention, while the number of readmissions decreased by 6%.
- Ongoing outpatient visits also increased 17% among patients who participated in the intervention.

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AWARD NOMINATION PROFILES

Sexual Assault Forensic Examiner Program ALBANY MEDICAL CENTER

Year the Program Started

1998

Program Description and Goals

The Sexual Assault Forensic Examiner (SAFE) program is an educational outreach effort that trains health care providers in the best techniques and approaches for delivering compassionate and effective care to victims of sexual assault and for conducting professional forensic examinations of these patients. The program's goals are to ensure that all victims of sexual assault receive highly skilled and compassionate care and counseling in a timely manner; and to ensure that these victims receive a professional forensic examination in a timely manner to enhance the opportunities for successful prosecution of perpetrators.

Partners

- New York State Division of Criminal Justice Services
- New York State Coalition Against Sexual Assault
- Bronx Sexual Assault Response Team
- Strong Memorial Hospital
- Albert Einstein College of Medicine

Outcomes

Victims of sexual assault treated at Albany Medical Center now receive highly skilled and compassionate care in a timely manner and receive consistently professional forensic exams that increase the likelihood of successful prosecution of perpetrators.

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Community Wellness Initiative

ALBANY MEMORIAL HOSPITAL

Year the Program Started

2006

Program Description and Goals

The Community Wellness Initiative is an ongoing series of community education programs and events targeting vulnerable populations. Education is provided through interactive lectures, small group sessions, health fairs, and screenings. The goals of the program are to raise community awareness of cardiovascular disease and diabetes, decrease the burden of diabetes and cardiovascular disease in the community through primary and secondary prevention education, and increase health literacy and empower community members toward self-advocacy within the health care system.

Partners

- Northeast Health Cardiac and Stroke Services
- Northeast Health Diabetes Center
- Senior centers and groups
- Mental health day programs
- Clinics
- Homeless shelters
- Worksites
- Faith-based organizations
- Community centers
- Low-income housing

Outcomes

In 2008, nearly 5,000 community members received health education publications or participated in a lecture, group session, health fair, or screening with a nurse educator.

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Franklin County First Response Agency

ALICE HYDE MEDICAL CENTER

Year the Program Started

2007

Program Description and Goals

The primary purpose and mission of the Franklin County First Response Agency (FC-FRA) is to provide a New York State-certified emergency medical technician (EMT) to volunteer fire department-based ambulance units in northern Franklin County during daytime hours when timely response to emergency calls is difficult or impossible due to very limited, unpredictable, and declining availability of volunteer staffing. FC-FRA provides a Basic Life Support First Response Unit staffed with an EMT employee of Alice Hyde Medical Center, who also serves as the Medical Center's Emergency Preparedness Coordinator.

Partners

- Franklin County Emergency Services
- Franklin County Legislature
- Bangor, Bombay, Burke, Chateaugay, Constable, Fort Covington, Malone, Moira, Owls Head, St. Regis Falls, and Westville Volunteer Fire and Emergency Medical Services (EMS)

Outcomes

- In 2008, FC-FRA responded to 232 calls and was in service for 247 days.
- FC-FRA provided services to all 11 volunteer fire and EMS agencies within northern Franklin County.
- FC-FRA services were used on calls including difficulty breathing, chest pain, cardiac arrest, building collapse, firefighter rehabilitation, diabetes, and trauma.
- A reduction of response times for EMS agencies allowed for better patient care.

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Kick-Start Childhood Obesity Program

BASSETT HEALTHCARE

Year the Program Started

2007

Program Description and Goals

The goal of the Kick-Start Childhood Obesity program is to identify children, ages seven to 13, who are at risk from being overweight and/or obese, and provide them with a free weight intervention program that includes nutrition education, exercise, and behavior modification. The Kick-Start Childhood Obesity Program provides free clinical body mass index assessment, blood pressure and glucose screening, and a consultation with a nurse practitioner at Bassett Healthcare; eight weeks of free exercise and nutritional education at the Oneonta Family YMCA five times a week; free family roundtable discussions on healthy eating, shopping tips, and behavior modification; and follow-up assessment and consultation at Bassett Healthcare.

Partners

- Bassett Healthcare—Oneonta
- Oneonta Family YMCA
- Bassett Healthcare's Clinical Nutrition Department
- State University of New York College at Oneonta Dietetics Department

Outcomes

The Kick-Start Childhood Obesity Program brought immediate attention and awareness to the problem of childhood obesity. Free clinical assessments for children took place over a two-week period, with 25 children identified as at-risk within the first week. The eight-week Kick-Start Program conducted at the Oneonta Family YMCA enjoyed a 90% participation rate by the children.

Contact

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Improving Heart Failure Care with the Implementation of a Care Management Model

BELLEVUE HOSPITAL CENTER

Year the Program Started

2006

Program Description and Goals

Bellevue Hospital Center recognized that nearly half (44%) of heart failure patients are readmitted within six months of discharge and that half of these readmissions are preventable. Because effective outpatient care provides the first line of defense against readmissions, improving heart failure outpatient care is the key to preventing readmissions. Bellevue used an evidence-based heart failure practice and other advanced technologies to improve quality of care for heart failure patients and undertook an aggressive effort to identify and target all heart failure patients for inclusion in the program to ensure that most of them benefit from this enhanced care. The heart failure program aimed to decrease the emergency, admission, and readmission rates.

Partners

- Many staff, including an attending physician; the Senior Associate Executive Director; Case Management Director; many nurses; and the Associate Director, Quality Management.

Outcomes

The program reduced emergency visits by 40%, readmissions by 41%, readmission days by 36%, admissions by 49%, and admission days by 48% of enrolled heart failure patients.

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Healthy Families Brookdale

BROOKDALE UNIVERSITY HOSPITAL AND MEDICAL CENTER

Year the Program Started

2007

Program Description and Goals

The Healthy Families program at Brookdale University Hospital and Medical Center is an intensive, voluntary home visiting service focused on promoting healthy parent-child interaction and bonding, promoting positive child health and development, and enhancing family functioning. The model is based on the statewide Healthy Families New York program. Families are assessed and transferred to a family support worker (FSW) for home visiting, if appropriate. FSWs form collaborations with community-based organizations, medical and mental health providers, and others to ensure that families have access to a comprehensive network of services to meet their varying needs.

Partners

- New York State Office of Children and Family Services
- Prevent Child Abuse New York
- Center for Human Services Research
- Home Visiting Council
- Caribbean Women's Health Association
- CAMBA
- Brooklyn Perinatal Network
- Brooklyn Young Mothers Collective

Outcomes

At the end of the first year:

- 100% of the target children and primary caretakers have been connected with a medical provider;
- 65% of participating mothers have breastfed their babies for at least three months;
- 100% of enrolled participants with domestic violence, mental health, or substance abuse issues were referred for appropriate services within six months of enrollment;
- mental health problems reduced from 31% to 21%, and stress or emotional issues reduced from 87% to 74%; and
- homeless/inadequate housing reduced from 64% to 47%.

Contact

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It Takes a Brain to Save a Brain—Stroke Awareness Program for Middle School Children

CATHOLIC HEALTH SYSTEM

Year the Program Started

2007

Program Description and Goals

The primary objective of the program was to educate students on stroke risk factors and prevention, how to recognize the warning signs of stroke among older relatives, and how to respond appropriately. Students were given incentives to bring their parents, grandparents, and older relatives to the outreach assemblies, creating an “intergenerational spillover effect.” This educational outreach program targeted middle-school students at 12 Catholic schools in the Buffalo area. Evening assemblies were scheduled at the middle schools. This facilitated attendance from the older family members. The program was based on the “Face/Arms/Speech/Time” (FAST) curriculum. Additional content included personal stories from a 9-1-1 dispatcher, emergency medical services personnel, and an emergency room nurse. A brain anatomy poster and 3-D model brain were employed as visual aids, and items such as small plastic “stress brains” were distributed as giveaways. Blood pressure screenings were offered to all adults in attendance.

Partners

- NorthEast Cerebrovascular Consortium
- Catholic Health System Community Education Department
- Catholic Health System Neurovascular Services
- Buffalo Catholic Elementary Schools

Outcomes

A total of 937 people attended the programs—819 children and 118 adults. Participants were tested on stroke knowledge before and after the programs. The average pre-test score for the children was 84%; the average post-test score was 96%. The average pre-test score for the adults was 97%. The average post-test score was 99%. Of the 78 blood pressures screened, 27 were abnormal, per American Heart Association guidelines. Education regarding high blood pressure was conducted immediately after obtaining the screening.

Contact

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Urgent Rx Program

CAYUGA MEDICAL CENTER AT ITHACA

Year the Program Started

2006

Program Description and Goals

Urgent Rx provides free prescriptions and outreach follow-up to people without health insurance who have an urgent health need and receive care at selected sites. Its goals are to help resolve the immediate health issue, to prevent the development of more serious health issues that could arise from not taking prescribed medication, and to provide follow-up information about other health insurance and prescription assistance programs. Urgent Rx prescription voucher packets are distributed to uninsured individuals at Cayuga Medical Center's emergency department, at an urgent care site, and on inpatient units. Kinney Drugs dispenses generic medications on an approved acute care formulary and is reimbursed at cost by the Human Services Coalition of Tompkins County with funds raised by United Way and The Brooks Family Foundation.

Partners

- Ithaca Free Clinic
- Kinney Drugs
- Tompkins County United Way
- The Brooks Family Foundation
- Human Services Coalition of Tompkins County

Outcomes

- Since inception in 2006, Urgent Rx has grown steadily. In 2008, it provided 1,500 vouchers for 2,600 prescriptions, 93% of which were filled within 48 hours. The average cost was \$18 per prescription, for a total cost of \$47,000.
- Follow-up calls for insurance outreach were completed, with 50% of voucher recipients and informational mailings to all.
- In a 2008 program evaluation of the outreach, 36% of participants reported using the referral information to access health-related services and nearly a quarter (23%) reported that they have health insurance because of Urgent Rx follow-up.

Contact

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North Country Diabetes Project

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER

Year the Program Started

2006

Program Description and Goals

The goal of the North Country Diabetes Project is to improve health outcomes and quality of life for people age 45 and older with diabetes, or those at risk for diabetes, in Clinton, Essex, and Franklin counties. The region is socio-economically disadvantaged, with median household income significantly below state and national levels, and has low education levels that adversely affect health behaviors and outcomes. This is reflected in the area's level of obesity, smoking, high blood pressure, and lack of regular exercise, causing significant rates of diabetes. To address this problem, a partnership was established between three community entities and funding was requested from the Rural Health Outreach Grant Program. The North Country Diabetes Project was designed based on best practice standards including the American Diabetes Association (ADA) guidelines for quality diabetes self-management education. The initiative uses strategies that build ongoing community collaboration among core health care providers to increase access to diabetes care through the development of a physician referral network, establishment of an ADA-recognized diabetes self-management education program, and expanding the availability of medical nutrition therapy using a registered nurse and registered dietitians.

Partners

- Clinton County Health Department
- Joint Council of Economic Opportunity of Clinton and Franklin Counties

Outcomes

The project has reduced the impact that diabetes has on the tri-county region by increasing community awareness, improving health outcomes (i.e., decreased blood glucose levels and reduced complications), and enhancing patient quality of life.

Contact

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“Let’s Clear the Air”

CLAXTON-HEPBURN MEDICAL CENTER

Year the Program Started

2004

Program Description and Goals

Claxton-Hepburn Medical Center (CHMC) formed a Tobacco Cessation Team to address tobacco use within CHMC and the community. CHMC committed to becoming tobacco-free and providing tobacco cessation services because this goal aligns with its mission of disease prevention. People are given the option of one-on-one counseling, attending workshops at CHMC sponsored by the Tobacco Cessation Center, or contacting the state Quitline via telephone or Internet. The goals of the program are:

- transition to a smoke-free campus and help staff to quit tobacco use;
- provide tobacco cessation instruction to patients and the local community; and
- develop a method for physicians and clinics to access tobacco cessation assistance for their patients.

Partners

- St. Lawrence County Tobacco-Free Coalition
- Seaway Valley Prevention Council
- St. Lawrence County Public Health Department’s Tobacco Free Community Partnership

Outcomes

- In 2006, CHMC implemented a smoke-free campus.
- CHMC continues to provide nicotine replacement/quit assistance to staff.
- All patients admitted to CHMC are assessed for tobacco use and their desire to quit.
- A 20-hour-per-week smoking cessation specialist position has been created.
- Patients who express an interest in quitting are given access to available resources including CHMC’s smoking cessation specialist.
- Community classes are offered twice each month, providing tobacco quit assistance and free nicotine replacement.

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Total Joint Replacement: Changing Lives One Step at a Time

CLIFTON SPRINGS HOSPITAL AND CLINIC

Year the Program Started

2007

Program Description and Goals

Clifton Springs Hospital and Clinic designed a Joint Replacement Center for patients undergoing total knee and total hip replacement surgeries, to provide each patient with high-quality care in a healing environment that promotes wellness of body, mind, and spirit. The Center strives to:

- improve patient satisfaction by enhancing the traditional hospital experience and focusing on a wellness approach to recovery;
- permit patients and families to receive care in individual and group settings; and
- improve patient outcomes through consistent care delivery by dedicated nursing and physical therapy staff.

Partners

- Interlakes Orthopaedic Surgery
- Marshall Steele and Associates
- Clifton Springs Hospital and Clinic administration
- The Springs Integrative Medicine Center
- Zimmer
- BioMet

Outcomes

- The Joint Replacement Center is ranked in the 99th percentile in the comparative database of Press Ganey patient satisfaction survey results.
- The on-unit physical therapy room has enabled 100% of patients to receive physical therapy services in both individual and group sessions. Patients enjoy the cheerful group physical therapy atmosphere and benefit from camaraderie with other patients.
- Ninety-nine percent of surgery patients attended the pre-operative education class.
- There was an overall 32% increase in patient volume, with 67% of all patients discharged directly to home from the hospital.
- Ninety-five percent of patients received services from The Springs Integrative Medicine Center during their stay on the Joint Replacement Unit.

Contact

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Preventing Obesity in a Rural Community

COLUMBIA MEMORIAL HOSPITAL

Year the Program Started

2008

Program Description and Goals

The goal of this program was to improve collaboration with the local Healthy Heart Coalition, schools, and other organizations to promote exercise and nutrition education through after-school programs, community events, and health fairs. The project helped children, their families, and others to make healthy food choices. The team provided a comprehensive, organized plan that engaged physicians, county department chairs, community leaders, youth groups, and seniors.

The project supported improved communication among partners and promoted exercise in seven area schools and the local youth center. A registered nutritionist and physical therapist provided age-appropriate education for children in an after-school program at a local elementary school where half of the children have an elevated body mass index.

Partners

- Physicians
- Columbia County Department of Health
- Taconic Hills, Germantown, Ichabod Crane, Chatham, and New Lebanon school districts
- Twin County Cardiology
- A registered dietician and physical therapist
- Academy of Christian Leadership
- Columbia County Healthy Heart Coalition
- Community groups
- Columbia County Youth Department

Outcomes

- The educational presentations provided by two local cardiologists attracted more than 600 participants.
- More than 1,300 pedometers were provided for community residents of all ages in a variety of settings, including schools, health fairs, community events, and after school programs.

-
- The improved communication among community groups encouraged collaboration and the sharing of resources.

Contact

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Telemedicine Program: Diagnosis and Treatment of Stroke

CORTLAND REGIONAL MEDICAL CENTER

Year the Program Started

2008

Program Description and Goals

As part of the New York State Rural Telemedicine Initiative, Cortland Regional Medical Center (CRMC) teamed with State University of New York (SUNY) Upstate Medical University/University Hospital in Syracuse to bring access to prompt, effective stroke and neurological treatment to the Cortland region. CRMC now has access to University Hospital neurologists who use Remote Evaluation of Acute Ischemic Stroke, a Web-based telemedicine service, to remotely examine patients at CRMC. Custom-built software integrates video, computerized tomography scan images, other patient information, and decision/treatment algorithms. Following the remote examinations, CRMC providers perform treatments based on neurologists' recommendations. In addition to improving health for the under-served, this program upgrades the skill level of emergency room and intensive care unit clinical staff.

Partners

- SUNY Upstate Medical University/University Hospital
- New York State Department of Health
- ReachMD Consult, Inc.
- Central New York Regional Emergency Medical Services Council

Outcomes

- During the first year, 45 people received neurology consults via telemedicine in CRMC's emergency department.
- Since implementation, 27 patients with stroke diagnoses were admitted to CRMC for acute care through the emergency department.
- As a result of telemedicine, CRMC emergency room providers have sufficient support to administer tissue plasminogen (t-PA), the thrombolytic agent shown to significantly reduce disability and death associated with ischemic stroke.
- In the months leading up to implementation, 85 CRMC staff received training in telemedicine application; 75 of this group became certified in acute stroke assessment.

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Geriatric Mental Health Integration Project: Senior Options and Solutions

EASTERN LONG ISLAND HOSPITAL, SOUTH OAKS HOSPITAL (THE LONG ISLAND HOME)

Year the Program Started

2008

Program Description and Goals

Untreated mental illness in older adults results in increased medical problems and reduced quality of life. The partners in this grant initiative put into place a routine screening process to identify mental health issues in older adults within the primary care setting. The program relies on collaboration between the physical health provider and the mental health professional. All adults over the age of 65 complete a routine depression screening during their regular office visit, and are provided, when appropriate, a referral to a mental health practitioner.

The goals of this program include:

- improving access to mental health services and screening those in need;
- assisting providers with patient mental health needs via assessment and linkage;
- developing a community education program;
- promoting local residents' independent living and sense of self-sufficiency;
- increasing the integration of physical and mental health systems; and
- decreasing hospitalization and deterioration of physical health.

Partners

- Town of Southold
- The Mental Health Association in Suffolk County

Outcomes

- The project completed 572 mental health screenings by the end of 2008.
- Mental health services were integrated at the Town of Southold Senior Center.
- Community education is achieved through a senior wellness series and support groups.
- Professional education is provided through monthly "Health Issues and Services for Seniors" meetings, and a seminar series.
- A Geriatric Center of Excellence now serves seniors' health care needs.

Contact

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Elementary School Intergenerational Initiative

ELANT AT NEWBURGH

Year the Program Started

2005

Program Description and Goals

Elant at Newburgh, a nursing facility, is working with Balmville Elementary School on a collaborative, intergenerational program. Once a month, sixth graders visit the nursing home and each is paired with a resident through the child's teacher and the facility activities director based on personality match.

The initial visit is spent getting to know the elders and what they have experienced during their lives. On the next visit, the students come prepared with interview questions to learn about lifestyle, work, as well as how they were affected by World War II or subsequent wars. The elders share their memories with their student partners. In subsequent visits, the students talk to the elders about music, dance, fashion, and leisure time interests.

The students take all the information from the interviews back to the classroom and write a play using music, song, dance, and dialog relating to the different decades of the elders' lives. Elders also have parts in the play and they participate through dance and costume. The play is presented so students can show off what they learned and so the elders can see their stories materialize in a play.

Partners

- Balmville Elementary School

Outcomes

Students and elders both benefit from the interaction and dialogue this program enables. Elders feel helpful to a young person, they feel important sharing their experiences, and they feel committed to the program. Elders feel proud of the students they mentored and when they see students perform in the play. Comments such as "that was my student" are often proudly announced.

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The Elderact Club

ELANT AT WAPPINGERS FALLS

Year the Program Started

2007

Program Description and Goals

The Elderact Club provides community outreach opportunities to the elderly who reside in a nursing home setting. By completing projects of their choice to contribute to the needs of the community, the elders appreciate and respond to the needs of others and recognize that their contributions are essential. The staff of Elant at Wappingers Falls provide guidance and assistance as needed, while encouraging self-determination among the elders. The goal is to challenge the notion that “institutionalized” elders are incapable of giving back to others. The Rotarian motto, “Service Above Self,” need not end because of physical and social limitations, but should continue based on the unique capabilities of all. Elant’s philosophy is that no contribution is too small.

Partners

- Rotary and Interact (teenage extension of Rotary)
- Semper Fi
- Society for the Prevention of Cruelty to Animals (SPCA)
- Local battered woman’s shelter
- Alex’s Lemonade Charity
- Castle Point Veterans Hospital

Outcomes

- Rotary clubs have sponsored Elderact Clubs and the concept is growing. The program was presented at the United Nations as an innovative program that can be replicated.
- The Elderact Club created a lemonade stand where residents raised money to fight childhood cancer, assembled gift baskets for the local battered women’s shelter during the holiday season, made bookmarks to give to the children of a local play group, created Valentine’s Day cards for the veterans at Castle Point Veterans Hospital, and made dog biscuits and took a trip to the Dutchess County SPCA to present the treats.
- The Elderact club worked on Operation Santa with the Semper Fi parents and the Interact Club, providing special gifts to U.S. troops overseas.

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Schenectady Hospitals' Unification and Restructuring

ELLIS HOSPITAL

Year the Program Started

2006

Program Description and Goals

The Commission on Health Care Facilities in the 21st Century report mandated major structural changes for Schenectady County's three hospitals. Bellevue Woman's Hospital was to close, while Ellis and St. Clare's hospitals were required to downsize. Ellis and St. Clare's commenced a formal process for developing a unified governance structure to achieve fiscal stability, retain important health care jobs in the community, rationalize bed capacity, minimize duplication of services, and enhance the viability of the region's health care system.

Partners

- St. Clare's Hospital
- Bellevue Woman's Hospital
- New York State Department of Health
- Physicians, hospital employees, community groups, and neighborhood associations
- Siena Research Institute

Outcomes

Ellis and St. Clare's focused on a culture of community involvement and health. This included more than 60 "community conversations" reaching more than 750 people, creating a joint public information Web site, and a community survey conducted by Siena Research Institute. In a short seven-month period, Ellis successfully assumed responsibility for the services of Bellevue and St. Clare's hospitals. In doing so, Ellis absorbed more than 1,100 employees (only about 15 jobs were lost), \$118 million in operating expenses, 10,600 additional patients, 43,000 additional days of care, 8,400 more surgeries, 39,000 more emergency department visits, family practices, dental clinics, residency programs, and two complete hospital campuses. Ellis consolidated most inpatient services at the Nott Street Campus, centralizing inpatient obstetric/gynecology services at the Bellevue campus, and developing the McClellan campus (former St. Clare's Hospital) for outpatient care and community health programs. Having started with three competing hospitals struggling to survive, Schenectady now has a unified hospital system that is financially stable.

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Focus on Health

ERIE COUNTY MEDICAL CENTER

Year the Program Started

2006

Program Description and Goals

Erie County Medical Center launched its Focus on Health series as part of the hospital's commitment to excellence in patient care and to enhance its role as an educational resource in the community. Focus on Health features an array of educational and outreach programs designed to address a variety of health and wellness needs. This program teaches people about important issues such as heart health, geriatrics and aging, stress management, diabetes, and fall prevention in a relaxed, open forum. Through informal lectures that are free and open to the public, physicians and other health care professionals provide valuable opportunities to learn and ask questions. Focus on Health provides tips on living a healthy lifestyle and the latest information about available medications. When appropriate, free blood pressure, glucose, cholesterol, and balance screenings are made available to seminar attendees.

Partners

- American Heart Association
- State University of New York at Buffalo

Outcomes

- The series has been enormously successful. More than 55 events were held in 2008. Several events, such as the Western New York Health Expo, Juneteenth, Gospelfest, and the P2 Collaborative, attracted more than 1,500 people per event.
- Exit interviews held at each seminar indicated that attendees were very pleased with the presentations and the speakers. Seventy percent of attendees indicated that they would like information about upcoming events.
- Each site that hosted a Focus on Health event has invited the hospital back for additional seminars.

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“To Your Health” Community Lecture Series

GOOD SAMARITAN HOSPITAL MEDICAL CENTER

Year the Program Started

2006

Program Description and Goals

Good Samaritan Hospital Medical Center offers free “To Your Health” community lecture seminars focusing on health concerns, services, and programs, and provides free cholesterol/glucose/blood pressure screenings on a regular basis. This initiative provides education on risk factors, diagnostic procedures, treatment options, and prevention to empower people to improve their health. The community lectures offer information about healthy living and support groups, with health screenings. Each lecture is coordinated by a health educator and presented by a physician specialist. Each series consists of up to five lectures, ending with an interactive question-and-answer session. Each lecture lasts three hours, with the first hour dedicated to registration, free cholesterol and glucose screenings, and light refreshments.

Partners

- American Cancer Society
- American Diabetes Association
- American Heart Association
- Babylon Breast Cancer Coalition
- West Islip Breast Cancer Coalition
- WomenHeart
- Westfield South Shore Mall Walkers
- Wellness Alliance of Bay Shore and West Babylon
- Bay Shore and West Islip COMPASS (Community, Parents, Students, Schools)

Outcomes

- The lectures reached more than 400 people in the first two years. Participants complete evaluations that help educators determine if the information presented is pertinent and useful, and provide ideas for future topics.
- The glucose and cholesterol screenings have led to higher attendance at the diabetes and women’s support groups, and the Cardiac Rehabilitation Center and the Diabetes Care Center have seen increased participation.

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Harlem Healthy Eating and Living Initiative

HARLEM HOSPITAL CENTER

Year the Program Started

2008

Program Description and Goals

Harlem Healthy Eating and Living (HHL) is a collaborative of elected officials, health care organizations, businesses, educational institutions, community sports and recreation organizations, and media partners working to reduce the incidence of obesity and related diseases. These community partners developed a multi-faceted program to increase community awareness of obesity and obesity-related illnesses, reinforce prevention and treatment strategies, facilitate access to health prevention and detection screenings and primary care, and encourage community residents to adopt healthy living habits.

Partners

- Congressman Charles Rangel
- Greater Harlem Chamber of Commerce
- New York City Department of Health and Mental Hygiene
- Hospital for Special Surgery, Mount Sinai Medical Center, NewYork-Presbyterian Healthcare, Ralph Lauren Center for Cancer Care and Detection, St. Luke's-Roosevelt Hospital Center
- *Amsterdam News, Daily News, New York Christian Times, The New York Times, Carib News, Harlem Community News, Positive Community Magazine*
- Broadcast media: 101.9 RXP, KISS FM, WHCR, WQXR, CD101.9, WBGO, WLIB, HOT97, WBLN, WNYC
- YMCA
- National Parks Service
- New York Road Runners Club
- New York City Department of Parks and Recreation
- New York Urban League
- NYC and Company
- Columbia University, City College of New York, and New York University
- National Association for the Advancement of Colored People
- National Medical Association

Outcomes

- HHL educated the community on prevention and treatment strategies for obesity, diabetes, heart disease, oral health, and mental health.
- Project partners increased community access to free prevention and detection screenings and primary care services.
- Partners co-sponsored the first annual Health Village Fair and Expo, and walking events that drew thousands of participants.
- The media highlighted HHL events and success stories about HHL participants.

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Promoting the Continuum of Care Through Telehealth

LONG ISLAND HEALTH NETWORK HOME CARE AGENCIES

Year the Program Started

2007

Program Description and Goals

Long Island Health Network (LIHN) holds its ten hospitals accountable for more than 200 quality indicators each quarter. For several quarters, a hospital significantly exceeded LIHN's benchmark readmission rate. An analysis revealed that a substantial number of the readmissions were patients with chronic obstructive pulmonary disease (COPD). LIHN's home health agencies reviewed the literature and found that telehealth can positively impact outcomes for the COPD patient, including fewer hospitalizations. The home health agencies and the hospital developed criteria to identify inpatients for inclusion in the project. Home health personnel also worked closely with the attending physicians to reduce paperwork, making the home health option more feasible. Nurses were trained in the Situation-Background-Assessment-Recommendation communication technique to make home health nurse and physician patient updates efficient and effective. This initiative applies clinical best practices with a focus on patient self-management through teaching self-management, early intervention recognition, medication management, exercise, and prevention of exacerbation. The goal was to decrease the number of emergency room visits and re-hospitalizations.

Partners

- Brookhaven Memorial Hospital Medical Center Home Health/Hospice
- Catholic Home Care
- Good Samaritan Hospital Home Health Agency
- South Nassau Communities Hospital Home Health Agency
- Winthrop-University Hospital Home Health Agency

Outcomes

The expansion of the telehealth program (from less than seven admissions per quarter for the first two years of the program to 26 per quarter for the last six months of 2008) substantially decreased 30-day readmissions. For the last six months of 2007, the COPD readmission rate was 26.1%; during the last six months of 2008, it dropped to 19.7%. These gains reflect both hardware enhancements, increased home health nurse sophistication in patient clinical management, and communication with physicians and family.

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Shoot for Better Health

LUTHERAN MEDICAL CENTER

Year the Program Started

2008

Program Description and Goals

Lutheran Medical Center established Shoot for Better Health in response to the rising rates of pediatric diabetes and obesity in its patient population. In some schools served by the Lutheran Family Health Centers' school-based health program, more than 50% of children are overweight or obese, compared to 14% of children across the country. The prevalence of pediatric obesity and the connection between obesity and diabetes is especially alarming given that on average, a child diagnosed with Type 2 diabetes by age ten will have his or her life shortened by 19 years. This program, which is endorsed by the American Diabetes Association, encourages students to follow the "5-2-1-0" wellness model developed by the American Academy of Pediatrics. The model calls for children to eat five or more fruits and vegetables daily, cut daily screen time (television, computer, video games, etc.) to two hours or less, participate in at least one hour of moderate physical activity every day, and restrict soda and sugar-sweetened drinks.

Partners

- Local schools: P.S. 169, P.S. 172, I.S. 88, Pershing J.H.S., Dewey M.S., and M.S. 821
- Nets Basketball
- American Diabetes Association
- A.T. Still School of Osteopathic Medicine

Outcomes

The Shoot for Better Health initiative directly impacted 4,940 students during the first school year. Examples of successful changes have included the elimination of bake sales, the expansion of physical education staff and programs, and the integration of physical activity into traditional academic lessons by using *Dance, Dance Revolution* for a fun workout. Students who achieve particular success in the program are eligible to receive prizes from Nets Basketball including tickets and transportation to Nets games, memorabilia, and a chance to assist Nets players in a pre-game shoot-around and deliver the official game ball to the referee prior to a Nets game. As part of their commitment to the health of children in Brooklyn, the Nets hosted a day-long "Shoot for Better Health" Basketball Clinic at I.S. 88.

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Office-Based Care Coordination Program

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER/CIPA

Year the Program Started

2008

Program Description and Goals

CIPA Western New York IPA, Inc. (CIPA), comprised of 840 physicians, Catholic Health System, and Mount St. Mary's Hospital and Health Center, is working to improve the health care system through clinical coordination. One of CIPA's major initiatives is to improve the care of patients with chronic health conditions in the clinical office setting. CIPA's goal is to reduce the burden of illness for patients with chronic health conditions by training clinical office staff in principles and practices of disease management and care coordination. CIPA's program for care coordination was designed to teach the fundamentals of office-based care management to clinical office staff—licensed practical nurses and registered nurses—to improve the care and treatment of patients with diabetes and congestive heart failure. Interventions include patient coaching/education, providing resources, pharmacy consultations, and care management.

Partners

- CIPA
- Private physician practices
- Catholic Health System
- McCauley Seton Home Care
- Local health plans

Outcomes

Early results show improvement in adherence to evidence-based medicine, high levels of participant satisfaction, and alignment with the “Patient-Centered Medical Home” model.

Contact

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Chinese Community Partnership for Health

NEW YORK DOWNTOWN HOSPITAL

Year the Program Started

1993

Program Description and Goals

The Chinese Community Partnership for Health (CCPH) offers preventive medicine and health education programs to the Chinese community, especially to elderly residents and to newly arrived immigrants who are not yet comfortable with the English language or the American health care system. For the past 15 years, CCPH has been providing free health care services to this under-served community.

CCPH offers myriad diverse health care services directly to the Chinese community in the New York City metropolitan area. The program plays a major role in promoting greater access to care, while developing a solid and mutually beneficial relationship with the Chinese community. CCPH is committed to enhancing the health status of the Chinese community and to removing barriers to health care access.

Partners

- Chinese business, civic, and family association members in the community
- Local community organizations, schools, health centers, community physicians, and business organizations

Outcomes

CCPH is a community-based initiative that has revolutionized the delivery of health care to New York's Chinese community. Its success in reaching, detecting, and preventing chronic disease in many of the most vulnerable members of the community has made CCPH a model program replicated in other cities. Since its inception, the program has served more than 140,000 people.

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Seniors Get Moving

NICHOLAS H. NOYES MEMORIAL HOSPITAL

Year the Program Started

2005

Program Description and Goals

This initiative's goals were to highlight the importance of exercise and physical activity for the senior population and to get inactive seniors moving. The challenge was to make participation easy and affordable for this age group. To accomplish this, the program was taken directly to the seniors through faith communities and senior living complexes. Each class met for one hour and included mostly movements using a chair or walker for balance. Care was taken to select music that was upbeat, fun, and familiar to this target age group. The goal between sessions was to encourage participants to take extra steps every day. To encourage this, the group identified a destination and each week each person's steps were converted to miles, added together. Progress toward this destination was plotted and watched by all, creating a real team effort. The health benefits of increased activity include a decrease in blood pressure, weight loss, increased flexibility and mobility, and better balance.

Partners

- Livingston County Coalition of Churches
- Livingston County Office for the Aging
- New York State Department of Health
- Two senior apartment complexes, two faith communities, and one senior social group

Outcomes

- In surveys, the seniors have said they take pride in their accomplishments and, by far, what is mentioned most is being able to socialize and motivate each other to attend.
- Walking and collecting miles between sessions increases activity. At one point, there was a friendly competition between the two initial senior complexes to see who could accumulate the most miles over a one-week period.
- Attendance has increased and now remains consistent. One site has at least half of the residents participating in the program each week. The entire program averages 50 seniors each week.

Contact

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Harvest Home Farmers Markets

NORTH BRONX HEALTHCARE NETWORK/ NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Year the Program Started

2007

Program Description and Goals

While a diet rich in fresh fruits and vegetables is key to supporting good health and preventing obesity and diabetes, there is a dearth of affordable, fresh produce available to Bronx residents. North Bronx Healthcare Network created a hospital-based farmers market, providing high-quality, regionally grown, and reasonably-priced produce, coupled with an engaging and informative nutritional education program and health screenings.

Partners

- Albert Einstein College of Medicine
- Harvest Home Farmers Market, Inc.
- The Mosholu Preservation Corporation
- Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- New York City Community Board 7
- New York City departments of health and mental hygiene, parks, police, and transportation
- New York State Department of Agriculture
- RAIN Eastchester, City Island, Bronx House, Andrew Jackson, and Tollentine senior centers
- Dewitt Clinton and Bronx Science high schools
- P.S. 226 Parents Association
- Bronx House Nursery School

Outcomes

- Consumer demand resulted in an extension of the market season to mid-November. Approximately 1,500 people attend each week.
- In the 2008 season, 4,450 people received nutrition education and counseling, 833 had blood pressure screening/counseling, 110 received smoking cessation counseling and nicotine patches, 94 obtained domestic violence information, 83 received medication safety information and counseling, 51 received influenza shots, and 105 received HIV counseling/rapid HIV testing.

-
- WIC coupons worth \$100,000 in produce were distributed to 4,228 families.
 - Local schools use the market for educational field trips; diabetes educators, family weight management educators, and WIC nutritionists use the market as a teaching tool.

Contact

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Florence and Robert A. Rosen Family Wellness Center for Law Enforcement and Military Personnel and Their Families

NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM

Year the Program Started

2007

Program Description and Goals

The principal goals of this program are to:

- provide education about behavioral health issues during pre-deployment, deployment, and post-deployment, and crisis counseling for military personnel and their families;
- educate law enforcement personnel and their families about behavioral health issues;
- facilitate access to appropriate local behavioral health services;
- provide state-of-the-art behavioral health services for post-traumatic stress syndrome and related psychiatric disorders;
- develop educational materials for providers; and
- formally train prospective treatment providers.

Partners

- North Shore-Long Island Jewish Health System (NS-LIJHS) Drug Treatment Education Center
- The NS-LIJHS Substance Abuse and Mental Health Services Administration supported National Child Traumatic Stress Network Center
- Colonel Stephen Cozza, M.D. (ret.), Associate Director of the Center for the Study of Traumatic Stress, Child and Family Programs at the Uniformed Services University of the Health Sciences
- Charles Marmar, M.D., and Suzanne Best, Ph.D., of the National Center for PTSD (Post Traumatic Stress Disorder)
- William Saltzman, Ph.D., and Patricia Lester, M.D., of the University of California, Los Angeles Medical Center
- Bob Woodruff Family Foundation
- Military Child Education Coalition
- New York metropolitan area National Guard and Reserve facilities and law enforcement organizations

Outcomes

- No-cost confidential mental health treatment has been provided to more than 75 veterans and their family members and 39 law enforcement personnel and their family members;
- Nearly 1,660 sessions were conducted of individual, couples, and family therapy.
- Crisis counseling and outreach services were provided to more than 2,500 people at military and law enforcement facilities.
- The Rosen Center retention rate for at least ten visits is 75%, while the national retention rate is 50%. Consequently, Rosen Center treatments produce very successful short-term outcomes.

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Lose to Win Weight Loss Program

NYACK HOSPITAL

Year the Program Started

2005

Program Description and Goals

The eight-week Lose to Win Weight Loss Program is for adults interested in losing weight, improving their nutrition, and increasing physical activity safely. Facilitators who have attended a free training course at Nyack Hospital lead this program at multiple sites throughout Rockland County. The program was developed by Nyack Hospital staff, including an exercise physiologist, registered dietitians, and a registered nurse-certified diabetes educator. The Lose to Win Weight Loss Program follows weight loss guidelines set by leading national health care and medical associations.

Lose to Win goals include engaging multicultural populations in health promotion activities, decreasing obesity, improving nutrition, increasing physical activity, and providing a sustainable, low-cost weight loss program. The program teaches how to incorporate an individual's existing ethnic, cultural, and religious food preferences into healthier meal plans. Handouts for Lose to Win are available in English, Spanish, Creole, and French. Fat, sugar, and salt food models, and a Jeopardy-like game are helpful educational tools employed at meetings. Program participants receive a pedometer from the Rockland County Department of Health (RCDOH) and enroll in the RC Walks program.

Partners

- RCDOH
- Hospitals, libraries, faith-based organizations, schools, and colleges
- YMCA
- Senior groups, assisted living facilities, and non-profit community organizations
- Mental Health Association
- Head Start

Outcomes

In 2008, the average weight loss per participant was 5.2 pounds. All participants increased fruit and vegetable servings per day and increased physical activity. Since the inception of this program, Nyack Hospital has trained 51 facilitators and conducted 55 weight loss programs. Twenty-six local organizations are involved. To date, 601 people have completed the program, losing a total of 2,400 pounds.

Contact

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Hispanic Health Day

PHELPS MEMORIAL HOSPITAL CENTER

Year the Program Started

2008

Program Description and Goals

In 2008, Phelps Memorial Hospital Center sent a team of both medical and non-medical staff to participate in a Hispanic Health Day to educate the Hispanic community on health topics. Physicians, nurse practitioners, nurses, mental health workers, a nutritionist, dentist, and several translators offered services to more than 100 families. General information and health screenings were offered, including breast exams, blood pressure readings, blood glucose testing, dental health evaluation, and depression assessment. The goals were to:

- heighten awareness of available health services;
- provide baseline screenings to those who are underinsured or uninsured;
- offer a referral base for people with abnormal findings;
- allow participants to sign up for insurance to cover health care costs; and
- establish trust between the Hispanic community and the agencies that serve it.

Partners

- Even Start Health Literacy Program
- Open Door
- Westchester Library Systems
- Planned Parenthood
- Cornell Cooperative Extension
- Westchester County Department of Health
- Dominican Sisters
- New Hope Fellowship Dentists
- Siemens Corporation
- Hudson Health Plan

Outcomes

More than 100 people were screened for hypertension, blood glucose levels, breast abnormalities, dental health, and depression. Families signed up for medical insurance through Hudson Health Plan. Glucometers were provided to people with elevated blood sugar. Open Door served as a referral source for those needing mammography or other medical services.

Contact

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The Witness Project

ROSWELL PARK CANCER INSTITUTE

Year the Program Started

2006

Program Description and Goals

The Witness Project is a community-based breast and cervical cancer education program that recruits, trains, and provides resources to African American women so they can become “Witness” role models (cancer survivors) or “Lay Health Advisors” (community educators). These women provide educational, inspirational, and empowerment messages to increase the practices of breast self-examination, mammography, clinical breast examination, pelvic examination, and Pap testing. The goal is to provide coordinated, collaborative, and systematic education with navigation to mammography. Due to the number of “no-shows” for mammogram appointments, the Witness Project collaborated with the Sheehan Health Network and Niagara Falls Memorial Medical Center to provide “one-stop-shop” (OSS) mammography. Held on Saturdays or evenings, OSS allows women to come to a single location to receive education and then carpool or be transported to the screening facility. Recently, in collaboration with eight influential pastors’ wives in Buffalo and other health care partners, the Witness Project presented the first annual Gospel Explosion to promote breast cancer education and early detection.

Partners

- Western New York Affiliate of Susan G. Komen for the Cure
- American Cancer Society
- Avon Foundation
- Niagara Falls Memorial Medical Center
- Sheehan Health Network
- Center for Transportation Excellence
- AIDS Community Services
- Buffalo and Niagara Falls Municipal Housing Authority
- Partners for Prevention in Erie County
- First Student Bus Company
- Healthy Living Partnership of Niagara County
- Univera Community Health
- First Ladies of Western New York
- Area churches

Outcomes

- From 2006 to 2008, the Witness Project conducted 140 programs and educated 1,539 African American women. More than 250 men and women attended the Gospel Explosion; 25 women obtained mammograms following the event.
- Ninety-eight percent of Witness Project women offered a screening incentive (\$20 gift card) through a collaborative marketing program completed a mammogram.
- OSS significantly decreased the “no-show” rate for mammography from more than 50% to less than 20%.
- There has been a 24% increase in African American patient referrals to Roswell Park Cancer Institute, a direct reflection of the success of the Institute’s outreach efforts.

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Annual Conference on Caregiving: Caring for the Caregiver

**SAINT FRANCIS HOSPITAL AND HEALTH CENTERS/
SAINT FRANCIS HOME CARE SERVICES**

Year the Program Started

2004

Program Description and Goals

The Annual Conference on Caregiving brings resources to caregivers to help them understand and meet the needs of those for whom they care. These resources include information on various products, resources, and services that are available to the caregivers within their community.

Partners

- Alzheimer's Association, Hudson Valley Chapter
- Dutchess County Office for the Aging
- Manor at Woodside
- Premier Home Health Care Services, Inc.
- Wingate Healthcare

Outcomes

Over the past four years, more than 500 caregivers attended the Annual Conferences on Caregiving. All caregivers acquire knowledge from these Conferences that enables them to better care for their loved ones. Caregivers gain a means to contact available services and the knowledge to utilize new techniques. Currently, more than 30,000 elderly citizens reside in Dutchess County, which is almost 10% of the county's population. With Dutchess County being the fastest growing county in New York State, an increased demand for caregiver services is expected in the area.

Contact

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Homeless Women’s Health Initiative

SAINT VINCENT CATHOLIC MEDICAL CENTERS OF NEW YORK

Year the Program Started

1996

Program Description and Goals

The Homeless Women’s Health Initiative enables homeless women to use the health care system effectively for preventive care and treatment of illness, with direct involvement in the decision-making process. Program staff include physicians; nurse practitioners; patient educators; nurses; mid-level practitioners; social workers; outreach staff; and others who provide direct medical services, case finding, health screening, and case management. The program also offers health education, HIV services, crisis intervention, and long-term counseling at shelters, drop-in centers, and single-room occupancy hotels. The goals of the Homeless Women’s Health Initiative are to provide health screening services and necessary specialty care services, implement group and individual health education programs that foster self-care, and encourage patients to enter into primary and preventive health care.

Partners

- Homeless Health Care Consumer Advisory Board
- Volunteers of America
- New York City Department of Homeless Services
- New York City Department of Health and Mental Hygiene
- Shelters, drop-in centers, and single-room occupancy hotels
- Women-in-Need Alcohol and Drug Treatment
- Bowery Residents Committee
- Project Hospitality
- Grand Central Neighborhood Social Services Corporation
- New York State Department of Health and AIDS Institute
- Legal Aid Society
- Legal Action Center for the Homeless
- Coalition for the Homeless
- U.S. Department of Housing and Urban Development
- Interagency Council on the Homeless

Outcomes

Over the past year:

- more than 1,000 homeless women received services at shelter-based health stations; 820 homeless women received clinical breast examinations, 248 underwent Pap testing, and 331 were referred for mammograms, 897 women received tuberculosis skin testing, and 840 had complete physical exams;
- more than 200 homeless women received services at back-up Outpatient Department Health Care for the Homeless Program clinics and subspecialty clinics; and
- more than 700 patients were fully oriented to the process of securing primary health care services.

Contact

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No Woman Left Behind— Navigating the Difficult World of Breast Cancer Education, Screening, and Treatment

SAMARITAN HOSPITAL

Year the Program Started

2006

Program Description and Goals

No Woman Left Behind is an education, outreach, and navigation program designed to give medically under-served women the skills they need to obtain the health care they deserve. This program reaches into medically under-served communities and provides women from these neighborhoods with breast cancer education, screening, patient navigation services, and treatment. Removing barriers to screening and care may be the most significant challenge to equitable care and elimination of health care disparities.

Partners

- Riverside Family Medical Group
- Susan G. Komen for the Cure
- Family Medical Group in Rensselaer
- Newman's Own Foundation
- South Troy Health Center
- American Cancer Society
- Cohoes Family Care
- To Life!
- Waterford Family Health Center
- Cancer Services Program

Outcomes

- No Woman Left Behind has reached more than 900 women yearly with breast cancer education. The program has reached more than 100 women each year with breast cancer screening at no cost.
- Ninety percent of women who have a negative screening mammogram return the following year for another one.

-
- Between five and ten cases of breast cancer have been diagnosed each year.
 - The most significant indicator of success is the ability to detect breast cancer early enough for successful treatment in women who otherwise would not have been screened.

Contact

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Defy Diabetes!

SETON HEALTH

Year the Program Started

2007

Program Description and Goals

Defy Diabetes! is a comprehensive strategy for diabetes detection and management in adults that is improving public health, engaging primary care practitioners, and reducing medical costs. Building upon the Faith Community Nurse Program that Seton Health pioneered 20 years ago, Defy Diabetes! aims to improve prevention and disease management. The project provides stipends, training, and curriculum to Faith Community Nurses in targeted parishes. The nurses help people make lifestyle changes that can prevent or delay the onset of Type 2 diabetes. Defy Diabetes! also works with primary care practices to improve the management of patients with diabetes through the role of a nurse champion and innovative chart reviews. Defy Diabetes! promotes American Diabetes Association (ADA) best practices.

Partners

- Six faith communities in Cohoes, Troy, Watervliet, Albany, Rensselaer, and Waterford
- Hispanic Outreach Services
- Cornell Cooperative Extension
- Albany Medical Center
- ADA
- Northeastern New York Diabetes Educators
- Professors from Sage Colleges and SUNY School of Social Welfare

Outcomes

- Church talks, screenings, and health fairs have been delivered in six targeted parishes. Screening participants receive follow-up counseling, are referred back to their primary care provider, and are invited to attend the healthy living classes. Healthy living classes are conducted with a unique, holistic “body, mind, and spirit” perspective to diabetes education.
- Outcomes related to primary care intervention include a unique chart assessment tool, modeled on the National Committee for Quality Assurance recognition program. This tool allows each provider to receive an individualized quarterly report.

Contact

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Pediatric Asthma Management Program: Changing Community Outcomes

SOUTH NASSAU COMMUNITIES HOSPITAL

Year the Program Started

2007

Program Description and Goals

South Nassau Communities Hospital (SNCH) addressed the challenge of pediatric asthma using a multidisciplinary team approach. This team consisted of SNCH nursing, pediatric medicine, respiratory therapy, social work, performance improvement, pharmacy, and home care staff, and the Asthma Coalition of Long Island. Parents and children admitted to the hospital received asthma education during their stay and follow-up referrals to the Department of Health and to the SNCH Home Care Department. The pediatric nursing staff followed 22 families through telephone calls at one month, three months, and six months post-discharge. In March 2008, the program was expanded to the hospital's emergency department and a condensed tool was developed for more practical education in the emergency department.

Goals of the program were to decrease the rate of asthma-related emergency room visits, the rate of hospital readmissions for asthma, and missed school days for pediatric asthma patients of school age.

Partners

- Department of Health
- Long Island Asthma Coalition

Outcomes

- Missed school days decreased 89.7% (from 29 days to three days).
- Emergency department visits for asthma decreased 92.3% (from 39 to three).
- Hospital admissions for asthma decreased by 95.5% (from 22 to one).

Contact

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Fall Prevention: A Community Outreach Initiative

SOUTH NASSAU COMMUNITIES HOSPITAL HOME HEALTH AGENCY

Year the Program Started

2006

Program Description and Goals

In conjunction with Nassau County libraries, senior citizen centers, assisted living facilities, senior housing facilities, community health fairs, and a community-based dialysis center, South Nassau Communities Hospital (SNCH) Home Health Agency has provided fall risk factor education and evidence-based strategies to reduce the risk of falls among older adults and their caregivers in the community. The goals of the initiative were to increase awareness of and access to fall prevention programs in the community for vulnerable populations in need, improve identification processes and collaboration with community partners, expand services to high-risk community members, and ensure the effectiveness of interventions provided.

Partners

- Baldwin and Lynbrook public libraries
- East Rockaway, Roosevelt, Rockville Centre, Long Beach, and Hempstead senior citizen centers
- Town of Hempstead senior housing
- Sunrise Assisted Living
- Senior Care and Atria assisted living facilities
- Rockville Centre, Freeport, and SNCH community health fairs
- SNCH Outpatient Dialysis Center

Outcomes

- From 2006 through 2008, 684 people were identified to be at a high risk for falls and were referred to SNCH's fall prevention program. Of these, 274 were referred from the community. After receiving the program interventions, 249 of the community participants (91%) did not fall.
- SNCH Home Health Agency has increased awareness with collaborative partners in the community and provided effective public education strategies in a variety of initiatives to reduce falls among older adults in the community. Participants have learned about the epidemiology and scope of falls in the elderly and their economic and personal impact.

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Southern Tier Child Advocacy Center and Sexual Assault Forensic Examiner Program

SOUTHERN TIER HEALTH CARE SYSTEM

Year the Program Started

2007

Program Description and Goals

This initiative is a multi-disciplinary approach to the problem of child abuse and sexual abuse that reduces trauma on the victim, while enhancing cooperation among various community agencies and institutions. The program is designed to promote justice, foster healing, and empower victims. A multidisciplinary team of doctors, counselors, child protective service workers, law enforcement officers, prosecutors, and victim advocates work with Southern Tier Child Advocacy Center (STCAC) staff to help abused children. The Sexual Assault Forensic Examiner (SAFE) program is designed to reduce victim trauma and to provide admissible evidence in case of a crime. If someone has been sexually assaulted and is willing to be treated, a victim advocate and a specially trained SAFE provider are called in immediately. The SAFE team at the hospital focuses on collection of evidence, sexually transmitted disease prevention, and patient safety.

Partners

- Cattaraugus County and Allegany County District Attorneys
- Olean General Hospital
- Jones Memorial Hospital
- Cattaraugus and Allegany County Sheriffs' offices
- New York State Police
- Olean, Wellsville, and Salamanca police departments
- Allegany and Cattaraugus County child protective service workers
- STCAC staff

Outcomes

- In its first year, STCAC helped 186 abused children and their families. To date, more than 240 children have been helped by STCAC.
- From September 2008 to February 2009, the SAFE program conducted 13 examinations.

Contact

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Facilitated Enrollment Program

ST. ELIZABETH MEDICAL CENTER

Year the Program Started

2000

Program Description and Goals

In 1999, St. Elizabeth Medical Center identified that three to four inpatients per day were admitted to the hospital with little or no insurance. Often, these patients were very sick because they hesitated to seek medical care. The facilitated enrollment program's goal is to identify all self-pay and/or underinsured patients while they are inpatients, determine if they are eligible for available coverage programs, and initiate applications for those programs.

Once these patients are identified, an account specialist will meet with the patient and/or family to explain the services available. If the patient/family agrees to seek services, the account specialist asks the patient to sign an authorization so the hospital may represent the patient and begin the application process. Similar goals are set for the emergency department and other departments.

The goal is to make contact with 100% of the self-pay population and initiate applications for all those eligible for services.

Partners

- Local county departments of social services
- Mohawk Valley Perinatal Network

Outcomes

Since the program's inception, it has grown tremendously. In 2008, the program saw more than double the number of accounts reviewed by the account specialists, compared to 2007. The hospital also saw a 43% increase in Medicaid applications.

Contact

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Teddy Bear Clinic

ST. LUKE'S CORNWALL HOSPITAL

Year the Program Started

1996

Program Description and Goals

Emergency physicians and nurses at St. Luke's Cornwall Hospital developed the Teddy Bear Clinic to improve outcomes for pre-school and grade school children. This specialized group of nurses and physicians recognized that this age group exhibits signs of anxiety and fear that interfered with their emergency department experience. Through the interactive Teddy Bear Clinic, children from local schools visit the emergency department and are encouraged to bring teddy bears. Together, students and teddy bears venture through the emergency department experience. The goal is to increase awareness of the emergency department and healthy lifestyle choices, while decreasing stress.

Partners

- Mobile Life Support System
- Montgomery Volunteer Ambulance
- Cornwall Volunteer Ambulance
- Footprints Nursery, The Vails Gate Elementary, Balmville Elementary, Ostrander Elementary, Most Precious Blood, South Junior High, St. Joseph's, St. Thomas of Canterbury, Washingtonville Elementary, and Montgomery Elementary Schools

Outcomes

Outcomes are not formally measured. However, staff who participate in the Teddy Bear Clinic have observed that care delivery is expedited, and fears and anxieties of young children and their families are lessened.

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Health Care That Leaves No One Behind

ST. MARY'S HOSPITAL, AMSTERDAM

Year the Program Started

2003

Program Description and Goals

This program provides a full-time enrollment specialist who assists individuals and families in enrolling in state-sponsored health insurance programs such as Family Health Plus, Child Health Plus, and Medicaid. The goal is to enroll 500 people each year. Supplemental information and referrals to charity care, financial assistance, cancer care and screening, and discount prescription drug programs are also provided. In addition to working at the hospital, the enrollment specialist appears at health fairs, family events, and outreach sites. This program collaborates with other health insurance enrollment entities to increase access to health care coverage among the Hispanic community by offering the services of bi-lingual enrollers and by offering telephone and video translation services. It also increases access to coverage through various local "Cover the Uninsured Week" events held in the community.

Partners

- Amsterdam Memorial Healthcare
- Fidelis Care
- Nathan Littauer Hospital and Nursing Home
- Local Departments of Social Services (Fulton and Montgomery Counties)
- Hispanic Outreach Services
- Catholic Charities of Fulton and Montgomery Counties/Family Room
- Catholic Charities of Fulton and Montgomery Counties/Food Pantry
- The Cancer Services Program of Fulton and Montgomery Counties
- Local churches and social service agencies

Outcomes

Nearly 2,000 uninsured individuals have been enrolled in health insurance because of the services offered by this program and collaborating partners. On average, the program reaches out to nearly 1,000 and enrolls 500 individuals annually in health insurance. Additionally, the local Cover the Uninsured Week events have reached nearly 300 people since 2006.

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Community Health Awareness Fair

ST. JAMES MERCY HEALTH SYSTEM

Year the Program Started

2008

Program Description and Goals

St. James Mercy Health System held its Community Health Awareness Fair twice in 2008, bringing together the public, health care agencies, community organizations, and service lines for a day of education, exhibits, and screenings. The goals include:

- provide information through screenings, dialogue, materials, and demonstrations to educate consumers about their current health status;
- motivate participants to make positive health behavior changes; and
- demonstrate the depth of quality health care services and specialties available.

Partners

- Steuben County Office of the Aging
- Wellness Council of the Southern Tier
- ProAction/Bonebuilders
- Wal-Mart Vision Services
- Southern Tier Hospice
- Steuben County Public Health Nursing
- Beltone Better Hearing Centers
- Rochester/Finger Lakes Eye and Tissue Bank
- Clinical Associates of the Southern Tier
- Home and Health Care Services, Inc.
- New York Connects
- Turning Point of Hornell
- Hornell YMCA
- Steuben Rural Health Network
- Southern Tier Tobacco Awareness Community Partnership

Outcomes

Two hundred members of the community attended the two Community Health Awareness Fairs. Of the 58 attendees who completed written evaluations, 55 rated the Fair “excellent,” 36 planned to use the health information themselves, and 42 planned to share the information with others. Five participants discovered an unknown health problem and 16 planned to see a doctor. In addition, 56 participants received influenza shots, seven received the pneumonia vaccine, four received tetanus shots, 12 underwent cholesterol tests, and another 12 had mammograms.

Contact

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Tobacco Recovery Coalition of the Capital District

ST. PETER'S HEALTH CARE SERVICES

Year the Program Started

2004

Program Description and Goals

The objective of the Tobacco Recovery Coalition of the Capital Region was to develop strategies and provide support to New York State Office of Alcoholism and Substance Abuse Services (OASAS)-certified treatment programs to establish tobacco-free facilities and to address abstinence from tobacco with the community. Specific goals included:

- help providers become “tobacco-free” facilities;
- promote integration of tobacco-free services into OASAS-certified programs;
- offer education on topics related to promotion of tobacco recovery and compliance with OASAS regulatory requirements; and
- support and promote staff recovery from tobacco dependence.

Partners

- St. Peter's Hospital
- Albany County Department of Mental Health
- Office of Alcoholism and Substance Abuse Services
- Seton Health Smoking Cessation Center
- American Cancer Society
- Whitney M. Young Methadone Maintenance Program
- The Addictions Care Center of Albany
- Hudson Mohawk Recovery Center
- New Choices
- Pahl House
- Pearl Street Counseling Center
- Seton Addiction Services
- Senior Hope
- Equinox
- The Next Step
- Twin County Recovery

Outcomes

- Three annual conferences provided education to more than 250 participants.
- Resources created included patient and staff brochures; sample timelines, policies, and treatment plans; and committee charters.
- Fourteen agencies became tobacco-free facilities by February 2007.
- Linkages were established with community based-resources for ongoing staff education and other resources including nicotine replacement products for patients.

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Breastfeeding Initiative

STATEN ISLAND UNIVERSITY HOSPITAL

Year the Program Started

2007

Program Description and Goals

The goal of the Staten Island University Hospital Breastfeeding Initiative is to have 75% of infants nursing at time of discharge from the hospital. The Breastfeeding Initiative coordinator oversees the activities of a breastfeeding committee. With a research-driven model, this nurse-led, multidisciplinary team combined staff education and strong community alliances to transform the culture of the hospital to one that supports breastfeeding.

Partners

- March of Dimes
- New York City Department of Health and Mental Hygiene
- United Hospital Fund
- Richmond University Medical Center of Staten Island
- Prenatal Care Assistance Program
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Outcomes

The hospital has:

- rewritten its breastfeeding standard of care, and education related to this new standard has begun;
- trained 15 registered nurses to be certified breastfeeding consultants;
- established breastfeeding education seminars for providers, pediatricians, nurses, physician assistants, nurse practitioners, midwives, and ancillary staff;
- reached out to outpatient clinics and private offices to provide support;
- initiated a breastfeeding “warm line” for breastfeeding support by telephone;
- printed and distributed the Staten Island Breastfeeding Resource Guide, breastfeeding welcome packs, and refrigerator magnets; and
- developed a computerized data input for breastfeeding information to accurately assess rates and use information for future research. Breastfeeding rates from April 2008 through December 2008 were 56%, well below the recommended 75%. The rates show a gradual, but steady increase during each month of the Breastfeeding Initiative.

Contact

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Center for Community Health Promotion and Wellness

SUNY DOWNSTATE MEDICAL CENTER/UNIVERSITY HOSPITAL OF BROOKLYN

Year the Program Started

1996

Program Description and Goals

The Center for Community Health Promotion and Wellness leads community health promotion outreach in collaboration with community-based organizations, public officials, local school districts, and businesses, reaching thousands of Brooklyn residents. The goal is to promote wellness, illness prevention, early detection, and appropriate access to care to address health disparities. The Center offers culturally relevant programs focusing on the community's needs, free of cost, including cardiac risk and asthma screening, expectant family education, smoking cessation programs, a stroke club, diabetes club, kidney club, and a "4 O'clock Club" for children and teens with diabetes. The Center offers monthly community health promotion lectures, screenings at senior citizen centers, and an immunization program.

Partners

- New York Organ Donor Network
- Managed Care Groups
- American Cancer Society
- American Diabetes Association
- American Association of Kidney Patients
- American Heart and Stroke Association
- American Lung Association
- Brooklyn Perinatal Network, Inc.
- Juvenile Diabetes Research Foundation
- New York City Department of Health
- The Greater Brooklyn Health Coalition
- The Brooklyn Diabetes Task Force
- Arthur Ashe Institute for Urban Health
- SUNY Downstate Master of Public Health Program
- Healthy Families Initiative
- Holy Cross Roman Catholic Church
- New Creation Community Health Ministries
- Physicians, dietitians, educators, social workers, students, and administrators

Outcomes

This past year, the Center has seen 13,000 community members, participated in more than 100 community health events, provided numerous referrals, and followed up with many community members.

Contact

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Amaus Health Services

SUNY UPSTATE MEDICAL UNIVERSITY/UNIVERSITY HOSPITAL, SYRACUSE

Year the Program Started

2007

Program Description and Goals

Amaus Health Services offers free primary care to the homeless, unemployed, working poor, refugees, parolees, and others who fall through the health care cracks. The Amaus Health Services clinic provides accessible primary care to often-overlooked patients of many ages with complex, chronic conditions and makes referrals to its network of volunteer medical specialists. The Onondaga County Department of Health supported and encouraged an influenza vaccination program that dispensed 200 doses during the 2008 flu season. Both adults and children were vaccinated at the clinic and two other locations in the community. Amaus Health Services added a foot clinic over the winter of 2007-2008.

Partners

- Cathedral of the Immaculate Conception
- LeMoyne College
- Syracuse University
- Onondaga Department of Health

Outcomes

More than 350 SUNY Upstate Medical University students have volunteered at the Amaus Health Services clinic, providing more than 1,900 service hours, while two faculty members volunteered more than 500 hours. They have seen 750 people, providing physical examinations, taking histories, and prioritizing needs.

Contact

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Fit Families: The Healthy Lifestyle Family Program

SUNY UPSTATE MEDICAL UNIVERSITY AND UNIVERSITY HOSPITAL

Year the Program Started

2003

Program Description and Goals

The goal of Fit Families: The Healthy Lifestyle Family Program, is to provide a family-centered approach to healthy eating and physical activity habits to reduce child obesity. Families obtain the skills necessary to promote a home and social environment that effectively deters excess weight gain. Families work closely with a multidisciplinary team of professionals including a pediatrician, pediatric nutritionist, clinical social worker, and physical therapist. This program offers group educational classes and counseling on an individual basis. The group sessions focus on nutritional, behavioral, and physical activity lifestyle changes. The program also offers a bi-weekly, community-wide educational class that is open to both enrolled patients and the community free of charge.

Partners

- YMCA
- Institute for Human Performance
- Volunteer nutrition, psychology, and exercise science graduate students from Syracuse University
- Volunteer physicians from the SUNY Upstate Medical University pediatric residency program

Outcomes

Since the start of the Healthy Lifestyle Family Program, nearly 400 children have been evaluated. Preliminary results from a chart review of patient data over a two-year period suggest that the children enrolled in the program had an average body mass index (BMI) increase of 0.0294 units/month. The children not enrolled in the program had an average BMI increase of 0.1191 units/month.

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Get Up! Fuel Up!

THOMPSON HEALTH

Year Program Started

2007

Program Description and Goals

The goals of Get Up! Fuel Up! are to combat the rising prevalence of childhood obesity and its subsequent health risks, to help children develop self-esteem and a savvy understanding of media/societal influences, and to help schools recognize the connection between the health of students and their academic success. This program involves various aspects of the community working together in a way that is effective, creative, and fun. The program has three distinct levels that correspond to New York State health and physical education standards. At each level, the lessons can be tailored to the needs of the school district. Each level has its own learning assessment that measures pre- to post-learning outcomes so that lessons can be fine-tuned and made more effective.

Partners

- Ontario County Youth Bureau
- Canandaigua City School District
- Bloomfield Central School District
- Midlakes School District
- Red Jacket School District

Outcomes

To date, 1,640 second- through seventh-graders have participated, with measureable improvements in nutrition knowledge, media literacy, and healthy behavior changes:

- **Elementary Level 1:** Among Bloomfield Elementary second-graders, there was a 29% increase in the number of students who chose whole wheat flour instead of white or enriched wheat flour.
- **Elementary Level 2:** Among Canandaigua fifth-graders, there was a 46% increase in the number of students who reported finding it “very easy” to determine whether a food was high enough in fiber.
- **Secondary Level 1:** At Red Jacket Middle School, there was a 55% jump in the number of sixth-graders who knew it takes 20 minutes to realize their stomach is full.
- Many parents have reported that their cupboards and refrigerators are stocked with healthier choices, that their televisions get less use, and that they are making a concerted effort to be active together.

Contact

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Chautauqua County Witness Project

WCA HOSPITAL

Year the Program Started

2007

Program Description and Goals

The goal of the Witness Project, a culturally competent, faith-based breast and cervical cancer education and screening program, is to educate African American women on breast cancer risks and facts, thus decreasing late-stage diagnosis and mortality rates. It is designed to increase the number of African American women who practice regular cancer screening through clinical breast and cervical examinations, mammography, and breast self-examination. The Witness Project program is offered to congregations and opens with a hymn and a prayer and proceeds with a “Witness Role Model”—a breast or cervical cancer survivor who shares her personal experience by “witnessing” her triumph over cancer. The witness role model’s presence is seen as proof that cancer is not a death sentence if detected and treated early. Trained “Lay Health Advisors” then provide facts and dispel myths about breast and cervical cancer, while demonstrating how to do a breast self-exam. WCA’s patient navigator is also present to assess those women who need services for any barriers to accessing care.

Partners

- Chautauqua County Partners for Prevention
- Erie/Niagara Witness Project at Roswell Park Cancer Institute
- The United Way of Southern Chautauqua County
- Chautauqua County Breast Health Task Force
- Area churches
- Community Outreach Partnerships Center
- Chautauqua County Job Corps
- American Cancer Society, Eastern Division
- Susan G. Komen for the Cure

Outcomes

- The Witness Project provided education on breast/cervical cancer to 545 women age 20 and older.
- The initiative found that 25 women in need who participated in the Witness Project completed their mammogram and cervical screenings.

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- Eleven women were identified who had not had mammograms within the past three to five years.
 - Seven women had their mammograms within one to three months of attending a Witness Project program—two required further navigation for follow-up testing.

Contact

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Hudson Valley Shaken Baby Prevention Initiative

WESTCHESTER MEDICAL CENTER

Year the Program Started

2004

Program Description and Goals

The goal of this initiative is to educate parents of newborns in New York State about normal infant crying, how to handle it, and the terrible consequences of shaken baby syndrome—before they take their baby home from the hospital. Maternity nurses provide parents this information, along with written and video educational materials. Surveys are conducted to track program effectiveness.

When launched, the program was called the Hudson Valley Shaken Baby Prevention Initiative, which grew to a network of 22 hospitals in the lower Hudson Valley. Due to the success of the program, the state awarded the team a grant to fund expansion of the program to every hospital in the state with maternity services. A partner program at Women and Children’s Hospital of Buffalo is expanding to the hospitals in counties north of the Hudson Valley region, and the team at Maria Fareri Children’s Hospital at Westchester Medical Center is expanding the program to all hospitals in New York City and Long Island. The new program is called the New York Shaken Baby Prevention Program.

Partners

- William B. Hoyt Memorial Trust Fund of the Office of Children and Family Services of New York State
- Women and Children’s Hospital of Buffalo
- Nurses at the participating hospitals

Outcomes

- This program educated the parents of 82,509 newborns, which was 84% of the births at the participating facilities from 2004 to 2008.
- Follow-up interviews were conducted with several hundred parents, and 89% of parents interviewed indicated that they remembered the information about how to calm a crying baby and that shaking was bad.
- Tracking the incidence of shaken baby syndrome in the geographical region served by the participating hospitals shows a reduction of at least 33% of cases after program implementation as compared to the five years before program implementation.

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