



# Community



## CONNECTING WITH COMMUNITIES

COMMUNITY HEALTH INITIATIVES ACROSS NEW YORK STATE

2011 EDITION



Healthcare Association  
of New York State

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## INTRODUCTION

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New York State's hospitals have provided leadership in connecting with their communities for years, developing and expanding partnerships to ensure they reach the entire population with initiatives to prevent disease and improve health.

The case for creating a culture of health is demonstrated by the national public health goals in *Healthy People 2020*, which provides a national framework and important goals for enhancing the health of our nation. The Affordable Care Act (ACA) includes incentives to become accountable for overall population health, and builds on the *Healthy People* framework by establishing the National Prevention, Health Promotion, and Public Health Council, which will coordinate and lead the activities of more than a dozen federal agencies. ACA also includes incentives to promote employee health and wellness programs.

The Healthcare Association of New York State's (HANYS) *Connecting With Communities: Community Health Initiatives Across New York State* features a wide variety of initiatives by hospitals and health systems that focus on improving the health of communities. These profiles were obtained through the annual nomination process for HANYS' Community Health Improvement Award.

In the 45 nominations received for the Community Health Improvement Award in 2011, HANYS continues to see strong collaboration and great strides among hospitals and continuing care providers in outreach, education, and prevention programming.

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 additional information on this award or about HANYS' community health agenda, contact Sue Ellen Wagner, Vice President, Community Health, at (518) 431-7837 or at [swagner@hanys.org](mailto:swagner@hanys.org). For additional copies of this publication, please contact Sheila Taylor, Executive Assistant, at (518) 431-7717 or at [staylor@hanys.org](mailto:staylor@hanys.org).



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## 2011 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

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### The Healthy Sundays Program CATHOLIC HEALTH SERVICES OF LONG ISLAND



*Luz Puello, Project Coordinator for Catholic Health Services of Long Island, accepts the 2011 Community Health Improvement Award from HANYS' President Daniel Sisto (left) and Joseph McDonald, President and Chief Executive Officer of Catholic Health System (right).*

YEAR PROGRAM STARTED: 2005

#### Program Description and Goals

The Healthy Sundays program's 300 volunteers provide services to more than 7,000 people across Long Island at 23 parishes and community centers. These volunteers reach the under-served, financially distressed, and undocumented in dire need of health care. Healthy Sundays educates populations that lack access to the traditional health care system, providing a safe venue and improved access to vital primary care. Screenings include tuberculosis, diabetes, cholesterol, blood pressure, body mass index, skin cancer, prostate cancer, and influenza immunizations. The program improves patient quality of life, decreases morbidity and mortality, and reduces the burden on the emergency care system.

**PARTNERS:** Good Samaritan Hospital Medical Center; Good Samaritan Nursing Home; Mercy Medical Center; St. Catherine of Siena Nursing Center; St. Charles Hospital; St. Francis Hospital; Catholic Home Care; Good Shepherd Hospice; Our Lady of Consolation Nursing and Rehabilitation Center; St. Joseph Hospital; Mary Haven Center of Hope; Fidelis Care; New York State Cancer Services Program; St. Lucy's Eye Care Center; Wellwood Medical Associates; Nassau-Suffolk Urology Associates; South Bay Cardiovascular; County Community Health Centers

#### Outcomes

- In 2010, more than 7,000 patients participated in 44 outreach events, 4,900 screenings, and 2,616 immunizations.
- In 2010 alone, 494 participants were referred to the Bishop McHugh Health Center for free care.
- More than 300 Catholic Health Services volunteers contributed 2,157 hours during 2010.
- Through disease management, more than 50% of patients with chronic conditions like hypertension and diabetes were brought into normal range within 60 days of service.

**CONTACT:** Luz M. Puello, Project Coordinator, Catholic Health Services of Long Island; (631) 465-6304; luz.puello@chsli.org



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## HONORABLE MENTION

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### Building Healthy Children STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCHESTER MEDICAL CENTER



Steven Goldstein (left), President and Chief Executive Officer of Strong Memorial Hospital, receives Honorable Mention for HANYS' 2011 Community Health Improvement Award. Presenting the award is Joseph McDonald (right), President and Chief Executive Officer of Catholic Health System.

YEAR PROGRAM STARTED: 2007

#### Program Description and Goals

Monroe County has one of the highest rates of teen pregnancy in New York State and teen families face increased risks for child abuse, neglect, emotional difficulties, behavioral problems, and developmental delays in children, and ultimately foster care placements. Early intervention and support is critical to helping teens raise healthy, successful children.

Building Healthy Children provides and evaluates preventive interventions for teen families and their children. Using a combination of four evidence-based practices, the hospital supplies young mothers with parenting education, parent-child attachment,

maternal depression therapy, and any needed support services such as food, housing, and transportation for three to five years.

Program goals include decreasing the number of families involved with Child Protective Services and promoting positive parent-child relationships with healthy child development.

**PARTNERS:** Strong Memorial Hospital/University of Rochester Medical Center Departments of Pediatrics and Family Medicine, and Social Work Division; Mt. Hope Family Center; Society for Protection and Care of Children; Monroe County Nurse Family Partnership; Monroe County Department of Human Services; Monroe County Department of Health; The United Way of Greater Rochester

#### Outcomes

Preliminary analyses suggest positive trends for the treatment group:

- a 99% avoidance rate of foster care placements;
- a 95% avoidance rate of child protective services;
- approximately 98% of families have complied with obtaining pediatric care for children and are up to date with well-child visits and immunizations; and

- 
- ninety percent have demonstrated an increase in their parenting knowledge.

**CONTACT:** Gwenn Voelckers, Director, Health Communications and Outreach,  
University of Rochester Medical Center, Center for Community Health;  
(585) 224-3056; [gwenn\\_voelckers@urmc.rochester.edu](mailto:gwenn_voelckers@urmc.rochester.edu)

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## HONORABLE MENTION

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### Center for Tobacco Control NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM



*Patricia Folan, Director of the Tobacco Control Center at North Shore-Long Island Jewish Health System, receives Honorable Mention for the 2011 Community Health Improvement Award. Presenting the award are HANYS' President Daniel Sisto (left) and Joseph McDonald (right), President and Chief Executive Officer of Catholic Health System.*

YEAR PROGRAM STARTED: 1999

#### Program Description and Goals

The Center for Tobacco Control (CTC) provides a free tobacco dependence treatment program for community members and health system employees. This cessation program is the only regularly scheduled free cessation program in Nassau County. Since its inception in 1999, nearly 5,000 tobacco users have been treated at CTC. The program is run by advance practice nurses and adheres to federal guidelines for tobacco dependence treatment. Additionally, with grant funding from the Department of Health (DOH) Tobacco Control Program, CTC provides education and assistance to hospitals, clinics, private physician offices, and health care providers to assist them in effectively treating patients who use tobacco.

CTC has provided education to 20 hospitals and more than 20,000 providers.

**PARTNERS:** DOH Tobacco Control Program; Tobacco Action Coalition of Long Island; Nassau County Department of Health; Suffolk County Department of Health; Asthma Coalition of Long Island; Healthy Schools New York; American Lung Association; American Cancer Society; American Heart Association; New York City Police Department; Fire Department of the City of New York; Nassau County Police Department; Local elementary, middle, and high schools; local colleges, universities, medical and nursing schools

#### Outcomes

- This program has treated nearly 5,000 community members for tobacco dependence; the one-year quit rate is 40%.
- CTC educated 20,000 health care providers about evidence-based treatment for tobacco dependence.
- This initiative helped increase the “provider assist to quit rate” in New York State from 37.4% in 2003 to 50.9% in 2008.

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- CTC also assisted hospitals with the implementation of smoke-free campus initiatives, with 100% compliance on Long Island by December 2011.

**CONTACT:** Patricia Folan, M.S., R.N., Director, Tobacco Control Center, North Shore-Long Island Jewish Health System; (516) 466-1980; pfolan@nshs.edu

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## NOMINATIONS

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### Total Joint Program ALICE HYDE MEDICAL CENTER, MALONE

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

Alice Hyde Medical Center's hospital, nursing home, and orthopedic/sports medicine staff designed a Total Joint Program for patients undergoing total knee and hip replacement surgeries. The program focuses on providing education to help patients through each treatment step, including diagnosis, pre-hospitalization preparation, rehabilitation, and recovery. The program was designed to:

- improve patient satisfaction by educating participants on how to prepare, what to expect, and how to plan for their recovery; and
- improve patient outcomes through the consistent delivery of care by dedicated staff, while increasing patient satisfaction and reducing infections and recovery time.

**PARTNERS:** Orthopedic surgeons from Alice Hyde Medical Center's Orthopedic and Sports Medicine Center; clinical and administrative staff, including physicians, nursing, rehabilitation, pharmacy, and discharge planning personnel

#### Outcomes

- All patients scheduled for a total hip or knee replacement attended the comprehensive pre-operative educational and treatment planning class.
- Using an antimicrobial soap, the program reduced the infection rate from 2.8% to 1.3%.
- All patients in 2010 were swabbed for Methicillin-resistant *Staphylococcus Aureus* before hospitalization.
- Twenty percent of total joint replacement patients underwent rehabilitation at Alice Hyde Medical Center's skilled nursing facility before being discharged home for intensive physical and occupational therapy.

**CONTACT:** Linda McClarigan, R.N., B.S.N., M.S., Senior Vice President, Patient Care Services, Alice Hyde Medical Center; (518) 481-2262; [lmclarigan@alicehyde.com](mailto:lmclarigan@alicehyde.com)

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## The Priority Community Health Care Center ARNOT OGDEN MEDICAL CENTER, ELMIRA

YEAR PROGRAM STARTED: 2009

### Program Description and Goals

Arnot Ogden Medical Center's Priority Community Health Care Center (PCHCC) provides primary care to Medicaid recipients and functions as a medical home to improve access, continuity of care, and reduce costs. PCHCC affords participating Medicaid patients oversight through a physician and team of ancillary health care professionals. Patients receive basic primary care and intensive case management that includes education and disease management, coordination with other community service providers, and non-traditional interventions to improve engagement, compliance, and health outcomes. PCHCC targets specific chronic disease states, implements standards of care, and actively monitors patients to improve outcomes and reduce emergency room (ER) utilization for primary care. Enrollment is managed through the Chemung County Department of Social Services (DSS), using a partial capitation payment model.

**PARTNERS:** Arnot Medical Services; Chemung County; Priority Community Health Center; Southern Tier Area Plan; Southern Tier Priority Healthcare; Twin Tier Physician Management

### Outcomes

Indicators of success include:

- **The number of enrollees:** To date, approximately 13,500 Medicaid recipients have been identified as potential members of PCHCC. In the first year, 2,500 patients were enrolled, with anticipation of total enrollment exceeding 4,000 patients by the end of year two.
- **A decrease in inappropriate ER visits:** Data provided by Chemung County DSS indicated that 25% of current PCHCC members used the ER more than 12 times during the most recent calendar year prior to enrollment in the program. Using integration and tracking software, a group of 400 enrolled members were tracked for ER utilization following enrollment. Initial results indicate a decrease in ER usage for the study group during PCHCC's first year.

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- **A decrease in Medicaid spending as a result of more efficient utilization of health care services:** Analysis by Chemung County DSS identified an almost 2% savings in Medicaid expenditures for enrolled patients during the first year. In addition, tracking of a select group of patients indicated decreased utilization of certain pharmaceuticals used for exacerbated disease states.
  - **Healthier patients as a result of improved access and disease management:** Initial studies reveal that certain health status indicators such as blood pressure improved significantly for approximately 50% of the patients tracked.

**CONTACT:** Cathleen Mathey, Director of Community Outreach and Telehealth Services, Arnot Ogden Medical Center; (607) 737-4469; cmathey@aomc.org

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## UpClose Cardiac Surgery Program

### **BASSETT MEDICAL CENTER, COOPERSTOWN**

YEAR PROGRAM STARTED: 2003

#### Program Description and Goals

Bassett’s UpClose Cardiac Surgery program teaches seventh-grade students how to adopt heart-healthy habits. Through lectures, participatory challenges, and viewing live open-heart surgery, students learn how to choose behaviors that lead to improved heart health. Student learning is assessed by pre- and post-testing, an essay contest, and teacher feedback. Educators include Bassett physicians, exercise physiologists, nutritionists, and nurses.

The program, offered to schools in eight counties, is based on the principle that young people need to “consciously connect the consequences of their choices.” Using heart surgery as an example of the consequences of advanced coronary artery disease, emphasis is placed on the concept that habits/behaviors adopted when young have a direct connection to future risk of heart disease.

**PARTNERS:** Bassett Medical Center, Division of Cardiac Surgery; Bassett Medical Center Research Institute; School districts in Chenango, Delaware, Fulton, Herkimer, Montgomery, Otsego, and Schoharie counties; Bassett school-based health programs

#### Outcomes

- Since 2003, the UpClose program has provided education to more than 4,000 students from 28 schools in seven rural upstate New York counties.
- Nearly 1,200 students attend each year.
- Nearly 80% of participating schools are in Delaware, Otsego, Montgomery, or Schoharie counties.
- The program administers a pre-test to participating students before their arrival at Bassett Medical Center. These results are compared to post-test scores (administered at the students’ schools after the program). This quantitative assessment revealed significant learning and retention, as the average aggregate number of scores that were marked correctly on the post-test after being initially incorrect



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on the pre-test increased by 16.8%. In addition, comparison of the scores allows UpClose staff to better understand which teaching messages require more emphasis.

**CONTACT:** Steven Garner, Manager, Community Health Programs, Bassett Medical Center; (607) 547-3037; [steven.garner@bassett.org](mailto:steven.garner@bassett.org)

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## Asian Services Center

### **BETH ISRAEL MEDICAL CENTER, NEW YORK CITY**

YEAR PROGRAM STARTED: 2005

#### Program Description and Goals

Beth Israel Medical Center's Asian Services Center addresses the Asian community's health needs by offering world-class medical treatment; culturally sensitive, linguistically supportive compassionate care; easily accessible enhanced services; and community and professional education. With the hospital administration's full commitment, the Center thrives under the direction of an all-Asian team of health care professionals who are highly regarded in the community. The keys to the Center's strength are multi-disciplinary cooperation across departments; individual staff participants who are each outstanding in their fields and who find the special services integral and vital to their delivery of care; and a registered nurse executive director who has many years of experience, deep and far-reaching ties in the Asian community, and tireless dedication to serving patients.

**PARTNERS:** Asian Americans for Equality; Betances Health Center; China AIDS Fund; Chinatown Summer Festival; Chinese American Alzheimer's Coalition; Chinese American Healthy Heart Coalition; Chinese American Independent Practice Association; Chinese American Medical Society; Chinese American Planning Council; New York Asian Women's Center; Chinese Consolidated Benevolent Association of New York; New York City Human Resources Administration, Medical Assistance Programs; Department of Health and Human Services, Central Medicaid Services; Indochina Sino-American Community Center; Neighborhood Naturally Occurring Retirement Community, Chinatown; Chinese Community Social Service and Health Council; New York City Administration for Children's Services; New York City Department for the Aging; Saint Margaret House, Senior Living; Salvation Army—Chinatown, Senior Citizens Center

#### Outcomes

- A dedicated Asian inpatient unit was established with 12 bilingual nursing staff members under the leadership of an Asian nursing manager.
- Through intense multi-disciplinary collaboration, three dedicated medical programs of excellence were established: the Asian Cardiovascular Services, the Asian Pulmonary Program, and the Chinatown Multi-Specialty Group.

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- From 2006 to 2010, the Center saw a 75% increase in average monthly inpatient admissions, while cardiac procedures rose from 320 to 710 per year. Admissions in psychiatry, especially difficult because of cultural stigmas, increased from zero to 30% of all admissions. Monthly outpatient referrals increased from 100 to 280.
  - Beth Israel Medical Center's Asian Family Caregiver Program helps Asian caregivers increase coping skills and knowledge and reduce anxiety through counseling, referrals, and a *Caregiver Handbook* and *Caregiver Resource Directory*, available in Chinese and English.

**CONTACT:** Selina Chan, R.N., Executive Director, Asian Services Center, Beth Israel Medical Center; (212) 844-6788 or (917) 573-8238; sechan@chpnet.org

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## The *Eat Well, Be Well* Nutrition Program BLYTHEDALE CHILDREN'S HOSPITAL, VALHALLA

YEAR PROGRAM STARTED: 2006

### Program Description and Goals

The *Eat Well, Be Well* nutrition program is a hospital- and school-based program that serves Kindergarten through eighth-grade students throughout Westchester and lower Putnam counties, where the rate of overweight/obese youths is statistically higher than the national average. Recognizing that the prevention of obesity during childhood is likely the most effective approach for addressing the obesity epidemic, Blythedale Children's Hospital developed a comprehensive, age-appropriate curriculum based on evidence-based guidelines to assist schools in meeting current nutrition education requirements and objectives. By emphasizing healthy eating and daily physical activity habits at young ages, the program conveys the message that children, as well as adults, can make informed choices in their daily lives that positively impact their long-term health.

**PARTNERS:** Kohl's Department Stores; Westchester Government/County Health Department; Cornell Cooperative Extension; Westchester and Lower Putnam school districts/Wellness Committees; Local Parent-Teacher Associations

### Outcomes

- Since its 2006 inception, the program has delivered healthy lifestyle messages to approximately 50,000 children in Westchester and lower Putnam counties.
- *Eat Well, Be Well* has been implemented in 37 schools in 30 districts.
- Adolescent knowledge increased from an average pretest score of 41% to an average post-test score of 72%.
- To help meet the continued demand and growth of the program, an additional clinical nutritionist was hired in 2010.

**CONTACT:** Lena Cavanna, Director, Media and Community Relations, Blythedale Children's Hospital; (914) 592-7138 ext. 374; lenac@blythedale.org

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## Mobile Dental Health Services

### **COLUMBIA MEMORIAL HOSPITAL, HUDSON**

YEAR PROGRAM STARTED: 2007

#### Program Description and Goals

Columbia Memorial Hospital provides comprehensive mobile dental services to Columbia and Greene County residents, including children. The school-based mobile dental services include examinations, x-rays, cleaning, sealants, and fluoride treatments by a licensed dentist and hygienist for students in the local school districts. Services also include fillings, extractions, and other treatment for the care of dental decay. In addition to mobile dental services, the program utilizes portable dental equipment for preventive dentistry in the school building and education for both parents and children. Oral health education is also provided in under-served communities including Supplemental Nutrition Program for Women, Infants, and Children (WIC) sites and the Columbia Memorial Hospital birthing unit.

**PARTNERS:** Catholic Charities of Columbia and Greene Counties—WIC; Columbia County schools; Greene County schools; Greene County Rural Health Network; Columbia County Healthcare Consortium; Columbia Opportunities; Columbia County Department of Health—Migrant Farm Program; Community Foundations; New York State Department of Health, Bureau of Dental Health; Greene County Early Childhood Learning Center; Greene County Department of Social Services; Columbia County Association for Retarded Citizens; Greene County Legislature

#### Outcomes

- Access to dental health care improved.
- Dental treatment services were provided for 538 children age pre-Kindergarten to twelfth grade, and 178 adults.
- This program improved access to dental care and preventive treatment for all age groups residing in under-served areas of two counties.
- Low-income populations are now aware of good oral health.

**CONTACT:** Mary Daggett, R.N., B.S., Director, Community Health Services and Grants, Columbia Memorial Hospital; (518) 828-8013; mdaggett@cmh-net.org

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## Senior Options and Solutions

### **EASTERN LONG ISLAND HOSPITAL, GREENPORT**

YEAR THE PROGRAM STARTED: 2008

#### Program Description and Goals

The development of a Geriatric Center of Excellence has long been a priority of the Eastern Long Island Hospital Board of Trustees. This program set and achieved the following goals:

- develop a system that identifies seniors at risk and provide them with an in-home assessment and linkage to beneficial services;
- provide outreach and education to the community on health care issues and resources to maintain health and safety;
- improve knowledge and assistance with entitlement resources that assist with aging in place;
- improve access to mental health services and screening of those in need through integration of services;
- promote local residents' independent living and sense of self-sufficiency by improving their knowledge of local resources and services; and
- decrease hospitalization and deterioration of physical health through early intervention.

**PARTNERS:** Town of Southold; The Mental Health Association in Suffolk; The Long Island Home/South Oaks Hospital

#### Outcomes

- Mental health integration and depression screening of patients at the East End Geriatric and Adult Medicine practice began in March 2008. Additional practices were added, resulting in 1,846 screenings, 220 assessments, and 445 follow-up visits by the end of 2010.
- Data analysis showed a reduction in depressive symptoms of individuals identified as needing treatment.
- The Senior Wellness Series/Support Groups provided community education and prevention screening events to 519 people on 25 topics.

**CONTACT:** Juliet Frodella, M.S., C.R.C., L.M.H.C., Project Director, Eastern Long Island Hospital; (631) 477-5425; jfrodella@elih.org

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# Medication and Patient Safety Collaboration Project

## ELLENVILLE REGIONAL HOSPITAL

YEAR PROGRAM STARTED: 2008

### Program Description and Goals

This multi-year project led to medication reconciliation at all levels of care (inpatient, swing, emergency department, and ambulatory surgery), and a collaborative network with community partners to increase access to care and provide patient-centered clinical pharmacy services. The goals of the project include:

- medication reconciliation at all levels of care in-house and throughout the community;
- provision of clinical pharmacy services at multiple locations in the Town of Wawarsing, Village of Ellenville, and adjacent communities;
- increased access to health care resources, bringing medication status under control and reducing adverse drug events;
- creating safe and effective medication experiences by integrating primary care and clinical pharmacy services; and
- teaching the concept of patients being active participants in their own health care, not passive recipients.

**PARTNERS:** Family Practice Center of Ellenville; Matthews Pharmacy; Ellenville First Aid and Rescue Squad; Albany College of Pharmacy; Ellenville Senior Housing

### Outcomes

- Clinical pharmacy services were provided to 1,397 consumers in two years.
- Ellenville Regional Hospital developed collaborative partnerships leading to several community service sites for providing clinical pharmacy services.
- This program identified and addressed 622 potential adverse drug events and 135 actual drug events, and decreased actual number of doses consumed per day by 10%.
- The program achieved complete medication reconciliation at all levels of care in a community setting to increase adherence and medication safety.

**CONTACT:** Ashima Butler, Director Performance Improvement, Ellenville Regional Hospital; (845) 647-6400, ext. 237; abutler@ellenvilleregional.org

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## Schenectady City Mission Free Clinic

### ELLIS MEDICINE, SCHENECTADY

YEAR PROGRAM STARTED: 1999

#### Program Description and Goals

The Schenectady City Mission Free Clinic (SCMFC) is open one evening each week at a homeless shelter and soup kitchen staffed by volunteer family medicine residents, medical students, nurses, and faculty. Services are available to anyone in the community, and patients are seen at no charge, with no effort to bill for services even if the patient is insured. By using volunteers and donated supplies and pharmaceuticals, the budget is under \$100 per year. The goals are to:

- provide a physician for patients with limited access to health care;
- provide immediate health care for patients with urgent and chronic health conditions; and
- assess health needs to direct patients to community health clinics for more comprehensive care.

**PARTNERS:** Schenectady City Mission; Schenectady County Public Health Services; Ellis Family Health Center and Ellis Family Medicine Residency

#### Outcomes

- Care is provided to patients with no other source of primary care (81% have no source of primary care).
- Most patients come for specific, timely, health needs (70% used the clinic only once, and only 11% were seen six or more times).
- Most patients need pharmaceuticals, and benefit from low-cost medications (samples or prescriptions were given to patients in 58% of visits).
- Smoking cessation was found to be a significant community need, and is now being addressed for this population (81% of patients report being smokers).

**CONTACT:** Dave Smingler, Communications Specialist, Government Affairs, Ellis Medicine; (518) 243-4840; sminglerd@ellismedicine.org



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# Grider Street Farmer’s Market—Growing Healthy Together

## **ERIE COUNTY MEDICAL CENTER, BUFFALO**

YEAR PROGRAM STARTED: 2010

### Program Description and Goals

Erie County Medical Center’s (ECMC) Grider Street Farmer’s Market is increasing access to fresh fruits and vegetables from local farms, but it is more than just a market; it is also a meeting place, a healthy lifestyle learning center, and a focal point to convene neighborhood walks and healthy living presentations. The goal is to promote wellness and reduce the burden of chronic disease. The program directly benefits low-income households, including children and seniors. Direct marketing of agricultural commodities from farmers to consumers in this urban community also strengthens the local economy. Healthy eating programs held in collaboration with block clubs within walking distance increase demand for fresh fruits and vegetables and promote the Grider Street Farmer’s Market.

**PARTNERS:** Mt. Olive Baptist Church; Ephesus Ministries; Delavan Grider Community Center; Durham Block Club; City of Buffalo; St. Philip’s Episcopal Church; Grider Street Block Club; Roswell Park Cancer Research Institute; P2 Collaborative of Western New York; Delavan/Grider Community Block Club; Erie County

### Outcomes

The Grider Street Farmers Market:

- is part of a strong hospital community partnership with more than ten organizations;
- has increased access to fresh fruits and vegetables for 214 low-income individuals;
- improves access to wellness programs for 214 low-income individuals, including weekly exercise programs and influenza vaccinations; and
- enhances employee wellness by increasing access to fresh fruits and vegetables.

**CONTACT:** Rita Hubbard-Robinson, J.D., Community Health Education and Outreach Director, Erie County Medical Center; (716) 898-3509; hrobins@ecmc.edu

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## Hypertrophic Cardiomyopathy Community Health Screening

### FINGER LAKES HEALTH, GENEVA

YEAR PROGRAM STARTED: 2008

#### Program Description and Goals

Finger Lakes Health's community health screening event provided education and a thorough evaluation for student athletes grades seven to 12 to identify hypertrophic cardiomyopathy, the most common congenital cardiac abnormality and leading cause of sudden death in young athletes. Joseph Gomez, M.D., Chief of Cardiology, and his team recruited 250 volunteers for the day-long screening including cardiologists, sonographers, and other clinical staff from a five-county area. Each student was screened individually and questioned about his or her family's history, and any symptoms. They then underwent an electrocardiogram and limited echocardiographic examination. Finally, a physician explained the results to students and their parents. Follow-up care was coordinated as needed.

**PARTNERS:** Biotronik; Mortara; Finger Lakes Health Foundation; Pepsi; Geneva Community Center; Philips; Geneva General Cardiology Associates; Siemens; Geneva Printing Company; Rochester Institute of Technology; Lyons National Bank; Wegmans

#### Outcomes

- There were no life-threatening findings that required limitation of activities.
- No enlarged septums or hypertrophic cardiomyopathy diagnoses were found.
- One child was diagnosed with *patent ductus arteriosa*.
- Three students were found to have bicuspid aortic valves.

**CONTACT:** Lara Turbide, Vice President, Community Services, Finger Lakes Health; (315) 787-4053; lara.turbide@flhealth.org

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## The Geriatric Lifestyle Medicine Integration Project

### FLUSHING HOSPITAL MEDICAL CENTER

YEAR PROGRAM STARTED: 2007

#### Program Description and Goals

The goals of the Integration Project are to de-stigmatize mental illness for people of all cultures over age 50; increase access to mental health care for these individuals to integrate evidence-based screening, assessment, and treatment for mental disorders into primary geriatric care; improve physical health; and increase interdisciplinary quality improvement collaboration by using a Life Style Medicine framework.

**PARTNERS:** Flushing Hospital Medical Center's Department of Psychiatry and Addiction Services; Ambulatory Care Center; Department of Medicine/ Geriatric Medicine; Medical Residency Program; Community Advisory Board

#### Outcomes

- Since November 2007, 1,309 patients over age 50 have been screened, assessed, and offered lifestyle medicine interventions (psycho-social, self-management, and psycho-pharmacological) in 8,373 visits.
- Patient Health Questionnaire (PHQ)-9 scores decreased.
- Generalized Anxiety Disorder (GAD)-7 scores decreased.
- Cognitively impaired individuals have been identified.
- Mental illness has been de-stigmatized.

**CONTACT:** Ira Frankel, Ph.D., Administrator, Department of Psychiatry and Addiction Services, Flushing Hospital Medical Center; (718) 670-5968; ifrankel.flushing@jhmc.org

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## Readmission Reduction Initiatives

### GLENS FALLS HOSPITAL

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

Glens Falls Hospital was a participant in a one-year grant by the New York State Health Foundation to implement a successful care transitions program. During implementation, the multi-faceted nature of the 30-day readmission population became an area of intense focus, leading the hospital to pursue a variety of readmission reduction initiatives. The 2008 regional skilled nursing facility (SNF) Medicare 30-day readmission rate was 46%, significantly higher than the New York State average of 29%. The first phase of the hospital's readmission reduction initiative was to engage SNFs in identifying and addressing the causes of readmission. This evolved into a sustained initiative to successfully engage community providers, create shared goals for patients, and implement processes to support an improved community care model.

**PARTNERS:** Fort Hudson Nursing Center; The Pines of Glens Falls; The Stanton Nursing and Rehabilitation Center; The Orchard Nursing and Rehabilitation Center; Indian River Rehabilitation and Nursing Center; Adirondack Tri-County Health Care Facility; Westmount Health Facility; IPRO

#### Outcomes

- All-cause, 30-day Medicare/SNF fee-for-service readmissions were reduced.
- The SNF adopted Medical Orders for Life-Sustaining Treatment (MOLST), a regional advanced care planning standard.
- SNF staff were educated about a variety of strategies to prevent readmissions.
- There is an ongoing coordinated effort to ensure continued engagement of all parties.

**CONTACT:** Christine Freire, Director, Care Management, Glens Falls Hospital; (518) 926-3301; cfreire@glensfallshosp.org

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## Fall Prevention for the Mature Adult

### **GOOD SAMARITAN HOSPITAL MEDICAL CENTER, WEST ISLIP**

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

In 2009, to address the issue of falls Good Samaritan Hospital Medical Center's rehabilitation department began offering free balance screens to mature community members, who are especially at risk. The screens were performed by physical therapists at the facility and at off-site venues such as community health fairs, senior appreciation days, and senior citizen centers. As the program developed, collaborative efforts with a local business club and senior centers enabled the hospital to provide free community lectures to educate mature adults on fall risk factors and ways to stay independent. The program has been integrated into the community through collaboration with the Suffolk County Department of Health and other community entities.

**PARTNERS:** Suffolk County Department of Health; New York State Department of Health; Centers for Disease Control and Prevention

#### Outcomes

- The hospital provides resources to individuals with positive readings and who have issues that may affect their balance and put them at risk for a fall.
- Individuals who present without risk factors are advised to be re-screened yearly, or before if they have any concerns.
- Participants receiving results showing impairment are offered full assessments, and screen reports are sent to patients' primary care physicians.
- Timely risk fall identification and intervention increase the chances of a person remaining independent and reduce the likelihood of sustaining serious injuries.

**CONTACT:** Michele Dykstra, Assistant Director of Rehabilitation Services, Good Samaritan Hospital Medical Center; (631) 376-4109; michele.dykstra@chsli.org

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## Leon Root, M.D. Pediatric Outreach Program HOSPITAL FOR SPECIAL SURGERY, NEW YORK CITY

YEAR PROGRAM STARTED: 1987

### Program Description and Goals

The Hospital for Special Surgery is recognized as a world leader in the fields of orthopedics and rheumatology, improving and restoring the mobility of individuals with musculoskeletal injuries and disorders. Caring for disadvantaged children has been a critical part of the hospital's mission since its founding in 1863. Continuing its dedication to providing care to those most in need, the Hospital for Special Surgery launched the Pediatric Outreach Program (POP) in 1987. First started as a school-based musculoskeletal screening program, POP has evolved to include a pediatric orthopedic clinic and a nutrition education program. Its overall goal is to prevent long-term disability from musculoskeletal disease or injury and to educate parents and children about musculoskeletal health through education and early detection, with a focus on under-served, multi-cultural communities.

**PARTNERS:** *Clinical/Academic Partners:* Charles B. Wang Community Health Center; Clinical Translational Science Center, Community Engagement Core, Weill Cornell Medical College; NewYork-Presbyterian Hospital; Memorial Sloan-Kettering Cancer Center; Hunter College School of Nursing; Cornell University Cooperative Extension—New York City; Weill Cornell Medical College—Department of Pediatrics; *Community-Based Organization Partners:* International Center for Disabilities—YES Project; Girl Scout Council of Greater New York; *Government/Public Partners:* New York City's Public Schools; New York State Osteoporosis Prevention and Education Program; New York City Head Start Programs at Hamilton Madison House, Educational Alliance, Area 145 Day Care, Action for Progress DCC, Coalition for Human Housing Day Care Center, Grand Street Settlement Child Care Center

### Outcomes

- The school-based screening and orthopedic clinic combined have screened more than 24,800 children and referred 16% for follow-up orthopedic care.
- POP delivered more than \$430,000 in free follow-up medical care to children.
- In the last two years, POP identified numerous surgical cases; for example, a cervical tumor case and a hip replacement case due to osteonecrosis and a child with Trevor's Disease.

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- Nutrition program has educated more than 7,000 children through hands-on workshops and school health fairs.

**CONTACT:** Laura Robbins, D.S.W., Senior Vice President, Education and Academic Affairs, The Hospital for Special Surgery; (212) 606-1057; [robbinsl@hss.edu](mailto:robbinsl@hss.edu)

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## Healthier Tomorrows HUNTINGTON HOSPITAL

YEAR PROGRAM STARTED: 2006

### Program Description and Goals

Healthier Tomorrows is a 15-week program helping children ages nine to 16 reverse early weight problems. It combines fun group exercise sessions with nutritional guidance and psycho-social support. Because children still need nutrition and calories to sustain growth, Healthier Tomorrows focuses on food choices rather than dieting. A dietitian helps youngsters understand how foods impact their well-being. To address the social and emotional implications of weight management issues, a psychologist leads bi-weekly group discussion sessions. Twice weekly, exercise specialists from the YMCA hold 45-minute group exercise classes that include warm-ups, aerobics, and activities such as swimming, rock wall climbing, and games. The \$10 weekly fee is waived for those unable to pay.

**PARTNERS:** Huntington Hospital; Huntington YMCA; Dolan Family Health Center; Huntington Station Enrichment Center; Holiday House

### Outcomes

- Of 205 children enrolled, 117 children completed the sessions; 75% of those 117 showed a decrease or maintenance of body mass index.
- Sixty-eight percent of parents whose children completed the program more than one year earlier reported a positive impact on their child's self-esteem.
- One year after completion, 71% of parents reported that they and/or their children still used the strategies learned in the program.

**CONTACT:** Theresa Jacobellis, Director, Public Affairs, Huntington Hospital; (631) 470-5207; thjacobellis@hunthosp.org



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## The Harvest Home Farmer’s Market JACOBI MEDICAL CENTER, BRONX

YEAR PROGRAM STARTED: 2007

### Program Description and Goals

The incidence of obesity and diabetes has grown at an alarming rate in the Bronx. While it is well known that 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 patients who live in the communities served by Jacobi Medical Center. The hospital’s leaders were convinced that a hospital-based farmer’s market, providing high-quality, regionally grown, and reasonably priced produce, coupled with an engaging and informative nutrition education program and health screenings, would provide powerful support for its chronic disease management and health promotion programs—and locating the market at the hospital’s entrance would provide a powerful message to the community at large.

**PARTNERS:** This program is the result of collaboration by entities representing hospital leadership and clinical programs, local, state, and federal agencies, senior centers, and schools. These include: Harvest Home Farmer’s Market; Supplemental Nutrition Program for Women, Infants, and Children; New York City Department of Health and Mental Hygiene; New York City Police Department; Albert Einstein College of Medicine; New York State Department of Agriculture; Senior Citizen Centers; Elementary and high schools; Jacobi Medical Center’s public affairs, nutrition, nursing, family weight management, social work, chronic disease service, HIV/AIDS, and smoking cessation program staff

### Outcomes

A survey of 979 market customers over an eight-week period revealed:

- eighty-nine percent learned how to improve family health;
- eighty-four percent tried new fruits or vegetables;
- ninety-two percent of families are eating more fruits and vegetables;
- forty-four percent attended the market in concert with a medical appointment;
- twenty percent lived in the community;
- twenty-six percent were hospital employees; and
- sixty-nine percent were repeat users.

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The market's success was replicated at five other New York City Health and Hospitals Corporation facilities. Each is a natural and welcomed site for nutrition/health education, and the screenings provided nutrition education to 3,000 people, blood pressure screenings to 550 people, smoking cessation counseling and nicotine patches to 110 people, and domestic violence information to 94 people.

**CONTACT:** Hannah M. Nelson, Associate Executive Director, External Affairs, Jacobi Medical Center; (718) 918-5318; [hannah.nelson@nbhn.net](mailto:hannah.nelson@nbhn.net)

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## “Clear the Air” Smoking Cessation Program JAMAICA HOSPITAL MEDICAL CENTER, BRONX

YEAR PROGRAM STARTED: 2009

### Program Description and Goals

Jamaica Hospital Medical Center started the “Clear the Air” Smoking Cessation Program in 2009 in collaboration with the New York City Department of Health and Mental Hygiene after smoking cessation was identified as a community health priority. The goal of the program is to increase awareness of the harmful impact of smoking and reduce the prevalence of smokers in the community. The hospital partnered with Queens Quits to provide in-service education to physicians and staff on current smoking cessation guidelines and strategies. The hospital’s nine Ambulatory Care Health Centers counsel smokers, provide appropriate therapy, and refer them to Queens Quits, which provides cessation classes and ongoing counseling.

**PARTNERS:** New York City Department of Health and Mental Hygiene; Queens Quits

### Outcomes

The program:

- provided 21 in-service education sessions to physicians and staff;
- referred more than 379 smokers for additional support;
- increased awareness by distributing more than 8,000 flyers; and
- created a recognition program to ensure the program’s continued success and to further improve results.

**CONTACT:** Frederick Beekman, Vice President, Ambulatory Care, Jamaica Hospital Medical Center; (718) 206-7051; fbeekman@jhmc.org

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## Promotion of Healthier Lifestyles in Our Community

### **JONES MEMORIAL HOSPITAL, WELLSVILLE**

YEAR PROGRAM STARTED: 2010

#### Program Description and Goals

Jones Memorial Hospital developed a coordinated effort to encourage healthier lifestyles in the community and among staff. An employee and community health screen identified obesity as the number one risk. As a result, the hospital initiated two weight loss and exercise programs. The hospital held a farmer's market in the parking lot weekly throughout the summer. In the fall, the hospital offered vouchers for families to purchase fresh fruits and vegetables at a local fitness event for children. A multi-disciplinary childhood obesity program was developed that includes baseline lab tests, medical, physical therapy, dietary evaluations, and family/team planning.

**PARTNERS:** Allegany Western Steuben Rural Health Network; Local pediatricians; Wellsville Chamber of Commerce; Allegany County Schools; Wegmans

#### Outcomes

- More than 100 families participated in education and completed a survey regarding family food choices and habits.
- Weekly farmer's markets were held at the hospital grounds over the summer.
- Physical therapy staff evaluated 22 children for the childhood obesity program. Only 13 children had follow-up visits with preliminary results showing 62% (8) having a decrease in their body mass index.
- Staff at the hospital lost more than 600 pounds over the last year.

**CONTACT:** Brenda Mong Szabo, P.T., D.P.T., Vice President of Diagnostics and Rehabilitation, Jones Memorial Hospital; (585) 596-4011; szabob@jmhny.org

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## Learning and Mentorship Program

### **KINGSBROOK JEWISH MEDICAL CENTER, BROOKLYN**

YEAR PROGRAM STARTED: 2008

#### Program Description and Goals

Kingsbrook Jewish Medical Center designed this mentorship program for students ages 15 to 20 who are interested in health careers. The program exposes students to the intricate process of producing health education for various media. The hospital and its partners identify health issues most relevant to young people and research those topics for production of a health newsletter and a health and wellness television talk show.

**PARTNERS:** Brooklyn Queens Long Island Health Education Center; WATCH High School, Brownsville Multiservice Health Center; Caribbean Women's Health Association

#### Outcomes

- This program has served more than 50 high schools/colleges, and 100 students from schools in Brooklyn, Queens, Long Island, and Staten Island.
- The program's print and television products reach more than 500,000 viewers and 8,000 students.

**CONTACT:** Enid Dillard, Director of Marketing and Public Affairs, Kingsbrook Jewish Medical Center; (718) 605-5201; edillard@kingsbrook.org

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## Decreasing Disparity in Colorectal Cancer Outcomes in a Minority Community

### LINCOLN MEDICAL AND MENTAL HEALTH CENTER, BRONX

YEAR PROGRAM STARTED: 2003

#### Program Description and Goals

Colorectal cancer is the second most common cause of cancer mortality in the Bronx. In 2002, the number of colonoscopies performed was 778, and the no-show rate for scheduled colonoscopies was 67%. Ninety-four Lincoln Medical and Mental Health Center patients had adenoma, with an adenoma detection rate of 12%; and 35% of cancers were detected in stages 0 and 1.

This program set (and achieved) the following goals:

- use community outreach to improve awareness and access to colon cancer screening services;
- increase rate of colorectal cancer screening by colonoscopy;
- navigate patients through the screening process to decrease no-show rates;
- if patients screen positive, ensure follow-up and access to cancer treatment services; and
- use navigators to recall patients with adenomas at recommended scheduled intervals for follow-up evaluation.

**PARTNERS:** New York City Department of Health and Mental Hygiene; American Cancer Society; Community Board; Cancer Services Program

#### Outcomes

- Colorectal cancer screening increased to 2,210, with an adenoma detection rate of 20% and an interval colorectal cancer rate of 0.3%.
- No-show rates for scheduled colonoscopies decreased to less than 10%.
- All patients with detected colorectal cancer were contacted by the navigators and all kept their appointments for evaluation for cancer treatment either at Lincoln or at another health care facility.
- Seventy-six percent of patients who had adenomas received a surveillance colonoscopy arranged by the navigators.

**CONTACT:** Melissa P. Schori, M.D., M.B.A., Chief Medical Officer, Lincoln Medical and Mental Health Center; (718) 579-5235; melissa.schori@nychhc.org

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## Coalition to Prevent Underage Drinking, Marijuana, and Tobacco Use

### LONG BEACH MEDICAL CENTER

YEAR PROGRAM STARTED: 2000

#### Program Description and Goals

The Coalition's goals are to establish and strengthen collaboration among the community to prevent and reduce youth substance use, and reduce by 20% the rates of alcohol, marijuana, and tobacco use among youth. The Coalition and its partners use evidence-based environmental protection strategies to address issues related to underage substance use. The Coalition addresses factors that put youth at risk (e.g., laws and norms favorable to substance use) and factors that are protective toward youth (e.g., school opportunities for social involvement). The Coalition has changed and enforced consequences for youth who use substances; modified, enforced, and monitored policies that reduce risk of substance use; and provided information and support to youth, parents, schools, and community organizations.

**PARTNERS:** Long Beach School Board of Education; Long Beach Police Department; Long Beach Senior High and Middle School Administration and Director of Health/Physical Education; Long Beach City Council; Long Beach Corporation Council; Nassau County District Attorney; Parent-Teacher-Student Associations (Central Council, High and Middle School); Morning Madness After-Prom Committee; Student's Against Destructive Decisions; Long Beach Chamber of Commerce; *Long Beach Herald*; Martin Luther King Center; NAACP; *Circulo de la Hispanidad*; Interfaith Clergy Association; Long Beach Auxiliary Police

#### Outcomes

Between 2000 and 2008, as measured by the American Drug and Alcohol and Youth Development surveys, Long Beach youth demonstrated:

- an 80% decrease in alcohol use among seventh graders;
- a 36.2% decrease in alcohol use among ninth graders;
- a 71.4% decline in marijuana use among ninth graders; and
- a 239% increase in the number of ninth graders who perceive alcohol use to be harmful.

**CONTACT:** Douglas L. Melzer, Chief Executive Officer, Long Beach Medical Center; (516) 897-1208; dmelzer@lbmc.org

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## Moms Net Collaborative

### **MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER, LEWISTON**

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

Moms Net is a multi-agency collaborative, founded in February 2009, which provides screening, education, peer intervention, outreach and support group opportunities, a “24/7” peer-supported crisis “warm” line, and additional services (including health insurance facilitation for those who are uninsured or underinsured) to women post-childbirth to identify postpartum depression early, before serious consequences occur. It includes a collaboration of hospitals providing labor and delivery services, educational institutions providing nursing education, local obstetric providers, and county agencies.

**PARTNERS:** Niagara University Department of Nursing; Niagara Falls Memorial Medical Center; Niagara County Community College Department of Nursing; Eastern Niagara Health Center; Fidelis Care New York; The Mental Health Association in Niagara County; Catholic Charities of Western New York; Niagara County Health Department

#### Outcomes

Since 2009:

- more than 20,000 educational brochures on postpartum depression were distributed throughout Niagara County;
- more than 200 women were afforded direct intervention through the “warm line”;
- three support groups formed, and one support group for Spanish-speaking women; and
- more than 2,600 packets of educational materials outlining support-related service were options distributed to women.

**CONTACT:** Honor Martin, R.N., M.S., N.E.-B.C., C.H.C.Q.M.-F.A.I.H.Q., Director of Education and Organizational Development, Mount St. Mary's Hospital and Health Center; (716) 298-2299; honor.martin@msmh.org



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## Radiology Revolution

### **NATHAN LITTAUER HOSPITAL AND NURSING HOME, GLOVERSVILLE**

YEAR PROGRAM STARTED: 2010

#### Program Description and Goals

Scanning the Internet, there are thousands of anonymous confessions, such as, “Having a mammogram tomorrow—I’m really scared.”

Nathan Littauer Hospital and Nursing Home found that all the technology investment in the world will not do any good if someone is too afraid to have a mammogram. Radiology Revolution ([www.radiologyrevolution.com](http://www.radiologyrevolution.com)) is an information portal using social media to alleviate patient anxiety. Created for patients and providers, the site includes stories such as Ask the Radiologist, Research Corner, and Meet the Technicians, and shows common diagnostic exams on YouTube. Each video features a technician who walks the viewer through an exam, making it appear less ominous. Calming and informative, [radiologyrevolution.com](http://radiologyrevolution.com) shows the “machine, manpower, and examples of the diagnostic procedures.”

**PARTNERS:** Nathan Littauer does not limit this tool to just its patients—it is available to anyone with an Internet connection. Practitioners from outside the hospital’s treatment area have heard about the Web site and say they use the site for their patients. The site includes links to other organizations such as: The American College of Radiology, LiveStrong, WebMD, My Radiologist, The American Cancer Society, The Food and Drug Administration, National Cancer Institute, National Library of Medicine, Safety in Pediatric Imaging, as well as many others.

#### Outcomes

- The site has been an overwhelming success. More than 8,000 people worldwide have viewed the YouTube videos featured on Radiology Revolution.
- Patients use the site to alleviate fears, doctors use the site to learn about Nathan Littauer’s diagnostic capabilities, and students use the site to gain a greater understanding of the exams. The site also features Nathan Littauer’s radiologists, who are frequently the unseen link in the diagnostic system, adding to patient comfort.
- Physicians can now refer patients to the site in advance of a radiological exam, and answer any questions about the exam.

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- In all, nine videos were created covering mammograms, magnetic resonance imaging, computerized tomography scans, bone density scans, nuclear medicine, epidural steroid injections, X-rays, and ultrasound. The diagnostic team members enjoyed showing off their skills.

**CONTACT:** Cheryl McGrattan, Director, Public Relations, Nathan Littauer Hospital; (518) 773-5533; [cmcgrattan@nlh.org](mailto:cmcgrattan@nlh.org)

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## Diabetes Telemonitoring Program Collaboration with Primary Care Clinics **NEW YORK CITY HEALTH AND HOSPITALS CORPORATION**

YEAR PROGRAM STARTED: 2007

### Program Description and Goals

Care management has been shown to improve the glycemic control of diabetics, thereby decreasing the risk of debilitating complications. Central Brooklyn Family Health Network (CBFHN) patients are referred to the program based on diagnosis, insurance, and willingness to participate. Fingerstick blood glucose and blood pressure measurements are transmitted via modem from the patients' home to a Web-based telemonitoring application where care management nurses can review the results in real-time. Nurses contact patients by telephone weekly and whenever indicated, such as instances of dangerous hypoglycemia, hyperglycemia, or hypertension. Nurses provide patients with diabetes self-management education, support for home self-insulin titration, help patients navigate the complex health care system, and help improve patient-provider communication. The goals are achieving glycated hemoglobin (A1C) less than 7.0, a blood pressure less than 130/80, and low-density lipoprotein (LDL) cholesterol less than 100.

**PARTNERS:** Central Brooklyn Family Health Network Primary Care Clinics, which include Kings County Hospital Center and the East New York Diagnostic and Treatment Center; New York City Health and Hospitals Corporation Health and Home Care Services, House Calls Telemonitoring Program

### Outcomes

- One hundred and forty-seven patients participated in the intervention for at least one year or more.
- There was a statistically significant difference in the mean values of A1C and LDL levels pre- and post-intervention.
- Modest improvements in blood pressure control were also observed.

**CONTACT:** Alfrède D. Provilus, P.A.-C., M.P.H., C.D.E., Chronic Disease Coordinator, New York City Health and Hospitals Corporation; (718) 245-3422 or (917) 554-4107; [alfrede.provilus@nychhc.org](mailto:alfrede.provilus@nychhc.org)

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## Medical Student Interpreter Training Workshop NEWYORK-PRESBYTERIAN HOSPITAL, NEW YORK CITY

YEAR PROGRAM STARTED: 2007

### Program Description and Goals

The Medical Student Interpreter Training Workshop is designed to enhance delivery of cultural and linguistically appropriate care by medical students, at an optimal time in the medical school curriculum—during “transition week,” when students who finish their classroom years are on the precipice of their clinical rotations.

The lecture portion reviews policies regarding the care of limited English proficiency patients. Use of proper interpreter techniques are discussed and taught.

Post-lecture, group sessions reinforce skills and introduce students to community demographics and health practices. Small groups are co-led by academic health professionals, including professional and volunteer trained interpreters, and lay home visitors from a community-based organization. Within these groups, students practice using an interpreter and communicating about local health beliefs.

**PARTNERS:** Columbia College of Physicians and Surgeons; *Alianza Dominicana*; NewYork-Presbyterian Hospital Interpreter Services Department; Morgan Stanley Children’s Hospital of New York General Pediatrics Department; Pacific Interpreters

### Outcomes

- Pre-clinical students place a high value on achieving skill in best-practice health care communication techniques.
- Students appreciate learning from community members and experienced staff about how best to approach culturally and linguistically diverse populations.
- Giving medical students the opportunity to discuss cultural differences in a supportive, controlled environment reduces their anxiety.
- More than 700 medical students and dozens of medical interpreters trained over the last five years.

**CONTACT:** Ariel Lenarduzzi, Manager, Interpreter Services, NewYork-Presbyterian Hospital; (212) 305-9607; arl9002@nyp.org

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## Geriatric Assessment Program

### NEWARK-WAYNE COMMUNITY HOSPITAL, NEWARK

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

The Geriatric Assessment Program (GAP) is a community-based program for seniors experiencing recurrent medical conditions. The program offers telehealth consultations with a geriatrician in Rochester, New York (Monroe County) from a rural office practice in Wolcott, New York (Wayne County). Targeted to seniors suffering from urinary incontinence, chronic pain, functional decline, frequent falls, dementia or delirium, or who need end-of-life care, GAP provides non-emergency, specialized care with a geriatrician, geriatric nurse practitioner, and care manager. The program is provided at no charge to patients without insurance. GAP's unique feature is individualized care management offered in comprehensive services and referrals, including in-home assessments. Clinical outcomes include treatment plans to remediate and stabilize patients, working with primary care providers. GAP also educates community caregivers and health care providers.

**PARTNERS:** Newark-Wayne Community Hospital; Wayne County Rural Health Network; Rochester General Hospital's Geriatric Consultative Services; The Alzheimer's Association of Rochester, New York; Wayne County Agency on Aging and Youth; The Finger Lakes Geriatric Education Center, Gerontology Institute at Ithaca College

#### Outcomes

- Thirty-five geriatric patients received comprehensive mental and physical assessments with a geriatrician, nurse practitioner, and care manager.
- Thirty-four experienced improvements in their recurrent medical conditions.
- Eighty-nine caregivers and health care providers attended two specialized training classes on Death and Dying and Delirium, Dementia, and Depression.
- About 350 individuals and health and human service professionals have attended presentations and learned about this valuable resource in the county that allows geriatric patients to stay in the community without being hospitalized and without traveling more than 100 miles to receive a geriatric consultation.

**CONTACT:** Emilie Sisson, Manager, Wayne County Rural Health Network, Newark-Wayne Community Hospital; (315) 483-3266; emilie.sisson@rochestergeneral.org

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## The Nursing Home Liaison Program

### **NORTH BRONX HEALTHCARE NETWORK, JACOBI MEDICAL CENTER/NORTH CENTRAL BRONX HOSPITAL, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, BRONX**

YEAR PROGRAM STARTED: 2000

#### Program Description and Goals

Most nursing homes have become expert at compassionate, high-quality, sub-acute care for their patients, who are functioning within a clinical equilibrium that is tenuous at best. When clinical needs escalate and acute care is indicated, nursing homes all too often face a significant loss of control in ongoing coordination of care.

The Nursing Home Liaison Program (NHLP) was created more than a decade ago to address these challenges. NHLP is a novel and highly successful approach to high-quality, coordinated health care, which prevents the tendency for these patients to fall through the cracks, minimizes unnecessary hospitalizations, focuses attention on length of stay, and provides a unique long-term partnership in the seamless provision of hospital-based and ancillary services for nursing home patients.

**PARTNERS:** King's Harbor Multicare; Riverdale Manor Nursing Home; Workmen's Circle; Park Gardens; Bronx Center for Rehabilitation; Bronx County Medical Society; Hospitals Care Management/Discharge Utilization Department

#### Outcomes

- NHLP partnered to provide both inpatient and outpatient services on an ongoing basis with 81 skilled nursing facilities and adult homes.
- Since the establishment of NHLP, nursing home admissions grew from 420 to 1,361.
- In 2009, the NHLP coordinated 1,257 outpatient diagnostic and therapeutic services for these patients.
- NHLP established the first inpatient geriatric psychiatry unit in the Bronx in 2006, a 23-bed unit dedicated exclusively to providing care for the special mental health and medical needs of the elderly.

**CONTACT:** Hannah M. Nelson, Associate Executive Director, External Affairs, Jacobi Medical Center; (718) 918-5318; hannah.nelson@nbhn.net

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## Diabetes Community Outreach

### NYACK HOSPITAL

YEAR PROGRAM STARTED: 2002

#### Program Description and Goals

This initiative provided global attention to diabetes in Rockland County through diabetes self-management classes, support groups; an annual diabetes symposium; and education in local clinics, community lectures, and health fairs.

Its goals are to promote awareness of diabetes, prevent/delay onset of diabetes, educate individuals with diabetes about behavior modification, prevent/delay complications of diabetes, provide a supportive environment for individuals with diabetes, provide diabetes education to under-served populations, and implement diabetes education for health care professionals.

**PARTNERS:** Rockland County Department of Health; Community physicians; Federally funded health clinics; Rockland County YMCA; Local libraries, schools, senior centers, and faith-based organizations

#### Outcomes

This initiative achieved increased community awareness about diabetes: in 2010, 1,094 community members (an increase of 400% from the previous year) received diabetes prevention and management education through lectures and health fairs at 38 locations within the county.

- A series of three classes focusing on diabetes self-management targeted for under-served populations was developed and taught at local health clinics.
- Glycated hemoglobin (A1C) results demonstrated clinical improvement in patients with diabetes who attended the American Diabetes Association (ADA)-recognized program. In 2010, A1C levels decreased from 7.8% pre-program to 6.4% post-program.
- People attending the ADA-recognized program reported sustaining positive behavior changes after six months and high levels of satisfaction with the program.

**CONTACT:** Linda Suarez, M.S., R.N., C.D.E., Manager, Community Health Education, Nyack Hospital; (845) 348-2876; suarezl@nyackhospital.org

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# Occupational Health Services Firefighters Program

## O'CONNOR HOSPITAL/BASSETT HEALTHCARE, DELHI

YEAR PROGRAM STARTED: 2009

### Program Description and Goals

HealthWorks, a program of Bassett Healthcare's New York Center for Agricultural Medicine and Health (NYCAMH), provides on-site health screening and employee health/wellness opportunities for area businesses. Area employers work directly with Bassett Healthcare Network's O'Connor Hospital to obtain post-hire health services, pulmonary function testing, stress testing, ergonomics, on-site injury management, and early intervention programs. HealthWorks offers Delaware County firefighters and emergency medical service (EMS) workers health screening, testing, clearance examinations, respiratory fit testing, and immunizations, with full administrative and medical record services offered.

The goals are to increase access to primary care, improve community health in Delaware County, offer occupational health and education to firefighters and EMS personnel, and reduce community illness and injury risk through health screening services.

**PARTNERS:** John May, M.D., Director of NYCAMH/Bassett Research Institute; Diana Gaetano, B.S., R.N., C.O.H.N.-S., HealthWorks Supervisor; Wendy Whiteman, HealthWorks Marketing Coordinator; Bassett Healthcare Network Physician Group; O'Connor Hospital staff

### Outcomes

- Clearance/health screening services were provided to 25 of 30 Delaware County fire houses.
- Delaware County firefighters without a current physician (38%) were directed to and are currently served by a primary care provider.
- Occupational health services (e.g., early intervention, return to work, injury management) have been provided to 100 employees from participating Delaware County employers.
- More than 400 Delaware County firefighters/EMS workers received physical exams in 2010, compared to 204 in 2009.

**CONTACT:** Karen Maher, Director of Community Outreach, O'Connor Hospital/Bassett Healthcare; (607) 746-0528; karen.maher@oconnorhosp.org



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## The Hope Dispensary of the Southern Tier OUR LADY OF LOURDES MEMORIAL HOSPITAL, BINGHAMTON

YEAR INITIATIVE STARTED: 2009

### Program Description and Goals

The Hope Dispensary is a freestanding, licensed pharmacy that provides free prescription medications for people who do not have insurance coverage and who are at, or below, 200% of the federal poverty level. In addition to dispensing medications, the program staff help individuals determine eligibility for public insurance coverage or to enroll in hospital financial assistance programs; help is also provided in linking people to a medical home to provide a regular source of primary care for those who do not have a provider.

**PARTNERS:** Broome County Departments of Health and Social Services; Community Free Clinic; Excellus Blue Cross/Blue Shield; Nashville Dispensary of Hope; Rural Health Network of South Central New York

### Outcomes

Through this project, the hospital has been able to provide people with substantial access to health care. Since the Hope Dispensary opened its doors in August 2009:

- more than 1,800 people were served and 6,229 prescriptions were filled;
- another 1,825 prescriptions have been filled through Pharmaceutical Assistance Programs from various pharmaceutical companies' indigent care programs;
- more than 150 people were enrolled in Medicaid or Family Health Plus and many more now have patient financial assistance;
- more than 150 people were registered with a primary care physician so they now have a regular source of primary care; and
- in the first year, the Hope Dispensary generated an estimated \$1,159,627 in bad debt savings for local hospitals, as calculated by the Nashville Dispensary of Hope, using a formula of \$3.65 savings for each dollar's worth of medication distributed. This indicates that an estimated \$1.1 million has been saved by the health care community because of this project. This does not take into account the savings to clients and the

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wider community, or savings resulting from client enrollment with primary care physicians or connections to community services.

**CONTACT:** Sister Marilyn Perkins, Vice President, Mission Integration, Our Lady of Lourdes Memorial Hospital; (607) 798-5515; mperkins@lourdes.com

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## *Esperanza y Vida* (Hope and Life)

### **ROSWELL PARK CANCER INSTITUTE, OFFICE OF CANCER HEALTH DISPARITIES RESEARCH, BUFFALO**

YEAR PROGRAM STARTED: 2007

#### Program Description and Goals

The goal of *Esperanza y Vida* (*EyV*) is to provide culturally tailored education outreach with navigation to mammography, clinical breast examinations (CBEs), and follow-up services for the Latino community in Western New York to increase breast cancer knowledge and awareness, screening behaviors, and ultimately early diagnosis. The program features a Latina breast cancer survivor who educates women and men about breast cancer awareness, and speaks about her triumph over breast cancer to increase awareness, knowledge, and screening in the Latino community. Using Spanish language materials, women and their partners are instructed about breast cancer facts, resources, and how to obtain appropriate screening. Women who are non-adherent to screening guidelines are provided with assistance in obtaining a mammogram following the program.

**PARTNERS:** John R. Oishei Foundation; Western New York Affiliate of Susan G. Komen for the Cure; American Cancer Society; New York State Department of Health Cancer Services Program; Kaleida Health/Niagara Family Health Center; Los Tainos Senior Center; Hispanic United of Buffalo; Alianza Latina; Mount Sinai School of Medicine

#### Outcomes

- *EyV* conducted 55 programs and educated more than 700 men and women (71% were women).
- *EyV* navigated 210 women to mammography, 230 for CBEs, and 40 for Pap tests.
- The Women's Day Event (*Día de la Mujer*) enhanced the hospital's mammography screening efforts, and a total of 101 women were screened through a partnership with a local health clinic.
- Approximately 40% of women who reported being non-adherent to current screening guidelines at the time of the education program reported receipt of the Pap, CBE, and/or mammography by the initial follow-up period at two months.

**CONTACT:** Deborah O. Erwin, Ph.D., Director, Office of Cancer Health Disparities Research, Roswell Park Cancer Institute; (716) 845-2927; [deborah.erwin@roswellpark.org](mailto:deborah.erwin@roswellpark.org)

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## The BEST Backstretch Clinic

### SARATOGA HOSPITAL

YEAR PROGRAM STARTED: 2005

#### Project Description and Goals

The Backstretch Employee Service Team (BEST) Backstretch Clinic provides on-site primary care, disease management, prevention, and other health care services for the approximately 1,500 backstretch workers at Saratoga Race Course. Services are provided by a bilingual team and are designed specifically to meet the needs of a transient population that is unaccustomed to seeking routine medical care and often mistrustful of those who provide it. Goals include significantly increasing utilization; providing more comprehensive, convenient care; improving disease management; and promoting healthier lifestyles.

**PARTNERS:** Saratoga Emergency Physicians; Saratoga Hospital Medical Staff; Saratoga County Public Health; New York Racing Association and New York Thoroughbred Horsemen's Association

#### Outcomes

- Utilization dramatically increased from 89 in 2008 to 626 visits in 2009, and 702 visits in 2010.
- The hospital dramatically improved the scope and quality of service. Saratoga Emergency Physicians provides a bilingual team of six physicians and one physician assistant, marking the first time backstretch workers had on-site access to that level of expertise. Saratoga County Public Health provides immunizations. Saratoga Hospital provides dietitians and physical therapists, arranges visits by a mammography van, and arranges specialty care.
- The hospital increased both the number of months the clinic was open and the hours of operation. The clinic is now open May through October, including six days per week during the peak season.
- The hospital implemented disease management protocols for the most prevalent chronic conditions: diabetes, asthma, high blood pressure, and high cholesterol.

**CONTACT:** Bradley L. Sexauer, Vice President, Strategy and Market Development, Saratoga Hospital; (518) 583-8441; bsexauer@saratogacare.org

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## The Courage to Quit—Tobacco Recovery Program for the Homeless

### SETON HEALTH, TROY

YEAR PROGRAM STARTED: 2008

#### Program Description and Goals

The Courage to Quit Program was a two-year grant-funded program that provided evidence-based tobacco dependence services including cessation counseling, cessation medication, and health care provider intervention at six homeless shelters in New York’s Capital District.

The project offered ongoing smoking cessation group sessions, access to nicotine withdrawal treatment, follow-up, assistance with marketing and recruitment of program participants, and training of shelter staff to enable the program to sustain itself. Two of the shelters were faith-based rescue missions that had medical clinics on-site. The project demonstrated that evidence-based cessation services for homeless individuals can be implemented and sustained when cessation medication and technical assistance is available and the shelter supports the effort.

**PARTNERS:** Six homeless shelters: Capital City Rescue Mission, City Mission of Schenectady, Lwanga and Mercy House in Albany, Roarke Center and Lansing Inn in Troy; The Homeless and Travelers Aid Society; Whitney M. Young, Jr. Health Center; Seton Health Parish/Faith Community Nurse Program; Rensselaer Cares Prescription Assistance Program; Rensselaer County Department of Social Services; Albany County Department of Social Services

#### Outcomes

- More than 1,200 people attended at least one support group meeting; 737 attended multiple meetings.
- At least 127 made a quit attempt and 119 quit for at least seven days. (Due to the transient nature of the population, and other issues such as mental illness, Seton Health was unable to track others who may have made a quit attempt or, in fact, quit).
- The philosophy and structure of the rescue missions make those sites particularly favorable for this type of program and able to sustain the services after the conclusion of the grant-funded program.

**CONTACT:** Peggy Keigley, Director, Center for Smoking Cessation, Seton Health; (518) 459-2550; pkeigley@setonhealth.org

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## Women, Infants, and Children Peer Counselor Program

**SOUND SHORE MEDICAL CENTER OF WESTCHESTER,  
NEW ROCHELLE**

YEAR PROGRAM STARTED: 1994

### Program Description and Goals

Since its beginning, Sound Shore Medical Center's (SSMC) Supplemental Nutrition Program for Women, Infants, and Children (WIC) has recognized breastfeeding as a natural/normal process and has encouraged mothers through its Peer Breastfeeding Program.

In 2005, SSMC earned recognition from the Department of Health (DOH) for achieving the Healthy People 2010 goals for breastfeeding five years ahead of schedule. In 2008, because of the successes achieved by programs such as SSMC's, DOH mandated all WIC programs adopt breastfeeding peer counselor programs to help achieve Healthy People 2010 goals.

SSMC's WIC Program is dedicated to increasing awareness of breastfeeding and facilitating its exclusive use for an infant's first six months and its continued use until 12 months of age.

Its achievements are a measure of its mothers' commitment and the success of SSMC's long-established breastfeeding peer program.

**PARTNERS:** WIC Program; Sound Shore Medical Center administration; Breastfeeding Committee; DOH Bureau of Nutrition; La Leche League

### Outcomes

- As a result of the peer counselor program, mothers are prepared for what to expect in the first few hours after delivery and know that breastfed babies tend to be healthier and have fewer allergies. Mothers also learn the benefits of breastfeeding in protecting against certain forms of cancer and other health problems.
- From January to September 2005, 84% of mothers who worked with a peer counselor initiated breastfeeding and 85% of those mothers stated that peer counselors were helpful.
- SSMC's Peer Counselor Program initiation rate exceeded New York State's average in each of the last three years. For 2010, SSMC's

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average initiation rate was 86.8% compared to New York State's 73.1%. In 2010, SSMC's WIC Program was recognized by New York State for the highest breastfeeding initiation rate above 80%.

**CONTACT:** Onidis Gonzalez, C.D.N., C.L.C., Breastfeeding Peer Counselor Coordinator, Sound Shore Medical Center of Westchester; (718) 231-5800; [tfeathers@sshsw.org](mailto:tfeathers@sshsw.org)

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## Diabetes Education Center

### ST. JOSEPH HOSPITAL/CATHOLIC HEALTH SERVICES OF LONG ISLAND, BETHPAGE

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

The Diabetes Education Center provides both outpatient and inpatient education to improve health and prevent readmissions. Outpatient education includes: the *Core Curriculum* program, *Cooking Lite and Eating Right*, *Sit Down and Get Moving*, *Get the Scoop on Desserts and Snacks*, and *Supermarket Smarts*. Each program is designed using the AADE7 Self-Care Behaviors™. In addition, St. Joseph Hospital offers a free monthly community diabetes support group and a quarterly insulin pump support group. The Diabetes Nurse Champion Program is an inpatient initiative, educating all registered nurses about diabetes. The Diabetes Education Center's unique program design allows for continuity between inpatient and outpatient services, providing the community with a holistic approach to diabetes care and education.

**PARTNERS:** Catholic Health Services of Long Island; St. Joseph Hospital; Diabetes Education Center Advisory Board; American Association of Diabetes Educators; American Diabetes Association; Lions International District 20K2

#### Outcomes

- More than 260 patients received diabetes education during the tracking period of September 2009 to December 2010; of that group, 138 attended the Core Curriculum program. Seventy-six percent of all patients that returned for their three-month follow-up visit realized a decrease in glycated hemoglobin (A1C) level. Eighty-seven percent of all patients that returned for their three-month follow-up visit lost weight. Although any decrease is considered a success, the largest decrease realized to date was 5.7% in A1C and weight loss of 49 pounds.
- Fifteen inpatient Diabetes Nurse Champions completed a three-month, comprehensive education program designed to improve the care of the inpatient with diabetes and prevent readmissions due to complications associated with diabetes. Eight Diabetes Nurse Champions returned for their first annual Keeping the Skills Alive program designed to encourage continued education in the field of diabetes education and to mentor, coach, and grow future Certified Diabetes Educators.



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- The partnership with Lions International District 20K2 enabled 24 uninsured patients to receive diabetes education.
  - Fourteen free community support group meetings were held.

**CONTACT:** Lucille Hughes, R.N., M.S.N./E.D., C.D.E., Director, Diabetes Education Services, St. Joseph Hospital; (516) 520-2214; [lucille.hughes@chsl.org](mailto:lucille.hughes@chsl.org)

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## Latino Health Care Access Program

### ST. MARY'S HOSPITAL, AMSTERDAM

YEAR PROGRAM STARTED: 2009

#### Program Description and Goals

The Latino Health Care Access Program, started in early 2009, is an integral part of St. Mary's Hospital's commitment to "leave no one behind" by providing culturally sensitive, comprehensive health care services to the Latino population, including migrant workers. The program employs a full-time *Promotora de Salud*, whose work is focused on establishing a trusting relationship between the hospital and the Latino community and on promoting the importance of primary health services and prevention efforts, doing so in a culturally sensitive manner. The overall goal of this initiative is to improve the health, well-being, and quality of life for this most vulnerable segment of the population through enrollment in primary care services.

**PARTNERS:** Finger Lakes Migrant Health Care Project; Fulton and Montgomery County New Dimensions Health Care; Domestic Violence/Crime Victims Services; Alzheimer's Association of Northeastern New York; Homelessness Task Force (Amsterdam); Cancer Services Program of Fulton and Montgomery Counties; Board of Cooperative Educational Services Migrant Services Program; Fidelis Care Insurance; New York State Police; Local Dental Providers; St. Mary's Hospital family health centers, prenatal care and assistance program, behavioral health services, urgent care and emergency services, patient financial services, health insurance enrollment department, diabetes center, and specialty care and surgical services

#### Outcomes

- Twenty-two migrant community members were provided health care services through this program, most of whom had never before seen a health care provider.
- The program resulted in 150 patient visits including primary care, lab, urgent care, emergency care, prenatal care, dental care, behavioral health, and surgery.
- The *Promotora* assists with 200 client contacts/communications per month.

**CONTACT:** Julie Pierce, Community Benefits and Outreach Manager, St. Mary's Hospital; (518) 841-7448; piercej@smha.org

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## Addiction Recovery Services Homeless Program

### ST. PETER'S HEALTH CARE SERVICES, ALBANY

YEAR PROGRAM STARTED: 1997

#### Program Description and Goals

Through this program, St. Peter's Health Care Services significantly increased its investment and involvement in the fight against homelessness, helping homeless individuals move into subsidized apartments while finding permanent housing for men and women at the emergency homeless shelter.

St. Peter's also works collaboratively with the county government and a coalition of other providers to create a rapid re-housing program and a federally-funded program to assist homeless families with substance abuse and mental illness. Apartment units were filled through a rent subsidy program, while a related program helped individuals and families move out of local shelters and into permanent housing.

The 11-bed emergency shelter was recently expanded to work with county officials to help find apartments for as many as 100 homeless people each year.

**PARTNERS:** Homeless and Traveler's Aid Society; Albany County Department of Social Services; St. Catherine's Center for Children; Clearview Center; Advocates for Human Potential; Interfaith Partnership for the Homeless

#### Outcomes

This initiative:

- helped 70 homeless individuals to move into subsidized apartments;
- found permanent housing for 47 men and women from the emergency homeless shelter;
- filled another 30 apartment units through a rent subsidy program; and
- enabled 51 men to leave for permanent housing after completing drug treatment in the Men's Community Residence.

**CONTACT:** Sister Gail Waring, Vice President, Mission Services, St. Peter's Hospital; (518) 525-1550; gwaring@sphcs.org

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## Colonoscopy Patient Navigator Program THE BROOKLYN HOSPITAL CENTER

YEAR PROGRAM STARTED: 2009

### Program Description and Goals

To address low rates of colorectal cancer screening in the community, The Brooklyn Hospital Center's Division of Hematology and Oncology began a Colonoscopy Patient Navigator Program in 2009. Through retrospective analysis, the hospital identified a clear association between screening compliance and patient navigator-based intervention in the hospital, and saw a decrease in no-show rates among at-risk patients.

**PARTNERS:** New York City Department of Health and Mental Hygiene Cancer Prevention and Control Program

### Outcomes

- There is a statistically significant association between screening colonoscopy compliance and patient navigator-based intervention in this community hospital.
- Improvement in the no-show rate was seen across all races. Data support patient navigation as an effective tool in overcoming some health care system barriers.
- There was significant improvement in no-show rates among both males and females.
- Utilization among Hispanics increased due to the navigator's language proficiency.

**CONTACT:** Gina Villani, M.D., M.P.H., Chief, Division of Hematology/Oncology, The Brooklyn Hospital Center; (718) 250-6960; gmv9002@nyp.org

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## Get Up! Fuel Up!

### THOMPSON HEALTH, CANANDAIGUA

YEAR PROGRAM STARTED: 2007

#### Program Description and Goals

Thomson Health created “Get Up! Fuel Up!,” a prevention-based program that relies on data analysis to help combat childhood obesity. Thomson takes the program into schools, with three levels tailored to particular age groups. The program is delivered with a positive, imaginative approach crafted to fully engage students and their parents. Children learn which foods are healthy and why, how the media and social influences affect choices, and how to be empowered regarding their health. In 2010, Thomson expanded the program to bridge the gap between classroom nutrition education and cafeteria offerings. The School Food Independence Committee was formed between Thomson and seven school food service directors. As a result, each is offering a locally-sourced, plant-based entrée this year.

**PARTNERS:** Ontario County Youth Bureau; New York Wine and Culinary Center; Seeking Common Ground; School Food Independence Committee; Christa Tyson, Yoga Instructor; Ontario County School Districts: Canandaigua City, Bloomfield Central, Midlakes (Phelps - Clifton Springs), Red Jacket (Manchester - Shortsville), Naples Central, Honeoye Central and Victor Central

#### Outcomes (from 2009-2010)

- Among 55 third-graders at Naples Elementary School, there was a 43% increase in self-reported consumption of five or more servings of fruits and vegetables on the day prior (69% post-program).
- Among 259 fourth-graders at Canandaigua Elementary School, there was a 49% increase in students who acknowledged that fiber is the secret ingredient in whole grains that makes hearts healthy (87% total post-program).
- Among 35 sixth-graders at Midlakes Middle School, there was a 65% increase in students who acknowledged that potato chips made with soybean oil were healthier than ones made with hydrogenated oil (100% total post-program).
- Among 37 sixth-graders at Red Jacket Middle School, there was a 32% increase in students who realized that watching television during meal times can lead to overeating (100% post-program).

**CONTACT:** Tina Culver, Family Health and Wellness Manager, Thomson Health; (585) 396-6491; [tina.culver@thompsonhealth.com](mailto:tina.culver@thompsonhealth.com)

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## OASIS

### UPSTATE MEDICAL UNIVERSITY, SYRACUSE

YEAR PROGRAM STARTED: 1998

#### Program Description and Goals

OASIS is a national educational organization designed to enrich the lives of adults ages 50 and older through programs in the arts, humanities, health, technology, and volunteer service. Participants benefit by discovering more in life, learning, developing talents, connecting with others who share their interests, staying healthy and active, and making a positive impact in the lives of others. The goals of the OASIS program are to empower and engage older adults through volunteerism, lifelong learning, and civic leadership. In order to serve a diverse audience, OASIS develops partnerships with local agencies, businesses, schools, residential communities, libraries, and other public and private sector partners.

**PARTNERS:** Artist Pianos Center; Clover Corner at Huntington Family; Central New York Reads Consortium; InterFaith Works of Central New York; Syracuse City School District; The AT&T Foundation; Westcott Community Center

#### Outcomes

- More than 70 volunteers provided 9,921 hours of service in 2010.
- Membership increased 5% from 8,261 in 2009 to 8,708 in 2010.
- Community partner site enrollment increased 15% from 505 in 2009, to 581 in 2010.
- Gifts increased 35% from \$21,679 in campaign year 2008 to \$29,263 in campaign year 2009.

**CONTACT:** Tracie Alexander, OASIS Program and Volunteer Manager, Upstate Medical University; (315) 464-1745; alexandt@upstate.edu

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## Perinatal Mood Disorders Initiative: A Safety Net for New Mothers

### WINTHROP-UNIVERSITY HOSPITAL, MINEOLA

YEAR PROGRAM STARTED: 2008

#### Program Description and Goals

The hospital developed a realistic screening and referral process that empowers the nurse to assess and refer a mother who has the potential of developing a perinatal mood disorder to home care for continued assessment and evaluation after discharge.

**PARTNERS:** Suffolk Perinatal Coalition; New York University Langone Medical Center Reproductive Psychiatry Partnership Program; Postpartum Support International of New York; Postpartum Resource Center of New York; The Diane Goldberg Maternal Depression Program at North Shore Child and Family Guidance Center

#### Outcomes

- Screening with four simple questions is realistic and has identified many women in need in the community
- Since 2008, out of 8,269 deliveries, 1,581 received referrals, 64% received telephone calls, and 18% received house visits.
- Alerting the pediatrician provides an additional safety net within the area.
- A brochure is given to all new mothers to raise awareness, educate, and remove stigma within the community.

**CONTACT:** J. Edmund Keating, Vice President, Marketing and Advertising, Winthrop-University Hospital; (516) 663-2234; ekeating@winthrop.org

