CONNECTING WITH COMMUNITIES:

Community Health Initiatives Across New York State

2023 EDITION

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Thank you to our 2023 reviewers

Sylvia Pirani, former director, Office of Public Health Practice, New York State Department of Health

Julia Resnick, MPH, senior program manager, The Value Initiative, American Hospital Association

Julie Trocchio, senior director, community benefit and continuing care, Catholic Health Association of the United States

About HANYS' Community Health Improvement Award

HANYS established 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 hospitals and health systems for their programs that target specific community health needs related to the New York State *Prevention Agenda*, emphasize the importance of health equity, demonstrate leadership, collaborate among diverse groups and achieve quantifiable results.

CONNECTING WITH COMMUNITIES:
Community Health Initiatives Across New York State

HANYS is pleased to present the 27th edition of *Connecting with Communities: Community Health Initiatives across New York State*. This publication highlights the HANYS 2023 Community Health Improvement Award winner and nominees.

CHIA recognizes member hospitals and healthcare systems for engaging local stakeholders to help improve the health of their communities. Hospitals and healthcare systems collaborate in many ways with a variety of partners to achieve shared community health goals.

The initiatives described in this publication are directly linked to New York State's *Prevention Agenda* priorities. The *Prevention Agenda* aims to make New York the healthiest state for people of all ages; it serves as a blueprint for local community health improvement.

HANYS appreciates the continued support of our member hospitals and health systems and for sharing their community-focused initiatives. We are honored to recognize our members' continuous efforts to keep their communities healthy.

QUESTIONS ABOUT HANYS' COMMUNITY HEALTH IMPROVEMENT AWARD?
Contact Kristen Phillips, director, trustee education and community health policy, at 518.431.7713 or kphillip@hanys.org.

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2023 AWARDEE

CATHOLIC HEALTH (LONG ISLAND)
"Food is Care" food insecurity initiative

INITIATIVE DESCRIPTION AND GOALS

Catholic Health is a mission-based organization with six hospitals across Long Island. As part of its mission and with the belief that "food is care," CH has committed to addressing food insecurity as a top priority in its facilities and communities. Developed and led by Patrick O'Shaughnessy, DO, MBA, since his promotion to system president and chief executive officer in 2020, this initiative's focus on well care versus sick care aligns with the New York State *Prevention Agenda's* "Prevent Chronic Diseases Action Plan, Focus Area 1."

Spearheaded by a system-wide workgroup, the CH food insecurity initiative's long-term goal is to screen every patient that comes into contact with the integrated healthcare system. Statistics show an expected rate of food insecurity in patients ranging from 6% to 15%, depending on the communities served. This initiative has multiple components that create a coordinated approach to addressing food insecurity within the patient population. CH's community-based organization partners are vital to the success of this program.

PARTNERS

Long Island Cares, Catholic Charities, Health and Welfare Council of Long Island, Smile Farms, God Loves We Deliver and Town of Islip.

OUTCOMES

- CH distributed hundreds of “to-go” bags to individuals who need food as part of its Hunger Vitals assessment and senior community efforts.
- CH has screened more than 65,780 people and provided more than 350 Supplemental Nutrition Assistance Program referrals.
- The Home Health pilot phase 1 results showed that out of the 38 patients in the program, 17 had been hospitalized during the prior year and only four were hospitalized during the program.
- CH demonstrated an immediate impact in providing individuals with nutritionally balanced food, access to long-term resources and decreased hospitalization within the home health population.

LESSONS LEARNED

The biggest lesson learned from this initiative is that you must continually innovate to meet the community where they are, physically and mentally, while working with CBOs to understand best practices when addressing food insecurity in general.

SUSTAINABILITY

The CH food insecurity initiative will continue to evolve for years to come to reach its goal of bending the disease curve within the patient population and meeting CH’s mission of serving its communities, especially the most vulnerable.

CONTACT

Lisa Santeramo, Vice President, Government Relations
and Regulatory Affairs
lisa.santeramo@chsli.org | 631.372.6205

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ALBANY MED HEALTH SYSTEM

Mission Critical: Bringing Needed Medical Care to Double H Ranch Campers

INITIATIVE DESCRIPTION AND GOALS

The mission of Albany Med Health System's Double H Ranch is to provide specialized programs and year-round support for children and their families dealing with life-threatening and chronic illnesses. The Double H Ranch enriches lives and provides otherwise-denied experiences that are memorable, exciting, fun, empowering, physically safe and medically sound.

Albany Med's current New York State *Prevention Agenda* work includes service to chronically ill patients. The health system extends its emphasis on this *Prevention Agenda* priority to Double H.

PARTNERS

These partner organizations each play a vital role in helping campers with special needs: The SeriousFun Children's Network, Albany Medical College, Glens Falls Hospital, Glens Falls Hospital Cancer Center (Cindy's Comfort Camp), CDC, DOH, American Camping Association, National Ski Patrol, Bravehearts (serving children on public assistance), Golisano Children's Hospital, Pathways Nursing and Rehabilitation Center, Children's Hospital at Montefiore, Brookdale Children's Hospital, Children's Hospital at Dartmouth and the Rensselaer Polytechnic Institute Design Lab.

OUTCOMES

The Ranch's medical director, Chris Woll, MD, is a childhood cancer survivor, former camper and a pediatric emergency physician at Albany Med. He said, "In the world that we live in today it can be hard to make a connection in the community. Double H has helped make this connection happen for tens of thousands sick children and their families."

The value and impact of Double H result in healthier, more social and confident children. Alumni campers surveyed by the SeriousFun Children's Network in 2021 credited camp experiences with having a lasting influence on their lives, including:

- 90% developed a willingness to try new things;
- 88% developed an appreciation for diversity;
- 86% developed a sense of empathy and compassion; and
- 85% developed greater self-confidence.

LESSONS LEARNED

Little things go a long way. For example, creating a more flexible schedule for campers created an atmosphere of continuity and better care. A sense of connection developed with one another has resulted in life-changing resilience and a support structure that helps in their emotional, physical and mental health development.

SUSTAINABILITY

The programs and services provided through the partnership between Double H Ranch and Albany Med Health System will be supported by several dynamic factors: a strong and heavily active board of directors populated by community, business and medical leaders; an active Medical Advisory Board; a health system that has supported the ranch since the beginning and empowers eager clinical staff and volunteers to be involved; and strong fundraising support from health system partners.

CONTACT

Dennis P. McKenna, MD, President and Chief Executive Officer
smithj42@amc.edu | 518.262.3421

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ARNOT HEALTH
ACCEL Community Health Clinic

INITIATIVE DESCRIPTION AND GOALS

When data from Common Ground Health identified lead exposure in the older homes of Elmira, Arnot Health partnered with local agencies to address this health concern. Chemung County has some of the highest lead levels in the state, impacting a disproportionate number of low-income children. The goals for the Arnot Health, Chemung County Health Department and Economic Opportunity Program initiative were twofold: educate the families about the danger in their homes and get them into medical treatment quickly, including assistance with health insurance, if needed.

PARTNERS

Arnot Health, Economic Opportunity Program, Inc., Lake Erie College of Osteopathic Medicine, City of Elmira, Excellus BlueCross BlueShield and Chemung County Public Health.

OUTCOMES

- A total of 216 people were tested for lead exposure, mostly children.
- The percentage of children who tested beyond the safe range for lead was 12.5%, higher than the expected 11% across Chemung County and much higher than the state average of 4%.
- Families impacted by this testing had a blood test and an appointment with a provider at Arnot within 48 hours.

LESSONS LEARNED

No single agency can tackle an issue of this scope. Bringing these stakeholders to the table allowed each organization to offer its particular asset.

Care must be taken with racially diverse, low-income residents, who often distrust government agencies. The success of the program is partially due to the established relationship that the EOP has with its clients.

SUSTAINABILITY

With the partnership intact and continued financial support from Excellus BlueCross BlueShield, the ACCEL Community Health Clinic hopes to expand its offerings to include diabetes screening, support for food insecurity, smoking cessation and other efforts to decrease societal barriers for racially diverse, low-income residents.

CONTACT

Kenneth J. Roberts, Director, Communications and Marketing
kenneth.roberts@arnothealth.org | 607.795.8105

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ELLENVILLE REGIONAL RURAL HEALTH NETWORK

Rural Health Network Wellness Program

INITIATIVE DESCRIPTION AND GOALS

Understanding that people in rural communities are at greater risk of chronic disease, the Rural Health Network at Ellenville Regional Hospital's mission is to continuously pursue healthier lives for everyone in the community. Using the Chronic Care and Community Health Worker models, a free Wellness Program is offered to guide individuals through the prevention and management of chronic diseases.

Members of the Wellness Program have access to a community health worker, nutritionist and physical health educator who work collaboratively to provide personal health coaching tailored to each participant's needs through evidence-based goal-setting techniques such as motivational interviewing and brief action planning. The program also offers free fitness classes, nutrition and tobacco cessation education, and health education informative seminars to all members of the community regardless of participation in the Wellness Program.

PARTNERS

Ellenville Regional Hospital, The Institute for Family Health, Ulster County Department of Health, Ulster County Department of Mental Health, Cornell Cooperative Extension of Ulster County, Ellenville Central School District, Ellenville/Wawarsing Youth Commission, Ulster County Office for the Aging, Ulster County Community Action Coalition, The Food Bank of the Hudson Valley, Ulster County Correctional Facility, Rondout Valley Growers Association, Planned Parenthood of Greater New York, Orange County Department of Health, Alzheimer's Association, Orange County Office for the Aging, Sullivan 180 and Catholic Charities Community Services of Orange, Sullivan and Ulster.

OUTCOMES

Since the establishment of the Rural Health Network Wellness Program in 2018, Ellenville Regional Rural Health Network has engaged with community members by offering various services and programs. The top three outcomes include:

- One hundred and sixty-nine individuals who are at risk of or managing chronic disease and 53 families who are obese or at risk for developing obesity have enrolled in the Wellness Program to work one-on-one with a community health worker and nutritionist.
- Seventy-two clients meet regularly for consultations with the community health workers and nutritionist.
- More than 1,500 community members have participated in programming such as physical activity, nutrition or health education classes annually.

LESSONS LEARNED

Throughout the development of the Wellness Program, ERRHN found that being present in the community is beneficial for recruitment and keeping the local population engaged in the programming. The importance of adaptability has become apparent as the program has expanded to various community locations. Offering programs at varying times reaches more of the community and accounts for any barriers they may experience.

SUSTAINABILITY

ERRHN plans to sustain and expand this program by acquiring new grants and investigating the future of charging for preventive treatments as the value-based care system continues to advance. The program will also evolve and develop as future community needs assessments are performed and new problem areas become prevalent in the community.

CONTACT

Samantha Black, Population Health Program Coordinator
sblack@erhny.org | 845.647.6400 x215

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ERIE COUNTY MEDICAL CENTER CORPORATION

Controlling Hypertension in a Disparate Population with Comprehensive Remote Patient Monitoring

INITIATIVE DESCRIPTION AND GOALS

Erie County Medical Center developed a remote patient monitoring program using home blood pressure techniques, telehealth and comprehensive care coordination to improve hypertension control in a socioeconomically disadvantaged, disparate population. Needs assessment data revealed that ECMC's patients suffer from disproportionately high rates of cardiovascular disease, hypertension, diabetes and obesity.

Cardiovascular disease is the leading cause of death in the U.S. and hypertension is the most prevalent risk factor for CVD. Fifty percent of U.S. adults are diagnosed with hypertension and half of those cases are uncontrolled. In comparison, a staggering 80% of hypertensive black adults are uncontrolled — a clear disparity. At ECMC, 56% of hypertensive patients were categorized as uncontrolled, 58% of ECMC's patients are black and 29% of residents live below the poverty line. These data correlate with the New York State *Prevention Agenda's* "Focus Area 4: Chronic Disease Preventative Care & Management of Priority Areas."

ECMC's program aims to eliminate transportation barriers and increase patient engagement to improve adherence and self-management. Lifestyle modifications, medication counseling and care coordination are tailored to patients' needs, accounting for disparities and barriers.

PARTNERS

The Buffalo Center for Health Equity, Highmark Healthcare Company, Univera Healthcare, Independent Health Association and Brook Health Companion.

OUTCOMES

Through a qualitative, prospective, repeated-measures, pre-post validated approach, ECMC monitors progress weekly to study the effectiveness of remote patient monitoring on improving behavioral intentions, healthcare access, utilization and clinical outcomes for hypertensive patients. ECMC's Controlling Hypertension in a Disparate Population with Comprehensive Remote Patient Monitoring Program enrolled more than 300 patients, with a less than 1% dropout rate. Hypertension control compliance has skyrocketed from 24% in August 2022, to 71% as of May 2023. More than 50% of enrolled patients have seen a reduction in systolic blood pressure.

LESSONS LEARNED

ECMC learned the impact that disparities have on a patient's ability to manage hypertension. The most important lesson came from feedback gathered from patients regarding behavioral intention and perceived behavioral control. A critical factor in designing a care plan that works is understanding how patients perceive access to care, family support, their ability to participate in care, the importance of health and how controlling hypertension will make them feel.

SUSTAINABILITY

- ECMC and its partners intend to use the impactful results of this program to ignite policy analysis, research, community engagement and payer reform to support needed changes in the way healthcare is delivered to reduce health disparities.
- ECMC aims to extinguish the common fallacy that simply providing great medicine is the ticket to improving health by promoting the meaningful results of this program and continuing to partner with payers on RPM coverage needs.

CONTACT

Lucia Rossi, Vice President, Ambulatory Services and Population Health
lrossi@ecmc.edu | 716.961.6949

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FLUSHING HOSPITAL MEDICAL CENTER

A Healthier Community: Implementing the National Diabetes Prevention Program

INITIATIVE DESCRIPTION AND GOALS

Flushing Hospital Medical Center designed this initiative to prevent chronic diseases, specifically the onset of Type 2 diabetes. With the launch of the National Diabetes Prevention Program, FHMC strives to reduce Type 2 diabetes diagnoses in pre-diabetic participants in its community.

The program is a full-year course created to educate patients on healthier eating, the importance of physical activity and ways to reduce stress. The program goal is to have participants lose 5% to 7% of their initial weight, which, along with healthy lifestyle changes, has proven to reduce the risk of developing Type 2 diabetes by 58%.

PARTNERS

This program is made possible in collaboration with in-house hospital departments including information technology, food and nutrition, and primary care physicians from the ambulatory care clinic; Quality and Technical Assistance Center of New York; New York City Department of Health and Mental Hygiene and New York Office for the Aging.

OUTCOMES

Program results include:

- To date, 78 participants have completed the program and have lost a total of 845 pounds.
- FHMC is currently running a course of seven participants via Zoom.
- Participants who reached the program goals have reported reduced or normal levels of glycated hemoglobin and cholesterol.
- Follow-up calls have been made to 50 participants who completed the program; results show that 14 continued to lose 106 pounds collectively, 16 collectively gained 98 pounds and 18 sustained their weight. Eleven continued to be pre-diabetic, three developed Type 2 diabetes and 36 are no longer pre-diabetic.

LESSONS LEARNED

Through these efforts, FHMC has learned that:

- the camaraderie that develops during group sessions has proven a source of encouragement and accountability for participants to reach their goals; and
- using Zoom is an effective meeting method.

SUSTAINABILITY

To continue serving the community, FHMC will:

- maintain certification for its lifestyle coaches by facilitating annual programs;
- recruit new potential participants via lifestyle coaches who conduct outreach events and provide program brochures;
- continue collaborations with in-house departments and partnering organizations for recruitment and optimal health in the community; and
- uphold full recognition from the CDC by continuing to meet program standards.

CONTACT

Yessica Siguencia Salazar, Project Manager
ysiguenc.flushing@jhmc.org | 718.670.3042

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GLENS FALLS HOSPITAL

Bike Glens Falls

INITIATIVE DESCRIPTION AND GOALS

The top leading causes of premature death in Warren and Washington counties are chronic diseases: cancer and heart disease. However, chronic diseases are also among the most preventable. Modifiable risk behaviors such as unhealthy eating and lack of physical activity are largely responsible for the incidence, severity and adverse outcomes of chronic disease. When people have the ability to be more active through multi-modal options, they can increase how physically active they are each day, helping reduce the risk for chronic disease and improving overall health.

In 2022, Creating Healthy Schools and Communities of Glens Falls Hospital partnered with Bike Glens Falls to conduct a community survey to better understand who was biking in the City of Glens Falls and why or why not. Many respondents listed the lack of bike lanes in the city as a main concern. As a result, Glens Falls Hospital partnered with key stakeholders to conduct a Bike Demonstration Day in downtown Glens Falls that showcased various street pattern design enhancements that could be made to improve the "bikeability" of the area. This initiative aligns with the New York State *Prevention Agenda* goal to improve community environments that support active transportation and recreational physical activity.

PARTNERS

The City of Glens Falls, Bike Glens Falls, Evergreen Bicycles, Common Roots, Rick's Bike Shop, Glens Falls Collaborative, CDPHP, Adirondack Cycling Advocates, Labella Associates and the Feeder Canal Alliance.

OUTCOMES

Forty-two participants completed a community survey related to bikeability in Glens Falls. The top three reasons respondents listed for not biking were: roadways are too busy/cars are too fast (24.6%), lack of bike lanes/path (22.3%) and roads are in poor condition (16.2%).

The city passed a "complete streets policy" ensuring all future projects completed are required to be planned, designed, operated and maintained to enable safe, convenient and comfortable travel and access for users of all ages and abilities, regardless of their mode of transportation.

Glens Falls passed an Americans with Disabilities Act transition plan, further ensuring access for all.

LESSONS LEARNED

In Glens Falls Hospital's years of experience, the greatest lesson learned is that collaboration and taking the time to listen, educate and gain broad support are essential. Key stakeholders must feel empowered to actively contribute their opinions and expertise in an iterative process until the best possible outcome is identified. Not only does this ensure that a chosen initiative moves forward and is sustainable, it guarantees the end result is of the highest quality.

SUSTAINABILITY

This event showcased a desire from the citizens of Glens Falls to have more opportunities to be active in a safe way. The hospital was able to show the decision-makers of Glens Falls tangible ways to accomplish this through a collaborative approach. In passing a Complete Streets Policy and establishing an ADA transition plan, the City of Glens Falls has shown its commitment to sustainable change, keeping its citizens safe and healthy and ensuring access for people of all ages and abilities.

CONTACT

Shannon Gaczol, Manager, Health Promotion Center
sgaczol@glensfallshosp.org | 518.926.5936

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GREAT LAKES HEALTH SYSTEM
MATTERS

INITIATIVE DESCRIPTION AND GOALS

The MATTERS program was designed to prevent and mitigate substance use disorders. The program's focus is on implementing a path for patients to be efficiently assessed, considered for medication initiation and referred to treatment in an effective manner regardless of geography, co-morbidities and other factors. The program's mission, vision and values highlight inclusivity for all patients, regardless of the complexity of their situation.

As the MATTERS program has grown, Great Lakes Health System has continued to hold those principles at the forefront and has applied them as the health system developed its voucher and telemedicine programs. The volume of patients using telemedicine has surpassed the physical referral environments. This fact further demonstrates the importance of flexibility and meeting patients where they are.

PARTNERS

MATTERS has 1,500+ community partners. Key funders and community stakeholders include: UBMD Emergency Medicine, Jacobs School of Medicine and Biological Sciences, University at Buffalo, DOH, New York State Office of Addiction Services and Supports, Erie County Department of Health, National Institutes of Health HEALing Communities Study, Substance Abuse and Mental Health Services Administration, HHS, Highmark of Western New York, U.S. Department of Justice Bureau of Justice Assistance, John R. Oshei Foundation and Catholic Charities Care Coordination Services.

OUTCOMES

- MATTERS has facilitated more than 2,000 referrals since its electronic referral platform launched in 2019.
- MATTERS has distributed nearly one million drug testing (fentanyl and xylazine) strips to individuals and organizations across the state. Emergency telemedicine services have been the source of nearly half of all MATTERS referrals in 2023.

LESSONS LEARNED

- Patients needing access to SUD care may not be able to physically get to a treatment location. Integrating emergency and ongoing tele-addiction care has helped these patients access care.
- Medication cost for underinsured or uninsured patients presents a barrier to treatment. Developing a robust medication voucher program has helped mitigate this barrier.

SUSTAINABILITY

MATTERS constantly pursues various funding mechanisms for continued program enhancement. Partnering with state and federal agencies, along with state legislators, has provided sustainability for many years. Billing for services in a limited capacity will also contribute to sustainability.

CONTACT

Katie Rossi, Director, Operations
krossi@mattersnetwork.org | 716.525.9442

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JAMAICA HOSPITAL MEDICAL CENTER — SCHOOL-BASED HEALTH CENTER

Addressing Obesity in Students at P.S. 223 after COVID-19

INITIATIVE DESCRIPTION AND GOALS

The nurse practitioner at P.S. 223's School-based Health Center conducted a parent-teacher association presentation on childhood obesity after the pandemic. The significance of using the phytonutrient spectrum checklist for kids and the importance of exercise and sleep were discussed. Parents and students were educated that to promote good health, it is important to eat fruits, vegetables, nuts, seeds and whole grains of varied colors of the rainbow each day. A nutritionist also provided a parent workshop on healthy eating habits.

An NP tracks overweight and obese students every one to two months. Verbal and written instructions on healthy eating and doable exercise routines are provided during each visit to fit the student's lifestyle. Parents are included in the treatment plan (knowing what to buy or not to buy/keep at home), according to their cultural preferences. During the visit with the NP, water, juice and soda intake is discussed, along with sleep hygiene, which includes duration and quality of sleep.

The principal started several exercise-related initiatives, including:

- students coming in early to participate in track before starting classes;
- weekly gym for students in each class;
- daily recess where students are encouraged to have free play for 40 minutes under the supervision of school aides; and
- use of water bottles to prevent dehydration during play.

PARTNERS

Jamaica Hospital School-based Health Center and P.S. 223 elementary school in Queens.

OUTCOMES

- Body mass index percentages were reduced.
- Weight stabilization was achieved.
- Students learned the importance of phytonutrients.

LESSONS LEARNED

Collaboration with the school and community was critical for success.

SUSTAINABILITY

Jamaica Hospital Medical Center will continue all programs next school year and will add mind-body skills tools for teachers, students and their families.

CONTACT

Jogesh Syalee, MD, Medical Director, Jamaica Hospital School-based Health Center
jsyalee@jhmc.org | 917.689.8079

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KALEIDA HEALTH
Emergency Room Care Navigation Program

INITIATIVE DESCRIPTION AND GOALS

Kaleida Health developed the Emergency Department Care Navigation program with the goal of coordinating outpatient services for primary care and specialty services for patients without a community provider. This initiative aims to reduce readmissions and coordinate patient care in the community.

The project proposal covered four main points:

- creating care navigation programs supporting the successful transition of patients across the continuum;
- increasing primary care provider attribution on a regional level;
- engaging patients to participate in programs aimed at health management, primary preventive care and improvement in overall health status; and
- using existing transition of care model in the health system's readmission prevention activities.

The workflow included provider and patient consent to a program referral and thoughtful conversations surrounding the patient's post-emergency department visit follow-up needs. Upon receipt of referral care, navigators verify:

- primary care attribution;
- specialist scheduling;
- coordination for imaging and procedures;
- social determinants of health screening and community coordination;
- appointment reminders/follow-up calls post-appointment; and
- 30-day follow-up calls for patients at high risk for readmission (based on clinical diagnosis scoring).

PARTNERS

Paul Shields, DO, chief executive officer and chief medical officer, Great Lakes Integrated Network; David Janicke, MD, PhD; Rebecca Lenz, PA; Barbara Mastrole, RN, PhD, NP, senior director, patient management, Kaleida Health; Kristin Cortese, vice president, population health, GLIN; Kathryn Witherell, director, post-acute services, GLIN/General Physician P.C.; Katherine Palumbo, associate director, post-acute services, GLIN.

OUTCOMES

This initiative has resulted in connection with more than 200 patients monthly, a reduction in readmissions and increased patient satisfaction.

LESSONS LEARNED

Communication between inpatient and outpatient providers is critical to a successful care navigation program, and connecting with patients after their hospitalization or ED visit is an important extension of their overall patient experience.

SUSTAINABILITY

Kaleida has used this initiative as a springboard for a hospital-wide physician referral program that will provide the same care coordination and follow-up to all patients, connecting inpatient and outpatient providers with the same goal of improving patient experience and outcomes.

CONTACT

Paul Shields, DO, Chief Executive Officer and Chief Medical Officer, Great Lakes Integrated Network
shields.paul@glin.com | 716.481.4837

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LORETTO
Dedicated COVID-19 Transition Facility

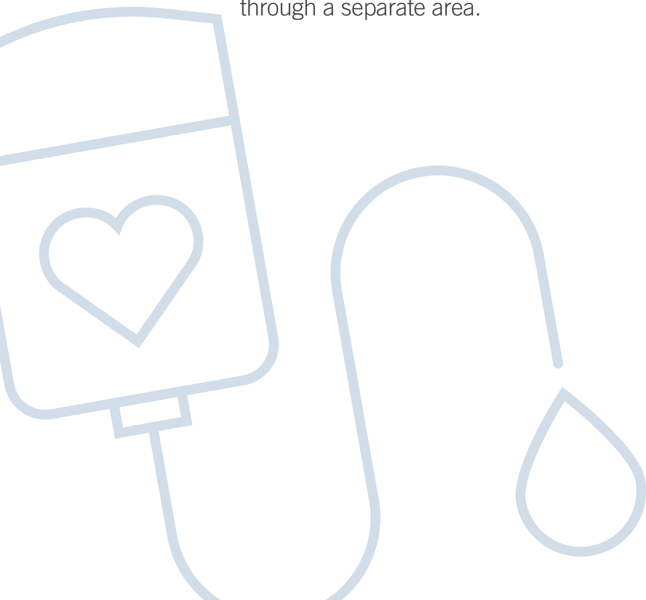
INITIATIVE DESCRIPTION AND GOALS

During the pandemic, Loretto was designated as the COVID-19 transitional facility in Onondaga County. Loretto's goals included protecting residents and staff from the spread of the virus, supporting regional hospitals, treating recovering COVID-19 patients, providing hope and comfort to the community and creating a model that inspired other individuals and organizations to think creatively about potential solutions to community challenges.

Through the combined resources of this collaboration, Loretto developed one of the most extensive COVID-19 units to date. There was a dedicated, secure entrance for patients and another for employees. For employees, the first two rooms on each floor were dedicated to changing into scrubs and personal protective equipment. Plastic zip walls separated this area from patient rooms. The last room on the floor was dedicated to scrub removal and all staff had to exit down one stairwell. Ultraviolet boxes to kill germs were provided for staff's personal items, including cell phones and glasses.

Each floor had a negative-pressure isolation unit for stable and pending COVID-19 patients, as well as state-of-the-art technology and 24/7 remote monitoring for doctors and specialists. Dedicated staff exclusive to this unit worked 12-hour shifts to minimize the number of people, and thus, exposure risks. Extensive safety protocols allowed for careful transport and management of patients.

There was even a precise plan and strategy behind the delivery and disposal of food and supplies. Food was delivered on the "clean side" of the stairwell entry point — where staff entered the units — and removed through a separate area.



PARTNERS

DOH, Onondaga County, Upstate Medical University, Crouse Health and St. Joseph's Health.

OUTCOMES

- Nearly 400 patients were decanted from local hospitals and cared for at Loretto's COVID-19 transitional facility.
- Loretto helped all three major hospitals in Syracuse avoid reaching "Red Zone" status, which would have enacted restrictions to significantly limit commerce and other economic activities.
- Loretto applied learnings to expand its restorative care unit and continue to free up hospital beds long-term.

LESSONS LEARNED

The biggest lessons from this initiative were the importance of always seeking opportunities for collaboration and the need for constant, proactive, two-way communication with everyone internally and externally.

SUSTAINABILITY

While this initiative was designed to be temporary, Loretto continues to develop and operate some of the most innovative units in long-term care through this sustainable model of constantly pushing boundaries and seeking opportunities for partnerships.

CONTACT

Kimberly Townsend, MBA, MPA, JD, EdD, CPA, GPHR, President and Chief Executive Officer
corporatecommunications@lorettosystem.org | 315.469.5570

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MAIMONIDES HEALTH – COMMUNITY CARE OF BROOKLYN

Community Care of Brooklyn Navigator

INITIATIVE DESCRIPTION AND GOALS

The Community Care of Brooklyn Navigator program provides access to a newly integrated network of services, connecting Maimonides Health patients and Brooklyn residents to over 300 community-based social, behavioral and medical services and programs. The CCB Navigator offers individuals the resources they need to stay safe, access quality services and avoid health crises.

With the overarching mission of providing equitable access to resources for all community members, the initiative's goals include identifying and addressing social determinants of health and care management needs, and relieving the administrative burden on already taxed community-based organizations and primary care providers.

The three components of the CCB Navigator program are a network of partner resources, a person-centered assessment and matching tool and staff navigators. Using the custom screening tool, navigators assess individuals via phone and, with the support of a team of care managers, connect them to free services already available in their community.

The CCB Navigator supports the New York State *Prevention Agenda's* "Promote Well-Being" priority and the focus area to strengthen opportunities to build well-being and resilience across the lifespan.

PARTNERS

Community Care of Brooklyn is a network of more than 1,000 health and social service organizations, including Maimonides Health, One Brooklyn Health System, SUNY Downstate, Brooklyn Health Home, Brooklyn Communities Collaborative and Community Care of Brooklyn IPA, JASA, Brooklyn Perinatal Network, and many others working to improve the health and well-being of Brooklyn residents. In addition to the CCB network, CCB Navigator is connected to the Unite NYC network of providers through the Unite Us platform.

OUTCOMES

- Implementation of this program has not only positively impacted patients, it has improved coordination between inpatient, outpatient and community-based care providers.
- Among all individuals screened for social determinants, 93% responded "yes" when asked if they wanted referrals and were subsequently directed to services, highlighting a high need for program resources.
- Most frequent referral service connections are made to: healthcare management/coordination (68%), individual and family support (26%) and housing and shelter (17%).

LESSONS LEARNED

- There is an overwhelming need for additional support and community services for older individuals and the Medicare population, particularly focused on transportation and housing.
- Despite the coordination provided through the CCB Navigator program, the ongoing social needs continue to outpace the availability of resources.

SUSTAINABILITY

By creating a pipeline of referrals from participating health systems and providers to care management and CBO resources, the CCB Navigator program is more effectively and equitably managing the spectrum of care coordination, sending targeted referrals to the programs Brooklynites want and need. The program has attracted significant attention from Brooklyn health systems and community organizations, and was awarded a Congressionally Directed Spending Award to dramatically scale up the initiative's capacity.

CONTACT

Magdalena Gordon, Assistant Vice President, Complex Care and Population Health
magordon@maimonidesmed.org | 718.283.5949

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MEMORIAL SLOAN KETTERING CANCER CENTER

Community Cancer Screening Referral Program

INITIATIVE DESCRIPTION AND GOALS

Memorial Sloan Kettering Cancer Center's Community Cancer Screening Referral Program uses community partnerships and a mobile health unit to perform outreach to underserved and immigrant populations in New York City and navigates individuals from those communities into cancer screening at the MSK Ralph Lauren Center in Harlem.

The CCSRP supports the New York State *Prevention Agenda's* prevent chronic diseases action plan goal to increase cancer screening rates. As reported in MSK's 2022-2024 Community Service Plan, the CCSRP aims to navigate at least 450 eligible people into cancer screening and organize 20 cancer screening events with community-based organization partners by the end of 2024. MSK is currently on pace to exceed those goals.

The mobile health unit team partners with CBOs on outreach and can schedule cancer screening appointments at MSK RLC via this outreach. Eligible, uninsured residents can access no-cost screenings for breast, cervical and colorectal cancers at MSK RLC through the New York State Cancer Services Program. MSK RLC also offers PSA testing for prostate cancer and referrals for lung cancer screening.

PARTNERS

Church of God (Manhattan), Little Sisters of the Assumption, Abyssinian Baptist Church, Union Settlement, the Hispanic Federation, NY Common Pantry, American Senegalese Association, Fort Washington Collegiate Church, New Testament Temple Church of God (Bronx), Mexican Coalition, St. Michael's Church (Brooklyn), Iglesia de la Santa Cruz, Arab American Family Support Center, Our Lady of Perpetual Help (Mixteca), Masjid At-Taqwa, Beit El Maqdis, PS 287 K, Our Lady of Sorrows (Queens), St. Gabriel's Church, Travers Park, LaGuardia Airport, Voces Latinas, Iglesia El Corban, Queens Public Library, John F. Kennedy International Airport, DSI International and La Colmena (Staten Island).

OUTCOMES

In 2022, the CCSRP scheduled 799 cancer screening appointments at MSK RLC, with 294 appointments completed (37% completion rate), including screenings for colorectal cancer (105, with 57 fecal immunochemical tests returned), breast cancer (60), cervical cancer (37), prostate cancer (88) and lung cancer (1). There were 35 abnormal findings from these screenings, with four resulting in cancer diagnoses.

Upwards of 90% of the community members referred to MSK RLC for cancer screening are from non-white populations that experience disparities in terms of access to cancer screening and care, as well as cancer outcomes.

The program partners with more than 40 local CBOs.

LESSONS LEARNED

- The MHU functions best at small- to mid-size events (less than 500 people) where meaningful connections can be made with community members and trust can be built by repeat visits to the same location.
- Community members were unlikely to call and schedule a cancer screening appointment at MSK RLC on their own after an interaction with the MHU. They were more likely to schedule an appointment in the moment while they were still with the MHU staff, so the CCSRP team can schedule appointments on the spot.

SUSTAINABILITY

The MHU is funded in part by the Mother Cabrini Health Foundation, the U.S.-Mexico Border Health Commission and CDC. Ongoing fundraising and grant writing support this effort. MSK RLC is supported by MSK, the Ralph Lauren Corporate Foundation and other donors. Maintaining participation in the NYS Cancer Services Program will allow uninsured residents to continue accessing no-cost screenings for breast, cervical and colorectal cancers at MSK RLC.

CONTACT

Cynthia McCollum, Senior Vice President, Hospital Administration
mccolluc@mskcc.org | 212.639.5988

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MOUNT SINAI HEALTH SYSTEM

Mount Sinai Robert F. Smith Mobile Prostate Cancer Screening Unit

INITIATIVE DESCRIPTION AND GOALS

The Milton and Carroll Petrie Department of Urology at Mount Sinai launched the Mount Sinai Robert F. Smith Mobile Prostate Cancer Screening Unit to support prostate health in the Black community aligning with the New York State *Prevention Agenda's* plan for chronic disease preventive care and management.

The mobile van is equipped to perform screenings and tests including the prostate-specific antigen test, digital rectal exam, ExactVu™ micro-ultrasound system, EchoNous bladder scanner and genomics testing.

Mount Sinai Health System joined forces with local community partners to raise awareness about the services offered by the mobile unit, set up prostate screening appointments in highly concentrated Black neighborhoods and schedule follow-up visits as needed for patients with MSHS urologists.

PARTNERS

Harlem Congregations for Community Improvement, Majestic Heights SDA, 71st Precinct Community Day Wingate Park Brooklyn, Grace Moravian Church, International Pentecostal City Mission, Whereitzat, Community Health Advisor Jehovah Jireh Baptist Church of Christ, Brooklyn Jewish Temple, Rochdale Park, Living Word Christian Fellowship, First Corinthians Baptist Church, City Hall Initiatives Manager, Local One (Westin Hotel) and Kamilah Ali, PhD from Tuoro College.

OUTCOMES

- Since the launch of the program, the team saw more than 2,000 patients, surpassing its initial goal for the first year of 1,000.
- Nearly 20% of those screened with elevated PSA required further follow-up. Importantly, 69% of those seen were Black men.
- The unit continues to raise awareness about the disease for a vulnerable community and is an invaluable service. The services and education can also help close the gaps in high-risk diagnostic and fatality rates.

LESSONS LEARNED

Introducing patients to primary healthcare by going to the settings where they already are can empower long-term care and comfort. Providing a relaxed environment with community-trusted partners can eliminate perceived stigma.

SUSTAINABILITY

From connections with community partners to the multidisciplinary team of staff at the forefront of urological care, the unit will continue to provide steadfast care to those in need.

CONTACT

Ash Tewari, MD, System Chair, Urology, Icahn School of Medicine at Mount Sinai
amorgan@skdknick.com | 405.543.5136

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NEWYORK-PRESBYTERIAN HOSPITAL

Turn 2 Us Mental Health Promotion and Prevention Expansion

INITIATIVE DESCRIPTION AND GOALS

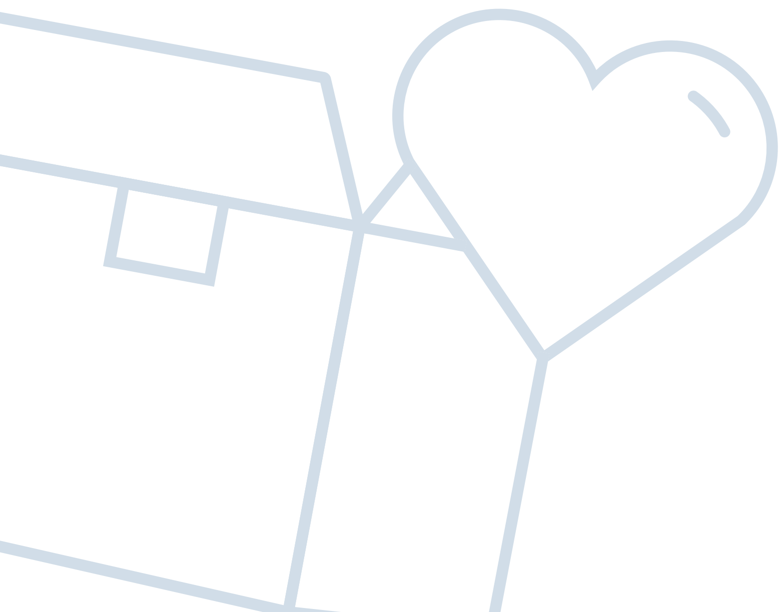
NewYork-Presbyterian Hospital's Turn 2 Us program uses a social-ecological approach to promote mental health and academic success in at-risk children in underserved communities. The program provides mental health literacy education for school staff and parents so they are better equipped to address the mental health needs of their students and/or children.

Turn 2 Us closely relates to the New York State *Prevention Agenda's* "Prevent Mental and Substance Use Disorders Action Plan" priority as NewYork-Presbyterian aims to increase the confidence and ability to identify disorders, refer as needed and provide early intervention. This intervention is unique in that it offers not only psycho-education workshops for school personnel but also provides:

- support to students by teaching stress management strategies (in-class mindfulness exercises) alongside their classroom teachers;
- mental health literacy training for parents so all adults are given the opportunity to support the community's youth; and
- consultation with school personnel to address the more challenging cases.

PARTNERS

Turn 2 Us partners with Public Schools 4M, PS8M, 28M, 48M, 115M, 152M, 173M and 189M; Sports and Health in the City; Emma L. Bowen Community Service Center; Community League of the Heights; and NewYork-Presbyterian Hospital Pediatric Psychiatry Department school-based mental health clinics.



OUTCOMES

- When comparing pre- and post-mental health literacy education results, there was a 19.2% increase in knowledge and a 29.2% decrease in stigma.
- Sixty-two percent of school personnel reported lack of familiarity before the intervention and there was a significant decrease post-intervention, with 36% of school personnel reporting lack of familiarity.
- Ninety-three percent of teachers reported feeling confident or very confident in referring students for services pre-intervention and 97% felt that way post-intervention.
- When reviewing the pre-survey data, 35% of teachers reported noticing when their body is stressed, compared to 52% who reported awareness after the program.

LESSONS LEARNED

- One lesson learned was the benefit of offering a hybrid platform. Being able to provide workshops and initiatives in person and virtually enables the hospital to reach more people.
- In addition, NewYork-Presbyterian learned the importance of flexibility. Being able to adapt quickly and modify programming is key to successful implementation.

SUSTAINABILITY

The hospital identified and trained staff from its school site to continue the mental health literacy efforts beyond the program.

Selecting key personnel is crucial to ensure sustainability efforts. NewYork-Presbyterian also collaborates with its pediatric psychiatry department school-based mental health clinics, which allows for the spread and sustainability of a school-wide culture of mental health and the ability to assist with mental health challenges beyond these efforts.

CONTACT

Julie Flanagan, LMSW, Program Manager
juf9058@nyp.org | 646.856.2621

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NORTHWELL HEALTH
Gun Violence Awareness Campaign

INITIATIVE DESCRIPTION AND GOALS

Gun violence is now the leading cause of death in children; 13 children die from guns every day nationwide. Northwell Health, New York's largest health system and private employer, has initiated several programs to tackle this issue.

Also, in response to the shocking statistics, Northwell rallied more than 1,000 other hospitals, associations and health systems to spread the campaign's message, "It Doesn't Kill to Ask."

PARTNERS

More than 1,000 hospitals and health associations, including the American Hospital Association, Children's Hospital Association and Catholic Health Association of the United States. See the full list of organizations at hospitalsunited.com.

OUTCOMES

- Campaign advertisements were shared in the New York area almost 2,200 times from the end of September to December 2022 alone. Parents who saw the campaign are 89% more likely to ask other parents about an unlocked gun in the home.
- The spots were also shared on social media and created more than 38 million impressions and more than 425,000 engagements.
- On the media/public relations side, 205 media clips resulted in more than 24 million impressions.

LESSONS LEARNED

While they compete, health systems can come together to make positive change in their communities. There was much communication, coordination, collaboration on materials and flexibility on the part of Northwell Health to ensure the message was supported in all communities across America — the west, north, south and east.

SUSTAINABILITY

Campaign materials are evergreen so the messaging can be in markets now and in the future. Northwell Health will use this campaign as a platform for more efforts and is optimistic other health systems will do the same. Northwell stays in touch with the contacts made during this campaign to activate them on related initiatives, like its CEO council, which gathers health-care system CEOs across the country to discuss and tackle gun violence.

CONTACT

Emily Ng, Associate Vice President, Marketing and Communications
eng3@northwell.edu | 516.321.6701

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SAMARITAN MEDICAL CENTER
Hospital Readmissions Reduction Program

INITIATIVE DESCRIPTION AND GOALS

The combination of home health monitoring, patient education and improvements in telemedicine have made it possible for Samaritan Medical Center to successfully establish a sustainable hospital readmissions reduction program for patients with congestive heart failure. The program has successfully implemented several interventions under the New York State *Prevention Agenda's* focus area on congestive disease preventive care and management. In alignment with Goal 4.3, the Samaritan hospital readmissions program promotes evidence-based care to prevent and manage cardiovascular disease by specifically reducing readmissions of congestive heart failure patients.

This has been accomplished by promoting a team-based approach through Samaritan's home health program, run by a program coordinator in collaboration with hospitalists and the surrounding community's primary care providers.

The data captured proves the program has been successful in decreasing readmissions of CHF. The goal set for readmissions was to see no more than 10.7% readmitted between February 2022 and March 2023; Samaritan surpassed that goal, with only 9.7% of those patients readmitted.

PARTNERS

Fort Drum Regional Health Planning Organization and the North Country Initiative.

OUTCOMES

The top three most successful outcomes of Samaritan's hospital readmissions reduction program were:

- reducing the number of readmissions in 2023 thus far from an observation/expectation rate of 1.01 to .58;
- reducing the number of readmissions in 2022 from an observation/expectation rate of 1.13 to 1.01; and
- reducing the number of readmissions in 2021 from an observation/expectation rate of 1.35 to 1.13.

LESSONS LEARNED

- One lesson learned in the implementation of Samaritan's hospital readmissions reduction program was the value of community partnerships.
- A second lesson was that even through a healthcare pandemic, innovation and advancement in fields such as telemedicine and home healthcare can still be realized.

SUSTAINABILITY

Samaritan Medical Center's readmissions reduction program has successfully laid the groundwork for how hospitals across the North Country region can successfully reduce readmissions of patients with congestive heart failure. The technology purchased will not need to be replaced in the foreseeable future and the home healthcare program is financially sustained under the Samaritan Medical Center operating budget.

CONTACT

Mario Victoria, MD, Vice President, Medical Affairs and Chief Medical Officer
ldistefano@shsny.com | 315.785.4504

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ST. MARY'S HEALTHCARE

The Cancer Services Program of Fulton, Montgomery and Schenectady Counties

INITIATIVE DESCRIPTION AND GOALS

The Cancer Services Program of Fulton, Montgomery and Schenectady counties at St. Mary's Healthcare strives to increase access to high-quality chronic disease preventive care and management in both clinical and community settings. The cancer screening program serves a three-county area and provides age-appropriate breast, cervical and colorectal cancer screenings and diagnostic services to uninsured and underinsured men and women.

Through outreach and case management, the program facilitates access to high-quality screenings conducted by participating providers and healthcare systems. The program staff conduct needs assessments and identify, develop, implement and evaluate interventions to increase breast, cervical and colorectal cancer screening and address barriers among priority populations that are disproportionately burdened by an increased risk of cancer and/or who are medically unserved or underserved.

This program addresses the state's *Prevention Agenda* "Preventing Chronic Disease" priority area with the goal to increase breast, cervical and colorectal cancer screenings.

PARTNERS

Ellis Medicine, Nathan Littauer Hospital, Bassett Healthcare Network, Hometown Health Centers of Amsterdam and Schenectady, Montgomery County Public Health Department, Fulton County Public Health Department, Schenectady County Public Health Department, To Life!, Catholic Charities of Fulton and Montgomery Counties, Centro Civico/Ibero, *The Daily Gazette*, Montgomery County Office for Aging, Inc., Fulmont Community Action Agency, Hamilton-Fulton-Montgomery BOCES Adult Literacy Education, Seventh Day Adventist Church, Unitarian Universalist Society of Schenectady and African Methodist Episcopal Church of Schenectady.

OUTCOMES

The goal of 60% of eligible, uninsured patients who were rescreened with a mammogram within 24 months has been met and exceeded, with either a first or second place ranking position in New York state.

- For cervical cancer, 82.1% of women ages 40 to 65 have had a pap smear within the last three years. Performance measures indicate that the goal of 35% has been met and exceeded; 38.5% of eligible, uninsured women who were provided a program-funded cervical screening were defined as rarely/never screened.
- Among adults ages 50 to 64, more than 70% have had an appropriate colorectal cancer screening.

LESSONS LEARNED

- Patients are more likely to attend when comprehensive screenings are offered at one appointment. Patients who attend the cancer screening events are offered age-appropriate screenings based on their risk factors and health history.
- To reach the priority population, the screening team has focused outreach efforts toward churches and community organizations. The team provides onsite education to members who attend community events at partner organizations to increase screenings.

SUSTAINABILITY

The program staff educate stakeholders by garnering earned media; communicating with and making educational visits to legislators, other elected officials or high-ranking community members and decision-makers; and using client stories and testimonials to enhance earned media and in-person visits.

The program staff engage in population-based education about the importance of early detection via mass media, publications and one-on-one/group education.

CONTACT

Suzanne Hagadorn, Program Manager
hagadorns@nysmha.org | 518.770.6814

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ST. PETER'S HEALTH PARTNERS MEDICAL ASSOCIATES

Healthy Options Program (SHOP) aka Food Farmacy

INITIATIVE DESCRIPTION AND GOALS

The "food as medicine" approach improves diabetes management in patients who have limited access to healthy food and increases knowledge regarding how food improves health.

Under St. Peter's Health Partners Medical Associates' food as medicine approach, individuals identified themselves as food insecure or screened as food insecure through an electronic medical record questionnaire. People were identified when being discharged from the emergency department, treated in behavioral health settings and through the diabetes education program.

Through this initiative, St. Peter's was able to offer a food farmacy program that supplies shelf-stable foods to help those who were screened and patients with diabetes and their families who are struggling with food insecurity.

Initially, participants come for an in-person weekly group meeting focusing on healthy eating and food preparation. The participants were then offered fresh and frozen fruits, vegetables and lean proteins to support five days each week for two meals each day. With the COVID-19 health emergency, in-person groups transitioned to virtual groups and St. Peter's collaborated with Tech Valley Transportation to deliver food to participants' homes.

As the referrals grew, a food farmacy coordinator was hired to manage deliveries and coordinate the expansion of St. Peter's food insecurity programs to include emergency food bags to the entire service line and community agencies in need.

Providing fresh and frozen fruits, vegetables and lean proteins with education will improve health outcomes. Individuals who are able to actually see the benefit of these healthy foods and learn how to purchase and prepare healthy yet less expensive meals will continue to do so.

PARTNERS

St. Peter's Health Partners Medical Associates, SPHP Community Health and Wellbeing, St. Peter's Diabetes and Endocrine Care Diabetes Education program, SPHP Philanthropy, Mother Cabrini Health Foundation, Regional Food Bank of Northeastern NY, Tech Valley Transportation, Amsterdam Fire Department, Capital Region Chamber of Commerce, City of Gloversville, Resource Center for Independent Living, Gloversville Water Works, Centro Civico, Montgomery County Cares Coalition, Amsterdam Department of Public Works, Catholic Charities, HFM Prevention Council, FulMont Community Action, Wolf Hollow Brewing Company, Back Barn Brewing Company, City of Amsterdam, Schenectady Coalition for a Healthy Community, Fulton Montgomery Regional Chamber of Commerce, Schenectady County Public Health and the Gloversville Transit System.

OUTCOMES

- Over seven cohorts, a total of 123 participants were served.
- The average weight loss per participant was 12.3 pounds.
- Hemoglobin A1C of 2.08% declined significantly, from an average of 8.77% to 6.69%, meeting the American Diabetes Association recommendations of A1C < 7%.
- Participants have better knowledge of foods that are more nutrient dense, less expensive and easy to prepare.

LESSONS LEARNED

- The food is medicine approach, with education, positively changes health with a decline in weight and HbA1C.
- In-person sessions have a greater impact on weight loss and lowering A1C.

SUSTAINABILITY

Going forward, St. Peter's Partners Medical Associates plans to return to a hybrid (virtual/in person) group meeting for one hour each month to increase attendance. To allow time for significant change, both physical and behavioral, St. Peter's will offer the program for 24 weeks.

The Mother Cabrini grant has been applied for and will offer an additional grant for the upcoming year. The Regional Food Bank has also received a grant that they would like to offer as support and to expand this program. St. Peter's will continue to partner with The Collaboratory on Food as Medicine programs to expand its reach.

CONTACT

Lynn Sutton, RD, RDN, CDCES, Coordinator, Diabetes Education Program and Sheilah McCart, Manager, Community Engagement and Community Health and Well-being
lynn.sutton@sphp.com | 518.471.3224

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STONY BROOK EASTERN LONG ISLAND HOSPITAL

NARCAN Rescue Stations

INITIATIVE DESCRIPTION AND GOALS

The Narcan Rescue Station Life Saving Program was established to launch Narcan Rescue Stations across Long Island's East End community through local businesses and establishments to prevent potential opioid overdoses.

This community health initiative is a vital and life-saving program that is the first of its kind on Long Island. It aligns with the New York State *Prevention Agenda* priority area to promote well-being and address mental health and substance use disorders with a goal to prevent opioid and other substance misuse and deaths.

The Narcan Rescue Stations are a tool to save lives, like an automated external defibrillator. The stations come with multiple doses of naloxone, the life-saving drug that prevents death from opioid overdose, along with detailed administering instructions. Free training is provided to any business. The Narcan Rescue Stations come at no cost to participating establishments as the program has been underwritten by the initiative partners.

PARTNERS

Stony Brook Eastern Long Island Hospital, Greenport Harbor Brewing Co., Greenport Village Business Improvement District and Community Action for Social Justice.

OUTCOMES

- Seventeen stations were installed at local businesses.
- Twenty stations were installed in local park districts.
- Fifty stations were installed in local schools.

LESSONS LEARNED

CASJ previously distributed Narcan kits to local businesses but had limited success due to societal bias toward substance use and a public lack of knowledge. Under the joint program, there is increased education, public discussion and public empowerment by providing a lifesaving service that increases community cohesiveness and public safety.

SUSTAINABILITY

As the program is locally unlimited and funding is secured, the goal is to continue to work within this community and to promote the program to other communities.

CONTACT

Linda Sweeney, Vice President, Public Relations
linda.sweeney2@stonybrookmedicine.edu | 631.477.4598

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UNITED MEMORIAL MEDICAL CENTER (ROCHESTER REGIONAL HEALTH)

Perinatal Task Force

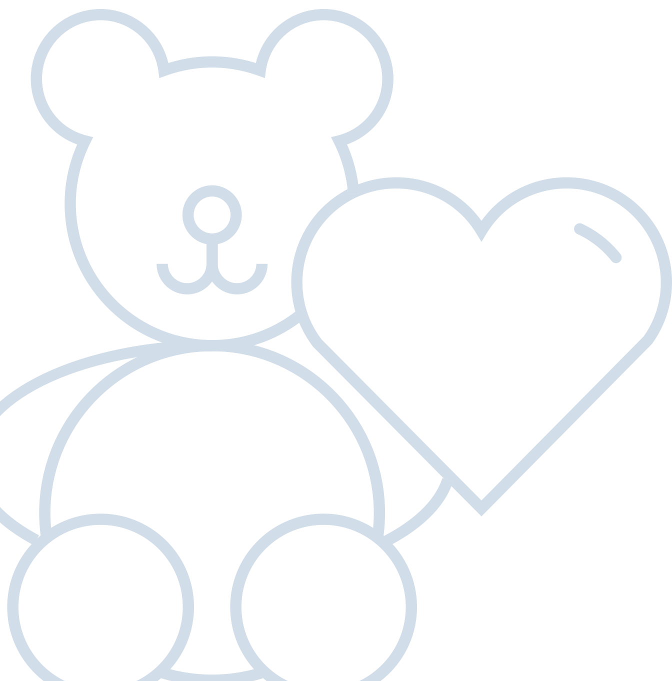
INITIATIVE DESCRIPTION AND GOALS

Rochester Regional Health–United Memorial Medical Center's Perinatal Task Force works with community agencies that support parenting and pregnant families, positively impacting their pregnancy and birth outcomes by connecting them to community resources they self-indicate they need.

Established in March 2021, this task force is a direct result of collaboration between the MOMS Program and the Women's Care Centers at UMMC. Through direct partnerships and referrals to community agencies, this initiative addresses several New York State *Prevention Agenda* priority areas, including preventing chronic diseases; promoting healthy women, infants and children; promoting wellbeing; and preventing mental and substance use disorders. Task force partnerships allow for warm client hand-offs and address the state's cross-cutting principles to improve health outcomes, enable well-being and promote equity across the lifespan.

PARTNERS

Partners on the Perinatal Task Force include: UMMC Maternal Services, UMMC Women's Care Centers, UMMC Baby Cafe, UMMC Maternity Floor, Batavia Primary Care, GCASA, Genesee County Department of Health, Horizon Health, Change InSight PLLC, Project Stork, PICHC, Whole Love Doula Wellness Companions, Batavia Community Schools, Baby and Me Tobacco Free Facilitator, Oak Orchard WIC, Community Action of Orleans and Genesee, Planned Parenthood and Head Start.



OUTCOMES

- As a result of the task force, the number of pregnant individuals connected to community agencies has increased significantly in the past year, with 70 moms assisted as of May 31, 2023, compared to a total of 82 assisted in 2022.
- Introducing Whole Love Doula to UMMC's obstetric team has created a respectful working relationship that positively impacts the birthing families.
- Collaborating with maternal services in providing prenatal breastfeeding education has improved UMMC's exclusive breastfeeding rates from 58% to 61%.

LESSONS LEARNED

Strong communication among agencies and the community improves the experience of those UMMC serves. This is achieved by breaking down barriers, addressing support gaps, decreasing duplicative services, finding means to provide services and reviewing processes regularly. People are best served when healthcare providers meet them where they are.

Responses from the referral form are used to connect individuals to the self-identified requested services. UMMC is asking what people want instead of assuming they know.

SUSTAINABILITY

The MOMS Program will solicit, engage and maintain the commitment of current stakeholders and recruit more partners to the task force. UMMC has demonstrated a financial commitment to the MOMS Program, which includes facilitation of the perinatal task force and community benefit programming, recognized through the Genesee County Community Health Improvement Plan process and community survey. Additionally, funding received through perinatal and infant community health collaboratives extends the task force through June 2027.

CONTACT

Megan Boring, MOMS Program Coordinator and
Perinatal Task Force Leader
mboring@ummc.org | 585.344.5355

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UNIVERSITY OF ROCHESTER MEDICAL CENTER

Center for a Tobacco-Free Finger Lakes

INITIATIVE DESCRIPTION AND GOALS

The Center for a Tobacco-Free Finger Lakes is committed to equipping the health systems in an 11-county area with the current best practices for treating tobacco cessation among the population by:

- optimizing policies, training strategies, performance evaluation and access to resources (for providers and patients);
- assisting with the design and implementation of policy-based protocols to identify nicotine-dependent patients and clients at every encounter; and
- implementing strategies to treat nicotine dependency.

Resources are provided for health systems to quickly and easily refer their patients to evidence-based cessation services. CTFFL is a dedicated team and part of the New York State Department of Health's Tobacco Control Program.

PARTNERS

Fifty-two organizations, including: UR Medicine, Rochester Regional Health and affiliated hospitals, Rochester Psychiatric Center, federally qualified health centers (Jordan Health, Mosaic Health, Oak Orchard Health), Monroe County Medical Society, American Cancer Society, American Lung Association, community health improvement workgroups and others.

OUTCOMES

- Provider referrals to the Quitline increased.
- To date, $18,000 has been distributed in "mini-grants" for use toward tobacco prevention, health policy change, etc.

LESSONS LEARNED

Champions come from all different levels and professions within an organization and URMC is thankful to have partners who are vested in the work to advance tobacco control and prevention.

SUSTAINABILITY

CTFFL's ongoing work provides a supporting entity for healthcare systems and maintains the ever-necessary focus on public health best practices with regard to tobacco control and prevention, especially during this tumultuous time in healthcare.

CTFFL offers a "train-the-trainer" program for healthcare systems, allowing the newly trained staff to also use and provide the slides and training as part of ongoing education for their health systems (onboarding, yearly in-service, etc.)

CONTACT

Scott McIntosh, PhD, Co-director, Tobacco Cessation and Prevention Research Program
scott_mcintosh@urmc.rochester.edu | 585.802.9944

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WHITE PLAINS HOSPITAL

Youth Summit: Building a Diverse Workforce for the Future

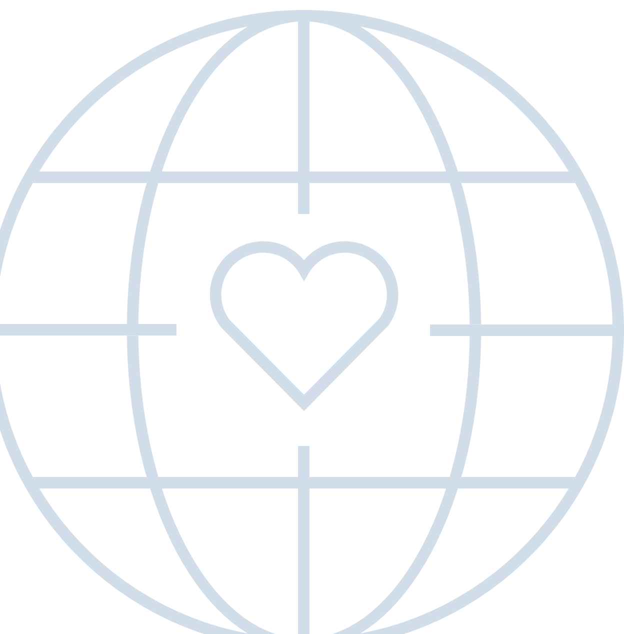
INITIATIVE DESCRIPTION AND GOALS

White Plains Hospital committed to bringing awareness of opportunities in healthcare to all minorities by hosting New York's first Youth Summit to promote racial, ethnic and gender diversity among healthcare professionals. WPH partnered with Black Men in White Coats, a national organization that created the documentary series of the same name and seeks to increase the number of Black men in the field of medicine. WPH also collaborated with multiple medical schools, community leaders and partners in other Montefiore hospitals for this first-of-its-kind event.

The goal of the Youth Summit was to show attendees that there is a pathway to economic stability and inspire the next generation of healthcare providers with the belief that "if they can see it, they can be it." WPH's Youth Summit aligns with the New York State *Prevention Agenda* priority area to "Promote Well-Being and Interventions."

PARTNERS

Albert Einstein School of Medicine, New York Medical College, Westchester County Government, City of White Plains, Calvary Baptist Church, Thomas H. Slater Center, Montefiore Health System, White Plains Youth Bureau, El Centro Hispano, Westchester Community Health Center, Pace University, Morgan State University and White Plains Public School District.



OUTCOMES

The Youth Summit was an undeniable success, exceeding all expectations and leaving a lasting impact on participants and the community. While a direct correlation between the Youth Summit and a decrease in health disparities may not be easily quantifiable in the short term, WPH hopes that it will contribute to positive change. A post-event survey was performed to collect feedback as WPH continues to expand upon its efforts in the coming years. The majority of respondents were "very satisfied" with every session offered and agreed that the program "effectively provided an engaging and inspiring experience."

LESSONS LEARNED

During execution of the summit, WPH learned important lessons. The hospital recognized that its messaging needed to include all genders. WPH felt it was important to provide parents with a roadmap that provided practical information regarding financial and academic planning through their child's school years. Furthermore, WPH realized that it needed more space to better enable tabling for its university partners. All of these lessons will be addressed in this year's Youth Summit.

SUSTAINABILITY

The Youth Summit served as a dynamic platform for youth to come together and explore the many careers within the healthcare field. It was a tremendous representation of WPH's commitment to advancing health equity in the community. WPH has recognized the importance of continuing these efforts and has committed to hosting another Youth Summit, in partnership with the Black Men in White Coats organization and more internal and external stakeholders on Nov. 4, 2023.

CONTACT

Ashley Liberatore, Director, Community Outreach
aliberatore@wphospital.org | 914.681.2303

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HANYS Celebrates Previous Community Health Improvement Award Winners

2022 Mohawk Valley Health System
Lead-free and Healthy Homes
Mohawk Valley Coalition

2021 Northwell Health
Advancing Health Equity through Community-based Partnerships to Fight COVID-19

2020 UR Medicine–Jones Memorial Hospital, Wellsville
Promotion of Healthy Life Styles

2019 Montefiore Medical Center, Bronx
Healthy Food Initiative

2018 Unity Hospital–Rochester Regional Health
Healthy Moms

2017 Schuyler Hospital, Montour Falls
Healthy Eating Active Living (HEAL) Schuyler

2016 Strong Memorial Hospital, Highland Hospital (UR Medicine)/Rochester General Hospital, Unity Hospital (Rochester Regional Health)
High Blood Pressure Collaborative – Hospital Partners

2015 Bassett Healthcare Network, Cooperstown
School-based Health/Oral Health Program

2014 Bassett Medical Center, Cooperstown
Cancer Screening Outreach – Medical Screening Coach

2013 Arnot Health at St. Joseph's Hospital, Elmira
Chemung County School Readiness Project

2012 Sound Shore Medical Center, New Rochelle
Outpatient Pediatric Immunization Center

2011 Catholic Health Services of Long Island, Rockville Centre
The Healthy Sundays Program

2010 Brookdale University Hospital and Medical Center, Brooklyn
Live Light...Live Right Childhood Obesity Program

2009 Strong Memorial Hospital/University of Rochester Medical Center
Health-e-Access Telemedicine Network

2008 Jamaica Hospital Medical Center
Palliative Care Collaborative

2007 Rochester General Hospital, Clinton
Family Health Center

2006 Ellis Hospital/Northeast Health (Samaritan Hospital and Albany Memorial Hospital)/ St. Peter's Health Care Services/Seton Health System, Schenectady/Albany/Troy
Seal a Smile: A Children's Oral Health Initiative

2005 Strong Memorial Hospital/University of Rochester Medical Center
SMILEmobile Dental Office on Wheels

2004 NewYork-Presbyterian/Columbia University Medical Center
Breast and Cervical Cancer Screening Partnership

2003 St. John's Riverside Hospital, Yonkers
School-based Asthma Partnership

2002 Strong Memorial Hospital, Rochester
Project Link

2001 Canton-Potsdam Hospital/Claxton-Hepburn Medical Center, Potsdam and Ogdensburg
St. Lawrence County Health Initiative

2000 Harlem Hospital Center, New York City
Injury Prevention Program

1999 Women's Christian Association Hospital, Jamestown
Women's Health Initiative

1998 United Health Services, Binghamton
Pediatric Asthma Program

1997 St. Mary's Hospital/Unity Health System, Rochester
HealthReach Program

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