CONNECTING WITH COMMUNITIES:

COMMUNITY HEALTH INITIATIVES ACROSS NEW YORK STATE

HANYS®
Always There for Healthcare

2021 EDITION

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*, demonstrate leadership, collaborate among diverse groups and, most importantly, achieve quantifiable results.

THANK YOU TO OUR 2021 REVIEWERS:

Sylvia Pirani (retired), former director, Office of Public Health Practice, NYSDOH

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

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Connecting with Communities: **Community Health Initiatives** Across New York State

2021 Edition

HANYS is pleased to present the 25th edition of *Connecting with Communities: Community Health Initiatives across New York State*. This publication highlights the winner and nominations for HANYS' 2021 Community Health Improvement Award.

HANYS' Community Health Improvement Award recognizes member hospitals and healthcare systems for engaging key community stakeholders to implement programs to 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* vision is to make New York the healthiest state for people of all ages; it serves as a blueprint for local community health improvement. Hospitals and health systems will continue to be leaders in improving community health across the state.

Due to the COVID-19 pandemic, many hospitals had to put their existing community health initiatives on hold or take a different direction. Many of the initiatives in this publication described what hospitals have done to address the effects of COVID-19 in their community. HANYS commends hospitals for their community health efforts during this challenging time.

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

For 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.

Northwell Health

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

INITIATIVE DESCRIPTION AND GOALS

Northwell Health's large-scale COVID-19 testing and vaccination deployments in vulnerable communities address the New York state *Prevention Agenda* priority area of preventing communicable diseases, focusing on reducing COVID-19 infection rates and increasing vaccination rates to improve community health and safety.

Northwell leveraged its vast network and strong emergency response capabilities, in collaboration with government agencies and trusted community leaders, to deliver large-scale COVID-19 testing and vaccination deployments in vulnerable communities. Northwell's innovative model combined emergency preparedness, deployment expertise, grassroots disbursement of educational materials and innovative technology to help bridge the digital divide.

Northwell's model for testing and vaccination focused on fostering trust and collaboration in communities where this often does not exist in relation to healthcare, along with the innovative use of technology — most notably, artificial intelligence chatbots — for the rapid delivery of test results, educational materials and follow-up information.

PARTNERS

Office of Governor Andrew Cuomo, Nassau County, Suffolk County, Town of Hempstead, Heath Equity Taskforce (comprised of more than 100 community and faith-based leaders across Nassau and Suffolk counties and Tribal Nations leaders), Adelante, Association for Mental Health and Wellness, Choice for All, Dejana Foundation, Family and Children's Association, Family Service League, Health and Welfare Council, Hempstead Hispanic Civic Association, Hispanic Counseling Center, Interfaith Nutrition Network, Long Island Coalition for the Homeless, Long Island Federally Qualified Health Center, Long Island NAACP, OLA of Eastern Long Island, Project Hope, Sun River Health FQHC and United Way of Long Island

OUTCOMES

- COVID-19 testing was conducted at about 100 faith- and community-based sites, reaching nearly 85,000 underserved community members, resulting in a sharp reduction of infection rates.
- More than 500,000 COVID-19 vaccines were administered to 250,000 community members at over 100 locations, including faith- and community-based sites.
- The Heath Equity Taskforce meets regularly to discuss education, outreach and community planning, to help ensure equitable vaccine distribution. Vaccination distribution events have been held at more than 60 locations identified by the taskforce.

LESSONS LEARNED

Northwell learned it cannot accomplish advancements in health equity independently. Partnerships with trusted community leaders were critical to the initiative's success. Additionally, the pandemic illuminated a longstanding issue: many people remain without access to the internet or lack internet literacy. Through this work, Northwell learned first hand that you must take into consideration the digital divide to successfully reach communities.

SUSTAINABILITY

The sustainability of the work that Northwell has done is facilitated by the organization and its vast network of partners, including the Health Equity Taskforce, which will continue to focus on addressing key community needs that have been exacerbated by the pandemic, such as mental health and trauma, food insecurity, youth programming and employment. Northwell's model has developed into a toolkit that will be adapted for use to address future public health crises.

FOR MORE INFORMATION

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2021 Community Health Improvement Award
Nominated Profiles

1. **Bassett Healthcare Network**
   CDHC Growth and Expansion in the Bassett Healthcare Network

2. **Bassett Medical Center–New York Center for Agricultural Medicine and Health**
   John May Farm Safety Fund

3. **Cancer Services Program of Warren, Washington and Hamilton Counties at Glens Falls Hospital**
   Colorectal Cancer Screenings of Uninsured

4. **Catholic Health Good Samaritan Hospital**
   Good Samaritan and Town of Islip–Brentwood COVID-19 Testing

5. **Claxton-Hepburn Medical Center**
   Lions Diabetes Education Suite

6. **Ellenville Regional Rural Health Network**
   Ellenville Regional Cardiac Wellness Program

7. **Erie County Medical Center**
   COVID-19 At-risk Community Education and Testing Program

8. **Long Island Community Hospital**
   COVID-19 Vaccination Clinics

9. **Mount Sinai South Nassau**
   Vaxmobile

10. **NewYork-Presbyterian Queens**
    Caring for Queens: A Hospital-Community Partnership to Improve Community Health

11. **NewYork-Presbyterian Queens**
    Just Breathe: Integrating Technology to Improve Outcomes in Pediatric and Young Adult Asthma

12. **Rochester Regional Health–United Memorial Medical Center**
    LEAD Program (Lactation Education After Discharge)

13. **Saint Joseph's Medical Center**
    Saint Joseph's Family Health Center Forms Innovative Partnerships to Address Food Insecurity

14. **St. Mary's Healthcare**
    Cancer Prevention in Action

15. **St. Peter's Health Partners**
    The Butt Stops Here Smoking Cessation Virtual Program

16. **White Plains Hospital**
    White Plains Hospital Food Distributions and Food Pharmacy

Bassett Healthcare Network

CDHC Growth and Expansion in the Bassett Healthcare Network

INITIATIVE DESCRIPTION AND GOALS

The American Dental Association established the community dental health coordinator role to bridge the gap between patients in need of dental care and existing community oral health resources. Employing a CDHC, Bassett created an organizational and operational blueprint for patient outreach and care coordination, education and establishment of dental homes for a rural, underserved population.

The overarching strategy of the New York state *Prevention Agenda* is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. Bassett's CDHC program aligns with the *Prevention Agenda* priority area to promote healthy women, infants and children; in particular, the goal to reduce dental caries among children. It is undeniable that access to routine dental care reduces and prevents chronic disease through preventive care and management, teaches healthy eating habits and prevents the use of tobacco.

PARTNERS

Through partnerships with its hospital emergency departments, primary care practitioners, insurance navigators and community dental practices, Bassett developed workflows and relationships needed to carry out the highly individualized, very time-consuming work of establishing dental homes for the underserved, ultimately linking patients to resources that improve individual and population oral health.

OUTCOMES

The CDHC program was established in February 2020. With the onset of COVID-19, access to care was severely limited for key populations. Even with these significant limitations, this program was able to help 43 patients establish dental homes. Thirty-seven of these patients attended their first appointment, 35 were referred to pediatric dental services and 16 were referrals from emergency departments, which resulted in a 3.6% decrease in repeat emergency room visits.

LESSONS LEARNED

Collaboration between private practice dentists and their counterparts in community health centers is an important part of any long-term strategy to improve access to healthcare for underserved populations. Lack of dental providers participating with Medicaid or state dental insurances contributes to poor dental health. Understanding how patients respond to care options will help Bassett learn how to partner other health providers.

SUSTAINABILITY

As the patient population grows by referrals and increased access to care, the dental services department's revenue will increase through insurance reimbursement, increased efficiency and decreased expenditures for costly and complicated procedures.

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Bassett Medical Center – New York Center for Agricultural Medicine and Health

John May Farm Safety Fund

INITIATIVE DESCRIPTION AND GOALS

Agricultural workers experience among the highest rate of work-related fatalities and injuries in the country, compared to workers in other industries. Farmers also suffer from elevated rates of occupationally-driven health disorders such as chronic obstructive pulmonary disease and arthritis. To address the high rates of occupational injury and health problems in this population, John May, MD, created the New York Center for Agricultural Medicine and Health in the early 1980s along with his Bassett colleague, David Pratt, MD. NYCAMH offers a combination of safety training, technical expertise, occupational healthcare and tailored interventions for keeping farmers safe.

Given the slim profit margin in farming, it is difficult for farmers to invest in safety improvements, despite the substantial reductions in risk that they could ensure. In response, NYCAMH launched the John May Farm Safety Fund to provide cost-sharing and technical expertise to farms interested in making necessary safety improvements. Projects have tackled key factors that typically drive injury on farms. These include addressing livestock handling systems to prevent the severe injuries or deaths that can ensue when handling large animals, making electrical repairs to prevent barn fires and electrocution and establishing eye-wash stations to address exposures to toxic chemicals.

The program has been an incredible success and meets many of the New York state *Prevention Agenda* objectives, such as preventing chronic diseases, promoting a safe and healthy environment, promoting well-being and preventing communicable diseases.

PARTNERS

C. J. Heilig Foundation, Friends of Bassett, New York State Agriculture and Markets, New York State Farm Bureau, Northeast Organic Farming Association, Center for Agricultural Development and Entrepreneurship and Cooperative Extension

OUTCOMES

- On-farm safety inspections were initiated and improvements were made on 141 small and mid-size farms.
- There is increased interest from the farm community in making safety investments — a four-fold increase in applicants since the program was launched in 2016.

LESSONS LEARNED

- To improve the health and safety of at-risk populations, organizations must be willing to invest time and money into assisting with vital improvements.
- Dedication to providing a 100% positive experience with health improvement programs is vital to maintaining interest.

SUSTAINABILITY

Given the success and interest in the program, NYCAMH will continue to work with donors and state agencies like Agriculture and Markets to ensure funding for cost-sharing safety project rebates is maintained. To promote and fund the program, NYCAMH began by reaching out to local philanthropic organizations, such as the C. J. Heilig Foundation and the Community Foundation for South Central NY.

The pilot was successful and NYCAMH project staff began reaching out to other potential funders to continue to raise funds to cost-share safety program projects approved through the program. The Friends of Bassett fundraising team raised substantial funds for the program through Bassett's annual fundraising gala event in the early years of the program. The program currently has sufficient funding to maintain operations into 2022 and is working to ensure future funding for John May Farm Safety Fund project rebates.

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Cancer Services Program of Warren, Washington and Hamilton Counties at Glens Falls Hospital

Colorectal Cancer Screenings of Uninsured

INITIATIVE DESCRIPTION AND GOALS

The Cancer Services Program of Warren, Washington and Hamilton Counties has successfully worked with healthcare providers to put a system into place to remind individuals of their colon cancer screenings that are due. The program initiates follow-up calls to individuals due for their screens and to educate the patient at the same time as to why these screenings are so important. The initiative has worked with local radio stations and newspapers to spread the message and make the public aware of the need for screenings. The program has removed barriers such as time needed for screenings and cost so that individuals can perform necessary colon cancer screenings in their own home (FIT test) if they meet low-risk criteria, and at no cost.

The Cancer Services Program of Warren, Washington and Hamilton Counties initiative is related to the New York state *Prevention Agenda* priority to increase cancer screening rates.

PARTNERS

Glens Falls Finance Department, Hudson Headwaters Health Network, Glens Falls Hospital Medical Centers, GI Associates and Irongate Family Practice

OUTCOMES

- Colorectal screenings by FIT test increased by 30%.
- The return rate of FIT tests back for processing increased from 40% to 87%.
- Colorectal screenings in men age 50 and over increased 57%.

LESSONS LEARNED

- By making the instructions easy to understand at any reading level, clients were more likely to complete the FIT test sent to them.
- Following up with the client to help with any questions they may have along the way was also a crucial step. This helped clients who may have had questions and were hesitant to reach out to the Cancer Services Program.

SUSTAINABILITY

The changes the Cancer Services Program made to the practice of distributing FIT kits and communication with clients and providers have been made standard operating procedure. This program is embedded with the CR Wood Cancer Center at Glens Falls Hospital and will continue to provide services with the full support of Glens Falls Hospital.

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Catholic Health Good Samaritan Hospital

Good Samaritan and Town of Islip–Brentwood COVID-19 Testing

INITIATIVE DESCRIPTION AND GOALS

Identified by the New York State Department of Health as a hot spot for COVID-19, Brentwood and its surrounding communities need preventive health measures for their high percentage of underinsured and uninsured residents. The drive-through Brentwood testing site was set up to increase testing and tracing of COVID-19 and provide health and wellness education throughout the pandemic.

PARTNERS

Catholic Health Good Samaritan physician assistants, nurses and pathology; the Town of Islip; the Town of Islip Community Development Agency; and the Brentwood Rotary Club

OUTCOMES

- The Brentwood testing site provided 2,131 tests through May 2021, of which 248 detected COVID-19, an overall positivity rate of 12%.
- The testing site addressed the need for testing in Brentwood and its surrounding communities. Data show that 41% of tests were for Brentwood residents, 20% for Bay Shore and 9% for Central Islip — the closest neighboring towns.
- Of the overall number of 2,131, 10% (210 people) continued to come to the site for repeat testing to keep themselves and others safe moving through the pandemic.

LESSONS LEARNED

The Brentwood testing site assisted in efforts to reduce the positivity rate of COVID-19. In March 2021, the positivity rate was 15%. Through education, testing and tracing in May 2021 the rate was reduced to 2%. The number of tests decreased due to more residents being tested and traced, education of guidelines and the availability of COVID-19 vaccines.

SUSTAINABILITY

In the event of any future waves of COVID-19 or another pandemic, both Good Samaritan and the Town of Islip now have the experience and skill to mobilize a similar screening operation quickly and efficiently, allowing them to assist the community faster during their time of need.

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Claxton-Hepburn Medical Center

Lions Diabetes Education Suite

INITIATIVE DESCRIPTION AND GOALS

Claxton-Hepburn Medical Center bases its diabetes education programming on yearly community health assessments completed with its partners, Behavioral Risk Factor Surveillance System data, payer data and data collected by the state and referral trends. The program interventions are evidence-based practices and provide a place where families and people of all ages can find resources and solid education to help them be the healthiest person they want to be.

The work Claxton-Hepburn Medical Center does through its diabetes services ties directly to the New York state *Prevention Agenda* priority area to prevent chronic disease action and correlates with the focus areas of healthy eating and food security, physical activity and chronic disease prevention and management.

PARTNERS

Lions Club International, CDC, Stanford University, St. Lawrence Health Initiative, New York State Office for the Aging, North Country Initiative, Fort Drum Regional Planning Organization and the University at Albany's Quality and Technical Assistance Center

OUTCOMES

- Patients who were seen by Claxton-Hepburn educators dropped their A1c value by 1.45 percentage points on average and 49% of participants have A1Cs below 7%.
- Patients with A1c values greater than 9% decreased by an average of 2.9 percentage points and 71% are below the National Committee for Quality Assurance target of 8%.
- Since 2014, when CHMC started its first diabetes education program, Claxton-Hepburn has helped participants shed more than 1,800 pounds.

LESSONS LEARNED

Adequate staffing is vital to the success of any patient outreach program. Keeping up with the standards for each program and the administrative duties, as well as teaching and patient one-on-one time can be overwhelming when the program is understaffed, especially during times like the COVID-19 pandemic. As far as planning and future expansion, dream big and always think outside the box when planning.

SUSTAINABILITY

Since receiving a Lions International grant award, the program received several smaller grants that are used for materials and to add additional programming, like the new $25 Feeds 5 whole food cooking program. Claxton-Hepburn's foundation is working on other grants and, with support from friends of the hospital and local donors, the hospital hopes to expand the suite to include the teaching kitchen and multipurpose activity room.

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Ellenville Regional Rural Health Network

Ellenville Regional Cardiac Wellness Program

INITIATIVE DESCRIPTION AND GOALS

The goal of the Ellenville Regional Rural Health Network's Cardiac Wellness Program is to reduce the disparate rate of cardiovascular disease and other chronic health conditions in the community of Wawarsing by using the evidence-based community health worker model. Ellenville Regional Rural Health Network has put forth a wellness program that aligns with the New York state *Prevention Agenda* priority area, prevent chronic diseases.

This priority area is being addressed through the goals of ensuring that every community member in the medically underserved Wawarsing community who is at risk of developing cardiovascular disease has access to a community health worker at no cost. It is the responsibility of the CHW to help these at-risk individuals navigate the existing health services in Wawarsing and help them overcome the social determinant of health barriers that restrict their ability to lead healthy lives. This is done through one-on-one work between the CHW and the at-risk individual and through open classes and programs available to all members of the Wawarsing community.

PARTNERS

Ellenville Regional Hospital, The Institute for Family Health, Ulster County Department of Health and 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, Catholic Charities Community Services of Orange, Sullivan and Ulster, The Food Bank of The Hudson Valley, Ulster County Correctional Facility, Rondout Valley Growers Association and Planned Parenthood of Greater New York

OUTCOMES

- Since 2019, the Cardiac Wellness program has provided no-cost calcium score CAT scans to 442 people and carotid ultrasounds to 242 people, far exceeding the goal of 100 over a three-year period.
- In 2019, instructional physical activity classes, self-care classes and support groups offered by ERRHN were accessed just over 2,000 times by 567 individuals.
- The program's "Farm-acy" provided 950 bags of produce to families in 2019, up from 703 bags in 2020.

LESSONS LEARNED

An important lesson learned throughout implementation of the Cardiac Wellness Program is that participation and collaboration between many agencies is a key factor to reach the largest number of community members possible in a meaningful way. In addition, the ability to cater and adapt the program to the needs of each specific group of the target population is important when trying to keep the community engaged and stimulated.

SUSTAINABILITY

The ERRHN plans to sustain and expand this program through grants and is exploring the future of billing for preventive services as the value-based care environment evolves. The program will also adapt and change as new health disparities emerge and a greater need for different focuses arises.

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Erie County Medical Center

COVID-19 At-risk Community Education and Testing Program

INITIATIVE DESCRIPTION AND GOALS

In June 2020, during the height of the COVID-19 pandemic, ECMC developed an initiative to support efforts led by faith-based and community-based organizations with Delivery System Reform Incentive Payment funds to provide reliable, trustworthy information on the pandemic while broadening opportunities for COVID-19 testing in at-risk, poor communities in Western New York. The purpose was to eliminate myths connected to the pandemic, while simultaneously urging citizens to take necessary preventive measures (e.g., masking, hand hygiene and social distancing) and to get tested for the virus as quickly as possible.

PARTNERS

Community Health Center of Buffalo, ECMC Family Health Center, Evergreen Health, Jericho Road, Kaleida Health, Neighborhood Health Center, Niagara Falls Memorial Medical Center, Rapha Family Wellness Center, The Chautauqua Center and Urban Family Practice

OUTCOMES

- More than 25,000 telephone calls were made to area residents. The call centers referred 135 people to behavioral healthcare at Endeavor Health Services, introduced 154 people to local primary care practices, enrolled 154 people in health insurance and helped 640 people get tested for COVID-19.
- Contactless food delivery was provided to 3,635 families in their homes.

LESSONS LEARNED

Committed, like-minded institutions can come together, even with finite funding, and make a positive impact on the health and welfare of at-risk residents.

SUSTAINABILITY

The ability to sustain vital programs such as this depend on support from key federal and state partners.

FOR MORE INFORMATION

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Long Island Community Hospital

COVID-19 Vaccination Clinics

INITIATIVE DESCRIPTION AND GOALS

The COVID-19 vaccination program at Long Island Community Hospital was initiated to prevent the spread of COVID-19 and protect frontline workers and the community from this deadly virus. This initiative aligns with the New York state *Prevention Agenda* priority area of preventing chronic disease, with the primary focus on chronic disease preventive care and management.

COVID-19 not only affects those with chronic disease at a higher rate, but can also cause new chronic illnesses. By vaccinating as many people as possible, LICH helped achieve its *Prevention Agenda* goals, and by providing the vaccinations to at-risk members of the community and frontline workers, LICH promoted and supported wellness by preventing chronic illnesses.

PARTNERS

New York State Department of Health, Suffolk County Fire, Rescue and Emergency Services, South Country Ambulance, Suffolk County Community College and St. Joseph's College

OUTCOMES

A point-of-dispensing plan was created for mass vaccination of the external population within the facility, with a safe and direct means of access and egress from an outside entrance. The vaccine team provided an effective clinic with the ability to vaccinate up to 418 individuals a day, successfully administering 16,100 vaccines, of which 7,122 went to members in priority areas, making the vaccine accessible to vulnerable and marginalized populations.

Using social media communications, LICH engaged its target population with 390,000 total posts viewed and 7,300 click-throughs from April 1, 2020 to May 1, 2021. By rapidly communicating the availability of vaccine, appointments filled in record time: 400 in a 10-minute timeframe.

LESSONS LEARNED

LICH's internal POD plan needed to change to accommodate more patients, allow for more effective use of limited personnel resources and include volunteers from both inside and outside the organization to ensure the team could vaccinate as many people as possible. LICH's social media platforms, website and email were the most efficient and cost-effective methods of making the public aware of vaccine availability.

SUSTAINABILITY

The process of creating a POD for external use can be applied to any community crisis moving forward. The template can be recreated to accommodate both external and internal emergency vaccination and preventive care. Policies and procedures are integrated into LICH's emergency management program and can be activated for the next incident with confidence by both the staff and the community.

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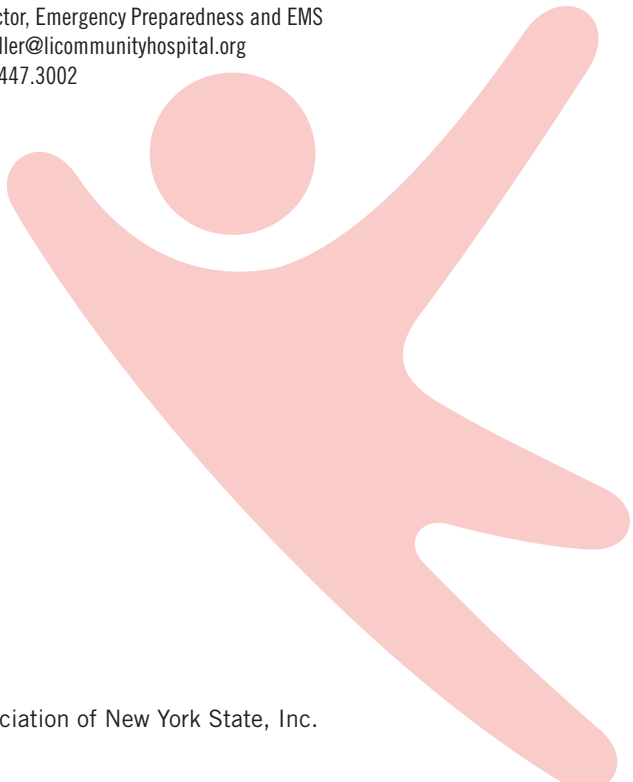

Mount Sinai South Nassau

Vaxmobile

INITIATIVE DESCRIPTION AND GOALS

In late March, Mount Sinai South Nassau and the Town of Hempstead launched the region's first COVID-19 vaccination mobile unit. Dubbed the "Vaxmobile," the bus was funded with CARES Act money the town received to provide relief for unbudgeted, COVID-19-related expenses. The primary mission of the mobile vaccine program was to reduce transportation, language and technology barriers to vaccination and bring one-dose vaccines directly to hard-hit communities.

In its first four months, the Vaxmobile delivered more than 3,500 vaccines to residents in more than a dozen communities in the Town of Hempstead. The vaccinations are administered primarily outdoors in a seamless, drive-up setting. Immobile patients stay in their cars to receive the immunization. Following immunization, patients remain at the vaccination site for observation for 15 minutes.

Mount Sinai South Nassau and the town communicated directly with community leaders to schedule visits to convenient and trusted locations, including faith-based organizations, recreation centers, senior centers, parks and train stations. Initially, all vaccines administered at the mobile site were by appointment, but as vaccine availability and supply increased, the Vaxmobile began accepting walk-ins. The handicap-accessible bus is staffed by a bilingual clinical team from Mount Sinai South Nassau. Translation services are offered at every stop.

This initiative addresses the New York state *Prevention Agenda* priority area, prevent communicable diseases.

PARTNERS

Schools: De LaSalle, Freeport, Baldwin, Elmont, Hempstead, Lynbrook, Oceanside, Rockville Centre, Seaford and Wantagh; *Churches/religious groups:* St. Mary of the Isle Roman Catholic, Long Beach, Our Lady of Good Counsel, Inwood, Assembly of God, Hempstead and Young Israel of Woodmere; *Civic groups:* Hispanic Brotherhood, Sandel Senior Center, MLK Center of Long Beach, United Healthcare of Hempstead, Seaford Kiwanis, Elmont Kiwanis, Town of Hempstead senior centers, Five Towns Community Center, Freeport Recreation Center and Rockville Centre Recreation Center; *Town and village halls:* East Rockaway and Island Park

OUTCOMES

- More than 3,500 vaccines have been administered to date.
- Of those 3,500, approximately 700 vaccines were given to children ages 12 to 17 and more than 400 seniors were inoculated.

LESSONS LEARNED

- Mount Sinai South Nassau learned the importance of involving all of the hospital's teams.
- It is critical to have community partners at each site.

SUSTAINABILITY

Mount Sinai South Nassau plans to deploy the mobile unit to advance community health education and screening for other diseases. Ideas include screening for blood pressure, body-mass index, diabetes, prostate-specific antigen and routine blood testing.

FOR MORE INFORMATION

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NewYork-Presbyterian Queens

Caring for Queens: A Hospital-Community Partnership to Improve Community Health

INITIATIVE DESCRIPTION AND GOALS

The Robert Center for Community Health Navigation was launched in January 2020 with a clear focus on chronic disease prevention and those social determinants of health that interfere with disease self-management. The RCCHN aims to empower patients to navigate the health-care system, to connect to care and to access resources at NewYork-Presbyterian Queens and in local communities to address clinical and social needs.

In partnership with Make the Road New York and Public Health Solutions, a community health worker program was implemented to serve as a bridge between the hospital and community for patients in need of additional support to manage their chronic diseases. In the local emergency department, a patient navigator program was developed to support patients who frequent the ED because they are not well connected to care. Six bilingual practical nurses were hired to deliver culturally-sensitive education and support, to connect patients to health insurance and financial resources and to schedule primary and specialty care appointments. In response to the urgent need for access to food, NewYork-Presbyterian Queens' Choosing Healthy and Active Lifestyles (CHALK) program further engaged partners to enhance and coordinate local food distribution efforts.

PARTNERS

Make the Road New York, Public Health Solutions and Westside Campaign Against Hunger

OUTCOMES

- *Practical nurses:* Between February 2020 and March 2021, 1,193 patients were supported by six practical nurses. Among patients without a primary care provider, 98% had a primary care provider and appointment upon discharge. For those patients with appointments scheduled by the PNs, 84% attended the follow-up appointment.
- *CHWs:* Between March 2020 and March 2021, four community health workers made 826 wellness check calls and addressed urgent needs including access to food, technology support, housing and access to medication refills.
- *Food insecurity:* Between July 31, 2020 and March 19, 2021, 513,000 pounds of healthy food was distributed to nearly 4,000 unique households and 16,369 individuals.

LESSONS LEARNED

When COVID-19 struck Queens, the solid hospital-community partnership foundation between NYP Queens and local community-based organizations enabled them to respond quickly and effectively to ensure that community residents received the urgent care and support needed. This would not have been possible at this scale had these trusted relationships not already been established.

SUSTAINABILITY

The RCCHN is currently funded by private donors and NYP Queens has committed to provide long-term support. The CHALK food insecurity efforts are funded by NYP.

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NewYork-Presbyterian Queens

Just Breathe: Integrating Technology to Improve Outcomes in Pediatric and Young Adult Asthma

INITIATIVE DESCRIPTION AND GOALS

Patients were engaged in a pilot to determine if using care management strategies and Bluetooth technology would increase medication adherence and reduce hospital utilization for NewYork-Presbyterian Queens Asthma Center patients. Interventions included: patient care directed by a pulmonologist, use of smart medication Bluetooth inhaler sensor devices, remote patient monitoring, education, home visits including environmental home assessments and distribution of asthma trigger reduction items and educational materials.

The target population was patients with moderate to severe asthma, including those who had at least one ED visit or hospitalization within a year and/or those who were prescribed a corticosteroid and/or rescue inhaler. The pilot ran January 2019 to May 2021. The majority of patients were non-English speaking, received coverage through Medicaid and lived in Queens.

Pilot goals were to:

- sustain and expand collaboration among existing and new partners;
- reduce potentially avoidable ED visits and hospitalizations due to preventable asthma exacerbations;
- remediate and reduce environmental asthma triggers in patient homes;
- educate providers and care managers on tools and workflow for patient engagement and monitoring;
- encourage patients to become self-adherent to the medication regimen; and
- increase patient and provider satisfaction.

Several New York state *Prevention Agenda* priority focus areas and goals were linked including preventing chronic diseases, promoting a healthy and safe environment, promoting healthy women, infants and children and fostering well-being.

PARTNERS

St. Mary's Home Care and the Asthma Coalition of Brooklyn, Queens and Staten Island

OUTCOMES

- Twenty-six patients referred, three re-referred, 20 enrolled and 20 completed six months of monitoring.
- Achieved 81.2% overall medication adherence against a target of 75%.
- Zero program-enrollee hospitalizations for asthma.
- Significantly improved Asthma Control Test scores for nine patients — some improving from 10-11 to 23-24.
- 100% patients/caregivers increased understanding of asthma self-management.
- Four potential ED visits avoided with RPM medication alerts triaged by St. Mary's and referring physician.
- Thirty-nine home remediation items distributed.

LESSONS LEARNED

A few times a patient's Wi-Fi was off or spotty — this requires additional nursing intervention. Re-education on device-use and self-management helped. Translation services and flexibility scheduling lengthy in-home visits, especially during COVID-19, requires provider patience and persistence.

SUSTAINABILITY

Positive results captured the interest of community providers and proved that savings from preventable ED visits and hospitalizations outweigh device and maintenance costs. COVID-19 has proven that telehealth is a viable method of keeping patients safe and healthy at home when used in combination with nursing visits and physician contact. Insurance companies are expected to soon fund RPM services at sustainable rates.

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Rochester Regional Health–United Memorial Medical Center

LEAD Program (Lactation Education After Discharge)

INITIATIVE DESCRIPTION AND GOALS

Rochester Regional Health–United Memorial Medical Center's LEAD program offers free one-on-one lactation counseling and education, a 24-hour lactation messaging line and extended Babycafe evening hours for moms returning to work to access lactation consultant expertise. Additionally, LEAD provides an "Adjustment to Motherhood" peer support group that includes resources for perinatal mood and anxiety disorders.

This program aligns with the New York state *Prevention Agenda* focus areas for perinatal and infant health and increasing breastfeeding, using interventions like increasing access to peer and professional support.

PARTNERS

Locally, the hospital worked with WIC, Genesee County Mental Health, Three Little Birds Pediatrics, MOMS Program and other local pediatricians and mental health professionals. Postpartum Support International supplied resources and a directory for providers that specialize in perinatal mood and anxiety disorder.

OUTCOMES

- LEAD offers one-on-one outpatient lactation services regardless of age, race or socioeconomic status.
- The Adjustment to Motherhood peer support group helps address new mom struggles with a focus on PMADs.
- Accessibility to lactation consultants increased via the Babycafe by offering evening hours for return-to-work mothers.
- LEAD reached out to over 600+ new mothers, 200+ used at least one service offered and about 25% of those moms used a repeated service.

LESSONS LEARNED

The medical center learned that working within a larger health system takes patience, flexibility and perseverance, especially when introducing a new program. Starting a new program during the pandemic presented even more challenges. With the office closed, the program had to meet mothers where they were. This just happened to be at home. LEAD quickly transitioned to virtual care to accommodate that need.

SUSTAINABILITY

Currently the medical center is working with its billing department to look at options to bill for outpatient lactation services. In the meantime, the program has reached out to other grantors for sustainability because this is a very useful and needed program within the community.

FOR MORE INFORMATION

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Saint Joseph's Medical Center

Saint Joseph's Family Health Center Forms Innovative Partnerships to Address Food Insecurity

INITIATIVE DESCRIPTION AND GOALS

Saint Joseph's Medical Center developed an onsite food pantry at its health center, a project that was born out of the realization that the monthly emergency mobile food distribution the hospital offered in partnership with Feeding Westchester was not enough to sustain or reach all patients in need.

Through this initiative the medical center is able to identify food-insecure patients, offer them healthy food they can leave the office with and have a discussion about nutrition. The health center is able to serve the community in ways that affect people outside the hospital doors, improving the health of patients and the community.

Patients can look to Saint Joseph's Medical Center to address not only their medical issues, but the social issues that affect them in the community as well. With healthcare and chronic disease, St. Joseph's understands that the more time they have with their patients, the more successful they will be with their health outcomes. The Saint Joseph's team also hopes this initiative will bring more opportunities to serve others in the community who might not otherwise have walked through the hospital doors — because your own health takes a back seat when you are struggling to feed your family.

This initiative aligns with the New York state *Prevention Agenda* focus area, healthy eating and food security, with an overarching goal to reduce obesity and the risk of chronic disease.

PARTNERS

Feeding Westchester, Charter School of Educational Excellence and the devoted staff at Saint Joseph's Family Health Center

OUTCOMES

- The Family Health Center distributes 750 pounds of food each month to registered patients.
- To date, since its inception in July 2020, the mobile food distribution site at the hospital and food pantry in the Family Health Center have met the food insecurity needs of 5,292 individuals and 873 households.
- Staff engagement and satisfaction have improved.
- Through this program, Saint Joseph's is also educating students on healthy eating, community needs and the rewards of community service.

LESSONS LEARNED

- Saint Joseph's learned that its community has been dealing with a high level of food insecurity. The number of patients screening positive on the social determinants of health questionnaire has been eye-opening. The staff and the providers have learned to take the time and to ask questions in a different way, not just to check off a box.
- Patients have learned that Saint Joseph's mission and dedication to the community reaches beyond its doors. In turn, this has increased patients' compliance with care.

SUSTAINABILITY

This project is sustainable because Saint Joseph's staff and the community partners are invested. Working together, this project is strong and has become part of the workflow in the health center. The partnership with Feeding Westchester includes monthly reporting that identifies trends, changes in community needs and who the program is serving by age, household size, etc. This valuable information enables Saint Joseph's to adapt to the changing needs of the community.

FOR MORE INFORMATION

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St. Mary's Healthcare

Cancer Prevention in Action

INITIATIVE DESCRIPTION AND GOALS

Through the Cancer Prevention in Action program, St. Mary's Healthcare brings cancer prevention education, resources and practices to local communities. Since 2018, the CPiA program has worked throughout Fulton, Montgomery and Schenectady counties, promoting local policy, systems and environmental changes that take action against cancer.

CPiA assists community partners in the adoption of their own policies to promote sun safety and prevent skin cancer within their organizations and within the community. This program is actively increasing the adoption of sun safety policies and practices in community settings where residents live, work and play.

CPiA aligns with New York state *Prevention Agenda* goals by promoting the use of evidence-based care to manage chronic diseases.

PARTNERS

Amsterdam Head Start, Busy Bear Daycare, Canajoharie Head Start, City of Amsterdam–Outdoor Recreation, City of Amsterdam–Outdoor Worksite, City of Gloversville, Creative Connections Clubhouse, Creative Minds Childcare, Fort Plain Head Start, Fulmont Community Action Agency–Early Childhood Services, Fulmont Community Action Agency–Energy Services, Girls Inc., Gloversville Head Start, Grow Amsterdam, Ladybug Daycare, St. Mary's Institute and Oppenheim-Ephratah–St. Johnsville Head Start

OUTCOMES

- Through community partnerships and adoption of sun-safety policies, the CPiA team has been able to reach 121,116 local residents within Fulton, Montgomery and Schenectady counties since 2018.
- CPiA has successfully submitted and participated in a total of 140 media placements, 77 decision maker meetings, 86 education events, 22 cancer prevention policies passed and 25 installations of sun-safety materials.

LESSONS LEARNED

- St. Mary's Healthcare found creative ways to continue CPiA efforts throughout the COVID-19 pandemic. These efforts to continue providing preventive services to the community include shifting to online education, virtual meetings and socially distant interactions.
- While individuals can practice sun-safety prevention on their own, the CPiA initiative has demonstrated that making changes to the community environment, workplaces, schools and outdoor parks can help make a lasting impact for all.

SUSTAINABILITY

CPiA is a five-year, New York state grant-funded initiative that uses a policy, systems and environmental change approach to prevent and reduce the risk of cancer in New York communities. This program has been sustained through its strong community partnerships along with its online web presence to inform partners and the community on the services available to take action against cancer.

FOR MORE INFORMATION

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St. Peter's Health Partners

The Butt Stops Here Smoking Cessation Virtual Program

INITIATIVE DESCRIPTION AND GOALS

For many years, St. Peter's Health Partners offered an in-person smoking cessation program throughout the greater Capital District. Developed in 2001, The Butt Stops Here has helped many thousands break free from nicotine dependence.

In April 2020, as a result of COVID-19, SPHP formed a partnership with several community providers and pivoted The Butt Stops Here to a new, online format, called the Virtual Butt Stops Here. The VBSH addresses key objectives of the New York state *Prevention Agenda:* to increase the percentage of smokers who receive assistance from their healthcare providers and to decrease the prevalence of cigarette smoking by adults in general and, specifically, adults living with disabilities:

- SPHP identified (via electronic medical records) current tobacco-using patients in SPHP's medical group practices and sent them concise messages about VBSH via email or text. This greatly increased program enrollment.
- SPHP's partnership includes the Independent Living Center of the Hudson Valley, whose extensive knowledge and experience in assisting people living with disabilities has helped SPHP in myriad ways.
- The online format has also enabled a large number of typically underserved rural community members to participate.

PARTNERS

MVP Healthcare, Ellis Medicine, Independent Living Center of the Hudson Valley, The Community Foundation for the Greater Capital Region, St. Joseph's Health and CDPHP

OUTCOMES

- In one year, more than 1,100 smokers enrolled in VBSH, compared to approximately 50 the previous year for the in-person BSH program.
- Most attendees reported they had either quit (30.8%) or reduced (39.7%) their smoking. Another 10.3% stated they quit smoking but started again.
- Nearly 20% of those who registered did so because their healthcare provider recommended it. This response includes the possibility that providers felt the patient needed such a program or that the individuals asked their provider to help them quit.

LESSONS LEARNED

- *Cost:* The planning team considered what, if anything, to charge participants. After much discussion, the team decided to cover the program's costs — not an insignificant decision: 48% of those who registered said they did so because it was free.
- *Medical community:* Healthcare providers who intervene with smokers can have a positive impact. Brief interaction can make it much more likely that a patient will attempt to quit. Nearly 20% said a healthcare provider's recommendation was key to their registering for the program.

SUSTAINABILITY

The BSH program has been in existence for more than 20 years, with various forms of funding supporting it throughout. Though funding has waned over time, SPHP has found ways to make the program sustainable by advocating for health plan coverage, enlisting employed staff to run group sessions during their workday and partnering with local organizations that are able to support some of the program costs. The combination of these factors will enable the continued existence of this program for future years.

FOR MORE INFORMATION

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White Plains Hospital

White Plains Hospital Food Distributions and Food Pharmacy

INITIATIVE DESCRIPTION AND GOALS

Westchester County was one of the first areas in the country to be hit by the COVID-19 pandemic in March 2020. With rising unemployment rates, food insecurity skyrocketed and doubled from the previous year. Partnering with Feeding Westchester, White Plains Hospital set up socially-distanced drive-through and walk-up stations in a parking lot across from the hospital early one Saturday morning in May. Hundreds of people showed up for a bag of donated food, illustrating the extent of the food insecurity problem in the community. Hospital volunteers handed out bags and slipped groceries in car trunks. White Plains Hospital hosted multiple food distributions between May and June and provided thousands of families with fresh vegetables and canned goods.

It was the genesis for a more formalized and ongoing approach to dealing with food insecurity in the community: "The Food Pharmacy" at White Plains Hospital's Family Health Center. Individuals who are food insecure are disproportionately affected by chronic diseases. By housing the pantry onsite, the hospital is able to routinely address myriad health issues, in alignment with the New York state *Prevention Agenda* priority area, prevent chronic diseases and focus area, healthy eating and food security.

PARTNERS

Feeding Westchester, White Plains Food Insecurity Task Force, United Way, Lifting Up Westchester, El Centro Hispano, Calvary Baptist Church, YWCA, White Plains School District, Thomas H. Slater Center, White Plains Youth Bureau, White Plains Housing Authority, White Plains Police Department and Caperberry

OUTCOMES

Between May and June 2020, White Plains Hospital hosted five COVID-19 food distributions and helped feed more than 1,274 households and 5,445 individuals. The hospital used the distributions as an opportunity to offer education on COVID-19 such as frequently-asked questions, where to get COVID-19 testing and the importance of social distancing and handwashing. The Food Pharmacy was formally launched on Jan. 14, 2021 at the Family Health Center. Coupling the Food Pharmacy with the Family Health Center aids clinical providers to better manage and treat chronic diseases while focusing on the patients in a more holistic way. To date, the program has served 280 households, 267 children, 361 adults and 172 seniors.

LESSONS LEARNED

Hosting food distributions allowed the hospital to take a closer look at food insecurity and identify an opportunity to help better serve the White Plains Hospital service area. It was an eye-opening experience and the genesis for a more formalized and ongoing approach to dealing with food insecurity in the community. By instituting the onsite pantry, the hospital can routinely address this social determinant of health and its clinicians can develop more holistic treatment plans for patients.

SUSTAINABILITY

The key to sustainability is integrating the screening process and workflow into every visit. All patients receive a screening questionnaire and, if the patient qualifies for the program, he/she is given a bag of food. Following that, the clinician discusses food insecurity with the patient and monitors the patient as part of the care plan. All data are compiled and tracked monthly. The hospital holds quarterly training sessions to identify any new issues that may hinder the process and educate new staff.

FOR MORE INFORMATION

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HANYS Celebrates Previous Community Health Improvement Award Winners

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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