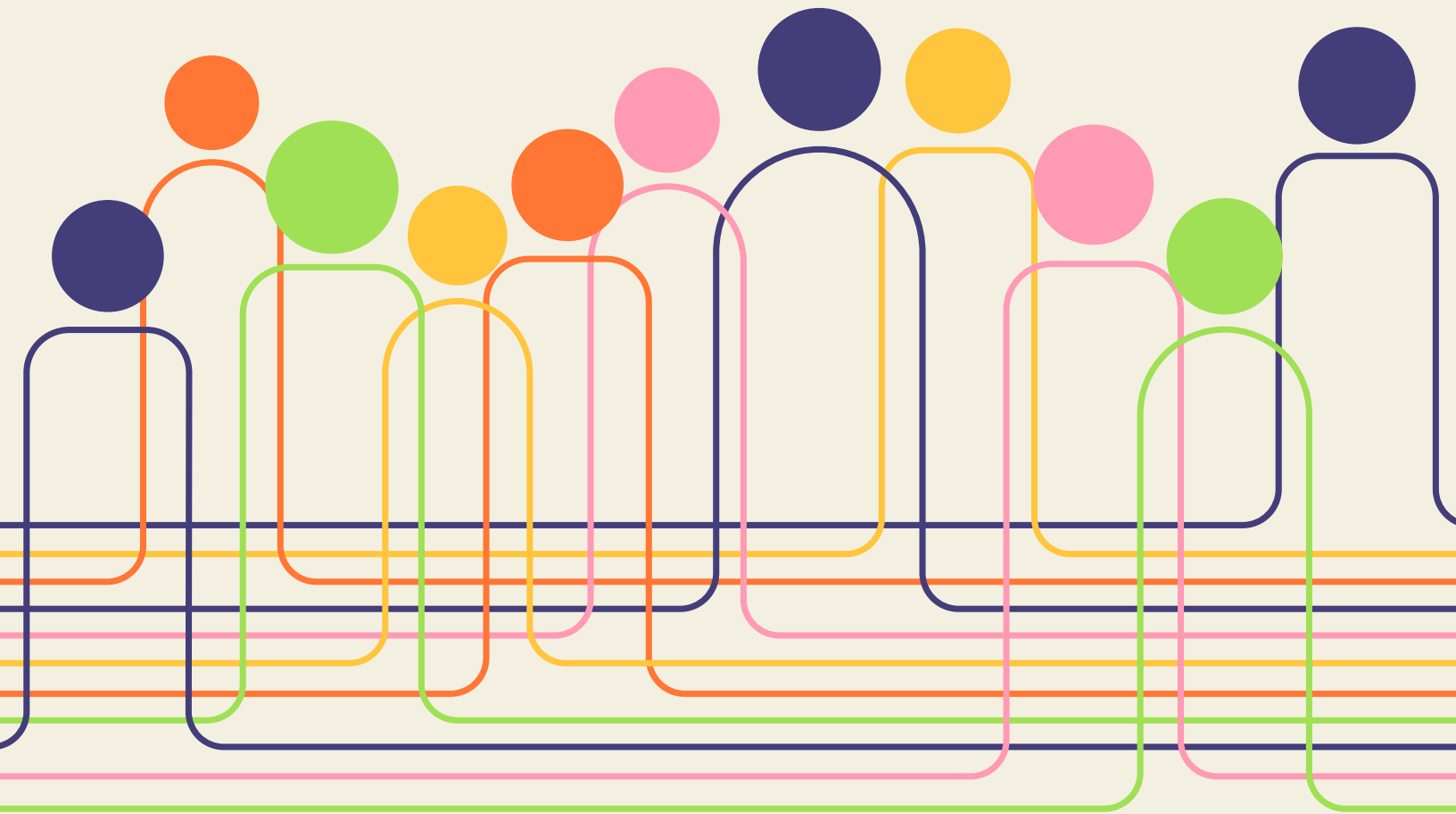


CONNECTING WITH COMMUNITIES: Community Health Initiatives Across New York State

2026 EDITION



Thank you to our 2026 reviewers

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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 30th edition of *Connecting with Communities: Community Health Initiatives Across New York State*. This publication highlights the winner of and nominations for HANYS' 2026 Community Health Improvement Award.

HANYS' Community Health Improvement Award recognizes member hospitals and healthcare systems for engaging community 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 the priorities of the New York State *Prevention Agenda*. The *Prevention Agenda* aims to improve the health status of New Yorkers and reduce health disparities through a strong emphasis on prevention.

HANYS appreciates the continued support of our member hospitals and health systems for sharing their community-focused initiatives. We are honored to recognize our members' continuous efforts to keep their communities healthy. We were excited to receive a record number of award submissions this year – 45! We've identified the top five initiatives in this book.

All 2026 award submissions will be included in HANYS' Community Health Initiatives Tool available online at hanys.askflorence.org/data/chia. This searchable tool categorizes the initiatives by the domains and priorities of the *Prevention Agenda* framework. We hope members and their community partners will use this resource to inspire new ideas as they develop community health initiatives.

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.

MOUNT SINAI HEALTH SYSTEM

Mount Sinai Adolescent Health Center

INITIATIVE DESCRIPTION AND GOALS

Mount Sinai Adolescent Health Center delivers comprehensive primary, mental, sexual and reproductive healthcare and prevention services to adolescents and young adults ages 10 to 26 at no direct cost to patients.

Through an integrated, confidential, youth-centered model that includes six school-based health centers, bilingual providers and trauma-informed care, the Adolescent Health Center removes financial, structural and stigma-related barriers to access.

The initiative advances New York State *Prevention Agenda* priorities by promoting childhood behavioral health, preventing substance misuse and expanding equitable access to preventive services for vulnerable adolescents across New York City.

PARTNERS

New York City public schools, Youth Represent, community-based youth organizations and public health agencies.

OUTCOMES

- The Adolescent Health Center serves more than 8,400 adolescents and young adults annually, delivering more than 32,000 visits across its clinical services at no direct cost to patients.
- While youth across the nation face often insurmountable barriers to mental healthcare access, in 2025 the Adolescent Health Center screened more than 6,000 youth for mental health needs and served 1,490 young people in its mental health programs.
- More than 3,100 young women access contraceptive care and sexually transmitted disease testing annually.

LESSONS LEARNED

Adolescents are significantly more likely to engage in care when services are confidential, youth-centered and delivered in welcoming environments. Integrating medical, mental health and social support services as part of a youth-friendly model of care improves outcomes for young people facing complex social and behavioral health challenges.

Additionally, Mount Sinai has learned that incorporating young people’s voices through youth advisory boards and other mechanisms — from conceptualization to evaluation of services — can increase utilization of these services and ensure young people’s changing needs are met.

SUSTAINABILITY

Sustainability is supported through diversified funding streams, including philanthropy, grants and insurance reimbursement, and through embedded school-based clinics and strong institutional leadership. Longstanding community partnerships and a nationally recognized training program further ensure continued impact and scalability.

CONTACT

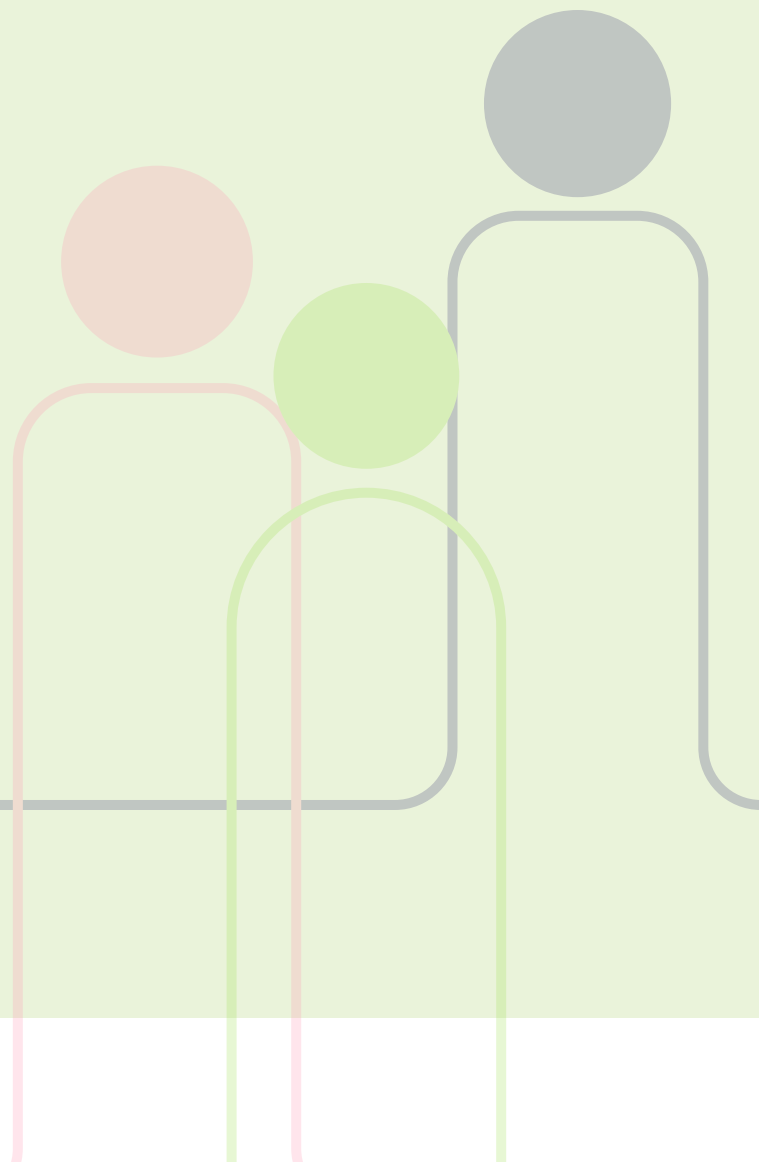
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ALBANY MED HEALTH SYSTEM

School-based Virtual Care

INITIATIVE DESCRIPTION AND GOALS

Every parent dreads the mid-morning call from school saying their child is sick. Now, partnerships between Albany Med Health System and regional school districts allow students to receive an evaluation and treatment for common ailments from an urgent care provider quickly via secure telehealth visits without leaving school. This program expands access to care while reducing unnecessary absenteeism, alleviating parents from the burden of taking time off work and supporting school nurses who have limited options to treat students.

Parents must consent for their child's participation and are encouraged to join the virtual appointment. Urgent care clinicians work with the school nurse to check ears, noses and throats, test for strep or flu, and assess minor health issues. If ordered, the school nurses may dispense certain medications and the student can return to class. If a student needs further care, the information from their visit is shared with Albany Med urgent care sites, which are ready for their arrival.

Inspired by a presentation for urgent care physicians, the Albany Med team pitched the idea to leadership in spring 2024. The first district went live that fall and by early 2026 ten districts had signed on.

PARTNERS

Broadalbin-Perth Central, Cairo-Durham Central, Canajoharie Central, Catskill Central, Germantown Central, Hartford Central, Johnstown City, Northville Central, Schoharie Central and Watervliet City school districts.

OUTCOMES

As of February 2026, the program had served 75 student patients at eight sites:

- 62% of students who would otherwise have gone home were instead evaluated, treated and sent back to class;
- 35% of visits resulted in a prescription ready for pickup the same day;
- only 1% required an in-person visit to an urgent care clinic; and
- only 1% of visits had a recommendation of going to the emergency department.

LESSONS LEARNED

School nurses must be engaged: If there is no nurse buy-in, there are no visits. Albany Med added a nurse practitioner to its team to work with the school nurses and develop clinical protocols appropriate for telehealth that fit school regulations.

Rural communities require more engagement to build trust. The Albany Med team attends local events to introduce the health system and highlight the benefits of connecting. The team also seeks opportunities to showcase the program and technology.

SUSTAINABILITY

Albany Med developed and implemented best practices for increasing enrollment, seeing patients and empowering school nurses to engage with the program. The team continues outreach to invite more schools to join and to engage with parents to encourage enrollment.

The health system also regularly checks in with the schools to make sure that everyone remains engaged and that there are no issues. Post-visit surveys go to families and school nurses so the team can review suggestions and concerns.

CONTACT

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ALBANY MEDICAL CENTER

“On Your Feet and Independent” – An Adult Fall Prevention Program

INITIATIVE DESCRIPTION AND GOALS

As the regional trauma center for a large portion of northeast New York, southern Vermont and western Massachusetts, Albany Med Health System has a responsibility to systemically track and address the leading causes of traumatic injury in the region.

Albany Med’s trauma registry collects comprehensive data on patients treated for serious injuries (such as falls, accidents or assaults) from pre-hospital care through hospital discharge. Reports from this specialized, secure database highlight leading causes of injury and are used to inform, guide and prioritize the health system’s injury prevention outreach efforts throughout the region.

The goal is to reach and educate seniors in every county in Albany Med’s catchment area, especially in geographically and economically disadvantaged areas.

PARTNERS

State Bureau of Occupational Health and Injury Prevention, Guardian Society, Albany Housing Authority, county offices of the aging and health departments, and all district facilities of a well-known health and fitness organization.

OUTCOMES

Program numbers:

- twelve adult fall prevention tabling events;
- twenty-six “On Your Feet and Independent” presentation events;
- 451 seniors educated;
- nine counties reached; and
- current trauma registry data show performance has stabilized since 2020. This consistency reflects that Albany Med’s educational efforts have successfully prevented regression. The health system now has a strong foundation to refine its strategies.

Post-course participant assessments:

- 100% believe they are better prepared to prevent adult fall injuries.
- 93% believe their fear of falling has decreased in some way following this presentation.
- 100% stated they would recommend Albany Med’s presentation to friends or family.

LESSONS LEARNED

- This presentation is ever evolving to meet the needs of the attendees. On the post-course assessment, each participant is encouraged to list any topic not covered in the presentation. These suggestions are then researched, and if these ideas are supported by science, they are added to the presentation.
- The post-program assessment shows more must be done to better address fear of falling.
- This educational program is best suited for participants who are still relatively mobile.

SUSTAINABILITY

This program is extremely sustainable through minimal donor funding for giveaway bag materials. Personnel salary and travel costs are covered by the Albany Med Health System.

As this program evolves, the same presentation will have new content every one to two years to reinforce those who have already attended and to provide the best experience for those who haven’t.

Efforts are underway to make this presentation content available online to reach a much wider audience.

CONTACT

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BLYTHEDALE CHILDREN'S HOSPITAL

The Community Café

INITIATIVE DESCRIPTION AND GOALS

The Community Café at Blythedale Children's Hospital provides free, nutritious meals to families of hospitalized children to address food insecurity and support whole-person well-being. Parents of medically fragile children often face intense stress, financial strain and limited access to healthy food. The Café reduces this burden by offering reliable meals that allow caregivers to remain at their child's bedside instead of traveling home to acquire food. By creating a welcoming communal space, the Café fosters connection, reduces isolation and supports emotional and spiritual resilience. The initiative aligns with the New York State *Prevention Agenda* priority area of nutrition security by ensuring caregivers have access to healthy food while navigating medical crises.

PARTNERS

Current partners include the Shames JCC on the Hudson, local schools and Girl Scout troops, with ongoing recruitment of faith-based, cultural and community service organizations to sponsor meals, volunteer and offer supportive programming.

OUTCOMES

- Basic nutrition needs are met, resulting in reduction of caregiver stress and improved emotional resilience.
- The enhanced family presence at the bedside strengthens parent-child attachment and reduces anxiety.
- The welcoming and communal meal-time environment enhances social support and reduces isolation.

LESSONS LEARNED

Meeting nutritional needs significantly improves caregiver emotional capacity and presence at the bedside. Community partnerships enrich the Café's offerings and deepen its sustainability.

SUSTAINABILITY

The Café's long-term viability is supported by partnerships with local faith-based, cultural and community groups that sponsor meals and volunteer regularly. Expanded community engagement will ensure consistent meal provision and opportunities for supportive programming.

CONTACT

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CATHOLIC HEALTH (LONG ISLAND)

Farm to Patient

INITIATIVE DESCRIPTION AND GOALS

In 2023, Catholic Health partnered with Smile Farms to create a six-bed cooperative garden at the Mercy Hospital outpatient behavioral health clinic. Due to the success of this program, Catholic Health added a second 12-bed cooperative garden in 2024 at the Mercy Hospital main campus. In 2025, a third garden was opened at St. Catherine of Siena Hospital.

These gardens have two main purposes:

- to support food insecure patients at the Mercy Family Care Center by providing them with free fresh fruits, vegetables and herbs; and
- to provide meaningful employment and a sense of purpose to Personalized Recovery Oriented Services patients at the outpatient center.

PROS is a comprehensive, team-based mental health program that integrates rehabilitation, treatment and support services for adults with serious mental illness. PROS patients learn valuable job skills while contributing to the community.

This program directly aligns with several New York State *Prevention Agenda* priorities related to unemployment, nutrition security, anxiety, stress and healthy eating. Produce grown in the garden is provided to patients at the clinic for free and promotes access to healthy food and healthy eating. The garden provides an opportunity for PROS patients to be employed for cultivating the food. PROS patients who are employed or volunteer their time in the garden build a sense of community that reduces anxiety and stress and improves resilience.

PARTNER

Smile Farms.

OUTCOMES

- A total of 390.75 pounds of food was distributed in 2025 to the Mercy Family Cares Center to support food insecure individuals.
- There are six individuals in the PROS program with stable employment (plus five volunteers).
- Three gardens to date have opened through the program.

LESSONS LEARNED

- To maximize participation, it is imperative to receive community input as to the types of fruits and vegetables grown.
- There is a strong desire within the outpatient patient population to participate in a program such as this.

SUSTAINABILITY

Continued partnerships with Smile Farms support the employment and consultant financing for the program. Catholic Health staff are dedicated to continuing the program to support food insecure patients.

CONTACT

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CAYUGA HEALTH, A MEMBER OF CENTRALUS HEALTH

Community Dining: Connecting Older Adults for Good Health

INITIATIVE DESCRIPTION AND GOALS

Cayuga Health, a member of Centralus Health, initiated a new partnership with Foodnet Meals on Wheels and Tompkins County Office for the Aging to expand access to nutritious meals and social support for older adults in Tompkins County. This community dining partnership repurposes vacant retail space at The Shops at the Ithaca Mall to create a welcoming environment for adults age 60 and older to enjoy nourishing food and conversation in close proximity to Cayuga Health's primary care, cardiology and lab services.

Each hot, freshly prepared meal is designed by Foodnet's registered dietitian to provide at least one-third of the daily nutritional requirements for an older adult. During meals, the registered dietitian is available to address specific nutritional needs or dietary questions. In-home nutrition counseling is available for clients to help them navigate healthy eating. There is no charge for eligible participants.

In addition to aligning with the nutrition security and healthy eating New York State *Prevention Agenda* priority areas, this initiative promotes health literacy. Educational sessions that incorporate plain language, visual aids, motivational interviewing and actionable information are facilitated by local health and social care providers, creating a web of loving support and mutual learning.

PARTNERS

Foodnet Meals on Wheels, Tompkins County Office for the Aging and The Shops at the Ithaca Mall.

OUTCOMES

- Since its inception, this initiative has served over 200 meals, nourished 38 older adults, increased reliable access to nutritious food and reduced social isolation.
- Five healthcare providers and three social care providers have facilitated educational sessions, strengthening cross-sector collaboration and expanding referral pathways and continuity of care.
- Foodnet's registered dietitian presented two nutrition education programs, equipping participants with practical strategies to support healthy aging and skills to maintain strength, mobility and overall wellness.

LESSONS LEARNED

- True collaboration takes time to build trust, create a common language and develop shared goals. This initiative is the culmination of five years of true collaboration among leaders in healthcare, food service, local government and retail.
- Alignment with New York state goals and programs may support long-term sustainability of community health interventions. This initiative aligns with *Prevention Agenda* priorities selected by the county and the New York State Office for the Aging's requirements for community dining sites.

SUSTAINABILITY

By working closely with the county office for the aging to meet state office for the aging requirements, Cayuga Health was able to secure funding for program implementation. While there is no charge for meals, nutrition information or counseling, each person is given the opportunity to make a suggested voluntary contribution for meals to help serve more people.

CONTACT

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COLUMBIA MEMORIAL HEALTH

Removing Barriers to Accessing Diabetic Eye Exams in a Rural Area

INITIATIVE DESCRIPTION AND GOALS

This initiative addressed gaps in preventive eye care among rural patients with diabetes by integrating retinal screening directly into primary care settings. Data showed many patients were not completing annual eye exams due to transportation barriers, long travel distances and limited access to specialty care. In response, primary care leaders, diabetic educators and ophthalmic partners implemented onsite retinal imaging within clinics where patients already receive diabetes management.

The approach embedded preventive services into routine chronic disease care, with diabetic educators identifying overdue patients, conducting outreach, coordinating screening events and supporting referrals.

The goals are to increase annual screening rates, detect diabetic retinopathy and other eye diseases earlier, reduce preventable vision loss and strengthen care coordination. By delivering services in trusted community settings, the program has expanded access to community-based care and reduced structural barriers affecting rural populations.

PARTNERS

Multiple primary care centers in Columbia and Greene counties: Callan Family Care, Cairo Family Care Center, Cairo Main Street, Chatham & Ghent Family Care, Columbia Memorial Family Care, Coxsackie Lafayette Family Care Center, Hudson Medical Care, Jefferson Heights Family Care Center, Kinderhook Medical Care, Prime Medical, Tannersville Family Care Center, Valatie Family Care and Windham Care Center.

OUTCOMES

- More people completed their annual diabetic eye examination.
- This initiative achieved early identification of eye disease with successful referral to specialty treatment for multiple patients annually.
- Columbia Memorial Health established a process and workflow that is sustainable and can be spread to other locations.

LESSONS LEARNED

- Coordination with individual primary care providers is essential to ensure that all patients scheduled to attend a screening event have active orders for the diabetic eye examination. Establishing a workflow that allows for orders to be in place streamlines the process by which results flow into the electronic medical record and subsequent referrals to specialists.
- It is important to identify electronic interfaces that allow for eye examination images and results to be readily available for the patient's care team. During this initiative, the hospital transitioned the electronic medical record to Epic, requiring a concerted effort to maintain data flow during screening events.

SUSTAINABILITY

Maintaining positive working relationships with the primary care centers, clinical informatics teams, diabetic educator and medical technology manufacturers is key to sustaining this effort and expanding access to more people in the community.

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ELLIS MEDICINE

Improving Health Equity in Mental Health Services

INITIATIVE DESCRIPTION AND GOALS

Ellis Medicine implemented a behavioral health equity initiative from early 2023 through late 2024 to improve access to mental health services and address disparities in hospitalization among Schenectady County residents.

Led by the Health Equity Subgroup of the Ellis Medicine Diversity, Equity, and Inclusion Committee, the initiative used a Plan-Do-Study-Act framework to strengthen care transitions, expand telemental health access within primary care settings, promote the Ellis Living Room crisis program as an alternative to emergency department utilization and implement transition support (“bridger”) services for patients returning to the community following hospitalization.

Social determinants of health screening and resource referral were integrated into discharge planning to address barriers such as housing instability and food insecurity. The initiative aimed to reduce avoidable inpatient and emergency department utilization, improve follow-up engagement after hospitalization, and advance health equity across racial and ethnic populations. During the initiative period, population-level behavioral health hospitalization rates declined substantially across racial and ethnic groups, with a narrowing of disparities between Black and White residents.

The initiative aligns with New York State *Prevention Agenda* priorities related to promoting mental health, improving access to community services and support, and addressing SDOH.

PARTNERS

Ellis Mental Health Services, Ellis Primary Care, Ellis Hospital, The Living Room, Schenectady County Public Health Services and aptihealth.

OUTCOMES

- Behavioral health hospitalization rates declined substantially across racial and ethnic groups between baseline and post-implementation periods, including a 44.7% reduction among Black residents (137.9 to 76.2 per 10,000) and a 64.6% reduction among Hispanic residents.
- The disparity gap between Black and White residents narrowed by approximately 36%.
- Internal utilization data demonstrated a 35% reduction in the Black-to-White inpatient admission disparity ratio between 2022 and 2024, coinciding with implementation of expanded access and transition support interventions.

LESSONS LEARNED

- Integrating SDOH support into discharge planning improves patient engagement and reduces barriers to recovery.
- Strong interdisciplinary leadership and community partnerships are critical to advancing behavioral health equity and sustaining improvements beyond a single intervention.

SUSTAINABILITY

Sustainability is supported through integration of transition support services, telemental health access and Living Room program referrals into standard clinical workflows. Established partnerships with community providers and ongoing review of utilization and equity metrics through organizational leadership structures ensure continued implementation and opportunities for expansion.

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ERIE COUNTY MEDICAL CENTER

Population Health Community Outreach Initiative

INITIATIVE DESCRIPTION AND GOALS

Erie County Medical Center's Population Health Community Outreach Initiative is a nurse-led, community-based program designed to improve access to preventive care and reduce health disparities among underserved residents of Erie County. The initiative brings health education, screenings and care navigation directly into trusted community settings, meeting individuals where they are and addressing barriers related to health literacy and social needs.

Core activities include blood pressure screenings, chronic disease education, cancer screening referral support, tobacco cessation resources and linkage to primary care, specialty care (including behavioral health) and community supports. The program emphasizes early identification of health risks, rapid referral to treatment and ongoing care coordination to support long-term health outcomes. The initiative's goals are to increase engagement in preventive services, improve chronic disease management, strengthen health literacy and connect individuals to medical and social supports. Through strong partnerships with community-based organizations and a multidisciplinary care model, the program builds trust, promotes equity and expands access to care.

This initiative aligns with New York State *Prevention Agenda* priority areas related to preventing chronic diseases; promoting healthy women, infants and children; promoting mental health; preventing substance use; and promoting healthy and safe environments. By focusing on cardiovascular health, cancer prevention, behavioral health resources and social determinants of health, ECMC advances health equity and improves community well-being.

PARTNERS

Independent Health Foundation's Good for the Neighborhood program, American Lung Association, Delevan Grider Community Center, Labor Management Healthcare Fund, Buffalo/Niagara YMCA Centers, Forever Young, Mount Olive Baptist Church, Buffalo Prenatal-Perinatal Network, Buffalo Charter Schools, Calvary Baptist Church, American Heart Association, First Shiloh Baptist Church, Power 96.5 WUFO, American Cancer Society, Erie County Sheriff's Office, Erie 1 District Schools, American Diabetes Association, Northland Workforce Training Center, West Side Bazaar and The Witness Project.

OUTCOMES

From 2023 to 2025, ECMC's community outreach efforts more than doubled:

- In 2023, the team attended 33 events and engaged 5,120 individuals.

- In 2024, this increased to 50 events and over 9,000 interactions, and in 2025 to 74 events and more than 11,000 interactions. This represents a 124% increase in events and 115% increase in community reach.
- In 2025, these efforts resulted in 42 primary care referrals, five specialty care referrals and assistance with scheduling 61 screening mammograms.

LESSONS LEARNED

Two lessons learned through this initiative relate to health literacy:

- Many women believed they were up to date on their cervical cancer screening when they had only received STI testing, highlighting gaps in preventive care knowledge.
- Many individuals with uncontrolled hypertension felt well and were unaware of their risk. Community-based blood pressure screening supports early identification, timely linkage to care and prevention of downstream cardiovascular complications.

SUSTAINABILITY

Sustainability is supported through ongoing funding and partnerships with organizations such as Independent Health and the American Heart Association, combined with strong institutional commitment from ECMC leadership. The organization prioritizes staff time, training and resources to support community engagement, recognizing prevention as a critical investment in long-term health outcomes. These combined external and internal supports ensure continued program delivery, growth and community impact.

CONTACT

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FINGER LAKES HEALTH, UR MEDICINE

Functional Mobility Screening for Adults 65 and Older to Prevent Falls and Maintain Independence

INITIATIVE DESCRIPTION AND GOALS

UR Medicine Finger Lakes Health is committed to preventive medicine and keeping its community well. Finger Lakes Health's rehabilitative services provide monthly screenings for adults 65 years of age and older in the three counties it serves: Ontario, Seneca and Yates. This screening tests the participant in balance, strength, flexibility, endurance and posture. The goal of the free program is to provide a mobility "report card."

The tested parameters are scored and compared to age-specific targets. Scores falling outside the norms can indicate a risk for falls and decreased ability to perform activities of daily living and live independently in the community. Participants are provided exercises in areas where scores indicate an area that may become a concern. A physical therapist performs the free screening and educates the participant on the exercises. Participants are encouraged to schedule an annual follow-up to help ensure their ability to live in the community independently.

The program's goal is to make participants aware of their functional mobility, prevent falls and keep them living in the community. The program has had participants every month at three outpatient therapy clinics. If a participant has scores that put them at a high risk for falls or decreased ability to perform activities, the therapy team works in collaboration with the participant and their primary care provider to obtain additional services to ensure their improvement and increase their safety so they can remain an active member of the community.

PARTNERS

Geneva YMCA, Yates County Public Health Department, Geneva Red Wings, Newark Pilots, Penn Yan Car Show, Seneca Falls It's a Wonderful Life, Seneca County Office of the Aging, Penn Yan Fall Festival and UR Medicine Finger Lakes Health Primary Care.

OUTCOMES

- All mobility screen participants have received exercises specific to areas of concern.
- Eighteen percent of participants were recommended for more formal interventions to help maintain independent community living.
- Understanding the importance of wellness and prevention for the community, the Finger Lakes Health rehabilitation team donates 30 minutes at a time to provide the functional screen with registered participants each month, helping community members before there is an injury and life-altering event.

LESSONS LEARNED

- Community outreach and participation in events help raise awareness of the program.
- The devastating effects of a fall on people age 65 and older can cause them to lose the ability to live independently; Finger Lakes Health's screening provides a specific intervention to each individual to prevent a fall and help them remain active community members.

SUSTAINABILITY

The therapy team and health system are committed to the program and have sustained it for five years. Wellness and prevention is a critical part of the success of the community.

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GLENS FALLS HOSPITAL

Promoting Walkability and Bikeability to Everyday Destinations

INITIATIVE DESCRIPTION AND GOALS

Using the Active Communities Tool, in collaboration with Washington County Public Health, Glens Falls Hospital assessed the Village of Hudson Falls' and the Town of Kingsbury's laws, policies, plans and active efforts to create an active-friendly community. Assessment results led to an action plan that included inventorying maps and data points including bike racks on multi-use trails and recreational areas and increasing safe biking and walking education.

Implementation of the goals included coordination with the village clerk and department of public works to install bike racks at everyday destinations with QR code signage that is connected to a digital map showing locations of community bike racks. The Walk Left Bike Right/Be Safe and Be Seen Safety Campaign, designed by Glen Falls Hospital, simply communicated the rules of the road for all users.

This project aligned with New York State *Prevention Agenda* goals including increasing opportunities for physical activity through active transportation, decreasing crash-related injuries through safe active routes and increasing access to community services. The results of expanding the built environment and the new safety campaign increased affordable and accessible active transportation, physical activity, safe walking and biking, and access to community services and everyday destinations.

PARTNERS

Washington County Department of Public Health, Town of Kingsbury, Village of Hudson Falls, Washington County Planning Department, Washington County Youth Bureau, Washington County Real Property, Village of Whitehall, Town of Whitehall, Whitehall Improvement Network, Whitehall Central School District, Whitehall Department of Public Works and Transportation, Hudson Falls Department of Public Works, Freakopolis Geekery, Skenesborough Museum, The Railyard Restaurant and Whitehall Chamber of Commerce.

OUTCOMES

- This project began in one village and eventually expanded to seven towns and villages in Washington County. It has already been extended into the city of Glens Falls in neighboring Warren County. Bike racks and signage in the Village of Hudson Falls includes seven locations and 19 county-wide.
- Bike racks and digital maps have increased the communities' use of bikes, knowing that there is a secure spot to place their bikes when traveling to different locations within villages, towns and the county. With reported use at locations like health centers, this project has shown increased access to everyday destinations.

LESSONS LEARNED

- It is important when implementing a project that involves installation, government department support and partner communication to possess a thorough understanding of the laws, code and permits needed to accomplish the project. This should be discussed and researched at the beginning of the planning process.
- Continued communication about scheduling, competing priorities and change in leadership will help to avoid barriers to the project.
- A memorandum of understanding that is clear and concise about each partner's responsibilities is key.

SUSTAINABILITY

There will continue to be a collaborative effort to maintain the projects in the Village of Hudson Falls and Whitehall. GFH and Washington County Public Health will use the safety campaign each year and further expand into other towns and counties. A community group in Whitehall plans to complete a large walk audit that will allow the village DPW and community members to improve the sidewalks, either through cement replacement or cleaning away debris.

CONTACT

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ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI

Mount Sinai Institute for Health Equity Research

INITIATIVE DESCRIPTION AND GOALS

The Mount Sinai Institute for Health Equity Research advances health equity through community-engaged research, data science and system-level reform to eliminate structural health disparities. Working with community leaders, policymakers and clinicians, the Institute identifies inequities in chronic disease, mental health and access to care, and translates findings into measurable policy and practice changes.

Through equity dashboards, race-free clinical tools and language access initiatives, the Institute advances New York State *Prevention Agenda* priorities focused on preventive services, early intervention, and addressing poverty and housing instability as drivers of health outcomes.

PARTNERS

New York City Community Engagement Alliance to End COVID-19 Disparities, Institute for Family Health, Harlem Health Initiative, RiseBoro, New York Common Pantry, Voces Latinas, Bronx Health REACH and Community Action Board members.

OUTCOMES

- This initiative has generated more than \$175 million for equity-focused programs. Its mental health partnerships now operate in over 40 community-based organizations and youth sports leagues to address rising suicide rates among Black youth, while faith-based mental health programs have served more than 4,000 residents in the past year alone.
- Community-led chronic disease programs have reached over 10,000 New Yorkers with measurable reductions in weight and glucose and improved physical activity and quality of life.
- More than 1,000 community health workers and navigators have been trained to conduct vaccine outreach to over 100,000 people.

LESSONS LEARNED

- Justified mistrust can be transformed into meaningful collaboration when transparency and equity guide every phase of research.
- When lived experience drives research priorities, innovative, scalable solutions emerge that reduce disparities and shift how institutions deliver care and define health.

SUSTAINABILITY

Sustainability is achieved through National Institutes of Health and extramural funding, internal pilot-grant infrastructure, institutional integration of equity-monitoring tools and ongoing workforce development programs that build the next generation of health equity leaders.

CONTACT

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JAMAICA HOSPITAL MEDICAL CENTER

elevateHER Diabetes Centering Program

INITIATIVE DESCRIPTION AND GOALS

elevateHER Diabetes Centering at Jamaica Hospital Medical Center launched in early 2025 to address rising gestational and pregestational diabetes among pregnant and postpartum patients, particularly women of color facing racial, ethnic and socioeconomic inequities. Building on the hospital's CenteringPregnancy experience, the program uses group prenatal visits, continuous glucose monitoring and in-home community health worker support.

Community health workers address health-related social needs and reinforce care plans. Group sessions foster peer learning across diverse cultures and languages, supported by interpretation services. Multidisciplinary care by obstetric providers, dietitians, lactation consultants, behavioral health professionals and social workers is coordinated through the electronic health record to enable timely intervention. Collaborations with community partners provide nutrition support including medically tailored meals, infant supplies and postpartum resources.

Program goals are early identification of diabetes, improved self-management capacity and reduced diabetes-related maternal and infant complications. elevateHER offers group prenatal visits that improve access to care, chronic disease management, mental health support and nutrition security. The program advances access to and use of prenatal care; access to community services and support; healthy eating; nutrition security; and prevention of infant and maternal mortality, anxiety, stress and depression.

PARTNERS

Public Health Solutions; God's Love We Deliver; Women, Infants and Children; River Fund; and New York State Department of Health.

OUTCOMES

The elevateHER Diabetes Centering program has achieved the following key outcomes:

- Among 66 participants with gestational diabetes, 94% adhered to their diabetes management program. Among the same group, 88% adhered to dietary guidance. Both rates are far above the 50% to 60% national averages.
- Among all patients enrolled in the CHW home-visiting component, repeated CHW screenings increased identification of health-related social needs from 7.9% to 20.6%, enabling targeted support.

LESSONS LEARNED

One key lesson learned is the transformative impact of peer-based group care, which reduced isolation, strengthened support and increased engagement. Patients consistently described peer connection as one of the most meaningful aspects of the program. Another key lesson is the indispensable role of CHWs who bridge clinical care with social and behavioral support. Their ability to build trust and address health-related social needs has been central to patient retention and success.

SUSTAINABILITY

Sustainability is ensured through reimbursable CHW services, institutional support and community partnerships. Standardized workflows, data infrastructure and ongoing staff training enable scalability and continuity.

By integrating clinical care with culturally competent social support and leveraging peer groups, home visits, technology and collaboration, the program can adapt, maintain impact and serve as a replicable model.

CONTACT

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MAIMONIDES HEALTH

Brooklyn Parenting Center

INITIATIVE DESCRIPTION AND GOALS

The Brooklyn Parenting Center integrates social and emotional care across the first thousand days in a safety net hospital system. Launched in 2023, BPC is an innovative, resilience-based program that integrates mental healthcare and support to provide whole-person health at three formative touchpoints: prenatal obstetric care, inpatient postpartum and neonatal intensive care, and pediatric primary care. This three-pronged approach expands access to comprehensive social and emotional care for parents and children in a low-barrier setting where families already access care for physical needs.

The goal is to improve maternal-child health via:

- universal access to integrated social and emotional support throughout the first thousand days;
- evidence-based models addressing unmet social and emotional needs; and
- support for parents to become the caregivers they want to be through optimizing positive development for their children.

BPC addresses New York State *Prevention Agenda* priority areas related to anxiety, stress, depression, adverse childhood experiences, access to community services and support, prevention of infant and maternal mortality and early intervention. It also addresses the childhood behavioral health, poverty and preventive services areas.

PARTNERS

ACP Early Intervention, Arab-American Family Support Center, Brooklyn Perinatal Network, Catholic Charities Brooklyn & Queens, Challenge Early Intervention, Child Development Support Corporation, Family Health Centers at NYU Langone, Grand Street Settlement, Healthy Start Brooklyn, Healthy Families, JCCA, Jewish Board of Family and Children, Jewish Community House, Lulo, Maimonides WIC Program, New York Legal Assistance Group, NIA Community Services Network, Power of 2 and SimpliFed.

OUTCOMES

In two years:

- BPC saw 5,656 unique dyads at 7,821 visits: 758 prenatal, 3,799 inpatient and 1,949 pediatric patients and families; and
- 796 patients were seen by two providers and 113 families were seen at all three touchpoints.

Three-fourths of 200+ surveyed patients reported high impact of BPC services on overall well-being and ability to parent the way they wanted. Families reported high satisfaction (N = 225, 86%) and were able to access the services and resources needed (N = 248, 93.2%), with no significant difference found by language, race, ethnicity or religion. Among respondents, 89% (N = 261) had never met with someone for mental health needs before BPC, indicating reach to underserved populations.

LESSONS LEARNED

- Building a program in a low-resourced, high-needs environment is challenging. Working across departments at a large institution, all with unique leadership and previously siloed infrastructure means collaboration requires many meetings with many stakeholders.
- Communication and referrals among providers, accessing and analyzing data, and linking families to track outcomes across the first 1,000 days in multiple electronic health records is difficult.
- Healthcare systems using a central EHR might avoid such obstacles.

SUSTAINABILITY

Sustainability is essential for BPC. Maimonides maintains five positions after grant funding through integration into existing hospital infrastructure and a plan for billing across clinical areas. In ambulatory settings, BPC providers bill for social determinants of health and mental health screenings and services, with customized EHR notation incorporating physician signatures, as necessary. Due to bundled maternity care, inpatient social work is not reimbursed; Maimonides highlights cost-saving measures like decreased length of stay.

CONTACT

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MONTEFIORE EINSTEIN

Community Health Worker Institute

INITIATIVE DESCRIPTION AND GOALS

Montefiore Einstein's Community Health Worker Institute embeds trained community health workers into primary care, inpatient, pediatric, obstetric, behavioral health and specialty settings to address social determinants of health that drive healthcare disparities, including housing instability, food insecurity, transportation barriers and unemployment.

Grounded in prevention, the CHWI proactively identifies social needs through large-scale screening and sustained outreach, connecting patients to community-based services before unmet needs escalate into avoidable illness or delayed care. Many CHWs are Bronx residents who bring lived experience and culturally competent work, strengthening trust and engagement.

The initiative aligns with the New York State *Prevention Agenda* by expanding access to community services and preventive care, improving chronic disease outcomes and addressing poverty-related barriers. The CHWI also advances workforce development by creating healthcare career pathways for local residents while improving health outcomes for the communities Montefiore Einstein serves.

PARTNERS

Community-based housing organizations, food access providers, workforce development agencies, LaGuardia Community College, social service organizations, environmental health agencies and local community organizations across the Bronx and Westchester County.

Groups that have been particularly active include the New York City Department of Health and Mental Hygiene, Bureau of Bronx Neighborhood Health, Bronx Integrated Pest Management Program, SUNY North Bronx Career Counseling and Outreach Center, Community Justice Connect and God's Love We Deliver.

OUTCOMES

- The CHWI has now served more than 16,500 patients and an estimated 82,820 Bronx households; more than 94% of participants reported progress or resolution of social needs.
- The program contributed to a 30% reduction in adult inpatient readmissions and a 34% decrease in missed specialty care appointments, including cancer care, where unmet social needs were shown to delay treatment by 45 days.
- The CHWI is projected to deliver a positive return on investment (1.2:1) through new Medicaid reimbursement pathways and fewer no-shows and readmissions.

LESSONS LEARNED

- Embedding CHWs directly into care teams transforms social care from referrals into accountable, measurable prevention.
- Long-term impact depends on strong community partnerships that enable resolution of social needs, not just identification.

SUSTAINABILITY

Montefiore Einstein sustains CHWI through standardized training, data integration and alignment with Medicaid reimbursement, enabling the initiative to transition beyond time-limited grant funding. Workforce development partnerships, including training and certification pathways, and system-wide integration ensure long-term scalability and stability.

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MONTEFIORE NYACK HOSPITAL

Breast Cancer Screenings Enhanced with Nutrition Counseling to Reduce Obesity and Cancer Risk

INITIATIVE DESCRIPTION AND GOALS

Montefiore Nyack Hospital offers free breast cancer screenings in collaboration with New York's Medicaid Cancer Services Program to more than 200 women per year who are uninsured or underinsured. Most of these women (94%) are Hispanic and 88% of them have a body-mass index over 25, indicative of overweight or obesity.

This program aligns with the New York State *Prevention Agenda* priority areas related to reducing chronic diseases, in particular obesity, which is closely linked to breast and other types of cancers. At each screening event, the program provides bilingual nutrition education that covers meal planning (USDA My Plate), portion control and consumption of fruits and vegetables. Women visit an information table while they wait for their screening.

Starting in October 2024, a bilingual registered dietitian nutritionist from the hospital has been offering individual counseling sessions at the events. Close to 25% of women coming to the event use this complementary service at which they receive a full nutrition assessment, a targeted meal plan, personalized SMART goals around healthy eating and information about local programs and resources that they can use to improve their health, including a comprehensive list of local food pantries that is updated twice per year.

During the week following the screening events, the health coach calls all women who expressed interest in any of the health programs to assist them with registration and/or to answer any follow-up questions.

PARTNERS

Medicaid Cancer Services Program, Montefiore Nyack Hospital Breast Center, Montefiore Nyack Hospital Outpatient Nutrition Services, Haverstraw Collaborative, Office of Senator Bill Weber and the Cancer Support Community Greater NY & CT.

OUTCOMES

- Women attending free breast cancer screening events have nutrition-related concerns; 88% are overweight/obese, 55% have pre-diabetes and 36% have diabetes. Food insecurity is evidenced by 99% of women receiving a list of local food pantries and expressing not having food that lasts a month and/or money to buy more fresh fruits and vegetables.
- Offering nutrition education about meal planning, portion control and increased intake of fruits and vegetables is well received among this group. Individual nutrition counseling further empowers women to set "SMART" (Specific, Measurable, Achievable, Relevant and Time-bound) goals for eating healthier.

- Having information available about health and physical education programs and local food pantries helps to motivate women to make changes and access help. Next steps are to follow-up with women who join programs to assess weight change.

LESSONS LEARNED

- Women attending free breast cancer screening events care about eating healthy to lose weight and prevent diseases. Barriers to seeking nutrition services are lack of health insurance, time and/or transportation. Offering nutrition counseling at screening events helps to close this gap.
- Informing women beforehand about the free nutrition visit could help them plan better to be able to stay to meet with the dietitian.
- More health education and weight loss programs need to be offered in the evenings for high-risk working women. Evening and weekend food pantry hours are needed.

SUSTAINABILITY

The program is sustainable because it uses a dietitian from staff to provide nutrition counseling and dietetic interns, volunteer nurses and/or health coaches to staff the nutrition information table and place follow-up calls with the help of a script. Free education materials can be downloaded from [USDA.org](https://www.usda.gov), [EatRight.org](https://www.eatright.org), [Heart.org](https://www.heart.org), etc. Recruitment for the events is done by the cancer services program and the hospital's breast center. Donated giveaways and snacks are nice but not fundamental.

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MOUNT SINAI SOUTH NASSAU

Community Emergency Preparedness and Response

INITIATIVE DESCRIPTION AND GOALS

In 2022 and 2023, Mount Sinai South Nassau's community education department began offering bystander lifesaving skills. The program was launched due to rising health crises in Nassau County regarding pedestrian safety, opioid fatalities and low out-of-hospital cardiac arrest survival rates.

Oceanside S.A.F.E. said overdose remains the leading cause of death for Nassau residents ages 18 to 35. While 2023 saw a decline in fatalities, 2022 marked the peak of the crisis in Nassau County, with fatal drug overdoses largely attributed to fentanyl. Violent assaults resulting in severe bleeding have increased in the county; serious injury accidents rose by 17%.

Over the past decade, more than 16,000 people on Long Island were seriously injured in crashes, often requiring "Stop the Bleed" techniques. Survival rates for out-of-hospital cardiac arrest remain low at 10% in the Northeast. High-profile tragedies have transformed Long Island into a focal point for cardiac safety advocacy. The deaths of several student athletes highlight why bystander training is essential. To address avoidable deaths in the community, the hospital began instructing residents in Stop the Bleed, hands-only CPR, use of an automated external defibrillator and Narcan® training.

PARTNERS

American Heart Association, Oceanside S.A.F.E. (Substance Abuse Free Environment) Coalition, Stop the Bleed-American College of Surgeons and New York State Opioid Overdose Program.

OUTCOMES

The community education team validated the skills of each participant during Stop the Bleed, hands-only CPR and Narcan training. Certifying the participants in these lifesaving programs changes the culture of a community and moves it from reactive to ready. Bystanders are empowered, not helpless. Certifications have reached:

- Stop the Bleed: 1,078;
- Narcan training: 1,340; and
- hands-only CPR and AED use: 1,778.

LESSONS LEARNED

- Community health improvement is not a hospital-centric service. By decentralizing training and providing American Heart Association Anytime® Training Kits, MSSN triggered a multiplier effect that reached beyond the 4,000+ graduates.
- Education must be paired with equipment; this led to the installation of AEDs in 18 senior centers.
- By partnering with the Town of Hempstead, Nassau County senior centers and local libraries, MSSN moved the "classroom" to where the people already gather.

SUSTAINABILITY

- As an American Heart Association training center, MSSN provides year-round education.
- Collaborations with universities, local fire departments and the Nassau County Police Department ensure a pipeline of participants and shared resources.
- By working with the New York State Opioid Overdose Program and the Stop the Bleed Coalition, the program remains aligned with public health mandates and state funding.
- By requiring return demonstrations, MSSN ensures that community members have mastered a lifesaving competency.

CONTACT

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NEWYORK-PRESBYTERIAN

SDOH Screening and Navigation Program

INITIATIVE DESCRIPTION AND GOALS

As health systems expand social needs screening, the gap between identifying needs and connecting patients to services has become increasingly clear. After embedding social needs screening into routine practice, NewYork-Presbyterian uncovered high levels of food and housing insecurity and significant challenges in linking patients to community-based organizations. To address this, the health system co-developed an innovative, closed-loop referral model with CAMBA, Henry Street Settlement and Public Health Solutions — three multiservice organizations deeply rooted in their communities.

The partnership created unified workflows, consistent outcome definitions and flexible technology solutions that honor each organization's capacity. NYP's emergency department patient navigators anchor the model, offering culturally responsive support, conducting social determinants of health screening and coordinating referrals based on geography. NYP also invested directly in partner capacity through predictable funding and staffing support, strengthening the community infrastructure needed for timely follow-up.

This initiative advances the New York State *Prevention Agenda* priority of economic stability, expanding access to nutrition and housing supports for patients across diverse neighborhoods.

PARTNERS

CAMBA, Public Health Solutions and Henry Street Settlement.

OUTCOMES

From October 2024 to September 2025, nearly 13,000 patients were screened at the four EDs included in the program. Of those:

- more than 950 patients were referred to the three CBO partners from the ED navigation team; and
- 70% of these patients had a successful connection with the CBO to assist with services.

Many services were provided by the CBO partners including housing applications and recertifications, ride coordination, assistance with Supplemental Nutrition Assistance Program/Women, Infants and Children nutrition benefits, emergency one-time assistance, food pantry connection and housing mediation.

The initiative strengthened relationships with local organizations; clarified the true demand for nutrition, housing supports, transportation and other social needs; and created a replicable model that can extend to other sites and social care domains.

LESSONS LEARNED

- Co-designing with community partners is essential; aligning on simple workflows and shared definitions builds trust and makes referrals reliable.
- Flexible technology pathways were equally important, allowing each partner to participate fully while still achieving closed-loop visibility and consistent communication.

SUSTAINABILITY

The program is designed for long-term sustainability through predictable funding for community partners, standardized workflows and shared technology pathways that can scale across sites. A formal research partnership will evaluate cost, utilization and outcomes, generating the evidence needed to guide future investment and support sustained system-wide adoption.

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NORTH SHORE UNIVERSITY HOSPITAL AND LONG ISLAND JEWISH MEDICAL CENTER, NORTHWELL HEALTH

Wellness Wednesday Program

INITIATIVE DESCRIPTION AND GOALS

North Shore University Hospital and Long Island Jewish Medical Center partnered with the Town of North Hempstead to deploy a mobile unit, bringing free skin cancer screenings directly to the community. Conducted by board-certified dermatologists, these screenings are offered at easily accessible, high-traffic locations such as town parks, pools and beaches during the summer months. This approach maximizes reach to diverse populations, including adults, seniors and high-risk groups like lifeguards. A streamlined process with Northwell's dermatology service line ensures prompt local follow-up appointments for any patients with suspicious findings.

The primary goals are to:

- increase early detection and identify potential skin cancers and suspicious lesions at their earliest stages among vulnerable populations;
- overcome barriers to care by providing free, convenient and accessible dermatological screenings that residents might not otherwise seek due to cost, time or lack of awareness; and
- ensure follow-through by providing immediate and comprehensive follow-up care for high-risk patients, preventing treatment delays.

This program directly aligns with the New York State *Prevention Agenda* priority area related to chronic disease preventive care and promoting well-being.

PARTNER

Town of North Hempstead.

OUTCOMES

- A total of 241 patients have been screened since the program's inception in 2023.
- In 2025, nearly 20% of all screened patients presented with suspicious findings requiring follow-up.
- In 2025, the program saw a notable increase in critical outcomes: of 90 patients screened, 17 were identified for follow-up and there were eight immediate referrals for biopsies, more than doubling referrals from previous years.

LESSONS LEARNED

- There is a substantial need for free and convenient skin cancer screenings within the target communities. Many patients hadn't seen a dermatologist in years and stated they wouldn't have sought screening otherwise, demonstrating the program fills a critical gap in healthcare access and addresses significant barriers to care. The high rate of suspicious findings (nearly 20% in 2025) further underscores this need.
- Identifying suspicious findings is only half the battle; ensuring timely follow-up for those findings is equally crucial to prevent treatment delays. Establishing a direct referral process with the dermatology service line was critical to ensure patients received prompt local appointments.

SUSTAINABILITY

- The Town of North Hempstead serves as a strong partner to promote sustainability.
- Guaranteeing that detected issues lead to treatment fosters trust within the community, which is essential for continued participation and support, and prevents the program from being seen as merely a "screening-only" effort.
- Continuous evaluation of tracking data allows for efficient allocation of resources, appropriate staffing levels and targeted deployment of the mobile unit, ensuring the program runs effectively with available resources and adapts to community needs.

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NORTHERN DUTCHESS HOSPITAL

Diabetes Prevention Program

INITIATIVE DESCRIPTION AND GOALS

The CDC National Diabetes Prevention Program at Northern Dutchess Hospital was launched in response to a clearly identified and persistent community health need. Over the last four Community Health Needs Assessments, chronic disease prevention has consistently been selected as a priority for the hospital's service area.

The DPP focuses on prevention, access and early intervention for people at greatest risk for type 2 diabetes and its complications. Participants meet regularly with a certified nutritionist to learn practical strategies for healthy eating, physical activity, stress management and sustainable lifestyle change. The program begins with weekly sessions and transitions to monthly meetings to reinforce skills and support long-term success.

Eligibility is limited to individuals with prediabetes or CDC-identified risk factors, ensuring resources are directed to those most likely to benefit. By combining evidence-based education with sustained support, the program advances the New York State *Prevention Agenda* priority of preventive services for chronic disease prevention and control.

PARTNER

CDC.

OUTCOMES

- **Improved glycemic control:** Participants in the most recent cohort achieved an average 0.467% reduction in hemoglobin A1C, indicating improved blood glucose management and reduced risk of progression to type 2 diabetes.
- **Sustained weight loss:** Two 12-month cohorts completed in 2024 reported average weight loss of 5.6% and 7.3% by program completion.
- **Increased physical activity:** Participants report an average of 245 minutes of physical activity per week, exceeding the CDC recommendation of 150 minutes of moderate-intensity activity for adults.

LESSONS LEARNED

- Lifestyle change is a powerful catalyst for whole person health. Improvements in nutrition and physical activity not only reduce diabetes risk but also positively impact mental health, energy levels, confidence and overall quality of life.
- Meaningful, life-changing health improvements can be achieved through sustainable behavior change, demonstrating that prevention and risk reduction are possible without medication.

SUSTAINABILITY

The program's sustainability is strengthened by numerous factors, starting with it being offered at no cost to participants, eliminating financial barriers to access. Ongoing community outreach and promotion support consistent enrollment, while continuous quality improvement is maintained through regular data tracking and reporting to the CDC. The program is not dependent on grant or philanthropic funding, which positions it for long-term impact in chronic disease prevention.

CONTACT

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NORTHWELL HEALTH

Community Health Worker Program

INITIATIVE DESCRIPTION AND GOALS

Northwell's Community Health Worker Program addresses health-related social needs of Medicaid recipients with complex health requirements. Community health workers who are trusted individuals sharing similar life experiences with members, integrated into inpatient, ambulatory and physician practice locations, screen for non-medical needs like food insecurity upon enrollment. A central support team then connects Medicaid enrollees to community resources through a standardized, efficient and accountable pathway.

Collaboration with community-based organizations, managed care organizations and ambulatory practices drives success. They serve as both primary referral sources and essential community resources for addressing Medicaid recipient needs. The CHWP team provides personalized support, such as accompanying participants to appointments and facilitating public benefits applications to help ensure positive outcomes. Program enrollment assistance services are also taken to where needs are greatest, like homeless shelters and faith-based organizations.

By addressing root causes of poor health, this initiative improves health for all and reduces preventable healthcare utilization while supporting New York State *Prevention Agenda* priorities of promoting healthy environments and preventing chronic disease.

PARTNERS

Department of Social Services, more than 35 New York City metropolitan area CBOs, managed care organizations and local community colleges.

OUTCOMES

The top three measurable CHWP outcomes are:

- average 78% relative reduction in inpatient hospital utilization for members enrolled for at least 12 months (2024 data);
- average 75% relative reduction in emergency department utilization for members enrolled for at least 12 months (2024 data); and
- 16,000 SDOH needs identified and addressed over a 12-month period (2025), including connecting thousands of members to food and transportation services.

LESSONS LEARNED

- A centralized team to manage resource connections is crucial for efficiently and successfully addressing member needs and ensuring program team member accountability.
- Significant barriers to successful resource connections include member engagement and documentation requirements, highlighting the need for enhanced participant assistance and advocacy to make sure all requirements are met.

SUSTAINABILITY

- Long-term sustainability is provided via organizational commitment and state-level integration. The program is growing across additional Northwell facilities and clinical service lines like obstetrics.
- Most critically, alignment with the state's Community Health Worker Plan Amendment provides stable structural and financial support. This state-policy integration formally recognizes CHW roles and services, securing durable funding and community service capacity for the foreseeable future.

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NYC HEALTH + HOSPITALS

One Stop Benefits

INITIATIVE DESCRIPTION AND GOALS

NYC Health + Hospitals created a holistic One Stop Benefits access model to proactively address patients' financial needs to improve health, well-being and equity, and address the significant gaps in access to public benefits among low-income New Yorkers. Means-tested and insurance-based public benefits have historically been underutilized, with uptake of Medicaid and Supplemental Nutrition Assistance Program benefits among eligible New Yorkers being particularly low.

NYC Health + Hospitals has a significant workforce of ~60 telephonic financial counselors who screen uninsured patients for health insurance or healthcare access programs and help them enroll based on their eligibility. The OSB model adds additional public benefits to this screening and assistance workflow.

Goals of the OSB model are to:

- screen patients for eligibility for tax credits (Earned Income Tax Credit and Child Tax Credit);
- a local public transportation discount (Fair Fares) and SNAP/ Women, Infants and Children;
- if eligible, assist with submitting a SNAP application and fast-track enrollment for Fair Fares; and
- share information via email on how to access WIC, EITC and CTC, including through free onsite and virtual tax preparation services and WIC centers.

PARTNERS

New York City Department of Social Services, New York City Department of Human Resources Administration, Robin Hood, Institute for Community Health and Benefits Data Trust.

OUTCOMES

- A total of 8,598 patients were screened for additional public benefit eligibility.
- Ninety-five percent of patients receiving the additional screening reported a satisfaction level of four or five on a scale of five stars.
- Eighty percent of staff reported that they feel very prepared to carry out their job tasks.

LESSONS LEARNED

- Implementation hinges on a commitment to addressing poverty among patients, strong internal scaling and adoption, leveraging existing workflows, a skilled workforce and effective quality improvement efforts.
- Successful enrollment relies on deep, ongoing technical coordination with external government partners that administer public benefits to remove systemic workflow barriers and ensure interoperability of systems.

SUSTAINABILITY

- The OSB initiative at NYC Health + Hospitals plans to achieve sustainability by incorporating the model into the system's standard scope of services.
- The health system will use evaluation findings to inform the model's future and sustainability plan, with the goal of justifying the cost of staff time through an in-depth evaluation of efficiency.

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NYC HEALTH + HOSPITALS/ELMHURST

Safety Net and Street Health Outreach and Wellness

INITIATIVE DESCRIPTION AND GOALS

The Elmhurst Safety Net and Street Health Outreach and Wellness initiative aims to serve patients who are experiencing homelessness, both sheltered and unsheltered. This multidisciplinary team meets patients where they are and provides medical and social services wherever a PEH is willing to receive it. The SHOW team aims to build trust and a relationship over time that will address the patient's goals and health needs.

The SHOW team focuses on harm reduction, patient-centered care and street medicine. The SHOW van provides primary care, substance use and mental health treatment, connections to resources and material goods including food, water and hygiene items to people who are unsheltered and in need. The goal is to connect them to the brick-and-mortar safety net clinic where they can receive comprehensive primary care services to treat, control and prevent chronic disease. The clinic also provides preventive screenings and supports clients with connection to long-term housing resources.

PARTNERS

Department of Homeless Services, Breaking Ground, Voces Latinas, Make the Road, and Union Hall Safe Haven and Drop-in Center.

OUTCOMES

- Care for diabetic patients increased from 31 patients in January 2025 to 55 patients at the end of January 2026, with a 45% diabetes control rate.
- Care for patients with high blood pressure increased from 37 patients in January 2025 to 53 patients at the end of January 2026, with a 68% control rate.
- The colonoscopy screening rate increased from 93.8% in January 2025 to 96.3% by the end of January 2026.
- The breast cancer screening rate increased from 48% in May 2025 to 58.3% by the end of January 2026.

LESSONS LEARNED

- Working with PEH involves patience and persistence. It takes an average of 25 encounters before a client engages meaningfully with the care team.
- Providing small acts of kindness starts this process and can lead to meaningful engagement with the healthcare system, but it can take many encounters over many months.
- This is possible by having a complete team with multiple disciplines, from social workers to physicians.
- This kind of initiative requires buy-in from leadership as it takes time for traditional results to become apparent.

SUSTAINABILITY

Sustainability hinges on maintaining the two-tier model of SHOW mobile care paired with a brick-and-mortar safety net clinic. Reducing emergency department and inpatient utilization are the primary drivers of financial sustainability. Collaboration with other city agencies and community partners helps provide an effective multidisciplinary solution to the complex challenges PEH experience. These meaningful results and positive outcomes improve staff morale and sustain personnel.

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NYC HEALTH + HOSPITALS/METROPOLITAN

Asthma Counselor Program

INITIATIVE DESCRIPTION AND GOALS

The Asthma Counselor Program at Metropolitan Hospital provides comprehensive asthma education and case management to children with poorly controlled asthma. The program aims to reduce asthma-related deaths, hospitalizations, emergency room visits and school absenteeism by improving medication adherence, addressing environmental triggers and mitigating social determinants of health. Through hospital-based referrals, culturally responsive education and community partnerships, the program supports families in achieving long-term asthma control. This initiative aligns with the New York State *Prevention Agenda* priority area of preventing chronic diseases and reducing health disparities among high-risk pediatric populations.

PARTNERS

East Harlem Neighborhood Health Action Center, Center for Health Equity and Community Wellness – Bureau of Harlem Neighborhood Health, New York City Housing Authority, Boundary Exterminate Corp., Healthy Homes, NYC Health + Hospitals Housing for Health, Public Health Solutions, Charlie Health, pulmonology, dermatology, endocrinology, early intervention, and allergy specialists, Committee on Preschool Special Education, Committee on Special Education, and back-to-school and Asthma Day events.

OUTCOMES

- Emergency room visits among graduates decreased by 63.2%.
- Hospitalizations among graduates decreased by 50%.
- Missed school days among graduates decreased by 86.2%.

These outcomes were achieved through consistent asthma education, medication adherence support, environmental interventions, and coordination of medical and social services.

LESSONS LEARNED

- Culturally responsive education and consistency are essential to improving asthma outcomes.
- Families are more engaged when education reflects their beliefs, language and lived experiences.
- Regular follow-up reinforces learning, improves adherence and builds trust, leading to fewer asthma-related emergencies.

SUSTAINABILITY

Sustainability is achieved through integration with Metropolitan Hospital's pediatric services and strong community partnerships. Ongoing referrals to housing, legal, mental health and food resources ensure continuity of care. Graduates transition to community health worker programs for continued support.

CONTACT

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ONE BROOKLYN HEALTH SYSTEM

Health Equity and Diabetes

INITIATIVE DESCRIPTION AND GOALS

Established in 2022 in the post-pandemic era when patients with diabetes were disproportionately affected by COVID-19, the One Brooklyn Health System created the Diabetes Center of Excellence with two clear aims:

- addressing inequities in access to advanced diabetes technology in resource-poor communities; and
- reducing barriers to diabetes education and self-management through peer-led education.

One Brooklyn Health System partnered with Health People, Inc., a community-based organization, to build a rigorous peer workforce pipeline: 133 potential peer leaders were identified, 44 interviewed and 17 were selected as peer candidates; 14 completed a structured four-week leader training and now deliver standardized peer-led DSME workshops covering meal planning, food labels, problem solving, emotions, stress, monitoring and action planning.

To close gaps in access to both education and technology, daily operations are anchored in five operating principles:

- expand access to care;
- peer-led self-management education;
- advancing diabetes technology;
- continuous team improvement; and
- commitment to learning (and humility).

This work aligns with New York State *Prevention Agenda* priority areas by expanding preventive services for chronic disease management and control through evidence-based self-management support and equitable access to continuous glucose monitoring and insulin pump therapy. The peer-led classes were supported by a grant from the Altman Foundation.

PARTNER

Health People, Inc.

OUTCOMES

- **Peer-led DSME reach:** 478 patients have completed the full six-week course, delivered in a standardized, peer-led workshop format focused on practical skills (meal planning, label reading, problem solving, stress management, monitoring and action planning).
- **DSME results:** In 88 participants with paired A1c values, average A1c fell by 0.8 percentage points; about 70% improved, with the biggest gains in adults under age 60.

- **Insulin pump/automated insulin delivery program:** 89 active pump users. In 25 users with paired A1c, average A1c improved from 10.2% to 7.9%. CGM data showed time-in-range increased from about 38% to 66%, while low-glucose time improved from 2.4% to 0.7%, supporting safe implementation.

LESSONS LEARNED

- DSME is best delivered through a trusted community partner and should be peer-led. In this program, engagement was high and the peer-led format created a joyful, supportive learning environment.
- Advanced diabetes technology can be offered at scale safely and effectively in communities with significant social determinants of health when operations are strong, especially with accessible, highly trained nursing staff. SDOH should never be a barrier to access to CGM or automated insulin delivery systems.

SUSTAINABILITY

- Sustainability is achieved by building durable infrastructure and a continuous-learning system that reliably delivers measurable outcomes, then aligning those outcomes with future reimbursement pathways.
- The health system standardized workflows, staffing and data reporting so services can run predictably at scale, and uses outcomes monitoring to drive continuous improvement. As quality and reach are documented, reimbursement systems that value outcomes can support ongoing DSME delivery and technology access.

CONTACT

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ORLEANS COMMUNITY HEALTH

Healthy Communities Program

INITIATIVE DESCRIPTION AND GOALS

The Healthy Communities Program is designed to improve health outcomes across all ages in a rural community. Recognizing barriers such as cost, access and health literacy, the program delivers free and low-cost education, screenings and safety initiatives in trusted, community-based settings.

Prevention begins early through the Teddy Bear Clinic, relaunched in 2022, which invites pre-K, kindergarten and homeschool children to tour the hospital and learn about healthcare in a friendly, hands-on way. This early exposure reduces fear, builds health literacy and supports lifelong engagement in preventive care.

Community-wide wellness fairs and seasonal events provide an average of 200 preventive screenings per event while connecting residents to local resources and partner organizations across the county. Targeted initiatives such as cancer services and education events emphasize early detection and feature powerful personal stories that reinforce the importance of screening.

Family-focused programs, including CPR training and bike helmet distribution for children address injury prevention and promote safe, healthy lifestyles. By meeting residents where they are and combining education, early detection and access to care, the Healthy Communities Program advances a comprehensive prevention agenda that strengthens health equity and community well-being.

PARTNERS

GO Health, Orleans County Mental Health, UConnect Care, local school districts, YMCA, Community Action of Orleans and Hospice of Orleans.

OUTCOMES

- **Access to preventive screenings:** 200 screenings per fair (there are plans to split these into men's and women's screenings to increase the number of people served).
- **Access to care for children (pediatric services in a rural community):** 500 children have come through the doors for events.
- **Family care:** 100 attended a CPR/first aid for children class and received information on healthy eating and meal planning.

LESSONS LEARNED

- Single health fairs do not enable Orleans Community Health to provide more focused resources to men and women individually. Additionally, these events do not provide what is needed for populations like the Amish community.
- Having a children's fair in two portions of the county, the health system also expects to increase the focus it can provide to children and families.

SUSTAINABILITY

- The Healthy Communities Program is sustainable through strong community partnerships, integration with existing community health services and ongoing community demand.
- By embedding prevention activities into annual events, using multidisciplinary staff and collaborating with local organizations, the program maintains consistent outreach while maximizing resources and long-term impact.

CONTACT

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PUTNAM HOSPITAL CENTER

Utilizing FMEA to Ensure Safety, DOCCS Women's Imaging Initiative

INITIATIVE DESCRIPTION AND GOALS

The initiative goal was simple: get patients to Putnam Hospital Center anytime during the scheduled day between 8 a.m. and 3 p.m., eliminating the issues surrounding timing of appointments, missed/late transportation, etc. Putnam Hospital Center was provided with the names of the patients, along with any prior imaging and the written order from the Department of Corrections and Community Supervision provider; the rest was to be handled through to completion whenever they arrived.

Once the patients arrived, they were managed up through and including diagnostic mammography, breast and targeted ultrasound. No patients required breast MRI or biopsy, but provisions were in place to handle these services should the need arise.

PARTNERS

David Natoli, RT, BSRS, manager, imaging services; Andrea Croniser, BS, RN, administrative nursing supervisor; Anthony Bochicchio, manager, security; Kathy Peverini, RT(R)(M); Cathy Lane, MS, RN, CPHQ, director, quality; Derrick Bradley, DOCCS regional health services administrator; and Zachary DeBartolo, DNP, MSN-RN, acting assistant director, DOCCS.

OUTCOMES

- To date, 62 imaging studies were successfully performed; 18 inmates refused follow-up.
- Each new case is handled in real time to avoid patients becoming overdue for follow-up imaging studies.
- The backlog has been eliminated and the hospital is working closely with DOCCS to keep a timely course for follow-up visits and examinations.

LESSONS LEARNED

- The team gained an appreciation for the intricacy and complexity required to provide healthcare to the incarcerated population. Incarcerated individuals are not informed of impending studies/travel due to security concerns, leading to a lower participation rate than expected.
- The more flexible the hospital made its scheduling processes, the more patients it was able to care for. This “bring them whenever you can” approach has been employed in other imaging disciplines with similar success.

SUSTAINABILITY

The “bring them whenever you can” model has been deployed throughout imaging at Putnam Hospital Center, leading to increased utilization of services in the DOCCS population but also not limiting availability for the community by having DOCCS patients occupy appointment slots that they were late for or cancelled.

CONTACT

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REFUAH HEALTH CENTER

Care4Her

INITIATIVE DESCRIPTION AND GOALS

Refuah Health's Care4Her is a pioneering walk-in women's health urgent care service designed to address acute OB/GYN concerns that arise outside of traditional business hours. The initiative recognizes the unique lived reality of women who manage family, caregiving and career responsibilities throughout the day, often only finding time to address their own health needs late at night after their households have settled. By offering specialized care until midnight — including expanded Saturday night winter hours (Motzei Shabbos) at the flagship Spring Valley location and services in rural South Fallsburg — Care4Her provides a trusted alternative to emergency departments.

The program offers hospital-level diagnostics, such as non-stress tests, ultrasound imaging and laboratory testing, overseen by the chief of maternal-fetal medicine. A core goal is ensuring continuity of care; the team coordinates directly with the patient's regular provider, referring the patient back to the center for any necessary follow-up care.

This initiative directly supports the New York State *Prevention Agenda* priority for the prevention of infant and maternal mortality by ensuring that high-risk obstetric and gynecologic issues receive timely, expert intervention, regardless of a patient's ability to pay.

PARTNERS

Westchester Medical Center (emergency escalation), Sullivan County Legislature, Town of Fallsburg and FidelisCare.

OUTCOMES

- **ED diversion and clinical scale:** Managed 6,435 visits to date with 150% year-over-year growth; successfully treated 1,080 urgent ICD-coded cases and 14 high-risk nonstress tests in-clinic, diverting significant volume from local EDs.
- **Reaching the underserved:** To date, 67% of all patients are uninsured, Medicaid or low-income, with flagship utilization reaching 75%, ensuring high-quality OB/GYN care for the most vulnerable populations.
- **Rural expansion:** Refuah Health successfully scaled the urban model to rural Sullivan County, where 52% of initial patients are from underserved backgrounds, addressing critical "maternal care deserts."

LESSONS LEARNED

- **Timing and access:** Women often suppress health concerns while juggling work and caregiving, only realizing a need for care late at night. Providing after-hours access ensures they do not delay critical care.
- **The trust advantage:** Offering hospital-grade diagnostics (NSTs, ultrasounds) in a familiar, calm community setting reduces ER anxiety and ensures continuity of care as patients are seamlessly referred back for follow-up.

SUSTAINABILITY

As a Federally Qualified Health Center, Refuah uses a sliding fee discount schedule and a diverse billing model (Medicaid/private insurance), ensuring long-term viability regardless of a patient's ability to pay. Continuity is secured through a "closed-loop" referral system, where urgent visits are integrated into the patient's permanent health record for seamless follow-up care. The successful expansion from urban to rural sites proves the model is scalable and resilient.

CONTACT

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ROCHESTER REGIONAL HEALTH

HealthySteps

INITIATIVE DESCRIPTION AND GOALS

Rochester Regional Health integrated the HealthySteps model into its ambulatory pediatric practices. This interdisciplinary pediatric primary care initiative is dedicated to enhancing the health, well-being and school readiness of infants and toddlers, particularly those from low-income families. HealthySteps, a nationally recognized and evidence-based program developed by the Zero to Three organization, has been in operation for over 30 years.

By embedding HealthySteps specialists within pediatric care teams, the program offers a holistic approach to child health during well child visits. These experts in early childhood development bridge the gap between clinical care and the everyday challenges of raising young children. They support parents and caregivers during well child visits and follow up on essential screenings such as developmental, social-emotional, family needs and maternal depression. They also provide developmental and behavioral guidance, educate caregivers to strengthen parent-child relationships, and connect families with vital community resources and services.

Parenting infants and toddlers presents emotional and practical challenges, especially for caregivers who lack essential support and resources. RRH's pediatric leadership recognizes the importance of supporting caregivers of the youngest patients to ensure the best possible health and well-being outcomes.

PARTNERS

RRH Healthy Moms, Monroe County Early Intervention, Genesee County Early Intervention, Wayne County Early Intervention, Ontario County Early Intervention, Boys & Girls Club, UMMC Healthy Living Center and Healthy Baby Network.

OUTCOMES

- **Well child visit completion rates:** In 2025, 90% of Tier 3 children (most at risk) enrolled in HealthySteps completed six or more well child visits within the first 15 months of life.
- **Screening rates:** Over 80% of children enrolled in HealthySteps were screened for developmental and social emotional needs and over 70% of mothers were screened for maternal depression.
- **Positive parenting education:** 93% of families who met with a HealthySteps specialist received guidance and information on positive parenting practices.

LESSONS LEARNED

- It is essential to maintain flexibility in workflows and service delivery methods to address the unique needs of each site.
- Providing comprehensive support for the entire family within a single location — including addressing non-medical concerns — delivers significant advantages.
- Manual data collection was both inefficient and unsustainable. Thanks to grant funding, the organization was able to upgrade its Epic electronic medical record system by implementing the HealthySteps Turbo Charger package.

SUSTAINABILITY

- RRH recognizes the critical importance of identifying and implementing robust sustainability strategies to ensure the continued success of HealthySteps beyond the initial grant-funded period. A statewide New York collaborative has been established to help HealthySteps sites develop comprehensive sustainability plans.
- Current efforts are focused on developing internal EMR infrastructure to support preventive behavioral health billing, with pilot billing initiatives set to launch in 2026.
- New York policymakers are considering legislation (S.7833A/A.8048A) that would create an add-on payment for pediatric practices implementing the HealthySteps model. If enacted, these bills would enable existing sites to sustain their work.

CONTACT

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ROCHESTER REGIONAL HEALTH – ST. LAWRENCE REGION

Strengthening Maternal Health through Restored Childbirth and Breastfeeding Classes

INITIATIVE DESCRIPTION AND GOALS

At the beginning of the COVID-19 pandemic, all in-person childbirth education classes were halted in the region. Offering childbirth education and breastfeeding classes is a powerful strategy for reducing health disparities in a community, especially for populations that have historically had less access to high-quality prenatal education and postpartum support.

In July 2024, Canton-Potsdam Hospital began a collaboration with the North Country Children's Museum. Over the course of the next nine months, CPH was able to implement childbirth preparation, prenatal and postpartum breastfeeding classes. Marketing teams from CPH and the North Country Children's Museum assisted in reaching the target population of all birthing individuals in the community through print advertising, social media posts and invitations to appropriate obstetrics patients.

This initiative began with short- and long-term goals:

- By March 2026, all classes offered would have a 50% increase in registered participants and 100% of participants will complete end-of-class electronic surveys to provide feedback.
- By June 2026, 90% of breastfeeding class participants that deliver at Rochester Regional Health would successfully breastfeed throughout their hospital stay.
- By December 2026, birthing individuals who complete the childbirth education series would indicate that they feel better prepared for the labor experience as indicated on survey responses and have a 10% reduction in medical interventions (early epidurals, elective inductions, primary cesarean section).

These goals relate to the New York State *Prevention Agenda* priorities of access to and use of prenatal care and community services and support, opportunities for continued education, and prevention of infant and maternal mortality.

PARTNERS

North Country Children's Museum.

OUTCOMES

- Completed participant responses show 92% are very satisfied with the overall childbirth education program (8% responded satisfied); likewise, 92% feel adequately prepared for childbirth (8% responded somewhat prepared).
- All participants rated the educators as being very effective and would recommend this program to others.

- By offering no-cost, evidence-based classes in a trusted community setting, the program ensures that birthing individuals — including those with limited prenatal care access, transportation challenges, lower health literacy or socioeconomic constraints — receive essential guidance on safe labor practices, breastfeeding, postpartum wellness and early warning signs.

LESSONS LEARNED

- Providing education outside of the hospital setting improves engagement, comfort and trust among participants.
- Partnering with a community organization such as the North Country Children's Museum created a welcoming environment that reduced healthcare-related anxiety and strengthened community ties.
- Offering the program free of charge is essential, as financial barriers would have limited participation among families facing socioeconomic challenges, particularly those with limited prenatal care access or transportation constraints.

SUSTAINABILITY

The use of experienced labor and delivery nurses as educators proved highly effective, as participants consistently reported feeling more prepared, more confident and more supported due to the nurses' clinical expertise and their ability to address questions in real time. This approach will continue to guide the program's development and ensure its long-term sustainability.

CONTACT

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ROSWELL PARK COMPREHENSIVE CANCER CENTER

Community Outreach and Engagement Center

INITIATIVE DESCRIPTION AND GOALS

In October 2023, Roswell Park Comprehensive Cancer Center opened a new Community Outreach and Engagement Center, also known by its “907 Michigan” address, located in the heart of the east side of Buffalo. The center was created with community stakeholders to ensure that every aspect reflects the voices, needs and priorities of the neighborhoods it serves.

The center serves the Western New York eight-county catchment area’s underserved and hard-to-reach populations including rural, urban, uninsured, underinsured, racial and ethnic minorities, and immigrant and refugee communities. The center’s mission is to provide a welcoming space that strengthens partnerships, empowers residents and supports health and well-being.

The mission of the center directly aligns with New York State *Prevention Agenda* priority areas related to chronic disease prevention and control and access to community services and support. The center’s mission advances these priority areas by promoting early detection, healthy behaviors and evidence-based interventions to achieve better long-term health outcomes.

PARTNERS

The team has partnered with over 200 community-based organizations, including civic, faith-based, advocacy, government/public services, arts/culture, employment, environment/sustainability, healthcare/wellness, sports/recreation, education and housing/urban development.

OUTCOMES

- Since 2023, the center has welcomed more than 16,000 community members. It has hosted over 800 events; about 500 of those were led directly by community partners.
- The community outreach staff has reached over 9,000 community members through community-focused programs reaching higher-risk and underserved communities.
- A total of 500 local neighbors and community members attended the annual outdoor community event and nearly 200 people signed up for additional health-related services and information.

LESSONS LEARNED

It is important to include community voices at each stage of planning a community outreach center. The goal was to create a “community first” building not just in name, but in practice. It was crucial to host community listening sessions where residents shared their concerns, hopes and expectations for the space. Their input ensured the center’s mission and the community’s need for a meaningful, people-centered resource were equally reflected.

SUSTAINABILITY

The center’s sustainability relies on strong community partnerships that expand outreach, education and engagement. Long-term viability is reinforced by the cancer center’s senior leadership and support from elected officials, with the center’s central location further strengthening its ability to serve the community.

CONTACT

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TOP 5

ST. JOHN'S EPISCOPAL HOSPITAL

Maternal Social Determinants of Health Program

INITIATIVE DESCRIPTION AND GOALS

The Maternal Social Determinants of Health Program at Episcopal Health Services' St. John's Episcopal Hospital, the only hospital in Far Rockaway, Queens, is a targeted perinatal mental health initiative that combines universal Edinburgh Postnatal Depression Scale screening, SDOH and warm hand-offs to behavioral health and community resources for high-risk pregnant and postpartum patients.

Leveraging support from the Mother Cabrini Health Foundation, the program achieved a 58% reduction in EPDS scores and a 71% reduction in the prevalence of clinically significant anxiety among enrolled participants. Through partnerships with God's Love We Deliver, Love Nana, Campaign Against Hunger and Allied Foundation Diaper Bank, patients gained reliable access to food, baby supplies and other essentials, which substantially reduced stress related to unmet basic needs.

By addressing concrete social and economic stressors alongside mental health treatment, the program improves maternal well-being, enhances resilience in the postpartum period and advances equity in perinatal outcomes.

PARTNERS

God's Love We Deliver, Love Nana, Campaign Against Hunger, Allied Foundation Diaper Bank and Mother Cabrini Health Foundation.

OUTCOMES

- This program has been embedded into routine obstetric workflows through electronic medical record-integrated EPDS and SDOH tools, standardized referral pathways, and defined roles for social work and community trained doulas.

LESSONS LEARNED

- Systemic EPDS and SDOH screening is only effective when paired with warm hand-offs and dedicated care coordination.
- Trust building with high-risk patients requires culturally responsive, trauma-informed communication and consistent follow-up beyond the immediate postpartum stay.

SUSTAINABILITY

Sustainability is supported by embedding this initiative into obstetric workflows and tools, standardized referral pathways, and defined roles for social work and community trained doulas. The hospital is exploring alignment with Medicaid doula reimbursement, value-based payment and maternal quality incentives, and training all on this model to ensure ongoing capacity without reliance on short-term grants.

CONTACT

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TOP 5

ST. JOSEPH'S HEALTH

Food Farmacy at St. Joseph's Hospital Health Center

INITIATIVE DESCRIPTION AND GOALS

Across a two-year project/funding period, the Food Farmacy at St. Joseph's Hospital Health Center will continue eligibility criteria across all organizational sites to include individuals with any chronic condition who have food insecurity identified using the Social Needs Screening Assessment. St. Joseph's will continue to employ one full-time community health worker, one part-time CHW and one full-time registered dietitian.

The Food Farmacy increases access for patients by accepting referrals from St. Joseph's ambulatory service line locations, medical and psychiatric emergency departments, and acute care. The program focuses on purchasing healthier, affordable food options to meet patient/client dietary needs and purchasing cooking tools and items for use when transporting groceries to and from the Food Farmacy and/or local grocers.

The program builds on concepts from previous instances, from 2021 forward, including:

- all state-eligible chronic conditions are accepted;
- patients receive care at any of the organization's ambulatory, emergent or acute care sites;
- the local food pantry network helps address food insecurity;
- a CHW network is vital to address barriers to care;
- collaboration with key stakeholders is vital to evaluate program sustainability, including reimbursable billing;
- collaborative work done with Syracuse Onondaga Food Systems Alliance; and
- an RD collaborates with the local food bank to conduct educational cooking demonstrations and provide nutritional assessments and education for patients.

New in 2026, Syracuse Northeast Community Center will receive funding to create an at-home farming/growing program to encourage sustainable food access through herbs in pots and community gardens. InterFaith Works will focus on providing culturally relevant food items at 15 area food pantries through its Food Justice Program. Systemic racism and inequity are two root causes of food insecurity and, by providing foods that people not only need but prefer, they are able to find comfort in food selections and are more apt to eat in a healthy manner.

To share information learned, the Food Farmacy holds regular meetings where Food Farmacy staff and community-based organization partners present findings, share education opportunities and recipes, and respond to inquiries and requests.

PARTNERS

Syracuse Northeast Community Center, Syracuse University, InterFaith Works CNY, PEACE Inc., Westcott Community Center, Brady Market, Syracuse Northeast Community Center, Food Bank of CNY, Delaney Farms, Salt City Harvest Farms and Lipari Wholesale.

OUTCOMES

- The Food Farmacy conducted 1,183 social care needs screenings, in which all received a referral for appropriate services.
- A total of 2,319 meals were distributed through the program, while CBO partners distributed another 268,296 meals.
- Weight is monitored, but this is an area where staff are developing a method to gather relevant data in line with individual care plans because some patients are trying to gain weight due to a history of disordered eating; it can be counterproductive to focus on regular weigh-ins due to their fear of gaining weight and flawed way they view their bodies. Program participants are losing weight at different rates with some losing as much as 50 pounds.

LESSONS LEARNED

- The importance of procuring healthier food alternatives became clear when the program network expanded to local farmers and grocers to enable the program to provide participants with appealing, nutrient-dense "better-for-you" food alternatives.
- CHWs became a vital part of the program, both for the Food Farmacy and across CBO partners. These positions create an access point/resource, allowing for increased awareness of community resources and programming that directly impact those served.

SUSTAINABILITY

- The Food Farmacy partners with the Syracuse-Onondaga Food Systems Alliance to raise awareness and explore sustainability through its Food as Medicine workgroup.
- The Food Farmacy engages with Health Care Without Harm, Practice Greenhealth and Food as Medicine Community of Practice to share best practices and strengthen procurement strategies.
- The state's development of a CHW reimbursement framework under the Medicaid 1115 waiver is monitored for sustainable measures and St. Joseph's is in the process of building a Medicaid reimbursement model for CHWs and registered dietitians.

CONTACT

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SAINT JOSEPH'S MEDICAL CENTER

Daphne and Jay Paul Residence

INITIATIVE DESCRIPTION AND GOALS

The Daphne and Jay Paul Residence is a 15-bed short-term program with a multidisciplinary staff providing 24/7 intensive crisis interventions and support to help the individual stabilize and return to their previous level of functioning. It can also serve as a step-down from inpatient hospitalization to support the transition back to the community. Saint Joseph's Medical Center's approach is to provide clients with quality crisis stabilization services in a safe, supportive, community-based, home-like setting where they can face an acute psychiatric crisis and/or period of acute stress that significantly impairs their capacity to cope with life circumstances.

The goals of this intensive crisis residence include providing an alternative to psychiatric hospital admissions and readmissions, shortening length of hospital stays, and providing support and resources as an alternative to repetitive emergency department visits. This in turn reduces overall healthcare costs and provides clients with quality crisis stabilization services in a supportive, community-based, home-like setting.

The ICR program relates to several of the New York State *Prevention Agenda* priority areas including providing preventive services geared toward reducing suicide, injuries and violence, and substance misuse and overdose. The ICR increases access to community services and supports by linking clients to aftercare treatment. The ICR also focuses on reducing depression, anxiety, stress, and alcohol and tobacco/e-cigarette use by addressing those issues with clients in the program.

PARTNERS

New York State Office of Mental Health, Westchester County Department of Community Mental Health, PROJECT ALLIANCE (network of crisis services within Westchester County), Westchester County Behavioral Health/Emotional Wellness College Collaborative, Westchester Suicide Prevention Task Force, Westchester County Suicide Fatality Review Board, Westchester County Police Department, Westchester County Department of Probation, Westchester County Department of Emergency Services, NAMI Westchester, White Plains Hospital and Westchester Medical Center.

Saint Joseph's Medical Center is working with two hospital systems, one in New York City and one in upstate New York, to develop additional intensive crisis residences.

OUTCOMES

- **Reduction in psychiatric inpatient admissions:** Data since date of ICR opening through January 2026 show that 87% of ICR clients were not admitted to an inpatient unit within 30 days.

- **Linkage/access to community care:** Linkages to transition care providers were tracked and showed that 80% of discharged ICR clients followed through on their aftercare with care providers within seven days of discharge.
- **Community need:** The ICR has had 270 admissions since opening in late October 2024 and the occupancy level for the ICR has been over 85%, demonstrating the need for this crisis stabilization level of care for the community. The program fills a gap in the crisis response system and is recognized as a valuable, vital resource for the community.

LESSONS LEARNED

- The ICR level of care successfully provides an alternative to psychiatric hospitalization, reduces healthcare costs and most importantly, provides clients with quality crisis stabilization services.
- The ICR has successfully provided crisis stabilization for those who are experiencing unstable housing, including shelter system referrals. It provides continuing support to shelter clients upon discharge including placement and linking the client to services to ensure their continued engagement with clinic care and medication adherence.

SUSTAINABILITY

- Since it opened in 2024 the ICR business plan has shown sustainability. A broad referral base in crisis services has ensured a continuous occupancy rate of at least 85%, achieving revenue to cover operating costs.
- The organization has an efficient billing system for revenue including Medicaid, HMOs and commercial insurance. Additionally, the health system receives Office of Mental Health gap funding toward the ICR's operations. Marketing includes direct outreach and contact with all hospital referral sources including local emergency departments, police, community-based organizations and colleges.

CONTACT

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TOP 5

ST. PETER'S HEALTH PARTNERS SAFE CARE NY

INITIATIVE DESCRIPTION AND GOALS

Each year, thousands of children across upstate New York experience sexual abuse. In rural communities, these children face additional barriers to care, including geographic isolation, workforce shortages and limited access to trauma-informed services. St. Peter's Health Partners created the Sexual Assault Forensic Examiner — Children & Adolescent Response and Education Program (SAFE CARE NY) to close this gap. The initiative aligns with the New York State *Prevention Agenda* priorities related to healthcare access and quality and social and community context.

SAFE CARE NY partners with child advocacy centers, law enforcement, hospitals, schools and community-based organizations across 35 counties to provide pediatric forensic medical services where children live. Guided by the principle that access to specialized care should never depend on ZIP code, the program deploys regional forensic nurse coordinators to deliver developmentally appropriate, trauma-informed care within trusted community settings.

SAFE CARE NY is not only reducing disparities and minimizing re-traumatization, it's building a more equitable system of care that supports healing, restores dignity and protects the long-term health of children.

PARTNERS

Child advocacy centers, hospitals and health systems, law enforcement, prosecutors, Child Protective Services and Departments of Social Services, mental health providers, victim advocacy agencies, school districts, local health departments and rural community-based organizations serving 35 communities and counties.

OUTCOMES

- More than 3,200 children have received trauma-informed forensic medical care and healthcare coordination close to home since 2021.
- In 2025, 422 children were served, reflecting sustained growth in access and reduced reliance on distant urban hospitals.
- Pediatric forensic services now reach communities representing 56% of New York state's geographic area, significantly reducing rural disparities and strengthening coordinated multidisciplinary response systems.

LESSONS LEARNED

- Embedding regional forensic nurse coordinators within communities builds trust, strengthens local partnerships and ensures children receive care where they feel safest.
- Lasting impact depends on shared responsibility. When healthcare, child welfare, education and justice partners work together, communities create a coordinated, compassionate system that protects children and promotes healing.

SUSTAINABILITY

Sustainability is achieved through diversified funding, including New York State Office of Victim Services Forensic Rape Exam billing, institutional commitment and strong multidisciplinary partnerships that embed SAFE CARE NY within community response systems. By integrating services into local infrastructure and maintaining continuous quality improvement, the initiative is built to endure — ensuring children and families will continue to have equitable access to care for years to come.

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STONY BROOK EASTERN LONG ISLAND HOSPITAL

Dignity in Care: Support Behavioral Health Patients through Community Giving

INITIATIVE DESCRIPTION AND GOALS

Dignity in Care is a community-driven initiative launched by Stony Brook Eastern Long Island Hospital and the Eastern Long Island Hospital Foundation to support behavioral health patients who arrive for care without access to basic necessities, particularly appropriate clothing. Recognizing that unmet basic needs can negatively impact recovery, dignity and safe discharge, the program provides clean, seasonally appropriate clothing to patients during hospitalization and upon transition back into the community.

The initiative's approach centers on whole-person, equity-focused care. Through a hospital-wide and community-supported clothing drive, Dignity in Care addresses a critical social determinant of health by reducing barriers related to socioeconomic status, stigma and access to resources. The program engages hospital staff, volunteers and community partners to ensure patients are supported beyond clinical treatment alone.

The primary goals of Dignity in Care are to enhance patient dignity, support mental and emotional well-being, facilitate safe discharge planning, and improve continuity of care for behavioral health patients across inpatient, outpatient and recovery settings.

This initiative aligns with the New York State *Prevention Agenda* priority area to promote healthy mental and emotional well-being, particularly the objective to reduce disparities and improve outcomes for individuals with mental health conditions. By addressing non-clinical needs that directly affect recovery and reintegration, Dignity in Care advances equitable, compassionate care for vulnerable populations in a rural community setting.

PARTNERS

Eastern Long Island Hospital Foundation, Opportunity Shop, North Fork community members, local civic and community organizations, hospital staff volunteers, community volunteers, local donors, local businesses, *The Suffolk Times* and local media partners.

OUTCOMES

- More than 200 bags of new and gently used clothing were collected through a community-wide drive, establishing a sustainable supply of essential items for behavioral health patients.
- To date, more than 200 patients across inpatient behavioral health, outpatient services in Riverhead and SBELIH-supported recovery homes have been provided clothes, with distribution ongoing.
- Barriers to dignity and safe discharge were reduced by addressing a key SDOH, improving patient comfort, confidence and readiness for recovery and community reintegration.

LESSONS LEARNED

- Addressing unmet basic needs such as clothing improves dignity, mental well-being and safe discharge for behavioral health patients, reducing disparities related to poverty, stigma and access to resources.
- Using existing community partnerships and local assets allows hospitals to implement equitable, sustainable interventions that improve outcomes without adding burden to clinical operations.

SUSTAINABILITY

Dignity in Care is sustained through established community partnerships, ongoing donation guidelines, and a structured collection and distribution process coordinated by the Eastern Long Island Hospital Foundation and the Opportunity Shop. By leveraging existing staff, volunteers and community assets rather than high-cost resources, the program remains financially sustainable, scalable and adaptable to evolving patient needs.

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STONY BROOK UNIVERSITY HOSPITAL

Trauma-informed Patient Navigator Program

INITIATIVE DESCRIPTION AND GOALS

Stony Brook University Hospital created the Trauma-Informed Emergency Department Patient Navigator Program to better support patients whose medical visits are shaped by abuse, violence and longstanding trauma. Many present with anxiety, substance use concerns, chronic pain or stress-related symptoms tied to deeper unmet needs. Using a trauma-informed, interprofessional model, the program identifies eligible patients and partners with them to clarify their priorities and overcome barriers such as insurance limits, waitlists and language needs to connect them with trauma-focused therapy and community supports.

The goals are to improve follow-through with behavioral health-care, strengthen continuity after emergency department visits, reduce disparities for Medicaid-insured and socially vulnerable patients and minimize revictimization by linking individuals to timely, appropriate services.

Since its 2024 launch, it has reached highly vulnerable patients and successfully connected more than 80% to needed referrals or assistance. By replacing passive referral lists with active, relational navigation and leveraging strong collaboration through the Family Violence Prevention Program and community partners, the initiative advances trauma-informed care and New York State *Prevention Agenda* priorities.

PARTNERS

Empowerment of Long Island; Family Service League; HWCLI Hotline Reference Guide for Nassau and Suffolk; Long Island Against Domestic Violence; Long Island Fatherhood Initiative; Northwell Center for Traumatic Stress; Resilience and Recovery; Stony Brook Adult Outpatient Psychiatry; Sepa Mujer; Stony Brook Gastroenterology for disorders of gut-brain interaction; Stony Brook Mind Body Center and Erin Berenz, PhD.

OUTCOMES

Over 17 months, the health system enrolled 136 trauma survivors, most low-income and facing significant medical and socioeconomic challenges. The following outcomes were achieved among the first 94 patients with ten months of data:

- follow-up: 81.9%;
- accepted post-discharge support: 68.1%; and
- saw a mental health provider while enrolled: 31.2%.

Patients expressed strong appreciation for the support and consistent check-ins, including the following: “[I’m] making a lot of progress,” “you were so helpful when I needed you,” “thank you for always checking on me!” and “thank you for listening and not judging me.”

LESSONS LEARNED

- Active relational navigation — personally connecting patients to appropriate providers and offering support throughout the process — significantly increases engagement compared with passive referral lists.
- Strong interprofessional collaboration is essential for effective and sustainable implementation.
- Embedding the program within the family violence prevention framework and maintaining robust community partnerships ensures accurate referrals, coordinated efforts, shared accountability and long-term viability.

SUSTAINABILITY

- Sustainability is achieved through integration within the Family Violence Prevention Program under doctor of nursing practice leadership, with strong executive and inter-professional support.
- The model leverages existing resources, supervised trainees and established community partnerships. Ongoing data tracking demonstrates impact, informs improvement and supports continued operational and leadership commitment.
- With access to additional staffing resources, the health system anticipates further expansion.

CONTACT

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THOMPSON HEALTH, UR MEDICINE

Mental Health First Aid

INITIATIVE DESCRIPTION AND GOALS

Thompson Health's goals were to enhance mental health literacy and increase individuals' understanding and awareness of mental health. The pandemic resulted in a rise in mental health struggles, substance use and suicide. One of Thompson Health's priorities through the New York State *Prevention Agenda* was to promote well-being and prevent mental and substance use disorders. The goal was to reduce the prevalence of major depressive disorders.

Taking this initiative from a prevention standpoint, MHFA helps those who take the course gain a better understanding about mental health. It also gives participants the tools and confidence to assist those in need of help and to seek resources. Thompson Health believes it is its responsibility to assist in addressing this issue. This training will be used for hospital staff and the community.

PARTNERS

Hobart and William Smith Colleges, Finger Lakes Community College, Wood Library, Ontario County Public Health and Shortsville EMS/Fire Department.

OUTCOMES

- After course completion, 100% of participants responded that they felt confident that they could recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.
- 96% of participants felt confident they could assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help or personal supports.
- There was a 69% increase in participants who felt more confident they could offer a distressed person basic "first aid" level information and reassurance about mental health and substance use challenges.

LESSONS LEARNED

- Offering the course as one full day instead of two half-days allows more people to successfully attend and complete the course.
- Use information and scenarios within the course that reflect the audience being taught. For example, college faculty received higher education material that included statistics and scenarios that were specific to the college setting. The discussions from the scenarios were more impactful, thoughtful and helpful for individuals to use within their lives.

SUSTAINABILITY

- This initiative has been sustained since 2023 due to support and the program's impact. The health system leadership have been champions of this program. They invited MHFA to present at System Leaders, a systemwide in-person meeting with all leaders from every department, to encourage every leader to attend the course and encourage their associates to attend as well.
- The MHFA program advances the goals of the New York State *Prevention Agenda* in supporting the community's health and well-being. Making this a priority as part of the *Prevention Agenda* ensures its sustainability.

CONTACT

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UNITED HEALTH SERVICES HOSPITALS

UHS Food Pantry: Roots, Routes and Resources

INITIATIVE DESCRIPTION AND GOALS

The UHS Food Pantry was created in response to high rates of food insecurity identified through universal Epic electronic medical record system-embedded screening. Using a hub-and-spoke model, a central pantry supplies shelf-stable, refrigerated and frozen foods to clinical sites where staff can support patients during visits.

Cold storage added in 2025 expanded access to fresh foods, including produce grown in two UHS supported garden plots and donated by employees. Twice weekly prepared meal deliveries ensure access for patients with limited cooking capacity. Care coordinators link patients to the Supplemental Nutrition Assistance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children; mobile groceries; and community pantries.

The initiative advances the New York State *Prevention Agenda* by reducing food hardship, improving access to nutritious food and addressing social determinants impacting low-income households, seniors and medically complex patients.

PARTNERS

United Health Services, Broome County Council of Churches Community Health Outreach Warehouse, Food Bank of the Southern Tier and VINES.

OUTCOMES

- The pantry achieved major increases in monthly distributions, growing from 19 adults, one child, two seniors and 13 households in April 2024 to serving 182 adults, 129 children, 52 seniors and 258 households in November 2025.
- Cold storage enabled distribution of fresh produce, including items grown by UHS volunteers, and expanded access to proteins and dairy.
- Twice weekly prepared meal deliveries increased support for patients with limited cooking ability, enhancing overall reach and impact.

LESSONS LEARNED

- Embedding screening in Epic ensured equitable, real-time identification of food insecurity across all settings.
- Immediate, dignified onsite access supported by resource totes, reusable grocery bags and fresh produce grown by employees reduced stigma, strengthened trust and increased engagement with long-term supports.

SUSTAINABILITY

Sustainability is supported through a full-time coordinator, integrated Epic workflows, resource totes, strong partnerships with CHOW, the Food Bank and prepared-meal suppliers, plus ongoing produce from employee garden plots, home-grown donations and workforce drives. In 2026 the initiative will add a nutritional health coach to provide motivational interviewing, goal-setting and empowerment to strengthen its model.

CONTACT

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UNIVERSITY OF ROCHESTER MEDICAL CENTER

Healthy Together Family Program

INITIATIVE DESCRIPTION AND GOALS

The American Academy of Pediatrics and the U.S. Preventive Services Task Force recommend intensive behavior and lifestyle modifications as the foundation of obesity treatment for children. This type of intensive intervention was not offered in URMCC's community. Through referrals and discussion, the health system identified that primary care clinicians had little support in caring for these patients. As the rates of pediatric obesity continue to increase, there was a critical need to provide additional resources to address this.

The URMCC Center for Community Health & Prevention developed a six-week group intervention program for families of children struggling with obesity. The target population was children ages seven to 13 with a body mass index above the 95th percentile.

The goal for participants was to increase health knowledge, enhance confidence in making healthy choices and implement positive lifestyle changes. These outcomes serve to optimize each individual's health and prevent chronic metabolic diseases.

PARTNERS

URMCC primary care network, Golisano Children's Hospital pediatric practice, URMCC pediatric sleep medicine, Eastman Institute for Oral Health and Excellus BlueCross BlueShield.

OUTCOMES

- Since starting the program, 63% of all child and adult participants reported making positive changes in their life and the remaining 37% reported this was somewhat true.
- New diagnoses of hypertension (in two children), hyperlipidemia and prediabetes (in two children) were discovered during the individual visits with participants.
- All child participants felt that health was a bigger priority for their families since starting the program.

LESSONS LEARNED

- Parents and children within each family often have conflicting goals and views of health. It is critical to foster communication between family members to create shared goals for lifestyle changes.
- The timing of a family-based intervention can be a major barrier. It was difficult for many families to commit to several weekly sessions due to busy schedules, transportation issues, etc. URMCC hopes to sustain this initiative by remaining flexible in timing to meet the needs of the participants.

SUSTAINABILITY

Sustainability is supported by the URMCC team's extensive experience with creating clinical programs for the community and constantly seeking new ways to meet the needs of patients. The health system's training and experience with Self-Determination Theory enables the team to optimally support participants' psychological needs to elicit behavior change.

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UR MEDICINE

Food Pantry

INITIATIVE DESCRIPTION AND GOALS

Food insecurity remains one of the most commonly reported social needs among UR Medicine patients. The UR Medicine Food Pantry aims to provide patients with food insecurity a healthy supply of food before leaving UR Medicine sites. Since its establishment in 2021, the UR Medicine Food Pantry has expanded to 15 locations. In 2025, the pantry provided over 42,000 pounds of food to 3,263 patients, representing a 52% increase in patients served compared to 2024.

Those who most frequently use the food pantry live in the ZIP codes of greatest need in Rochester, often experiencing poverty and poor health outcomes. In 2025, UR Medicine targeted four sites with high rates of food insecurity. These sites represent some of the most vulnerable patients in the community: those with high rates of social needs, psychiatric needs and children experiencing food insecurity. The pantry has served 164 patients from those four sites alone and expects volumes to increase in 2026.

Efforts to expand to sites with specific vulnerable populations align with the New York State *Prevention Agenda's* food access/ economic stability goal. UR Medicine has expanded access to its food pantry and actively looks to engage other sites for onboarding to best serve the community.

PARTNER

Foodlink NY.

OUTCOMES

- **Increased pantry utilization:** There was a 52% increase in pantry use between 2024 and 2025.
- **Increased utilization by pediatric patients:** There was a nearly 80% increase in use by pediatric patients from 2024 to 2025.
- **City of Rochester residents' utilization of the pantry:** All ten city of Rochester ZIP codes were identified, indicating the stark disparity in food insecurity between the city of Rochester and surrounding areas.

LESSONS LEARNED

Champion advocates are critical. Identifying champions is a requirement before proceeding with onboarding. The champion is responsible for receiving buy-in of the staff, communicating changes and updates, ordering food bags and ensuring data collection is sound at each site. Regular check-ins with champions and reinforcing workflows managed overall success. UR Medicine has since instituted a six-month onboarding period to monitor volumes, workflows and staff engagement closely.

SUSTAINABILITY

- The UR Medicine Food Pantry was designed for sustainability and scalability. A dedicated staff member was hired to support the food pantry by packing bags and delivering them across the hospital.
- The workflow standardization has been a significant contributor to the scalability of the program, while the clarity and ease in each step of the process has supported the program's sustainability.

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UVM HEALTH – ALICE HYDE MEDICAL CENTER

Bright Futures: Malone Community Youth Health Fair

INITIATIVE DESCRIPTION AND GOALS

Alice Hyde Medical Center partnered with the Malone Central School District to launch the Bright Futures: Malone Community Youth Health Fair — an initiative designed to address high childhood poverty, limited access to services, food insecurity, and rising behavioral and physical health challenges identified in the Community Health Assessment.

By integrating this event into the district's annual back-to-school program held at the Malone Middle School each year in August, nine AHMC departments and 16 partner agencies offered free health education, preventive resources, nutrition guidance, physical activity demonstrations, oral health supplies, primary care access information and essential school items.

The initiative supports multiple New York State *Prevention Agenda* priorities, including childhood behavioral health, healthy eating, preventive services and expanding access to community supports. Its goal is to reduce health disparities, strengthen family well-being, and provide children with the tools and resources they need to begin the school year healthy, supported and ready to learn.

PARTNERS

Malone Central School District, Citizen Advocates, St. Joseph's Rehabilitation Center, Community Health Center of the North Country, Monroe Ambulance, National Grid, National Army Reserves, NYSED-Access VR, Healthy Heart Network, Franklin County Public Health Division of Community Services, Cornell Cooperative Extension – SNAP-ED Program, Community Connections of Franklin County, Hudson Headwaters Health Network, DefCon Fitness, CrossFit Malone and MVP Healthcare.

OUTCOMES

- About 1,000 children and family members attended the event.
- More than \$5,000 in free school supplies, backpacks and educational materials were distributed to local students. This meaningful contribution was courtesy of a grant received by event partner National Grid through its community impact grant program.
- Community partners collaborated to deliver a coordinated, high-impact event that expanded access to health education, preventive support and essential resources.

LESSONS LEARNED

The event demonstrated that collaborative, community-centered outreach can deliver meaningful results. Families, partners and children consistently highlighted the accessibility and value of the services offered. Strong teamwork and a shared sense of purpose were central to the event's success, reinforcing the power of collective effort to improve the well-being of those served.

SUSTAINABILITY

The Youth Health Fair model is sustainable due to strong partner engagement, shared use of space, low operating costs and broad community interest. By integrating the event into an established program, it is well positioned to maintain high participation and achieve lasting community impact.

CONTACT

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TOP 5

VASSAR BROTHERS MEDICAL CENTER

Community Care Team

INITIATIVE DESCRIPTION AND GOALS

An estimated 1,700 people experience homelessness in Poughkeepsie, a population disproportionately affected by substance use and behavioral health challenges that make exiting homelessness especially difficult. Launched in 2021, the Vassar Brothers Medical Center Community Care Team improves care for at-risk individuals by coordinating wrap-around medical, behavioral health and social services through strong community collaboration. The program aligns with the New York State *Prevention Agenda* priorities related to substance use and economic and mental well-being.

Led by a high-risk navigator, 30 to 40 agencies meet biweekly to discuss clients and develop shared, interagency treatment plans for individuals who consent to participate. Partners determine their roles, coordinate services and hold one another accountable, while the navigator oversees all clients and tracks their progress on the team's behalf.

The goals are to engage high-risk individuals in stable health-care and treatment outside of emergency department settings and connect them to community services that address unmet health-related social needs. This unified approach has created a coordinated system of care with far greater power to influence health than any single institution could achieve alone.

PARTNERS

Regular participants in the Community Care Team include: Arms Acres, Council on Addiction Prevention & Education, City of Poughkeepsie Police Department, Dutchess County Department of Mental Health, Dutchess County Department of Community and Family Services, Dutchess County Lead, Dutchess County Mobile Crisis Team, Dutchess County Office for the Aging, Dutchess County Stabilization Center, Dutchess Outreach, Empowerment Center, Grace Smith House, Hudson River Housing, Hudson Valley Community Services, Law Enforcement Assisted Diversion, Lexington Center for Recovery, Mental Health America, PEOPLE-USA, Recovery Centers of America and Sun River Health.

OUTCOMES

Since its launch in 2021, the CCT has assisted more than 250 clients and achieved three major outcomes with measurable impact:

- **Client stability improved:** In 2025, 25 clients gained new physical health providers, 16 connected with new mental health providers and 116 accessed substance use treatment.
- **Housing stability increased:** 15 clients were newly housed and 25 were placed in shelter or temporary housing.
- **Community partnerships strengthened:** About 40 agencies met biweekly and more than 100 engaged overall, collectively contributing to a 60% reduction in ED utilization and a 90% reduction in inpatient stays among program participants.

LESSONS LEARNED

- Collaboration is essential — no single agency can meet the complex needs of people facing homelessness, behavioral health challenges and poverty. Strong relationships and trust between partners move care forward, supported by flexibility to meet clients where they are.
- Centering lived experience improves engagement and treating housing as a core health intervention is critical for stability and recovery.

SUSTAINABILITY

Sustainability relies on diversified, stable funding. By weaving hospital, Medicaid, government, philanthropic and federal resources — and aligning with priorities like the New York State *Prevention Agenda* and Medicaid reform — the program remains viable beyond grant cycles. Shared data and continuous outcome tracking, including ED use, housing stability and treatment engagement keep partners aligned and funders committed.

CONTACT

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WHITE PLAINS HOSPITAL

Revolutionizing Diabetes Transitional Care: A Nurse-led Model to Advance Equity and Patient Outcomes

INITIATIVE DESCRIPTION AND GOALS

The Diabetes Remote Patient Monitoring Program at White Plains Hospital is a nurse-led, 90-day post-discharge initiative for adults with poorly controlled diabetes. Leveraging continuous glucose monitoring technology, nurses deliver real-time clinical oversight, personalized education, medication management and care coordination. The program integrates technology with comprehensive support, addressing social determinants of health through referrals to primary care, endocrinology, community paramedicine, social services and transportation resources.

Its goals are to improve glycemic control, reduce preventable hospital utilization and expand equitable access to evidence-based diabetes management beyond traditional clinical settings. The initiative has improved glucose outcomes and decreased hospital utilization by 14% per patient enrolled. This program aligns with the New York State *Prevention Agenda* priorities of preventive care and management, strengthening chronic disease prevention and advancing health equity.

PARTNERS

White Plains Hospital, Scarsdale Volunteer Ambulance Corps, White Plains Physicians Associates, Scarsdale Medical Group, Family Health Center, Uber Business, DoorDash, United Way and Feeding Westchester.

OUTCOMES

- This program achieved significant HbA1c improvement (1.92% absolute reduction).
- This initiative has resulted in a 14% decrease in emergency department visits and readmissions, with demonstrated equitable outcomes across historically underserved populations.
- White Plains Hospital is the only U.S. hospital to receive the 2025 ANCC Magnet Prize®, sponsored by Press Ganey, recognizing exemplary nursing innovation in patient care and research that improve health outcomes related to the diabetes remote monitoring program.

LESSONS LEARNED

- Technology alone does not improve outcomes; pairing monitoring with community-based support drives sustained change.
- Addressing social determinants alongside clinical management is essential for reducing disparities in diabetes outcomes.

SUSTAINABILITY

Sustainability is achieved by embedding the program into routine chronic disease management and nursing workflows. Nurse-led oversight, standardized escalation protocols and equity dashboards ensure consistent outcomes. Leveraging existing nursing expertise and hospital infrastructure avoids parallel systems, while equity tracking supports long-term community impact and alignment with *Prevention Agenda* goals to reduce disparities in access and quality of preventive services.

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WYCKOFF HEIGHTS MEDICAL CENTER

Family, Community & Beyond Program

INITIATIVE DESCRIPTION AND GOALS

The Family, Community & Beyond Program is an initiative focused on improving maternal, infant and family health outcomes by reducing barriers to care during pregnancy and the postpartum period. The program is funded by the state Perinatal and Infant Community Health Collaboratives grant and closely relates to two New York State *Prevention Agenda* priorities: access to and use of prenatal care, and access to community services and support.

Through a community health worker model, the initiative provides individualized care planning and coordination, health education and resources navigation. Families are connected to prenatal and postpartum care, primary care, mental health services, nutrition assistance and other essential supports. Services are delivered in person or virtually, in-home or in the office, and promote accessibility and trust through sustained engagement.

The program's goals are to increase timely use of prenatal and postpartum care, reduce preventable maternal and infant health risks, address social determinants of health and advance health equity. By strengthening cross-sector partnerships and centering culturally responsive, family-driven support, the initiative helps build healthier families and more resilient communities.

PARTNERS

ACS – Infant Safe Sleep, WIC Program, CAMBA iCare, Grand Street Settlement – Early Head Start & Child Care, Hope and Healing Family Center, Moms for Moms, Aura of Hope Psychotherapy, Exhale to Inhale, Sistahs of Motherhood LLC, New York City Department of Health and Mental Hygiene, Motherhoodlogy/EI Club de Mamas, Greater Ridgewood Youth Council, Citywide Doula Initiative, By My Side Birth Support Program, Operation HOPE, God's Love We Deliver, Caribbean Women's Health Association, PS Family Support Services, Make the Road New York, Healthy Start Brooklyn, mPOWHER, New York Psychotherapy and Counseling Center, and Expecting Relief.

OUTCOMES

- **Improved postpartum care engagement:** Postpartum visit attendance within 12 weeks rose from 35% in 2022 to 58% in 2023 and to 71% in 2025, indicating sustained improvement in timely postpartum follow-up.
- **Strengthened care coordination and social needs resolution:** From 2023 to 2025, over 3,300 referrals were facilitated with a 99% completion rate, addressing food insecurity, housing instability, insurance enrollment, primary care, mental health and family planning.

- **Expanded community reach through prevention and education:** The initiative engaged more than 675 additional community members through group education sessions, coordinated outreach and partner-led prevention activities.

LESSONS LEARNED

- Trust-based, culturally responsive engagement improves outcomes. Community-based relationships, linguistically appropriate services and consistent follow-up significantly increase participation in preventive care and improve referral completion.
- Addressing social drivers of health is critical to maternal outcomes. Proactively resolving barriers such as housing instability, food insecurity, language access, childcare and transportation improves continuity of prenatal and postpartum care.

SUSTAINABILITY

- The initiative is sustained through the five-year New York state Perinatal and Infant Community Health Collaboratives grant, integration of the CHW model into routine clinical operations and strong cross-sector partnerships.
- Continuous data monitoring and quality improvement guide program refinement and ensure accountability.
- Formalized referral pathways, workforce development and institutional commitment support long-term viability and scalability beyond grant funding.

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HANYS Celebrates Previous Community Health Improvement Award Winners

2025	Northwell Health Street Medicine Program	2010	Brookdale University Hospital and Medical Center, Brooklyn Live Light...Live Right Childhood Obesity Program
2024	SBH Health System SBH Health and Wellness Center	2009	Strong Memorial Hospital/University of Rochester Medical Center Health-e-Access Telemedicine Network
2023	Catholic Health (Long Island) Food is Care	2008	Jamaica Hospital Medical Center Palliative Care Collaborative
2022	Mohawk Valley Health System Lead-free and Healthy Homes Mohawk Valley Coalition	2007	Rochester General Hospital, Clinton Family Health Center
2021	Northwell Health Advancing Health Equity through Community-based Partnerships to Fight COVID-19	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
2020	UR Medicine–Jones Memorial Hospital, Wellsville Promotion of Healthy Life Styles	2005	Strong Memorial Hospital/University of Rochester Medical Center SMILEmobile Dental Office on Wheels
2019	Montefiore Medical Center, Bronx Healthy Food Initiative	2004	NewYork-Presbyterian/Columbia University Medical Center Breast and Cervical Cancer Screening Partnership
2018	Unity Hospital–Rochester Regional Health Healthy Moms	2003	St. John's Riverside Hospital, Yonkers School-based Asthma Partnership
2017	Schuyler Hospital, Montour Falls Healthy Eating Active Living (HEAL) Schuyler	2002	Strong Memorial Hospital, Rochester Project Link
2016	Strong Memorial Hospital, Highland Hospital (UR Medicine)/Rochester General Hospital, Unity Hospital (Rochester Regional Health) High Blood Pressure Collaborative – Hospital Partners	2001	Canton-Potsdam Hospital/Claxton-Hepburn Medical Center, Potsdam and Ogdensburg St. Lawrence County Health Initiative
2015	Bassett Healthcare Network, Cooperstown School-based Health/Oral Health Program	2000	Harlem Hospital Center, New York City Injury Prevention Program
2014	Bassett Medical Center, Cooperstown Cancer Screening Outreach – Medical Screening Coach	1999	Women's Christian Association Hospital, Jamestown Women's Health Initiative
2013	Arnot Health at St. Joseph's Hospital, Elmira Chemung County School Readiness Project	1998	United Health Services, Binghamton Pediatric Asthma Program
2012	Sound Shore Medical Center, New Rochelle Outpatient Pediatric Immunization Center	1997	St. Mary's Hospital/Unity Health System, Rochester HealthReach Program
2011	Catholic Health Services of Long Island, Rockville Centre The Healthy Sundays Program		



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