



# CONNECTING WITH COMMUNITIES

COMMUNITY HEALTH INITIATIVES  
ACROSS NEW YORK STATE

2010 EDITION



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## INTRODUCTION

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The Healthcare Association of New York State (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 facilities and programs that target specific community health issues, demonstrate leadership, collaborate among diverse groups, and, most importantly, achieve quantifiable results.

HANYS is pleased to present its 13th annual Community Health Improvement Award to Brookdale University Hospital and Medical Center for its Live Light . . . Live Right Childhood Obesity Program. The initiative serves obese children, 95% of whom are minorities and nearly half of whom live in poverty. The program has been able to achieve optimal clinical management, prevent the early onset of diabetes and cardiovascular disease, promote healthy eating and exercise habits, and affect long-term behavior to improve health outcomes.

HANYS awarded an Honorable Mentions to: the University of Rochester Medical Center for its Rochester Youth Violence Partnership Program, and to SUNY Downstate Medical Center for its Community Health Promotion and Wellness Center.

As the 46 nominations in this publication indicate, HANYS' membership continues to develop innovative programs to improve the health of communities across New York State. Many of this year's nominations focus on the ten prevention priorities established by the New York State Department of Health for hospitals to include in their community service plans.

The community outreach programs in this publication not only reflect the mission of hospitals and continuing care providers to improve the health of individuals and communities, but also illustrate health care providers' dedication to collaboration and providing compassionate care that makes a difference in people's lives.

For more information, contact Sue Ellen Wagner, Vice President, Community Health, at (518) 431-7837 or at [swagner@hanys.org](mailto:swagner@hanys.org).

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## TABLE OF CONTENTS

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### 2010 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

<b>LIVE LIGHT . . . LIVE RIGHT CHILDHOOD OBESITY PROGRAM</b> . . . . .	1
Brookdale University Hospital and Medical Center	

### HONORABLE MENTIONS

<b>ROCHESTER YOUTH VIOLENCE PARTNERSHIP</b> . . . . .	3
University of Rochester Medical Center	
<b>CENTER FOR COMMUNITY HEALTH PROMOTION AND WELLNESS</b> . . . . .	5
SUNY Downstate Medical Center	

### PROFILES

<b>THE HEART CARE PROGRAM</b> . . . . .	7
Arnot Ogden Medical Center	
<b>THE REBIRTH OF MATERNITY SERVICES AT A COMMUNITY HOSPITAL</b> . . . . .	9
Auburn Memorial Hospital	
<b>ONEONTA COMMUNITY HEALTH CENTER</b> . . . . .	10
Aurelia Osborn Fox Memorial Hospital	
<b>RURAL HEALTH EDUCATION NETWORK OF DELAWARE, OTSEGO, MONTGOMERY, AND SCHOHARIE COUNTIES (RHENDOMS)</b> . . . . .	11
Bassett Healthcare	
<b>MOMS AND TEENS FOR BREAST HEALTH</b> . . . . .	13
Catholic Health System	
<b>COMMUNITY-BASED PALLIATIVE CARE: A PARTNERSHIP BETWEEN AN INPATIENT PALLIATIVE CARE PROGRAM AND HOSPICE</b> . . . . .	14
Champlain Valley Physicians Hospital Medical Center	
<b>COMMUNITY TEACHING DAY</b> . . . . .	15
Columbia Memorial Hospital	
<b>SENIOR OPTIONS AND SOLUTIONS</b> . . . . .	16
Eastern Long Island Hospital	
<b>RURAL TELEMEDICINE STROKE PROJECT</b> . . . . .	17
Edward John Noble Hospital of Gouverneur	
<b>MEDICAL HOME INITIATIVE</b> . . . . .	18
Ellis Medicine	
<b>PARTNERSHIP FOR DIABETES EDUCATION SERVICES: THE COMMUNITY DIABETES EDUCATION PROGRAM</b> . . . . .	19
Faxton-St. Luke's Healthcare and St. Elizabeth's Medical Center	
<b>CONSUMER PRICE LINE</b> . . . . .	20
F. F. Thompson Hospital	

<b>HYPERTROPHIC CARDIOMYOPATHY COMMUNITY HEALTH SCREENING</b> .....	<b>21</b>
Finger Lakes Health	
<b>INCORPORATING MULTI-FAMILY GROUP THERAPY INTO AN ADOLESCENT SUBSTANCE ABUSE DAY PROGRAM</b> .....	<b>22</b>
Glen Cove Hospital	
<b>GIRLS ON THE RUN</b> .....	<b>23</b>
Glen Falls Hospital	
<b>CHILD LIFE PROGRAM</b> .....	<b>24</b>
Good Samaritan Hospital Medical Center	
<b>THE COLONOSCOPY PATIENT NAVIGATOR PROGRAM</b> .....	<b>26</b>
Jamaica Hospital Medical Center	
<b>COALITION TO PREVENT UNDERAGE DRINKING</b> .....	<b>27</b>
Long Beach Medical Center	
<b>LOW-COST INTERVENTIONS TO CREATE THE IDEAL TRANSITION HOME</b> .....	<b>29</b>
Long Island Health Network Home Care Agencies	
<b>HEALTHY HEART WORKSITE INITIATIVE</b> .....	<b>30</b>
Medina Memorial Health Care System	
<b>RENAL/TRANSPLANT SPECIALTY PROGRAM</b> .....	<b>31</b>
Metropolitan Jewish Health System	
<b>HEART AND SOUL IN THE NEIGHBORHOOD</b> .....	<b>32</b>
Mount St. Mary's Hospital and Health Center	
<b>HEALTHY SCHOOLS HEALTHY FAMILIES</b> .....	<b>33</b>
NewYork-Presbyterian Hospital	
<b>DIABETES EDUCATION SELF-MANAGEMENT PROGRAM</b> .....	<b>35</b>
Nicholas H. Noyes Memorial Hospital	
<b>ACTIVITY WORKS PROGRAM</b> .....	<b>36</b>
North Shore-Long Island Jewish Health System	
<b>THE "F5" PROJECT: FEAR FACTOR FOR HEALTH AND FITNESS</b> .....	<b>37</b>
Northern Dutchess Hospital	
<b>HEALTHY HEART PROGRAM</b> .....	<b>38</b>
Orange Regional Medical Center	
<b>PRE-SCHOOL SPEECH AND LANGUAGE SCREENING AND EDUCATION PROGRAMS</b> .....	<b>39</b>
Phelps Memorial Hospital Center	
<b>EZ DETECT COLORECTAL CANCER SCREENING</b> .....	<b>40</b>
Rome Memorial Hospital	
<b>RENSSELAER COUNTY TASK FORCE ON SUICIDE PREVENTION</b> .....	<b>41</b>
Samaritan Hospital	
<b>SCHUYLER STEPS OUT</b> .....	<b>42</b>
Schuyler Hospital	
<b>MEDICAL NUTRITION THERAPY SERVICES</b> .....	<b>43</b>
Sound Shore Medical Center of Westchester	

---

<b>IMPROVING THE EARLY IDENTIFICATION OF LUNG CANCER IN OUR COMMUNITY</b> . . . . .	<b>44</b>
South Nassau Communities Hospital	
<b>COMMUNITY OUTREACH INITIATIVE FOR ORAL HEALTH CARE</b> . . . . .	<b>45</b>
St. Barnabas Hospital	
<b>KERNAN ELEMENTARY SCHOOL-BASED HEALTH CENTER</b> . . . . .	<b>46</b>
St. Elizabeth Medical Center	
<b>PROSPECT HILL DEVELOPMENT INITIATIVE</b> . . . . .	<b>47</b>
St. Joseph’s Hospital Health Center	
<b>MOBILE GERIATRIC OUTREACH PROGRAM</b> . . . . .	<b>48</b>
St. Mary’s Hospital, Amsterdam	
<b>RENSSELAER CARES PRESCRIPTION ASSISTANCE PROGRAM</b> . . . . .	<b>49</b>
St. Mary’s Hospital/Seton Health and Samaritan Hospital/Northeast Health	
<b>ST. PETER’S REGIONAL ALS CENTER</b> . . . . .	<b>50</b>
St. Peter’s Health Care Services	
<b>PROMOTING HEALTH LITERACY THROUGH HEALTHY PARTNERSHIPS</b> . . . . .	<b>52</b>
Staten Island University Hospital	
<b>UNITED AGAINST CANCER</b> . . . . .	<b>53</b>
United Health Services Hospitals	
<b>EDUCATING AND EMPOWERING CONGESTIVE HEART FAILURE PATIENTS AND CAREGIVERS</b> . . . . .	<b>54</b>
United Memorial Medical Center	
<b>JOURNEY TO THE 21ST CENTURY</b> . . . . .	<b>55</b>
Upstate University Hospital	

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## 2010 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

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# Live Light . . . Live Right Childhood Obesity Program

## BROOKDALE UNIVERSITY HOSPITAL AND MEDICAL CENTER



*HANYS' Board Chairman Joseph Quagliata presents the Community Health Improvement Award to Sarita Dhupar, M.D., Founder and Executive Director of the Live Light . . . Live Right Program and Director, Division of Pediatric Cardiology, accepting on behalf of Brookdale University Hospital and Medical Center.*

### Year the Initiative Started

2001

### Program Description and Goals

The Live Light . . . Live Right (LLLR) childhood obesity program is a hospital- and community-based non-profit program that serves obese children, 95% of whom are minorities, and nearly half of whom live in poverty. The initiative aims to achieve optimal clinical management, prevent early onset of diabetes and cardiovascular disease, promote healthy eating and exercise habits, and influence long-term behavior to improve health outcomes.

These goals are accomplished by thoughtful integration of multidisciplinary services, including specialized medical care, nutrition and behavioral counseling, and tailored physical fitness training. For the community, the program strives to generate understanding of obesity as a serious health issue, enhance the skills of medical providers, and coordinate resources. Since its inception, LLLR has served more than 2,000 children with extremely positive outcomes, enabling ongoing sustainability through public and private funding.

### Partners

Bedford-Stuyvesant and Flatbush YMCAs; Brookdale Family Care Centers; Brooklyn Public Library; Brownsville Recreation Center; Caribbean Women's Health Association; Cornell University Cooperative Extension; Fresh Air Fund; Groundwork, Inc.; Health Corps; Healthy Families America; New York City Departments of Education, Parks and Recreation; New York City Food and Fitness Forum, Head Start, and Housing Authority; Police Athletic League; St. John's University

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## Outcomes

Of the more than 700 participants who enrolled in the program for an average of 20 months:

- sixty-seven percent reduced their body mass index score;
- fifty-seven percent reduced their cholesterol and triglyceride levels;
- fifty-one percent reduced their insulin levels and blood pressure; and
- the incidence of new onset of Type 2 diabetes among participants has been less than 1%.

## Contact

Sarita Dhuper, M.D., Founder and Executive Director, Live Light . . . Live Right,  
and Director, Division of Pediatric Cardiology  
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## HONORABLE MENTION

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# Rochester Youth Violence Partnership UNIVERSITY OF ROCHESTER MEDICAL CENTER



*HANYS' Board Chairman Joseph Quagliata (left) presents the Community Health Improvement Award Honorable Mention to Steven Goldstein, President, Strong Memorial and Highland Hospitals, accepting on behalf of University of Rochester Medical Center.*

### Year the Initiative Started

2006

### Program Description and Goals

University of Rochester Medical Center (URMC) believes youth violence is a community health problem that requires a community solution. The Rochester Youth Violence Partnership (RYVP) is a hospital-based violence intervention program that targets trauma victims under the age of 18 when they present for medical care following a knife or gun injury. Established in 2006, RYVP is a partnership headed by URMC's regional trauma center and supported by 28 local non-profit, government, and service-based organizations. The hospital serves as the "first responder" by recognizing the problem, identifying at-risk patients, and treating injuries. Once the patient is stabilized and

psychological/social issues identified, a coordinated series of law enforcement and community partner-led interventions occur to help reduce violence in this vulnerable population.

### Partners

URMC-Strong Regional Trauma Center and Golisano Children's Hospital; Rochester General Hospital; Pathways to Peace; Rochester Police Department; Project Exile Advisory Board; City School District; U.S. Attorney General's Office; New York State Division of Criminal Justice Services; Monroe County Offices of Child Protective Services, Health and Human Services, County Executive, and Probation Department; Monroe County Mobile Crisis Team and Family and Crisis Intervention Team; Partners Against Violence Everywhere; Action for a Better Community; National Council on Alcoholism and Drug Dependence; Center for Restorative Justice and Center for Public Safety Initiatives, Rochester Institute of Technology; Community Support Groups: Baden Street Settlement House, Anthony Jordan Health Center, Coordinated Care Services, Coalition for the Beloved Community, Camp Good Days and Special Times, Families and Friends of Murdered Children and Victims of Violence, Baber AME Church



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## Outcomes

- **Youth Served:** Since the inception of RYVP, 177 youths have been treated for gunshot or stab wounds at the regional trauma center. Of these, 155 received a comprehensive social work assessment; 108 were referred to the gang intervention team; and 91 inpatient psychiatric evaluations were conducted.
- **Recidivism Has Declined:** In 2007, nine youths previously injured by violence returned as a result of violence. In the three years since, there has not been one.
- **Intervention Video Is Making a Difference:** After admission into the hospital, youths watch a 15-minute video—a graphic wake-up call urging them to re-think their choices.
- **Attitudes and Procedures in the Emergency Room Are Changing:** RYVP has liberalized hospital admissions so that more youths are admitted overnight to keep them safe. In addition, policies have been developed to assure patient and staff safety in the emergency room.

## Contact

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## HONORABLE MENTION

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# Center for Community Health Promotion and Wellness

## SUNY DOWNSTATE MEDICAL CENTER



*Maria Yomtov, Director of the Center for Community Health and Wellness, accepts the Community Health Improvement Award Honorable Mention on behalf of SUNY Downstate Medical Center from HANYS' Board Chairman Joseph Quagliata.*

### Year the Initiative Started

1996

### Program Description and Goals

The Center for Community Health Promotion and Wellness has a devoted, diverse staff of seven and is supported by a multidisciplinary team that provides free health education and prevention services on-site and in the community. This includes lectures, workshops, health screenings for all ages (including a cardiac risk assessment clinic and mobile asthma screening center), immunizations, prenatal and expectant family education classes, chronic conditions clubs (diabetes, stroke, weight management), and smoking cessation programs, in addition to patient care. Staff operate the program daily, including evenings and weekends. The goal

is to meet growing community demand and provide a comprehensive health education, awareness, and prevention program to an inner-city community.

### Partners

American Heart Association; American Cancer Society; American Diabetes Association; Greater Brooklyn Health Coalition; Brooklyn Center for Health Disparities; New York City Board of Education; New York City Department of Health; Brooklyn YMCA; local community leaders; elected officials; more than 100 faith-based organizations

### Outcomes

Of those tested in the past year, the program identified:

- thirty-three percent were hypertensive;
- thirteen percent had high blood glucose;
- twenty-seven percent had elevated cholesterol; and
- twenty-five percent had evidence of asthma (adults and children combined).

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All required further follow-up. Those reached by telephone stated they had already visited (55%) or plan to visit a doctor (45%).

### Contact

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## PROFILES

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# The Heart Care Program

## ARNOT OGDEN MEDICAL CENTER

### Year the Initiative Started

2000

### Program Description and Goals

The Heart Care Program at Arnot Ogden Medical Center is an outpatient disease management program for patients with congestive heart failure (CHF). The program provides patients with ongoing case management to assist with referral and access to other supplementary health maintenance services, including medical social work, home care, food and meal assistance, and help with pharmaceuticals and prescriptions. Registered nurses from the Medical Call Center at Arnot Ogden Medical Center provide education and support through a system of coordinated interventions and communications.

The program, which is offered at no charge to members of the community, aims to help patients control symptoms, improve their quality of life, and reduce hospital readmissions to reduce health care costs.

### Partners

Chemung Valley Rural Health Network; Arnot Health Heart and Vascular Institute and area primary care providers; Chemung County Health Department; Healthy Living Partnership of Chemung County; Diabetes Action Program and Shape Up Chemung; Chemung County Cornell Cooperative Extension; Chemung County Office for the Aging; Health Ministries of the Southern Tier

### Outcomes

- The Heart Care Program served 347 patients from 45 different ZIP Codes. It generates referrals from a three-county, 1,000-square mile area that is home to more than 450,000 people.
- Program interventions improved the physical quality of life for participants as measured by the “SF12” psychometric physical component summary. In 2007, 60% of participants showed improvement; in 2009, 84% showed improvement.

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- Program interventions improved the psychological quality of life for participants as measured by the SF12 mental component summary. In 2007, 70% of participants showed improvement; in 2009, 85% showed improvement.
  - Program participants have a lower readmission rate than overall facility and state averages. For people with CHF, the New York State readmission rate is 24%, the facility readmission is 30.4%, and The Heart Care Program participant readmission rate is 15%.

## Contact

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# The Rebirth of Maternity Services at a Community Hospital

## AUBURN MEMORIAL HOSPITAL

### Year the Initiative Started

2007

### Program Description and Goals

Auburn Memorial Hospital's (AMH) maternity services decreased between 2000 and 2006, and the hospital was in danger of having to close the unit. As AMH is the only hospital in the county, the loss of obstetric services would severely compromise access to women's health care, impacting the most vulnerable in the community. Beginning with a new administration in 2007, obstetrics/gynecology (OB/GYN) physicians were aggressively recruited, and now there are three physicians and three certified midwives. Education of the nursing staff was stressed, quality is now rigorously monitored, and the hospital launched a variety of childbirth educational programs.

The goals of the initiative were to revitalize maternity services, offer the highest quality care to obstetric patients and babies, and grow from under 300 births to 500 births per year.

### Partners

Cayuga County Department of Health; Supplemental Nutrition Program for Women, Infants, and Children (WIC); Medicaid Obstetrical Maternal Services program; YMCA

### Outcomes

- The number of service providers increased from two physicians and two nurse midwives to three physicians and three nurse midwives.
- The number of births per year increased from 270 in 2007 to 408 in 2009.
- Quality of care improved.
- Operational gains from births increased from \$1,350,000 in 2007 to \$2,040,000 in 2009.

### Contact

Beverly Miller, Director of Community Relations  
(315) 255-7239 [bmiller@auburnhospital.org](mailto:bmiller@auburnhospital.org)

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# Oneonta Community Health Center

## AURELIA OSBORN FOX MEMORIAL HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

The Oneonta Community Health Center is a community-based organization that provides free health care services to the uninsured and other designated patient populations in Oneonta and the surrounding communities of Otsego and Delaware Counties.

The goal of Oneonta Community Health Center is to treat the uninsured with compassion and respect. Its mission is to enrich the community through serving the health and wellness needs of uninsured people in Otsego and Delaware Counties by providing free primary health care. Aurelia Osborn Fox Memorial Hospital supports the Oneonta Community Health Center by providing free laboratory and radiology services for patients at the clinic. The hospital also allows members of its medical staff to volunteer their services there. The Oneonta Community Health Center Medical Director is an Aurelia Osborn Fox Memorial Hospital-employed physician.

### Partners

Unitarian Universalist Society; churches in Oneonta and the surrounding communities; The United Way; Future for Oneonta Foundation; individuals; Central New York Radio Group; Sidney Federal Credit Union

### Outcomes

- The Oneonta Community Health Center has had more than 400 patient visits.
- Care is provided by 13 provider volunteers, 11 registered nurse volunteers, and 31 non-medical volunteers.

### Contact

Laura Palada, R.N., Patient Safety Coordinator  
(607) 431-5045 | [lpalada@foxcarenetwork.com](mailto:lpalada@foxcarenetwork.com)

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# Rural Health Education Network of Delaware, Otsego, Montgomery, and Schoharie Counties (RHENDOMS)

## **BASSETT HEALTHCARE**

### Year the Initiative Started

1999

### Program Description and Goals

The mission of RHENDOMS is to address under-served rural community health needs by promoting excellence and innovation in health education. Bassett Healthcare's prevention agenda conveys the message that children and adults can be responsible for their own health by making conscious, educated choices for healthy behaviors. Program goals include prevention of obesity and dental disease and their associated chronic conditions, and recruitment and retention of rural health care practitioners. RHENDOMS includes:

- wellness programs in many worksites and healthy eating and activity teams in schools;
- nutrition workshops for community, worksite, and school groups;
- programs designed to educate children at the earliest possible opportunity: Nutrition Detectives™, YogaKids® International Tools for Schools program, Girls on the Run International, Up Close Cardiac Surgery, and dental health education; and
- programs that support recruitment and retention of area health care providers: annual School Nurse Symposium, New Visions program, Summer Medical Academy, and Science Research Training Program.

### Partners

Delaware, Otsego, Montgomery, and Schoharie county departments of health and public health nursing services; Cornell Cooperative Extension; Bassett Healthcare Network: The New York Center for Agricultural Medicine and Health, Community Heart Care Institute, Bassett Research Institute, Health Works Occupational Health Services, School-Based Health Centers, and Community Health Programs; Otsego Northern Catskills Board of Cooperative Educational Services, and Catskill-Hudson Area Health Education Center; and school districts, worksites, private schools, community organizations, and businesses.

### Outcomes

- Worksite wellness programs and nutrition workshops were offered to 1,400 community members at 50 venues.



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- School programs educated 9,100 pre-school through high school students about leading a healthy lifestyle.
  - More than 90% of the students who participated in the Science Research Training Program and in the New Vision and Summer Medical Academy chose to pursue health care careers.
  - More than 10,000 community members have been provided healthy lifestyle educational materials.

## Contact

Linda Keller, Ph.D., Executive Director, RHENDOMS  
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# Moms and Teens for Breast Health

## CATHOLIC HEALTH SYSTEM

### Year the Initiative Started

2008

### Program Description and Goals

The purpose of the Moms and Teens for Breast Health program is to save lives through early detection and treatment of breast cancer among African American and medically under-served women in Western New York. This is accomplished by educating and motivating high school girls in the targeted communities to inform and encourage their adult female family and friends to practice breast self-examination and receive clinical breast exams and mammograms. In addition, the program establishes an intergenerational dialogue to instill good breast health habits among all age groups.

An important “train the trainer” component for high school health educators and school nurses helps sustain the education efforts. Catholic Health System facilitates access to breast examinations and mammography services. All participants take a pre- and post-test to gauge their breast health knowledge.

### Partners

Buffalo public school system; Partners in Prevention; Sisters of Charity Hospital Radiology Services

### Outcomes

- The school-based breast health program served 753 teen girls.
- Thirty-one female family members attended a follow-up evening breast health program.
- To continue to provide breast health instruction to students and families, 68 high school health educators and nurses were trained in breast health education.
- Breast health knowledge increased from an average pre-test score of 56.6% to an average post-test score of 78.7%.

### Contact

Mike Hickok, Director of Online Services and HealthConnection  
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# Community-Based Palliative Care: A Partnership Between an Inpatient Palliative Care Program and Hospice

## CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER

### Year the Initiative Started

2006 (three-year program ending in 2009)

### Program Description and Goals

Champlain Valley Physicians Hospital Medical Center's Palliative Care program impacts the community through a nurse-led, patient-focused multidisciplinary team that works to improve quality of care and life for individuals with a life-limiting diagnosis or serious illness. Consultations by a palliative care nurse improve pain and symptom management. Collective efforts of the palliative care team increase the likelihood that the patient will die in his/her desired setting and circumstances and that advanced directives are in place.

Because of this program, physicians, patients, and their families are more aware of the benefits of a longer hospice stay. In addition, individuals are able to receive non-medical services and support from Hospice of the North Country's Transitions program through its coordinator and volunteers, resulting in improved quality of life.

### Partners

Hospice of the North Country; Excellus BlueCross BlueShield (funder);  
Foundation at Champlain Valley Physicians Hospital Medical Center (funder)

### Outcomes

- The program served 580 palliative care inpatients over three years.
- The number of patients with health directives increased to 60% for palliative care inpatients and 85% for hospice and Transitions program clients.
- Referrals by primary care physicians to hospice increased, resulting in a 20% longer length of stay, with a 19% increase in length of stay for cancer diagnosed individuals and a 29% increase for non-cancer diagnosed individuals.
- The percentage of patients who die in their desired setting (those who experience non-sudden death and who designated a preference) increased to 70%.
- Pain and other symptoms decreased for patients served by the palliative care program. Over the three-year period, there was a 65.6% improvement in pain management for 580 palliative care inpatients.

### Contact

Rachael Hite, R.N., B.A., O.C.N., C.H.P.N., Palliative Care Nurse  
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# Community Teaching Day

## COLUMBIA MEMORIAL HOSPITAL

### Year the Initiative Started

2009

### Program Description and Goals

Columbia Memorial Hospital and a group of regional atrial fibrillation experts developed Community Teaching Day with a goal to provide quality education on how to advance knowledge in cardiovascular health. The panel focused on the latest advances of treatment of atrial fibrillation and focused on the magnitude of the problem of atrial fibrillation, drug therapy, cardio-version, Coumadin therapy, catheter ablation, and surgery. The program also provided information on evidence-based, long-term strategies to prevent future vascular events in patients after hospital discharge, and information on the management of Coumadin therapy. The four-hour event allowed for questions from the community and provided practical approaches to maintaining health.

### Partners

Twin County Medical Associates; St. Peter's Hospital; Columbia County Medical Society

### Outcomes

More than 100 community members received information on a complex topic that is often confusing to the general public. The team supplied community members with information on normal anatomy, arrhythmias, advances in medical technology, and the importance of recognizing signs and symptoms of atrial fibrillation.

### Contact

Mary Daggett, B.S., R.N., Director, Community Health and Grant Services  
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# Senior Options and Solutions

## EASTERN LONG ISLAND HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

The development of a Geriatric Center of Excellence was a key priority of the Eastern Long Island Hospital Board of Trustees. The program goals include:

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

### Partners

Eastern Long Island Hospital; Town of Southold; The Mental Health Association in Suffolk; The Long Island Home d/b/a South Oaks Hospital

### Outcomes

- To identify needs and gaps in services, a community needs survey was conducted to determine the changing needs of seniors in the community; 386 residents responded.
- A Web site and brochure were developed to promote community use of Senior Options and Solutions.
- Mental health integration and depression screening of patients at the East End Geriatric and Adult Medicine practice began in March 2008. Additional practices were added, resulting in 1,111 screenings, 146 assessments, and 188 follow-up visits by the end of 2009.
- Community education and prevention screening events through the senior wellness series and support groups covered 17 topics and attracted 333 participants.

### Contact

Juliet Frodella, M.S., C.R.C., L.M.H.C., Project Director  
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# Rural Telemedicine Stroke Project

## EDWARD JOHN NOBLE HOSPITAL OF GOUVERNEUR

### Year the Initiative Started

2009

### Program Description and Goals

Working in partnership with SUNY Upstate Medical Center, Edward John Noble Hospital implemented a Telemedicine Stroke Care program for its community. A patient presenting with stroke-related symptoms is provided with an immediate consultation with a neurologist at SUNY Upstate Medical Center. This provides patients the benefit of a neurologist being actively involved in their care at the earliest possible stage.

The goals for this program are to:

- provide expert stroke leadership 24 hours per day (neurologist);
- help community members recognize stroke signs and symptoms using the “FAST” mnemonic;
- provide ongoing stroke education for health care providers to ensure that patients benefit from the most up-to-date medical knowledge; and
- renew efforts to encourage smoking cessation at all patient contacts.

### Partners

SUNY Upstate Medical Center; Gouverneur Rescue Squad; St. Lawrence County Public Health Department

### Outcomes

Edward John Noble Hospital’s Level 3 emergency department has about 8,000 patient visits per year. Over the past year, 12 patients presented with symptoms that were initially triaged as possibly stroke-related. Four of these patients were subsequently diagnosed as stroke-related and received a telemedicine neurology consult and subsequent transfer to SUNY Upstate Medical Center. One of these four patients experienced complete resolution of symptoms following initial emergency treatment in the emergency department and subsequent emergency treatment at SUNY Upstate Medical Center.

### Contact

Kim Carr, R.N., Clinical System Analyst  
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# Medical Home Initiative

## ELLIS MEDICINE

### Year the Initiative Started

2008

### Program Description and Goals

Ellis Medicine’s Medical Home, which employs two registered nurse “health services navigators,” combines guided access to a full range of primary care services—including on-site family health, pediatric health, and dental clinics—with needed inpatient care and direct social services support such as free transportation to medical appointments, facilitated enrollment in health insurance, and assistance from community partners. The Ellis Health Center, a primary care and outpatient facility located on the site of the former St. Clare’s Hospital, implements the Medical Home initiative.

### Partners

City Mission, Catholic Charities, Bethesda House (ministries and support), Fidelis Care (facilitated enrollment); Hometown Health Center (primary care and dental care); Salvation Army (food pantry and social services); Schenectady Community Action Program (provides community services navigators); YMCA and YWCA (residential, domestic violence, and wellness programs); Schenectady City School District; Schenectady County Public Health Services; Visiting Nurse Service; Schenectady Inner City Ministry

### Outcomes

- Care is provided to patients who do not have a primary care provider—224 patients cared for by Medical Home per month have no primary care provider.
- Care is provided to uninsured patients—238 patients per month are uninsured.
- Care is provided to patients who lack transportation—about 18 patients per month use the free shuttle service.
- Early data show a slight downward trend in “self-pay” emergency department use on this campus.

### Contact

Dave Smingler, Government Affairs Specialist  
(518) 243-4840 [sminglerd@ellismedicine.org](mailto:sminglerd@ellismedicine.org)

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# Partnership for Diabetes Education Services: The Community Diabetes Education Program **FAXTON-ST. LUKE'S HEALTHCARE AND ST. ELIZABETH'S MEDICAL CENTER**

## Year the Initiative Started

1993

## Program Description and Goals

The Partnership for Diabetes Education Services and The Community Diabetes Education Program are a unique collaborative effort between Faxton-St. Luke's Healthcare and St. Elizabeth's Medical Center to establish comprehensive diabetes education services.

The project goal was to create a sustaining force to reduce the incidence and improve the outcomes of diabetes in Oneida County, where the rate of uncontrolled diabetes was significantly higher than the statewide and national averages. The organizations developed an educational program using American Diabetes Association (ADA) guidelines, and opened two additional ADA-approved expanded sites in rural settings in Oneida and Herkimer counties, providing services to those with limited access. The scope of the program expanded from general diabetes education to attaining insulin pump training center designation and establishing a continuous glucose monitoring center.

## Outcomes

The program reports outcomes twice yearly through an interdisciplinary advisory committee. The positive program outcomes include weight loss, glycated hemoglobin (A1C) reduction, adherence to foot and eye exams, and glucose monitoring.

## Contact

Caroline Jacobus, Ph.D., R.N., C.D.E., Program Coordinator  
(315) 624-5621    [cjacobus@mvnhealth.com](mailto:cjacobus@mvnhealth.com)



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# Consumer Price Line

## F.F. THOMPSON HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

The first of its kind in the region, a consumer telephone line was established to provide answers to community members' questions regarding hospital costs and general financial concerns. Assistance is available for flexible spending questions and out-of-pocket requirements, providing pricing transparency. The goal is to ensure access to a dedicated employee who can answer all questions regarding the financial portion of hospital treatment. Every person who calls into the price line is provided with a personalized price quote to assist with their decision making, and receives detailed attention to their financial concerns in conjunction with their medical care. The free service strives to deliver pertinent, quality data from a professional and caring person, lessening callers' anxiety regarding medical care.

### Partners

Finger Lakes Migrant Health Care Project, Inc. (Penn Yan Office, Geneva Community Health, and Sodus Community Health); Finger Lakes Mennonite Community; Canandaigua Medical Group; University of Rochester: Strong Radiology; Canandaigua Anesthesia Group; Eye Care Center; Lakeside ENT Group; Elm Manor Nursing Home; Finger Lakes Cardiology; Interlakes Oncology and Hematology, PC

### Outcomes

- In the first year of existence, the price line received 330 calls.
- The second year saw a 6% increase in calls, to 351.
- In 2009, residents in 47 different ZIP Codes accessed price line information, demonstrating the effectiveness of targeted awareness campaigns.
- Community members who followed through on price line inquiries increased rendered services charges by \$403,704 in 2009 for care that might otherwise not have been accessed.

### Contact

Lisa Poworoznek, Director of Reimbursement  
(585) 396-6474    [lisa.poworoznek@thompsonhealth.com](mailto:lisa.poworoznek@thompsonhealth.com)

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# Hypertrophic Cardiomyopathy Community Health Screening

## FINGER LAKES HEALTH

### Year the Initiative Started

2008

### Program Description and Goals

Finger Lakes Health's hypertrophic cardiomyopathy community health screening event provided education and a thorough evaluation for student athletes, grades seven through 12, to identify hypertrophic cardiomyopathy, the most common congenital cardiac abnormality and leading cause of sudden death in young athletes. The Chief of Cardiology for Finger Lakes Health and his team recruited 275 volunteers for the day-long screening, including cardiologists, sonographers, and other clinical staff from a five-county area. The planning committee met over the course of one year. The screening took place at a health fair that focused on cardiovascular fitness. Students were questioned about their family history and any symptoms they might have. They then underwent an electrocardiogram and limited echocardiographic examination. The results were then explained to students and their parents by participating physicians. Follow-up care was coordinated, as needed.

### Partners

Anthony Bates Foundation; Biotronik; Cherry Pharm; Fastenal; Finger Lakes Health Foundation; Finger Lakes Radio Group; GE Healthcare; Geneva Community Center; Geneva General Cardiology Associates; Geneva on the Lake; Jreck Subs; Maco Bags; United States Marine Corps; Philips Health Care; Physician Sales and Service; Siemens Medical Solutions; Waterloo Premium Outlets

### Outcomes

- Forty-five students were found to have a cardiac abnormality.
- Two students had signs of hypertrophic cardiomyopathy.
- Three students were found to have bicuspid aortic valves instead of tricuspid valves.
- Two students were found to have Wolf-Parkinson-White syndrome.

### Contact

Lara Turbide, Vice President, Community Services  
(315) 787-4053    [lara.turbide@flhealth.org](mailto:lara.turbide@flhealth.org)

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# Incorporating Multi-Family Group Therapy Into an Adolescent Substance Abuse Day Program

## GLEN COVE HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

The program treats adolescents, age 13-18, five days per week, who present with substance abuse and psychiatric disorders. On-site academic classes are provided, as the adolescents no longer attend their regular school setting. Families participate weekly in multi-family groups and bi-weekly family therapy. Parents are required to support program rules at home. The program goals are:

- provide intensive treatment, focusing primarily on substance abuse, as well as the associated emotional, behavioral, and school difficulties;
- restore the adolescent's functioning within an average nine-month timeframe, so they can return to their regular educational or vocational plan;
- assist parents with parenting skills, limit-setting, communication, and insight into their adolescent's difficulties; and
- prevent/reduce substance relapse, psychiatric admissions, or referrals to residential care.

### Partners

Referring school districts; Department of Probation and Persons In Need of Supervision (PINS) diversion agencies; community mental health and substance abuse treatment agencies; referring psychiatric hospitals; Family Court and Juvenile Drug Treatment Court; Local Inter-Agency Council

### Outcomes

- Total patient visits increased from 4,169 in 2008 to 5,409 in 2009.
- The program achieved greater cohesiveness between families. A patient satisfaction survey indicated 87% approval.
- The program increased parent effectiveness, with 87% follow-through with staff recommendations such as implementing behavioral strategies/consequences at home or filing a PINS petition for legal support.
- Verbal participation reached 100% (both direct staff observation and adolescent and parent facilitation).

### Contact

Howard Riesel, L.C.S.W., C.A.S.A.C., Program Coordinator, Adolescent Services Unit  
(516) 674-1877 hriese1@nshs.edu

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# Girls on the Run

## GLENS FALLS HOSPITAL

### Year the Initiative Started

2003

### Program Description and Goals

In 2005, Glens Falls Hospital was awarded a Department of Health grant for diabetes prevention in children. The grant expanded the Girls on the Run program the hospital initially piloted in 2003 in two school-based health centers. Girls on the Run is an experiential learning program for girls that combines a five-kilometer (5K) run with lessons that encourage positive emotional, social, mental, spiritual, and physical development. The mission of the program is to educate and prepare girls for a lifetime of self-respect and healthy living. Short-term program goals include enhanced self-esteem, increased physical activity, and healthier nutritional choices. To date, Glens Falls Hospital has implemented the program in 21 area elementary schools, three middle schools, and two area YMCAs.

### Partners

Glens Falls and Saratoga YMCAs; Zonta Club; Adirondack Runners Club; Elementary Schools: Fort Edward, Corinth, Hudson Falls, Harrison Avenue, Ballard Road, Kensington, Sanford Street, Big Cross, Whitehall, Hadley Luzerne, Skano, Karigon, Tanglewood, Salem, Greenwich, Schuylerville, Dorothy Nolan, Bolton, Cambridge, Warrensburg, and North Warren; Middle Schools: Schuylerville, Fort Edward, and Salem

### Outcomes

- Program attendance was 93%.
- Ninety-four percent of participants increased scores on the following indicators: physical activity behavior, body image, skill for physical activity, and consumption of fruits and vegetables.
- Seventy-seven percent of participants participated in the 5K event.

### Contact

Jodi Brynes, Program Coordinator  
(518) 926-5942    [jbrynes@glensfallshosp.org](mailto:jbrynes@glensfallshosp.org)

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# Child Life Program

## GOOD SAMARITAN HOSPITAL MEDICAL CENTER

### Year the Initiative Started

2004

### Program Description and Goals

The Child Life program focuses on a child's social, emotional, and medical health care experience, promoting play and stress reduction for pediatric patients, their parents, and siblings. The program uses tools familiar to childhood, such as art, music, play, and education. Child Life also uses the hospital environment to create a feeling of well-being for patients and their families by providing soothing and stimulating spaces that promote healing and relaxation.

In the community, Child Life continues to address the needs of children at local elementary schools, community health and wellness fairs, special events, and children's first visits to the hospital. The goal of the pediatric Child Life program is not only to make children medically well, but to continue to promote positive and healthy development.

### Partners

Starlight Children's Foundation; YMCA Unity in the Community; Down Syndrome Connection of Long Island; Discover the Smile; Splashes of Hope; Angels of Hope; Pilots Club; American Society of Landscape Architects, New York Chapter; Jeff Dragan, Landscape Architect; Community Garden Clubs; Game Crazy

### Outcomes

- Since its inception in 2006, more than 1,000 families have attended the Prepare for Surgery class.
- Since 2004, Child Life has provided 38 hospital first visits to pre-school children, hosted by more than 100 Teddy Bear Clinics at local elementary school health fairs for more than 4,000 children, and presented *Preparing Your Child for a Visit to the Doctor, Dentist, or Hospital* and *Helping Your Child Cope with Medical Care* education programs for families of both well children and children with special needs.
- Child Life received a 2008 professional award from the New York Chapter of the American Society of Landscape architects for a rooftop pediatric garden and play area adjacent to the pediatric inpatient hospital playroom to improve patient care.

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- Child Life serves more than 3,000 inpatients annually, providing developmental support and minimizing the stress often associated with illness or injury, to enhance normal patterns of living, and to promote the child's optimum growth and development.

### Contact

Joan Alpers, Director, Child Life Program  
(631) 376-3717 joan.alpers@chlsi.org

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# The Colonoscopy Patient Navigator Program

## JAMAICA HOSPITAL MEDICAL CENTER

### Year the Initiative Started

2008

### Program Description and Goals

Jamaica Hospital Medical Center's Colonoscopy Patient Navigator Program (CPNP) is committed to increasing colonoscopy screening throughout the Queens community and to reducing barriers that result in lower screening rates. CPNP achieves these goals through colonoscopy education and communication. An effective patient contact, data tracking, and evaluation system enables the facility to outreach, monitor, and assess program performance.

The CPNP patient contact system starts by initially meeting patients in person at gastrointestinal clinics and providing a colonoscopy overview. A reminder letter, instructions sheet, and colonoscopy educational kit are mailed 15 days before the procedure. The patient navigator calls patients seven days before the test and reviews instructions. If any issues arise, the patient navigator can administer any changes.

### Partners

New York City Department of Health and Mental Hygiene–Cancer Prevention and Control Program; American Cancer Society–Queens Partnership; New York City Health and Hospitals Corporation

### Outcomes

The following data use 2007 as the baseline year (before CPNP was implemented) compared with CPNP performance in 2009.

- The average number of scheduled colonoscopies per quarter has increased by 8%, from 581 per quarter in 2007 to 629 per quarter in 2009.
- The current average colonoscopy completion rate per quarter is 91%, an 8% increase.
- The average number of completed colonoscopies per quarter increased 13%, from 483 per quarter to 543.
- On average, there are 12 no-shows per quarter, compared to 32 no-shows per quarter before implementation of the initiative.

### Contact

Ethel Onate, Colonoscopy Patient Navigator  
(718) 206-7951 eonate@jhmc.org

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# Coalition to Prevent Underage Drinking

## LONG BEACH MEDICAL CENTER

### Year the Initiative Started

2000

### Program Description and Goals

The goals of the Coalition to Prevent Underage Drinking are to:

- establish and strengthen collaboration among community members to prevent and reduce youth substance use; and
- reduce by 20% the rates of alcohol, marijuana, and tobacco use among youth (and, over time, adults) by decreasing community factors that increase risk of substance abuse and promoting factors that minimize the risk of abuse.

The Coalition to Prevent Underage Drinking uses an environmental approach that emphasizes risk and protective factors, and incorporates the Community Anti-Drug Coalition of America's seven strategies for change: providing information; enhancing skills; supporting youth; enhancing access to services; changing/enforcing consequences; changing physical design; and modifying, enforcing, and monitoring policies that reduce risk.

### Partners

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

### Outcomes

- A city ordinance was enacted that requires youth cited for minor possession to appear in court and attend a three-session substance abuse awareness program at Long Beach Medical Center.
- Long Beach was the first municipality in New York State to enact "social host" legislation that holds adults criminally responsible for alcohol consumed by minors in their homes.
- Between 2000 and 2008, this initiative achieved a significant decrease in youth who had used substances in the past 30 days (seventh-graders' alcohol use dropped from 35% to 7%; marijuana use declined from 12% to 0.9%; and tobacco use went from 20% to 2%). For ninth-graders, alcohol



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use dropped from 47% to 30%, marijuana use decreased from 35% to 10%, and tobacco use declined from 12% to 8%.

- Between 2000 and 2008, youths' perception of harm from substance use increased dramatically: ninth-graders' perception of alcohol harm jumped from 23% to 78%, perception of marijuana harm increased from 37% to 48%, and smoking harm soared from 49% to 91%. The results were similar for seventh-graders and eleventh-graders.

## Contact

Douglas L. Melzer, Chief Executive Officer  
(516) 897-1208 [dmelzer@lbmc.org](mailto:dmelzer@lbmc.org)

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# Low-Cost Interventions to Create the Ideal Transition Home

## LONG ISLAND HEALTH NETWORK HOME CARE AGENCIES

### Year the Initiative Started

2008

### Program Description and Goals

Five home care agencies collaborated to develop clinical guidelines for their top diagnoses. The process combined evidence-based standards of care with their collective clinical expertise and patients' unique values. Early on, it became evident that greater education was needed to improve outcomes and reduce re-hospitalizations. The agencies postulated that standardized and disease process-focused education for heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (COPD) would lead to a reduction in re-hospitalizations and better outcomes. Booklets were designed to give patients and their families a better understanding of the disease process and to promote them as integral members of the health care team. In addition, the agencies purchased DVDs about the diagnoses to augment the program.

### Partners

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

### Outcomes

- Long Island Health Network Home Care Agencies are averaging 17% lower re-hospitalization rates than the national average.
- Re-hospitalization of COPD patients referred to home care on telehealth decreased by 53% between 2007 and 2009 at one agency.
- A related 25% reduction on COPD mortality was seen during the same time period.
- The collaborative approach enables clinicians to provide the highest quality of care in meeting the complex needs of their patients.

### Contact

Kathleen Masiulis, Senior Vice President  
(631) 420-6800    [kmasiuli@lihn.org](mailto:kmasiuli@lihn.org)

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# Healthy Heart Worksite Initiative

## MEDINA MEMORIAL HEALTH CARE SYSTEM

### Year the Initiative Started

2005

### Program Description and Goals

The goals of this initiative are to work with worksites to implement workplace wellness strategies focused on cardiovascular disease, Type 2 diabetes, and obesity. Goals include:

- increasing physical activity among workers;
- enhancing access to, and consumption of, healthy foods;
- increasing access to, and use of, preventive health programs designed to reduce risk factors for chronic disease among workers with elevated risk for chronic disease;
- demonstrating senior management support of comprehensive worksite wellness at each worksite;
- designating a wellness coordinator and/or committee at worksites; and
- conducting a pre- and post-assessment of policies and environmental supports at worksites.

### Partners

Medina Memorial Health Care System's Community Partners Wellness Center; a dietician, health and wellness coordinator, and certified diabetes educator; targeted worksites; Orleans County Health Department; Orleans County Smoke Free Now; Lake Plains Community Care Network; local physician offices; local farmers; Western New York Osteoporosis Coalition; American Cancer Society

### Outcomes

- **Nutrition:** 55% of the worksites implemented at least one environmental change to address nutrition.
- **Physical Activity:** 91% of the worksites implemented at least one environmental change to address physical activity.
- **Cardiovascular Disease Prevention:** 91% of the worksites implemented on-site blood pressure monitoring stations with education and guidelines.
- **General Wellness:** 100% of the worksites established an on-site wellness committee and/or designated a wellness coordinator.

### Contact

Cindy Perry, Director, Community Partners Wellness Center  
(585) 798-6641 [cperry@medinamemorial.org](mailto:cperry@medinamemorial.org)

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# Renal/Transplant Specialty Program

## METROPOLITAN JEWISH HEALTH SYSTEM

### Year the Initiative Started

2007

### Program Description and Goals

The goal of Metropolitan Jewish Health System's Renal/Transplant Specialty Program is to reduce avoidable post-transplant hospitalizations and length of stay. Transplant coordinators implement healthy partner relationships with eligible clients. Pre-transplant, patients interact with an interdisciplinary team multiple times per week. Post-transplant, exposure to, and interaction with, this support network decreases.

Four best practices specific to renal disease (pre- and post-transplant) were developed and implemented:

- hospital risk assessment;
- emergency care planning;
- medication management; and
- telephone monitoring.

Post-transplant, patients are at risk for re-hospitalization due to decreased communication. Early identification of symptoms and early reporting have led to numerous interventions, decreasing acuity and reducing length of stay.

### Partners

SUNY Downstate Hospital Transplantation Team

### Outcomes

- **Increased Survival Rates:** Survival rate one month post-transplant improved from 96% to 97%, statistically significant compared to the expected rates.
- **Reduced Length of Stay Post-transplant:** Acuity of symptoms has decreased because of early intervention, shortening hospital stays by 1.0 to 1.5 days. This is a tremendous cost savings to Medicare and Medicaid.
- **Reduced Missed Appointments:** The care coordinator reminds patients about physician appointments and discusses transportation to see the doctor. Often, the care coordinator arranges transportation similarly to a concierge service. This has reduced missed doctor visits. The care coordinator reviews questions and concerns before the patient's appointment and follows up within 24 hours afterward to facilitate changes to the patient's care.

### Contact

Lydia Galeon, R.N., M.B.A., Vice President, Long Term Care  
and Business Initiatives  
(718) 759-4759 | [lgaleon@mjhs.org](mailto:lgaleon@mjhs.org)

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# Heart and Soul in the Neighborhood

## MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER

### Year the Initiative Started

2004

### Program Description and Goals

Heart and Soul in the Neighborhood is a collaborative-based program established by Mount St. Mary's Hospital to provide primary care to the residents served by the Heart Love and Soul Food Pantry in the City of Niagara Falls. Based on the Parish Nurse Model, the goal of this outreach program is to improve the health needs and the quality of life of those who are poor and vulnerable by connecting clients who come to the soup kitchen with services already present in the area and to provide follow-up as needed.

### Partners

Niagara County Office of the Aging, Department of Mental Health, Department of Social Services, Child Protection Services, and Healthy Living Partnership; Cornell Cooperative Extension; Catholic Charities; Carolyn's House (a home for abused and homeless women and children)

### Outcomes

- **Medical Home:** The Parish Nurse is able to make appointments for the clients to be seen regardless of their ability to pay because of the arrangement with the neighborhood health center.
- **Insurance Enrollment:** Since many of the clients are without health insurance or are under-insured, the availability of an insurance facilitator and social worker helps clients begin the process of obtaining services that were previously not available to them.
- **Prescriptions:** Since most clients do not have prescription coverage, compliance with medication is a major problem. To assist with compliance, arrangements have been made with a local pharmacy to obtain prescriptions at-cost for those who are without insurance or having difficulty affording their co-payments until social services are established.
- **Inappropriate Use of the Emergency Room:** Data support the fact that 16.4% of adults living in Niagara Falls with household incomes of less than \$10,000 regularly use the emergency department—as often as 14 times each year for their primary care. Before the institution of this program, clients from Heart and Soul sought medical attention through the emergency department for both urgent and non-urgent types of problems.

### Contact

Barbara Malinowski, Parish Nurse Coordinator  
(716) 298-2474 [barbara.malinowski@msmh.org](mailto:barbara.malinowski@msmh.org)

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# Healthy Schools Healthy Families

## NEWYORK-PRESBYTERIAN HOSPITAL

### Year the Initiative Started

2004

### Program Description and Goals

Healthy Schools Healthy Families (HSHF) is a health promotion program serving seven elementary schools in Northern Manhattan. The coalition is comprised of more than 15 organizations led by NewYork-Presbyterian Hospital, Columbia University Community Pediatrics, and Weill-Cornell Medical Center. The program goal is to promote healthy lifestyles and mental well-being in the school community. Specifically, the program:

- cultivates a school culture that values physical activity, healthy eating, and mental wellness;
- achieves environment and policy changes that promote healthy lifestyles and support healthful behaviors;
- facilitates access to services for children with health needs, particularly asthma;
- facilitates insurance enrollment for children and families; and
- ensures 100% of children have completed their required immunizations.

### Partners

Schools: P.S. 4 Duke Ellington, P.S. 102 Jacques Cartier, P.S. 128 Audubon, P.S. 132 Juan Pablo Duarte, P.S. 152 Dykman Valley, P.S. 180 Hugo Newman, P.S. 206 Jose Celso Barbosa; Asthma Basics for Children; Food Bank for New York City; Katchkie Farm; Asthma Free School Zone; Punk Rope; New York Road Runners; Choosing Healthy and Active Lifestyles for Kids (CHALK); New York City departments of Education, and Health and Mental Hygiene; City Harvest; Community Healthcare Network; Turn 2 Us Foundation; Cornell Cooperative Extension; Washington Heights/Inwood Network; Family PEACE Program; Affinity Health Plan (WIN) for Asthma

### Outcomes

- This academic year, 302 high-risk asthmatic children have been referred to the WIN Program for Asthma care coordination program to date.
- The schools have met or exceeded the Department of Education requirements of 97% student body immunization compliance for five consecutive years.
- In collaboration with partners, HSHF hosted 414 nutrition events, yielding 36,166 participant encounters across all seven HSHF schools last academic year.

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- This year, HSHF schools are averaging 96.7 minutes/week/class of physical activity, 41% of which can be attributed to HSHF programming and train-the-trainer programs.

### Contact

Melissa Pflugh, HSHF Program Manager  
(212) 342-0713    [mep7006@nyp.org](mailto:mep7006@nyp.org)

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# Diabetes Education Self-Management Program

## NICHOLAS H. NOYES MEMORIAL HOSPITAL

### Year the Initiative Started

2004

### Program Description and Goals

This is a multifaceted diabetes education program in two locations, staffed by a full-time registered nurse who is a certified diabetes educator, and a part-time registered dietitian. The program goals are to empower patients to assume responsibility for the effective management of their condition and to provide the needed information, support, and resources to enable self-management. The education begins with survival skills and progresses to advanced skills through classes and individual counseling. The program tracks the reduction in glycated hemoglobin (A1C), and behavior change related to foot checks and the reduction in the risk for lower extremity problems and amputation. The program is recognized by the American Diabetes Association.

### Partners

Livingston County Department of Health; Public Health Nurses and the Prevent Team; Genesee Valley Health Partnership (representing 40 organizations); Cornell Cooperative Extension in Livingston County; Catholic Charities of Livingston County; Livingston County Office for the Aging and Department of Social Services; Community Service Block Grant; area physicians and health care providers; Lions Clubs of Dansville, Wayland, Cohocton, and Canaseraga; Genesee Parish Outreach Center

### Outcomes

- The program resulted in an increase in foot checks, from 42% checking at initial meeting, to 81% checking at three months and 84% checking at six months.
- Levels of A1C lowered by 1.1 points at six months; specifically, 72% have lowered their A1C and 6% maintained their levels.
- There was an increase in the overall number of classes from one per month in one location to three to four classes per month in two locations.
- Class participation has doubled.

### Contact

Nancy M. Johnsen, R.N., C.D.E., Diabetes Program Coordinator, Coordinator of Community Health Education  
(585) 335-4355    [njohnsen@noyes-hospital.org](mailto:njohnsen@noyes-hospital.org)



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# Activity Works Program

## NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM

### Year the Initiative Started

2007

### Program Description and Goals

The goal of the Activity Works Program (AWP) is to increase children's daily physical activity to prevent obesity, especially among ethnically diverse, low-income elementary school children who are at high risk for obesity. AWP is a classroom teacher-delivered, curriculum-compatible, reward-based activity program with ten-minute, age-appropriate physical activity segments delivered on DVDs and CDs. AWP also includes support materials on nutrition and physical activity for teachers, students, and parents. North Shore-Long Island Jewish Health System developed AWP using feedback from an eight-month discovery process involving educators, administrators, parents, public health, and health care professionals. AWP was piloted in five multi-ethnic and varied socio-economic elementary school districts.

### Partners

Nassau, Eastern Suffolk, and Western Suffolk Boards of Cooperative Educational Services; Nassau County Department of Health and its Healthy Nassau Youth Committee; Long Island Obesity Coalition; Glen Cove, North Bellmore, Roosevelt, Valley Stream, and Westbury school districts

### Outcomes

- Teacher satisfaction survey results showed improved student focus and increased energy and knowledge of academic, physical activity, and nutrition subject matter. Students using AWP participated in more physical activity than those in the control group.
- AWP students showed improved self-confidence compared to control group students, according to results of the Harter Self-Perception Profile for Children.
- Approved by the State Education Department, AWP was integrated into the physical education curricula and school wellness policies of pilot schools.
- The Nassau County Department of Health's Healthy Nassau Youth Committee adopted the program as part of its School Wellness Initiative.

### Contact

Nancy Copperman, M.S., R.D., C.D.N., Director, Community Health and Public Policy  
(516) 465-3180    [ncopper@nshs.edu](mailto:ncopper@nshs.edu)

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# The “F5” Project: Fear Factor for Health and Fitness

## NORTHERN DUTCHESS HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

“F5” Project: Fear Factor for Health and Fitness is designed to combat childhood obesity in Northern Dutchess county. A collaborative effort of the Red Hook Central School District, Northern Dutchess Hospital, and other public and private entities, this wellness initiative incorporates physical fitness and exercise, nutritional education and counseling, and improvements in school cafeteria menus and vending machine offerings. Goals include helping children understand the importance of nutrition, exercise, and body mass index; serving fresher, more nutritious food in schools; helping parents plan healthier meals; teaching children to learn good eating habits and make healthier food choices; and educating the families about activities that will keep them active and fit outside the classroom.

### Partners

Red Hook Central School District and Board of Education Wellness Committee; Culinary Institute of America; Executive Chef to the Governor of New York; Red Hook Farmers’ Market; Adams Fairacre Farms; Red Hook Library; Red Hook Town Offices; various local restaurants

### Outcomes

- More than \$800,000 in grants was awarded from 2008 to 2010 to the school district.
- Students’ BMI index improved more than 5% in one year (2008-2009) to 80%.
- Students achieved the highest level (77.1%) in “Fitness Gram Zone” (National Health Physical Fitness Test with new, stringent requirements), exceeding the school’s goal of 75%.
- Public, private, and corporate participation and attendance at “F5” program extra-curricular events increases every year.

### Contact

Gina D’Angelo-Mullen, Director, Public Relations  
(845) 871-3500 gmullen@health-quest.org

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# Healthy Heart Program

## ORANGE REGIONAL MEDICAL CENTER

### Year the Initiative Started

2005

### Program Description and Goals

Healthy Heart Program is a free mobile screening service that is performed to determine a patient's heart disease and stroke risk. This free mobile service screens participants for abnormal blood pressure, body mass index, total cholesterol, triglycerides, low-density lipids, high-density lipids, and blood sugar. The patient's risk for heart disease can then be calculated. The goal is to reach 1,000 new participants each year and to follow up with previous participants to determine their risk levels. Heart health counseling and education is achieved by literature distribution and visual models. Those who have abnormal findings are encouraged to see their health care professional. Orange Regional Medical Center assists in finding health care professionals and refers patients who cannot afford one to a community health clinic.

### Partners

Agriculture Business Child Development; Department of Health Center of Discovery; Conway Freight; Cornwall Middle School; Crystal Run Village Health Fair; Valley View Nursing Home; Rockland Psychiatric Center; Downstate Correctional Facility; Ellenville Seventh Day Adventist Church; Epicor Relay for Life; Scotchtown Presbyterian Church; Board of Cooperative Educational Services; Healthy Harvest Health Fair, Middletown; Heart Walk/American Heart Association (Minisink Valley High School); Meadow Hill Elementary School; Hudson River Health Care; Middletown Beauty School; Middletown and Valley Central high schools; Port Jervis Middle School; Orange County Community College; Mount Saint Mary's College; Orange County Department of Mental Health; Shoe Drive/Groo's Shoes; ShopRite; PRG Scenic Technologies; Family Fun Day (Wurtsboro Airport); YMCA; Orange Classic

### Outcomes

In 2009, the Healthy Heart Program:

- screened 2,121 people through outreach, for a total of 6,367 screened since 2005;
- screened 1,300 people through outreach at risk for heart disease;
- initiated steps for 1,300 participants to reinforce lifestyle goals and to encourage follow-up with a health care professional; and
- initiated four educational presentations for heart-healthy awareness, reaching out to the population that declined screening.

### Contact

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# Pre-School Speech and Language Screening and Education Programs

## PHELPS MEMORIAL HOSPITAL CENTER

### Year the Initiative Started

1980

### Program Description and Goals

This program is conducted on-site at nursery schools and day care centers by two speech-language pathologists. The program has two objectives: to identify children between the ages of two and five who may be at risk for speech and language delays, and to provide information to teachers and parents about normal speech and language development, as well as signs of possible delays. Early identification of children with potential speech and language disorders and provision of treatment before first grade can build a strong foundation for future learning.

### Partners

Home School; Tarrytown Nursery School; Days of Wonder; Accent on Learning; Community Nursery School; Children's Space; Good Shepherd Nursery School; Greenburgh Hebrew Center; Rivertown Preschool; Robin's Nest; YMCA; Briarcliff Nursery School

### Outcomes

Data from the 2005-2006 and 2007-2008 programs showed the following results:

- Four out of five children referred for the screening failed and were recommended for a full speech-language evaluation.
- Teachers (128) were educated regarding appropriate age-related speech and language skills and expectations.
- Children who receive speech-language therapy in the preschool years have fewer learning issues in first grade. Most children in speech-language therapy enter regular first grade, although some continue their therapy programs and/or receive support services.

### Contact

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# EZ Detect Colorectal Cancer Screening

## ROME MEMORIAL HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

In Oneida County, less than 42% of colorectal cancer is detected in its earliest stages when it is easiest to treat. The EZ Detect Colorectal Cancer Screening program was developed to increase the number of people screened for colorectal cancer. Despite previous efforts to reach more people through improved distribution, education, and monetary incentives, the number of people screened still lagged. By using the new U.S. Food and Drug Administration-approved EZ Detect screening tool, Rome Memorial Hospital was able to address negative attitudes toward collecting and returning stool specimens. Rather than collecting a stool sample and bringing it in for analysis, people are able to simply drop a test pad into the toilet after three consecutive bowel movements and record their results to share with their primary care physician.

### Partners

Primary care providers; churches and schools; senior centers and senior housing; Rescue Mission/Welcome Hall; local media

### Outcomes

Before 2006, Rome Memorial Hospital's traditional colorectal screening program reached approximately 30 people over the age of 50 annually.

- When the hospital collaborated with other facilities and added a monetary incentive, the numbers increased from 50 in 2006 to 80 in 2007, but still lagged behind the hospital's goals.
- By implementing the EZ Detect tool, Rome Memorial Hospital was able to address a primary barrier to screening and reach significantly more members of the community: 433 people in 2008, and 537 in 2009.

### Contact

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# Rensselaer County Task Force on Suicide Prevention

## SAMARITAN HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

In response to alarming statewide suicide data and losses shared by the local community, county leaders identified a need to partner in a meaningful and active way. A county-wide task force was developed to collaborate on improving awareness and developing an active approach to suicide prevention. The task force has focused on engaging key community stakeholders and service providers, with a mission to develop a community of compassion, provide education, and spearhead suicide prevention efforts. The initiative, which aligns a county-wide plan with the four-year statewide plan, recognizes that a public health approach is essential to succeed.

### Partners

Rensselaer County Executive; Unified Services; Troy Police Department; Rensselaer County Medical Examiner's Office; New York State Office of Mental Health; New York State Suicide Prevention Center; Mental Health Empowerment Project; Northeast Career Planning; American Foundation for Suicide Prevention; Hudson Valley Community College; Rensselaer Polytechnic Institute; Unity House; Student Assistance Program in Rensselaer County Public Schools; Survivor Representatives; Troy Housing Authority; local clergy; the Samaritans Crisis Hotline and 211 Referral Call Center

### Outcomes

The Task Force has accomplished increased public awareness and has set an agenda going forward for suicide prevention within Rensselaer County. Meeting monthly, the Task Force has more than doubled initial membership, has provided training to more than 75 people in the county, and plans to do significantly more. The Task Force has begun to collaborate with similar task forces and share best practices and effective responses to promote a "suicide-safer" community.

### Contact

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# Schuyler Steps Out

## SCHUYLER HOSPITAL

### Year the Initiative Started

2007

### Program Description and Goals

The Schuyler Steps Out community walking challenge was developed to get Schuyler County residents to move more during the dreary winter months. It has evolved under the multi-faceted mission of battling diabetes, hypertension, and obesity in a high-risk community. While many teams are workplace-based, service clubs, churches, senior citizen complexes, and scouts have formed teams. All that is required is walking daily for eight weeks (reduced from 12 weeks), logging steps walked with pedometers, and reporting to the hospital weekly. In return, the hospital issues weekly hints and tips, as well as heavy doses of motivation.

### Partners

Excellus BlueCross BlueShield; Wal-Mart; Sullivan Trail Red Cross; Lakewood Vineyards; Chemung Canal Trust Company; Watkins Glen International

### Outcomes

Schuyler Steps Out has grown from 750 participants on 16 teams logging 630 million total steps in 2007, to a record 900 walkers on 33 teams (5% of the county's population) logging 673 million total steps in 2009. Participants in 2009 reported:

- weight loss;
- reduced use of medication;
- joining local gyms;
- healthier habits;
- positive lifestyle changes; and
- generally feeling better.

### Contact

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# Medical Nutrition Therapy Services

## SOUND SHORE MEDICAL CENTER OF WESTCHESTER

### Year the Initiative Started

2006

### Program Description and Goals

Sound Shore Medical Center (SSMC) developed the Medical Nutrition Therapy (MNT) initiative in response to a growing awareness of the importance of nutrition in health maintenance and disease prevention and control. The goal of MNT is to increase individual awareness of nutrition and wellness, promote healthy eating, and fight obesity and other chronic diseases and conditions. Through one-on-one counseling, MNT teaches pediatric and adult patients about their disease or condition, including what steps they can take for successful modification of lifestyle and eating habits. MNT also promotes professional education as well as community and public awareness of nutrition. The clinical outcomes for CCMC's 116 outpatients—representing nearly 200 visits in 2009—are a measure of the program's success.

### Partners

Sound Shore Medical Center's Diabetes Center, Diabetes Outpatient Education Program, and Surgical Weight Loss Program; Mount Vernon Hospital; Department of Health Pinnacle Health Care Diabetes Coalition; New Rochelle Department of Aging; North East Bronx Senior Center; Parker Elementary School

### Outcomes

- In 2009, 116 patients entered the program. Of those, 110 were adults and six were pediatric patients. Forty-three percent of the 116 required more than one visit (on average, 2.6 visits, or 134 visits for the year).
- Forty-three patients (86%) having two or more visits showed improvement.
- Forty-one patients set weight management as a goal. Of those, 28 (68.3%) achieved weight loss—the average loss was 8.8 pounds.
- Thirty-six patients set blood glucose control as a goal. Of those, 80.6% achieved improvement and 52.8% reached the American Diabetes Association goal of a “fasting” glucose test of under 130 mg/dl.

*Note: Surgical weight loss patients (120 in 2009) attend only one educational session and are excluded from the annual visit count and measurement data reporting.*

### Contact

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# Improving the Early Identification of Lung Cancer in Our Community

## **SOUTH NASSAU COMMUNITIES HOSPITAL**

### Year the Initiative Started

2007

### Program Description and Goals

Lung cancer is rarely discovered until the disease has progressed to a late stage. In early 2007, South Nassau Communities Hospital's tumor registry data revealed that in 2006 only 18% of newly diagnosed lung cancers were identified at Stage 1. The hospital participated in the International Early Lung Cancer Action Program, allowing improved access to care and diagnostic service to those with limited income or insurance. The hospital collaborated with an outside positron emission tomography (PET) imaging company that provided scans free of charge. People 50 years of age or older, current smokers, and former smokers who smoked at least one pack per day for 20 or more years could apply for participation. Community physicians could refer at-risk patients. The goal was to improve the number of lung cancer cases diagnosed at Stage 1 by 10%.

### Partners

Rockville PET Imaging, P.C.; community physicians

### Outcomes

- The identification of lung cancer at Stage 1 increased by 47%. The tumor registry data in 2006 showed that the percent of lung cancer diagnosed at Stage 1 was 18.6 out of 145 total cases. Interventions began in 2007 and by 2008 the total cases diagnosed at Stage 1 were 45 of 164 total lung cancer cases.
- Identification of lung cancer at Stage 1 allowed for appropriate and early intervention. The number of surgeries for lung cancer in 2005 was 29 and the number of surgical interventions in 2008 was 53, an 82.8% difference.

### Contact

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# Community Outreach Initiative for Oral Health Care

## ST. BARNABAS HOSPITAL

### Year the Initiative Started

1989

### Program Description and Goals

Cognizant of the fact that oral disease affects every community, especially those designated as medically under-served, the St. Barnabas Hospital Department of Dentistry designed and implemented a community-based oral screening and educational initiative for residents of the hospital's service area and surrounding communities. In a concerted effort to ensure the efficacy of the project, the hospital conducted a needs assessment in collaboration with neighborhood service providers, including Bronx District Public Health Office, New York City Department of Education, and the Archdiocese of New York.

The intent of the initiative was to implement an oral health care program that is comprehensive in scope and accessible to the uninsured and underinsured. The efficacy of the oral care program is determined using evaluative measures including a patient satisfaction questionnaire, and planning and evaluation conferences with staff from participating organizations.

### Partners

Residences for mentally retarded and/or developmentally disabled individuals; an educational institution for the blind and visually impaired; public and parochial elementary and middle schools; homeless shelters; programs for the elderly; Head Start programs; Section 202 residences for the elderly and handicapped

### Outcomes

The Community Outreach Initiative for Oral Health Care:

- improved the dental health status of area residents;
- encouraged the use of the hospital's dental facilities in the ambulatory care network;
- educated community residents about the importance of continuity of care; and
- significantly reduced the unnecessary use of the hospital's emergency department for dental care.

### Contact

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# Kernan Elementary School-Based Health Center

## ST. ELIZABETH MEDICAL CENTER

### Year the Initiative Started

2007

### Program Description and Goals

The School-Based Health Center (SBHC) operates as a primary care clinic within Kernan Elementary School. The goal of the Center is to increase access to primary health care services for children living in low socio-economic areas, with the overall goal of improving health outcomes. The location was chosen because of the high number of free and reduced-cost lunches reported in the school, which indicates a large proportion of children live in low-income households.

### Partners

Utica City School District; United Cerebral Palsy; Department of Health School Health Unit; New York State Coalition for School-Based Health Centers; St. Elizabeth Family Medicine Center; St. Elizabeth Family Medicine Residency Program

### Outcomes

- Seventy-five percent of the students at the schools served by SBHC are enrolled in SBHC.
- Eighty-eight percent of students enrolled in SBHC have a documented annual comprehensive physical exam.
- Based on latest quarter chart reviews, 100% of students enrolled in SBHC have up-to-date immunizations per the Advisory Committee on Immunization Practices schedule and Department of Health guidelines.
- SBHC identifies insurance status of all participating children; uninsured children's families receive a facilitated enrollment packet from SBHC, with the goal of decreasing the number of uninsured children.

### Contact

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# Prospect Hill Development Initiative

## ST. JOSEPH'S HOSPITAL HEALTH CENTER

### Year the Initiative Started

2008

### Program Description and Goals

St. Joseph's Hospital Health Center is leading a major revitalization effort in the surrounding community, where 30% of residents live below the poverty level. The collaborative Prospect Hill Development Initiative has expanded existing businesses, attracted new business, and stabilized housing to create a more economically diverse community. The initiative is rehabilitating historic homes to increase home ownership, renovating properties for sale and as market-rate rentals to attract hospital employees, and creating 50 units of affordable town homes. It has started a workforce development program for unemployed and underemployed residents, and promotes arts and culture and the community's history as an immigrant neighborhood. Implementation of a master plan will spur further development.

### Partners

Metropolitan Development Association; Home Headquarters; Housing Visions; Northside Collaboratory; Central New York Regional Planning Board; New York State Energy and Research and Development Authority; City of Syracuse; County of Onondaga; New York state and federal government

### Outcomes

- In December 2009, the hospital began phase 2 of its \$220 million expansion project, the largest green design and construction project in the region. Construction will employ up to 600 people and generate more than \$2 million in local revenue.
- Also in 2009, the career-training program graduated 26 students.
- The first units in the new housing development were available in February 2010.
- A community art gallery has opened, a new Web site and newsletter are promoting the neighborhood, and renovation continues to convert a vacant structure into a business development center.

### Contact

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# Mobile Geriatric Outreach Program

## ST. MARY'S HOSPITAL, AMSTERDAM

### Year the Initiative Started

1988

### Program Description and Goals

The Mobile Geriatric Outreach (MGO) Program was established in response to an extraordinarily high number of elderly patients with mental illness presenting to local emergency departments and a lack of critical services needed to address the unique needs of these patients. The primary goal of this program is to reduce unnecessary emergency department visits, inappropriate hospitalizations, and decompensating behaviors in the mentally ill elderly by providing home- and community-based intervention services. Services provided by the program are comprehensive, entirely mobile, and include psychological/social assessment, direct care, client monitoring, and education to community providers on the special needs of the elderly. The program serves those 60 years of age and older with mental illness or impairments or those age 50 and older with multiple comorbidities.

### Partners

St. Mary's Hospital Behavioral Health Services and Wilkinson Nursing Facility; Fulton and Montgomery County Offices for the Aging; Fulton and Montgomery County Department of Social Services; Catholic Charities of Fulton and Montgomery Counties; Local Physician Offices; Local Adult Homes; Home Health Care Agencies

### Outcomes

- MGO is currently the only mobile-based comprehensive service program in the Fulton and Montgomery county area.
- In 2009, MGO conducted 4,372 client visits.
- MGO has improved the quality of life of 1,013 people in the community.

### Contact

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# Rensselaer Cares Prescription Assistance Program

## ST. MARY'S HOSPITAL/SETON HEALTH AND SAMARITAN HOSPITAL/NORTHEAST HEALTH

### Year the Initiative Started

2007

### Program Description and Goals

Seton Health, Northeast Health, Rensselaer County Medical Society, and Whitney M. Young, Jr. Health Center came together to create a prescription assistance program to help their uninsured/underinsured low-income patients. The program employs a care coordinator who helps individuals obtain prescription drugs through access to existing free or low-cost programs available from pharmaceutical manufacturers. Prescribing physicians (and their office staff) refer potentially eligible patients who require a prescription to the program. Once the individual's prescription requirements are met, the coordinator evaluates other health-related needs. Those who need a primary care physician are referred to one. Participants that might be eligible for government-sponsored health care coverage are referred to an insurance coordinator.

### Partners

Seton Health/St. Mary's Hospital; Northeast Health/Samaritan Hospital; Rensselaer County Medical Society; Whitney M. Young, Jr. Health Center (Troy Clinic)

### Outcomes

From January 2007 through January 2010, the program:

- assisted 2,108 patients in obtaining 8,037 individual prescriptions, with a retail value of more than \$3.5 million;
- filled 97% of prescription requests; and
- referred 278 patients to an insurance coordinator to determine eligibility for public insurance programs.

### Contact

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# St. Peter's Regional ALS Center

## ST. PETER'S HEALTH CARE SERVICES

### Year the Initiative Started

1988

### Program Description and Goals

The Regional ALS Center provides medical and emotional care, rehabilitation therapy, equipment loans, and other services to people suffering from Amyotrophic Lateral Sclerosis ("Lou Gehrig's Disease"). The Center served 140 ALS patients from a 17-county region in 2009. Volunteers are an integral part of the services to patients and fundraising efforts, allowing the Center to provide most of its services at no cost to patients. It is the only such service in Northeastern New York.

### Partners

Muscular Dystrophy Association; Respironics, Inc.; Upstate Clinical Research; Pride Mobility Products Corporation; Pepsi Cola Bottling Company; Eazy Lift Stair Lifts

### Outcomes

In 2009, accomplishments included:

- ALS Center provided services to 140 patients and families:
  - ALS provided 267 clinic visits, including physical, occupational, respiratory, and speech therapy;
  - registered nurses conducted 97 home visits at no charge;
  - loaned 622 pieces of medical and communication equipment free of charge; and
  - nursing case management involved more than 3,000 conferences and telephone calls with patients and families.
- Volunteers enable ALS Center to provide most of its services at no charge:
  - volunteers logged 1,560 hours in 2009, including fundraising that allows the Center to provide most of its services at no charge;
  - volunteers conducted 60 home visits, providing respite breaks for family members, along with companionship and other services to ALS patients; and
  - a new partnership with the Pepsi Cola Bottling Company resulted in the free delivery of nearly 100 pieces of medical and communications equipment, saving the ALS Center about \$5,000.
- An ALS patient created a Web site to help military veterans with ALS obtain benefits from the U.S. Veterans Administration:
  - The unique Web site brings together all the forms and information necessary to file for benefits.
- A new partnership with the national Muscular Dystrophy Association (MDA)

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makes ALS' rehabilitation clinic one of nearly 40 MDA/ALS clinics across the country. As a result, the Center:

- hired additional social work support and per-diem nursing staff;
- repaired medical and augmentative equipment; and
- paid for clinic visits for patients without insurance.

## Contact

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# Promoting Health Literacy Through Healthy Partnerships

## STATEN ISLAND UNIVERSITY HOSPITAL

### Year the Initiative Started

2008

### Program Description and Goals

By promoting health literacy (HL), Staten Island University Hospital's (SIUH) objective is to minimize negative health outcomes while improving patient/provider communication. At the organizational level, SIUH has restructured its approach to patient education by simplifying language in print materials and encouraging health care providers to use the "teach-back" method. SIUH shares the HL curriculum developed at SIUH with community partners involved in adult education who implement these lessons in their classrooms. To ensure students understand the health information, a health care professional attends the class to give an expert presentation on the topic. Additionally, this program brought together health care and adult literacy organizations at the first HL conference hosted by SIUH. An outcome was the formation of the HL Collaborative of Staten Island.

### Partners

Staten Island Jewish Community Center; Literacy Assistance Center; New York Public Library; Visiting Nurse Services of New York; El Centro del Inmigrante; American Cancer Society; YMCA of Staten Island

### Outcomes

- Staten Island's First Annual Health Literacy Conference, sponsored by a grant from the National Library of Medicine, attracted 60 participants.
- The first island-wide Health Literacy Collaborative was organized and launched, with 20 partner organizations.
- The HL curriculum developed by SIUH includes lessons on infection control, influenza prevention, cancer prevention and detection, diabetes, nutrition, stress, yoga, navigating the health care system, financial assistance, pharmacy literacy, and health information on the Internet. The curriculum was used in 55 classrooms, reaching 700 adult learners.
- SIUH launched a hospital-wide initiative to promote HL by simplifying language in patient/provider communications and developing a standard policy for patient education materials that will follow HL criteria for simplicity.

### Contact

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# United Against Cancer

## UNITED HEALTH SERVICES HOSPITALS

### Year the Initiative Started

2008

### Program Description and Goals

United Against Cancer, an extensive community outreach effort, combined a media campaign with on-site cancer screening and follow-up navigation services. Four events were held in three different counties that focused on cancer prevention, early detection, and risk reduction education.

Physicians, medical residents, nurses, financial advocates, laboratory technicians, health educators, and nutritionists provided services in high-risk areas. Clinical breast exams, testicular cancer clinical exams, prostate specific antigen blood tests, digital rectal exams, cervical cancer screening (Pap test and internal exam), and skin and oral cancer screenings were provided on-site.

The goal was to increase awareness of cancer risk, educate people on what to do, provide screening, and engage those who need follow-up.

### Partners

Action for Older Persons; American Cancer Society; Broome County Health Department; Healthy Living Partnership; Mothers and Babies Perinatal Network; New York State Senator Thomas Libous; Tioga County Health Department; Chenango Health Network; Tobacco Free Broome and Tioga; Tobacco Free Chenango; Team Act, the Cessation Center

### Outcomes

- In the four events, United Health Services Hospitals provided a total of 740 cancer screenings to 385 individuals.
- There were 122 positive findings, indicating that roughly one-third of those screened needed medical attention. Their primary care providers were notified of the screening results. Those patients now receive follow-up telephone calls from United Health Services Hospitals' cancer nurse coordinator.
- Patients who did not have positive findings but who should be monitored because of risk factors or other concerns have been contacted and will receive follow-up calls to monitor their status.
- Physician referrals were provided to 28 patients who did not have primary care providers.

### Contact

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# Educating and Empowering Congestive Heart Failure Patients and Caregivers

## UNITED MEMORIAL MEDICAL CENTER

### Year the Initiative Started

2009

### Program Description and Goals

This project stimulated change in care delivery that improved transitions from acute care to home care for patients with a diagnosis of congestive heart failure (CHF). This project has:

- improved patient and caregiver understanding of their roles in the care transition;
- improved systems and support to increase involvement by patients and their caregivers;
- reduced the number and acuity of admissions and readmissions;
- identified and resolved medication discrepancies by reconciliation; and
- assisted patients and caregivers in identifying/obtaining measurable goals to maximize and maintain patient health.

A “transition coach” provides education, medication review, medication containers, weight scales, a graduated cylinder, a health diary, and materials on diet and heart disease. Patients are followed at specific intervals of one, three, and six months after initial home evaluation.

### Partners

Community Health Foundation; County Office of the Aging—Assuring Your Wishes program; County Health Department; Visiting Nurse Association

### Outcomes

Fifty percent decrease in the average length of stay for CHF admissions demonstrating decreased acuity.

- Notable improvement in patient and caregiver understanding of the disease process and improved ability to articulate symptoms to physician and staff.
- Fifty three percent reduction in the number of cases resulting in financial loss and a 60% decrease in the average loss for these cases.
- Total revenue per patient as a percent of cost has increased by six percent (6%).

### Contact

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# Journey to the 21st Century

## UPSTATE UNIVERSITY HOSPITAL

### Year the Initiative Started

2003

### Program Description and Goals

Journey to the 21st Century is a compilation of initiatives focused on changing the culture and environment of Upstate University Hospital, using the tenets and basic principles of patient- and family-centered care for strategic planning, operations, and decision making. The impetus was the construction of a six-story patient care tower, crowned by a new children's hospital within a hospital. The tower includes 209 private beds with a full bath and sleeping area for families. The 209 beds are broken down by 71 pediatric beds and 138 adult beds. The facility includes state-of-the-art technology with a focus on improving patient and employee safety and satisfaction.

### Partners

Employees, patients, and families; Ronald McDonald House Charities of Central New York; Institute of Family Centered Care; school districts and local public libraries; Family Advisory Council; corporate partners and businesses, including Bristol Myers Squibb and Panera Bread

### Outcomes

- Patient satisfaction scores improved according to Press Ganey and Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) surveys; of the 14 measures, 13 showed an upward trend.
- The initiative met all environmental standards.
- Policies were changed to reflect a more open, yet safe environment for patients, families, and visitors.

### Contact

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