HEALTHCARE ASSOCIATION OF NEW YORK STATE

CONNECTING WITH COMMUNITIES

COMMUNITY HEALTH INITIATIVES ACROSS NEW YORK STATE

2012 EDITION

HANYS Healthcare Association of New York State

15 Years of Community Health Improvement

This year marks the fifteenth year of the Healthcare Association of New York State's (HANYS) Community Health Improvement Award (CHIA). It began in 1997 as a way to honor hospitals and continuing care providers for improving the health of their communities. Each year, the bar for recognition has been raised as hospitals and continuing care providers continue to significantly improve their prevention, education, wellness, and health awareness programs.

Over the past 15 years, HANYS has seen tremendous growth in the number of hospitals and health systems that collaborate with local organizations to enhance the health of their communities. In developing these community health initiatives, New York's hospitals and health systems are taking a leadership role in chronic care disease prevention and educating communities about improving health.

In addition, over the past 15 years, we have seen improvement in the level of collaboration between hospitals and local health departments in conducting community needs assessments, which are used to develop health care priorities for communities. With the right tools and resources, these partnerships will grow.

2012 Award Winners

The winner of the 2012 Community Health Improvement Award is **Sound Shore Medical Center** for its *Outpatient Pediatric Immunization Center*.

Honorable Mentions are presented to **Rochester General Hospital** for its *Refugee Healthcare Program* and to **Lutheran Medical Center** for *Project SAFE*.

ABOUT HANYS' COMMUNITY HEALTH IMPROVEMENT AWARD

HANYS created the Community Health Improvement Award in 1997 to recognize outstanding initiatives aimed at improving the health and well-being of communities. The award is presented to member facilities and programs that target specific community health programs, demonstrate leadership, collaborate among diverse groups, and most importantly, achieve quantifiable results.

Please join HANYS in celebrating the 15 years it has committed to developing and growing its community health agenda and the successes of its members in building and sustaining healthy communities.

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

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2012 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

HONORABLE MENTIONS

NOMINATIONS PROFILES

Outpatient Pediatric Immunization Program

SOUND SHORE MEDICAL CENTER

Year Initiative Started 2005

Contact **Trish Feathers, Director of Media Relations**
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PROGRAM DESCRIPTION AND GOALS

Sound Shore Medical Center created the Pediatric Outpatient Immunization Program to help achieve 90% or greater vaccination coverage among its patients who are two years old and younger. This program ensures vaccination services are readily available, barriers are identified and minimized, vaccination status is reviewed at every office visit, and caregivers are educated about the risks/benefits of vaccination in culturally-appropriate and easy-to-understand language.

Bilingual pediatricians, nurse practitioners, and registered nurses ensure scheduled vaccinations are given on a timely basis, follow-up appointments are scheduled before patients leave the clinic, and reminders are provided if appointments are missed. In addition, a social worker is available for any identified psycho-social needs.

This program is part of Sound Shore Medical Center's long-standing commitment to childhood immunization and the state's Vaccine for Children Program.

PARTNERS

- Area school nurses
- Child Care Council of Westchester–United Way
- Westchester Jewish Community Services
- Lower Hudson Valley Perinatal Network
- Department of Health (Healthy Mom/Healthy Baby Program)
- Sound Shore Medical Center
  - Administration/Board of Governors
  - Obstetrics Clinic

OUTCOMES

- From 2008 to 2009, the program increased vaccinations by 35%. In 2010, the improvement was 50% over 2008. In addition, these numbers produced a 25% increase in clinic visits and the inherent ability to be proactive in other areas of patient's health care administration.
- Between 2008 and 2010, immunizations more than doubled, increasing from 9,982 to 20,116.
- The Outpatient Pediatric Immunization Program was awarded a Certificate of Excellence for achieving the Healthy People 2010 immunization goals for two-year-old children—***two years ahead of the national target***.
- Post-Healthy People 2010, the program has a 94% success rate for children 12 months of age completing the series of vaccinations recommendation by the Advisory Committee on Immunization Practices.

Project SAFE

LUTHERAN MEDICAL CENTER/LUTHERAN FAMILY HEALTH CENTERS

Year Initiative Started 2008

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PROGRAM DESCRIPTION AND GOALS

Project SAFE (Speak out on AIDS Facts and Education) is a teen leadership and peer education program that trains youth ages 13 to 19 to educate their peers about human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) prevention. Project SAFE focuses on youth development and has provided 350 youths with intensive training, group support, and opportunities to become leaders in their communities.

Training sessions consist of interactive activities that explore issues such as adolescent development and sexuality; HIV transmission, prevention, and treatment; group facilitation; and healthy decision-making skills. Annually, peer educators provide life-saving information to 2,500 of their peers through community outreach, dance and theatre performances, new media technology, and educational workshops, ensuring that youth in their communities have the skills, information, and resources they need to make healthy decisions.

PARTNERS

- Good Shepherd Services
- Red Hook Community Justice Center
- Center for Family Life
- Ali Forney Center
- Cornell University's HIV/AIDS Education Project
- Caribbean Women's Health Center
- Young Women of Color HIV/AIDS Coalition
- Community Healthcare Network's Teen Patient Assistance Program
- HEAT (Health and Education Alternatives for Teens) Clinic

OUTCOMES

In the 2010-2011 school year:

- As a result of attending the workshop or community event, 92% of participants reported an increased knowledge of HIV and pregnancy prevention.
- Eighty-two percent of those attending community events reported that they would be more likely to go for HIV and/or sexually-transmitted disease (STD) testing as a result of the workshop or event.
- At the community events, 225 youth were tested for HIV and 628 were given HIV counseling.
- Results from the Web-based survey that all peer educators completed at baseline and after six months of training indicate that peer educators were now more likely to have been tested for STDs (39% versus 75%).

Refugee Health Care Program

ROCHESTER GENERAL HOSPITAL

Year Initiative Started 2009

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PROGRAM DESCRIPTION AND GOALS

Rochester resettles 16% of refugees entering New York State (approximately 800 per year). Most of these refugees are resettled from Bhutan, Burma, Iraq, and sub-Saharan countries. While they come from different parts of the world, these refugees share some common characteristics: inadequate past medical care, exposure to diseases that have gone untreated, experiences that often include torture and terrorism, and poverty. Adequate health care is essential, yet difficult to provide in a cost-effective manner.

Rochester General Hospital created a Refugee Healthcare Program with the goal of assisting the community by entering newly-arrived refugees into primary care practices. The program coordinates care, addresses complex language needs, acts as a liaison with outside agencies, and has increased capacity and the cultural competency of medical providers in the region.

PARTNERS

- Catholic Family Center
- Monroe County Department of Public Health
- Rochester City School District

OUTCOMES

- In last three years, 2,439 refugees were seen by primary care practices.
- Ninety-six percent of all newly-arrived refugees in Monroe County were established with primary care practices; 97% of those are established within 30 days of arrival.
- The average wait time to enter a primary care practice is 11 days.

Mobile Dental Clinic

ADIRONDACK MEDICAL CENTER

Year Initiative Started 2009

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PROGRAM DESCRIPTION AND GOALS

In 2009, Adirondack Medical Center began operating a Mobile Dental Clinic that now serves six rural towns in upstate New York. Two of the towns are located in a county that has no dentists. All of the counties that Adirondack Medical Center serves are Dental Health Professional Shortage Areas. The goals of the project are to:

- provide additional dental services, particularly for the Medicaid population;
- bring dental services closer to home for patients; and
- educate people about the importance of oral health.

PARTNERS

- Regional BlueCross BlueShield
- Adirondack Medical Center Foundation
- Five local school districts, six town government officials, and a local foundation
- New York State Department of Health

OUTCOMES

- Adirondack Medical Center has provided dental services, caring for 1,700 patients in about 4,000 visits in 2008, and caring for 2,800 patients in about 6,000 visits in 2010 and 2011, respectively.
- Mobile Dental Clinic visits: 193 in 2009, 450 in 2010, and 508 in 2011.
- The percentage of Medicaid, Medicaid managed care, and self-pay patients increased by 55% in 2008. In 2010, the percentage increased by 69% at the fixed dental clinic and 74% at the mobile dental clinic.
- The number of patients served from remote ZIP Codes increased.

Healthy Life

ALBANY MEDICAL CENTER

Year Initiative Started 2009

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PROGRAM DESCRIPTION AND GOALS

"Healthy Life" links Albany Medical Center and the *Times Union*, the region's largest daily newspaper, to reach thousands of health care consumers by working collaboratively to encourage women especially to live well and maximize their options for the healthiest life possible. It involves popular free seminars developed by Albany Medical Center that attract scores of women; promotion of these seminars in the *Times Union* and online; and a specially created magazine, *Healthy Life*, to enhance understanding of women's health issues, published by the *Times Union*.

The goals of "Healthy Life" are to help educate the community about healthy lifestyles and about prevention of chronic disease, with an emphasis on diabetes and heart failure. The initiative also showcases Albany Medical Center's physicians and health care experts.

PARTNERS

- *Times Union* newspaper
- Health-related organizations, including American Heart Association, American Cancer Society, and the Susan B. Komen Foundation

OUTCOMES

- Increased numbers of people are attending the "Healthy Life" seminars—from about 75 at the first seminar to nearly 250 at the most recent one.
- As part of Albany Medical Center's broader program to address incidence of diabetes, length of stay for diabetes has declined.
- As part of Albany Medical Center's broader program on heart disease, congestive heart failure admissions have declined steadily each year.
- Increased advertising and magazine size indicate growing interest in *Healthy Life* magazine.

Creating Healthy Places to Live, Work, and Play

ARNOT HEALTH

Year Initiative Started 2010

Contact **Rosemary L. Anthony, B.S.N., M.S.E., R.N., Community Health Program Coordinator**
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PROGRAM DESCRIPTION AND GOALS

"Creating Healthy Places to Live, Work, and Play" focuses on preventing obesity and diabetes by implementing evidence-based environmental, policy, and systems changes that increase physical activity and access to fresh fruits and vegetables in under-served areas of Elmira. The goals of the initiative are to:

- build diverse collaborative partnerships,
- plan sustainable evidence-based strategies to increase physical activity and access to fresh fruits and vegetables, and
- seek funding to promote healthier lifestyles.

PARTNERS

- Chemung County Health Department
- Chemung Valley Rural Health Network
- Local hospitals and health care agencies
- Cornell Cooperative Extension
- The City of Elmira, Departments of Community Development and Public Works

OUTCOMES

This initiative built a collaborative network of more than 30 community partners from public, private, and non-profit sectors and was awarded grant funds from the New York State Department of Health.

- It increased access to and safety of parks and playgrounds by replacing playground equipment in two parks in the city of Elmira, painting textured crosswalks, installing bike racks on buses, and adding reduced speed signage near parks and playgrounds.
- It increased access to fresh fruits and vegetables by building two community gardens and providing a mobile, "edible wall garden" and a supporting curriculum for an elementary school in an under-served area of the city.
- Local restaurants changed their menus and policies, adding healthier food options on menus, a coupon incentive campaign, and offering all dressings on the side, salt substitutes, and to-go options.

Reducing Death and Injury on New York State Farms Through the Social Marketing of Tractor Rollover Protective Systems (ROPS)

BASSETT HEALTHCARE NETWORK—NEW YORK CENTER FOR AGRICULTURAL MEDICINE AND HEALTH

Year Initiative Started 2006

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PROGRAM DESCRIPTION AND GOALS

This program seeks to prevent farm fatalities and injuries from tractor overturns, the leading cause of death in New York's largest and most dangerous industry. Before this program began, half of New York tractors lacked highly effective roll bar systems and few farmers intended to invest in ROPS. After extensive interviews identifying barriers and motivators, Bassett Healthcare Network's New York Center for Agricultural Medicine and Health began a social marketing initiative featuring hotline services and financial rebates. Extensive evaluation demonstrated a clear impact, including a ten-fold increase in roll bar sales.

Over the ensuing five years, 982 roll bars have been placed, and participating farmers report more than 80 serious events in which the roll bar likely prevented significant injury. Similar programs have been started in Vermont, New Hampshire, and Pennsylvania, with interest in several other states and Canada.

PARTNERS

- New York Farm Bureau
- Northeast Equipment Dealers Association
- New York State Senate and Assembly Agriculture Committees
- Farm Family Insurance
- County Farm Bureaus
- Three farmer advisory groups, and numerous individual farm advisors
- Academy for Educational Development (now called FHI 360)
- Agricultural Statistical Service

OUTCOMES

- Nearly 1,000 tractors have been outfitted with ROPS.
- Survey data documented more than 80 serious events with no serious injury, due to the installation of ROPS.
- Prevention of injury and death on New York farms saves millions of dollars and keeps farms intact.

Hospital at Home

BETH ISRAEL MEDICAL CENTER

Year Initiative Started 2010

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PROGRAM DESCRIPTION AND GOALS

The Hospital at Home program addresses the needs of older adults with chronic illness and psycho-social needs, offering multidisciplinary care in their homes. Directed by a social worker, an initial assessment is completed and, in partnership with the patient, individual care plans developed. Selected team members visit the patient providing services, including medication reconciliation, monitoring vitals, health/disease education, psychiatric evaluations, counseling, fall prevention, spiritual support, case management, and escort.

The goals are two-fold:

- ensuring the older adult remains safely in the community by addressing his or her unique problems when transitioning from hospital to home, reducing the risk for re-hospitalization; and
- workforce development through training and educating the next generation of clinicians in the care and treatment of the growing older adult population.

PARTNERS

- Dorot, Inc.
- Educational Alliance
- Hudson Guild
- Jewish Board of Family and Children's Services
- New York Legal Assistance Group
- Beth Israel Senior House Calls
- Certified Home Care Agencies

OUTCOMES

This program:

- decreased the 30-day re-admission rate to 12%;
- significantly reduced emergency room visits;
- provided 449 home visits with coordinated multidisciplinary services; and
- increased the number of trained geriatric care practitioners to 35.

Eat Well, Be Well

BLYTHEDALE CHILDREN'S HOSPITAL

Year Initiative Started 2006

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PROGRAM DESCRIPTION AND GOALS

Initiated in 2006 to help combat rising obesity rates, "Eat Well, Be Well" is a nutrition outreach program that services schools, Kindergarten through eighth-grade students, and parents throughout Westchester and lower Putnam counties. Staffed by dietitians, the program provides nutrition lessons in the classroom; helping schools meet the nutrition components of the state-mandated health curriculum.

Lessons provide repetitive messages about healthy lifestyle habits and knowledge needed to shift behaviors toward those that promote well-being and stave off obesity in the pediatric population. The program also offers staff and parent workshops, participates in school and community events, and uses various media outlets to dispense valuable information to school districts. Grant funding allows "Eat Well, Be Well" to offer all services and materials free of charge.

PARTNERS

- Kohl's Department Stores
- Westchester Government/County Health Department
- Westchester and lower Putnam County school districts and parent-teacher associations

OUTCOMES

- "Eat Well, Be Well" meets 18.5 out of 24 New York State Health Curriculum Standards for Functional Knowledge in the area of physical activity and nutrition.
- Since its 2006 inception, the program has delivered healthy lifestyle messages to approximately 67,000 children.
- To date, "Eat Well, Be Well" has been implemented in 45 schools in 38 districts.
- Student knowledge increased from an average pretest score of 41% to an average post-test score of 72%.

Heart Failure Medication Management Clinic

BROOKDALE UNIVERSITY HOSPITAL AND MEDICAL CENTER

Year Initiative Started 2010

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PROGRAM DESCRIPTION AND GOALS

The Heart Failure Medication Management Clinic focuses on improving the transition from inpatient to outpatient care. The Heart Failure Clinic includes a multidisciplinary team consisting of a physician, pharmacists, nurse, and nutritionist who follow patients after discharge for comprehensive medication and nutrition management. Clinic services include monitoring of weight and vital signs, thorough medication review, reconciliation and assessment of adherence, optimization of heart failure medications, physical examination, and individualized medication and nutrition education.

The goals of the clinic include decreasing the 30-day readmission rate for heart failure patients, optimizing medication management, improving patient compliance with medication therapy, and lifestyle modifications.

Clinic-based care has led to a decrease in hospitalizations and emergency room use as well as improvement in patient quality of life.

PARTNERS

- Department of Ambulatory Care Services
- Department of Pharmacy

OUTCOMES

- The 30-day hospital readmission rate due to heart failure exacerbation among patients followed in the clinic was only 3%.
- Sixty-six patients seen in the clinic surpassed the 30-day mark without being readmitted.
- The most common types of pharmacist interventions included initiation of therapy (43%) of ACE inhibitors/ARBs (23%) and beta-blockers (24%) and dosage titration (47%).
- All of the patients seen in the clinic have been matched with a primary care provider.

Amputee Rehabilitation Pathway

CATHOLIC HEALTH SYSTEM

Year Initiative Started 2009

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PROGRAM DESCRIPTION AND GOALS

This program is designed to assist individuals (and their families) before, during, and after an amputation to help them recover and regain their functional independence as they re-integrate into the community (school, work, etc.). A key component of the program is education on what to expect throughout the amputation process including each level of rehabilitation and acquiring a prosthetic limb.

Participants first meet with a patient educator who outlines their road to recovery and answers any questions they may have about issues such as insurance coverage, recovery time, and receiving a prosthetic limb. They are then guided through each level of rehabilitation (acute, post-acute, home care, and outpatient), and an individual plan is developed to assist patients in achieving their rehabilitation goals and maximizing their recovery.

PARTNERS

- Nelson Prosthetics and Orthotics
- Tonawanda Limb and Brace
- Moving Forward Amputee Support Group
- Little Pebble Foundation (a not-for-profit organization to support children with amputations)

OUTCOMES

The Catholic Health Amputee Rehabilitation Pathway:

- formed Moving Forward, the only amputee support group in Western New York; and
- established a multidisciplinary clinical pathway that leads patients undergoing an amputation through the continuum of care.

EXPLORE

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER

Year Initiative Started 2000

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PROGRAM DESCRIPTION AND GOALS

EXPLORE (Experience and Professional Opportunities Result in Excellence) is a creative continuing education consortium formed by nine local organizations to provide top quality continuing education for health care professionals locally, often by national experts, since travel to national conferences is difficult and costly. In addition, EXPLORE offers educational sessions for members of the community, attached to a full-day conference, when appropriate.

EXPLORE is a collaborative program that capitalizes on talents and resources of member organizations. The consortium strives to avoid duplication of effort and remain financially self-sufficient. Program topics are based on a needs assessment of health care professionals. Program evaluations have been extremely positive. All programs provide contact hours for nurses and most programs provide continuing medical education credits.

PARTNERS

- Adirondack Chapter of Nurse Practitioner Association of New York State
- Adirondack Health

- Alice Hyde Medical Center
- Clinton County Community College
- Clinton County Health Department
- New York State Nurses Association (District 8)
- Sigma Theta Tau International—Gamma Delta Chapter
- The State University of New York (SUNY) College at Plattsburgh

OUTCOMES

- EXPLORE held 45 conferences between 2000 and 2011 attended by 5,601 professionals, and held 14 community programs attended by 1,635 community members.
- Health professionals' knowledge and competence has increased.
- Community members' knowledge has increased.
- There is the potential to improve patient outcomes through improved care.

The Stephen and Suzanne Menkes Child Advocacy Center

COLUMBIA MEMORIAL HOSPITAL

Year Initiative Started 2006

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PROGRAM DESCRIPTION AND GOALS

The Stephen and Suzanne Menkes Child Advocacy Center, developed in partnership with multiple community agencies, has worked since 1999 to address the needs of victims of abuse. Accomplishments include the coordination and development of a 38-member multidisciplinary team of professionals that operates with 21 agencies that share a mission to reduce trauma, provide expert medical care, and enhance collaboration in the investigation, prosecution, and treatment of child abuse. The services provided include the provision of medical care, enhanced collaboration, trauma reduction, victim services, and improved prosecution and treatment of child abuse.

PARTNERS

- New York State Police (Livingston and Catskill)
- Columbia County Department of Social Services
- Columbia County Sheriff's Department
- Greene County Sheriff's Department
- Greene County Department of Social Services
- Greene County Mental Health
- Columbia County Mental Health Services

- Columbia County Probation
- Greene County Probation
- Columbia County District Attorney's Office
- District Attorney Greene County
- Hudson Police Department
- Catskill Police Department
- Support agencies

OUTCOMES

Since the start of the program, more than 1,200 children have been served. As a result of the coordinated approach to addressing child abuse, the following outcomes have been realized:

- improved response to the investigation of child abuse allegations;
- improved communication among responders;
- improved education of team members; and
- reduction in the number of interviews and improved chances of effective prosecution.

Senior Options and Solutions

EASTERN LONG ISLAND HOSPITAL

Year Initiative Started 2008

Contact **Juliet Frodella, C.R.C., L.M.H.C., C.C.M., Project Director**
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PROGRAM DESCRIPTION AND GOALS

The development of a Geriatric Center of Excellence has long been a priority of the Eastern Long Island Hospital Board of Trustees. The goals of the Senior Options and Solutions program include:

- Develop a system that identifies seniors at risk and provides them with an in-home assessment and access 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.
- Decrease hospitalization and deterioration of physical health through early intervention.

PARTNERS

- Town of Southold
- The Mental Health Association in Suffolk
- The Long Island Home (South Oaks Hospital)

OUTCOMES

- Mental health integration and depression screening of patients at the East End Geriatric and Adult Medicine practice began in March 2008. Additional practices were added, resulting in 2,707 screenings, 301 assessments, and 656 follow-up visits by the end of 2011.
- Data analysis can help reduce depressive symptoms of individuals identified during assessment as needing treatment and follow-up visits.
- Community education and prevention screening events expanded to cover three local townships via senior wellness series/support groups: 25 topics and more than 700 attendees.
- This initiative included extensive outreach and education to community organizations, families/caregivers via mailings, participation in community events, and meetings with community agencies, organizations, service providers, and practitioners.

Pulmonary Disease Management Program

F.F. THOMPSON HOSPITAL

Year Initiative Started 2010

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PROGRAM DESCRIPTION AND GOALS

The goal of the Pulmonary Disease Management Program (PDMP) is to improve quality of life for those with asthma, chronic obstructive pulmonary disease (COPD), recurrent respiratory infections, lung cancer, and other breathing problems. F.F. Thompson Hospital's Respiratory Therapy Department provides education on proper health maintenance and respiratory techniques for management of chronic lung disease, exercise training, and psycho-social intervention. Participants establish their goals, which the hospital helps them achieve through multiple interventions.

The program meets two days each week in a new outpatient fitness center, which provides ample space for participants, state-of-the-art exercise equipment, a modern aesthetic, and easy accessibility.

PARTNERS

- Better Breathers Club
- Referring primary care physicians and pulmonologists
- Cardiac rehabilitation services, nutrition therapy, and the Sleep Disorders Center at F.F. Thompson Hospital

OUTCOMES

- On average, F.F. Thompson Hospital patients improved their lung function capacity by nearly 12% in the first three to 19 months in the program.
- Two participants qualified for and received lung transplants after participating in the program.
- In survey results, participants report a quantifiable improvement in overall quality of life and increased ability to ambulate.
- The number of hospital admissions has decreased—only one of the active participants was readmitted in the past two years.

Patient-Centered Medical Home, Diabetes Awareness Day Program

FAXTON-ST. LUKE'S HEALTHCARE

Year Initiative Started 2011

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PROGRAM DESCRIPTION AND GOALS

The Diabetes Awareness Day program at Faxton-St Luke's Healthcare is an outpatient primary care initiative designed to assist diabetic patients who are at risk for complications in determining their needs and maintaining control of their diabetes.

Patient self-care is an important part of the Patient Centered Medical Home (PCMH) model, which works to build a proactive relationship between patients and their doctors to prevent illness. The 2011 National Committee for Quality Assurance (NCQA) PCMH standards require that practices conduct activities to support patient self-management. The Diabetes Awareness Day program brings various community resources directly and conveniently to patients, as part of their regular visit to their primary care provider. Education is the cornerstone of successful diabetes management, and this program strives to provide patients the education and awareness they need to lead a healthier lifestyle.

PARTNERS

- Central New York Diabetic Education Program
- Faxton-St Luke's Healthcare Pharmacy Department
- The Wellness Center at Faxton-St. Luke's Healthcare
- Foot care specialist
- Faxton-St. Luke's Healthcare Infection Prevention Department

OUTCOMES

- Through this program, Faxton-St. Luke's Healthcare is better able to identify and manage high-risk diabetic patients.
- Patient confidence increased in self-management of diabetes; the average self-efficacy score increased from 6.7 pre-Awareness Day to 8.4 post-Awareness Day.
- Patients expressed high satisfaction with the program: average score of 8.3 out of 10.
- Glycated hemoglobin (A1C) levels improved for 27.3% of participants.

The Integration Project

FLUSHING HOSPITAL MEDICAL CENTER

Year Initiative Started 2007

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PROGRAM DESCRIPTION AND GOALS

The goals of The Integration Project are to de-stigmatize mental illness for people of all cultures; increase access to mental health care; integrate evidence-based screening, assessment, and treatment for mental disorders into primary care; improve physical health; and increase interdisciplinary collaboration to prevent and manage chronic, multiple medical conditions by using a lifestyle modification approach.

PARTNERS

- Flushing Hospital Medical Center's Community Advisory Board
- The Flushing Central Lions Club
- The Chinese American Independent Practitioners' Association
- The Tzu Chi Foundation
- The Chinese Planning Council Nan Shan Center

OUTCOMES

- Since November 2007, more than 1,500 patients over age 18 have been screened, assessed, and offered Life Style Modification and psychiatric interventions (psycho-social, self-management for maladaptive health behaviors affecting medical condition, and psycho-pharmacological) in more than 10,000 visits.
- Personal Health Questionnaire (PHQ-9) scores have decreased.
- Generalized Anxiety Disorder (GAD-7) assessment scores have decreased.
- Cognitively-impaired individuals have been recognized.
- Mental illness has been de-stigmatized.

Project Promise

GENEVA GENERAL HOSPITAL

Year Initiative Started 2010

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PROGRAM DESCRIPTION AND GOALS

Project Promise is a community initiative designed to provide prenatal and life skills education to pregnant teens in the Geneva area, including:

- Prenatal Education: covering pregnancy, labor and delivery, postpartum care, and infant care.
- Child Care Center Internship: "shadow" experiences with an infant care teacher at pre-delivery and post-delivery (with newborn) intervals.
- Cooking Classes: focused on safe food handling and nutrition.
- "Teen Moms" Meetings: with emphasis on parenting activities and group discussion. Child Care is provided during attendance at club meetings.
- Early Childhood Literacy Classes: planned addition in 2012.

PARTNERS

- Child and Family Resources
- Geneva Schools Head Start Program
- Finger Lakes Health Child Care Center
- Family Birth Center, Geneva General
- Medical Associates of the Finger Lakes
- Geneva Community Center/Presbyterian Church of Geneva

OUTCOMES

2011 results included:

- Teen Mom Support Network: six Teen Club Meetings and Cooking/Nutrition Classes with 25 teen moms and two teen dads participating.
- Child Care Center Internship: four teen moms took advantage of the program.
- Specialized Education Programs: five teen moms and one teen dad attended prenatal classes.

Warren and Washington County Complete Streets Program

GLENS FALLS HOSPITAL

Year Initiative Started 2010

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PROGRAM DESCRIPTION AND GOALS

The Complete Streets Program encourages communities to develop transportation policies and make environmental changes that promote physical activity, particularly walking and cycling.

The goals are:

- Municipalities will adopt policies that require planners to accommodate pedestrians, bicyclists, and public transit users in every road project.
- Bicycle parking and pedestrian resting areas will be installed to help foster a culture of walking and bicycling.
- A county-wide bicycle plan will be updated to provide a framework for future improvements that will result in a more comprehensive network of bicycle facilities.
- Community members will take "Share the Road" pledges in a campaign to raise awareness about the need for pedestrians, cyclists, public transit users, and motorists to safely travel throughout the community.

PARTNERS

- Warren County Safe & Quality Bicycling Organization
- Adirondack/Glens Falls Transportation Council
- Washington County Healthy Communities Coalition
- Greater Glens Falls Transit

OUTCOMES

- Three villages/towns passed "Complete Streets" resolutions.
- The Warren County Master Bicycle Plan was updated to identify new potential, interconnected bicycle routes in 11 towns and one city.
- Nine new bicycle routes were identified and marked with appropriate signage.
- Eleven benches and seven bicycle racks were installed to encourage pedestrian and bicycle activity.

Medically Complex Children's Program

GOOD SAMARITAN HOSPITAL MEDICAL CENTER

Year Initiative Started 2010

Contact **Catherine Caronia, M.D., Director of Pediatric Intensive Care Unit and Medical Education**
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PROGRAM DESCRIPTION AND GOALS

The goal of the Medically Complex Children's Program is to help children reach their full potential and minimize the need for hospital admissions and emergency department visits. The program's philosophy is to promote the physical and psycho-social well-being of medically complex children in a manner that is comprehensive, integrative, and respectful of their dignity.

The program consists of a team working together to provide individual care to each patient and includes the coordination of physicians delivering specialty care; a licensed clinical social worker and other specialists, as needed; as well as child life experts, nutritionists, and physical therapists. Working with each patient's primary care physician, a care management plan is formulated, addressing any additional needs a child may have.

PARTNERS

- Good Samaritan Hospital
- Good Samaritan Center for Pediatric Specialty Care
- Affiliated and nonaffiliated pediatricians
- Parents/guardians
- Home health care
- Friends of Karen

- Contractors for Kids
- Ariane Thomas-Lutchmedial Traumatic Brain Injury Foundation
- Saints Cyril and Methodius Church

OUTCOMES

The following are examples of patients who have benefitted from this program (their names have been removed):

- Patient DJV, after a history of multiple hospitalizations, was stabilized after tracheostomy placement with ventilatory support at night. Through close follow-up, he has been managed as an outpatient and the frequency of his hospital admissions decreased dramatically.
- Patient CO was assisted with obtaining registered nursing level care for 20 hours per day, seven days per week through strong advocacy and letter writing. In this way, she can continue to receive all the necessary therapies within the context of a loving home.
- Patient JV has a catastrophic disease that will limit his lifespan. Within the context of the program, he and his family are receiving assistance with end-of-life care, management, decisions, and planning.
- Patient JM is a globally developmentally delayed patient who had severe obstructive sleep apnea, which required surgery. Due to his frequent and recurrent respiratory infections, his surgery kept getting postponed and cancelled. Through the efforts of this program, his care was coordinated with a pulmonologist and infectious disease specialist to achieve medical stability. After one year of rescheduled surgeries, he was finally able to undergo surgery and has clinically improved dramatically.

SNEAKER© (Super Nutrition Education for All Kids to Eat Right)

HOSPITAL FOR SPECIAL SURGERY

Year Initiative Started 2003

Contact **Laura Robbins, D.S.W., Senior Vice President, Education and Academic Affairs**
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PROGRAM DESCRIPTION AND GOALS

The Hospital for Special Surgery is recognized as a world leader in the fields of orthopedics and rheumatology, improving and restoring the mobility of individuals with musculoskeletal injuries and disorders. Caring for disadvantaged children has been a critical part of The Hospital for Special Surgery's mission since its founding in 1863. In response to the childhood obesity epidemic and in an effort to educate children about the link between healthy eating and physical activity and achieving/maintaining optimal mobility throughout their lives, the hospital developed and launched SNEAKER© (Super Nutrition Education for All Kids to Eat Right) in 2003.

SNEAKER is a nutrition and physical activity education program that targets under-served communities and is designed to accommodate different educational formats ranging from small group sessions to large groups attending health fairs.

PARTNERS

- Clinical/Academic Partners: Weill Cornell Medical College–Department of Pediatrics; NewYork-Presbyterian Hospital–Weill Cornell Medical College of Cornell University; Charles B. Wang Community
- Government/Public Partners: New York State Osteoporosis Prevention and Education Program; PS 140 (Bronx); PS 140 (Manhattan); PS 16; St. Aloysius; Gan Chamesh Early Childhood Center; Yeshiva Darchei Torah School
- Community-Based Organizations: International Center for Disabilities; Girl Scout Council of Greater New York; Safe Kids International; Lenox Hill Neighborhood House

OUTCOMES

- SNEAKER has reached 11,000 children and adults with community-based programming. There have been 13,487 views of the SNEAKER Web page.
- Results indicate that children showed positive behavior change in the areas of fiber, fruit, vegetable, and calcium intake as well as making healthier snack choices.
- Ninety-three percent of children reported drinking calcium-fortified orange juice at the end of the program and 100% at the three-month follow-up, compared with 82% at the beginning of the program.
- All of the children reported eating fruit at the end of the program, compared with 85% at the beginning.
- Significantly more children reported consuming whole wheat bread at program end and three months thereafter (98% increase at program end and 109% at three-month follow-up).
- There was a 67% increase in the number of participants who ate brown rice at the end of the program.

IMPACT—Intensive Multidisciplinary Primary Action Care Team

JAMAICA HOSPITAL MEDICAL CENTER

Year Initiative Started 2011

Contact **Angelo R. Canedo, Ph.D., Vice President**
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PROGRAM DESCRIPTION AND GOALS

IMPACT helps medically complex patients with medically under-managed conditions, who receive significant amounts of health care, lack a usual source of care, have poor adherence and complicating psycho-social problems, and who are enrollees in a local Medicaid managed care organization (MCO). IMPACT provides comprehensive medical care management to these significant users of health care ($50,000 to $300,000 per person per year).

A key to the care management of these patients is the dedicated IMPACT team, which is comprised of a lead physician, social worker, and community health worker. IMPACT's goal is to proactively manage every aspect of each individual patient's complex medical, behavioral, and social needs to improve health and quality of life and to reduce preventable utilization of services.

PARTNERS

- New York City Human Resources Administration Advisory Council of Community Boards 12 and 13
- Catholic Charities of Brooklyn and Queens

- Episcopal Health Services
- Bayside Senior Center
- Visiting Nurse Service Home Care
- MJHS Home Care
- Center for Nursing and Rehabilitation
- Margaret Tietz Day Services
- New York City Department for the Aging
- New York City Department of Health and Mental Hygiene

OUTCOMES

- Twelve of 16 cases served in the first year of the program had lower costs during the third and fourth quarters of 2011.
- Results for nine of the 12 could be directly attributed to the program interventions. On the remaining three cases, some correlations were noted between the interventions and the actual outcome, but some of the diminution in use could be due to an awareness of monitoring of utilization by program staff.
- An annualized savings of $454,446 was obtained for these 16 cases, or an average savings of about $28,000 per case.
- Patients who were successful in reducing costs also expressed satisfaction and gratitude for being placed in the program.

Safe Steps of Long Beach—A Fall Prevention Task Force

LONG BEACH MEDICAL CENTER

Year Initiative Started 2009

Contact **Sharon Player, Director, Public Affairs**
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splayer@lbmc.org

PROGRAM DESCRIPTION AND GOALS

Long Beach Medical Center's Fall Prevention Task Force meets four to six times per year to plan, implement, and evaluate fall prevention awareness programs for the community. Its goals include:

- increase overall community awareness, especially among seniors, regarding the importance of fall prevention and the factors (e.g., medication, vision, environment, balance/strength) that impact one's fall risk status;
- provide an evidence-based fall prevention program to seniors who want to reduce their fall risk; and
- target outreach to physicians, health professionals, and other senior-serving agencies regarding their role in preventing falls among seniors.

PARTNERS

- Jewish Association of Services for the Aged (JASA) of Long Beach
- Advisory Board for the Aging, City of Long Beach
- Long Beach Housing Authority
- Department of Physical Therapy, New York Institute of Technology

- Long Beach Public Library
- A community advocate and local dance/movement therapist

OUTCOMES

- The City of Long Beach installed non-slip treads and a second handrail on stairs at the Senior Center.
- JASA of Long Beach trained its home health workers in National Council on Aging's falls prevention awareness curriculum.
- Approximately 290 seniors participated in fall screening and education programs.
- Sixty-two participants completed an eight-week, evidence-based program, "Matter of Balance." Pre- and post-test results demonstrated a statistically significant difference of 1.93 seconds on the Timed Up and Go Test, which requires proficiency in sitting to standing from a chair.

STOP Sports Injuries Campaign

NATHAN LITTAUER HOSPITAL AND NURSING HOME

Year Initiative Started 2010

Contact **Cheryl McGrattan, Director of Marketing**
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PROGRAM DESCRIPTION AND GOALS

There is a growing epidemic of preventable youth sports injuries that can destroy athletic dreams at an early age. Nathan Littauer Hospital and Nursing Home created a STOP Sports Injuries Program aimed at educating athletes, parents, providers, school administrators, and coaches. The program involves education, mentoring, and "Concussion Facts" clip boards for coaches and specific sports information. Using television, radio appearances, and community events, hundreds of people have participated in STOP Sports Injuries sessions.

Nathan Littauer was the first hospital in New York to join the National STOP Sports Injuries Campaign, which addresses four youth sports issues: concussion, heat illness, overuse injuries, and proper training techniques. The program is led by a physical therapist who also wrote a three-hour coaches' curriculum, which was approved by the STOP Sports Injury Medical Committee and is used throughout the country.

PARTNERS

- STOP Sports Injuries (STOPsportsinjuries.org)
- Nathan Littauer Rehabilitation Department
- Broadalbin Youth Commission
- Johnstown, Broadalbin Perth, Amsterdam, Ft. Plain, Mayfield, Gloversville School Districts
- Mohawk Valley Orthopedics
- Continuing Medical Education through Ellis Medicine in Schenectady

OUTCOMES

- Nathan Littauer created a comprehensive community outreach program to reduce and prevent youth-sport injuries.
- The hospital published *Preventing Sports Injuries in Young People*, a multi-media three-hour training dedicated to keeping kids safe while participating in sports.
- Overall, Nathan Littauer has seen an increase in people seeking medical care for concussions in the emergency department. In 2001, the emergency department saw 39 concussions; in 2011, there were 146 concussion-related visits. These data suggest that more people understand the severity of concussions and are seeking medical care.
- Broadalbin Perth Central Schools now requires that every coach complete the coach training curriculum every two years.

Follow Up After Discharge Phone Call Program

NICHOLAS H. NOYES MEMORIAL HOSPITAL

Year Initiative Started 2011

Contact **Tamara West, R.N., M.S.N., M.H.A., Vice President, Patient Services**
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PROGRAM DESCRIPTION AND GOALS

This initiative established a process whereby patients are called two days after discharge by a registered nurse (RN) who uses a scripted list of questions to ask the patients, including information about follow-up appointment scheduling, questions about medications they were discharged with, prescriptions, and public health referral, if applicable. Patients are also asked if they have any additional questions about their stay, their discharge, discharge instructions, medications, or follow-up care. Statistics are reported regarding the number of interventions achieved based on additional public health referrals, additional discharge planning/case management referrals, additional nursing intervention or teaching, or referrals to their primary care physician.

PARTNERS

- Physicians
- Case managers
- Local pharmacies
- Public health organizations

OUTCOMES

There were 11 referrals to case management for various reasons including needs for durable medical equipment or home health care. There were 16 referrals to primary care physicians for follow-up care or prescription questions. There were 52 nursing interventions or referrals to public health for in-home care, follow-up care, or help with understanding discharge instructions. Though difficult to quantify, these facts show the potential for decreasing readmissions based on the interventions that were performed.

Care Transitions Coach Program

NORTHEAST HEALTH

Year Initiative Started 2009

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PROGRAM DESCRIPTION AND GOALS

The program's goals are to decrease readmissions to the hospital by empowering patients to become partners in their care. The program focuses on patients with high-risk diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and end-stage renal disease (ESRD). After a registered nurse coach explains the benefits of the voluntary program, patients are enrolled prior to discharge.

The coach will visit the patient at home within 24 to 48 hours of discharge, providing medication reconciliation, education, tools to manage the disease, follow-up telephone calls once a week for 30 days, and ensuring that a follow-up visit with the doctor is scheduled.

PARTNERS

- Eddy Visiting Nurse Association
- Albany Memorial Hospital
- Samaritan Hospital
- Seton Health
- Saratoga Hospital

OUTCOMES

- The combined readmission rates for CHF, COPD, diabetes, and ESRD decreased from 25% to 13.4% in two years.
- Enrollment increased by 29%; 509 patients enrolled in 2010, increasing to 655 patients in 2011.
- Northeast Health partnered with two insurance companies for reimbursement.
- More than 90% of the patients attended their first post-hospital physician visit.

Teddy Bear Hospital

NYACK HOSPITAL

Year Initiative Started 1997

Contact **Linda Suarez, M.S., R.N., C.D.E., Manager, Patient and Community Education Department**
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PROGRAM DESCRIPTION AND GOALS

The Teddy Bear Hospital initiative provides children ages two to ten years old with a teddy bear, and the child becomes the teddy bear's "parent." The children name their bears and decide on what illness or injury their bears have. When the child and the bear enter "the hospital," the bear is assessed, given a diagnosis, and treated. There are many "teaching moments," such as hand washing and bike safety. The goals are to reduce a child's anxiety level should they need to visit an emergency room and to educate children and their parents on a variety of health-related issues. This program is provided as part of Rockland County's Youth Bureau.

PARTNERS

- Rockland County Youth Bureau
- DHS Systems
- Safe Kids
- Nyack Hospital Auxiliary
- Nyack Hospital medical, nursing, and ancillary staff

OUTCOMES

- General health education (i.e., hand hygiene and respiratory hygiene) was provided to 500 children in 2011.
- Specific education depending on illness or injury (e.g., use of bike helmets and pedestrian safety) was provided to 500 children in 2011.
- Health education was provided to 275 parents and caregivers, such as “Let’s Move” and “Never Leave Your Child Alone in a Car” handouts.
- The emergency room experience was presented in a manner which is non-threatening, but as realistic as possible, to 775 individuals.

Vitality Initiative

PHELPS MEMORIAL HOSPITAL CENTER

Year Initiative Started 2011

Contact **Ellen Woods, Program Coordinator**
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PROGRAM DESCRIPTION AND GOALS

The Vitality Initiative meets the unique health care needs of the adult and senior populations. Vitality incorporates the needs of the aging population into all aspects of hospital services, promotes healthy living in the community, and helps seniors to "age in place" independently, safely, and responsibly.

At the core of the Vitality Initiative are three programs: the Breakfast Club, Mind Games, and Living Well Programs. The Breakfast Club provides members with a nutritious meal, education on a topic of interest, and light exercise. Mind Games helps stimulate cognitive functioning, and the Living Well Program provides those living with chronic illnesses techniques to better manage their lives.

PARTNERS

- Community Helping Hands (Ossining/Briarcliff Manor)
- The Center for Aging in Place
- The Westchester County Department of Senior Programs and Services

OUTCOMES

- Phelps Memorial Hospital Center collaborated with 18 hospital departments on programs for adults and seniors.
- More than 3,200 people participated in Vitality-sponsored community fitness activities; 300 received health education, and 250 people were provided health information.
- Sixty seniors were surveyed to identify 1) health topics of interest, 2) optimal ways to communicate information, and 3) food preferences for proper nutrition.
- The Breakfast Club serves 175 seniors from 22 towns.

Rensselaer Cares Prescription Assistance Program

SETON HEALTH, SAMARITAN HOSPITAL

Year Initiative Started 2006

Contact **Pamela Rehak, Vice President, Planning and Communications**
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PROGRAM DESCRIPTION AND GOALS

Seton Health, Northeast Health, Rensselaer County Medical Society, and Whitney M. Young, Jr. Health Center created a coalition to develop a prescription assistance program to help uninsured/underinsured low-income patients. The program employs a care coordinator who helps individuals obtain prescription drugs through access to free or low-cost programs currently available from pharmaceutical manufacturers. Prescribing physicians (and their office staff) from the coalition refer potentially eligible patients to the program.

Once the individual's prescription requirements are addressed, the coordinator also evaluates other health-related needs. Those who need a primary care physician are referred to one. Participants who 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
- Rensselaer County Department of Social Services (referral source)
- Physician offices (referral source)

OUTCOMES

From January 2007 through December 2011:

- 4,064 patients were assisted in obtaining 15,371 individual prescriptions, with a retail value of more than $7.3 million.
- The coalition was able to fulfill 98% of the prescription requests.
- The coalition referred 670 patients to an insurance coordinator to determine eligibility for public insurance programs.

Mothers' Circle of Hope Perinatal Mood Disorder Support Group

ST. CATHERINE OF SIENA MEDICAL CENTER

Year Initiative Started 2009

Contact **Jennifer LoGiudice, Assistant Vice President, External Affairs and Strategic Initiatives**
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PROGRAM DESCRIPTION AND GOALS

St. Catherine of Siena Medical Center offered the first hospital-based perinatal mood disorder support group program in Suffolk County. Mothers' Circle of Hope is a ten-session peer support group to help women cope with both pregnancy and perinatal mood disorders. St. Catherine of Siena Medical Center offers the support groups at no charge, which meet for an hour and a half weekly at the community center on campus—a comfortable, non-intimidating, and non-clinical environment. Topics covered include: perinatal mood disorder basics, steps to wellness, support systems, motherhood fantasy vs. reality, family support, and friendships. The goals of the program are to provide emotional support and a safe environment for women to ultimately reduce anxiety and symptoms common with obsessive compulsive disorder and depression.

PARTNERS

- The Postpartum Resource Center of New York
- Obstetrical Department of St. Catherine of Siena Medical Center

OUTCOMES

- The program reached 55 participants, with an 82% program completion rate.
- The Edinburgh Postnatal Depression Scale (EPDS) demonstrated a mean decrease of 8.5, which showed that participants experienced less symptoms suggestive of depression.
- The Mills Depression and Anxiety Checklist demonstrated a mean decrease of 26.9, indicating that participants experienced less depression and anxiety post-program.
- Assisted the Postpartum Resource Center of New York to provide training to other local hospitals regarding how to start a group.

Think Smart—Concussion Management Program

ST. CHARLES HOSPITAL

Year Initiative Started 2010

Contact **Marilyn Fabbricante, Director, Public and External Affairs**
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PROGRAM DESCRIPTION AND GOALS

The Think Smart program provides education and baseline testing for student athletes prior to the sports season, and a continuum of care from injury through recovery and safe return to sport. Community outreach includes pre-season, neuro-cognitive baseline assessments for athletes participating in contact sports. If a concussion is suspected during the sport season, the baseline assessment is helpful in establishing a treatment plan tailored to each child or adolescent.

Hospital-based services begin with the emergency department, where staff are trained to triage and care for concussions. Through the outpatient Concussion Management Clinic, athletes are seen by a team of more than 50 clinicians with training in managing concussions through the recovery process and back to the playing field.

PARTNERS

- Orthopedic Associates of Long Island
- Advanced Rehabilitation Medicine
- Twenty-nine school districts in Suffolk County
- Brain Injury Association of New York State

OUTCOMES

- Education has been provided to all key stakeholders. To date, 29 school districts have signed up to participate in Think Smart, with education provided to all coaches, trainers, and athletic directors.
- To date, more than 10,800 student athletes have had the ImPACT™ baseline neurocognitive test administered by the trained professionals at St. Charles Hospital.
- Training for all athletic directors, athletic trainers, coaches, and school nurses was provided at all school districts participating in the program.
- To date, a total of 831 student athletes have been evaluated and treated for concussion at the clinic.

Wellness and Chronic Care Program

ST. JOSEPH'S HOSPITAL HEALTH CENTER

Year Initiative Started 1989

Contact **Kelly Quinn, Director of Marketing and Public Relations**
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PROGRAM DESCRIPTION AND GOALS

St. Joseph's Hospital Health Center's Wellness and Chronic Care Programs include The Wellness Place and cardiac and pulmonary rehabilitation, tobacco cessation, and diabetes self-management programs. The major health issues affecting St. Joseph's community are cardiac disease, pulmonary disease, and diabetes.

While medical care often focuses on acute care or reaction to a decline in one's health, the more appropriate focus should be on assisting individuals to live with their health issues in a positive and collaborative manner to prevent precipitous declines. St. Joseph's has identified the commonalities that can lead to these diseases and encourages members of the community to be proactive and change behaviors to improve their lives. Modifying unhealthy behavior can save lives.

PARTNERS

- St. Joseph's Hospital Health Center
- New York State Tobacco Control Program

OUTCOMES

- Sixty-nine percent of Pulmonary Rehabilitation participants in 2011 reduced their severity of shortness of breath.
- Eighty-three percent of Pulmonary Rehabilitation participants increased their walking distance over the course of therapy.
- Since 2004, calls to the NYS Smokers' Quitline increased from 209 calls in a three-month period to 5,889 calls.
- The percentage of adults who currently smoke decreased from 21.6% in 2003 to 15.5% in 2010.

Comprehensive Cancer Screenings for Under-Served Populations

ST. MARY'S HEALTHCARE, AMSTERDAM

Year Initiative Started 2008

Contact **Julie Pierce, Director of Community Benefits and Outreach**
(518) 841-7448
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PROGRAM DESCRIPTION AND GOALS

The goal of the Comprehensive Cancer Screenings for Under-Served Populations Program is to provide free breast, cervical, and colorectal cancer screenings to eligible men and women. The initiative provides free mammograms, clinical breast exams, pelvic exams, and Pap smear tests for uninsured women ages 40 to 64 and risk-based colorectal screenings to uninsured women and men ages 50 to 64.

The program model is a partnership with providers and community organizations and reflects the mission of St. Mary's Healthcare—to improve the health of the community with special attention to the poor and under-served.

PARTNERS

- Cancer Services Program of Fulton, Montgomery, and Schenectady Counties
- Fulton, Montgomery, and Schenectady Public Health Departments
- Healthlink of Nathan Littauer Hospital
- Ellis Medicine
- Little Falls Hospital

- Bassett Healthcare
- Schenectady Free Health Clinic
- American Cancer Society
- YWCA of Schenectady
- Cornell Cooperative Extension of Fulton and Montgomery County
- Capital Region Action Against Breast Cancer
- Local businesses, employers, and towns
- Local media venues, community members, and patient ambassadors
- Faith-based community organizations

OUTCOMES

- The program has screened 2,016 patients since 2008.
- Sixty percent of the patients screened are defined as "rarely/never" screened.
- Twenty-seven percent of patients screened received further diagnostic testing.
- Seventy-two percent of program patients received comprehensive cancer screenings (goal was 50%).

Multi-Hospital Infection Prevention Collaborative

STRONG MEMORIAL AND HIGHLAND HOSPITALS

Year Initiative Started 2008

Contact **Gwenn Voelckers, Director, Health Communications**
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PROGRAM DESCRIPTION AND GOALS

When members of the community go to the hospital, they expect to get better, not worse. They do not imagine that while being treated for one condition they will contract something else that may harm them. But, unfortunately, this can happen, and central line-associated bloodstream infections are among the primary culprits. In April 2008, a collaborative of six regional hospitals was formed to address this critical health issue that was posing significant risk for hospital patients and, therefore, the community at large.

Because surveillance for central line infections outside the intensive care unit was a new concept, the collaborative was initially cautious about setting goals for infection reduction. As excellent progress was made, however, the collaborative hospitals kept "Target Zero" in their sights, consistent with a nationwide movement.

PARTNERS

- Strong Memorial Hospital/University of Rochester Medical Center
- Highland Hospital/University of Rochester Medical Center
- Rochester General Hospital/Rochester General Health System

- Park Ridge Hospital/Unity Health System
- F.F. Thompson Hospital/Thompson Health
- Lakeside Hospital/Lakeside Health System

OUTCOMES

- Infection rates have declined by 44%, or about 100 fewer infections each year.
- Education and interventions have made nurses more aware of the causes of infection and how to manage them. In key areas such as "scrubbing the hub," which means properly disinfecting the catheter, nurses' knowledge on proper technique improved from just under 20% to nearly 80% after the intervention period.
- A lower infection rate means that fewer people are developing bloodstream infections, and patients are returning home sooner to resume their lives. The 44% reduction in the infection rate has meant that patients have spent 784 fewer days in the hospital.
- Health care costs have declined: Using a conservative estimate of $20,000 in additional expenditures per central line infection, a 44% reduction in infections has collectively saved participating hospitals an estimated $1,690,000 annually.

Wellness for Life

THE BROOKLYN HOSPITAL CENTER

Year Initiative Started 1995

Contact **Beryl Williams, Director, Community Outreach**
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brw9025@nyp.org

PROGRAM DESCRIPTION AND GOALS

Now in its sixteenth year, "Wellness for Life" is a nutritional initiative designed to help fight serious diseases through diet and information. Part of The Brooklyn Hospital Center's outreach efforts, the program takes the form of a monthly seminar that includes a weight loss challenge, medical lectures, educational films, and health discussions.

The Brooklyn Hospital Center's service area residents are, in general, less healthy than the New York City population as a whole. They are at much higher risk for hospitalization for heart disease, diabetes, stroke, cancer, and other diseases. The goal of the program is to effect healthy lifestyle changes in this largely low-income population, thus decreasing discomfort, hospitalization, and mortality from chronic illness.

PARTNERS

- Internal: oncology, cardiology, geriatric, podiatry, internal medicine, program for acquired immunodeficiency syndrome (AIDS) treatment and health, pharmacy, dentistry, nursing, and nutrition departments
- External: American Cancer Society, senior centers, local physicians and fitness instructors, local restaurants and eateries

OUTCOMES

Over the years, participants have lowered their cholesterol, blood pressure, and blood glucose levels. After the results are verified, the patient receives a "Picture of Health" award. Many members come to this program via their doctors' referral. The members report that their physicians are very satisfied with the results they have obtained by attending the meetings.

School Food Independence Committee

THOMPSON HEALTH

Year Initiative Started 2010

Contact **Tina Culver, Health Wellness Manager**
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PROGRAM DESCRIPTION AND GOALS

The School Food Independence Committee teaches children about the importance of healthy lifestyles and nutritious eating. It fosters partnerships between local farms and school districts in its mission to provide as many local, whole food options to students by sharing ideas, farm-to-school contacts, and other resources with the county's school districts. The program aims to bridge the gap between nutrition education in the classroom and cafeteria offerings.

PARTNERS

- Seven school food service directors
- 12 local farms
- Thompson Health's Wellness Department
- Teachers and students in area school districts

OUTCOMES

- Fifty people attended a pilot community dinner featuring locally-sourced foods.

- A “Farm-Fresh Cheesy Veggie Wrap” was created and sold at seven local school districts, bringing healthier food into school cafeterias.
- Twelve local farms partnered with the seven participating school districts, stimulating the local economy.
- Staff participated in four culinary training sessions with seasonal and local foods, resulting in a heightened sense of health-promoting foods.

International Health Screening Program

UPSTATE UNIVERSITY HOSPITAL

Year Initiative Started 2010

Contact **Nancy Daoust, Associate Administrator, Ambulatory Services**
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PROGRAM DESCRIPTION AND GOALS

The International Health Screening Program is a culturally sensitive program that provides initial health assessments for newly arrived refugees to the United States. The primary goal is to provide multi-cultural and multi-lingual health assessments for children and adults, in a family-friendly environment, while enhancing the education and primary care experience for physicians-in-training (residents), focusing on international health. This program is designed to facilitate timely, efficient, quality health care screenings, assessments, and referral care.

PARTNERS

- Catholic Charities of Onondaga County Refugee Resettlement Program of Syracuse
- Onondaga County Health Department, Bureau of Disease Control
- New York State Department of Health Bureau of Tuberculosis Control

OUTCOMES

- The quality of the intake exam was improved by including expanded exam and serologic testing, directly observed presumptive treatment of parasites, and immunizations necessary for citizenship advancement.

- Newly arrived refugees are triaged regarding medical issues that need acute or subacute attention that can be addressed in the outpatient setting rather than defaulting to the emergency room.
- The intake physical is linked to establishing primary care. Refugees are introduced to one facility and triaged to establish primary care in a timely, appropriate manner.
- This initiative offers positive encounters for refugees with medical learners (students and residents), staff, and faculty.

Maximizing Mammography Participation

WCA HOSPITAL

Year Initiative Started 2010

Contact **Toni DeAngelo, R.N., Community Health and Wellness Director**
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PROGRAM DESCRIPTION AND GOALS

Maximizing Mammography Participation (MMP) is a research-tested intervention program to increase the adherence of breast screening mammogram appointments among women 40 years of age and older who have missed, canceled, or are overdue for their annual screening.

The trained telephone navigator calls women, identifies and assesses their barriers for accessing screening, helps to resolve those barriers, educates them on breast health and the importance of early detection of breast cancer, and links them to a screening scheduler. Once the mammogram appointment has been completed, a gift card incentive with a "thank you for taking care of yourself" note is sent to the women. MMP has shown to improve future compliance, alter behavior, and change overall perceptions and "myths" of breast screening.

PARTNERS

- WCA Cancer Care Committee
- Chautauqua County Cancer Services Program
- Jamestown Primary Care

- Jamestown Breast Cancer Support Group
- Jamestown Women of Zonta
- Susan G. Komen for the Cure

OUTCOMES

- Since 2010, 452 women completed screenings that were missed, canceled, or overdue. Fifty-seven of those women had potentially suspicious findings.
- Two tested positive for breast cancer.
- Eighteen women were referred to the Cancer Services Program.
- Internal processes changed to increase easier access and scheduling of mammograms; i.e., scheduling after 4 p.m., and improved access to screening by 14 days by deleting menstrual cycle question on intake.
- The Certified Breast Nurse Navigator saw 8,592 women in 2011.

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