CONNECTING WITH COMMUNITIES

COMMUNITY HEALTH INITIATIVES ACROSS NEW YORK STATE

2013 Edition

HANYS Healthcare Association of New York State

Community Health Improvement Across New York State

2013 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

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

HONORABLE MENTIONS

Bassett Healthcare Network
School-Based Health: Doing What is Right for the Kids

Montefiore Medical Center
The Montefiore School Health Program

The Healthcare Association of New York State (HANYS) is pleased to present the winners and nominations for its 2013 Community Health Improvement Award (CHIA). As part of their mission, hospitals provide a number of programs and services to improve the health of their communities. This marks the 16th year that HANYS is recognizing hospitals for their commitment and dedication to community health. Each year, the bar for recognition has been raised as hospitals and continuing care providers improve their prevention, education, wellness, and health awareness programs.

The hospitals and health systems that develop these community health initiatives are leaders in chronic care disease prevention and educating communities about the importance of their health.

Over the past sixteen years, HANYS has seen improvement in the level of collaboration between hospitals and local health departments in conducting needs assessments to identify health priorities for their communities. With the right tools and resources, these partnerships continue to grow.

HANYS has been working with the Department of Health on the state's Prevention Agenda since its inception in 2008. We support hospitals working with their local county health departments to improve the health of communities. We also see the value of including community-based organizations in the process to improve the overall health of communities. While creating multi-stakeholder coalitions for community health improvement is challenging, HANYS is committed to assisting our members in these critical efforts.

As the health care system moves toward population health management, greater emphasis is being placed on preventive care and maintaining good health, rather than mainly treating illness. HANYS has been providing our members with the resources, tools, and education needed to assist them in preparing for this future health care delivery system.

2013 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

HONORABLE MENTIONS

NOMINATION PROFILES


2013 COMMUNITY HEALTH
IMPROVEMENT AWARD
WINNER

Chemung County School Readiness Project

ARNOT HEALTH AT ST. JOSEPH'S HOSPITAL, ELMIRA

YEAR PROGRAM STARTED
2006

PARTNERS:
Arnot Health at Arnot Ogden Medical Center and St. Joseph's Hospital

Physicians' offices

The Community Foundation

Comprehensive Interdisciplinary Developmental Services, Inc.

Local school districts

Chemung County Child Care Council

Chemung County Department of Social Services

PROGRAM DESCRIPTION AND GOALS

The School Readiness Project (SRP) is a multidisciplinary collaborative aimed at assessing all children up to age five for developmental delays, social/emotional issues, nutritional deficits, and other health concerns that put children at risk for being unprepared for entering kindergarten. The SRP partnership offers county-wide infant registration, a nurse home visitation program, parent education, and a cohesive system for referrals to and delivery of early childhood services. The goal of SRP is to increase the readiness of children entering kindergarten from 45% to 50% in five years.

OUTCOMES

- Increased efficiencies in identifying physical, mental, and developmental risks to learning and school readiness.
- Kindergarten school readiness increased an average of 21% in all of the county's school districts. In the poorest school district, there was a 22% increase in school readiness, from 45% to 67% of students prepared for Kindergarten.
- The number and quality of Head Start and prekindergarten programs increased.
- The number of children up to age four visiting the county's emergency rooms for asthma-related conditions decreased by 33%, and fell 50% below the New York State average.

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2013 COMMUNITY HEALTH IMPROVEMENT AWARD

HONORABLE MENTIONS

School-Based Health: Doing What Is Right for the Kids

BASSETT HEALTHCARE NETWORK, COOPERSTOWN

YEAR PROGRAM STARTED
1992

PARTNERS:
Cooperstown, Delaware Academy, Edmeston, Laurens, Middleburgh, Milford, Morris, Sherburne-Earlville, South Kortright, Sidney, Schenevus, Stamford, Worcester, and Unadilla Valley schools

Delaware County Rural Health Alliance

Leatherstocking Education Alcoholism/Addictions Foundation

Delaware, Otsego, and Chenango County public health officials

Delaware, Otsego, Schoharie, and Chenango County mental health agencies

Rural Health Education Network of Delaware, Otsego, Montgomery, and Schoharie counties

Bassett Research Institute

PROGRAM DESCRIPTION AND GOALS

Bassett Healthcare Network's innovative School-Based Health Program is the largest rural program in New York State, with 19 highly successful school-based health centers (SBHCs) in 14 school districts that ensure easy access to quality health care services, including dental and mental health services, for students from pre-kindergarten through twelfth grade.

The program aims to mitigate the real barriers to health care access including climate, geography, lack of insurance, and a host of socio-economic factors. A team of nurse practitioners, physician assistants, mental health care workers, physicians, and a dental hygienist, supported by licensed practical nurses and medical office assistants, provide care to students in the school setting. There are no out-of-pocket expenses for services provided by the SBHCs.

OUTCOMES

This program increased access to pediatric primary care in Bassett's rural eight-county region:

- School-Based Health Program enrollment ranges from 66% to 97% of the student population in the 19 sites, with total program enrollment of 7,414 students.
- Pediatric visits to SBHCs now outpace Bassett Medical Center's outpatient pediatric clinic visits: 18,562 vs. 10,988 (2008); 20,578 vs. 11,554 (2012).
- In 2013, the percentage of students with an asthma or asthma-related diagnosis who received influenza immunization increased to 82%.
- Thirty percent of all 30,578 SBHC visits in 2012 were for mental health services.
- In the 2011-2012 school year, 348 students received dental sealants; 1,209 students received a dental screening, cleaning, and fluoride application.

CONTACT

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The Montefiore School Health Program

MONTEFIORE MEDICAL CENTER, BRONX

YEAR PROGRAM STARTED
1983

PARTNERS:
New York State and New York City departments of health

City, state, and federal grants

Private foundations and individual donors

PROGRAM DESCRIPTION AND GOALS:

The Montefiore School Health Program provides comprehensive medical, dental, mental, and community-based services to students and their families in elementary, middle, and high schools—as well as health and wellness services to prevent and treat chronic conditions such as obesity, diabetes, and asthma. The mission is "To achieve health and well-being in all Bronx public school students through full access to high quality comprehensive primary and preventive health services regardless of ability to pay."

OUTCOMES:

- From 2005 to 2009, one high school with a comprehensive school-based health center (SBHC) reported a 50% reduction in the positive pregnancy test rate.
- Elementary school children with asthma attending schools with Montefiore SBHCs compared to asthmatic children in schools without SBHCs had a 50% reduction in hospitalizations for asthma, a 50% reduction in ER visits, and a three-day per year improvement in school attendance.
- Through the coordination of the "Cook-shop," more than 1,000 third-graders per year for the past five years have learned to cook more than a dozen recipes using fresh fruits, vegetables, and whole grains.
- The 1% non-sweetened milk campaign resulted in a reduction of 4.6 billion calories and 422 million grams of fat consumed per year by New York City school children.

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2013 COMMUNITY HEALTH IMPROVEMENT

NOMINATION PROFILES

File of Life

ALBANY MEMORIAL HOSPITAL

YEAR PROGRAM STARTED
2007

PARTNERS
Auxiliary

Volunteers

Volunteer patient representatives

Emergency responders, emergency medical technicians, and emergency department staff

PROGRAM DESCRIPTION AND GOALS

The program mission is to introduce and distribute the "File of Life" patient medical health history program throughout the community. The goal is to save lives while providing the community with a process that improves upon and eliminates problems discovered with the "Vial of Life" program.

OUTCOMES:

- Ninety-percent of patients screened stated they did not have a readily available tool to update and record their medical health history.
- The hospital developed a partnership with emergency responders and hospital emergency department staff who are able to access a patient's medical history upon arrival.
- One File of Life user reported that he believed that the recorded information concerning allergic reaction to a specific medication was vital to the proper care that he received.
- Users of the File of Life state that there is peace of mind knowing that they will receive appropriate care based on the life-saving information they provide.

CONTACT

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Creating a Health Literacy Action Plan: Improving Patient Outcomes through Clear Communication

ALICE HYDE MEDICAL CENTER, MALONE

YEAR PROGRAM STARTED
2011

PARTNERS
Franklin County Public Health

Adirondack Medical Home

North Country Healthcare Providers (rural health network)

Literacy Volunteers of Franklin and Essex Counties

PROGRAM DESCRIPTION AND GOALS

Health literacy is the ability to "find, read, understand, and act on health information." Navigating the health care system is becoming increasingly complex, and especially challenging for patients with low literacy skills. They have more than doubled the risk of hospitalizations than people with adequate literacy skills, they remain in the hospital nearly two days longer, and they have higher readmission rates. This translates into four times higher annual health care costs for these individuals.

Using the Agency for Healthcare Research and Quality's (AHRQ) Universal Precautions Toolkit as a guide, a clear, effective communication initiative benefits everyone. Alice Hyde Medical Center's action plan provides the structure to implement short-term and long-term activities that will be sustainable and will positively impact patient-centered care, improve patient compliance with care instructions, and reduce preventable readmissions.

OUTCOMES

- The patient-family communication committee revised its policy to ensure that new patient educational materials are developed using health literacy principles.
- Alice Hyde Medical Center initiated the National Patient Safety Foundation's "Ask Me 3" notepads in patient admitting packets and facility signage.
- The facility created a health literacy video presentation that is shown at new employee orientations and is mandatory for all staff to see.
- Two health literacy training sessions were held: a staff-development day, and a regional (five-county) conference, both grant-funded.

CONTACT

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Center of Distinction

BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER, PATCHOGUE

YEAR PROGRAM STARTED
2012

PARTNERS
Healogics

PROGRAM DESCRIPTION AND GOALS

The Center for Wound Care and Hyperbaric Medicine at Brookhaven Memorial Hospital Medical Center is a 2012 Center of Distinction. The Center of Distinction is awarded by Healogics and requires specific metrics be met or exceeded for 12 consecutive months. Located at 33 Medford Avenue in Patchogue and open Monday through Friday, the Center is a state-of-the art facility covering 8,000 square feet. It has five examination rooms and three hyperbaric chambers. In addition to specialized wound care and hyperbaric oxygen therapy, it also offers x-ray services and laboratory work, all done onsite.

OUTCOMES

Requirements	Actual Results
Patient Satisfaction (Greater than or equal to 92%)	97%
Healing Rate (Greater than or equal to 91%)	93%
Outlier Rate (Less than or equal to 19%)	15%
Median Days to Heal (Less than or equal to 30)	26

CONTACT

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Safe Sitter® Program

COLUMBIA MEMORIAL HOSPITAL, HUDSON

YEAR PROGRAM STARTED
1985

PARTNERS
Schools

Girl Scouts

Community agencies

Church groups

PROGRAM DESCRIPTION AND GOALS

The Safe Sitter® Program prepares young adolescents for the profound responsibilities of nurturing and protecting children. The goal is to provide quality education for students interested in babysitting. Students are taught life skills, safe habits, first aid, and business skills.

OUTCOMES

Students learned:

- cardio-pulmonary resuscitation;
- injury prevention;
- how to prevent problem behavior; and
- behavior management.

CONTACT

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Innovative and Integrated Community Medication Safety Program

ELLENVILLE REGIONAL HOSPITAL

YEAR PROGRAM STARTED
2008

PARTNERS
The Institute for Family Health (A Federally Qualified Health Center in Ellenville)

Albany College of Pharmacy and Health Sciences

Sullivan County Community College

Orange County Community College

Matthews Pharmacy (Local Pharmacy)

Ellenville First Aid & Rescue Squad

Ellenville Senior Housing

PROGRAM DESCRIPTION AND GOALS

The Ellenville area is a poor, medically under-served community with limited health literacy. The majority of the population lacks the skills to effectively manage their medications. Ellenville Regional Hospital established the Innovative and Integrated Community Medication Safety Program to effect positive change by identifying and mitigating adverse medication events and to promote access to care. This program counsels and educates community members, providers, and consumers on medication use, dosage, and interactions; reconciliation; and disease state management. It establishes a single source of comprehensive and accurate standardized medication documents. These documents are available to all people involved in the health care of consumers to enable effective hands-off communication, create a seamless process of medication management, and reduce errors as patients transition within and/or across organizations.

OUTCOMES

- Through this program, 2,398 community members have received clinical pharmacy services.
- Community-wide potential adverse drug events identified: 911.
- Community-wide actual adverse drug events identified: 172.
- 2012 data indicate a medication error rate of 0.03 occurrences per 1,000 doses dispensed.

CONTACT

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Care Central—
A County-Wide Multi-Provider Care Management Initiative

ELLIS MEDICINE, SCHENECTADY

YEAR PROGRAM STARTED
2008

PARTNERS
Ellis Medicine

Hometown Health (A Federally Qualified Health Center)

Visiting Nurse Service of Schenectady and Saratoga Counties

Schenectady County Public Health

Schenectady City Mission

Schenectady Community Action Program

More than 40 other Health Home partners

Nine other hospitals for the Medicare Community-Based Care Transitions Program

PROGRAM DESCRIPTION AND GOALS

Following the Berger Commission's mandate to consolidate Schenectady's hospitals, Ellis Hospital brought a number of health and community service providers together to guide development of a community-oriented population health management initiative. Different partners within the group have since joined to deliver a variety of care management programs—including a Medicaid Health Home and a Medicare Community-based Care Transitions Program—under the single name of "Care Central." Their goal is to most efficiently and effectively deliver holistic and comprehensive care management to the entire population of the county, eventually building a solid community-wide structure to improve care and reduce costs by promoting good health.

OUTCOMES

- Numerous health and community service agencies in the county are effectively collaborating.
- Patients are benefitting from care management, with more than 800 patients in the county receiving formal care management for the first time.
- Preliminary outcome metrics are mixed, but some suggest potential positive outcomes.
- The success of county-wide cooperation has led to successful region-wide, multi-county, multi-hospital cooperation.

CONTACT

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Farmers' Market—Growing Healthy Together

ERIE COUNTY MEDICAL CENTER, BUFFALO

YEAR PROGRAM STARTED
2010

PARTNERS
Citizens' Alliance, Inc.

Delavan Grider Community Center

Durham Street Block Club

Ephesus Ministries

Grider Street Block Club

Mt. Olive Baptist Church

P2 Collaborative of Western New York

St. Philips Episcopal Church

Second Temple Baptist Church

University of Buffalo School of Public Health and Health Professions

PROGRAM DESCRIPTION AND GOALS

Growing Healthy Together, an initiative of Erie County Medical Center (ECMC) and the Delavan-Grider Community Center to improve health, established the ECMC Farmers' Market at Grider. This initiative enhances the nutrition and economic health of the community by increasing access to fresh and affordable produce from local farms. The Delavan-Grider neighborhood can be classified as a "food desert." Therefore, this small but vibrant farmers' market initiative was established in concert with a range of community outreach initiatives. For example, the electronic benefit transfer (EBT) service enables patrons with public assistance the ability to shop. The goals of the Farmers' Market are to:

- increase access to healthy and affordable foods, and
- improve healthy behaviors in the community.

OUTCOMES

- Improved patronage of the market during the three years of the market;
- Implementation of the Supplemental Nutrition Assistance Program (SNAP) benefits EBT service for patrons on public assistance;
- Development of a healthy food demonstration program at the market; and
- Recently funded a "Van to Groceries" project to improve access.

NUMBER OF PEOPLE WHO USED THE FARMERS' MARKET (2010-2012)

Year	ECMC Employees	Target Community	Total
2010	614	223	837
2011	571	512	1,083
2012	647	1,031	1,678

CONTACT

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Pertussis Cocooning (Vaccination): Postpartum Mothers, Direct Care Providers of Newborns and Health Care Providers

FLUSHING HOSPITAL MEDICAL CENTER

YEAR PROGRAM STARTED
2012

PARTNERS
New York City Department of Health and Mental Hygiene, Bureau of Immunization

New York City Adult Immunization Coalition

PROGRAM DESCRIPTION AND GOALS

This initiative is a pilot project providing education for patients and staff on the use of diptheria toxoid and acellular (Tdap) vaccine for control and prevention of pertussis among vulnerable populations (newborns), to promote implementation of standing orders and protocols in hospitals, and to improve Tdap vaccination rates among health care workers and patients. Pre- and post-tests are administered to staff to gauge comprehension of information provided in educational sessions. The goals are to determine best practices for achieving high vaccination rates among postpartum mothers, direct caregivers of infants, and health care workers; to develop effective educational modules for staff and patients; and to spread this knowledge by publishing a peer-reviewed paper with methods, outcomes, analyses, and results.

OUTCOMES

The hospital adopted a standing order for administering tetanus toxoid, reducing Tdap vaccine to postpartum women.

The vaccination rate of postpartum mothers prior to hospital discharge improved:

- October 2012: 201/290 = 69.3%
- November 2012: 182/238 = 76.4%
- December 2012: 200/238 = 84.0%
- January 2013: 166/201= 82.5%

The number of health care personnel willing to be vaccinated following administration of a specific educational module increased from 65.2% to 80.4%.

CONTACT

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Preadmission Medication Reconciliation for Surgical Patients

GENEVA GENERAL HOSPITAL

YEAR PROGRAM STARTED
2011

PARTNERS
Geneva General Hospital Department of Pharmacy, Department of Surgery, and Preadmission Services

Community Pre-Admitted Patients Scheduled for Surgery at Geneva General Hospital

PROGRAM DESCRIPTION AND GOALS

Geneva General Hospital's pharmacy undertook this initiative to reduce missed medication doses in pre-admitted surgical patients by improving access to non-formulary medications. Before initiating this project, there was an average of six doses of non-formulary medications missed each week in surgical patients. The majority of the missed doses were due to non-formulary medications not being available. Since these patients are pre-admitted, these events were determined to be preventable by pre-planning for the needs of these patients prior to their arrival. The goal was to reduce or eliminate missed doses of non-formulary medications in the target population through pre-admission medication reconciliation. By creating a partnership between the patient and the pharmacist, planning could occur with the patient regarding medications for post-operative use.

OUTCOMES

- Patient education regarding medication reconciliation has been enhanced.
- A pharmacist conducted 94 pre-admission patient telephone calls to review medications, resulting in clarification of dose, form, frequency, medication names, and identification of non-formulary medications.
- Missed doses of medication decreased from an average of six per week to seven doses total in six months.

CONTACT

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Creating Healthy Places to Live, Work, and Play

GLENS FALLS HOSPITAL

YEAR PROGRAM STARTED
2010

PARTNERS
Adirondack/Glens Falls Transportation Council

East Side Center, a Warren and Washington Mental Health Association program

Cornell Cooperative Extension of Warren County

Healthy Communities Coalition of Washington County

Municipalities in Warren and Washington County

New York State Department of Health

Warren County Safe and Quality Bicycling Organization

Washington County Youth Bureau

PROGRAM DESCRIPTION AND GOALS

In an ideal healthy community, people can walk or bicycle to their destinations; physical activity opportunities are safe and accessible, inviting, and commonplace; and healthy food is readily available. The Creating Healthy Places to Live, Work, and Play (CHP2LWP) program in Warren and Washington counties is working toward this ideal. This initiative strives to prevent obesity and type 2 diabetes by creating an environment that fosters physical activity and healthy eating. Evidence-based policy, systems, and environmental changes include complete streets policies, community gardens, park revitalizations, and school public use policies. These sustainable improvements have a significant impact on the long-term health and well-being of the community.

OUTCOMES

Since its inception, CHP2LWP has established 33 new policy and environmental changes in 16 communities. Highlights of these changes include:

- **Promoted walking, biking, and traffic safety:** Eleven local complete streets policies adopted; leveraged over $844,000 of additional state and federal funding to support pedestrian and bicycle improvements in two communities.
- **Improved environment to support physical activity:** Fourteen bike racks and 21 pedestrian benches installed; city park revitalization resulted in an increased rating on the Physical Activity Resources Assessment instrument from 39% to 71%.
- **Increased access to healthy foods:** Eight new community gardens established; 118 families growing their own produce; 1,958 pounds of produce donated to local community meal programs.
- **Increased access to recreational facilities and sites:** Three school districts passed policies allowing public use of school facilities for active recreation.

CONTACT

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Spirit of Rockland, Special Victims Center

GOOD SAMARITAN REGIONAL MEDICAL CENTER/ BON SECOURS CHARITY HEALTH SYSTEM, SUFFERN

YEAR PROGRAM STARTED
2011

PARTNERS
Rockland County Office of the District Attorney

All Rockland County Police Departments

Rockland County Department of Social Services

Rockland County Department of Mental Health

Center for Safety and Change, including Sexual Assault Forensic Examiner (SAFE) Nurses

PROGRAM DESCRIPTION AND GOALS

The Special Victims Center is a network of services under one roof for those who experience abuse, especially childhood sexual abuse; domestic violence; human and sex trafficking; abuse of immigrants; geriatric abuse; and abuse of those who are physically, psychologically, or intellectually impaired. The goals of Good Samaritan Regional Medical Center, the Office of the District Attorney, and other partners are holistic care of all victims; arrest and prosecution of those who perpetrate crimes against those who are most vulnerable; community education about victimization; and cooperative streamlined services. Services are under one roof on the campus of Good Samaritan Regional Medical Center, and include counseling, video-taped testimony, support groups, victims assistance programs, appropriate referrals, and Lily—a therapy dog.

OUTCOMES

- The first successful prosecution of a human trafficking case in New York State (2012);
- Comprehensive care of victims—more than 200 victims have presented since September 2011, with at least 400 additional family members who also needed supportive services;
- Community education—provided to pediatricians, emergency department staff, Rotary Clubs, faith-based organizations, school districts, other community organizations (a DVD was completed for more widespread education); and
- A support group was established for parents/guardians/caregivers of children who are victims of abuse.

CONTACT

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Community Health Outreach Tables

GOOD SAMARITAN HOSPITAL MEDICAL CENTER, WEST ISLIP

YEAR PROGRAM STARTED
2011

PARTNERS
West Islip Public Library

West Babylon Public Library

Babylon Public Library

Bay Shore-Brightwaters Public Library

Life WORC

North Babylon Public Library

Great South Bay YMCA

Pronto of Long Island

Spangler Drive Senior Center

Tanner Park Senior Center

Town of Islip Senior Center

Wyandanch Senior Center

PROGRAM DESCRIPTION AND GOALS

Good Samaritan Hospital Medical Center created community health outreach tables to increase opportunities to provide educational information on health care concerns and encourage individuals' participation in their health care management. The display/conversation tables are manned by hospital staff with expertise in their fields, providing educational information on cardiology, hypertension, stroke, physical therapy, nutrition, diabetes, medications, breast cancer, palliative care, pediatrics, and other hospital services and programs. Routine displays offer an array of information on health and wellness including reducing health risks, identifying warning signs, the importance of early detection, encouraging healthy choices, managing chronic illness, and tools for participating in one's health care. Community health outreach tables are scheduled regularly at various locations and are part of the hospital's menu of free screenings and community events.

OUTCOMES

- Since January 2011, there have been 60 discussion tables at local public libraries to provide the community with educational information on health issues including diabetes, cancer, nutrition, heart health, physical therapy, orthopedics, radiology, palliative care, and other special hospital programs and services reaching a total of 1,848 people.
- The community health team has attended 11 community events offering free cholesterol, glucose, and blood pressure screening along with community health outreach tables reaching 912 people.
- There were 12 health lecture presentations in the community on topics such as heart health, diabetes, breast cancer, nutrition, and fall prevention, with educational tables reaching 379 people.
- To increase community outreach services and promote management of hypertension, free blood pressure screenings are offered at one location with a community health outreach table. To date, there have been seven screenings reaching 80 people.

CONTACT

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Congestive Heart Failure Program

JOHN T. MATHER MEMORIAL HOSPITAL, PORT JEFFERSON

YEAR PROGRAM STARTED
2010

PARTNERS
John T. Mather Memorial Hospital's nursing, nutrition, pharmacy, respiratory, social work, and physical therapy departments

Cardiologists

Home care agencies

New York State Partnership for Patients

PROGRAM DESCRIPTION AND GOALS

The program begins during the heart failure patient's hospital stay with education by nurses and other members of an interdisciplinary team. A nurse practitioner (NP) provides transitional care, visiting the patient on the unit and following the patient for 30 days post-discharge. The NP works closely with each patient, stressing the importance of keeping doctor appointments, following their prescribed low-sodium diet, monitoring their weight daily, and taking their medications as directed by their physicians. The NP also helps patients understand the symptoms that would require them to contact their physician. A heart failure support group provides patients with continued education and support after the four-week period ends. Goals include improving the continuity of care, reducing readmissions, and improving quality of life.

OUTCOMES

- The rate of 30-day readmissions to Mather Hospital for congestive heart failure patients was reduced by 37%, from 36.33 per 100 patients to 22.93 in the program's second year.
- The rate of potentially preventable readmissions was reduced by 62% from the first quarter 2011 (28.57%) to the second quarter 2012 (10.81%).
- Patients had a 92% average increase in their quality of life scores at the four-week follow up.

CONTACT

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Community Liaisons: Bridging the Cultural Gap in Health Care

LUTHERAN MEDICAL CENTER, BROOKLYN

YEAR PROGRAM STARTED
2008

PARTNERS
Lutheran HealthCare: Lutheran Medical Center, Lutheran Family Health Centers, Lutheran Augustana Center, and Lutheran Senior Housing

COMMUNITY PARTNERS
Arab American Association of New York

Arab American Family Support Center

Arab American Muslim Federation

Asian Community United Society

BINA Stroke and Brain Injury Assistance

Brooklyn Chinese American Association

Homecrest Community Services

MAS Youth Center

PROGRAM DESCRIPTION AND GOALS

As a health care system in one of the most culturally diverse areas of New York, Lutheran Medical Center has taken a novel approach to bridge cultural gaps experienced by providers and the communities they serve. Lutheran Medical Center coordinates services for the Arabic, Chinese, and Orthodox Jewish communities through one person—the community liaison—to streamline resources.

The program responsibilities fall into three areas: visiting and caring for all patients, liaison with affiliated providers, and establishing relationships with community/faith-based organizations.

The goal is to cross "silos" and work as a cross-functional team with various departments and community organizations to provide continuous and culturally competent service to patients as they navigate the health system and reenter the community.

OUTCOMES

- Lutheran Medical Center is able to proactively identify problems before they become big issues, and find culturally competent resolutions.
- Staff satisfaction has improved—staff now have a resource for cultural/problem resolution, and assistance in interpretations.
- The community perception of the organization has improved.
- This initiative has enabled Lutheran Medical Center to bring new and existing community partners to cultural task force meetings and system-sponsored events. In 2008, there were no community members sitting on Lutheran's cultural initiatives task forces. Lutheran now has 14 community organizations as members of its Arab and Chinese initiative committees.
- Since 2008, there has been a 98% increase in the number of community events.
- This initiative has helped identify system-wide issues affecting provider relations.
- Physicians are more satisfied with the emergency room—physician satisfaction scores have jumped 20 percentage points from 58% to 78% in the "my patients are well cared for" category.

CONTACT

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HERO (Health Education Raises Opportunities)

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER, LEWISTON

YEAR PROGRAM STARTED
2009

PARTNERS
The Mental Health Association in Niagara County, Inc.

The Niagara County Health Department

Fidelis Care New York

Niagara University Department of Biology, College of Education

Daemen College

Catholic Charities of Western New York

Northpointe Center

The Buffalo Diocesan Catholic Schools

Catholic Academy of Niagara Falls

St. Peter's Roman Catholic School

St. Matthew Lutheran School

The Niagara Charter School

DeSales Catholic School

Niagara Catholic High School

Parish Nursing Program

Dr. Sean Ferguson, Rainbow Pediatrics

St. Mary's Hospital and Health Center's education and staff development, mission integration, rehabilitation and sports medicine, and community relations departments

PROGRAM DESCRIPTION AND GOALS

HERO is a school health literacy collaborative program led by Mount St. Mary's Hospital and Health Center, provided in three distinct components to Niagara County students in elementary and high school, and parents. Through HERO, health experts from collaborative partners provide education on topics including nutrition, fitness, smoking, emotional health, and chronic diseases.

HERO's high school component provides internships for college credit to students interested in careers in the health occupations through a hands-on, preceptor-directed research program onsite at the hospital. Partnering With Parents, HERO's third component, provides seminars on health issues to parents and the community in targeted education programs. The goal of HERO is to help students and their families become better consumers of health care.

Instruction is provided relative to identified health in age-appropriate formats, with involvement and support of the county health department and local academic institutions of higher learning in the planning and assessment of program effectiveness.

OUTCOMES

- Education has been provided to more than 1,000 students and their families in Niagara County.
- Six schools, their faculties, and parent groups were served with customized health education and career programs.

In addition, this initiative offers the potential for successful outreach education by using a methodology whereby children "teach" their families about the content of their HERO courses, and the potential for expansion of HERO education topics to school health fairs, presentations, and other school and community events.

CONTACT

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Center for Healthy Aging at the Jackson Heights Family Health Center

NEW YORK HOSPITAL QUEENS

YEAR PROGRAM STARTED
2012

PARTNERS
The ElderCare Companies, Inc.

55 non-profit organizations of senior congregations (public and subsidized housing, senior centers, senior clubs, and place of worship)

51 Meals-on-Wheels social service organizations

PROGRAM DESCRIPTION AND GOALS

New York Hospital Queens collaborated with community-based senior programs and senior housing to educate seniors on how to develop strategies to age safely at home. The program provided information on health behaviors, individual automated fall risk assessments (computerized dynamic posturography), resource information on fall diagnostics and treatment, on-the-spot appointments, and care coordination. The goal was to develop an effective, sustainable, broad-based, grassroots community health initiative. This involved providing patient education and health care coordination among the patient, doctor, community agency, and hospital. The program provided support to seniors to access the appropriate health care services that allow them to age safely in their homes and decrease hospitalizations.

OUTCOMES

- More than 3,400 seniors received interactive oral and print materials on the Center for Healthy Aging and fall prevention at 55 locations in 120 workshops.
- More than 1,470 seniors received screenings on fall risk (balance, body mass index, vision, etc.), health histories, and health coach recommendations.
- Print materials on falls prevention were distributed to more than 2,000 shut-in seniors via Meals-on-Wheels programs.
- More than 3,400 seniors were offered personal assistance in seeking medical consultation.

CONTACT

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Health Smarts While You Wait

NEW YORK METHODIST HOSPITAL, BROOKLYN

YEAR PROGRAM STARTED
2007

PARTNERS
United Hospital Fund
Adult Literacy Media Alliance of the Education Development Center, Inc.

PROGRAM DESCRIPTION AND GOALS

Health Smarts While You Wait is a volunteer-based health literacy program that provides waiting patients with one-on-one consultations and group presentations regarding health literacy. Health Smarts volunteers are trained to teach patients about navigating and understanding over-the-counter and prescription medication labels, proper dosing and managing multiple medications, and nutrition basics (including interpreting the Nutrition Facts Label on food and beverage containers). The volunteers also encourage patients to ask their doctors and pharmacists questions, by reviewing lists of frequently asked questions.

OUTCOMES

- Each week, 250 patients are instructed in ways to manage their health through medication management and nutrition basics and are instructed to make the most of their doctor visits by speaking up, asking questions, and bringing all of their medicines in for review.
- More than 200 volunteers, many of whom are future health professionals, are now trained in clear communication skills and health literacy techniques.
- Twenty chemotherapy patients and their caregivers are instructed weekly on managing nutrition-related side effects.

CONTACT

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Burn Outreach and Community Education

NEWYORK-PRESBYTERIAN HOSPITAL, MANHATTAN

YEAR PROGRAM STARTED
1976

PARTNERS
Departments within NewYork-Presbyterian Hospital and Weill Cornell Medical College

Regional community-based social services agencies serving those at high risk of burns

New York Firefighters Burn Center Foundation and Fire Department, City of New York (FDNY)

Sekou Toure Regional Referral Hospital (SRRH), Mwanza, Tanzania, Africa

Community stakeholders at risk of and affected by a mass-casualty burn disaster

Health care professionals practicing in the greater New York City community

PROGRAM DESCRIPTION AND GOALS

Through evidence-based, multidisciplinary efforts reflective of NewYork-Presbyterian Hospital's approach to patient care, this program seeks to reduce the incidence and severity of burns in the community by delivering educational programming to all at risk of and affected by the tremendous burden of these injuries, especially pediatric, geriatric, occupational, specialized communities at highest risk, and survivors and their families.

OUTCOMES

Data provided for 2012 (most recent data unless noted):

- The hospital directly partnered with 200+ agencies to deliver educational information to 15,000 members of the general public and 750 health care professionals/students within the New York City region; indirectly reached 5.9 million local resident media users through mixed media delivery; directly educated 11,000 active FDNY members (2010 FDNY Safety Week) and 20,000 FDNY hires (1989-2009 most recent hires). This initiative approach provided community reintegration support to 700 people through school re-entry, peer support programming, and survivor support groups.
- The program initiated infrastructure to support, train, and mentor the creation of a self-sustaining pediatric burn unit in Mwanza, Tanzania, Africa to reduce the widespread devastation of burns in an under-served, developing world community.
- This initiative spearheaded a task force to create a regional burn disaster response plan, which has been adopted by the New York City Mayor's Office and the New York State Department of Health.

CONTACT

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Noyes Caregiver Resource Center

NICHOLAS H. NOYES MEMORIAL HOSPITAL, DANSVILLE

YEAR PROGRAM STARTED
2009

PARTNERS
Livingston County Office for Aging

Genesee Valley Health Partnership

Parish Outreach Center

Mental Health Services for Livingston County

Alzheimer's Association—Rochester and Finger Lakes Chapters

PROGRAM DESCRIPTION AND GOALS

In November 2009, with financial support from the Livingston County Office for the Aging, the Noyes Caregiver Resource Center started serving Livingston County caregivers. The program assists informal caregivers—spouses, adult children, or other family members; friends; and neighbors—in their efforts to care for older adults living at home, with special focus on families caring for those with Alzheimer's disease or other dementia-related illnesses. Many new programs and support services have been provided to caregivers in Noyes' rural service area, and the program has grown annually since inception.

The program goal is to support informal caregivers via information and assistance, educational programs, support groups, and respite care services to help them care for their loved ones living at home, in their community.

OUTCOMES

- **Support Groups:** These have grown from two to five monthly meetings since 2010 in four different locations. Monthly meeting attendance has increased 60% since 2009, with more than 45 families served.
- **Education Programs/Services:** The *Monthly Caregiver Newsletter* is available via e-mail, mail, Internet, and agency partner/community distribution sites, with more than 400 copies distributed monthly. *Powerful Tools for Caregivers* and *Matter of Balance* classes are held twice each year. More than 230 caregivers have been assisted and supported by one or more of the program's services since late 2009.
- **Annual Caregiver Symposium:** Since 2010, this community-wide annual event is coordinated by the Caregiver Resource Center and demonstrates true community collaboration. The event provides a wide variety of caregiver educational opportunities. Attendance averages 50 to 75 caregivers with 25 to 30 support service vendors, and includes keynote speaker, information sessions, and a free meal with gifts for all caregivers.
- **In-home Respite–Companion Care:** This is provided to support caregivers working "24/7" to care for their partners at home by either the local area Office for the Aging partnership or the hospital's personally-trained Retired and Senior Volunteer Program (RSVP) respite volunteers. The hospital's "Caregiver Menu of Services" tool includes all available respite care options available in the rural community. More than 50 families have been assisted by one or more of the available respite care options since 2009.

CONTACT

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The ABCs of Good Health

NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, GREAT NECK

YEAR PROGRAM STARTED
2011

PARTNERS
North Shore-Long Island Jewish Health System's Office of Community and Public Health

Long Island Regional Adult Educational Network

PROGRAM DESCRIPTION AND GOAL

In 2011, North Shore-Long Island Jewish Health System partnered with the Long Island Regional Adult Education Network to offer lesson units on health literacy. This five-hour workshop includes topics on personal hygiene, oral care, healthy lifestyles, pediatric health, immunization, diet, and safety issues. Additionally, students learn how to choose and communicate with their doctor by rehearsing the so-called "Ask Me 3" questions (What is my main problem? What do I need to do? Why is it important for me to do this?), highlights of the "Patient Bill of Rights," and what to expect during an emergency room visit.
The curriculum's objective is to teach students to obtain, process, and understand basic health information for healthy living and enhance their ability to make appropriate health decisions.

OUTCOMES

- This strong program provides an increase of health literacy and knowledge to students via instruction and an educational toolkit designed by highly-rated health care professionals and teachers.
- Through education of this type, the possibility of lowering statistics of annual health care costs for individuals with low literacy skills is feasible.
- Educating English as a Second Language (ESL) and General Education Development (GED) instructors is a short course of study in health literacy and health topics, accompanied by an educational toolkit, increases the possibility of healthier outcomes within communities.
- The incorporation of health and wellness topics into Long Island Regional Adult Education Network lessons provides an opportunity for more community members to learn how to access helpful health and wellness resources.

CONTACT

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Community Health Outreach Program—Elementary School Health Education Initiative

NORTHERN WESTCHESTER HOSPITAL, MOUNT KISCO

YEAR PROGRAM STARTED
2010

PARTNERS
Bedford Road School, Pleasantville

Crompond School, Yorktown Heights

Mohansic School, Yorktown Heights

Mount Kisco Elementary School, Mount Kisco

Pequenakonck Elementary School, North Salem

West Patent Elementary School, Bedford Hills

PROGRAM DESCRIPTION AND GOALS

In 2012, more than 7,000 students in area schools attended youth health education programs conducted by Northern Westchester Hospital. Interactive programs in elementary schools address nutrition (food guidelines), first aid/calling 911, and infection control. Classes of 20 to 30 students receive a 40-minute presentation in a single subject area, conducted by a trained professional. Outcomes were measured by pre-and post-education surveys to more than 700 children. These surveys were tailored to this age group and were developed to be unbiased quantitative measures.

The overriding goal of all programs is to support/advance healthy student behavior by:

- introducing facts, principles, and techniques in subject areas;
- providing strong encouragement for positive behavioral change; and
- increasing awareness, interest, and confidence about the subject to maintain good health.

OUTCOMES

Students increased their knowledge of nutrition/healthy lifestyles and intent to change behavior in this area, as evidenced by these statistics.

- Eighty percent reported they would "maybe" or "really" like to change their eating habits after the presentation.
- Twenty-nine percent said the program increased their knowledge of fruits and vegetables as the largest component of a healthy diet.
- Students increased their knowledge of basic first aid and understanding when to call 911.
- Seventy-nine percent of students reported confidence in their ability to dial 911 in an emergency.
- Twenty percent adjusted their assessment of a lost pet as an "emergency" after the program.
- Students increased their knowledge of hand hygiene and expressed their intent to practice good hand washing.
- There was a 29% increase in correct identification of hand-washing duration after the program, and 80% expressed a strong desire to improve hand hygiene habits.

CONTACT

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Outpatient Services Replace Hospital Closed by the Berger Commission

OSWEGO HEALTH

YEAR PROGRAM STARTED
2009

PARTNERS
Oswego County and City of Fulton Legislators

Oswego County Health Department

The New York State Department of Health

State Senator Patty Ritchie and State Assemblyman Will Barclay

Michaud Residential Health Services

PROGRAM DESCRIPTION AND GOALS

With the Berger Commission's closure of A.L. Lee Memorial Hospital in Fulton, Oswego Health was charged with redefining how health care would be delivered in the community. Not wanting to interrupt health care services with the closure, Oswego Health opened an urgent care center less than 24 hours after the hospital officially closed. This was a completely new service for the Fulton community.

Oswego Health continued to work with local and state elected officials and was awarded $22 million in legislative support, which was used to renovate the former hospital into a premiere outpatient center, named the Fulton Medical Center, offering urgent care, laboratory services, medical imaging, physical therapy, and occupational health services. Throughout construction, which concluded in 2012, urgent care and other services remained available to residents.

OUTCOMES

- Outpatient health care services remained uninterrupted in the Fulton community through the transition after the hospital closure.
- In 2008, the year before the hospital's closure, the facility's 24-hour emergency room provided care for 13,000 visitors. In 2010, the first full year that Oswego Health operated the urgent care center, which is open 12 hours daily, there were 21,187 patient visits. During 2012, volumes continued to grow, with 25,169 urgent care visits, up 3,200 from the previous year. In addition, in 2012, there were 76,875 lab tests, 13,940 medical images, and 2,340 physical therapy visits.
- There were 489 individuals in 2012 needing a higher level of care that were transferred to an appropriate facility.
- Urgent care patients are provided educational discharge summaries based upon their illness/injury.

CONTACT

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NYMC Phelps Family Medicine Residency Program

PHELPS MEMORIAL HOSPITAL CENTER, SLEEPY HOLLOW

YEAR PROGRAM STARTED
2011

PARTNERS
New York Medical College

Open Door Family Medical Centers

PROGRAM DESCRIPTION AND GOALS

Phelps Memorial Hospital collaborated with Open Door Family Medical Centers and New York Medical College to establish a new family medicine residency program accredited by the Accreditation Council for Graduate Medical Education in August 2011. The three-year program is designed to train medical school graduates to become well-rounded family physicians who care for individuals across their lifespan within the context of their family and community. More than 100 physicians have volunteered to train the hospital's residents, and innumerable other health care professionals and community agencies participate in developing well-rounded community physicians that the hospital plans to recruit into the community. The collective mission is to develop family physician leaders who provide outstanding clinical care and community service through partnership and innovation. This program provides excellent primary care to increasing numbers of people, especially the under-served.

OUTCOMES

- **Attract family physicians to the area:** 926 residency applicants for 2012 and 1,161 applicants for 2013.
- **Engage the medical community and thereby enhance the overall quality of care provided:** More than 100 physicians and many others are involved in teaching.
- **Address the physician shortage:** Six family physicians will graduate annually, starting in 2015, and two thirds are expected to stay in the Westchester/New York City area.

CONTACT

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Walk With a Doc

SAMARITAN HOSPITAL AND ST. MARY'S HOSPITAL (ST. PETER'S HEALTH PARTNERS), TROY

YEAR PROGRAM STARTED
2011

PARTNERS
Samaritan Hospital

Seton Health

PROGRAM DESCRIPTION AND GOALS

Walk with a Doc, a joint initiative of Samaritan Hospital and St. Mary's Hospital, was launched in conjunction with Samaritan's introduction of percutaneous coronary intervention. Dr. Robert Benton of Capital Cardiology suggested Walk with a Doc, a national program that encourages healthy physical activity in people of all ages to reverse the consequences of a sedentary lifestyle and improve their health and well-being. The WWAD program meets monthly at the Troy Farmer's Market (summer) and Russell Sage College (winter). Walkers join cardiologists, nurses, health technicians, and others on a 30-minute walk. Participating physicians present a ten-minute talk on a different health topic each month. Walkers have the opportunity to spend time with physicians and ask medical questions in an informal, relaxed way.

OUTCOMES

- The WWAD program has met continuously for two years, with only one cancellation due to snow.
- A core group of 20 walkers participate each month.
- More than 1,000 walkers have participated over the two years and were provided important health education and access to a cardiologist.
- A dedicated group of health care professionals donates their time and resources monthly.

CONTACT

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Annual Health Fair

ST. CATHERINE OF SIENA MEDICAL CENTER, SMITHTOWN

YEAR PROGRAM STARTED
2003

PARTNERS
Suffolk County Community College

Long Island Blood Services

St. Charles Hospital

Walgreens Pharmacy

Suffolk County Department of Health

NY Sports Club

Catholic Home Care

Costco

Local Nursing Homes

Bethpage Federal Credit Union

Hunter Emergency Medical Services

Eye Bank for Sight Restoration

PROGRAM DESCRIPTION AND GOALS

Since St. Catherine of Siena Medical Center began holding its Annual Health Fair in 2003, attendance has more than doubled; and in October of 2012, the event has reached more than 1,000 community participants. The hospital attributes the increase in attendance to the expansion of free screenings, vaccinations, facility tours, and other services offered ranging from basic blood pressure checks to prostate screenings by a board certified urologist. The entire leadership team, staff, volunteers, and physicians take ownership for the success of the event and proudly showcase their departments for the community. The hospital collaborates with many local businesses, private physicians, other not-for-profit organizations, pharmacies, and local schools. Tables featuring information and related giveaways are in most cases staffed by nurses, technicians, pharmacists, and physicians to answer any questions.

OUTCOMES

Top Four Outcomes	2010	2011	2012	Growth from 2010
Skin Cancer Screenings	30	72	75	150%
Cholesterol Test	137	246	223	63%
Flu Shots	175	370	340	94%
Tetanus/ Diphtheria/ Pertussis	Not Offered	76	116	N/A

CONTACT

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Taking it to the Streets: Transforming Care Delivery

ST. LUKE'S CORNWALL HOSPITAL, NEWBURGH

YEAR PROGRAM STARTED
2012

PARTNERS
Elant, Inc.

Willcare

Good Samaritan Homecare

Helen Hayes Hospital

Premier Home Health Care

Wingate

Orange County Department of Health

PROGRAM DESCRIPTION AND GOALS

St. Luke's Cornwall Hospital's "Taking it to the Streets: Transforming Care Delivery" program is an innovative, transformative project that drastically changes how care is delivered. The program focuses on discharge planning and home follow-up initiatives that reduce avoidable readmissions and help patients and their caregivers play a more active role in their health care. A key strength of the program is the innovative approach to outreach and education with patients and caregivers by offering a supportive environment for making long-term health and lifestyle changes.

OUTCOMES

- Avoidable readmissions were reduced.
- The length of stay for congestive heart failure patients was reduced from 5.4 days to 4.0 days.
- Care coordination between different locations and levels of care has improved.
- The hospital has seen improved health outcomes and increased patient and caregiver support.

CONTACT

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Palliative Care Consult Program

ST. MARY'S HEALTHCARE, AMSTERDAM

YEAR PROGRAM STARTED
2006

PARTNERS
St. Mary's Healthcare clinical and ancillary services health services

Liberty Enterprises and Lexington (Services for the Developmentally Disabled)

Mountain Valley Hospice and Community Hospice of Amsterdam

Local physician offices and cancer medicine centers

Local long- and short-term care facilities including local nursing homes

Home health care agencies

PROGRAM DESCRIPTION AND GOALS

Palliative Care begins with the understanding that every patient has his or her own story and is worthy of respect as a unique individual. In 2006, the St. Mary's Healthcare Palliative Care Program began in response to a high number of chronically ill patients seen by the system who did not have comprehensive care plans that address end-of-life issues. Goals identified by this program include preserving the dignity of the patient while providing excellent clinical care, ensuring patient wishes are addressed in a cultural and spiritual manner, reducing hospitalizations, increasing the number of patients who make informed decisions and have advanced directives, facilitating effective care transitions, and other goals as individually defined.

OUTCOMES

- High patient satisfaction has been achieved, as evidenced by a rating of 4.7 out of 5.
- Seventy percent of palliative care patients were discharged from the hospital, with 30% going home with the comfort of hospice care.
- Patients experienced excellent symptom management, including pain that was well controlled 92% of the time with post-palliative care involvement.
- There has been a 60% increase in patients who identify and complete advanced directives that outline their wishes.
- The program serves more than 350 people each year.

CONTACT

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St. Peter's Hospital Ronald McDonald Care Mobile

ST. PETER'S HOSPITAL, ALBANY

YEAR PROGRAM STARTED
2005

PARTNERS
Ronald McDonald House Charities

Albany City School District

Rensselaer City School District

PROGRAM DESCRIPTION AND GOALS

The goal for the St. Peter's Hospital Ronald McDonald Care Mobile is to improve access to oral care and treatment for the under-served children in the community. Through this program, St. Peter's Hospital provides complete dental services to more than 1,250 children annually, many of whom would otherwise not have access to dental care. The program visits six elementary schools that were identified by their extremely high percentage of students eligible for free or reduced cost lunches, indicating that these are among our community's poorest children.

OUTCOMES

For the period October 1 through December 31, 2012:

- Number of children served: 399
- Number of appointments provided: 946
- Number of sites visited: 3

CONTACT

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Preserving Smiles for People with Disabilities

STRONG MEMORIAL HOSPITAL/UNIVERSITY OF ROCHESTER MEDICAL CENTER

YEAR PROGRAM STARTED
1975

PARTNERS
Eastman Institute for Oral Health

Monroe Community Hospital

Local and regional referral organizations, including the regional developmental disabilities service office; 25 agencies that serve people with disabilities, and more than 80 community residences

PROGRAM DESCRIPTION AND GOALS

The hospital's "Preserving Smiles" program is a patient-centered model of oral health care for individuals with intellectual, learning, or developmental disabilities. The program's keystone is the sensitivity training embraced by the dental team, which promotes the delivery of care that respects each person's dignity and unique needs. As the regional safety net provider for those with disabilities, the goals include:

- providing accessible dental care that preserves the dignity of individuals with special needs;
- completing as much dental care as possible in a regular dental setting and reserving treatment with anesthesia as a last resort;
- educating existing and future dentists, residents, and dental hygienists on best practices for treating patients with disabilities; and
- serving as a national model demonstrating "Excellence Without Exception."

OUTCOMES

- The Preserving Smiles program treats approximately 550 individuals each year and conducts more than 1,200 office visits. An average of five new patients per month, age 18 to 85 years, are seen in the dental office.
- In terms of acute care interventions, the hospital's dental surgeon has treated more than 2,800 patients over the last 20 years, averaging more than 140 annually.
- One of Preserving Smile's proudest accomplishments and valuable contributions has been the development and dissemination of training materials and audiovisuals to help existing and incoming practitioners improve the quality and efficiency of oral health care for patients with special needs.
- Effectively using a "train-the-trainer" model, the protocols, procedures, and philosophy are updated annually and shared with the dental staff and beyond in symposia and lectures offered throughout the year, across the region, and country.

CONTACT

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Brooklyn Free Clinic

SUNY DOWNSTATE MEDICAL CENTER, BROOKLYN

YEAR PROGRAM STARTED
2008

PARTNERS
Elected officials, local pharmacies, and an interdisciplinary group of health practitioners

PROGRAM DESCRIPTION AND GOALS

The student-run Brooklyn Free Clinic provides free primary care and preventive health services to all uninsured adults. The Clinic holds free patient education workshops on diabetes, nutrition, exercise, and mental health.

OUTCOMES

- Brooklyn Free Clinic implemented pre- and post-health workshop surveys. It also conducted pre- and post-assessments of disaster areas impacted by Hurricane Sandy.
- The program has developed community educators.
- In expanding the Brooklyn Free Clinic mobile efforts following the devastation of Hurricane Sandy, the hospital worked to canvas the affected areas with the aim of encouraging residents to come in and receive health care.

CONTACT

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Brooklyn PACT (Physicians and Community Together)

THE BROOKLYN HOSPITAL CENTER

YEAR PROGRAM STARTED
2011

PARTNERS
Brooklyn Hospital Department of Community Outreach and Community Advisory Board

Brooklyn Borough President's Office

The International High School at Prospect Heights

La Providencia Family Health Center

PROGRAM DESCRIPTION AND GOALS

The Brooklyn Hospital PACT program is an innovative addition to the hospital's pediatric residency training program. The goal of the program is to provide pediatric residents and community members with reciprocal opportunities to engage in collaborative health education work within the local community. The PACT program offers pediatric residents a diverse experience in community-based participatory advocacy beginning in the first year of residency. The program strives to engender familiarity and effective partnerships among health care professionals and the community that they serve.

OUTCOMES

- Medical residents report limited knowledge of or exposure to the community prior to involvement in the PACT program. Medical residents find the program helpful and useful in their interaction with the community.
- Expansion of the program to other departments has led to a general increase in interest in community health among hospital staff.
- There is an expansion of community partners each year following the community tour orientation.

CONTACT

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Care Transitions Coach Program

THE EDDY/NORTHEAST HEALTH, TROY

YEAR PROGRAM STARTED
2009

PARTNERS
Eddy Visiting Nurse Association

Albany Memorial Hospital

Samaritan Hospital

Seton/St. Mary's Hospital

St. Peter's Hospital

PROGRAM DESCRIPTION AND GOALS

The program's goals are to decrease the 30-day readmission rate 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), pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease (COPD), and diabetes. 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 72 hours of discharge, providing medication reconciliation, education, tools to manage their illness, and follow-up telephone calls once a week for 30 days. The coach ensures that a follow-up visit with the doctor is scheduled within seven days of the patient's hospital discharge.

OUTCOMES

- The combined readmission rates for CHF, COPD, and diabetes decreased from 25% to 13.4% in two years.
- Enrollment increased by 29%; 509 patients enrolled in 2010; this increased 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.

CONTACT

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Strong Women, Strong Hearts

UPSTATE UNIVERSITY HOSPITAL, SYRACUSE

YEAR PROGRAM STARTED
2012

PARTNERS
Upstate University Hospital

HealthLink Oasis Center

Empire State College

PROGRAM DESCRIPTION AND GOALS

Strong Women, Strong Hearts is a not-for-profit educational event offered to the women in the community, free of charge. This event was conceptualized, organized, and implemented by cardiovascular nurses from the Upstate University Hospital Coronary Care Unit. The mission of this event was to increase awareness about heart disease among women and educate them about ways to prevent it. To date, the hospital has been able to provide education to more than 800 women regarding heart disease and their risk factors. The hospital also offered stress management and fitness sessions, which included reiki, massage therapy, yoga, zumba, and belly dancing demonstrations. To make it more inviting, shopping was also made available from local vendors selling their wares and a heart-healthy lunch was provided to all participants.

OUTCOMES

- Women in the community are more aware of heart disease signs, symptoms, and prevention.
- This program has ensured that participants understand their health screening numbers and what they mean.
- Attendance increased from 350 in 2012 to more than 500 in 2013.

CONTACT

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Breast Cancer Navigation Program

WHITE PLAINS HOSPITAL

YEAR PROGRAM STARTED
2011

PARTNERS
Westchester County Department of Health and Government

Gilda's Club

The American Cancer Society

Patient and Family Services of Westchester

Westchester Jewish Community Services

White Plains and Scarsdale school districts and senior center

Bloomingdale's of White Plains

YMCA of White Plains

Gaucho Grill

42 at the Ritz Carlton

White Plains Police Benevolent Association

White Plains Library

Pace University and Iona College

PROGRAM DESCRIPTION AND GOALS

The goal of this program is to improve the coordination of cancer care through clinical navigation services and help save lives by coordinating care and facilitating access to cancer care services. In this role, the breast program clinical navigator guides patients as they make their journey through cancer treatment and the recovery process. By providing practical and emotional support, the breast program clinical navigator enables the patient to focus attention and energy elsewhere.

OUTCOMES

- **Community Partnerships:** In 2011. there were six; in 2012. there were 25.
- **Lecture Series Attendance:** There were 32 survivor participants from January to June 2012; from October 2012 to March 2013, there were 69 survivor participants.
- **Navigation Registrations:** From July 2011 to January 2012, there were 25 survivors; from September 2012 to February 2013. there were 41 survivors.
- **Support Group Attendance:** From January 2012 to June 2012, there were 14 survivors who attended; from September 2012 to February 2013, there were 17.

CONTACT

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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 for their programs that target specific community health programs, demonstrate leadership, collaborate among diverse groups, and, most importantly, achieve quantifiable results.

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, contact Sheila Taylor, Executive Assistant, at (518) 431-7717.

PREVIOUS COMMUNITY HEALTH IMPROVEMENT AWARD WINNERS

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

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

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

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

2008 **Jamaica Hospital Medical Center, Jamaica**
Palliative Care Collaborative

2007 **Rochester General Hospital, Rochester**
Clinton Family Health Center

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

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

2004 **NewYork-Presbyterian/Columbia University Medical Center, New York City**
Breast and Cervical Cancer Screening Partnership

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

2002 **Strong Memorial Hospital, Rochester**
Project Link

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

2000 **Harlem Hospital Center, New York City**
Injury Prevention Program

1999 **Women's Christian Association (WCA) Hospital, Jamestown**
Women's Health Initiative

1998 **United Health Services, Binghamton**
Pediatric Asthma Program

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