

CONNECTING WITH COMMUNITIES

Community Health Initiatives
Across New York State



Healthcare Association
of New York State

COMMUNITY HEALTH INITIATIVES ACROSS NEW YORK STATE

2015 COMMUNITY HEALTH IMPROVEMENT AWARD

WINNER

Bassett Healthcare Network
School-Based Health/Oral Health
Program

HONORABLE MENTIONS

Columbia Memorial Health
Mobile Dental Health Services
Program

Montefiore New Rochelle
Healthy Lifestyle—Fit WIC
Program

The Healthcare Association of New York State (HANYS) is pleased to present the 19th edition of ***Connecting with Communities: Community Health Initiatives Across New York State***, which highlights the winners and nominations for HANYS' 2015 Community Health Improvement Award.

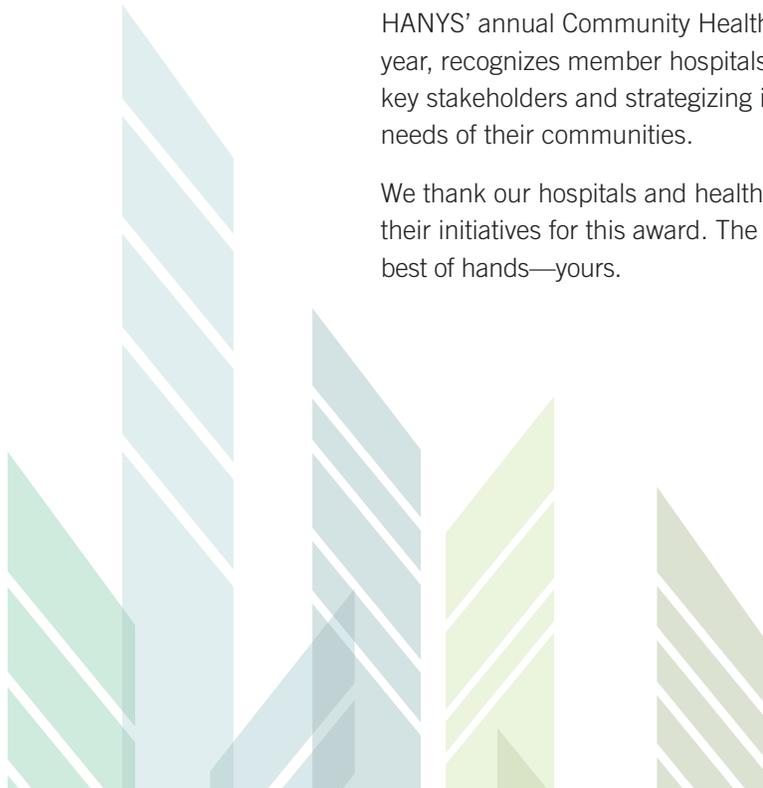
HANYS is proud to recognize the initiatives of our hospitals and health-care systems that are partnering to implement community benefit strategies in response to the imperatives of healthcare reform, as population health management gains momentum.

Recognizing that the health and well-being of our communities is at the center of healthcare reform, hospitals and healthcare systems are working diligently to achieve their community health goals under New York State's *Prevention Agenda 2013-2017*. Many of the innovative programs in this publication are linked to that *Agenda* and its goal to make New York State the healthiest state in the nation.

Hospitals are stewards of change at the heart of their communities, and HANYS continues its commitment to support their efforts to prevent disease and keep people healthy in their homes and communities. HANYS remains dedicated to helping members transition to patient-centered, integrated healthcare delivery models and develop ways to manage population health.

HANYS' annual Community Health Improvement Award, now in its 19th year, recognizes member hospitals and healthcare systems for engaging key stakeholders and strategizing in unique ways to meet the healthcare needs of their communities.

We thank our hospitals and health systems for submitting and sharing their initiatives for this award. The health of our communities is in the best of hands—yours.



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 needs, 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.

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Table of Contents

2015 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER:

- 1 Bassett Healthcare Network**
School-Based Health/Oral Health Program

2015 COMMUNITY HEALTH IMPROVEMENT AWARD HONORABLE MENTIONS:

- 2 Columbia Memorial Health**
Mobile Dental Health Services Program
- 3 Montefiore New Rochelle**
Healthy Lifestyle—Fit WIC Program

NOMINATED PROFILES:

- 5 Albany Medical Center**
Hypertension Initiative
- 6 Brookhaven Memorial Hospital Medical Center**
Diabetes Self-Management Education Program
- 7 Elizabethtown Community Hospital/
The University of Vermont Health Network**
Hunters' Health Screening
- 8 Ellis Medicine**
UMatter
- 9 Finger Lakes Health**
Walk and Talk for Health Program
- 10 Glens Falls Hospital**
Increasing Colorectal Screening Rates Using FIT Kits
- 11 Good Samaritan Hospital Medical Center**
Good Sam University Community Lectures
- 12 Jamaica Hospital Medical Center**
National Diabetes Prevention Program
- 13 Mount St. Mary's Hospital and Health Center**
Caring Smiles
- 14 Nicholas H. Noyes Memorial Hospital**
Kids Dig Dirt
- 15 North Shore-LIJ Health System**
Preparing for Life's New Journey
- 16 Northern Westchester Hospital**
Better in Balance—President's Junior Leadership Council
- 17 O'Connor Hospital/Bassett Healthcare Network**
GetOutAndWalk.org

Table of Contents (continued)

- 18 River Hospital**
River Community Wellness Program
- 19 St. Joseph's Hospital Health Center**
Center for Tobacco Health Systems
- 20 St. Mary's Healthcare**
Pregnancy Care Center
- 21 Upstate University Hospital**
The "She Matters" Program: Increasing Mammography
Screening in Under-served Women
- 22 WCA Hospital**
Improving Prenatal Care with Early Access and Integrated Services

WINNER**School-Based Health/Oral Health Program****BASSETT HEALTHCARE NETWORK, COOPERSTOWN****Year the Program Started: 2005****PARTNERS**

Cooperstown, Delhi, Edmeston, Morris, Laurens, Middleburgh, Milford, Schenevus, Sherburne-Earlville, Sidney, South Kortright, Stamford, Unadilla Valley, and Worcester central schools

New York State Oral Health Coalition

Otsego County Oral Health Coalition

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

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PROGRAM DESCRIPTION AND GOALS

The School-Based Health/Oral Health Program improves the oral health and, ultimately, the overall health of children and young people throughout the four counties it serves. It provides both preventive and restorative services, including comprehensive exams, cleanings, fluoride varnish, sealants, oral hygiene instruction, and assistance finding a dentist and dental insurance. For those most in need, it offers repair of caries, extractions, and root canals. These services are provided in collaboration with the primary medical and mental healthcare staff at 19 school-based health centers, all at no out-of-pocket cost to patients. This is a mature, successful program with an existing infrastructure that integrates somatic, mental health, and preventive dental services. The program addresses the New York State *Prevention Agenda* at several levels.

To make these services available, a dentist was hired and infrastructure was created within the sponsoring organization to provide restorative patient care. Systems were established to ensure proper electronic coding for scheduling patients, registering insurance, and billing. Additionally, the information technology department installed hardware and software to accommodate the new electronic dental record and digital radiography. Policies, procedures, and protocols were put in place for restorative and emergency after-hours care.

OUTCOMES

This program has significantly increased access to dental care and improved the oral health of children throughout Bassett's service area.

- In 2014, 2,160 students took advantage of preventive dental services; 439 students were deemed most in need and received treatment and restorative care.
- Oral health assessment has been integrated into students' well-child, sick, and school nurse visits. Oral health is considered whenever a student touches the school-based health system, regardless of the reason for the appointment.
- A comprehensive oral health program that includes treatment and restorative care was made available to students at three rural school-based health sites.



HONORABLE MENTION

Mobile Dental Health Services Program

COLUMBIA MEMORIAL HEALTH, HUDSON

Year the Program Started: 2007

PARTNERS

Catholic Charities of Columbia and Greene Counties—WIC

Columbia County School Districts: Chatham, Hudson, Germantown, Ichabod Crane, New Lebanon, and Taconic Hills

Greene County Schools: Cairo Durham, Catskill Central, Windham/Ashland Jewett Central, Coxsackie-Athens, and Hunter-Tannersville

Greene County Rural Health Network

Columbia County Healthcare Consortium

Columbia Opportunities

Columbia County Department of Health—Migrant Worker Farm Program

Community Foundations

New York State Department of Health Bureau of Dental Health

Greene County Early Childhood Learning Center

Greene County Department of Social Services

Greene County Legislature

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PROGRAM DESCRIPTION AND GOALS

Columbia Memorial's Mobile Dental Services provides comprehensive mobile dental services for residents in two counties, including children in grades Pre-Kindergarten to 12. The school-based mobile dental services include exams, x-rays, cleaning, sealants, and fluoride treatments by a licensed dentist and hygienist for students in local school districts and at Head Start sites. Services also include fillings, extractions, and other treatment for the care of dental decay.

In addition to mobile dental services, the dental program utilizes portable dental equipment for preventive dentistry in the school building, and education for parents and children. In alignment with the state's *Prevention Agenda*, oral health education and dental exams are provided in under-served communities, including Supplemental Nutrition Program for Women, Infants, and Children (WIC) sites and health fairs. Services are provided in a Dental Health Professional Shortage Area.

OUTCOMES

- Access to preventive dental treatment services for rural students and Medicaid/Children's Health Insurance Program recipients has improved.
- More than 3,500 patients have received dental services since the program began.
- The program has improved access to dental and preventive care and treatment for all age groups residing in under-served areas of two counties.
- Low-income populations are more aware of good oral health.

HONORABLE MENTION

Healthy Lifestyle—Fit WIC Program

MONTEFIORE NEW ROCHELLE

Year the Program Started: 2007

PARTNERS

New Rochelle YMCA

**New Rochelle and Mount Vernon
Public Libraries**

**Montefiore New Rochelle Pediatric
Clinic**

Local Pre-School Programs

Hispanic Coalition of Mamaroneck

**Latino/Hispanic Health Equity
Initiative**

**Westchester Jewish Community
Services**

**Boys and Girls Clubs of New
Rochelle**

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PROGRAM DESCRIPTION AND GOALS

The Healthy Lifestyle Program's (HLP) primary goal is the prevention of childhood obesity through increased consumption of low-fat/fat-free dairy and fruits and vegetables, and improved physical fitness. It provides nutrition education and instruction on being active and promotes fitness as fun. HLP measures and monitors body mass indices (BMI) and tracks improvement throughout the program in partnership with primary care physicians. Staff include certified dietitian nutritionists, registered dieticians, and certified personal trainers who provide nutrition education and safe activities. Parents/guardians participate with their children to ensure safety. Results are behavioral, and include making positive, healthy choices that are aimed at wellness sustainability through life-long change.

HLP's emphasis is on Focus 1 of the New York State *Prevention Agenda*: Reducing Obesity in Children and Adults. HLP directly supports multiple objectives of this agenda, including reducing the percentage of children and adults who are obese and creating community environments that promote and support healthy food/beverage choices and physical activity.

Obesity is linked to a rise in premature deaths and major health problems due to its role in the development of diabetes and cardiovascular disease, and these are particularly prevalent in the population Montefiore New Rochelle serves.

OUTCOMES

- The program has a 90% completion rate: 411 of 456 enrolled "at-risk" participants "graduated."
- Of the 411 enrolled at-risk participants, 250 lowered their BMI scores (61% success rate).
- Participants increased physical activity.
- Participants established better nutrition habits (consumption of low-fat dairy, more fruits/vegetables).

2015

NOMINATED FACILITIES



Hypertension Initiative

ALBANY MEDICAL CENTER

Year the Program Started: 2012

PARTNERS

American Heart Association

Albany Medical Center practices:

Albany Medical Center

(Clifton Park, Delmar, Latham, Malta, Round Lake, North Greenbush, and South Clinical Campus)

Malta Med Emergent Care

EmUrgentCare

(Coxsackie, Saugerties, and Glenville)

Albany Med Community Division

(Neurology: Albany, Clifton Park, and Troy; Endocrine: Albany; Gastroenterology and General Surgery: Kingston; and General: Poughkeepsie)

Allergy, Asthma, and Immunology

(Albany and Valatie)

AMC Neurosurgery

(Glens Falls, Greenwich, Kingston, and Wilton)

AMC Surgery

(Saratoga Springs)

General Pediatrics Group

Internal Medicine Group

Pediatrics Group (Latham)

Mid-HudsonCare Center

(AIDS and HIV Medicine)

Outpatient Physical Therapy

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PROGRAM DESCRIPTION AND GOALS

Albany Medical Center's Hypertension Initiative has made detection and treatment of hypertension a priority for its faculty practice of 425+ physicians and its community partners, thus making a significant difference in their patients' health by helping them get their "numbers under control" to lead healthier lives.

The program's goals are to improve treatment of high blood pressure by reaching every patient seen by Albany Medical Center physicians, enhancing collaboration in hypertension treatment between Albany Med's specialists and primary care doctors, and educating every employee about healthy lifestyles and hypertension. As both a protocol for chronic disease screening and an evidence-based approach to managing hypertension, this initiative supports a priority area of the New York State *Prevention Agenda 2013-2017*: preventing chronic diseases through preventive care and management.

OUTCOMES

- Albany Medical Center has developed protocols including following up on every patient whose blood pressure reading is above the norm (120 over 80), notifying the patient's primary care physician, and developing an individual treatment plan. Since adopting these protocols in 2012, the percentage of patients diagnosed with hypertension who were able to reduce their blood pressure through treatment rose from 66% in 2012 to 90% in 2014.
- As a result of this program, Albany Medical Center is collaborating with the region's primary care physicians in new and different ways, leveraging its expertise to impact the health of thousands of patients every year.
- As part of this initiative, "Know Your Numbers" is an ongoing, multi-faceted educational awareness program for Albany Med's more than 8,000 employees, informing them of key indicators of health, including high blood pressure, and encouraging them to get their numbers under control.

Diabetes Self-Management Education Program

BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER, PATCHOGUE

Year the Program Started: 2011

PARTNERS

American Diabetes Association

Juvenile Diabetes Research Foundation

Suffolk and Nassau County Lions Club

Bellport Community Garden

Sunvet Mall (Walking Club)

**Suffolk County Department of Health Services
(Diabetes Prevention Program)**

Bellport Primary Care Center

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PROGRAM DESCRIPTION AND GOALS

The Diabetes Self-Management Education Program offers educational classes, support groups, clubs, and activities focused on improving the lives of people with diabetes or at high risk for diabetes. The goals are to foster the individual's self-care practices through problem-solving and informed decision-making; and to improve the individual's overall health and quality of life. The approach is to provide a tailored, personal support system with tools and resources that enable each individual to make better choices in nutrition, exercise, medication management, and coping skills. Activities and clubs include: yoga, walking club, cooking demonstrations, and a garden club. In addition, the program supports collaboration with the patient's healthcare team to improve clinical outcomes.

The Diabetes Self-Management Education Program is part of Brookhaven's 2013 Community Service Plan to increase access to quality chronic disease preventive care and management in the clinical and community setting.

OUTCOMES

- Participation in diabetes educational classes increased from 30 participants in 2012 to 51 in 2014.
- Programming increased from nine educational sessions and seven lectures in 2013 to 52 classes, support groups, and clubs in 2014.
- Improved outcomes in behavioral goals in nutrition: In 2012, 16% of participants reached their individual goal; in 2013, 71% reached their individual goal; and in 2014, 100% met their individual goal for nutrition management.
- Improved outcomes in behavioral goals in physical activity/being active: In 2012, 33% of participants reached their individual goal; in 2013, 100% reached their individual goal; and in 2014, 88% reached their individual goal for physical activity.

Hunters' Health Screening

ELIZABETHTOWN COMMUNITY HOSPITAL/ THE UNIVERSITY OF VERMONT HEALTH NETWORK

Year the Program Started: 2005

PARTNERS

**Essex County Public Health
Department**

Essex County Sheriff's Office

**Department of Environmental
Conservation**

**Cancer Services Screening
Program of Essex and Franklin
Counties**

Cornell Cooperative Extension

Local Primary Care Physicians

**Local Exercise Specialist/Physical
Therapy**

Local Audiologists

Fidelis Care

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PROGRAM DESCRIPTION AND GOALS

Hunters exert themselves in areas that may be far from home and difficult to access by emergency personnel and without cellular service, so it is important that they have a yearly physical to ensure that there are no obvious health issues that make them vulnerable. This free health screening enables hunters, who tend to be remiss about yearly physicals, the opportunity to have a physical that will assess blood pressure, glucose, cholesterol, oxygen levels, electrocardiogram, vision, height, and weight, providing an overall health picture. Basic health evaluations allow physicians an opportunity to uncover physical conditions that can put individuals at risk. The hospital's mission includes protecting the health of its rural community, and the hunters' health screening demonstrates that.

OUTCOMES

- Fifty-two significant health issues were identified over the last five years of the program, ten of which involved an emergent health issue that needed immediate attention.
- The number of participating hunters has increased 221% (from 19 to 61) over the last five years. This is a significant increase in a very rural community.
- Community agencies that participate have grown from two to ten over the last five years.
- The hospital now hosts two other health screening nights to capture more adults in need of health screening—a Women's Health Screening and a Healthy Heart Screening.



UMatter

ELLIS MEDICINE, SCHENECTADY

Year the Program Started: 2012

PARTNERS

Schenectady County Public Health Services

Schenectady County Agencies

The Schenectady Foundation

The Chamber of Schenectady County

Schenectady YMCA

Hometown Health Center

Schenectady Community Action Program

Schenectady United Neighborhoods

Schenectady Inner City Ministry

Capital District Physicians Health Plan

Schenectady League of Women Voters

City of Schenectady

Union College

The University at Albany School of Public Health

Other non-profit organizations

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PROGRAM DESCRIPTION AND GOALS

“UMatter” was the name of a door-to-door and community survey that covered all ten neighborhoods of the city of Schenectady. The goal of UMatter was to gather neighborhood-level data to better understand the needs of the community, thereby informing targeted interventions. The broad-based coalition that has overseen this program from its inception has also played a major role in identifying and implementing evidence-based strategies to address community needs.

The results of the UMatter survey informed the development of Ellis’ Community Service Plan and the local health department’s Community Health Improvement Plan. These were submitted as a single document to the Department of Health. The coalition workgroups continue to work toward achieving the goals and objectives set forth in the plan.

OUTCOMES

- More than 2,000 surveys were completed across all ten neighborhoods of the city in a three-month period.
- This project brought together 70 diverse organizations to form a broad-based coalition.
- Ellis initiated 11 workgroups to implement the Community Action Plan.
- Funding was secured for survey implementation and workgroup activities, and the initiative continues to pursue other opportunities to support the coalition’s community health improvement initiatives.

Walk and Talk for Health Program

FINGER LAKES HEALTH, GENEVA

Year the Program Started: 2010

PARTNERS

Finger Lakes Health physicians, clinicians, and other staff

**Finger Lakes Health
College of Nursing students**

Local media outlets: *Finger Lakes Daily News, Finger Lakes Times, Reveille Between the Lakes, and Chronicle Express*

Local schools: Geneva, Waterloo, Seneca Falls, and Penn Yan

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PROGRAM DESCRIPTION AND GOALS

Since 2010, Finger Lakes Health has offered its Walk and Talk for Health program, where community members are encouraged to join with Finger Lakes Health healthcare providers for a brief walk and to start improving their health.

This program is an outgrowth of Finger Lakes Health's collaboration with county public health departments that identified similar health priorities: reducing obesity in children and adults, and reducing hypertension rates. Walking can help achieve both goals.

OUTCOMES

- In 2013, 146 community members participated in the Walk and Talk program, while 400 Finger Lakes Health employees participated in the Staff Steps program.
- In 2014, 172 community members participated and achieved 2,828,920 steps between Walk and Talk and walking on their own.
- In 2014, the employee Staff Steps teams accumulated more than 149 million steps.
- In 2014, 74 participants (ten business teams) across three counties competed in a business contest and reported more than 24 million steps over eight weeks.



Increasing Colorectal Screening Rates Using FIT Kits

GLENS FALLS HOSPITAL

Year the Program Started: 2010

PARTNERS

**Glens Falls Hospital and
The CR Wood Cancer Center**

**Gastroenterology Associates of
Northern New York**

**Business Improvement
Development of Glens Falls**

**Municipalities in Warren and
Washington counties**

**New York State Department
of Health**

**Warren and Washington county
public health departments**

CONTACT

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PROGRAM DESCRIPTION AND GOALS

This initiative aims to increase colorectal cancer screening rates in the Glens Falls area by simplifying the screening process and addressing common barriers of education, stigma, time, and distance. The percent of colorectal cancers caught at an early stage is significantly lower in this region of the state, by any measure. As the organization's health centers began focusing on population health, they identified the need for specific colorectal cancer screening education for staff and providers, as well as a contemporary screening test. Creative community action and social norming campaigns were actualized to bring the topic of colorectal cancer screening into the public conversation and make screening more accessible.

The initiative is linked to the *Prevention Agenda* and the hospital's Community Service Plan, whose stated priorities include the prevention of chronic disease and a focus on increasing access to care for all members of the community.

OUTCOMES

- Both primary care networks in the area have adopted the use of the FIT Kit.
- In 2010, just 23% of Cancer Services Program patients received colorectal cancer screening through the grant. By 2014, that number had more than doubled to 48%.
- Over the course of these same five years, the hospital's cancer registry reports the percentage of colorectal cancers diagnosed at an early stage to be on the rise, from 56% in 2010 to 67% in 2014.
- Community members now routinely call the Cancer Services Program office for information about colorectal cancer screening.

Good Sam University Community Lectures

GOOD SAMARITAN HOSPITAL MEDICAL CENTER, WEST ISLIP

Year the Program Started: 2012

PARTNERS

Bethpage Federal Credit Union

WALK 97.5 FM Radio

Sherry's The Healthy Gourmet

**Caring People Home
Healthcare Agency**

Teacher Federal Credit Union

Villa Monaco Restaurant

Lord & Taylor

Molloy College

Local Libraries

West Islip Fire Department

Wild By Nature

Shannon Falcone-Macleod, PC

Tropical Smoothie Café

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PROGRAM DESCRIPTION AND GOALS

Good Sam University (GSU) is a series of free health information and educational lectures for the community provided by physicians and experts from Good Samaritan Hospital Medical Center. The goals of the GSU lectures are to empower and educate the community to manage and be active in their healthcare decisions, and create and strengthen relationships between the community and the hospital.

GSU lectures are influenced by the needs of the community and the Community Health Needs Assessment. The three-lecture series—Women's Wellness, Aging Gracefully, and Food for Thought—are platforms to provide information on cardiology, cancer, diabetes, and nutrition. The lectures under each of these broad topics address information and education on new diagnostic procedures, treatment options, and awareness of health risk.

OUTCOMES

- Ninety-eight percent of attendees submit completed evaluation forms after lectures, providing demographic information and future lecture topic requests.
- Eighty-five percent provided email addresses and contact information for building relationships between the hospital and the community.
- Attendance for the newly-formatted lecture series increased by 62%.
- This series reached 979 community members in 2014.

National Diabetes Prevention Program

JAMAICA HOSPITAL MEDICAL CENTER

Year the Program Started: 2013

PARTNERS

**Medicaid Insurance Providers
(patient referrals)**

CONTACT

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PROGRAM DESCRIPTION AND GOALS

The National Diabetes Prevention Program is a year-long program facilitated by Jamaica Hospital Medical Center's primary care patient navigation staff. The organization has 19 facilitators who are trained as Lifestyle Coaches by the New York State Quality and Technical Assistance Center, and the sessions are run according to Centers for Disease Control and Prevention (CDC) and Diabetes Recognition Program standards.

The National Diabetes Prevention Program has shown a 58% reduction in participant risk of developing diabetes, while adults over the age of 60 were able to reduce their risk by 71%. Jamaica Hospital Medical Center facilitates this program in English and Spanish to accommodate the patient population. The goal is to help patients incorporate healthy lifestyle modifications to reduce their risk of developing diabetes while improving the health and well-being of the community.

OUTCOMES

- Participants have exhibited significant weight loss and have shown significant increase in physical activity, both of which are CDC outcome components.
- Additionally, the Medicaid Center has begun tracking A1C levels and has found that one of its participants has decreased their A1C level from 6.1 to 5.6. The organization is confident that as more data become available, similar outcomes will continue.



Caring Smiles

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

Year the Program Started: 2013

PARTNERS

Local not-for-profit clinic

Local professional society

Local food pantry

County health organization

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PROGRAM DESCRIPTION AND GOALS

The Caring Smiles Program is a collaborative with a local not-for-profit clinic to provide dental services to the adult poor in the Mount St. Mary's Hospital and Health Center community. It provides a wide array of services to the targeted population, including a dental program for individuals challenged by physical, mental, and financial disability.

The program utilizes the clinic's current service professionals, location, and process so that the uninsured who receive primary care via the Health Center can be connected with these critical services. Using grant funding, Mount St. Mary's reimburses the partner not-for-profit clinic at a discounted fee schedule.

OUTCOMES

- A total of 202 individuals were served through 539 patient visits.
- Cooperative work with another not-for-profit has yielded operational efficiencies.
- Collaboration with a local professional medical society fosters increased involvement.
- Obtaining full engagement of the partners has promoted sustainability.

Kids Dig Dirt

NICHOLAS H. NOYES MEMORIAL HOSPITAL, DANSVILLE

Year the Program Started: 2010

PARTNERS

Noyes Health community health education staff

Cornell Cooperative Extension Master Garden program staff

Director, staff, and children of the childcare program

Parents and siblings of children attending the childcare program

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PROGRAM DESCRIPTION AND GOALS

Kids Dig Dirt is an initiative that installs vegetable gardens at childcare locations in a different town each year. The objective is to have gardens in each of the 16 towns in the county. The first goal is to raise awareness of the importance of eating vegetables as snacks and part of lunch, and second, to educate the parents of these children about the importance of including fresh vegetables in families' diets.

The childcare staff, parents, and children participate in the gardens from start to finish, including planning, planting, weeding, harvesting, and preparing the fruits and vegetables for snacks and lunches. This project is part of the hospital's work with the county and state *Prevention Agenda* to reduce obesity in children and adults.

OUTCOMES

- Parents reported an increase of 50% in the percentage of children who are eating a new vegetable they would not have eaten before.
- All providers are offering healthy snacks and including more fresh vegetables from the gardens at lunch.
- Providers reported an increase of 33% in the number of children who will readily eat a new vegetable.



Preparing for Life's New Journey

NORTH SHORE-LIJ HEALTH SYSTEM, GREAT NECK

Year the Program Started: 2011

PARTNERS

**North Shore-LIJ Health System:
Office of Community & Public
Health; Departments of Obstetrics
and Gynecology; Pediatrics;
Psychiatry; Nursing Education;
Katz Institute for Women's Health**

New York State Safe Kids Coalition

**Hofstra North Shore-LIJ School of
Medicine**

**Nassau County Social Services
Department**

**Prenatal Care Assistance Program
coordinators (New York City)**

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PROGRAM DESCRIPTION AND GOALS

Preparing for Life's New Journey (PFLNJ) is a comprehensive educational program designed to educate, help, and support expectant parents at the end of the second/beginning of the third trimester of pregnancy as they plan for the arrival of their babies. The goal is to improve the physical and mental health of new parents and help ensure optimal outcomes for newborns. PFLNJ is divided into four sections: Preparing for Your Baby's Arrival; Caring for Your Baby; Caring for Yourself After Birth; and Making the Transition into Parenthood.

Given that having a center of care/access to care throughout life ensures enhanced health outcomes, this program begins with health before birth. Expertise in perinatal mood disorders, injury prevention, safety, pediatric care, and nutrition is provided.

Both the New York State *Prevention Agenda* and the *National Prevention Strategy* have been incorporated into the health system's strategic plan. North Shore-LIJ's approach has been to partner with communities to inform, enable, empower, and incentivize people to make the impactful behavior changes that will allow them to take an active role in their health and well-being and live healthier lifestyles. North Shore-LIJ's programs are sustainable, scalable, cost-effective, and replicable.

OUTCOMES

- The 320 participants in the PFLNJ program completed the comprehensive course and went on to successfully deliver their babies.
- Formal evaluations revealed that 100% of participants found that the course met or exceeded their expectations and was effective in terms of stress reduction, knowledge-building, access to community resources and support networks, reassurance, and confidence-building.
- The reported incidence of perinatal mood disorders among program participants was 1.8% compared with estimated national averages as high as 20%.
- Demand for the course remains high, as each course has been oversubscribed.

Better in Balance—President's Junior Leadership Council

NORTHERN WESTCHESTER HOSPITAL, MOUNT KISCO

Year the Program Started: 2013

PARTNERS

**Bedford, Byram Hills,
Katonal-Lewisboro, Yorktown,
Chappaqua, North Salem, Somers,
and Pleasantville Union Free
school districts**

Chappaqua Library

Boys and Girls Club of Mount Kisco

Chappaqua Recreation

Mt. Kisco Chamber of Commerce

Muscot Farm

Local farmers' markets

Yorktown Chamber of Commerce

Neighbors Link

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PROGRAM DESCRIPTION AND GOALS

In 2013, members of the hospital's President's Junior Leadership Council (PJLC) decided to create a campaign for healthy habits (primarily nutrition and physical activity) called "Better in Balance" to promote an achievable and sustainable healthy lifestyle. The students created an "advertisement" to embody the theme and "sell health." The campaign aimed to reach a wide audience through interactive learning stations ("Wheel of Nutrition"), formal lesson plans used in schools by hospital dietitians and council volunteers, and a social media campaign that includes Twitter, Instagram, and a Quick Response Code.

Westchester County has designated chronic disease as a priority area for its *Prevention Agenda* efforts. Diet and physical activity habits significantly impact risk of chronic diseases including diabetes, heart disease, and cancer. It is also the mission of Northern Westchester Hospital to improve the health of the community. PJLC is committed to improving the health, safety, and well-being of adolescents and young adults in Northern Westchester. Volunteer students chose to tackle the issues of nutrition and exercise because of their great potential to improve both long- and short-term health.

OUTCOMES

- Health messages reached students in eight Westchester school districts via poster promotion.
- Better in Balance lessons reached more than 5,000 youth via 100 programs and events.
- Students of PJLC and their peers learned how to promote health messages through lessons, advertisements, and social media.
- Five hundred health "advertisements" were printed (more than half have been distributed around the community to date), receiving attention and accolades from all who see them.

GetOutAndWalk.org

O'CONNOR HOSPITAL/BASSETT HEALTHCARE NETWORK, DELHI

Year the Program Started: 2013

PARTNERS

**Tri-Town Regional Hospital/
Bassett Healthcare Network**

**Health Alliance—Margaretville
Hospital**

UHS Delaware Valley Hospital

**Cornell Cooperative Extension of
Delaware County**

**Delaware County Public Health and
Nursing Services**

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PROGRAM DESCRIPTION AND GOALS

GetOutAndWalk.org is a collaborative initiative comprised of O'Connor Hospital, the local health department, three additional hospitals located within the county, and the local Cooperative Extension office. GetOutAndWalk.org uses the three Ps for an effective population health intervention—programs, projects, and policies—to address the hospital's Community Service Plan and reduce obesity in Delaware County. The programs include Prescription Trails and a 1,000 Mile Challenge. Projects include the marking, mapping, and promoting of walking routes and hiking trails; encouraging municipalities and large employers to adopt "Complete Street" practices and policies; and promoting Complete Street projects. Information and resources for all the projects, programs, and policies are hosted on the GetOutAndWalk.org website.

The initiative started in 2013 when the hospital wrote its Community Health Needs Assessment and Community Service Plan and addresses the New York State *Prevention Agenda's* Prevent Chronic Diseases focus area.

OUTCOMES

- The four hospitals in the county, representing three healthcare systems, are collaborating at unprecedented levels to address the county's healthcare needs. The outcomes are measurable in the hospitals' Community Service Plan updates.
- Three municipalities have passed Complete Street policies in Delaware County.
- More than 600 community members registered to participate in a 1,000 Mile Challenge.
- One municipality and one school system opened their adjoining property for public use. Four miles of hiking trails were built, and trail use is tracked by a counter and a sign-in box.

River Community Wellness Program

RIVER HOSPITAL, ALEXANDRIA BAY

Year the Program Started: 2013

PARTNERS

Fort Drum Behavioral Health

Tri-Care Service Provider

Jefferson County Community Services

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PROGRAM DESCRIPTION AND GOALS

The River Community Wellness Program is an intensive outpatient treatment program that serves the mental health needs of active duty service members stationed at Fort Drum who suffer from post-traumatic stress. The program focuses on building coping skills and providing education and support to soldiers who have been impacted by the horrors of combat. By establishing this program, River Hospital also had the professional staff necessary to make mental health services available to the residents of the surrounding communities.

One of the items in River Hospital's Community Service Plan is to promote mental health and prevent substance abuse. Developing the River Community Wellness Program provided this opportunity to make mental health services available to the local population, as well as the military.

OUTCOMES

- Inpatient length of stay is being reduced through continuity of care, if hospitalization is required.
- There was a 15% improvement in the Global Assessment of Functioning score from 2013 to a score of 99% in 2014.
- There was a 9% improvement from 2013 to 2014 in depressive symptoms in soldiers as measured by the Patient Health Questionnaire screening score.



Center for Tobacco Health Systems

ST. JOSEPH'S HOSPITAL HEALTH CENTER, SYRACUSE

Year the Program Started: 2004

PARTNERS

Eight federally qualified health centers

Twelve primary care, dental, and other clinics

Four specialty physician offices

Six behavioral health centers

One college health office

Six hospitals

Three chiropractic groups

One rescue mission

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PROGRAM DESCRIPTION AND GOALS

This comprehensive program offers technical assistance and staff support to help implement “best practice” clinical practice guidelines across a 14-county catchment area, identifying target organizations (federally qualified health centers, mental health facilities, and practices serving the at-risk and in need), and communicating with senior administrators who work to positively affect their clinical practices sites. To achieve sustainability in practice sites, the program goals focus on targeting policy change to affect patients’ smoking behaviors.

St. Joseph’s Community Health Needs Assessment Implementation Strategy Plan 2013-2016 focuses on community health initiatives collaboratively identified by the Department of Health and area hospitals. Related to Center for Tobacco and Health Systems initiatives, the plan outlines a need to “reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.”

OUTCOMES

- The program’s reach was expanded from three to 14 counties.
- The program’s sustainability was improved by switching from a clinical to an administrative focus.
- This initiative achieved more than 15 policy adoptions/augmentations in the last two years alone.
- A tobacco treatment policy template was created that has now been implemented by seven organizations.

Pregnancy Care Center

ST. MARY'S HEALTHCARE, AMSTERDAM

Year the Program Started: 1982; restructured in 2013

PARTNERS

Community maternity services

Domestic violence program

Legal Aid Society

Addiction services

Public health agency

New York State Troopers

Children's Aid Society

Multiple school districts

Tobacco-Free Coalition

Supplemental Nutrition Program
for Women, Infants, and Children
(WIC)

Planned Parenthood

Latino Outreach Program

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PROGRAM DESCRIPTION AND GOALS

In 1982, St. Mary's Healthcare identified the need to provide special care to low-income, high-risk pregnant women. Services were designed to provide access to early, consistent prenatal care to women who have limited resources. In 2013, the identification of a larger need—"wrap-ping" services around a pregnant woman and her family—changed the breadth of the program. A nurse navigator provides integrated lactation, childbirth, and nutrition education; facilitated enrollment; and patient advocacy. Multidisciplinary professionals, including a board certified obstetrician/gynecologist, registered nurse, dietician, and support staff, integrate clinical care with comprehensive education and referrals to community-based resources. The unique needs of each woman are considered and identified at the first appointment; re-evaluation occurs with every appointment, with a focus on empowering women to participate in their own care.

Teenage pregnancy, low birth weight babies, the benefits of breastfeeding, and the problem of addicted mothers were all identified in the state's *Prevention Agenda*. More than 43% of the women who seek services at the program are under 20 years of age. All of the 77 pregnant females who received services in 2014 received education from a lactation specialist. The team has integrated lactation education, support, and counseling into its regular visits. The program has built a collaborative model of care with a local addictions program to provide care for expectant mothers enrolled in methadone or subutex treatment programs.

OUTCOMES

- In two years, more than 160 women received services from the program.
- The program exceeded rates for successful early entry (84% compared to a cohort average of 63%) and post-partum return visits (83% compared to 2009 New York State Medicaid population average of 58%).
- Of the 77 new patients seen in 2014, only one baby was below birth weight.
- All new patients were evaluated for enrollment in Medicaid or a qualified insurance plan and were coached at every appointment by a registered dietician.

The “She Matters” Program: Increasing Mammography Screening in Under-served Women

UPSTATE UNIVERSITY HOSPITAL, SYRACUSE

Year the Program Started: 2014

PARTNERS

**Upstate Cancer Center and Upstate
Office of Diversity and Inclusion**

**Upstate Foundation and Upstate
Department of Public Health**

Syracuse Housing Authority

**Onondaga County Cancer Services
Program Partnership**

**Breast cancer community support
groups**

**Susan G. Komen Foundation of
Central New York**

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PROGRAM DESCRIPTION AND GOALS

Effective breast cancer screening exists through mammography, but not all women take advantage of this for early breast cancer detection, especially lower socio-economic women of color. Low-income, inner-city African American women are most at risk of having the highest levels of late-stage diagnosis.

The goal of this initiative is to reduce breast cancer health disparities in low-income women, focusing on African American women who live in public housing. The program uses specially-trained Resident Health Advocates (RHAs) and Community Health Workers to increase breast cancer awareness and increase the rates of screening mammography in under-served women.

This successful program has demonstrated the effectiveness of using RHAs to educate their peers about breast cancer prevention and the importance of screening and early detection.

Managing chronic diseases such as cancer is a priority identified in Upstate University Hospital's Community Needs Assessment. This is aligned with the New York State *Prevention Agenda* goal to increase the percentage of cancer cases diagnosed at an early stage of disease in New York residents to at least that of the Healthy People Goal of a 25% increase (from the 2000 to 2004 baseline).

OUTCOMES

- Increase the number of women age 40 years and older who get annual mammograms: 76 have had mammograms, with more than 50% never having had one or having been out of compliance with the recommended screening schedule.
- Provide access to breast health education for all women: 220 women are currently in the She Matters program and have received education.
- Eliminate barriers to care and help women navigate the continuum of recommended care: the use of regional health services helps women get the needed services and care.
- Increase access to free and reduced-cost services: six women have been referred to the County Cancer Services Program Partnership.

Improving Prenatal Care with Early Access and Integrated Services

WCA HOSPITAL, JAMESTOWN

Year the Program Started: 2013

PARTNERS

Local health department/health and human services

Local hospitals

Prenatal clinic physicians and support staff

Community health workers

Area medical transportation representatives

Office of Medicaid Representatives

Hispanic Outreach

Teenage Education and Motherhood (TEAM)

Family Planning

Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Women's Services

Tobacco cessation program

High school clinic nurse

Hospital behavioral health/substance abuse specialist

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PROGRAM DESCRIPTION AND GOALS

This multi-collaborative initiative provides opportunities to increase access to early prenatal care for women who are under-served, uninsured, or who lack resources to access prenatal care in the first trimester. This initiative is also focused on promoting and integrating preventive and disease management programs such as tobacco cessation, lactation consulting, and behavioral health specialists to women dealing with chemical dependency and substance abuse during their pregnancy and post-partum.

This initiative is directly aligned with this hospital's Community Service Plan and the county health department's goals and objectives selected from the *Prevention Agenda's* "Promoting Healthy Women, Infants, and Children" priority area. The county/hospital collaborative goal is to increase utilization of preventive health services among women of reproductive age to improve wellness and pregnancy outcomes, and reduce recurrence of adverse birth outcomes with early prenatal care in the first trimester.

OUTCOMES

- **Improved access to early prenatal care/increased obstetric providers:** Seven board certified physicians increased prenatal visits by 500 (10%) from 2013 through 2014, meeting the initiative's goal.
- **Decreased tobacco use during pregnancy and post-partum:** 105 pregnant women referred to tobacco-free program; 50 in counseling; 20 (40%) remain tobacco-free, exceeding goal.
- **Improved transportation:** All pregnant women, regardless of their age or address, are covered for Medicaid medical transportation to prenatal and six-week post-partum appointments in the county, meeting goal.
- **Improved referral process:** 98% of prenatal clinic patients are referred to the Community Health Worker program, meeting the initiative's goal.

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