Connecting with Communities:
Community Health Initiatives Across New York State

2016 Edition
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.
Community Health Initiatives Across New York State

The Healthcare Association of New York State (HANYS) is proud to offer *Connecting with Communities: Community Health Initiatives Across New York State*, which highlights the 2016 Community Health Improvement Award winners and nominees. As we celebrate our 20th Annual Community Health Improvement Award, HANYS is honored to recognize our members’ hard work and commitment to improving the health and well-being of our communities.

As a result of seismic changes in the healthcare landscape, today community health initiatives look dramatically different from the late 1990s when HANYS presented the first Community Health Improvement Award. As hospitals and health systems respond to the demands of healthcare reform and move toward population health management, they are strategizing with a broader range of partners to develop, implement, and measure multifaceted community benefit initiatives that prevent disease and keep people healthy. Projects are more innovative, evidence-based, and sustainable. New synergies are strengthening efforts to address income, ethnicity, education, and other disparities that are barriers to achieving the highest level of health for everyone.

Hospitals and healthcare systems continue to work diligently to achieve their community health goals under New York State’s *Prevention Agenda 2013-2018*. Many of the innovative programs in this publication are linked to the *Prevention Agenda* and its goal to make New York State the healthiest state in the nation.

HANYS’ annual Community Health Improvement Award recognizes member hospitals and healthcare systems for their outstanding programs to improve community health. Many thanks to our hospitals and health systems for submitting and sharing their initiatives. While a lot has changed since HANYS launched the Community Health Improvement Award two decades ago, much has remained the same. These initiatives represent the tremendous work of passionate people who put their patients and communities first, and we are proud to support their efforts today—and for the next 20 years.
20 Years of Community Health Improvement Award Winners

2016
- Strong Memorial Hospital, Highland Hospital (UR Medicine) Rochester
- Rochester General Hospital, Unity Hospital (Rochester Regional Health) Rochester
- High Blood Pressure Collaborative—Hospital Partners

2015
- Bassett Healthcare Network Cooperstown
- School-Based Health/Oral Health Program

2014
- Bassett Medical Center Cooperstown
- Cancer Screening Outreach—Medical Screening Coach

2013
- Arnot Health at St. Joseph’s Hospital Elmira
- Chemung County School Readiness Project

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
HANYS’ 20 YEARS
Community Health Improvement Award

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
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 Manhattan
Injury Prevention Program

1999
Women’s Christian Association 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
# TABLE OF CONTENTS

## 2016 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

<table>
<thead>
<tr>
<th></th>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strong Memorial Hospital, Highland Hospital (UR Medicine) Rochester General Hospital, Unity Hospital (Rochester Regional Health) High Blood Pressure Collaborative—Hospital Partners</td>
</tr>
</tbody>
</table>

## 2016 COMMUNITY HEALTH IMPROVEMENT HONORABLE MENTION

<table>
<thead>
<tr>
<th></th>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Good Samaritan Hospital Medical Center Healthier Families Program</td>
</tr>
</tbody>
</table>

## 2016 NOMINATED PROFILES

<table>
<thead>
<tr>
<th></th>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Arnot Health Sodium Reduction Project</td>
</tr>
<tr>
<td>4</td>
<td>Brookhaven Memorial Hospital Medical Center Bellport Primary Care Center Community Wellness Initiative</td>
</tr>
<tr>
<td>5</td>
<td>Calvary Hospital Bereavement Support for Adults, Teens, and Young Children</td>
</tr>
<tr>
<td>6</td>
<td>University of Vermont Health Network—Champlain Valley Physicians Hospital Breastfeeding Advocacy and Support Initiative</td>
</tr>
<tr>
<td>7</td>
<td>Columbia Memorial Hospital Safe Sitter®</td>
</tr>
<tr>
<td>8</td>
<td>Cortland Regional Medical Center NYS Breastfeeding Quality Improvement in Hospitals Learning Collaborative</td>
</tr>
<tr>
<td>9</td>
<td>Finger Lakes Health Choose Health Action Teen (CHAT) Program</td>
</tr>
<tr>
<td>10</td>
<td>Flushing Hospital Medical Center A Healthier Community: Implementation of the National Diabetes Prevention Program</td>
</tr>
<tr>
<td>11</td>
<td>Glens Falls Hospital Lung Cancer Screening and Prevention Program</td>
</tr>
<tr>
<td>12</td>
<td>Jamaica Hospital Medical Center Cigarette Free—Healthier Me</td>
</tr>
<tr>
<td>13</td>
<td>Long Island Jewish Medical Center Cancer Community Connection Program</td>
</tr>
<tr>
<td>No.</td>
<td>Hospital Name</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>14</td>
<td>Montefiore Hospital Medical Center</td>
</tr>
<tr>
<td>15</td>
<td>Montefiore Nyack Hospital</td>
</tr>
<tr>
<td>16</td>
<td>NewYork-Presbyterian/Allen Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Nicholas H. Noyes Memorial Hospital</td>
</tr>
<tr>
<td>18</td>
<td>Northern Westchester Hospital</td>
</tr>
<tr>
<td>19</td>
<td>Northwell Health</td>
</tr>
<tr>
<td>20</td>
<td>Olean General Hospital</td>
</tr>
<tr>
<td>21</td>
<td>Putnam Hospital Center</td>
</tr>
<tr>
<td>22</td>
<td>River Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Southampton Hospital</td>
</tr>
<tr>
<td>24</td>
<td>St. John's Episcopal Hospital</td>
</tr>
<tr>
<td>25</td>
<td>St. Joseph's Hospital Health Center</td>
</tr>
<tr>
<td>26</td>
<td>St. Mary's Healthcare</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>St. Peter's Health Partners</td>
</tr>
<tr>
<td>28</td>
<td>WCA Hospital</td>
</tr>
</tbody>
</table>
2016
WINNER
High Blood Pressure Collaborative—Hospital Partners

STRONG MEMORIAL HOSPITAL, HIGHLAND HOSPITAL (UR Medicine)
ROCHESTER GENERAL HOSPITAL, UNITY HOSPITAL
(Rochester Regional Health)
Rochester

PROGRAM DESCRIPTION AND GOALS

Strong Memorial and Highland hospitals (UR Medicine) and Rochester General and Unity hospitals (Rochester Regional Health) work in partnership with the High Blood Pressure Collaborative to improve control of hypertension in Monroe County. The Collaborative is a partnership of the Greater Rochester Chamber of Commerce and Finger Lakes Health Systems Agency, healthcare providers, and community organizations focused on improving health and reducing costs in the region. The hospitals are critical partners in the implementation of the nation’s first community-wide high blood pressure registry. The Blood Pressure Advocate Program, the Practice Improvement Consultant initiative, and Worksite Wellness efforts are innovative and successful interventions developed to achieve an 85% blood pressure control rate among adult patients with hypertension. Mechanisms to sustain continued funding to support the Collaborative have also been established.

LINKS TO THE PREVENTION AGENDA

The 2013-2016 Community Health Improvement Plan/Community Service Plan for each of the hospitals is consistent in listing “Increasing access to high-quality chronic disease prevention care and management in clinical and community settings” as a focus area. Evidence-based interventions from the Prevention Agenda inform the work of the hospitals, and the Prevention Agenda dashboards help to track success against state objectives.

OUTCOMES

• Over the past five years, hypertension control for adults in Monroe County has improved 13.7%, an increase of more than eight percentage points.
• Today, 71.3% of adults in Monroe County who have been diagnosed with hypertension have their blood pressure under control—compared to the national average of 52%.
• To date, the Blood Pressure Advocate Program has served more than 1,300 patients, and 496 patients have achieved controlled blood pressure, with 83% of the engaged patient populations reporting positive health changes.
• Blood pressure control rates in practices using a Practice Improvement Consultant improved from 72% in December 2013 to 81% in June 2015.
Healthier Families Program
GOOD SAMARITAN HOSPITAL MEDICAL CENTER, WEST ISLIP

PROGRAM DESCRIPTION AND GOALS
The Healthier Families Program is designed to educate and encourage students, parents, and guardians on the importance of adopting healthy lifestyle choices, healthy nutrition, and daily participation in physical activities. Classes are structured to provide educational formulae to achieve the long-term goal of good health for participants. Enrollment criteria: Grades 3 to 5 with a Body Mass Index in the 85th percentile or above.

Over ten weeks, students/parents/guardians must demonstrate commitment to the program by attending nutritional sessions together. Weight, height, body mass index (BMI), and measurement tracking are taken beginning, midway, and at the program’s conclusion. A multidisciplinary team including Good Samaritan, the school district, and the Community Wellness Alliance coordinate this effort. There is no fee to enroll.

LINKS TO THE PREVENTION AGENDA
Strategies include “Healthy Sundays,” an outreach program that offers free health screenings and immunizations to under-served and uninsured individuals at local parishes, and community educational lectures. The Bariatric Center of Excellence Program provides educational seminars to the public and support groups four times a month to address obesity. Good Samaritan’s employee health department has established initiatives such as an employee wellness committee, and the nutrition and food services department has established programs such as providing on-site farmers markets, serving heart-healthy meals with enhanced salad bars, and reducing the availability of sugary soft drinks in favor of water for both staff and patients.

OUTCOMES
• At least 50% of the students demonstrated relevant improvement in height/weight/BMI at the end of the ten-week session.
• Ninety percent of both students and parents demonstrated a greater knowledge and awareness of the importance of a healthy lifestyle.
• Eighty percent of student participants achieved a set goal of 500 minutes of exercise by the conclusion of the Healthier Family Session (the 500 minutes includes only exercise greater than ten minutes at a time, demonstrated on any one piece of equipment).
• Due to success and enthusiasm, a number of children and parents/guardians have repeated the program.
Sodium Reduction Project
ARNOT HEALTH, ELMIRA

PROGRAM DESCRIPTION AND GOALS
The Sodium Reduction Project is a collaborative effort among the public health department, healthcare systems, senior meal providers, a rural health network, local chefs, dieticians, and others in the community. The project aims to reduce sodium content in foods served in senior meal programs, skilled nursing facilities, and hospitals by 10% each year for three years. A baseline assessment was conducted to determine the most effective methods of reducing sodium levels and changes were implemented to meet these goals and objectives.

LINKS TO THE PREVENTION AGENDA
The 2013-2018 Prevention Agenda focuses on two key areas: reducing obesity in children and adults; and reducing illness, disability, and death related to heart disease and hypertension. The Sodium Reduction Project supports these objectives directly by providing an opportunity to systemically reduce sodium in prepared meals and promote a heart-healthy diet.

OUTCOMES
• In the first year of implementation, overall sodium content was reduced at five sites in two counties by 11.9%, exceeding the projected goal of 10% per year.
• In addition, Arnot Health introduced lower sodium “Well Being” meals and reduced sodium at Arnot Ogden Medical Center by 25.5%, St. Joseph’s Hospital by 21.9%, and Ira Davenport Memorial Hospital by 16.5% in the first year.
• More than 80 menu items were altered to reduce sodium levels and distributed through senior meal programs and healthcare systems to the most at-risk residents.
• Salt shakers have been removed from all cafeteria tables with no negative impact on customer satisfaction or organizational profitability.
Bellport Primary Care Center Community Wellness Initiative
BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER, PATCHOGUE

PROGRAM DESCRIPTION AND GOALS
Brookhaven Memorial Hospital Medical Center’s Bellport Primary Care Center opened in April 2014 to address a longstanding, critical need to create a medical home for local residents, and a community hub that partners with civic, religious, and educational groups to promote wellness and improved health outcomes.

This community severely lacked access to quality healthcare services and did not have any primary care providers. Residents often utilized emergency rooms to address their medical issues.

The goals of the Community Wellness Initiative are to provide high-quality accessible primary care, promote wellness and healthy living by engaging and partnering with community members and groups, and establish/maintain a comprehensive primary care center that will decrease acuity of patient illness and thus reduce emergency room visits by 20%.

OUTCOMES
- Access to Care: Volume increased more than 50% from 2014 to 2015. Total number of 2015 visits: 4,156.
- Preventive Care: 180 flu vaccinations were provided in 2015.
- Education/Outreach: Diabetes screenings, blood pressure screenings, and community health education fairs.
- Completion of hba1C test for patients with diabetes was 83% in fourth quarter of 2015.
Bereavement Support for Adults, Teens, and Young Children
CALVARY HOSPITAL, BRONX

PROGRAM DESCRIPTION AND GOALS
Calvary's evidence-based bereavement support is available to anyone, of all faith traditions, cultures, and backgrounds, who has lost a loved one, whether at Calvary Hospital, Calvary Home Hospice, or the community at large. All bereavement support is free of charge, including ten discrete groups for adults, young adults, teens, and young children, and an annual week-long summer bereavement camp for children and teens. Groups meet in Bronx, Brooklyn, and Manhattan. The goal is to help participants find healthy, therapeutic interventions for expressing grief within a safe, non-judgmental, supportive environment. Calvary uses pet therapy, journal writing, rituals, and holiday workshops to find ways of remembering loved ones and continuing with life.

OUTCOMES
• Mental health and well-being are strengthened by serving 700 to 800 individuals each year through bereavement support groups (including a group for Spanish-speaking participants), grief workshops, educational programs, and through Camp Compass for 85 children and teens.
• An additional 200 to 300 people are served outside the New York City metropolitan area annually through referrals and outreach.
• The program was expanded in 2015 to offer “The First Day”—a new, ten-week, unique, meaning-centered psychotherapy group program for people who have completed a bereavement support group and are ready to take the next step.
• A bereavement newsletter is published for more than 5,000 recipients, including those who have lost loved ones, and for counselors and funeral directors.
Breastfeeding Advocacy and Support Initiative
UNIVERSITY OF VERMONT HEALTH NETWORK—CHAMPLAIN VALLEY PHYSICIANS HOSPITAL, PLATTSBURGH

PROGRAM DESCRIPTION AND GOALS
Champlain Valley Physicians Hospital opened an outpatient lactation clinic in 2012, with services including outpatient clinic visits for moms with breastfeeding issues, telephone consults, and support on the mother-baby unit and throughout the facility before discharge. The clinic is staffed with two International Board Certified Lactation Consultants Monday through Saturday from 9:30 a.m. to 4:30 p.m. Services are provided regardless of ability to pay.

The program’s goals include:
• seventy-nine percent of infants initiate breastfeeding within the first hour of life;
• ninety percent of infants exclusively breastfeed; and
• all breastfeeding mothers receive assistance and support with breastfeeding.

OUTCOMES
The Clinton County Health Department analyzed 867 pediatric office patient records in 2013, and again in 2014 as a follow-up analysis, yielding the following results:
• in 2013, 52% of infants initiated breastfeeding within the first hour of life; in 2014, that grew to 88%;
• in 2013, 63% of infants were discharged from the hospital nursing whether exclusively or in combination with formula; in 2014, that grew to 87%; and
• in 2013, 80% of breastfeeding mothers received assistance and support; in 2014, that grew to 94%.

The community response to the clinic has been overwhelming. Satisfaction surveys have been 80% to 90% positive. The powerful impact and response of the community sparked the creation of a breastfeeding support group, “Nature’s Way Mothers Café,” which opened in March 2015. Services recently expanded to include a “returning to work and breastfeeding class.”
Safe Sitter®
COLUMBIA MEMORIAL HOSPITAL, HUDSON

PROGRAM DESCRIPTION AND GOALS
Safe Sitter® is a seven-hour training program that prepares adolescent students to be safe, nurturing babysitters. Students are provided information on how to handle a crisis, and how to nurture and guide a young child with a goal to reduce the number of accidental and preventable deaths among children cared for by babysitters.

The Safe Sitter program is competency-based and provides information on safety and security precautions as well as information on child development and age-appropriate activities. Educators also provide basic information on the business aspects of babysitting.

The program is measured with a rigorous practical and written test to demonstrate the key concepts and skills necessary to handle an emergency, including cardiopulmonary resuscitation (CPR), which is taught by a certified professional.

OUTCOMES
The Safe Sitter program has trained 940 students in:

- CPR,
- Preventing problem behaviors in children,
- Injury prevention, and
- Behavior management.

Year Initiative Started: 1995

PARTNERS
Schools
Community partners
Community centers
Faith-based community
Scouts

CONTACT
Mary Daggett, R.N., B.S.
Director, Community Health Services and Grants
(518) 828.8013
mdaggett@cmh-net.org
NYS Breastfeeding Quality Improvement in Hospitals Learning Collaborative
CORTLAND REGIONAL MEDICAL CENTER

PROGRAM DESCRIPTION AND GOALS
This is the second phase of a joint initiative between the New York State Department of Health and the National Institute for Children’s Health Quality. This 18-month initiative focused on promoting exclusive and improving overall breastfeeding rates.

The goal of the Breastfeeding Quality Improvement in Hospitals Learning Collaborative is to increase exclusive breastfeeding rates and the duration of any breastfeeding among new mothers, especially low-income women participating in the Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Medicaid. To do that, hospitals are focusing on implementing evidence-based maternity care practices. The practices include initiating breastfeeding within one hour of birth, allowing mothers and infants to remain together 24 hours a day (known as rooming in), and encouraging breastfeeding on demand, among others.

OUTCOMES
• Exclusive breastfeeding is at 92%, consistently higher than the project average and median from March 2015 to the present.
Choose Health Action Teen (CHAT) Program
FINGER LAKES HEALTH, GENEVA

PROGRAM DESCRIPTION AND GOALS
Finger Lakes Health’s Choose Health Action Teen (CHAT) program is a student education program in which high school and college-aged students are trained as volunteers to teach younger students how to choose healthy foods and stay active. The evidence-based curriculum used for CHAT is supplied by a local university and Cooperative Extension 4-H youth development program. The aim is to develop healthy nutrition and activity habits among children inspired by engaging lessons delivered by volunteer teen instructors. The CHAT curriculum is aimed at children ages 8 to 12 and targets those behaviors research shows to be most important for preventing childhood obesity and chronic diseases, such as heart disease and cancer.

LINKS TO THE PREVENTION AGENDA
Finger Lakes Health collaborates with public health departments and other human services providers in its service area, to use the framework of the New York State Prevention Agenda as a basis for community health planning. Finger Lakes Health and these groups worked together to conduct a Community Health Needs Assessment in 2012-2013 to establish health priorities for 2013-2018. After completion, the priorities going forward are to prevent chronic disease by reducing obesity in children and adults and by reducing hypertension and stroke. One way Finger Lakes Health addresses the health priority of reducing obesity in children and adults is by conducting the CHAT program in the city school district.

OUTCOMES
• In the 2012-2013 school year, seven trained CHAT mentors reached 178 children.
• In the 2014-2015 school year, 12 CHAT mentors reached 582 children and adults.
• In the 2015-2016 school year, five CHAT mentors have been trained and are on target to reach nearly 800 children and adults.
A Healthier Community: Implementation of the National Diabetes Prevention Program

FLUSHING HOSPITAL MEDICAL CENTER

PROGRAM DESCRIPTION AND GOALS
The purpose of the National Diabetes Prevention Program is to decrease the chance of complications associated with Type 2 diabetes. The initiative consists of 16 weekly core sessions and eight monthly post-core sessions.

In the core sessions, an emphasis is placed on how to control negative external influences and how to cope with psycho-emotional issues in a productive manner. The post-core component is designed to provide continuous support to strengthen the participant’s self efficacy.

OUTCOMES
As of February 2015, Flushing Hospital Medical Center engaged 36 individuals through its onsite program:

- Of those 36 people, 35 completed the program.
- Among the 35 individuals who completed the program, 269.7 pounds were lost.
- Patients reported reduced or normal levels of glycated hemoglobin and cholesterol.
Lung Cancer Screening and Prevention Program
GLENS FALLS HOSPITAL

PROGRAM DESCRIPTION AND GOALS
This initiative includes a screening and prevention program for individuals who are at high risk for developing lung cancer. The lung cancer screening program is developed to detect lung cancer at an earlier stage in coordination with community initiatives to prevent and reduce tobacco use through cessation programs, youth action, community engagement, and improvement in the delivery of guideline-concordant care.

LINKS TO THE PREVENTION AGENDA
The hospital utilized the Prevention Agenda framework to plan, inform, and guide the community health needs assessment process and corresponding Community Service Plan for 2013-2015. Within the Community Service Plan, Glens Falls Hospital prioritized all three focus areas under the Chronic Disease category. The three focus areas were determined to be the most significant health needs for the region and informed the development of the action plan.

OUTCOMES
- Lung cancers were identified at an early stage by screening 300 community members and identifying four previously undetected cancers.
- Tobacco consumption was reduced by providing four free smoking cessation group sessions for 20 people. Of those, seven individuals quit by the end of the sessions, five remained smoke-free after three months, eight documented a reduction in tobacco consumption, and five stated they were not ready to quit.
- A tobacco-free norm was promoted through the Living Tobacco-Free initiative by establishing five “Reality Check” groups in schools, engaging communities to create nine policy changes around tobacco-free multi-unit housing and tobacco-free outdoors, and partnering with 13 providers to implement policies and practices for screening and treating tobacco dependence.
Cigarette Free—Healthier Me
JAMAICA HOSPITAL MEDICAL CENTER

PROGRAM DESCRIPTION AND GOALS
Cigarette Free—Healthier Me is a multifaceted approach to addressing tobacco use among individuals within the community. Cigarette Free—Healthier Me has grown from referring patients to the local quit line, to incorporating an onsite support group program at Jamaica Hospital Medical Center, to now developing its own curriculum that will be brought to individuals who live in senior facilities within the hospital's catchment area.

The program's goals are to:

• assess 100% of the outpatient population for smoking; and

• provide tobacco intervention to 75% of the smoking population.

OUTCOMES

• In 2015, the smoking status of 93% of Jamaica Hospital Medical Center's patients was assessed and 69.2% of smokers received counseling during repetitive visits.

• As of February 2016, 2,587 patients who smoke were referred to the local quit line.

• Since its inception in October 2014, clinicians have referred 560 patients to the medical center’s onsite support group program.

• From October 2014 to February 2016, Jamaica Hospital Medical Center engaged 62 individuals through its support group program. Of the 62 participants, 49 completed the program; and of the 49 people who completed the program, 44.9% quit smoking, 40.9% cut down tobacco use, and 14.2% neither quit nor cut down.

Year Initiative Started: 2009

PARTNERS
American Lung Association
Local quit line

CONTACT
Certified Asthma Educator and Certified Tobacco Treatment Specialist
(718) 206-8494
jceide@jhmc.org
Cancer Community Connection Program
LONG ISLAND JEWISH MEDICAL CENTER, NEW HYDE PARK

PROGRAM DESCRIPTION AND GOALS
The Cancer Community Connection Program (CCCP) addresses pressing breast cancer disparities among populations in Southeast and Jamaica, Queens. Through evidence-based, culturally-sensitive education and outreach, and comprehensive support from a patient navigator, the program works to reduce breast cancer mortality rates, remove barriers to screening and treatment, and successfully navigate women across the care continuum. Strong community partnerships play an integral role in helping CCCP build trust and reach challenging populations to facilitate cancer screening and care.

In 2016, Long Island Jewish Medical Center anticipates educating 4,000 women from the target communities about cancer screening, and successfully navigating 240 under-served women across the care continuum.

LINKS TO THE PREVENTION AGENDA
The program directly supports Focus Area 3: Goal #3.1: Increasing screening rates for breast, cervical, and colorectal cancers, especially among disparate populations.

OUTCOMES
- Since 2012, more than 2,800 members of the community received direct education and outreach, with 1,127 patients receiving breast cancer screening services with culturally-competent patient navigation.
- There has been continuous growth of a network of collaborative partnerships with more than 60 organizations that are committed to improving access to preventive services.
- Long Island Jewish Medical Center cultivated an active and engaged community-based volunteer team of 27 community ambassadors who work to enhance collaboration by serving as culturally-competent resources between vulnerable populations and cancer screening services.
- The program ensured that all 19 patients with positive cancer diagnoses were navigated successfully into treatment and support services.
Community Outreach and Engagement Program
MONTEFIORE HOSPITAL MEDICAL CENTER, BRONX

PROGRAM DESCRIPTION AND GOALS
The Montefiore Mount Vernon Community Outreach and Engagement (COE) Program designs, implements, and supports interventions that improve the health and well-being of the community, which includes patients, Montefiore Hospital Medical Center associates, and the residents of the neighborhoods where they live. Since 1997, the medical center has operated a community-facing program that leverages and engages the local youth community, helps teach students of medicine and nursing about community health, integrates the faith-based community through partnerships with chaplains, coordinates educational workshops and health events, and promotes healthy living. The goal of this program is to build healthier communities and connect people to the care they need.

OUTCOMES
- In 2015, COE conducted 31 workshops in Mount Vernon and 48 health fairs touching more than 3,500 residents combined.
- In 2015, COE chaplain services (made up of 15 chaplains from 15 local community churches) conducted more than 1,865 visits in the hospital, providing continuity of religious services between the community and the healthcare delivery system.
- In 2015, COE engaged six youth to participate in career and life skills programming, and provided community health training to 60 medical students and 222 nursing students.
- Every year since 2007, COE has partnered with the Mount Vernon Mayor’s office to promote local farmers markets. In addition, COE has worked with the leadership of the hospital to ensure a tobacco-free campus and healthy dining options (including vending machines) for staff, patients, and families.

CONTACT
Geneva Jermin
Director of Community Health
(914) 361-6195
gjermin@montefiore.org

PARTNERS
Mount Vernon Department of Education
Mount Vernon Educational Foundation
Guidance Center of Westchester Early Childhood School District
Mount Vernon Sinai Free Synagogue
Mount Vernon Mayor’s Office
Mount Vernon Chamber of Commerce
United Black Clergy of Westchester
Police Commissioner, City of Mount Vernon
Fire Commissioner, City of Mount Vernon
Montefiore School of Nursing
St. George’s University Medical School
The Wartburg
Westchester Department of Senior Programs and Services
City of Mount Vernon Recreation Department
Westchester Community Opportunity Program

Year Initiative Started: 1997
**Mamas Maravillosa**  
MONTEFIORE NYACK HOSPITAL

**PROGRAM DESCRIPTION AND GOALS**
Mamas Maravillosa is a community-based program for post-partum Latina women who have been identified as being at high risk for developing Type 2 diabetes and other chronic diseases. Mamas Maravillosa is based on the U.S. Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program. This program is offered free of charge at a local community center and is presented in Spanish by bilingual healthcare professionals.

While the program’s main objective is to reduce the occurrence of Type 2 diabetes, it also offers additional health information for both the participant and her family, including reinforcement to continue breastfeeding, caring for your baby, and the importance of having regular check-ups during the inter-conception period.

**LINKS TO THE PREVENTION AGENDA**
The New York State Prevention Agenda is integral to Montefiore Nyack Hospital’s community service plan, specifically targeting the “promote healthy women, infants, and children” objective. Diabetes prevention focusing on the inter-conception period reduces the risk of developing gestational diabetes and future Type 2 diabetes, and lowers the risk for miscarriages, stillborn babies, birth defects, birth injuries, complications, Cesarean sections, premature births, and obesity and diabetes in future children.

**OUTCOMES**
In 2015, 38 women attended Mamas Maravillosa, a 75% increase from 2014. Participants reported:

- daily fruit and vegetable servings increased 44%;
- physical activity increased 34%;
- three daily dessert consumption decreased 37%;
- fried foods decreased 40%; and
- sugary drinks decreased 9%.
Golden Spoons Volunteer Program: Making a Difference One Bite at a Time
NEW YORK-PRESBYTERIAN/ALLEN HOSPITAL, NEW YORK CITY

PROGRAM DESCRIPTION AND GOALS
Golden Spoons Volunteer Program is a collaborative patient feeding program initiated at the Allen Hospital at NewYork-Presbyterian. Volunteers are trained to feed patients with the assistance of nursing, clinical nutrition, speech language pathology, and occupational therapy staff. Golden Spoons Volunteer Program volunteers assist patients who need help feeding themselves, with tray set-up, and/or socialization.

The goals of the program are to provide:

- assistance to optimize nutritional intake, reduce the prevalence of malnutrition, and decrease length of stay;
- companionship, social contact, and stimulation during meals;
- volunteer resources to nursing staff for patient mealtime assistance, allowing staff to tend to other responsibilities; and
- a unique opportunity for NewYork-Presbyterian/Allen volunteers to impact patients’ well-being through their gift of time and companionship at the bedside.

OUTCOMES

- A total of 720 patients were assisted with meals through the Golden Spoons Volunteer Program in 2015.
- Of these 720 patients, 104 (14%) who received assistance from the Golden Spoons Volunteer Program were identified with malnutrition during their stay in 2015.
- Thirty-nine percent of patients (234 of 593) ate 75% to 100% of their meals in 2015.
- The Golden Spoons Volunteer Program assisted patients with 818 meals in 2015.

Year Initiative Started: 2014

PARTNERS
Local colleges (i.e., Lehman College, New York University)
Internal partners (i.e., clinical nutrition, occupational therapy, food services, volunteer services, nursing, and speech language pathology)

CONTACT
Katie Szymona, M.P.H., R.D., C.D.N.
Clinical Nutrition Manager
(212) 932-5181
kas9149@nyp.org

Amy Bush
Volunteer Services Coordinator
(212) 932-5319
amb9056@nyp.org
Living Healthy: Chronic Disease Self-Management Program
NICHOLAS H. NOYES MEMORIAL HOSPITAL, DANSVILLE

PROGRAM DESCRIPTION AND GOALS
Living Healthy classes are six-session, evidence-based workshops designed for people living with an ongoing or limiting health condition or people who care for them. Participants learn self-management techniques and skills needed in the day-to-day management of any type of ongoing health condition. Evidence from clinical trials and program evaluations shows that these interventions can reduce pain and fatigue, improve quality of life, enhance range of motion, increase physical activity, improve psychological well-being, and boost participants’ confidence in their ability to manage their health. With support from the Quality and Technical Assistance Center of New York, Noyes Memorial Hospital established local Living Healthy programs. Classes are provided throughout the community and led by volunteer peer leaders under direction of the program coordinator.

LINKS TO THE PREVENTION AGENDA
Chronic disease management was one of Livingston County’s top two New York State Prevention Agenda priorities identified in the 2013 Community Health Needs Assessment. One of the key strategies in its Community Health Improvement Plan (CHIP) was the development of a county-wide Chronic Disease Self-Management Program (CDSMP) throughout Noyes’ service area. The hospital took the lead for this county-wide strategy. The outcomes of the past two years’ CDSMP classes have exceeded all projected CHIP goals.

OUTCOMES
- A program coordinator was hired and seven peer leaders were trained to facilitate multiple workshops.
- Living Healthy workshops: total of seven were provided, with 81 participants completing.
- Living Healthy with Diabetes workshop: one was provided, with 18 participants completing.
- Walk with Ease: 22 people enrolled in this program.

PARTNERS
Nicholas H. Noyes Memorial Hospital
Quality and Technical Assistance Center of New York
Genesee Valley Health Partnership and Rural Health Network
County Office for Aging and Department of Health
Retired Senior Volunteer Program
Local libraries, town halls, and senior living/nutrition sites
Local physician offices and human service agencies

CONTACT
Christa Barrows
Program Coordinator
(585) 335-4358
cbarrows@noyeshealth.org
Real Health for Real Life—
Salud Real Para La Vida Real
NORTHERN WESTCHESTER HOSPITAL, MOUNT KISCO

PROGRAM DESCRIPTION AND GOALS

Real Health for Real Life was designed to prompt attitude and behavior change to reduce health risks for Latino families with young children. A registered dietitian, bilingual health educators, and volunteer parent ambassadors worked together to provide a culturally-sensitive, interactive experience that raises awareness of eight healthy habits and encourages action by participants. Each of the six, one-hour weekly group sessions culminated in a “graduation,” with participants practicing new skills and using new knowledge at and between each class along the way.

Northern Westchester Hospital’s goal was to improve awareness of habits leading to better nutrition and increased physical activity by providing a hands-on nutrition and wellness educational program for parents. Parents are gatekeepers of their children’s health, and typically the agents of change for their families.

LINKS TO THE PREVENTION AGENDA

Real Health for Real Life targets three goals of the New York State Prevention Agenda: prevent chronic diseases; promote healthy and safe environments; and promote healthy women, infants, and children. It was also designed to address one of Northern Westchester Hospital’s 2013-2018 focuses: to reduce obesity in children and adults, and specifically to decrease the percentage of blacks and Hispanics dying prematurely from heart-related deaths.

OUTCOMES

• The percentage of parents who reported that their children eat fruits or vegetables at least every day increased from 41% to 65%.
• The percentage of parents who reported their children participated in one hour of physical activity on four or more days each week increased from 63% to 71%.
• The percentage of parents who reported their children “rarely” consumed sugary beverages increased from 34% to 56%, and many participants reported drinking more water.
• There has been enthusiastic participant involvement, planting the seed for peer-led health education from within the Latino community.
Healthy on the Hill
NORTHWELL HEALTH, GREAT NECK

PROGRAM DESCRIPTION AND GOALS
Healthy on the Hill is a population health initiative addressing two Prevention Agenda priorities: prevent chronic diseases, and promote a healthy, safe environment. Its goal is to improve community health by promoting healthy eating, active living, and community transformation around health using a collective impact model of public health. A community health assessment identified the need for access to fresh produce, chronic disease self-management strategies, and physical activity options. A walking group, the Stanford Chronic Disease Self-Management Program, and a farmers market were implemented. The market, in its third season, is supported by the Spinney Hill Partnership, managed by Northwell Health and local community-based organizations, and staffed by community youth market workers, undergraduate nutrition volunteers, and two farmers.

OUTCOMES

• Increased access to locally grown produce: 8,697 market visitors over three seasons.
• Increased utilization of government nutrition assistance benefits: 1,788 farmers market nutrition program benefit checks were redeemed, totaling $6,670; and $1,000 in Electronic Benefit Transfers were utilized at the market over the past three seasons.
• Increased produce consumption: Farmers market visitor-facilitated interview results: 74% reported that the market increased the amount of fruit and vegetables they ate, 53% felt that the market has improved the health of the community, and 100% of interviewed respondents residing in Spinney Hill ZIP Codes said this farmers market increased how often they ate fruits and vegetables.
• A cross-sector, sustainable community partnership was created using the collective impact model.

Year Initiative Started: 2013

PARTNERS
Long Island Greenmarket
Manhasset Great Neck Economic Opportunity Council
Manhasset Community Fund
Spinney Hill Partnership: Spinney Hill civic leaders, faith-based community leaders, housing and business organizations
Sustainable Long Island
Town of North Hempstead government agencies

CONTACT
Nancy Copperman, M.S., R.D., C.D.N.
Assistant Vice President, Public Health and Community Partnerships, Office of Strategic Planning
(516) 321-6888
ncopper@northwell.edu
ADA Recognized Diabetes Self-Management Education Program
OLEAN GENERAL HOSPITAL

PROGRAM DESCRIPTION AND GOALS
Olean General Hospital’s Diabetes Self-Management Education (DSME) Program offers comprehensive outpatient diabetes services with the curriculum based on the required topics outlined in the American Diabetes Association (ADA) Recognition national standards.

DSME program goals/objectives for 2015-2016 include:

• empower patients with the knowledge and skills to manage their diabetes;
• maintain required data to retain ADA recognition status;
• integrate with the hospital’s strategic plan for chronic disease care/services;
• ensure resources to provide a program that meets the required quality criteria;
• increase the target number of class participants by providing support and marketing services; and
• collaborate with the clinical integration organization initiatives to assure diabetes care is included to reduce costs and assure efficient, effective medical management of this population.

LINKS TO THE PREVENTION AGENDA
The hospital’s number one focus area in its Community Service Plan is to “Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings,” including diabetes.

OUTCOMES

• The average reduction in patients’ post-program hemoglobin A1C results was 1.6%.
• An average of 74% of patient self-reported behavior change outcomes goals were reached.
• There has been a 96% positive response on patient satisfaction surveys.
Smoking Cessation for Hospital Patients
PUTNAM HOSPITAL CENTER, CARMEL

PROGRAM DESCRIPTION AND GOALS
The goals of this program were to increase screenings and education within the hospital and create a seamless interaction between the hospital’s electronic medical record (EMR) and the New York State Quitline to boost patient enrollment and increase the odds patients will continue the program after discharge.

Putnam Hospital Center saw an opportunity to enhance the use of the EMR to screen patients at point of entry to determine if they were smokers. If a patient was identified as a smoker, the EMR triggered smoking cessation education. An interface was created with the New York State Quitline to facilitate the transmission of the patient information on discharge if he or she opted into the program.

LINKS TO THE PREVENTION AGENDA
This program was developed in conjunction with the hospital’s Community Service Plan, which opted to reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

OUTCOMES
- Ninety-seven percent of all inpatients and outpatients are now screened.
- All cancer center patients are screened; 57% of smokers agreed to opt into the smoking cessation program.
- There were 93 unique referrals to the New York State Quitline in Year one, and the relationship with the Quitline improved.
- Expanded to high-volume outpatient areas such as ambulatory surgery; ambulatory surgery screenings increased from 80% in 2014 to 99% in 2015.
River Community Wellness Program
RIVER HOSPITAL, ALEXANDRIA BAY

Year Initiative Started: 2013

PARTNERS
Claxton-Hepburn Medical Center
Fort Drum Behavioral Health Department
Upstate Medical Center
Credo Community Clinic

CONTACT
Brad Frey
Director of River Community Wellness Program
(315) 482-1203
bfrey@riverhospital.org

PROGRAM DESCRIPTION AND GOALS
The River Community Wellness Program is comprised of three distinct services:

• The Partial Hospitalization Program is an intensive outpatient program that serves the mental health needs of active-duty military servicemembers stationed at Fort Drum suffering from post-traumatic stress. The program focuses on building coping skills, and providing education and support to shorten inpatient hospitalizations of soldiers who have been impacted by the horrors of combat.

• The second aspect of the program is River Hospital’s outpatient behavioral health clinic for adults in the community.

• The final service is a child and adolescent clinic that delivers much-needed behavioral health services to adults and children in upstate New York, alleviates traditionally long wait times, addresses issues sooner, and meets a growing demand in the community.

LINKS TO THE PREVENTION AGENDA
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 offered the opportunity to make mental health services available to the local population, as well as the military.

OUTCOMES
• Post-traumatic stress disorder checklist scores improved by 74%.
• Patient Health Questionnaire (PHQ-9) scores improved by 78%.
• Program utilization is 86%.
• Reduced wait times: adults average 25 days; the child average is one day.
Fit Kids
SOUTHAMPTON HOSPITAL

PROGRAM DESCRIPTION AND GOALS
The Fit Kids program is offered to all fifth through eighth graders in the township of Southampton, including the Shinnecock Indian Reservation; it consists of six classes with a variety of different exercises and health and wellness trivia games. The goal is to increase the awareness of health, nutrition, and wellness, and improve self-esteem and self-worth.

Southampton Hospital uses different aerobic modalities, exposing kids to varieties of exercises and health/wellness tips. The purpose is to reduce obesity by modifying behaviors through education and exercise, and increasing awareness of primary healthcare and well care. Objectives are to modify risks by encouraging and increasing physical activity, encourage healthy over unhealthy food choices, and educate/encourage wellness behaviors that promote lifelong habits of healthy lifestyles. Likert surveys are used to assess progress.

LINKS TO THE PREVENTION AGENDA
This initiative is related to Southampton Hospital’s community outreach initiative that focuses on childhood obesity. The selection of priorities was informed by the results from the Congressional Budget Office survey, the health issues addressed in the Suffolk County Community Health Assessment, and the priorities set forth in the New York State Department of Health Prevention Agenda. The priorities are to prevent chronic disease, with the focus areas of reduce obesity and reduce the risk for diabetes.

OUTCOMES
Nutritional/Health Awareness:
- “How Often Do You Eat Fast Foods?” Pre-program: 44% never, 10% often; Post-program: 58% never, 6% often.
- “I drink soda and sweetened beverages” Pre-program: 5% never, 52% often; Post-program: 26% never, 22% often.

Behavioral Health/Health Awareness:
- “I change things in my life to reduce stress” Pre-program: 17% rarely/never, 20% always; Post-program: 0% rarely/never, 60% always.

Exercise and Activity:
- “How often do you exercise?” Pre-program: 5% never, 26% always; Post-program: 0% never, 49% always.
Family Resource Center
ST. JOHN’S EPISCOPAL HOSPITAL, FAR ROCKAWAY

YEAR INITIATIVE STARTED: 2009

PARTNERS
Rosedale Christian Academy
Outreach House
Administration for Children Services
St. Christopher-Ottile
The Child Center of New York
Community Medication

CONTACT
Catrina Gordon
Director of Children and Adolescent Services
(718) 473-2070
cgordon@ehs.org

PROGRAM DESCRIPTION AND GOALS
The Family Resource Center provides support to families and youth within high-need communities. In addition to assisting in reducing the isolation and stress of parenting a child with emotional and behavioral difficulties, this program helps parents and caregivers develop the knowledge and skills they need to become their child’s best advocate.

The Family Resource Center’s goal is to provide timely access to a comprehensive range of family support services to reduce parents’ and caregivers’ stress, strengthen relationships, and enhance skills. Advocates are able to provide families and youth with information, support, and advocacy to encourage empowerment—so the family can make informed decisions.

OUTCOMES
• Four evidence-based parenting classes were offered, exceeding the goal by two sessions.
• Advocacy and support services were provided to 375 youth and families, exceeding the goal by 32 youth and families.
• Family Assessment Scales: The Family Resource Center should be at 90% to 100% capacity. The Family Resource Center is currently and has a reputation of being at 93% and above.
• Community outreach: Advocates have successfully met their goal of completing four hours of outreach per week in the community.
Health Home Program

ST. JOSEPH’S HOSPITAL HEALTH CENTER, SYRACUSE

**PROGRAM DESCRIPTION AND GOALS**

The Clinical Care Network Health Home program provides enhanced care management for high-need/high-cost Medicaid recipients who have two or more chronic conditions (e.g., hypertension, diabetes, asthma) and/or a serious persistent mental illness (e.g., bipolar disorder, schizophrenia). The program's goal is to promote access to and coordination of primary, specialty, and behavioral healthcare while improving health outcomes and curbing costs.

New York's Medicaid program serves more than five million enrollees with a broad array of healthcare needs. Of those, nearly one million have been identified as high-cost/high-need. This Health Home program serves a patient population that is overwhelmingly composed of individuals with chronic health and/or mental/behavioral health needs.

**LINKS TO THE PREVENTION AGENDA**

The organization's Community Health Needs Assessment Implementation Strategy Plan 2013-2016 focuses on community health initiatives collaboratively identified by government and area hospitals, including the need to increase access to high-quality chronic disease preventive care and management, improve health outcomes for adults with two or more chronic conditions, improve access to primary care and other community-based services, reduce obesity, promote behavioral health, and prevent substance abuse.

**OUTCOMES**

- Emergency department overutilization has decreased from 18 visits per 100 Health Home enrollees per 30 days, to 12.1 visits per 100 Health Home enrollees per 30 days.

- Medical admissions have decreased from 5.3 admissions per 100 Health Home enrollees per 30 days, to 2.8 admissions per 100 Health Home enrollees per 30 days.
Concussion Awareness, Education, and Development of Safe Return to Learn and Sports Program

ST. MARY’S HEALTHCARE, AMSTERDAM

PROGRAM DESCRIPTION AND GOALS
Certified athletic trainers play a key role in concussion assessment and return-to-play management. In 2010, the St. Mary’s Healthcare Athletic Training Program developed a Concussion Education and Safe Return to Learn and Sports Program in response to a misunderstanding among area coaches, parents, and physicians about what a concussion is, and the danger of returning athletes too quickly back to school and sports. Area athletes that sustained a concussion were required to participate in the Safe Return to Learn and Sports Program.

Goals of the program include: educating the community about concussions, increasing the number of athletes and coaches who report concussion symptoms, ensuring athletes are symptom-free prior to returning to sports, and decreasing the cognitive load placed on students when returning to learning.

LINKS TO THE PREVENTION AGENDA
While not directly related, promotion of safe physical activity in young people is paramount to the Prevention Agenda. The “concussion return-to-play protocol” coincides with this initiative. Also, if concussions are not treated properly at an early age, it could lead to life-long chronic and activity-limiting conditions.

OUTCOMES
- Sixty-nine athletes were diagnosed with concussions and underwent the Safe Return to Learn and Sports Program in the first year. Eight athletes were diagnosed in the previous academic year—a 763% increase in the number of concussions reported.
- Only seven of 366 athletes (1.91%) who participated in the program since 2010 sustained a second concussion in the same sports season.
- On average, 60 athletes sustain concussions and go through the program each year.
- Athletes were out of competition for 12 to 15 days post injury, thus decreasing the chance for a repeat injury.
SPHP Medical Associates Home Visiting Physicians Program
ST. PETER’S HEALTH PARTNERS (SPHP), ALBANY

YEAR INITIATIVE STARTED: 2013

PARTNERS
Eddy Memorial Geriatric Center Foundation
SPHP Medical Associates—primary care physicians
Northeast Home Medical Equipment Community Hospice
W. Foley, Ph.D., Rensselaer Polytechnic Institute, external evaluator
SPHP hospitals—St. Peter’s Hospital, Albany Memorial Hospital, Samaritan Hospital, St. Mary’s Hospital
SPHP Community Services Division—Eddy Visiting Nurse Association
Empire Home Infusion Services
Homedical Associates
New York State Health Foundation

CONTACT
Michelle Mazzacco
Vice President, Eddy Visiting Nurse Association
(518) 270-1310
michelle.mazzacco@sphp.com

PROGRAM DESCRIPTION AND GOALS

This program was designed to become an in-home primary care service for chronically ill, homebound patients for whom significant functional impairment leaves them unable to get to medical appointments or access routine medical care. As a result, these individuals often wind up in emergency rooms or are frequently readmitted to hospitals. The SPHP team of physicians and nurse practitioners can provide the same quality, primary medical care in the patient’s home as a traditional physician’s office.

The goals of this program are to care for these at-risk patients at home, improve their outcomes and quality of life, and reduce total healthcare costs, while enabling patients to remain in their homes, avoid unnecessary trips to the emergency room, repeat hospitalizations, and premature nursing home placement.

This program directly relates to the Prevention Agenda, as it targets chronic disease categories because they impact the largest number of people in the most significant ways through their influence on other health conditions. They are also largely preventable and contribute most significantly to the cost of healthcare. Asthma and diabetes were the specific health conditions selected within chronic disease. The patients targeted by the Medical Associates Home Visiting Physician Program are at risk, with multiple chronic conditions, and are frequently diagnosed with asthma and diabetes as comorbid conditions.

OUTCOMES

- The program effectively reduced emergency room visits by 24% and hospitalizations by 15% for 154 discharged patients.
- For 105 patients who remain on service, the program effectively reduced emergency room visits by 43% and hospitalizations by 47%.
- Notably, the program also achieved a 96% completion rate of advanced care planning for its patients, which allowed 68% of patients who died while on service to die at home—as they requested and planned.
- The patient satisfaction rate for this program was a remarkable 97%.
Maternal, Infant, Child Health Initiative (MICH)
WCA HOSPITAL, JAMESTOWN

PROGRAM DESCRIPTION AND GOALS
This collaborative-building initiative brings community members, outreach organizations, local hospitals, and health departments together to assess needs and provide strategized programs to improve access to prenatal care in the first trimester, community breastfeeding support and resources to improve breastfeeding rates for up to a year, and expansion of tobacco cessation services to pregnant mothers to reduce the high rate of tobacco use by pregnant mothers in Chautauqua County.

LINKS TO PREVENTION AGENDA
The MICH initiative relates directly to the “promote healthy women, infants. and children” focus of the Prevention Agenda.

MICH goals:
- Increase utilization of preventive health services among women of reproductive age to improve wellness and pregnancy outcomes, and reduce recurrence of adverse birth outcomes.
- Increase the percentage of pregnant women who access prenatal care during the first trimester by at least 10%.
- Increase access to prenatal care and sustain partnership and implementation with the county health department and Maternal Infant Child Health Collaborative.

OUTCOMES
- The referral process for early access to care improved: 90% of prenatal patients were referred to the CHW program for community services; CHW enrolled 695 people into the program.
- Seven new OB/GYN providers have accepted 506 new patients from 2014 to 2015.
- Certified lactation consultant training: seven people trained, 565 people educated in the maternity ward, there are 199 breastfeeding Facebook page members, there were 16 calls to the breastfeeding nurse helpline, and 140 moms attended the “Community Baby Shower.”
- Prenatal Tobacco Cessation: 463 people were educated, 164 enrolled, and 44 quit.
For more information on this award or about HANYS’ community health agenda, contact Donna Evans, Director, Community Health Policy, at (518) 431-7713 or at devans@hanys.org.

For additional copies of this publication, contact Sheila Taylor, Executive Assistant, at staylor@hanys.org or at (518) 431-7717.
If we can help you with your printing needs, call us at (855) 853-5234. Check us out online at hanysprintingservices.com.