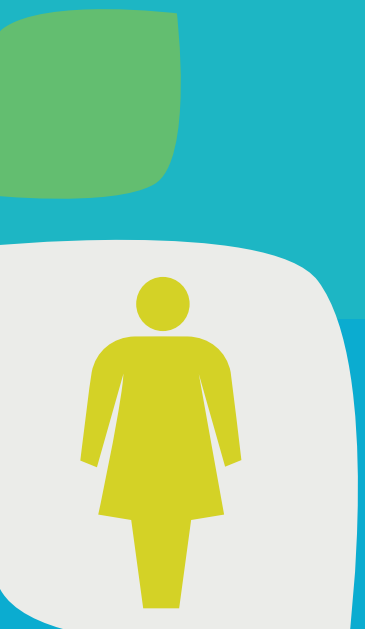
Connecting with Communities:

Community Health Initiatives Across New York State

2016 Edition



HANYS Healthcare Association of New York State

Community Health Improvement Award

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.

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 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

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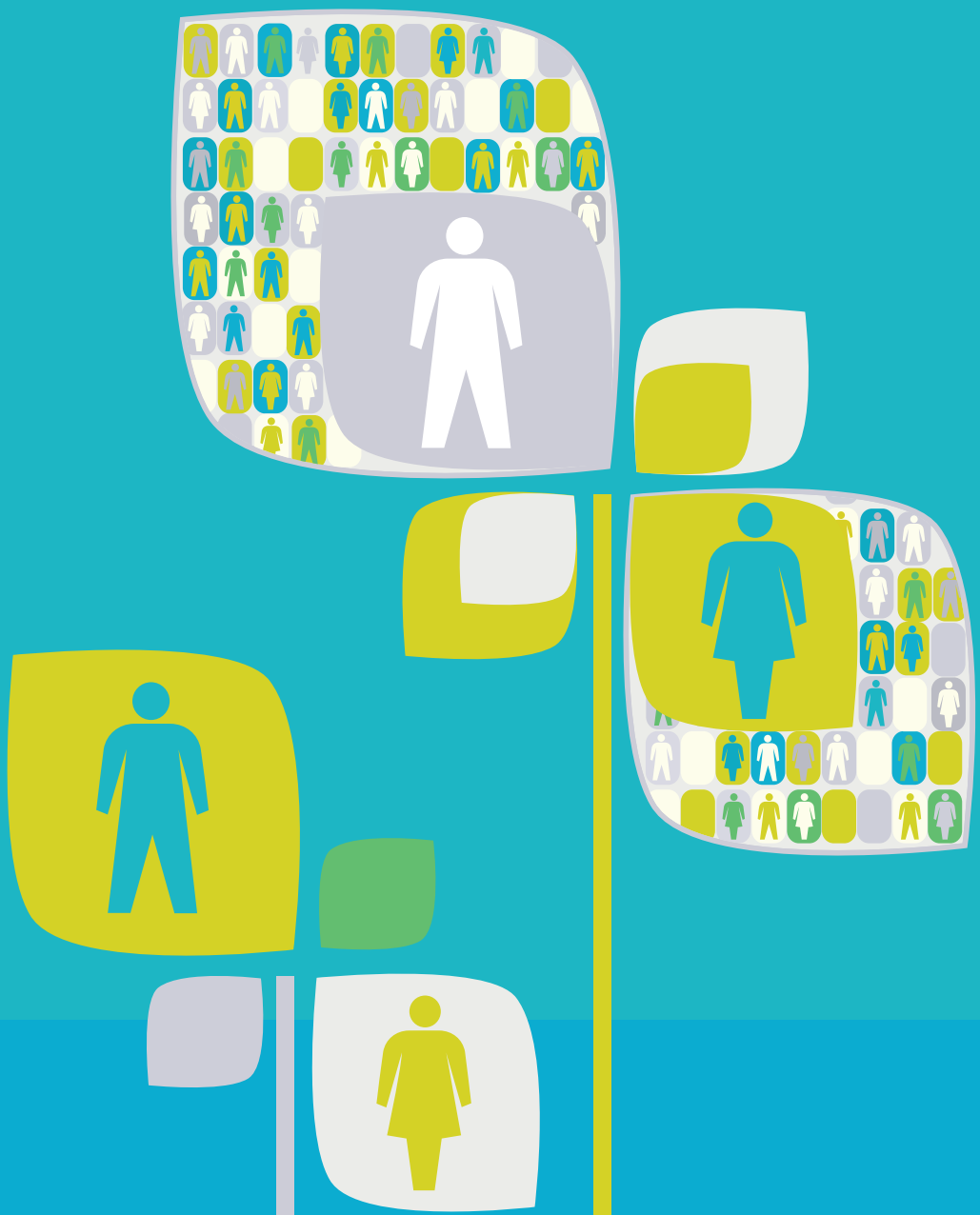
2016 WINNER



WINNER

High Blood Pressure Collaborative—Hospital Partners

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

Year Initiative Started: 2010

PARTNERS

Greater Rochester Chamber of Commerce

Insurance: BlueCross BlueShield, MVP Health Care

Finger Lakes Health System Agency

Monroe County Medical Society

Monroe County Department of Public Health

Community-based organizations

African American, Latino Health Coalitions

Local barber shops and salons

CONTACT

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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.

2016 HONORABLE MENTION

HONORABLE MENTION Healthier Families Program

GOOD SAMARITAN HOSPITAL MEDICAL CENTER, WEST ISLIP

Year Initiative Started: 2012

PARTNERS

Bay Shore School District

Bay Shore Community Wellness Alliance

CONTACT

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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.

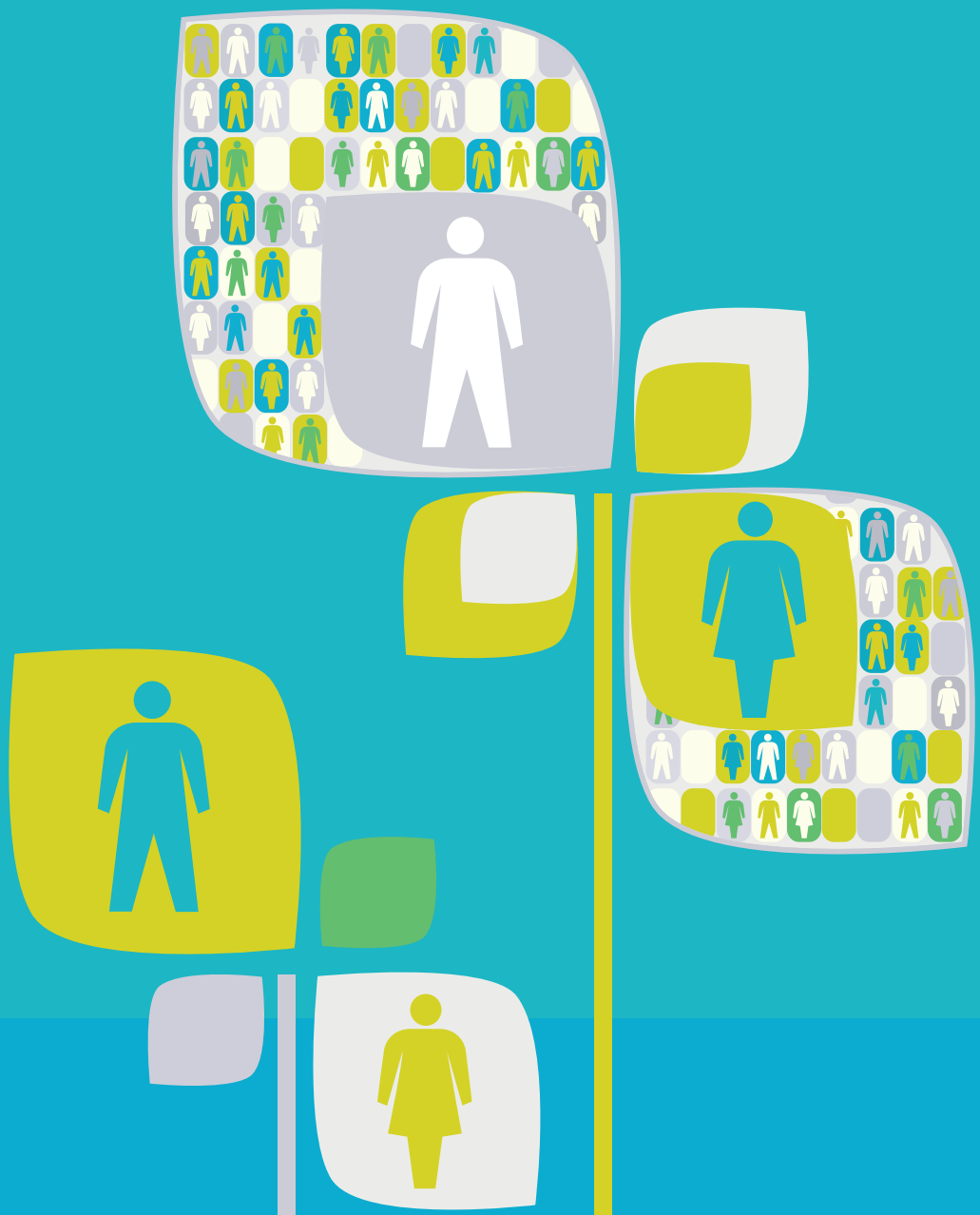
LINKS TO THE *PREVENTION AGENDA*

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.

2016 NOMINATED PROFILES



Sodium Reduction Project

ARNOT HEALTH, ELMIRA

Year Initiative Started: 2013

PARTNERS

Senior meal programs in Steuben, Yates, Seneca, and Schuyler counties

Hospitals:
Ira Davenport Memorial Hospital
Arnot Ogden Medical Center
St. Joseph's Hospital
Schuyler Hospital
St. James Mercy Hospital
Soldiers and Sailors Memorial Hospital
Guthrie Corning Hospital

Steuben County Health Department

S2AY Rural Health Network

CONTACT

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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

Year Initiative Started: 2014

PARTNERS

Bellport Hagerman East Patchogue Alliance

Bellport Boys and Girls Club

VFW Post 8300

Family Service League

Federation of Organizations

Patchogue YMCA

South Country Community Network

Great South Bay Coalition

HIV/AIDS Coalition

Nassau-Suffolk Hospital Council

Bank of America (provided a $25,000 grant to offer prevention education and wellness programs to the community)

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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

Year Initiative Started: 1990

PARTNERS

St. Joseph High School, Brooklyn

St. Jean Baptiste High School, Manhattan

Public and independent schools

Juvenile courts

Clergy and healthcare chaplains

Bereavement professionals, including funeral home personnel

Association for Death Education and Counseling

CONTACT

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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

Year Initiative Started: 2011

PARTNERS

Clinton County Health Department

Childcare Coordinating Council of the North Country

Plattsburgh Primary Care Health Practice

The Breastfeeding Coalition

The Foundation at Champlain Valley Physicians Hospital

CONTACT

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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

Year Initiative Started: 1995

PARTNERS

Schools

Community partners

Community centers

Faith-based community

Scouts

CONTACT

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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.

NYS Breastfeeding Quality Improvement in Hospitals Learning Collaborative

CORTLAND REGIONAL MEDICAL CENTER

Year Initiative Started: 2014

PARTNERS

WIC

Local obstetrical providers

Local pediatricians

CONTACT

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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

Year Initiative Started: 2013

PARTNERS

Geneva City School District

Hobart and William Smith Colleges

Finger Lakes Times, Finger Lakes Daily News

Seneca County Cornell Cooperative Extension

CONTACT

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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: Implemention of the National Diabetes Prevention Program

FLUSHING HOSPITAL MEDICAL CENTER

Year Initiative Started: 2015

PARTNERS

Quality and Technical Assistance Center

CONTACT

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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

Year Initiative Started: 2014

PARTNERS

Primary care physician practices within the community (Iron Gate and Hudson Headwaters Health Network)

Adirondack Radiology Associates

C.R. Wood Cancer Center

School districts and community partners in Warren, Washington, and Saratoga counties

CONTACT

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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

Year Initiative Started: 2009

PARTNERS

American Lung Association

Local quit line

CONTACT

Jennifer Ceide, A.E-C., C.H.E.S., C.T.T.S.
Certified Asthma Educator and Certified Tobacco Treatment Specialist
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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.

Cancer Community Connection Program

LONG ISLAND JEWISH MEDICAL CENTER, NEW HYDE PARK

Year Initiative Started: 2012

PARTNERS

New York State Department of Health Cancer Services Program (Queens and Nassau County)

Councilman Daneek Miller

National Council of Negro Women

Queens for the Cure

Sisters United in Health

CONTACT

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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

Year Initiative Started: 1997

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

CONTACT

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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.

Mamas Maravillosa

MONTEFIORE NYACK HOSPITAL

Year Initiative Started: 2014

PARTNERS

Nyack Hospital Prenatal Clinic

HRHCare

Catholic Charities SNAP

Rockland County Department of Health: Public Health Priorities Committee

Town of Ramapo Department of Parks and Recreation

Cornell Cooperative Extension: EatSmartNY

Rockland County Immigration Coalition

CONTACT

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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 Mammas 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

NEWYORK-PRESBYTERIAN/ALLEN HOSPITAL, NEW YORK CITY

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

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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.

Living Healthy: Chronic Disease Self-Management Program

NICHOLAS H. NOYES MEMORIAL HOSPITAL, DANSVILLE

Year Initiative Started: 2014

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

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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.

Real Health for Real Life—Salud Real Para La Vida Real

NORTHERN WESTCHESTER HOSPITAL, MOUNT KISCO

Year Initiative Started: 2014

PARTNERS

The Thomas and Agnes Carvel Foundation (funder)

Academy of Nutrition and Dietetics

Neighbors Link, Mount Kisco

Head Start sites, Mount Vernon and Yonkers

Little Steps Pre-school at Park Elementary School, Ossining

Individual fitness instructors: Susan Aarhus (Pilates), Helen Ansari (Zumba and yoga), Myrna Brady (dance fitness), Nick Logrea (Zumba), Maria Vargas (Zumba)

Real Health for Real Life Participants

CONTACT

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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

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

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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.

ADA Recognized Diabetes Self-Management Education Program

OLEAN GENERAL HOSPITAL

Year Initiative Started: 1993

PARTNERS

All local physicians by referral

YMCA

Ried's Food Barn

Cattaraugus County Health Department Healthy Livable Communities Consortium

WPIG Radio Station

Time Warner Cable Local Public Television

CONTACT

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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

Year Initiative Started: 2013

PARTNERS

New York State Quitline

The Center for a Tobacco-Free Hudson Valley/POW'R Against Tobacco

Putnam County Department of Health

Live Healthy Putnam County

CONTACT

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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

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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

Year Initiative Started: 2014

PARTNERS

Registered dietitian and physical education teachers at Southampton Schools

East Hampton YMCA/Wellness Foundation of East Hampton

Southampton Hospital Wellness Institute Certified Fitness Instructors

Southampton Youth Association summer camp program

Southampton School Systems

Tuckahoe School System

CONTACT

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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

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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

Year Initiative Started: 2013

PARTNERS

Oswego Hospital Health System

Catholic Charities of Onondaga County

Catholic Charities of Oswego County

Hutchings Psychiatric Center

Health Homes of Upstate New York

The Rescue Mission of Central New York

The Salvation Army of Central New York

Hillside Family of Agencies

Family Health Network

Oneida Hospital Health System and related primary care practices

Lewis County General Hospital (health system and related primary care practices)

Liberty Resources (trauma, behavioral healthcare coordination services)

Independent physician practices

CONTACT

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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

Year Initiative Started: 2010

PARTNERS

St. Mary's Healthcare Emergency Department

Broadalbin Perth Central School District

Greater Johnstown School District

Northville Central School District

Amsterdam Little Giants Football League

John Fedullo, D.O., Physical Medicine and Rehabilitation

Greater Amsterdam School District

Gloversville Enlarged School District

Mayfield Central School District

Fulton Montgomery Community College

St. Mary's Healthcare Speech Pathology Department

Gerald Ortiz, M.D., Orthopedic Surgeon

CONTACT

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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

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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

Year Initiative Started: 2013

PARTNERS

WCA and Brooks Memorial Hospital maternity wards, and wellness programs; WCA prenatal clinic

Chautauqua County Health Department, Community Health Workers (CHW)

Local obstetric/gynecology (OB/GYN) offices

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

Local tobacco cessation training programs through Chautauqua Health Network

Local faith-based organizations, Blackwell Chapel, and local jail

CONTACT

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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.

HANYS Healthcare Association of New York State

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