



2017 EDITION

CONNECTING WITH COMMUNITIES:

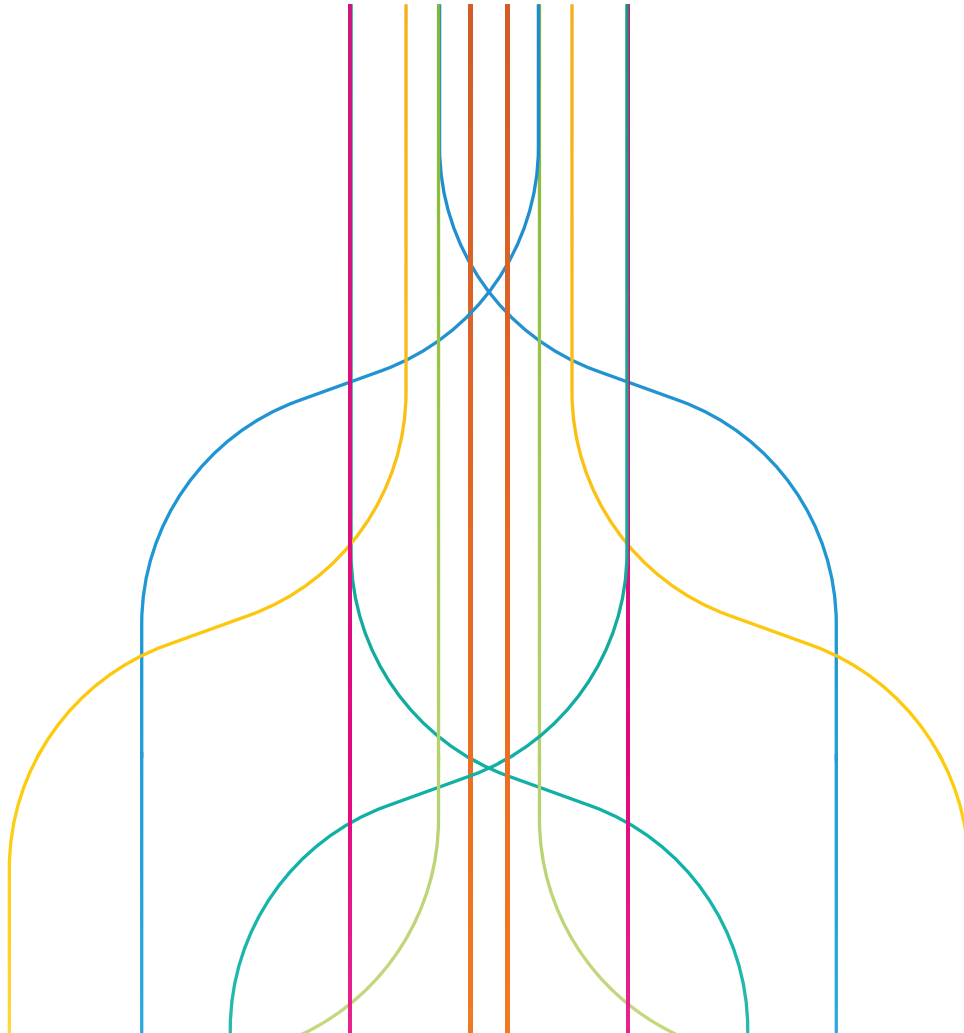
Community Health Initiatives Across New York State



Healthcare Association
of New York State

**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 hospitals and health systems 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, 2017 Edition

The Healthcare Association of New York State (HANYS) is pleased to present the 21st edition of *Connecting with Communities: Community Health Initiatives Across New York State*, which highlights the winners and nominations for HANYS' 2017 Community Health Improvement Award.

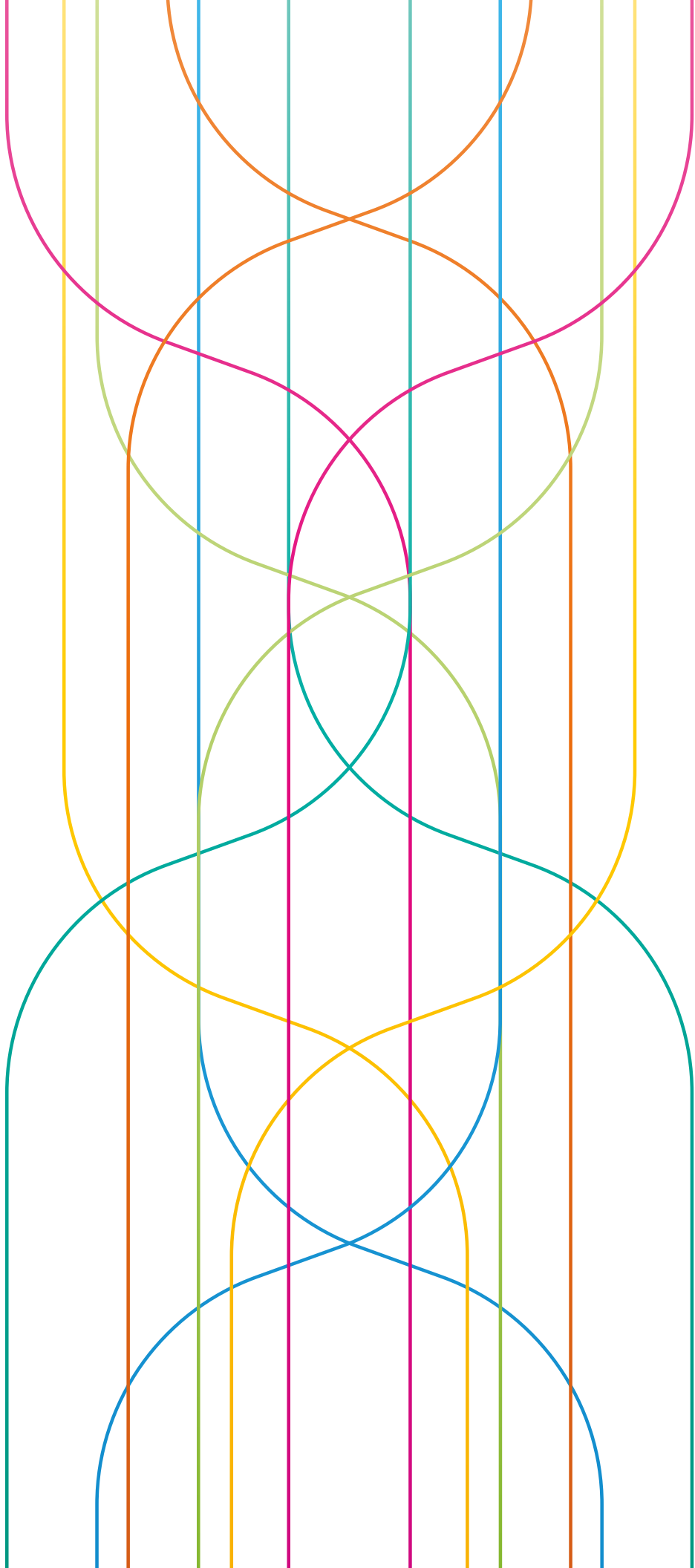
HANYS is proud to recognize our members' hard work and commitment to improving the health and well-being of their communities. Through collaborative partnerships, our hospitals and health systems are implementing innovative community benefit strategies as they advance population health improvement.

The work outside the walls of our hospitals and health systems takes on greater importance as the evidence mounts showing that where you live shapes your health. Hospitals and health systems across New York State are developing ways to reduce health disparities while strengthening efforts to address income, ethnicity, education, and other 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. The initiatives described in this publication are directly linked to Prevention Agenda priorities and New York's goal of becoming the healthiest state in the nation.

HANYS' annual Community Health Improvement Award recognizes member hospitals and healthcare systems for engaging key stakeholders and strategizing in unique ways to meet the health needs of their communities. We extend thanks to our hospitals and health systems for sharing their initiatives.

HANYS is honored to support member hospitals and health systems in their continuous efforts to prevent disease and keep people healthy. Thank you for your dedication to our communities and keep up the great work!



HANYS Celebrates Previous Community Health Improvement Award Winners

- 2016 Strong Memorial Hospital, Highland Hospital (UR Medicine)
Rochester General Hospital, Unity Hospital (Rochester Regional Health)
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
Health-e-Access Telemedicine Network
- 2008 Jamaica Hospital Medical Center
Palliative Care Collaborative
- 2007 Rochester General Hospital
Clinton Family Health Center
- 2006 Ellis Hospital/Northeast Health (Samaritan Hospital and Albany Memorial Hospital)/St. Peter’s Health Care Services/Seton Health System
Schenectady/Albany/Troy
Seal a Smile: A Children’s Oral Health Initiative

- 2005 Strong Memorial Hospital/University of Rochester
Medical Center
SMILEmobile Dental Office on Wheels
- 2004 NewYork-Presbyterian/Columbia University Medical Center
Breast and Cervical Cancer Screening Partnership
- 2003 St. John's Riverside Hospital
Yonkers
School-Based Asthma Partnership
- 2002 Strong Memorial Hospital
Rochester
Project Link
- 2001 Canton-Potsdam Hospital/Claxton-Hepburn Medical Center
Potsdam and Ogdensburg
St. Lawrence County Health Initiative
- 2000 Harlem Hospital Center
New York City
Injury Prevention Program
- 1999 Women's Christian Association 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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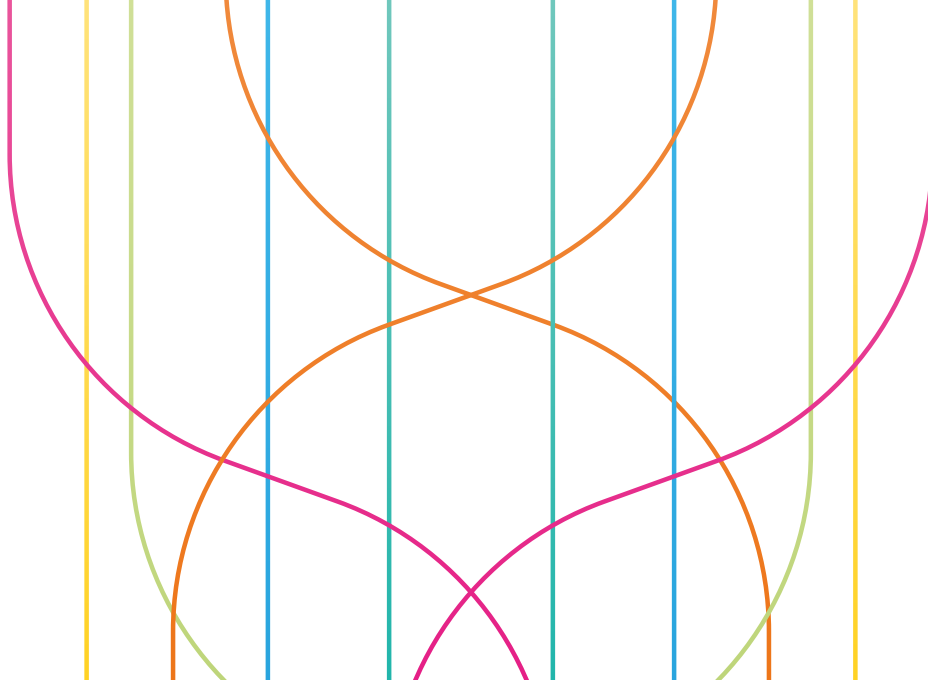
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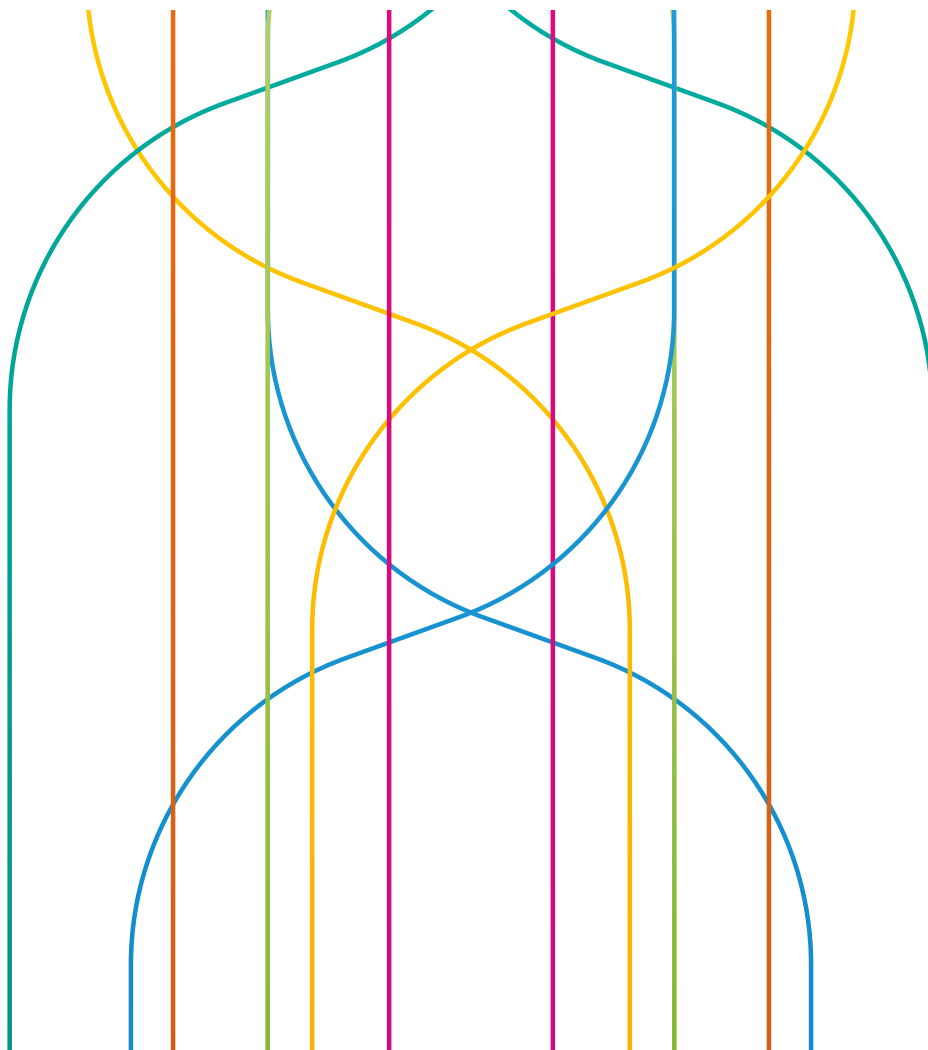
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2017 Community Health
Improvement Award Winner



2017 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

Healthy Eating Active Living (HEAL) Schuyler Schuyler Hospital Montour Falls

YEAR INITIATIVE STARTED

2011

PARTNERS

Schuyler Hospital
Schuyler County Public Health
Head Start
Harvest Café
Muddy Fingers Produce Farm
Cornell Cooperative Extension–Schuyler
Finger Lakes Eat Smart NY
The Greater Southern Tier (GST) BOCES
Watkins Glen School District
Exercise Enterprise (local fitness club)
Catholic Charities
The Arc of Schuyler
Food Bank of the Southern Tier
Local food advocates

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PROGRAM DESCRIPTION AND GOALS

Healthy Eating Active Living (HEAL) Schuyler was formed by Schuyler County Public Health and Schuyler Hospital in 2011, with a mission of: “By January 2015, to reduce the rate of obesity in Schuyler County by 10% through promotion of healthy eating and active lifestyles.” Using a multi-pronged approach, HEAL Schuyler addresses the New York State Prevention Agenda’s “Reduce Obesity in Children and Adults” focus area.

HEAL Schuyler promotes Schuyler Hospital’s free community walking program, Schuyler Steps Out. Schuyler Walks is an online resource for hiking trail maps and walks and runs throughout the county. A weekly Baby Café teaches and supports breastfeeding moms. Instructors are trained and Active Living Every Day classes are held.

Schuyler Hospital’s “Biggest Loser” program has been rolled out in other businesses. Choose Health helps restaurants clearly identify healthier options. Worksites and events are given tools to reduce or eliminate the use of sugar-sweetened beverages. HEAL Schuyler publishes a newsletter and advocates for creating healthy environments with the regional economic development council.

Healthcare providers are being given tools regarding how to talk with their patients about their weight, physical activity, and diet.

OUTCOMES

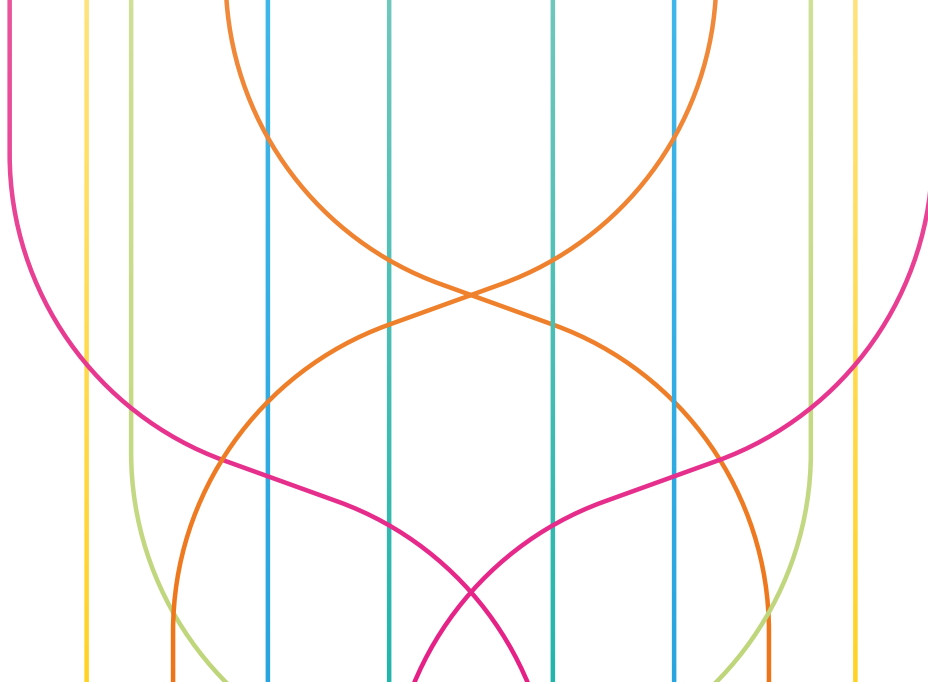
- There has been a 27% decrease in adults who are obese.
- With only 24.1% of adults reported as obese, Schuyler County is approaching the Prevention Agenda goal for 2018 to reduce the percentage of adults who are obese to 23.2%.
- There has been a 10% decrease in obese or overweight elementary school students and an 11% decrease in obese or overweight middle/high school students. Note that the Watkins Glen School District (one of three school districts in the county) is among several sites to make policy changes reducing the use of sugar-sweetened beverages.

LESSONS LEARNED

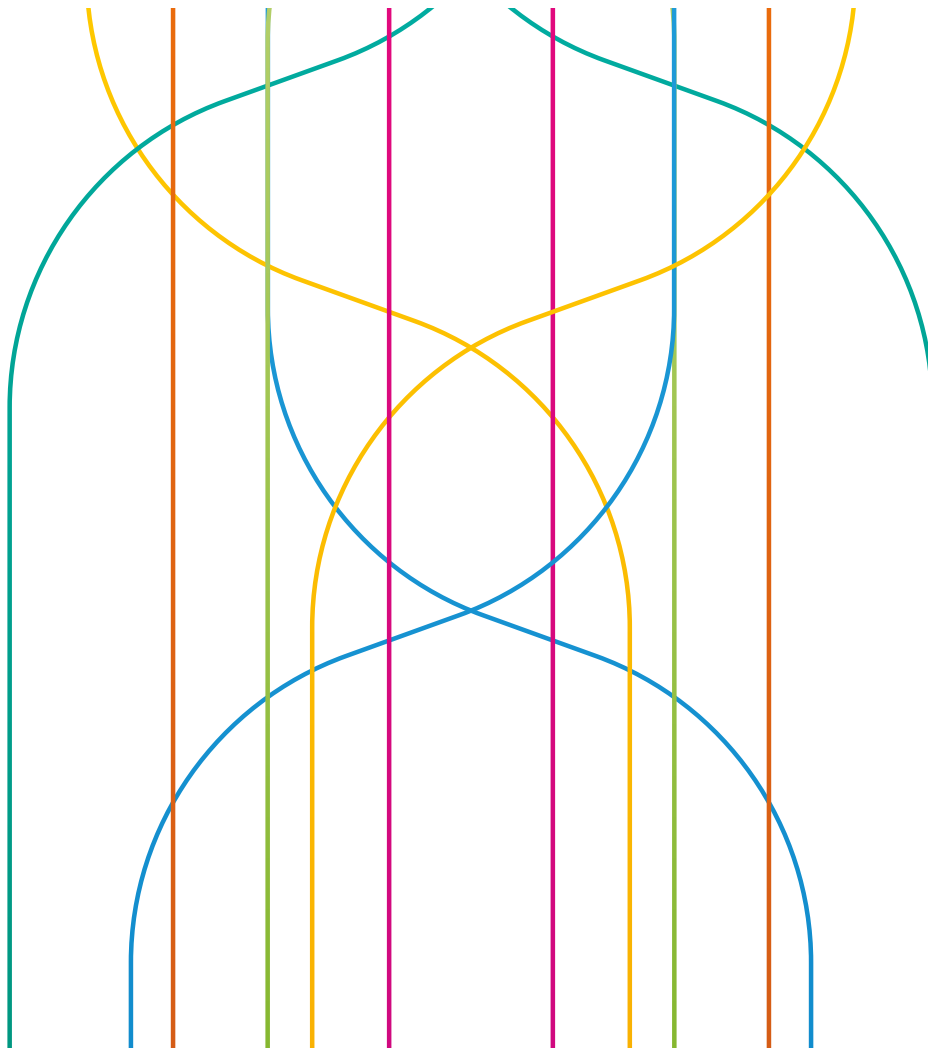
- Solutions to the obesity problem involve multiple layers of ways to change. Sustaining these efforts while making them easy for people from a broad range of ages; social groups; and academic, religious, and financial backgrounds, to fit choices into their everyday lives is a challenge.
- Due to varying priorities, HEAL Schuyler has struggled with keeping partners consistently interested, involved, and taking ownership of the problem.
- HEAL Schuyler needs to use data to show the effectiveness of the program.

SUSTAINABILITY

- Schuyler Hospital and Schuyler County Public Health have a solid working relationship, and are able to call on other community partners as needed.
- HEAL Schuyler will build on and expand successful interventions that have been implemented to date.
- Many interventions are free or low cost for HEAL Schuyler; and free to consumers to participate, such as the Baby Café, Health and Wellness Fair, walking trails, and Schuyler Steps Out. Active Living Every Day classes are low cost, and scholarships are available.



2017 Community Health
Improvement Award Honorable Mention



2017 COMMUNITY HEALTH IMPROVEMENT AWARD HONORABLE MENTION

Family PEACE Trauma Treatment Center NewYork-Presbyterian Hospital New York City

YEAR INITIATIVE STARTED

2011

PARTNERS

Manhattan Legal Services

Help USA

Harlem Independent Living Center

Violence Intervention Program

New York City District Attorney's Office

Children's Aid Society

Crime Victim Treatment Center at St. Luke's

Harlem Hospital

Connect, Domestic Abuse Treatment Center

Manhattan Family Justice Center

Northern Manhattan Improvement Corporation

Centro Altagracia de Fe y Justicia

The Dominican Women's Development Corporation

Jewish Board of Family and Children's Services

Northern Manhattan Perinatal Partnership

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PROGRAM DESCRIPTION AND GOALS

The Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center (FPTTC) is a licensed outpatient mental health clinic in the ambulatory care network at NewYork-Presbyterian Hospital. FPTTC is dedicated to improving the safety and well-being of children and caregivers who have been exposed to traumatic violence and abuse.

In an effort to interrupt the intergenerational transmission of violence and trauma, a goal that is in line with the Prevention Agenda of "Promoting Healthy Women, Infants, and Children," the program seeks to address the psychological impact of trauma exposure, improve the quality of parent-child attachment, and re-establish safety for the family.

In addition to being the only service provider in Washington Heights that offers mental health treatment for children under the age of five, the program strives to offer culturally- and linguistically-appropriate services, allowing women and children to feel comfortable and safe when seeking services. Further, FPTTC provides education and training for healthcare providers to appropriately screen for domestic violence and collaborates with community organizations and governmental agencies to advocate for the safety and treatment of children and families exposed to violence and abuse.

OUTCOMES

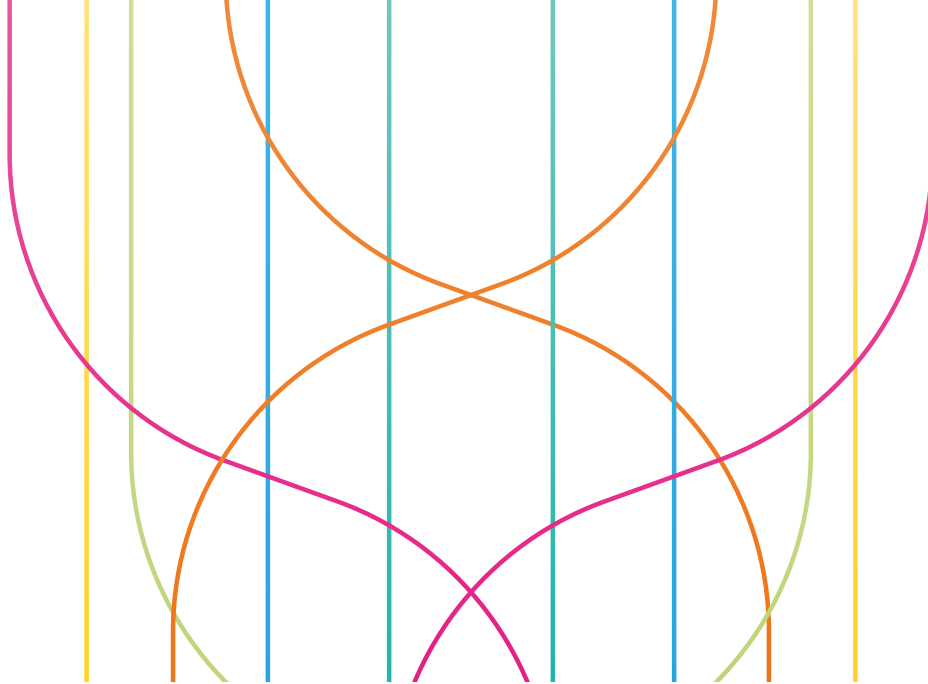
- Number of patients served: In 2016, 196 children and caregivers received treatment services, for a total of 1,920 visits.
- Significant reduction in patient symptoms at six months following intake: 75% of adult caregivers have decreased depression scores; 67% of adult caregivers have reduced parental stress scores; and 53% of children have decreased problem behaviors.
- Number of medical professionals trained: In 2016, 65 medical residents/students received education and training. Since inception, the program has trained more than 1,400 medical residents and students on how to screen for domestic violence in the primary care setting.

LESSONS LEARNED

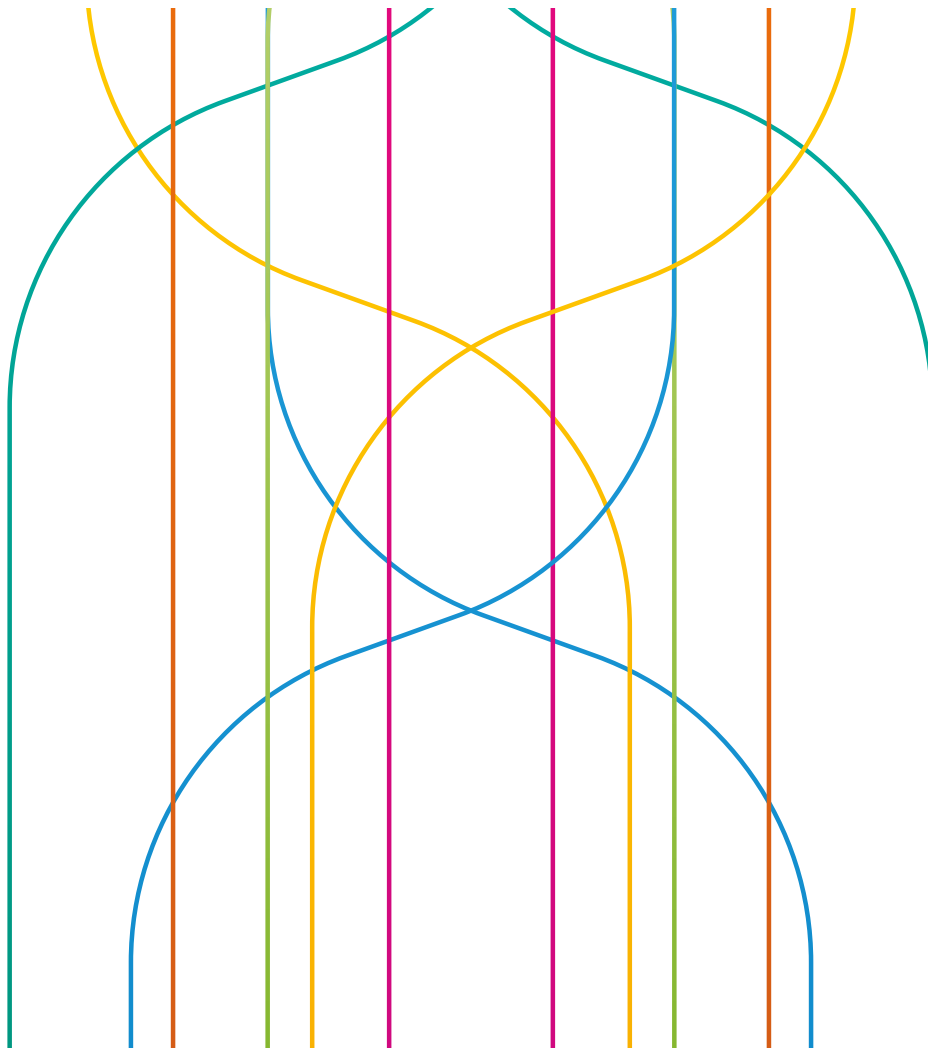
- When developing new programming, although informed by the needs of clients, it is necessary to sequence and prioritize new projects, remaining true to the mission, and the infrastructure must be in place to allow for sustainability.
- The various barriers clients face in accessing services due to language or immigration status has taught NewYork-Presbyterian Hospital that it is imperative to provide culturally and linguistically proficient services and employ staff who reflect the community it serves.

SUSTAINABILITY

- Demand for services: revenue generated by billing offsets operating costs paid for by the hospital, and the volume of patients continues to increase annually.
- A three-year state grant awarded in 2014 allows for expansion of treatment services to victims of child abuse. The grant will be renewed an additional two years through 2019.
- A five-year federal grant awarded in 2016 allows for billing of services. A business plan will be created to ensure sustainability beyond the term of the grant.



2017 Community Health Improvement Award Nominated Profiles



Pediatric Oral Health Integration
Bassett Medical Center
Cooperstown

YEAR INITIATIVE STARTED

2015

PARTNERS

New York State Department of Health

New York State Dental Foundation

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

Mohawk Valley Oral Health Coalition

Otsego County Oral Health Coalition

Bassett Medical Center Pediatric Department

Regional pediatric clinics
Fidelis

School-based health

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PROGRAM DESCRIPTION AND GOALS

Reducing dental caries is a New York State Prevention Agenda focus area, with the goal being to reduce the prevalence of tooth decay among New York's children by at least 10%. Children in Bassett Medical Center's region are at high risk of developing caries, with 44% of children having had experience with tooth decay by the time they reach third grade. In 2008, 8,400 visits to the emergency room or ambulatory surgery setting were due to childhood oral health issues.

To address barriers preventing children from having regular access to a dental home, this intervention integrates oral health risk assessment and preventive measures into the pediatric medical setting. Children under age seven attending their well-child visits receive this risk assessment and the application of fluoride varnish, if necessary. Oral health anticipatory guidance and education is provided to the caregiver at these visits.

OUTCOMES

- A total of 2,277 children were screened, 373 were deemed "at risk," and 632 received dental varnish.
- Forty-three clinics throughout the region have had staff trained in the initiative.
- A risk assessment tool (RAT) has been integrated into the electronic medical record. This means that the RAT auto-populates and auto-scores for well-child visits under the age of seven, directing providers to action.

LESSONS LEARNED

- Incorporating the oral health risk assessment consistently into already busy well-child visits can be challenging for medical providers. In addition, there is minimal education and training in medical school of dentition so not all clinicians are comfortable with providing an oral health risk assessment. Yet, most recognize that early childhood caries is the most common chronic childhood disease. An effective strategy to help overcome this barrier is identifying and training oral health champions within each setting to facilitate integration.
- Proper coding and documentation need to occur to ensure accurate data tracking and reimbursement rates.

SUSTAINABILITY

- The fluoride varnish reimbursement rate will continue to sustain purchase of dental varnish.
- The cost of preventive measures is far less than that for restorative care. Therefore, it makes sense from a community health perspective to invest in this simple intervention in areas where there is not community water fluoridation.
- Within two to three years, after further staff training and reinforcement, the practice will be a routine part of the well-child visit.

Stroke Center of Excellence Columbia Memorial Hospital Hudson

YEAR INITIATIVE STARTED

2011

PARTNERS

Emergency medical services

Local nursing homes

Tertiary hospitals

Faith community

Local community college

CONTACT

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PROGRAM DESCRIPTION AND GOALS

The Stroke Center of Excellence is a comprehensive system of care with a team that supports patients presenting to the hospital with signs and symptoms of stroke. The team is staffed by qualified care professionals who operate with written procedures that have been established and tested to rapidly respond to emergent situations.

The system of care is overseen by a coordinator who manages a multi-disciplinary team with representation from administration, including the medical director, hospitalist, neurologist, director of nursing, director of physical therapy, emergency department director, nurses from the emergency department, laboratory technicians, representatives from medical imaging, a community health nurse, a speech therapist, a hospitalist, and a representative from the education department.

The stroke team engages community agencies such as emergency medical services as soon as the onset of symptoms to ensure a prompt, efficient response that allows for timely treatment options. Consistent with the Prevention Agenda, the Center provides a resource for the community and local agencies on education in the prevention, care, and treatment of patients with symptoms of stroke.

OUTCOMES

- Access and treatment for victims of stroke has improved.
- The length of time from the onset of symptoms of stroke to treatment has decreased.
- Education on and awareness of signs, symptoms, and treatment of stroke has improved.

LESSONS LEARNED

- Partnership with a team of hospital departments, providers, and community is essential to success.
- Education for staff, community, and providers, including emergency medical services, contributes to positive outcomes, especially in high-risk communities.

SUSTAINABILITY

- The hospital is committed to quality care, and the education provided to staff ensures the team and the policies and procedures are part of the healthcare system's culture.

Million Hearts® Cardiovascular Disease Prevention Project Erie County Medical Center Corporation Buffalo (UB)

YEAR INITIATIVE STARTED

2015

PARTNERS

Millennium Collaborative
Care PPS, a New York State
DSRIP Organization

Kenneth Gayles, M.D.,
Buffalo Cardiologist

University at Buffalo (UB)
School of Nursing

UB Exercise Nutrition and
Dietetic Internship Students

UB School of Medicine

UB School of Pharmacy

American Heart Association–
Buffalo Chapter

GRUM Buffalo, a faith-based
collaborative of 65 partner
churches with the Greater
Buffalo United Accountable
Healthcare Network

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PROGRAM DESCRIPTION AND GOALS

Erie County Medical Center Corporation (ECMCC) is the lead entity in Western New York's Millennium Collaborative Care Performing Provider System (Millennium) formed in 2014 under the New York State Delivery System Reform Incentive Payment (DSRIP) program. To address uncontrolled blood pressure in the region, ECMCC facilitated a partnership including representation from its board treasurer, a prominent local bishop, another board member (Millennium's executive director), and ECMCC's assistant medical director, who serves as Millennium's chief medical officer.

Aligned with the national Million Hearts® initiative, the partnership aims to prevent heart attacks and strokes by improving access to effective care and quality of care for the “ABCs” of heart health— aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation. This partnership includes a steering committee with the University at Buffalo School of Nursing (UBSON) and Greater Buffalo United Church Ministries (GRUM Buffalo®), to bring “Million Hearts Health Screening Events” directly to the local community, including GRUM parishioners.

The project goal is to align the western New York regional rate of controlled blood pressure to 73.3% in keeping with the Prevention Agenda state goal. This project is aligned with the New York State Prevention Agenda's “Prevent Chronic Diseases” priority area.

OUTCOMES

- More than 222 people have participated in the Million Hearts screenings held at seven churches and three community events.
- About 24.5% of the participants were identified as having stage 1 hypertension, and approximately 7.7% have stage 2 hypertension.
- Seventy-eight University at Buffalo undergraduate and 30 registered nurse/bachelor of science nursing students have completed Million Hearts training and been involved in the health screenings.

LESSONS LEARNED

- Commitment and active participation from ECMCC's top leadership was instrumental in assembling the multi-organization partnership to implement the initiative.
- GRUM Buffalo identified parishioners residing in high-risk ZIP Codes targeted for this intervention.
- UBSON students completed an online clinical course module for Million Hearts through Ohio State University (OSU). Students used OSU course materials to complete a specific number of Million Hearts screenings at each community event.

SUSTAINABILITY

- The goal is to extend collaborative multi-sector partnerships to improve health outcomes across western New York counties where health disparities exist.
- The Steering Committee began planning for 2017 with four Million Hearts screening events in April in targeted ZIP Codes.
- Another hospital and university in Niagara County have begun plans to replicate the Million Hearts model through a coalition of healthcare, higher education institutions, and faith-based ministries.

Opiate Reduction Medicaid Accelerated Exchange Series Project Ellenville Regional Hospital

YEAR INITIATIVE STARTED

2015

PARTNERS

Ellenville Regional Hospital

The Institute for Family
Health

Local/Community Primary
Care Providers

CONTACT

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PROGRAM DESCRIPTION AND GOALS

Ellenville Regional Hospital (ERH) and The Institute for Family Health (IFH) initiated a community-wide Opiate Reduction Medicaid Accelerated Exchange Series Project (Max Project) as part of the New York State Delivery System Reform Incentive Payment (DSRIP) program. At ERH, a small percentage of patients (“super utilizers”) relied excessively on the hospital’s emergency department (ED) for chronic pain relief.

A cohort of 64 patients was identified who met the following criteria: chronic pain diagnosis, and five or more visits to the ED during the baseline period of May 2015 to October 2015 with treatment of chronic pain by opioids administered intravenously, intramuscularly, or subcutaneously. The project team developed a chronic pain policy with new ED treatment protocols using non-addictive pain medications and a warm hand-off to a care navigator to assist the patient to access primary care or other community-based health services.

This project falls under the Prevention Agenda’s “Promote Mental Health and Prevent Substance Abuse” priority area. Goals of the project are to reduce the administration of opioids to super utilizers in the ED, reduce the number of ED visits by this group, and link these patients to primary care providers and mental health and addiction services.

OUTCOMES

- Within a year of implementing the Max Project in November 2015, visits to the hospital’s ED by a cohort of 64 super utilizers dropped significantly from an initial baseline number of 69.7 ED visits per month to 36 visits per month (48.6% decline).
- Similarly, administration of opioids to super utilizers of the ED for chronic pain dropped from a baseline rate of 63.6 opioids administered per month to a rate of 22.6 per month (63.6% decline).
- In general, opioids administered to patients presenting to the ED (excluding the super utilizer group) also showed a decrease in administration from a baseline rate of 167 per month to a rate of 96 per month (42.5% decline).

LESSONS LEARNED

- Care navigation services should be offered 24/7 to provide a warm hand-off for this complex patient population that requires help with medical, social, and behavioral issues.
- Provider education is key to changing practice patterns for the care of chronic pain patients using the hospital’s ED. In addition, support from hospital and medical staff leadership is required to continue building this model of alternative care delivery for chronic pain patients.

SUSTAINABILITY

- ERH and IFH will continue to provide staff support for this program.
- This standardized chronic pain policy is sustainable, as it avoids the use of opioid-based medications for patients presenting to the ED, assuming that ongoing care for chronic pain will be addressed by the patient's primary care provider linking them to a pain management specialist or ancillary services to facilitate healing.

Choose Health Action Teen (CHAT) Program Finger Lakes Health Geneva

YEAR INITIATIVE STARTED

2013

PARTNERS

Geneva City School District

Penn Yan School District

Dundee School District

Hobart and William Smith
Colleges

Finger Lakes Times

Finger Lakes Daily News

Finger Lakes Radio Group

Seneca County Cornell
Cooperative Extension

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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 CHAT curriculum is aimed at eight- to 12-year-olds and targets those behaviors research shows to be most important for preventing childhood obesity and chronic diseases, such as heart disease and diabetes. The curriculum uses experiential learning to teach healthy eating and active play. While this is a program overseen by Finger Lakes Health, the teen CHAT volunteer mentors are key to its success.

Finger Lakes Health bases programming on areas of health and wellness that matter most in the communities it serves, as determined by health needs assessments done collaboratively between the health system and local public health departments. One of the priorities adopted from the New York State Prevention Agenda is "Reduce Obesity in Children and Adults." By conducting this CHAT program in local school districts, Finger Lakes Health directly impacts this Prevention Agenda priority.

Bad habits can be difficult to break, so the goal of the CHAT program is to address children's behaviors early—before lifelong habits are formed. Children who maintain a healthy weight are more likely to stay at a healthy weight as adults.

OUTCOMES

- With 86 kids surveyed after "Color Your Plate! Eat More Vegetables and Fruits," 65% said they will now cover half their plate at lunch or dinner with fruits and/or vegetables.
- With 96 kids surveyed after "Make Half Your Grains Whole! Eat More Whole Grains," 66% said they now know how to tell if a food is whole grain.
- With 111 kids surveyed after "Healthier Foods—Fast. Eat fewer high-fat, high sugar foods," 92% said they will make healthier choices when going to fast food restaurants.

LESSONS LEARNED

- Interactive, hands-on lessons are ideal for keeping kids of this age interested and engaged. They know that each lesson will be fun, fast-paced, and exciting.
- Teen facilitators are components to the success of the program. The strong curriculum enables the mentors to gain a high level of teaching competence quickly. The teens gain confidence and are able to be role models for the younger children.

SUSTAINABILITY

- CHAT is sustainable as long as school districts are open to the programming.
- Sustainability is easily attainable as long as a small budget is intact (and the health system is committed to continuing to support the program).
- There are few out-of-budget costs for the program.

A Healthier Community: The Implementation of the National Diabetes Prevention Program Flushing Hospital Medical Center

YEAR INITIATIVE STARTED

2015

PARTNERS

In-house departments including information technology, food and nutrition, and primary care physicians of the ambulatory care clinic

The Quality and Technical Assistance Center

New York City Department of Health and Mental Hygiene

Community faith-based organizations (i.e., First Baptist Church of Flushing and Young Women's Christian Association)

Tulane University School of Public Health and Tropical Medicine

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PROGRAM DESCRIPTION AND GOALS

This initiative is designed to prevent chronic diseases, specifically the onset of Type 2 diabetes. With the launch of the National Diabetes Prevention Program, Flushing Hospital Medical Center (FHMC) strives to reduce the diagnoses of Type 2 diabetes in pre-diabetic participants. The program is a full-year course created to educate patients on healthier eating, the importance of physical activity, and ways to reduce stress. The goal of the program is to have participants lose 5% to 7% of their initial weight, which, along with healthy lifestyle changes, has proven to reduce the risk of developing Type 2 diabetes by 58%.

OUTCOMES

- People in the first program cycle, which consisted of 36 participants, lost a total of 488 pounds.
- FHMC is currently running a second and third cycle combined, with 29 participants who have lost 120 pounds to date.
- Participants who have reached the program goals reported reduced or normal levels of glycated hemoglobin and cholesterol.

LESSONS LEARNED

- The camaraderie that develops during group sessions has proven to be a source of encouragement and accountability for participants to reach their goals.
- Using diagrams and visuals helps to communicate complex terms.

SUSTAINABILITY

- Flushing Hospital Medical Center maintains certification for its lifestyle coaches by facilitating programs annually.
- The Medical Center upholds collaborations with in-house departments and partnering organizations for recruitment and optimal health in the community.

Mall Community Health and Wellness Fairs Good Samaritan Hospital Medical Center West Islip

YEAR INITIATIVE STARTED

2014

PARTNERS

Westfield South Shore Mall
Westfield Sunrise Mall
Island Digestive Health Center
Youth Enrichment Services
Lord and Taylor
Fidelis Health Care
Wild by Nature
West Islip Breast Cancer Coalition
Good Samaritan Junior Volunteers
Personal Touch II
Teachers Federal Credit Union

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PROGRAM DESCRIPTION AND GOALS

The Westfield South Shore Mall Health and Wellness Fairs offer free health information, screenings, and services to a diverse community population, from pediatrics to senior citizens. Since February 2014, ten events have taken place, reaching and interacting with more than 4,500 people. Each event has a specific focus, including heart health, breast cancer, and children's health, with health information and services to promote overall wellness. These scheduled health events are open to the public and encourage attendees to visit display tables and take part in free screenings. Children and adults interact with physicians and clinical staff, asking questions and gathering information regarding healthy living, risk factors, new procedures, preventive information, and the Good Samaritan Hospital Medical Center's services and programs.

The Mall Health and Wellness Fairs provide the opportunity to address a number of Prevention Agenda topics. The main topics of the fairs—Open Your Heart to Health, Positively Pink Breast Cancer, and The ABCs of Children's Health—provide the opportunity to include information and free screenings for hypertension, obesity, vaccine-preventable diseases, child health, and maternal and infant health.

OUTCOMES

- More than 4,500 people participated at ten events held since 2014.
- Free health screenings for cholesterol, blood pressure, and body mass index were provided for 1,493 adults, and 24 women were assisted onsite for screening mammography appointments.
- Four events offered the opportunity to administer 158 free adult flu vaccines.

LESSONS LEARNED

- In a non-clinical setting, the community is more inclined to interact, take part in healthcare discussions, and seek information from medical professionals due to the more approachable environment.
- The health and wellness fairs are strategically set up in a friendly, welcoming manner, inviting all to learn and ask questions.

SUSTAINABILITY

- The ability to sustain this initiative is based on a strong partnership with the Medical Center's neighboring venue; and support of its associates, sponsors, and dedicated staff to meet the increased number of attendees participating in the free health screenings.
- As of January 2017, this program has been duplicated at the Westfield Sunrise Mall in Massapequa—a new captive audience and demographic.

Jam-Out/Breathe Better Jamaica Hospital Medical Center

YEAR INITIATIVE STARTED

2015

PARTNERS

School-Based Health Program at PS 155
School-Based Health Program at PS 223
School-Based Health Program at Campus Magnet
Asthma Coalition of Queens
MediSys Jamaica Medical Clinic
MediSys Hollis Family Care

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PROGRAM DESCRIPTION AND GOALS

The goal of Jamaica Hospital Medical Center's Jam-Out/Breathe Better initiative is to increase access to high-quality asthma care for children and teens up to age 18 in the Jamaica/Hollis community.

Consistent with the Prevention Agenda, Jamaica Hospital Medical Center aims to reduce asthma emergency department and asthma hospital discharge rates in the community and increase the percentage of members with persistent asthma who are dispensed the appropriate controller medication. Asthma hospitalizations are the result of exposure to factors that trigger asthma episodes and/or poor access to quality primary care; good outpatient asthma care could help prevent avoidable hospitalizations.

Significant asthma-related health disparities persist; asthma is more common and more severe in certain populations. Jam-Out/Breathe Better targets children who are affected by asthma at disparate rates. The Medical Center's clinics work with schools to minimize asthma symptoms and exacerbations. Staff use evidence-based guidelines to classify and treat asthma while empowering and motivating children and their families to self-manage their condition.

OUTCOMES

- Asthma action plans are an important part of asthma care. At baseline, a 0% completion rate was noted. After implementation, 91% of patients had an asthma action plan.
- Patients with persistent asthma require a controller medication. At baseline, 42% of patients with persistent asthma were prescribed an inhaled corticosteroid. At one year, 88% were prescribed an inhaled corticosteroid. In year two, a random audit of ten patients showed that 100% were prescribed an inhaled corticosteroid.
- Asthma control tests are important to evaluate and properly manage asthma and its symptoms. At baseline, 13% of patients had an asthma control test, and, after project implementation, 77% had a control test.

LESSONS LEARNED

- Jamaica Hospital Medical Center's success is largely attributed to staff training, teamwork, and strong relationships. Staff learned up-to-date asthma treatment guidelines and innovative methods to teach asthma self-management skills to kids and their families.
- Standardization of data captured helped compare one site to another and allowed the Medical Center to create a forum to discuss successes and help one another with challenges.

SUSTAINABILITY

- Use clinical practice guidelines with staff training, and ensure that each team member has a clear understanding of his or her role.
- Periodically assess the demographic makeup of the community to ensure that the education materials are in a language and at a literacy level appropriate for the children served.
- Focus on teamwork and build strong relationships and partnerships with all project stakeholders.

Walkable Community—Vision 2020

Jones Memorial Hospital

Wellsville

YEAR INITIATIVE STARTED

2015

PARTNERS

Jones Memorial Hospital
New York State Department
of Environmental
Conservation
Town and Village
of Wellsville
Alfred State College
Wellsville Chamber
of Commerce
Vision 2020
New York State Department
of Transportation
LC Whitford Co., Inc.
Army Corps of Engineers
Ardent Rural Health
Landowners

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PROGRAM DESCRIPTION AND GOALS

The WAG Trail is a nine-mile multi-use recreation trail and historic transportation corridor in Allegany County, extending between the Village of Wellsville to the Pennsylvania state line. Four miles of the trail previously were open to the public: the northern two miles and the southern two miles. The remaining five miles in the middle had a number of bridges and culverts that needed repair—which prevented the whole trail from being put to use. The hospital saw this as an opportunity to promote outdoor recreational use in the form of walking, running, biking, cross-country skiing, and snowshoeing.

The hospital contacted the Department of Environmental Conservation (DEC) to determine the barriers to completing the trail. DEC needed about \$10,000 in donated pressure-treated lumber to resurface the bridges. The hospital used the proceeds from two wellness events (Ridgwalk and Glow Run) to purchase the lumber. DEC was able to complete the bridges and open the trail to the community. The hospital's current projects include placement of kiosks that locate the walking trails and a sidewalk extension project under a busy bridge.

This initiative aligns with the New York State Prevention Agenda's focus on preventing chronic disease.

OUTCOMES

- The local government did not have a Complete Streets agreement. Now the Village and the Town of Wellsville have signed Complete Streets agreements.
- With the donation of the wellness money from the hospital, two bridges were completed and the trail opened from Wellsville to the Pennsylvania border. The WAG trail is actively used by the community.
- A sidewalk needs to be built under a bridge to connect to an existing sidewalk to avoid crossing the road at an unsafe location. A meeting with all the partners led to a plan to complete this project jointly. The applications are awaiting approval, with the plan to make the proposed changes in the summer of 2017.

LESSONS LEARNED

- When there are multiple agencies involved, working with them individually did not move the projects forward. It took the hospital leadership to pull all these groups together to support the goals.
- When the hospital brought these groups together around an issue that addressed community safety, everyone was willing to help facilitate the project.

SUSTAINABILITY

- Sustainability of these projects going forward is supported by the commitment of the hospital to population health, the Prevention Agenda, and a walkable community.
- The hospital has a very strong county and hospital wellness committee with great community partners, along with state partners of DEC, Department of Transportation, and Army Corps of Engineers.
- Financially, the runs/walks help supply some money for projects along with community agencies' in-kind donations.

Cardiovascular Education and Screening Program Kaleida Health Buffalo

YEAR INITIATIVE STARTED

2014

PARTNERS

Heart Caring® and Spirit of Women®

University at Buffalo,
Jacobs School of Medicine
and Biomedical Sciences

General Physician, PC

Erie County Department
of Health

Niagara County
Department of Health

Schools, businesses,
organizations including
faith-based and the
under-served

WUFO-AM, Great Lakes
Health Radio Program

Millennium Performing
Provider System

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PROGRAM DESCRIPTION AND GOALS

The high incidence of cardiovascular disease and its risk factors are cause for concern in the Buffalo region and the basis for Kaleida Health's goal to reduce these statistics to improve population health. Since 2014, Kaleida has implemented a multi-faceted cardiovascular education and screening program targeting multiple communities and diverse populations, with a focus on women and the under-served.

The program is aligned with the New York State Prevention Agenda priority to "Prevent Chronic Disease" as included in Kaleida's 2014-2016 and 2016-2018 Community Health Needs Assessment/Community Service Plans. Interventions are focused on increasing cardiovascular disease education and screening, in collaboration with county-based workgroups.

Through the evidence-based Heart Caring® platform, female patients of five community-based Kaleida OB-GYN Centers are provided a clinical risk assessment for cardiovascular disease at their annual gynecological visit. At-risk and high-risk patients are identified and provided further clinical screening, education, and follow-up. The program further provides several cardiovascular education and screening events, with outreach conducted throughout the health system and the community through businesses, schools, and organizations, including faith-based, and the under-served.

OUTCOMES

- In 2015-2016, of the 7,518 female patients, many under-served, receiving their annual gynecological exam at Kaleida OB-GYN Centers, 2,198 or 29% were voluntarily screened for cardiovascular disease. Of those screened, 59% were determined to be "at risk" and 10% were determined as "high risk" and were provided further cardiovascular education, consult, and follow-up.
- In 2014-2016, 6,573 people enrolled as members in the Spirit of Women® program and received monthly health and wellness information including cardiovascular disease and risk factor education.
- In 2014-2016, 10,949 individuals participated in cardiovascular education and screening events.

LESSONS LEARNED

- Cardiovascular education and screening in Kaleida OB-GYN Centers helped to alert women, many younger and under-served, about heart disease risk factors. The further identification and clinical follow-up of "at risk" and "high risk" women is key to improving the cardiovascular health of this population.
- Outreach to all populations, including the under-served, and the added support of clinical professionals were essential to the success of Kaleida's cardiovascular education and screening events.

SUSTAINABILITY

- This cardiovascular education and screening program is fully supported by Kaleida's executive team, clinical personnel, and physicians, and is provided at minimal cost as part of the health system's nonprofit commitment to improve the health of the community.
- The identification of these interventions in Kaleida's 2016-2018 Community Health Needs Assessment/Community Service Plan with alignment to county priorities and the Prevention Agenda further reinforces program sustainability.

Improving Community Health Through Tobacco Control Long Island Jewish Forest Hills/Northwell Health

YEAR INITIATIVE STARTED

2011

PARTNERS

Northwell Health

Long Island Jewish Forest
Hills Hospital

Center for Tobacco Control

Office of Strategic Planning

NYC Smoke-Free

Queens Tobacco Control
Coalition

Community Advocates

New York City Department
of Health and Mental Hygiene

New York State Department
of Health, Bureau of Tobacco
Control

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PROGRAM DESCRIPTION AND GOALS

Project goals were: 1) the promotion and development of tobacco-free environment policies in multi-unit dwellings (MUDs) in Queens; and 2) the development and implementation of tobacco-dependence treatment policies for inpatients and outpatients.

Long Island Jewish Forest Hills addressed the New York State Prevention Agenda priority “Promotion of a Safe and Healthy Environment” by reducing the burden of tobacco use and exposure to secondhand smoke (SHS). Populations with increased smoking rates and residents of MUDs with increased exposure to SHS were targeted. Education and technical assistance were provided to MUD developers, landlords, tenants, shareholders, and local community boards to effectively implement smoke-free housing policies. A system approach was undertaken to develop and implement policies to ensure that all patients received tobacco dependence treatment in the hospital and ambulatory setting using the evidence-based practice of tobacco dependence treatment.

The initiative’s success was achieved through a cross-sectional partnership of the hospital and health system administration, quality management, community outreach departments, the tobacco dependence treatment program, clinical and information technology staff, local health departments, community tobacco control coalitions, and community advocates.

OUTCOMES

- This initiative created 3,500 smoke-free MUD units in Queens County; 13 out of 14 community boards passed smoke-free housing resolutions supporting the establishment of new smoke-free MUDs.
- The NY Tobacco-free Hospital Campaign attained Gold Star status.
- Of 4,346 hospitalized patients admitted during the fourth quarter of 2015, 83.8% (3,640) were screened for tobacco use. Forty-five percent of the hospitalized patients who were smokers accepted counseling and cessation medications.
- At the ambulatory sites, in the fourth quarter of 2015, a sample chart review of 135 patients was completed, with 100% of the patients screened for tobacco use, with 100% of those identified as smokers offered counseling and cessation medications.

LESSONS LEARNED

- Effective changes to the built environment, and increasing the availability of smoke-free housing through policy change, resulted from a cross-sectional team of partners using a collective impact model of population health.
- For the tobacco-dependence treatment program, leveraging existing partner resources, adding additional supports to fill identified gaps, staff education, and the availability of evidence-based treatment embedded in the electronic health record were essential for success.

SUSTAINABILITY

- These initiatives are sustainable because they are policy-driven.
- For the tobacco-dependence treatment initiative, the electronic health record will be instrumental in sustaining the project.
- The above initiatives have been added to the hospital's 2016-2018 New York State Department of Health Community Service Plan to provide sustainability.
- Both programs also support the Delivery System Reform Incentive Payment "Triple Aim" and have been integrated into the project work plans.

Improving Breastfeeding Support Mercy Hospital of Buffalo

YEAR INITIATIVE STARTED

2012

PARTNERS

New York State
Department of Labor
United Way
Women, Infants, and
Children (WIC) Program
OBGYN Associates
Catholic Health System
McAuley-Seton Home Care
Corporation

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PROGRAM DESCRIPTION AND GOALS

The New York State Prevention Agenda aims to improve maternal and infant health by increasing the percentage of infants who are breastfed. Mercy Hospital of Buffalo began a multi-layer initiative to improve the overall breastfeeding rate by 10% in its community. A partnership with a private group of obstetrical physicians and the hospital prenatal clinic was instituted to achieve “Breastfeeding Friendly” designation for their practice. Re-training nursing staff to achieve the International Board Certified Lactation Consultant (IBCLC) certification helped Mercy Hospital to broaden its IBCLC coverage to 12 hours per day, seven days per week.

Partnership with community agencies enabled the hospital to train five additional staff members to achieve Certified Lactation Counselor status. Staff development across the entire women’s services division promoted skin-to-skin contact and initiation of breastfeeding within one hour of life. Establishing a Baby Café at two sites in the area assisted with post-discharge support. Childbirth education staff added classes for grandparents to support breastfeeding. The IBCLC team has implemented a new class to assist mothers returning to work.

OUTCOMES

- The overall breastfeeding rate at Mercy Hospital improved by 10% since the initiation of the partnerships; 2013: 68%, 2014: 62%, 2015: 79%, 2016: 78%.
- Patients have expressed increased satisfaction with the amount of breastfeeding support received in the hospital as evidenced by the decrease in complaints.
- The number of neonatal intensive care unit admissions purely for the diagnosis of hypoglycemia in the term infant has decreased since the initiation of the skin-to-skin/golden hour as well as the initiation of early breast feeds.

LESSONS LEARNED

- Community partnerships and relationships with key physician groups are essential to solving community-based problems. Physician-initiated education early in pregnancy can improve breastfeeding rates.
- The hospital has looked to other resources to support educational efforts to improve the quality of nursing staff education. Mercy Hospital is expanding its horizons to seek out grant funding from a variety of sources and will continue to support staff in the years to come.

SUSTAINABILITY

- The breastfeeding rate has risen steadily and has been sustained over the last three years thanks to continued partnerships with OBGYN Associates, WIC, and McAuley-Seton Home Care.
- The hospital is also a participant in the New York State Department of Health's National Institute for Children's Health Quality (NICHQ) breastfeeding grant program, in an effort to continue to increase exclusive breastfeeding rates. This grant has allowed the hospital to work with parent participants and establish additional staff development programs to enhance breastfeeding.

Montefiore Healthy Store Initiative Montefiore Health System Bronx

YEAR INITIATIVE STARTED

2015

PARTNERS

New York City Department
of Health and Mental Hygiene

Bronx REACH CHAMPS

Bronx Bodega Workgroup

Jetro Cash & Carry

Martes Food Center

Aqui Me Quedo Deli

Bronx New Way

Duverge Deli

Gold Grill Deli

J & E Deli

Mango Grocery

Vivian Grocery

Z & F Deli

Bronx Works

Church of God of Prophecy

Eagle School

Eastchester Presbyterian
Church

Eastchester Gardens
Community Center

Jacob's Place

Montefiore Medical Group

New Settlement Girls
Program

The Point

PS 246 Poe Center

Union Community Teen
Health Center

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PROGRAM DESCRIPTION AND GOALS

Through its Healthy Store Initiative (HSI), Montefiore Medical Center's Office of Community and Population Health is working to create sustainable food retail change through increasing community access to healthy foods and beverages by partnering with local bodegas and community-based organizations. The goals of the project include:

- increasing the supply of healthy food/beverages in local stores;
- enhancing promotion of healthy items in local stores; and
- developing collaborations with local community groups to increase demand for healthy items in stores.

Using a place-based approach to target bodegas in Bronx census block groups with large numbers of obese patients, four target areas were identified in April 2015. Montefiore Medical Center adopted a two-pronged strategy addressing both supply and demand-side factors related to availability and consumption of healthy food.

The work is in alignment with the state's Prevention Agenda priority area of "Preventing Chronic Diseases." Montefiore is focused on area 1: Reducing Obesity in Children and Adults, which has the targeted objective to decrease the percentage of adults ages 18 years and older who consume one or more sugary drinks per day by 5% from 20.5% (2009) to 19.5% among all adults and by 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < \$25,000.

OUTCOMES

- At follow-up, all stores (100%) sold water at eye-level in refrigerators, compared to 50% at baseline.
- There is an increase in availability of low-sodium canned beans. Twenty-five percent of stores carried them at baseline compared to 100% at the follow-up assessment.
- Montefiore observed an increase in availability of canned fruit in 100% juice/light syrup (50% to 88%), fresh ready-to-eat fruits (0% to 25%), and dried fruit (38% to 63%), from baseline to follow-up assessment.

LESSONS LEARNED

- In addition to offering concrete resources and educational opportunities for owners and community-based organization (CBO) partners, it is crucial to work on shifting residents' perceptions of what can be bought in bodegas and owners' perceptions of what consumers will buy.
- Enhancing the promotion of healthy items already sold in stores, while providing small quantities of new products that stores can pilot to assess sales, reduces upfront costs. As these items sell, owners will continue their stocking and promotion.

SUSTAINABILITY

- Montefiore continues to facilitate ongoing dialogue between owners and CBOs to ensure a shared commitment in which CBOs consistently purchase healthy items and owners continually offer these items while maintaining welcoming stores.
- Providing effective, cross-sector education and messaging increases community awareness about the impact of diet on health.
- The medical center provides technical assistance to food suppliers on increasing promotion and availability of healthy items for purchase by store owners.

Ambulatory Outreach Services Initiative NYC Health + Hospitals—Lincoln Bronx

YEAR INITIATIVE STARTED

2010

PARTNERS

MetroPlus

Consulates:

Mexico, Dominican Republic,
Guatemala, El Salvador,
Colombia, Costa Rica,
Ecuador, Honduras, Peru

Islamic Centers:

Fouta Djallon, Yankasa,
Imole Adinni, Muslim
Women's Institute, Masjid
Ibadu-Al Rahmaneh, Masjid
An-Nasr, Masjid Bilal Ben
Rabbah, Masjid Salam,
Islamic Sunnatul, Masjid
Ebun Abass, Masjid Makki
Fallah, Masjid Deyave,
Masjid Sidiki, Nurudeen,
Masjid Ali, Looqman Islamic,
Masjid Al-Wahab, Masjid
Omar, Hefatul Al-Islam
Mosque, African Islamic,
Masjid Al-Huda

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PROGRAM DESCRIPTION AND GOALS

The initiative fulfills several elements of the state's Prevention Agenda: "Prevent Chronic Diseases"; "Promote Healthy Women, Infants, and Children"; Promote Mental Health and Prevent Substance Abuse"; and "Prevent HIV/Sexually Transmitted Diseases and Vaccine-Preventable Diseases." NYC Health + Hospitals—Lincoln's bilingual, multi-ethnic staff provide health education workshops, screenings, and care coordination to immigrant communities at nine Latin American Consulates and 24 Islamic centers, eliminating barriers that keep immigrant groups from accessing healthcare, connecting them to services, and improving health outcomes.

Clients come to the Consulate to receive services; Muslims go to the Islamic centers for prayer. While there, they are encouraged by the Consul or Imam to participate in the program. The team also provides screenings. Those needing medical services are referred to the hospital. On the day of their first appointment, staff greet the patients in the lobby, reaffirming the hospital's commitment to their health. Patients also have the opportunity to enroll in a fee-scale program based upon income or a Medicaid managed care plan. The educators reassure clients that the hospital provides care to all regardless of immigration status or ability to pay, and that their immigration status is not shared.

OUTCOMES

- The Ambulatory Outreach Services Initiative at the Latin American Consulates has provided services to 6,300 people since its inception in 2010.
- Partnerships have increased 200%, from three Consulates to nine. Blood pressure screenings increased 37-fold, from 25 to 925.
- More than 400 clients without insurance were either enrolled in MetroPlus or fee-scaled, and 405 medical appointments were made for those disconnected from healthcare.
- The Islamic centers component has grown since it began in 2014. More than 2,000 people have participated, more than 500 received blood pressure screenings, nearly 100 people were connected to health insurance/fee-scaled, and the same amount received medical appointments.

LESSONS LEARNED

- It is important to develop strong working relationships with partners and to have an official contact person to establish client trust. It is easier to work with partners when they know that the hospital is a vested stakeholder.
- A referral form for use by partners lets them know that the hospital is available to their clients whenever services are needed, not just the day of the field visit. Referral/screening forms enable staff to track patients, fully capturing data.

SUSTAINABILITY

- The initiative expands by leveraging existing partnerships and establishing new ones, developing a strong communication strategy to share successes with large audiences.
- Ensuring access to affordable healthcare is a priority; increasing managed care enrollment is a strategic activity.
- Programs have been developed using feedback from the community, a major step to ensure the participation of key stakeholders in program development.
- A continuous evaluation cycle ensures that programs remain relevant.

Transitional Supportive Housing for the Homeless Rochester Regional Health System

YEAR INITIATIVE STARTED

2015

PARTNERS

Health Home Care Management
Homecare
Inpatient social work and care management staff
Outpatient social work and care management staff
Office of Mental Health
Department of Social Services
Local emergency shelters
Home infusion services
Local and hospital pharmacies
Permanent housing providers
Assisted living facilities
Durable medical equipment suppliers
Mental health services
Chemical dependency services
Alcoholics Anonymous
Narcotics Anonymous
Transportation services

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PROGRAM DESCRIPTION AND GOALS

The transitional supportive housing program aligns with the state's Prevention Agenda items of promoting mental, emotional, and behavioral well-being in communities, preventing substance abuse and other mental/emotional behavioral disorders, improving health status, reducing health disparities, and promoting a healthy and safe environment. The program aims to assist patients identified as homeless or at risk for homelessness in an inpatient setting and upon agreement create a discharge plan to a supported transitional site with the goal of getting these patients into permanent housing. In addition to promoting well-being in communities, the transitional location promotes preventing substance abuse by promoting a sober environment and assisting patients to Alcoholics Anonymous, mental health, and health appointments.

The program began in December 2015 with two behavioral health transitional beds and added eight medical transitional beds in April 2016. Since the program began, more than 70 patients have been placed in the transitional beds, with 80% being discharged to permanent housing.

Project goals include placement in permanent housing; reduction in emergency department visits, inpatient admissions, and length of stay; increased compliance with follow-up appointments; and health home care management enrollment.

OUTCOMES

- Data from December 2015 through December 2016 show that 69 patients were placed in transitional supportive housing with:
 - 80% discharged to permanent housing;
 - number of emergency department visits decreased by 54%; and
 - inpatient admissions decreased by 63%.
- The average Office of Mental Health Single Point of Access Housing Application timeframe decreased from 120 days to 35 to 40 days.

LESSONS LEARNED

- Increased and effective communication across the system is essential to achieve a collective goal of permanent housing.

SUSTAINABILITY

Rochester Regional Health System cites the following factors that contribute to the sustainability of this initiative:

- inpatient referrals double the amount of transitional beds;
- the health system strongly supports this program;
- processes and protocols were developed for identification, tracking, referrals, placement, addressing barriers, etc.;
- partnership with health home care management;
- interoperable electronic medical record system;
- reporting to analyze patient data, trends, and successes; and
- building additional funding sources with Medicaid managed care organizations, Department of Social Services, and other sources.

The Significant Other and Family Program South Oaks Hospital/Northwell Health Amityville

YEAR INITIATIVE STARTED

2015

PARTNERS

LI Helps Recovery Initiation
Families in Support
of Treatment (F.I.S.T.)
Narcotics Anonymous
New York State Department
of Health
Lindenhurst School District

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PROGRAM DESCRIPTION AND GOALS

The Significant Other and Family Program is comprised of therapists who treat individuals who have a loved one who is or has struggled with drug addiction. Other counselors help engage significant others and families by identifying family dynamic issues with patients and then referring them to licensed therapists to address these issues. The program offers weekly groups for significant others and groups for patients enrolled in the facility to provide further education regarding addiction and its impact on the family. The group setting allows family members and substance users to identify and share how substance abuse has affected them, and learn from their peers who have also been impacted in similar ways. In an attempt to engage as many people in need of treatment, family therapists offer weekly educational groups, open to all members in the community.

The Significant Other and Family Program is consistent with New York State's Prevention Agenda and Health Improvement Plan. New York State's Department of Health is committed to preventing substance abuse and other mental, emotional, and behavioral disorders to improve health outcomes and reduce health disparities. South Oaks Hospital's program aligns with this goal to promote mental, emotional, and behavioral well-being within the communities it serves.

OUTCOMES

- From July 2015 (start of the program) through December 2015, a total of nine family sessions were held, and 107 individual significant other sessions.
- From January 2016 through December 2016, 107 family sessions and 368 individual significant other sessions were held.
- From January 2017 to March 2017, a total of 17 family sessions and 29 individual significant other sessions were held.

LESSONS LEARNED

- More progress is documented when a significant other is engaged in the addicted patient's treatment plan from the beginning; requiring family involvement may increase the number of significant others involved in treatment.
- Free community offerings are more effective when they have an educational approach rather than a therapy format, so that those interested can also learn about recovery and addiction and the important role of a significant other.

SUSTAINABILITY

The program demonstrates continued growth while addressing a community need by:

- encouraging patients to involve a significant other/family member in treatment as part of the intake process;
- offering a significant other/family member their own individual treatment at the start of their involvement in their loved one's treatment; and
- expanding community member participation in free seminars, which has increased referrals of those who may not yet be in treatment, supporting early intervention.

Arterial Screenings for the East End Southampton Hospital

YEAR INITIATIVE STARTED

2016

PARTNERS

Stony Brook Vascular Center
Meeting House Lane Medical
Practice

Meeting House Lane Surgical
Specialties

Southampton Hospital
Foundation

Audrey and Martin Gruss
Foundation

Montauk American
Association of Retired
Persons

Southampton and
Westhampton Free Library

Southampton Greek Church

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PROGRAM DESCRIPTION AND GOALS

Arterial Screenings for the East End offers free arterial screenings for neighboring communities. Each screening includes three tests: bilateral carotid ultrasound, abdominal aorta ultrasound, and bilateral ankle brachial indexes. Patients are pre-screened and required to meet specific criteria. Southampton Hospital conducted five screenings throughout 2016 in various locations within the community. Each screening had 40 to 60 participants.

Results and education were reviewed with participants immediately after their tests. If an individual had an abnormal finding, he or she met with a vascular surgeon who explained the results and the importance of follow-up.

This project relates to the New York State Prevention Agenda by preventing chronic diseases and promoting a healthy and safe environment. Arterial screenings promote awareness and education for abdominal aortic aneurysms, carotid artery disease, and peripheral artery disease. These diseases are serious and life-threatening, often occurring without any symptoms.

Program goals include:

- screening 40 to 60 qualified individuals at each event;
- provide vascular education to heighten awareness, promote prevention, and explain treatment; and
- all individuals who provide consent will have their results provided to their primary care physicians.

OUTCOMES

- Participation:
 - average number of registrants at each screening: 50;
 - average percentage of attendance: 90%; and
 - total number of registrants: 249; total number of screened: 224.
- Abnormal Findings:
 - five people had carotids with stenosis greater than 50%;
 - six people had abdominal aortic aneurysms with 3cm or greater; and
 - twelve people had abnormal ankle brachial index exams, indicating the presence of peripheral artery disease.
- Follow-up to primary care physician is done by a screening registered nurse coordinator:
 - compliance with sending results to primary care physicians: 100%; and
 - compliance with a phone call made to primary care physician if an abnormal result was found: 100%.

LESSONS LEARNED

- It is important to focus on one small community at a time to make sure all individuals within that community have a chance to participate in the screening. Focus on using advertising directly related to the specific community.
- Partnering with local physician offices provides more organization and a better perspective on how to reach individuals within the community who can benefit the most.

SUSTAINABILITY

- Southampton Hospital will conduct five free arterial screenings in new locations throughout its community in 2017.
- The hospital will continue to provide free education seminars related to vascular disease awareness, prevention, and treatment.

“Your Story Isn’t Over: An Evening of Suicide Awareness” St. Mary’s Healthcare Amsterdam

YEAR INITIATIVE STARTED

2015

PARTNERS

St. Mary’s Healthcare
St. Mary’s Behavioral
Health Coalition
Catholic Charities
Hometown Health
Montgomery and Fulton
County Public Health
Fulton County Mental Health
Community Health Center
Hamilton, Fulton,
Montgomery Prevention
Council
Montgomery County
Office of Aging
National Alliance
for Mental Illness
Mental Health Association
in Fulton and Montgomery
Counties
Fulton-Montgomery Suicide
Task Force
The Family Counseling
Center
Greater Amsterdam
School District
Gloversville Enlarged
School District

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PROGRAM DESCRIPTION AND GOALS

St. Mary’s Healthcare coordinated two free community informational sessions with a goal of providing education about the difficult and uncomfortable topic of suicide. A secondary goal was to give participants an opportunity to receive information on appropriate mental health resources within the community.

During these free seminars, held in highly accessible locations in Fulton and Montgomery counties, a total of 120 participants heard from two speakers, both of whom had suffered the loss of a loved one to suicide. Participants were encouraged to share experiences and reach out to local resources. Information on local and regional support resources was disseminated at both events. A panel of local experts answered questions. Ten collaborative organizations staffed information tables and provided face-to-face interventions and resources. This program complimented two local Narcan training efforts.

This initiative relates to the Prevention Agenda’s “Promoting Mental Health” priority, specifically Focus Area 1: “Promote Mental, Emotional, and Behavioral Well-Being in Communities.”

OUTCOMES

- There were 120 participants; written evaluations indicated that 99% were able to identify resources that would be able to assist in the event that suicide was suspected.
- Ninety-nine percent of participants reported that they learned something new about suicide prevention.
- Participants welcomed the opportunity to be in a room where they could feel comfortable and validated in an open discussion surrounding suicide.

LESSONS LEARNED

- There are previously unidentified individuals in the service area who would benefit from awareness of mental health services.
- St. Mary’s Healthcare will identify methods for ensuring consistent flow of information and updated resources to the community.
- The program is effective when there is the ability to tailor the content to various populations. The first program was for the general public; the next was geared toward faculty and students, specifically in the Gloversville school district.

SUSTAINABILITY

- The program can be easily sustained with limited effort on the part of the collaborators. There are people willing to share their story and how they overcame a difficult time in their lives, whether they attempted suicide or were survivors of a loved one's loss.
- St. Mary's brought the program to Gloversville because of recent student suicides. The program is mobile and customizable, and can be done anywhere to suit the needs of a specific target audience with minimal monies or sponsorships.

Brooklyn Health Disparities Center
SUNY Downstate Medical Center
Brooklyn

YEAR INITIATIVE STARTED

2012

PARTNERS

Arthur Ashe Institute
for Urban Health

Brooklyn Borough President's
Office

United Hospital Fund

National Institute of Health

Summer Institute Program
to Increase Diversity in
Cardiovascular Health
Disparities Research

CONTACT

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PROGRAM DESCRIPTION AND GOALS

Brooklyn Health Disparities Center (BHDC) is a novel partnership formed in 2004 between a community-based organization (Arthur Ashe Institute for Urban Health), a government office (Brooklyn Borough President), and an academic research institution (SUNY Downstate Medical Center) that is committed to reducing health disparities in Brooklyn and increasing the level of engagement of academics, community members, and policymakers in the process.

Among BHDC's many offerings is training/educational programming for high school through graduate-level students to address health disparities. High school students enrolled in the summer program are trained on the basic research methodology and are connected with an internship at community-based organizations where they collaborate in groups on research projects under the supervision of SUNY Downstate faculty. Their research focuses on the health status of specific community groups, socioeconomic research on the factors that contribute to poor health, and program evaluation. Career mentoring/shadowing opportunities are provided to connect students to health professionals representing a diverse range of public health careers.

OUTCOMES

- Through the youth summer internship program, 200 high school students were trained on the basic research methodology.
- Ten college and post-college students were trained in research methodology.

LESSONS LEARNED

- BHDC must continue to foster equitable community-academic government collaborations, develop community-engaged projects, and increase the number of successful under-represented minorities' researchers.
- Through this initiative, employing community-engaged approaches, high school, undergraduate, and graduate-level under-represented minorities are trained to address health disparities in Brooklyn.

SUSTAINABILITY

BHDC has obtained funding through the following:

- a \$5.5 million National Institutes of Health (NIH) grant in 2012, with long-term objectives to foster community-engaged research that contributes to the elimination of racial/ethnic disparities in Brooklyn, and to disseminate the ensuing clinical and community defined evidence-based health findings among academic, community, and policy stakeholders;
- Empire State Development's Division of Science, Technology and Innovation (NYSTAR); and
- an NIH P20 grant.

Creating Community Supports for Breastfeeding in Chautauqua County UPMC Chautauqua WCA Jamestown

YEAR INITIATIVE STARTED

2014

PARTNERS

UPMC Chautauqua WCA
Maternity and Chautauqua
OB/GYN Prenatal Clinic

Chautauqua County Health
Department Community
Health Worker Program

Chautauqua County Nurse
Family Partnership Program

Brooks Hospital Maternity
Department

Chautauqua County Maternal
Infant Child Health Coalition

Blackwell Chapel Ame Zion
Church

The Chautauqua Center

Chautauqua County Cornell
Cooperative Extension

Chautauqua Opportunities

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PROGRAM DESCRIPTION AND GOALS

Creating Community Supports for Breastfeeding in Chautauqua County began in mid-2014 following the completion of the 2014-2017 Community Health Improvement Plan, which was developed in conjunction with the county's local health department and the four county hospitals. UPMC Chautauqua WCA's health planning team identified three collaborative priority areas from the New York State Prevention Agenda: "Prevent Chronic Diseases" and "Promote Mental Health and Substance Abuse" were selected by all partners, and "Promote Healthy Women, Infants, and Children" was selected by the local health department and the two hospitals that offer labor and delivery services.

OUTCOMES

- The percentage of infants who were breastfed exclusively in the hospital increased from 51.4% in 2011 to 58.4% in 2016.
- The number of hospital and community members professionally trained in lactation education increased: there are ten new Certified Lactation Consultants.
- Both hospitals have breastfeeding-friendly environments with the development of policies through the Great Beginnings NY and Breastfeeding Quality Improvement in Hospitals initiatives.

LESSONS LEARNED

- Navigating hospitalized new mothers to breastfeeding resources and follow-up after discharge increases the chances that they will continue to breastfeed longer than non-educated moms.
- Mothers need to be educated earlier in their pregnancies and breastfeeding needs to be promoted in the community to increase acceptability.
- Creative thinking is needed on how to use social media to reach out to young mothers, get them to attend the Baby Café, and call the county breastfeeding hotline.
- Collaborative work over the next several years will include thinking about how to effectively engage new mothers.

SUSTAINABILITY

- Breastfeeding policies incorporated into hospital administrative policy handbooks ensure that evidence-based education and resources are available to new mothers.
- Incorporating Certified Lactation Counselors within hospital maternity wards will provide consistent breastfeeding education and easy access to a trained professional.
- The local health department will maintain the breastfeeding helpline and closed Facebook group with trained individuals employed in the Maternal and Infant Health Program.

A Unique Community Partnership to Increase Colorectal Cancer Screening Upstate Medical University Syracuse

YEAR INITIATIVE STARTED

2014

PARTNERS

Upstate Cancer Center at
Upstate Medical University

77 Kinney Drug Stores

American Cancer Society

Samaritan Medical Center

Quest Diagnostic Lab

CONTACT

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PROGRAM DESCRIPTION AND GOALS

Colorectal cancer, the third most common cancer in the United States, can largely be prevented by screening, with removal of pre-cancerous polyps. Colorectal screening rates are 65.1% nationally and 69.4% in New York State. This indicates a need for a proactive community approach with the goal of prevention and early detection of colorectal cancer and subsequent mortality reduction.

A national goal to get 80% of the population screened by 2018 requires communities, businesses, and healthcare agencies to work collaboratively using creative approaches.

Upstate Medical University demonstrated that a unique partnership among a national cancer organization, a major academic healthcare system, a community health system, and a pharmacy chain increased colorectal cancer screening in individuals age 50 to 75 and raised overall awareness in the general population concerning colorectal cancer in New York State. This initiative focuses on the New York State Prevention Agenda's "Prevent Chronic Diseases" priority.

OUTCOMES

- Education and awareness about colon cancer screening and prevention increased, as evidenced by the increased return rate of Fecal Immunochemical Test (FIT) kits yearly; from 43.9% in 2014; to 56.0% in 2015; and 63.1% in 2016.
- Community participation around a common goal was achieved, especially addressing rural cancer screening by combining nontraditional healthcare partners, all focused on the same mission.
- The screening program was implemented for four weeks during each of three years. From 2014 to 2016, at least 13 cancers were prevented among 1,817 participants who returned the screening FIT kits.

LESSONS LEARNED

- Continued coaching by program staff is needed to follow up on any positive findings, with both the primary care physician offices and participants.
- Diligent coordination is needed to achieve success among healthcare partners and pharmacies to ensure that the kits are being distributed to those individuals who are truly eligible for colon cancer screening.

SUSTAINABILITY

- All partners were committed to the goal to have 80% of the eligible population screened for colorectal cancer by 2018.
- The healthcare systems involved provide the medical infrastructure that is needed. Working toward a common goal and building community support for screening in local communities has contributed to the success and will sustain the project yearly.

The Breastfeeding Support Group White Plains Hospital

YEAR INITIATIVE STARTED

2010

PARTNERS

Westchester County
Department of Health
Women, Infants, Children
program nutritionist

White Plains High School

Family Health Clinic, White
Plains Hospital

Thomas H. Slater Community
Center

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Director of Nursing

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PROGRAM DESCRIPTION AND GOALS

The first weeks after giving birth and trying to establish a routine with a newborn can be daunting for any new mother. Breastfeeding, which has become an area of increasing medical and social focus, can be particularly frustrating for women regardless of racial, ethnic, and economic backgrounds. The Breastfeeding Support Group is a program open to all who give birth at White Plains Hospital. This initiative was developed to assist postpartum women who have been discharged from the hospital and are struggling with breastfeeding during their babies' first month of life. In addition to addressing breastfeeding and a broad range of other infant feeding issues, the group is an accepting, non-judgmental place for new mothers to share their experiences during their first weeks of motherhood.

The goal of this initiative is to provide a resource where all new mothers can bring their newborns after discharge to have breastfeeding evaluated by an International Board Certified Lactation Consultant (IBCLC), toward the Prevention Agenda goal to increase the proportion of babies who are breastfed and to improve racial, ethnic, and economic disparities in breastfeeding rates.

OUTCOMES

- White Plains Hospital has seen a consistent increase in the percentage of exclusively breastfed babies in the hospital, jumping from 67.5% in 2015 to 76.8% in 2016; the numbers are consistent with data from the Healthy People 2020 goal to increase the proportion of infants who are ever breastfed.
- Patient satisfaction surveys are returned with positive feedback, and, since 2011, the mother/baby unit has scored in the top 10% of the nation.
- The hospital receives immediate verbal feedback directly from participants following meetings and numerous email messages from attendees relating how participation in the group was leading to successful individual breastfeeding outcomes.

LESSONS LEARNED

- There is an increased need to provide support for post-discharge lactation support.
- All new mothers could benefit from follow-up with a qualified lactation consultant before and after hospital discharge so they have the opportunity to individually address breastfeeding issues they may be having or, if no issues are apparent, to get reassurance that their baby is breastfeeding well.
- Skilled lactation staff should be a priority in maternity care settings.

SUSTAINABILITY

- To ensure long-term viability of the Breastfeeding Support Group program, White Plains Hospital seeks to maintain and grow a staff of skilled and qualified IBCLCs.
- To ensure all women who give birth at the hospital are reached, the availability of and access to the program is promoted to new mothers after they give birth and before discharge.
- While the program has been able to adjust to space challenges as it has grown, White Plains Hospital is looking to secure investment in a permanent and consistent location on its campus.

The Comprehensive Perinatal Education Program for Psychiatric Inpatients Zucker Hillside Hospital/Northwell Health Glen Oaks

YEAR INITIATIVE STARTED

2015

PARTNERS

Northwell's Center
for Equity of Care

Katz Institute for
Women's Health

Northwell's Perinatal
Program

CONTACT

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PROGRAM DESCRIPTION AND GOALS

The Comprehensive Perinatal Education Program for psychiatric inpatients is designed to offer new and expectant mothers the education and training they need while receiving psychiatric care. Medical professionals recognize that it is important for new and expectant mothers to receive education and resources while under treatment for psychiatric disorders so that they are equipped with this information once they return to life outside of the hospital. This program is aligned with two of the Prevention Agenda's priority areas: "Promote Healthy Women, Infants, and Children" and "Promote Mental Health and Prevent Substance Abuse."

In this program, while women are receiving the psychiatric treatment they need, they are also given a practical education and resources for their lives as a new or expectant parent, since the health of the mother both mentally and physically is correlated to the health of the infant and child. This program provides the training for staff; resources for books, handouts, and teaching materials; and customized curriculum to suit the level and need of the patients. Women struggling with mental health issues during this time need all the support and training sought out by women who are not dealing with mental health issues, and this program ensures that this is available to them.

OUTCOMES

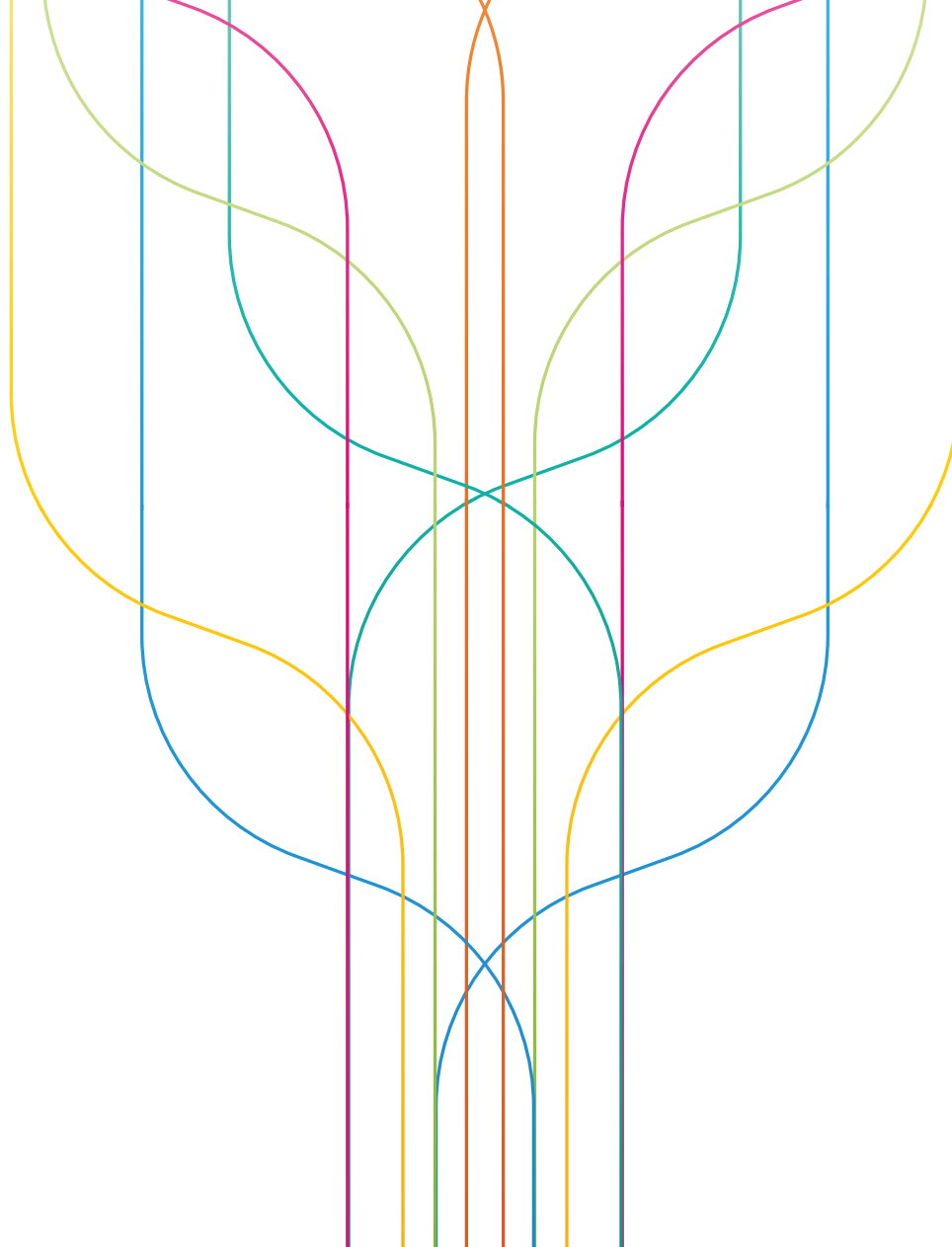
- The 20 to 30 staff trained at Zucker Hillside Hospital can educate perinatal inpatients.
- Weekly trainings are held for staff and patients receiving education.
- Responses of patients surveyed about the effectiveness and usefulness of the training showed they appreciated learning at their own pace and level of understanding.

LESSONS LEARNED

- Zucker Hillside learned the need to expand educational offerings for new and expectant mothers on important developmental milestones in their infants and children.
- It was advantageous to customize and modify the existing perinatal education curriculum and resources to accommodate the inpatient population.

SUSTAINABILITY

- This program has sustainability built into it by ensuring that all appropriate members of staff involved in inpatient education are properly trained with the peer-reviewed and evidence-based curriculum.
- Once the program has demonstrated a positive response from patients, funding opportunities for materials and resources for the training should be provided.



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