Connecting with Communities:

Community Health Initiatives across New York State

HANYS®
Always There for Healthcare

2019 Edition

About HANYS' Community Health Improvement Award

HANYS established 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 related to the New York state *Prevention Agenda,* demonstrate leadership, collaborate among diverse groups and, most importantly, achieve quantifiable results.

Thank you to our 2019 reviewers:

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The wording for each individual profile was submitted by each facility contact at the time of the nomination submission.

Connecting with Communities: Community Health Initiatives across New York State

2019 Edition

HANYS is pleased to present the 23rd edition of ***Connecting with Communities: Community Health Initiatives across New York state.*** This publication highlights the winner and nominations for HANYS' 2019 Community Health Improvement Award.

HANYS' Community Health Improvement Award recognizes member hospitals and healthcare systems for engaging key community stakeholders to implement programs to improve the health of their communities. Hospitals and healthcare systems collaborate in many ways with a variety of partners to achieve shared community health goals.

The initiatives described in this publication are directly linked to New York state's *Prevention Agenda* priorities. In early 2019, New York state unveiled a new *Prevention Agenda 2019-2024.* The *Prevention Agenda* vision is to make New York the healthiest state for people of all ages. The *Prevention Agenda* serves as a blueprint for local community health improvement, and hospitals and health systems will continue to be leaders in improving community health across the state.

HANYS appreciates the continued support of our member hospitals and health systems for sharing their community-focused initiatives. HANYS is honored to recognize our members' continuous efforts to keep their communities healthy.

For questions about HANYS' Community Health Improvement Award, contact Sue Ellen Wagner, vice president, community health, at swagner@hanys.org. For additional copies of the publication, contact Elizabeth Maze, project specialist, at emaze@hanys.org.

2019 Community Health Improvement Award

Winner

Montefiore Medical Center

Healthy Food Initiative

PROGRAM DESCRIPTION AND GOALS

The Healthy Food Initiative improves the availability of healthy foods in communities where Montefiore Medical Center's patients and associates live. The Healthy Food Initiative uses a multi-pronged strategy aimed at increasing the availability of and demand for healthier foods while reducing the promotion and availability of less healthful options.

With the overarching goal of improving population health through increased healthy food/beverage consumption, the goals of the initiative include:

- increasing the supply and availability of healthy foods/beverages in local communities;
- enhancing promotion of healthy items in local communities; and
- collaborating with local community groups to increase demand for healthy items.

The work of the Healthy Food Initiative aligns with the state's *Prevention Agenda* priority, Preventing Chronic Diseases. This initiative targets Focus Area 1: Reducing Obesity in Children and Adults, which aims 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 less than $25,000.

Outcomes

Sugary drink consumption by youth has dropped significantly in the Bronx. Rates are now (using the latest data from the 2017 Youth Risk Behavior Surveillance survey) at 41.0% of youth in grades 9-12 reporting drinking one or more sugary drinks in the past seven days, compared to 62.1% in 2007.

One year after engagement, all partner stores sold water at eye level in refrigerators, compared to 50% at baseline.

Montefiore observed increased 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

- You must work with key stakeholders across the continuum of food distribution, marketing and consumption to effect real change in the food environment in underserved communities.
- In addition to offering concrete resources and educational opportunities for stores and food programs, it is crucial to build the capacity of community members not only to choose healthier food, but also to be change agents in advocating for healthier offerings in their community as a whole.

Sustainability

By becoming "Bodega Buddies," local groups invest in this work and, with technical assistance from Montefiore's team, learn to partner with store owners on display, stocking and promotion of healthy food. They are also encouraged to cater from local stores for meetings/events and jointly develop healthy menu items.

To continue increasing knowledge of the impact of diet on health, the Healthy Food Initiative is currently partnering with systems to train youth community members to become health ambassadors.

PARTNERS

New York City Department of Health and Mental Hygiene

Bronx Health REACH

Bronx Bodega Partners Workgroup

Jetro Cash & Carry

Martes Food Center

Aqui Me Quedo Deli

Bronx New Way

Gold Grill Deli

J&E Deli

Bronx Zoo Deli

CCAM Deli

Titas Deli & Grocery

Mango Grocery

Vivian Grocery

BronxWorks

Church of God of Prophecy

Eagle School

Eastchester Presbyterian Church

Eastchester Gardens Community Center

Jacob's Place Day Care Center

Montefiore Medical Group

New Settlement Girls Program

The Point

Union Community Teen Health Center

City Harvest

WellCare

Jerome/Gun Hill BID

Community Board 3

Mott Hall School

PS93, PS/MS95, PS360, MS331, PS/MS280, PS51, PS73 and PS246

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2019 Community Health Improvement Award

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Claxton-Hepburn Medical Center

Stress Management: 101 Workshop

PROGRAM DESCRIPTION AND GOALS

This program was developed to assist schools in addressing the mental health needs of their students by collaborating with community partners who can assist the school districts in providing timely mental healthcare and reducing health disparities and traumatic experiences among youth in the community.

Outcomes

The *101 Workshop* reached more than 50 adults and 500 youth in 2018. After the first presentation, word spread and other schools scheduled presentations. More school-based and youth group presentations will be scheduled in 2019.

Lessons learned

- It is much easier to work with youth than adults to manage stress because you can catch them at an earlier stage in life and provide them with the necessary stress management tools.
- Schools are very open and willing to embrace what other community partners can provide, but they don't always know where to find those resources, so keeping these relationships strong is vital.
- Don't assume you know your communities' needs; research, ask and analyze before acting.

Sustainability

- This program is sustainable because it offers a non-threatening, fun and easy-to-deliver curriculum that requires no props, just staff working closely with school and community partners to find out what their needs are through regular data collecting and surveying.
- It is important to gather and analyze data both pre- and post-program to see if what was taught is what is needed and being utilized.

PARTNERS

St. Lawrence County Public Health

St. Lawrence County Health Initiative

Cornell Cooperative Extension

St. Lawrence/Lewis BOCES

Local law enforcement

Local colleges and schools

Kinney Drugs

Community Health Centers of the North Country

St. Lawrence Health System

Independent Living Centers

Seaway Valley Prevention Council

Gardenshare

Planned Parenthood

North Country Prenatal/ Perinatal Council

Massena Memorial Hospital

Clifton-Fine Hospital

The People Project

Hospice of St. Lawrence Valley

St. Lawrence NYSARC

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Flushing Hospital Medical Center

Breastfeeding and Beyond: Breastfeeding and Nutrition Education in the Community

PROGRAM DESCRIPTION AND GOALS

Breastfeeding and Beyond: Breastfeeding Education and Nutrition in the Community initiative is a community-based program in Queens designed to assist the state's *Prevention Agenda* goal of becoming the healthiest state for people of all ages. This begins at birth and encompasses the Healthy People 2020 goals of promoting breastfeeding. Through this initiative, Flushing Hospital Medical Center works with partners in the community to improve health and promote the well-being of women, newborns, infants, toddlers and children.

Outcomes

- Over three years, breastfeeding rates increased from 6% exclusive breastfeeding at birth to 30% upon discharge from the hospital after birth.
- More than 375 women with their children and families have been educated both prenatally and after birth.
- The intent to breastfeed upon admission to the hospital increased from 50% in 2015 to 96% in 2018, and the intent to breastfeed upon discharge from the hospital went from 29% in 2015 to 88% in 2018.

Lessons learned

- Education and information shared with individuals is more appealing to the members of the community when it is offered where they live and in the language they speak.
- Breastfeeding education offered prenatally, highlighting the benefits of breastfeeding to both the mother and infant, helps women to make informed decisions on feeding methods before giving birth. Methods of achieving their goal are strategized prenatally.

Sustainability

Sustainability is achieved by:

- financial support of Flushing Hospital Medical Center by employing the lactation consultant/dietician and allowing outreach into the community during working hours;
- desire and support of New York City public libraries in offering space and time for the community to gather in a learning and supportive environment; and
- continued desire by members of the community to attend the program and actively participate.

PARTNERS

MediSys Health Network: Flushing Hospital Medical Center

New York City Public Libraries

Supplemental Nutrition Program for Women, Infants, and Children

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Glens Falls Hospital

Tobacco-free Campus: A Project of the Living Tobacco-free Initiative

PROGRAM DESCRIPTION AND GOALS

In 2015, Glens Falls Hospital's Living Tobacco-free Initiative and Skidmore College formed a cooperative partnership to plan, implement and sustain a 100% tobacco-free campus policy. The initiative plays a key role in contributing to the state's *Prevention Agenda* goals related to tobacco use.

This initiative targets young adults with the primary goals to reduce youth initiation of tobacco use, current youth tobacco use rates and second-hand smoke exposure. Additional goals were to support all people trying to quit through the assistance of cessation counseling while continuing to change social norms related to nicotine and tobacco use.

The project's collaborative efforts directly align with the *Prevention Agenda's* Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.

Outcomes

- A 100% tobacco-free campus-wide policy was created that includes the use of electronic nicotine delivery systems.
- More than 2,500 students, 1,000 staff and an additional 500 first-year students entering Skidmore College each year are now protected from secondhand smoke exposure. This number is even higher when considering outside vendors, laborers, alumni and community members who visit and use the campus facilities for other activities. Nearly 900 acres within the community are protected from tobacco litter; this decreases the risk of fires and protects the environment and animals from the toxic chemicals in tobacco products.

Lessons learned

- Organizational buy-in and collaboration are essential for policy change to gain traction and come to fruition. While the collaborative team provided subject matter expertise, the initiative would not have been successful without the college's leadership driving the project forward.
- A diverse task force is key to thoughtful policy creation and sustainability. Involving a variety of stakeholders ensures all perspectives are considered as policy language is drafted and an implementation plan is created.

Sustainability

- The team regularly used a variety of communication channels to announce the policy leading up to implementation.
- Tabling events, including a main kick-off event, were held to raise awareness about the policy and answer questions.
- More than 500 NYS Smokers Quitline cards were distributed for cessation support.
- Skidmore added the policy to new hire, new student and vendor forms; the college handbook; the college website; and alumni event contracts.
- Nearly 500 permanent tobacco-free signs were installed throughout the campus.

PARTNER

Skidmore College

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Greater Hudson Valley Health System

Warrior Kids

PROGRAM DESCRIPTION AND GOALS

More than a third of New York state school children are overweight or obese. In the Greater Hudson Valley Health System catchment area in the Hudson Valley, 64% of the school districts have rates of student overweight and obesity that are higher than the state average, some significantly higher. GHVHS partnered with the American Heart Association, Boys and Girls Clubs of America, Cornell Cooperative Extension, Eat Smart New York, Studio Ayo Fitness, local schools and camps to bring a fun and meaningful program to children and youth development professionals.

The program was inspired by the television craze over shows like *American Ninja Warriors* and *Titans*. GHVHS's Warrior Kids initiative aims to be part of the solution to the growing childhood obesity epidemic by teaching children and the devoted professionals working with them the importance of everyday healthy behaviors.

The program directly supports the state *Prevention Agenda* priority area of Preventing Chronic Disease by Reducing Obesity in Children. The rhyme and formula for being a Warrior Kid – "5-2-1-Almost None" – is easy to remember and targets some of the key life-long habits that are known to improve health outcomes. While these behaviors reduce risk for obesity, they are also tied to reducing the likelihood of developing diabetes, heart disease and cancer.

Outcomes

More than 1,150 children and youth development professionals graduated through the four-week Warrior Kids program at 10 unique after-school program/camp locations throughout Sullivan and Northern Orange counties. Warrior Kids has engaged children and youth development staff in an additional 34,500 minutes of physical activity. Childhood obesity educational presentations led by health system leadership were held for the Sullivan County School Board Association, four individual school districts and three district staff professional development days reaching 300+ educators and impacting board approval of three district wellness policies.

Lessons learned

- Upstream community health work with youth is imperative. Schools, after-school programs, camps and county youth bureaus are starved for quality, no-cost programs led by trusted community organizations.
- Low-income families struggle to afford extracurricular activities for their children.
- As childhood obesity continues to increase, so do the racial disparities when comparing overweight/obesity rates of school districts with varying socioeconomic factors.

Sustainability

GHVHS's Warrior Kids was selected as the recipient of the local Community Foundation's Innovation Award, a $5,000 award recognizing nonprofit organizations that demonstrate innovation, creative thinking, novel approaches, efforts and new partnerships that improve the health and wellness of the community. All partners are devoted to seeing Warrior Kids continue its innovative approach for years to come.

PARTNERS

American Heart Association

Bethel Parks & Recreation

Boys and Girls Clubs of Sullivan and Northern Orange

Cornell Cooperative Extension

Eat Smart New York

Empire After School Program

Fallsburg Central School District

Liberty Central School District

Monticello Central School District

Pine Bush Central School District

Studio Ayo Fitness

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HealthAlliance of the Hudson Valley

School-based Mental Health Treatment Services

PROGRAM DESCRIPTION AND GOALS

Through a Community Health Needs Assessment, it was discovered that mental health services in the area were inadequate. Two focus areas in the New York state *Prevention Agenda 2013-2018* are to Promote Mental, Emotional and Behavioral Health and Prevent Substance Abuse and Other MEB Disorders. In 2015 HealthAlliance embarked on the pilot program for the School-based Mental Health Treatment Services initiative with the following objectives:

- gain insight into the mental health well-being and unmet needs of area residents, with a focus on youth;
- determine the priorities and success measures of the mental health service model that will be established; and
- provide needed mental health services.

Today, the program has grown significantly. Students who previously had to travel long distances to access mental healthcare now receive it in their own school through the program provided by HealthAlliance. Therapeutic counseling services to improve students' mental health and well-being are offered in person with licensed behavioral health counselors. If the on-site counselor identifies a need, the services of a board-certified psychiatrist are made available through the network's telemedicine program. While the program focuses primarily on youth, it is also available to adults in the community.

Outcomes

- A licensed psychologist is the designated program coordinator and three full-time licensed clinical social workers and one part-time mental health nurse practitioner provide mental health treatment in the schools and the hospital, along with telepsychiatry services provided through the network.
- The program expanded from two school districts to four.
- The program developed from serving 24 patients in 81 visits in the initial year to providing care for 138 patients (25 adults) in 1,511 face-to-face visits and 103 telepsychiatry visits as of Dec. 31, 2018, with more than 200 patients since inception and the program continues to grow.
- No patient is turned away due to inability to pay.

Lessons learned

- **Experience counts.** The program has succeeded because of the collective experience of the member hospitals and leadership staff in the network.
- **Safety first.** Because this program serves individuals with a wide range of mental health problems, including some that result in high-risk behaviors, procedures were implemented from the start for handling emergency situations.

Sustainability

Sustainability is ensured through the support and collective experience of the member hospitals and leadership staff in the network, including experience operating outpatient mental health services and grant-funded programs in rural communities and schools.

PARTNERS

Roxbury Central School District

Margaretville Central School District

Andes Central School District

Downsville Central School District

WMCHealth Network, including HealthAlliance of the Hudson Valley and Margaretville Hospital

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Jamaica Hospital Medical Center

Breastfeeding Volunteer Counselor Program

PROGRAM DESCRIPTION AND GOALS

Despite its resounding benefits, the prevalence of exclusive breastfeeding for six months in New York is less than 10%. Moreover, substantial race/ethnic disparities exist, with percentages for minority populations shockingly lower. Likewise, minority infants receive formula supplementation at these disturbingly disproportional rates. Disparities of this nature result from minorities being underserved and marginalized with respect to breastfeeding programming.

This prompted the creation, in 2015, of Jamaica Hospital Medical Center's Breastfeeding Volunteer Counselor Program, which focuses on recruitment, training and deployment of minority breastfeeding support professionals in the community. By doing so, the initiative combats existing community health disparities based on race and ethnicity. This initiative began with the goal of reducing minority reliance on formula supplementation in favor of exclusive breastfeeding. To achieve the needed breastfeeding support, the program aims to empower eligible individuals to sit for their International Board Certified Lactation Consultant®/Certified Lactation Counselor® exams and secure required experience benchmarks at no expense.

The Breastfeeding Volunteer Counselor Program is directly related to the state *Prevention Agenda's* Action Plan to Promote Healthy Women, Infants and Children Interventions for Focus Area 1 (Maternal and Infant Health) Goal Number #2 (Increase the proportion of babies who are breastfed).

Outcomes

- Two of the initiative's 10 enrollees already successfully passed the IBCLC exam and acquired experience requirements, two completed experience requirements to sit for exams in April 2019, four are completing experience hours with exams scheduled for October 2019 and two already secured CLC accreditation.
- Diversity of these enrollees is 43% African American/Hispanic and 14% Asian, addressing the void between minority breastfeeding role model demand and supply.
- Breastfeeding education among patients increased 23% in 2015 to 99% in 2018.
- Exclusive breastfeeding rates in the hospital increased from 2% in 2011 to 35% in 2018 with a corresponding reduction in formula reliance, resulting in "Baby-Friendly" status.

Lessons learned

Minority women indicate discomfort interacting with people perceived to have different socioeconomic experiences and express preference for professionals of similar race/ethnic backgrounds whom they perceive to possess similar life experiences. Minority breastfeeding professionals have historically been few and far between. The unfortunate reality created by this disconnect between demand and supply is that access to minority breastfeeding role models can be nonexistent.

Sustainability

- Recognition as a "Baby Friendly" facility with increased exclusive breastfeeding now actively fuels the long-term sustainability of this initiative.
- The core roster of minority breastfeeding support professionals are breastfeeding role models.
- Mothers demonstrating passion for breastfeeding are queried about interest in no-cost IBCLC/CLC accreditation under this program's tutelage. Within this supportive infrastructure is a self-sustaining stream of minority candidates to provide breastfeeding support for this program.

PARTNERS

Jamaica Hospital Medical Center's volunteer department: Refers Breastfeeding Volunteer Counselor Program candidates, assists with the application process and coordinates onboarding and orientation.

Postpartum unit: Provides enrollees required experience hours for IBCLC/CLC certification in hands-on setting.

Women's Health Center: Provides enrollees required experience hours in clinical outpatient setting, teaching expectant parents in the largely minority community.

Private Practice Lactation Consultants: Provides hours of post-discharge experience in home/office settings by allowing enrollees to shadow them.

Supplemental Nutrition Program for Women, Infants, and Children: Provides enrollees experience with discharged dyads beyond the newborn period.

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Katz Institute for Women's Health

Bridging Communities of Faith and Health

PROGRAM DESCRIPTION AND GOALS

The Katz Institute for Women's Health at Northwell Health established Bridging Communities of Faith and Health in 2017 as part of an effort to reach medically underserved and disengaged communities. Consistent with the New York state *Prevention Agenda* priority, Prevent Chronic Diseases, BCFH addresses Focus Area 4 of Preventive Care and Management and gave the medical center an opportunity to design and implement customized programs to raise the community standard of care.

With healthcare institutions being called upon to develop novel strategies to meet the goals of health promotion and disease prevention, KIWH partnered with leaders of faith-based organizations – these are trusted individuals and influencers in their communities. Health needs and priority health concerns were identified in large part by these community leaders.

KIWH built relationships with both clergy and congregants based on dignity, respect and trust, bringing education, screenings and access to health services to those with an historic mistrust of the medical community. Program participants receive vital information about preventing and managing health conditions. They learn that they, too, are members of the healthcare team, empowered to take an active role in their care, improving health through lifestyle changes and treatment management.

Outcomes

- BCFH has made a significant impact in the communities it serves through its various programs.
- Hundreds of individuals have participated in the educational programs. BCFH has received overwhelming positive feedback, with 100% of participants saying they "learned something new" and "plan to change what I do" in regard to their health and well-being.
- The Clergy Roundtable began with one church and three leaders of that church and within 18 months expanded to 21 houses of worship and more than 35 representatives.
- The heart-health program, with only 8% of participants presenting with normal blood pressure, concluded with 44.8% of participants showing a decrease in blood pressure.

Lessons learned

- Long-term partnerships work when they're built on trust. Partnerships with clergy leaders were initiated based on warmth, respect, open communication, transparency and shared storytelling.
- Listening to community members, understanding their needs and requests and responding efficiently and compassionately are essential.
- KIWH team members asked for community priorities and offered programs at the community's preferred location and times to ensure participation.

Sustainability

The mission of KIWH is to improve the health of the communities it serves. Approaches to sustainability for this initiative include:

- establish pillars that articulate the strategic plan and drive initiatives;
- ensure flexibility to adapt to changing community needs;
- properly allocate health system resources;
- partnerships that are built on trust are meaningful and long-lasting;
- providing valuable health information results in adoption of healthy behaviors; and
- senior leadership, board and philanthropic support.

PARTNERS

Hollis Avenue Congregation Church

Bridging the Gap Ministries

Church of Transfiguration

Greater Covenant Outreach

Springfield United Methodist Church

Holy Family Assembly

The Hindu Temple Society of North America

Outreach International Ministries

Highbridge Community Church

Clergy United for Community Empowerment

First Baptist Church at Bay Shore

Deliverance Tabernacle Church of Christ

Gethsemane Baptist Church

Pentecostal Church of God, M.I. Una Puerta Abierta

Deliverance Baptist Church

Bethel Church

Emanuel Baptist Church

Hollis Presbyterian Church

First Hempstead AME Church

Global Bible Ministries

United Church of Christ

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Long Island Community Hospital

Diabetes Wellness Education and Support

PROGRAM DESCRIPTION AND GOALS

The goals of this initiative are to:

- provide access to diabetes education and support services for everyone in need in the community;
- identify and provide solutions to any potential barriers such as transportation, financial and≈social issues that may prohibit an individual from receiving the necessary diabetes self-care management education and support services;
- work with program recipients to facilitate lifestyle changes toward improving blood glucose control and reducing diabetes-related complications;
- prevent emergency department and acute hospital admissions due to diabetes; and
- improve overall quality of life and general well-being.

Outcomes

- **A1c level improvement:** Overall, 55% of patients had follow-up A1c levels tested within one year and another 25% have a follow-up A1c scheduled within six months. There was an average 1.8-point reduction in A1c levels, a 3.0-point reduction for individuals with A1cs greater than 9% and a 0.9-point reduction for those with A1cs between 7% and 8%.
- **Emergency department/hospital admissions**: None of the patients followed had either an ED or hospital admission due to diabetes in 2018.
- **New stage 3 or 4 kidney disease diagnosis:** One of 83 (1%) patients had a preexisting diagnosis of stage 3 kidney disease; 99% of the patients did not have a new diagnosis of chronic kidney disease.

Lessons learned

- The majority of patients who receive diabetes self-management education experience improvements in A1c level and confidence that they can successfully manage their disease.
- As referring healthcare professionals see improved outcomes in their patients who receive diabetes self-management education, referrals have increased. However, specific strategies are being discussed to improve the show rate at one site and improve access to services at another.

Sustainability

- The number of community events, individual patient referrals and diabetes classes is currently sustainable, with a potential for growth.
- The efforts of Long Island Community Hospital's community relations department continue to increase the number of referrals from physicians and members of the community, driving up utilization of this valuable service.
- Efforts are underway to increase access to diabetes education services at a site whose demographics include economic and transportation barriers.

PARTNERS

Bellport Boys and Girls Club

Delivery System Reform Incentive Payment Program

Suffolk County Department of Health

The Patchogue Lions Club Diabetes Education Foundation

Patchogue Family YMCA

Suffolk County Department of Aging

Patchogue, Bayport-Blue Point and Bellport Chambers of Commerce

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Mercy Hospital of Buffalo

Heart Smart for Life

PROGRAM DESCRIPTION AND GOALS

The Heart Smart for Life program offers multiple sessions related to health and access to affordable, healthy foods and beverages; participants are provided with recipes, demonstrations and tastings. Recipes are sent home with fresh produce and simple instructions to increase skills and knowledge and support healthy food/beverage choices. This program has a physical activity component: creating community environments for exercise, including chair yoga sessions.

This initiative promotes tobacco cessation through education and referrals. The Heart Smart for Life program also has components related to medication safety and compliance, and alternative wellness programs that address the mind, heart, body and soul. This initiative is related to the state's *Prevention Agenda* priority, Prevent Chronic Diseases.

Outcomes

- Average blood pressure readings decreased from 145/89 to 134/82 in a three-month period.
- Eighty-three percent of participants scored 75% or higher for their knowledge of healthy eating habits in a post-test.
- Sixty-one percent reported a stop/reduction in the use of tobacco products.
- Sixty-seven percent of those measured as high risk decreased their cholesterol to under 200 mg/dL.

Lessons learned

Learn about the population you serve: Mercy Hospital started small with nutritional tabling events to gain trust and demonstrate hospitality. The hospital introduced the education in a fun, stress-free environment. As time went on, Mercy Hospital examined comments from participants and began building the program around basics: food, drink, activity and healthy living – incorporating heart-healthy wellness and prevention.

Sustainability

Sustainability of this program is supported by continued collaborations, increasing partnerships, working with community physicians to bring Heart Smart for Life to their populations and continued clinic outreach into the community.

PARTNERS

AstraZeneca HealthCare Foundation

Mercy Hospital Foundation

Key Bank

Eat Smart NY

Buffalo Urban League

Fidelis Health Care

Hanes Tools

Local food banks

Erie County Mobile Library

Roswell Cancer Society – Witness Project

Neighborhood Legal Services

The African Co-Op Farmers Market

Catholic Charities

Wellness Institute of Greater Buffalo

Population Health Collaborative of WNY

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NewYork-Presbyterian/Queens

Outpatient Antibiotic Stewardship Program

PROGRAM DESCRIPTION AND GOALS

Antibiotic resistance is a public health priority. An estimated 30% of antibiotics prescribed in the outpatient setting are unnecessary. NewYork-Presbyterian/Queens Outpatient Antibiotic Stewardship Program addresses the state *Prevention Agenda* priority of reducing antibiotic resistance and healthcare-associated infections. The program aims to decrease inappropriate antibiotic prescribing and decrease antibiotic resistance. It also aims to decrease future development of infections caused by multidrug-resistant organisms, adverse drug events and onset of infections. These goals are achieved with a multipronged intervention comprised of provider education, clinical decision support tools, delayed antibiotic prescribing services, data analysis and reporting and patient education.

This innovative intervention combines initiatives in the hospital and community-based programming. This program partners with local community organizations and delivers culturally appropriate patient education. Monthly educational seminars were conducted at local libraries, churches and senior centers. This initiative sought to target the diversity of NewYork-Presbyterian/Queens patient population to address gaps in education, opportunities for behavioral improvement and serious consequences resulting from the misuse of antibiotics.

Outcomes

- Practices lacked structured processes for supporting antibiotic stewardship. Practices reported the lack of respiratory tract infection treatment algorithms, computer decision support tools, delayed antibiotic prescribing programs and clinical documentation and education.
- Average antibiotic prescribing incidence during respiratory season for upper respiratory tract infections across all practices decreased after the implementation of Outpatient Antibiotic Stewardship Program protocols (49% to 38.4%).
- There was improvement in the appropriateness of antibiotic selection. Post-intervention, prescribing of the preferred antibiotic increased (from 25% to 30%) and the less-preferred antibiotic decreased (from 55% to 47%).

Lessons learned

Certain initiatives might not be applicable to all practice sites depending on the patient population or workflow, therefore requiring tailoring initiatives based on practice site.

The team must work collaboratively, remain open to feedback, continuously strive to enhance initiatives and adapt to change and external barriers. The long-term impact of decreased antibiotic resistance and *Clostridioides difficile* infection rates remains to be seen.

Sustainability

Sustainability of this initiative is supported by initial educational efforts, awareness of prescribing data and ongoing efforts to increase awareness in the community. The Outpatient Antibiotic Sterwardship Program continues to conduct monthly educational seminars in the community. Audience size has ranged from less than 10 to more than 100. Guideline compliance continues – prescribing incidence for the remainder of 2018 was 31.5%.

PARTNERS

NewYork-Presbyterian Queens Outpatient Practices: Ambulatory Care Center, Bayside Primary Care, Center for Developmental Disabilities, Jackson Heights Family Health Center, Special Care Center

Queens departments of ambulatory care, community health initiatives, community medicine, external affairs, grant funding, medical group leadership and data analysts, research (Lang Research Center)

New York State Department of Health

Queens Public Library – Flushing, Bayside, Fresh Meadows and Jackson Heights branches

Promise Church

World Journal

Self-Help Senior Center

Central Queens YM & YWHA

RAICES Astoria Senior Center

United Hospital Fund

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Northwell Health

Food as Health Program

PROGRAM DESCRIPTION AND GOALS

Food insecurity, a social determinant of health, limits community members' access to healthy foods and results in a population that develops obesity and chronic diseases such as metabolic syndrome, diabetes and hypertension. In this initiative, local community health data identified existing factors that are related to food insecurity.

The Food as Health Program takes a collaborative approach by combining healthcare clinical excellence with three community food resource organizations' expertise and two industry corporate social responsibility programs to identify food-insecure community members through hospital screening. It then provides emergency food assistance, linking them to community-based food resource partners both onsite and in the community to improve food security, nutrition and health outcomes.

The Food as Health Program addresses the state *Prevention Agenda's* Prevent Chronic Diseases Priority Area, Focus Area 1: Reduce Obesity in Children and Adults, Goal 1: Create Community Environments that Promote and Support Healthy Food and Beverage Choices and Physical Activity.

Outcomes

- Food insecurity prevalence, especially coupled with nutrition-related conditions, was demonstrated with one in four patients positive for food insecurity. In addition, 50% had two or more comorbid nutrition-related diagnoses.
- Twenty-nine percent of the Food as Health Program participants had Supplemental Nutrition Assistance Program applications filed; 80% were connected to their neighborhood food pantries and 25% were connected to non-food social service agencies.
- Patient experience metrics related to the program increased on average 24%, which demonstrates patient empowerment to manage their conditions, including improving food security.

Lessons learned

- Involve all partners in planning, implementation and evaluation. By including all partners in each, Food as Health was able to comprehensively address food from acute to chronic needs. The external partner insight was extremely valuable in that it widened the perspective of what the program's goals and objectives should be.
- Using quality improvement practices (Plan-Do-Study-Act cycles and huddles) to identify problems and test solutions enabled the program to address challenges.

Sustainability

- Innovative partnerships leveraging existing community food resources, industry corporate social responsibility programs and health system resources reduced costs.
- Care management organizations support the program as a social determinant of health intervention.
- The impact of food insecurity on nutrition-related conditions, health outcomes and utilization coupled with the change from fee-for-service payment models to value-based care payment models made the case for sustainability.

PARTNERS

Island Harvest

Long Island Cares

God's Love We Deliver

Baldor

U.S. Foods

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St. Mary's Healthcare

Cancer Services Screening Program

PROGRAM DESCRIPTION AND GOALS

The Cancer Services Program of Fulton, Montgomery and Schenectady counties at St. Mary's Healthcare strives to increase access to high-quality chronic disease preventive care and management in both clinical and community settings. This program addresses the Chronic Disease priority area of the state's *Prevention Agenda* with the goal to increase breast, cervical and colorectal cancer screenings. The cancer screening program serves a three-county area and provides age-appropriate breast, cervical and colorectal cancer screenings and diagnostic services to uninsured and underinsured men and women. Through outreach and case management, the program facilitates access to high-quality screenings conducted by participating providers and healthcare systems.

The program staff conduct needs assessments and identify, develop, implement and evaluate interventions to increase breast, cervical and colorectal cancer screening and address barriers among priority populations that are disproportionately burdened by an increased risk of cancer and/or who are medically unserved or underserved. The team works with strategic community partners to identify and recruit patients and to provide resources for those patients with barriers to care.

Outcomes

- The percentage of uninsured patients who were rescreened with a mammogram within 24 months improved to over 77%. Among women ages 50 to 74, 85.3% have had a mammogram within the last two years. This result is better than the statewide and national averages and exceeds the Healthy People 2020 target of 81.1%.
- For cervical cancer, the data indicate that 82.1% of women ages 21 to 65 have had a Pap smear within the last three years. Performance measures indicate that 68% of women who were provided a program-funded cervical screening were defined as rarely/never screened.
- Among adults ages 50 to 75, more than 80% have had an appropriate colorectal cancer screening. This is higher than the New York state average.

Lessons learned

- Patients are more likely to attend when comprehensive screenings are offered at one appointment. Patients who attend the cancer screening events are offered age-appropriate screenings based on their risk factors and health history.
- To reach the priority population, the screening team has focused outreach efforts toward local businesses that demonstrate a commitment to employee wellness. The team provides on-site education to employees to increase preventive cancer screenings.

Sustainability

- The program staff educate stakeholders by garnering earned media; communication with and making educational visits to legislators, other elected officials or high-ranking community members and decision makers; and using client stories and testimonials to enhance earned media and in-person visits.
- The program staff engage in population-based education about the importance of early detection via mass media, publications and one-on-one/group education.

PARTNERS

Ellis Medicine

Nathan Littauer Hospital

Hometown Health Center

Montgomery County Public Health Department

Fulton County Public Health Department

Schenectady County Public Health Department

To Life!

Catholic Charities

Centro Civico

Hamilton, Fulton, Montgomery Prevention Council

Hamilton, Fulton, Montgomery BOCES

The YWCA of NorthEastern NY

Alpin Haus Fitness

American Cancer Society

Schenectady Community Action Program

The Daily Gazette

Eastern Medical Support

Montgomery County Office for Aging, Inc.

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St. Mary's Hospital for Children

There's No Place Like Home: A Three-way Partnership Reduces the Burden of Pediatric and Young Adult Asthma

PROGRAM DESCRIPTION AND GOALS

With a vision to help better serve patients suffering from uncontrolled asthma, three organizations are working together to amplify existing community connections between providers, patients and families. In 2012 in Queens County, respiratory disease was the primary driver of 46,615 Medicaid inpatient admissions and 70,489 Medicaid emergency visits, according to the Department of Health. In addition, asthma emergency department visits were higher than the *Prevention Agenda* 2017 objective goal (81.1% versus 75.1%), and pediatric asthma ED visits were higher than the *Prevention Agenda* 2017 objective goal (229.9% vs. 195.5%) and higher than the state ratio (229.9% vs. 225.1%).

The partners implemented an asthma home-based self-management program to target patients with poorly controlled, persistent asthma, who had at least one ED visit or hospitalization within the last six months and/or those who had been prescribed a corticosteroid and/or rescue inhaler medication to reduce avoidable ED and hospital visits for this population. In addition, medication management for people with asthma fell below the *Prevention Agenda* benchmarks, so the group also targeted improving medication management as a secondary goal.

Outcomes

Outcomes for the period of March 2016 through August of 2017 are reported as:

- a total of 234 Comprehensive Home Assessments were completed;
- eighty-eight percent of families were able to demonstrate asthma skills and knowledge and 85% of patients had an asthma action plan;
- there were zero hospitalizations for Year 1 patients (n=96) for asthma in the 12 months post home visit;
- the burden of pediatric and young adult asthma through home-based asthma self-management programs has been reduced; and
- asthma awareness among primary care physicians, pharmacists, home care clinicians, patients and families has expanded resulting in a much greater understanding of asthma guidelines-based care.

Lessons learned

- Schedule primary care physician practice education and designate a practice member to serve as the "Asthma Captain."
- Have regularly scheduled touch-bases between the practice and the home care agency.
- To address family resistance to home visits, ask the primary care provider to reinforce the importance of a home visit. Schedule the registered nurse's visit as soon as possible after the patient's provider visit. Offer enrollment in a remote monitoring program for check-ins between face-to-face visits.

Sustainability

- New home care nurses receive Asthma Education Institute training to take the Asthma Educator Certification exam, thus allowing the home care agency to sustain a skilled nursing asthma workforce.
- Partners will continue to expand outreach to the community for home visits, which can be sustained through reimbursement by patients' insurance.
- Expanded telehealth regulations in 2019 will allow insurance to provide reimbursement to sustain the use of remote monitoring between home visits.

PARTNERS

NewYork-Presbyterian Queens is a community hospital serving Queens and metropolitan New York. It has 14 clinical departments, numerous subspecialties and a network of affiliated physician practices and community health centers.

St. Mary's Home Care, part of St. Mary's Healthcare System for Children, is a Certified Home Health Agency serving patients from birth to age 44 and provides nursing, physical therapy, occupational therapy, speech therapy, social work and nutrition services.

The Asthma Coalition of Brooklyn, Queens and Staten Island is one of four regional asthma coalitions funded by the NYSDOH to the American Lung Association. It's mission is to reduce the burden of asthma through a population health approach.

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St. Peter's Health Partners

Soccer for Success

PROGRAM DESCRIPTION AND GOALS

The Soccer for Success program is designed as a way to introduce underserved youth ages 6-14 to soccer and the importance of being physically active by using the sport as a hook to seamlessly integrate healthy lifestyle skills. Participants learn about eating right and other ways to stay healthy, and they gain important decision-making and relationship skills from their interactions with coach-mentors and peers. Soccer for Success coaches teach kids the fundamentals of soccer and strive to help children build confidence and recognize the value of hard work, teamwork and persistence in achieving personal goals. By learning what it takes to play a team sport, kids are also well prepared to be productive citizens.

The lessons Soccer for Success teach don't stop on the field. Coach-mentors meet with families regularly to educate parents and guardians about how to embrace an active and healthy lifestyle and nurture their child's personal growth. Learning about the importance of staying physically active will help impact childhood obesity.

Outcomes

- Eighty-eight percent of participants in Soccer for Success maintained or decreased their personal body mass index.
- Seventy-two percent of participants increased their aerobic capacity.
- Eighty-six percent of participants in Soccer for Success stayed away from anti-social behavior.

Lessons learned

- The program can be used for family engagement using weekly handouts.
- The partners in this initiative learned new ways to ensure repeating participants remain engaged in the program.

Sustainability

- The growth of the Boys and Girls Club of the Capital Area enables this initiative to continue serving more at-risk youth.
- Expanding the program to middle schools will ensure youth will be able to continue to build upon the skills and life lessons learned through Soccer for Success.
- Continued financial support is provided by St. Peter's Health Partners.

PARTNERS

Boys and Girls Clubs of the Capital Area

St. Peter's Health Partners

U.S. Soccer Foundation

Troy City School District (after-school programs)

City School District of Albany (after-school programs)

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United Health Services Hospitals, Inc.

Integrated Pregnancy Program for Women with Opioid Use Disorder

PROGRAM DESCRIPTION AND GOALS

United Health Services Hospitals launched this program to provide specialized treatment to pregnant and postpartum women who have opioid use disorders. It was developed within an existing, staffed, hospital-based opioid treatment program and has an average daily census of 245 patients. Recognizing a critical need, leaders set a goal of creating a dedicated program that would advance care and treatment for these patients across the continuum of providers and agencies. Community need was assessed through a review of state and federal data published over the past several years. Between 2010 and 2015, the hospital system's service area ranked in the top 10 in the state for per-capita opioid prescribing. The new, evidence-based approach was seen as a way to improve outcomes for pregnant women with opioid use disorder and their babies.

This program aligns with the state's *Prevention Agenda* priority to Promote Healthy Women, Infants and Children. Specifically, it addresses Goals 6 and 7 aimed at prevention of unintended and adolescent pregnancy and increased utilization of preventive healthcare services among women of reproductive age.

Outcomes

To date, the program has served more than 60 pregnant and postpartum women. Babies born to mothers who were maintained on buprenorphine avoided neonatal abstinence syndrome and admission to a neonatal intensive care unit. The program has a retention rate of nearly 90%, well above the retention rate for those in substance use treatment in general. Women who have remained in treatment have a high compliance rate with pediatric visits for their children and significant engagement with doctor's office visits and community support services.

Lessons learned

Increased contact with nurse educators has improved patient satisfaction and decreased nursing unit stigma about people with substance use disorders. Patients report feeling welcome during hospital admissions. Many using opioids face significant barriers accessing treatment or seek care only late in their pregnancies, an issue the hospital continues to address.

Sustainability

- The clinical components of the program are sustainable based on the Medicaid and insurance fees that pay for treatment services.
- All partners have voiced a strong commitment to the program, as they see value in it and have dedicated staff to it.
- A local foundation has a dedicated funding stream for addictions treatment and has pledged to ongoing funding of the contingency portion of the program.

PARTNERS

The program is inclusive of community agencies and encourages partnerships that lead to sustainability, focusing on agencies connected with healthcare, family systems and services to those with opioid use disorder. Healthcare partners include local hospitals, specifically the neonatal intensive care and labor and delivery units, high-risk pregnancy programs and OB/GYN practices. Other key partners include home visiting programs, the local prenatal network, the probation office and two county jails. This helps to ensure more effective patient referrals and decreased stigma for those with substance use disorders.

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University of Rochester Medical Center

Diabetes Prevention Program

PROGRAM DESCRIPTION AND GOALS

In 2011, the University of Rochester Medical Center's Center for Community Health & Prevention launched the Rochester Diabetes Prevention Program to increase community capacity for diabetes prevention through lifestyle change. URMC used an innovative train-the-trainer model to implement this evidence-based, group lifestyle change program with proven success at preventing diabetes. To reduce health disparities, the model was tested in physician practices and community agencies serving low-income African American and Latino urban residents, populations with disproportionately high levels of diabetes and obesity. Regional dissemination of this successful model is underway.

An interagency regional planning collaborative is offering care provider training to increase prediabetes identification, developing an electronic DPP referral system and facilitating community-wide obesity prevention mechanisms. The R-DPP is transforming the local landscape by expanding access to high-quality preventive care for diabetes and obesity – chronic disease prevention priority areas in New York state's *Prevention Agenda*.

Outcomes

- **Successful train-the-trainer DPP implementation model created**: The facilitator training supports competence in leading DPP in English and Spanish. The model was effective and sustainable for DPP implementation in physician practices and community settings serving high-risk populations and is being regionally disseminated.
- **Regional DPP access and leadership expanded:** From 2011 to 2018, R-DPP recruited and trained 121 DPP facilitators who delivered 55 programs in 25 sites for 863 adult participants.
- **Positive health outcomes achieved:** Mean weekly physical activity for program completers was 155.8 minutes. At least 85% of participants lost weight and 30% lost at least 5% of their body weight.

Lessons learned

- Physician practice referrals of prediabetic patients to a DPP can be improved by boosting DPP awareness and resources for all patient care staff in a practice, providing additional staff training in prediabetes identification and establishing an electronic referral system to community DPPs.
- Participant retention can be enhanced by inviting guest speakers, including a short walk or a cooking demonstration, providing childcare or incentives and by group bonding and accountability.

Sustainability

- As part of its broader community health mandate, the R-DPP team can continue to train and support site facilitators, using the training program created.
- Site facilitators can continue to provide the program within their sites in an organic way.
- Medical practices can access evergreen online training.
- DPP referrals will be supported by an electronic system.
- Collaborations developed will support continued regional efforts in diabetes and obesity prevention, e.g., walkability surveys.

PARTNERS

Project Lead: Rochester Diabetes Prevention Program, Center for Community Health & Prevention

ADVISORY GROUP:

Common Ground Health

Rochester Regional Health

Monroe County Department of Public Health

Rochester Regional Health Information Organization

YMCA of Greater Rochester

American Diabetes Association (Rochester chapter)

OTHER PARTNERS:

Physician practices from all local health systems and private practices in Monroe County

Interdenominational Health Ministry Coalition

Many local churches

Rochester City School District

East House, a mental health and drug rehabilitation service

Refugees Helping Refugees

African American and Latino Health Coalitions

City of Rochester Department of Recreation

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White Plains Hospital

Healthy Community Initiative

PROGRAM DESCRIPTION AND GOALS

White Plains Hospital engaged diverse partners to create its Healthy Community Initiative to promote healthy eating and physical activity in an underserved population. Partners were asked to identify the needs of their constituents and ensure they matched priorities in the state's *Prevention Agenda*. A questionnaire was distributed at a community center asking people to choose their three biggest health concerns and self-report health diagnoses, smoking habits, food insecurity, their level of physical activity and obstacles that keep them inactive.

More than 40 people responded to the survey and identified their top three goals: lower blood pressure, lose weight and become more physically active. Eighteen individuals committed to the *12 Weeks to Wellness* pilot program, which was designed to educate participants on the needs identified. Clinicians also provided health screenings at the start and end of the pilot program to evaluate its success. Program objectives involved ensuring that at least 15 individuals would attend at least 75% of the sessions and that at least 50% of the participants would have lowered their systolic blood pressure by at least 10 points. An additional objective was that a minimum of 75% of the participants would lose weight.

Outcomes

- Ninety-two percent of the participants decreased their systolic blood pressure by more than 10 points.
- Sixty-two percent lost weight during the program, 69% reduced their waist size and 54% decreased their body mass index.
- In aggregate, 74% participated in education sessions and 69% attended more than seven sessions.

Lessons learned

- Participants engaged with a "partner in health" who helped keep them accountable for attending sessions and their commitment to change behaviors.
- The low cost of the program – with no cost to the participants – was an important factor in recruiting and sustaining participants.
- When this program is offered again, a different time of year will be considered. The ability to access the sessions during winter weather was cited as a factor in inconsistent attendance.

Sustainability

- The low cost of this program is a primary factor supporting its sustainability. With volunteers providing most of the expertise, and some participant materials being donated, cost was kept to a minimum.
- Sustainability is also ensured by the tremendous support provided by White Plains Hospital; volunteers who provide the educational sessions came from the hospital and its partner medical groups and affiliate organizations.

PARTNERS

Deborah Augarten, assistant superintendent for special education and pupil personnel services, White Plains School District

Mack Carter, executive director, White Plains Housing Authority

Virgil Dantes, director of programs and network services, Feeding Westchester

Mariam Elgueta, assistant to mayor, City of White Plains

Maria Imperial, chief executive officer, YWCA

Heather Miller, executive director, Thomas H. Slater Center

Bhavana Pahwa, deputy director, White Plains Youth Bureau

Reverend Erwin Trollinger, president, Ministers Fellowship Council, Calvary Baptist Church

Isabel Villar, founding executive director, El Centro Hispano, Inc.

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HANYS Celebrates Previous Community Health Improvement Award Winners

2018 Unity Hospital, Rochester Regional Health
Rochester
Healthy Moms

2017 Schuyler Hospital
Montour Falls
Healthy Eating Active Living (HEAL) Schuyler

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

For more information about HANYS' Community Health Agenda or information within this publication,
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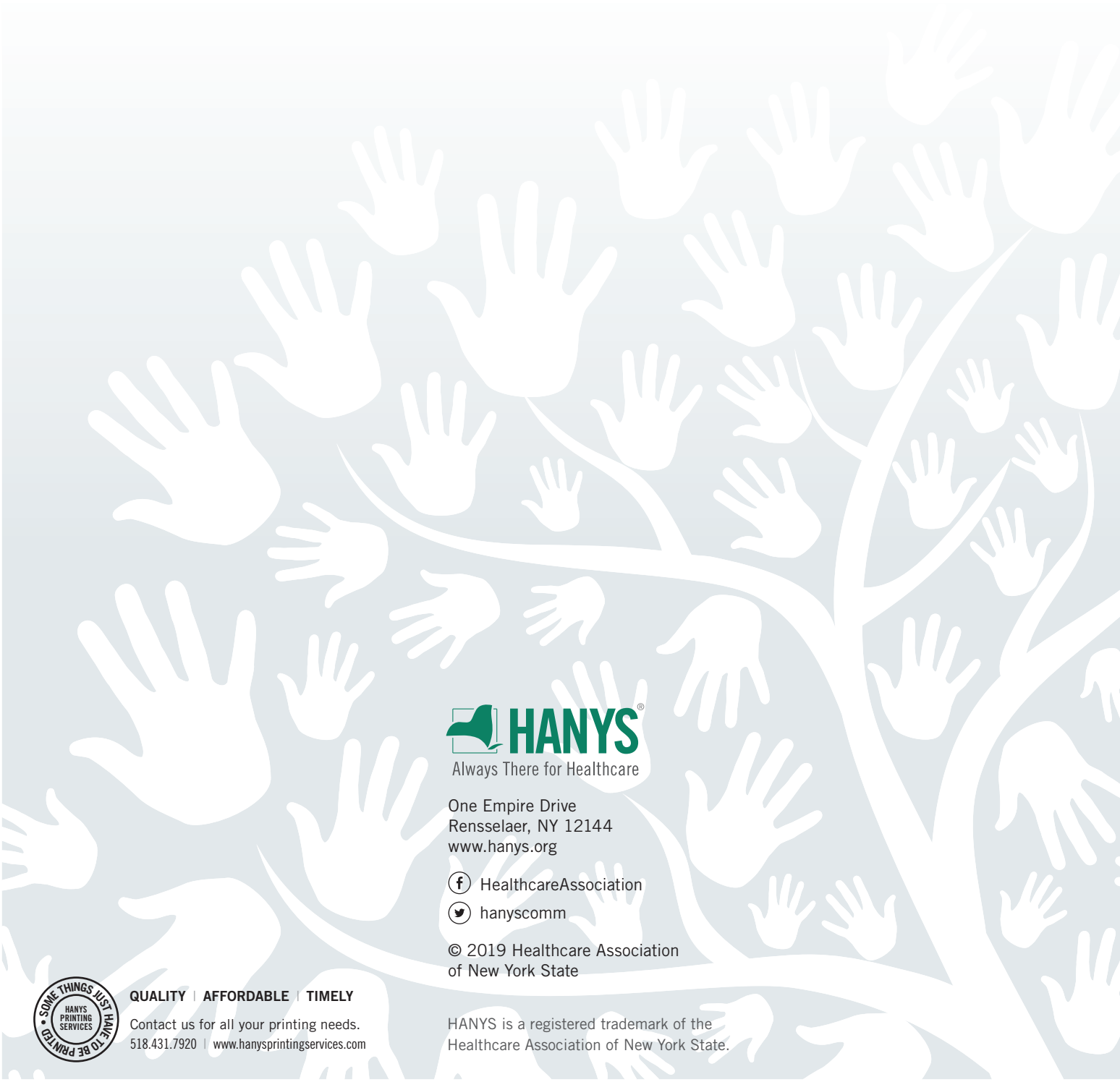

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