



Connecting with  
Communities:

# Community Health Initiatives

Across New York State

2020 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.

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### THANK YOU TO OUR 2020 REVIEWERS:

**Sylvia Pirani** (retired), former director, Office of Public Health Practice, NYSDOH

**Julia Resnick**, MPH, senior program manager, The Value Initiative, American Hospital Association

**Julie Trocchio**, senior director, community benefit and continuing care, Catholic Health Association of the United States

# Community Health Initiatives

## Across New York State

### 2020 Edition

HANYS is pleased to present the 24th edition of *Connecting with Communities: Community Health Initiatives across New York State*. This publication highlights the winner and nominations for HANYS' 2020 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 the priorities of the *New York State Prevention Agenda*. The *Prevention Agenda* aims to make New York the healthiest state for people of all ages and to serve as a blueprint for local community health improvement. 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' constant efforts to keep their communities healthy.

For questions about HANYS' Community Health Improvement Award, contact Kristen Phillips, director, trustee education and community health policy, at (518) 431-7713 or [kphillip@hanys.org](mailto:kphillip@hanys.org).





# UR Medicine Jones Memorial Hospital Promotion of Healthy Lifestyles

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## INITIATIVE DESCRIPTION AND GOALS

UR Medicine Jones Memorial Hospital's goal was to develop an infrastructure for widely accessible, readily available and safe walking, running and biking for families. In 2015, the community didn't have any designated walking trails. The hospital also identified an area where people were crossing a heavily trafficked area unsafely.

Allegany County is one of the poorest in New York. In 2014, the obesity rate in the county was 31.5% for adults and 17.2% in children, compared to the statewide rate of 5.5% and 16.7%, respectively. The age-adjusted heart attack rate per 10,000 population was 21.2, compared to a 14.0 statewide rate. Interventions included the Million Heart Initiative, which aims to increase physical activity for families by creating active friendly communities. This includes adoption of "complete streets," offering information regarding availability of parks and trails for patients seeking free activities close to home and creating walkable/bike-able communities.

This initiative, part of the hospital's Community Service Plan, focuses on the New York State *Prevention Agenda* focus areas, "Prevent Chronic Disease" and "Increase Access to High Quality Chronic Disease Care Management in the Clinic and Community."

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## OUTCOMES

- A "complete street" agreement was signed with the local town and village of Wellsville.
- Through a partnership with the DEC, treated lumber was purchased to complete two bridges and open the recreational WAG Trail. A community survey showed that use of the trail prior to completion was at 28%; after opening the WAG Trail from Wellsville to the Pennsylvania border, use increased to 52% with another 17% planning to use it.
- The river walk extension project was completed. Originally, community members crossed the street in an exit lane of traffic to a sidewalk on the opposite side; 89% of the community felt it was unsafe. Sixty-one percent currently use the river walk trail and another 16% plan to use it.

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## LESSONS LEARNED

- Build upon your relationships with local and state agencies. Small wins roll over into bigger projects as you gain traction and the community sees completed projects. The contacts you make will help you in future projects.
- Timing is also important. Some projects had been attempted a few years ago, with little progress made. They were re-attempted and with the change in personnel involved, progress was made the second time around.



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## SUSTAINABILITY

With facilitation from UR Medicine Jones Memorial Hospital, the Village of Wellsville became a lead agency in applying for a grant for the Local Waterfront Revitalization Program. Ten municipalities along the Genesee River signed onto this \$150,000 grant, which was awarded in December 2019. The plan that will be developed in the next 18 months will be a roadmap for the county to develop hiking and biking trails along the river with improved water access and economic growth.

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## PARTNERS

New York State Department of Environmental Conservation, Department of Transportation, Army Corps. of Engineers, Village of Wellsville, Town of Wellsville, LC Whitford, Alfred State College, Allegany County Economic Development, River Wilds and communities along the Genesee River.

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## FOR MORE INFORMATION

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# 2020 Community Health Improvement Award Nominated Profiles

- 1 **Arnot Ogden Medical Center**  
Health Meets Food
- 2 **Bassett Medical Center**  
Living Well
- 3 **C. R. Wood Cancer Center at Glens Falls Hospital**  
Skin Cancer Screening
- 4 **Ellenville Regional Hospital Rural Health Network**  
Rural Health Network  
Wellness Program
- 5 **Ellis Medicine**  
The Living Room
- 6 **Erie County Medical Center**  
Co-localization of Hepatitis C and Substance Abuse Treatment
- 7 **Erie County Medical Center**  
Increasing Community Breast Health Equity Through Primary Care Navigation
- 8 **Flushing Hospital Medical Center**  
A Healthier Community: Implementation of the National Diabetes Prevention Program
- 9 **Greater Hudson Valley Health System (now Garnet Health)**  
GHVHS Warrior Kids
- 10 **Hospital for Special Surgery**  
The Leon Root, MD  
Pediatric Outreach Program
- 11 **Jamaica Hospital Medical Center**  
The Jamaica Hospital  
Medical Center Volunteer Milk Depot
- 12 **John R. Oishei Children's Hospital**  
Children's Health Home of Western New York dba Oishei Healthy Kids
- 13 **Long Island Community Hospital**  
Buprenorphine in the Emergency Department
- 14 **Maimonides Medical Center**  
Wellness Empowerment for Brooklyn: Participatory Action Research
- 15 **Mercy Hospital of Buffalo**  
Stroke Support Group Partnership with Community Wellness Program
- 16 **Nathan Littauer Hospital and Nursing Home**  
Evidence-based Self-management Education Initiative
- 17 **NewYork-Presbyterian Hospital**  
Community Naloxone Rescue Kit Trainings
- 18 **NewYork-Presbyterian Hospital, Division of Community and Population Health, Ambulatory Care Network**  
Food FARMacia
- 19 **NewYork-Presbyterian Queens**  
HIV Peer-led Interventions
- 20 **Northwell Health**  
Food as Health
- 21 **NYC Health + Hospitals**  
Food and Nutrition Services Bundle
- 22 **NYC Health + Hospitals**  
OneCity Health Hospital  
Community Partnerships
- 23 **St. Mary's Healthcare**  
Community Food Drop and Medical Mission
- 24 **St. Peter's Health Partners**  
SPHP Farmers' Market
- 25 **UHS Delaware Valley Hospital**  
Integrating Tele-mental Health into Primary Care
- 26 **University Hospital of Brooklyn**  
Ready Set PrEPare
- 27 **The University of Vermont Health Network – Elizabethtown Community Hospital**  
Well Fed Collaborative – An Innovative Approach to Food Access
- 28 **Upstate University Hospital/Upstate Cancer Center**  
We Matter
- 29 **UR Medicine**  
Eat Your Colors
- 30 **White Plains Hospital**  
Stop the Bleed



# Arnot Ogden Medical Center

## Health Meets Food

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### INITIATIVE DESCRIPTION AND GOALS

Health Meets Food is a culinary medicine program dedicated to educating the local community about nutrition and its impact on people's overall health and well-being. Arnot Ogden Medical Center also started a pediatric counterpart that falls under the umbrella of this program and is modified to be more approachable for children of all ages.

The medical center aims to increase skills and knowledge to support healthy food and beverage choices. The Health Meets Food curriculum provides an innovative nutrition course that teaches how to fully engage patients in a meaningful dialogue about personal nutrition. This is accomplished by educating and coaching patients on healthy eating, budget-conscious food shopping and meal preparation. The pediatric Health Meets Food program uses modified lessons of healthy eating and cooking habits for a population that needs a basic introduction to the kitchen.

The program targets goals 1.2 in New York's *Prevention Agenda*, specifically within the "Prevent Chronic Diseases Action Plan" and the focus area, "Healthy Eating and Food Security." Due to new collaborations made with partnering organizations, Arnot Ogden hopes to fulfill the goals of increasing access to healthy and affordable food and increasing food security in the near future (*Prevention Agenda* goal 1.1, 1.3).

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### OUTCOMES

Data have been statistically significant in illustrating the students' belief that physicians can have a direct effect on a patient's dietary behavior. Additionally, students made changes in their diets such as incorporating more vegetables, fruits and legumes into their daily intake.

The pediatric respondents strongly agreed that their children exhibited more confidence in the kitchen after the course. Respondents also strongly agreed that their children developed more interest in preparing meals and snacks, demonstrated greater awareness of kitchen safety and displayed more knowledge about nutrition.

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### LESSONS LEARNED

- It is important to measure changes in the enthusiasm, confidence and willingness to make dietary changes vs. other statistical measures.
- The lack of substantial funds and partners is an obstacle. This hurdle has been preventing the hospital from reaching out to surrounding communities. The hospital's means of spreading awareness can only help so much without the proper funds to accommodate a larger-scale program.

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### SUSTAINABILITY

The program has been running for six years on its own through the support of collaborators and participants. It has stood on a solid foundation with marginal funding and support, due to the minimal number of organizations or businesses in the region. However, as a branch of the original program at Tulane University, Health Meets Food is already an example of how its outreach has benefited another distant region that has fallen victim of the obesity epidemic and health disparities.

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### PARTNERS

Tulane University Goldring Center for Culinary Medicine, First Presbyterian Church, Economic Opportunity Program, Lake Erie College of Osteopathic Medicine, Elmira College, Wegmans, Food Bank of the Southern Tier and Ernie Davis Community Center.

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### FOR MORE INFORMATION

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# Bassett Medical Center

## Living Well

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### INITIATIVE DESCRIPTION AND GOALS

Bassett Medical Center’s Living Well program is a collaborative and systematic community-clinical approach to delivering evidence-based, self-management workshops. The Living Well program has established community-clinical linkages that connect patients to the workshops and is developing a sustainable infrastructure for widely accessible, readily available self-management interventions linked to the clinical setting. Living Well is responsive to New York State *Prevention Agenda* focus area, “Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinic and Community Settings.”

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### OUTCOMES

For participants completing the diabetes self-management program, analysis of pre- and post-program measures showed a significant decrease in the Diabetes Distress Scale score and the percentage of participants in the high-distress category (16.9% to 7.8%). For participants with diabetes and a pre-program A1c > 9%, the most recent follow-up A1c in the medical record (at least three months after completing the diabetes self-management program) was below 9% for 53% of these participants and lower than baseline (though still above 9%) for 18%. For the 191 participants who completed the chronic pain self-management program, the pre-post comparison of percentage of those expressing uncertainty about self-efficacy showed improvement for each statement (average percentage uncertain went from 41.3% to 23.3%).

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### LESSONS LEARNED

To run a successful community-clinical collaboration, significant staff time needs to be dedicated to the program to navigate the many facets of building such a coalition. This includes identifying and supporting project champions within the medical system and in the community. In addition, when recruiting individuals for such a program, multiple modes of outreach, including via social media and methods of registering (online, in person, phone) need to be used.

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### SUSTAINABILITY

Bassett is taking several approaches to ensure sustainability. The suite of programs is embedded into Bassett Medical Center’s standard of care and Bassett is working with hospital, community and state stakeholders to integrate the diabetes self-management program into the reimbursable framework of diabetes self-management education. In addition, Bassett will present its data to local insurers and other payers and advocate for the self-management programs to become reimbursable.

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### PARTNERS

Bassett Healthcare Network (affiliate hospitals and primary care centers), Schoharie County Office for the Aging, Madison County Office for the Aging, Herkimer County HealthNet, Herkimer County Office for the Aging, Chenango Health Network, Madison County Rural Health Council, LEAF Council on Alcoholism and Addictions, Oneida Healthcare and Community Memorial Hospital.

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# C. R. Wood Cancer Center at Glens Falls Hospital

## Skin Cancer Screening

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### INITIATIVE DESCRIPTION AND GOALS

Skin cancer is the most prevalent cancer, though mostly non-malignant. Research has shown that the number of melanomas being diagnosed is increasing; early detection through annual skin cancer screening is important in management and treatment. This initiative, which enabled community members to receive a skin cancer screening, is related to the New York State *Prevention Agenda* priority area, “Increase Cancer Screening Rates.”

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### OUTCOMES

- This initiative increased skin cancer screening for community members who would otherwise not have been screened. Evaluation from the screening intake form shows that 81 people had not had a head-to-toe skin screening in the last year.
- Collaboration among multiple providers and health-care agencies helped combat health disparities within the community. A total of 151 patients attended the screening event, regardless of socioeconomic status.
- Community members without insurance or who have limited access to healthcare are referred to resources as needed. For example, an uninsured patient was navigated to obtain free cancer screenings for breast, cervical and colorectal cancer and for assistance in obtaining affordable health insurance.

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### LESSONS LEARNED

- This program is highly sought out by community members who look forward to it each year. That is evident by the 68 patients who stated that they had been to a previous screening event and that this is the only way they can afford such a service.

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### SUSTAINABILITY

Collaboration with many different community partners allows this program to be sustainable. Professional providers from the community continue to volunteer their time to help maintain a high-quality program. Glens Falls Hospital provides the space and services at no additional cost, enabling the program to continue to be offered free of charge to the community.

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### PARTNERS

Gateway Dermatology, Hudson Headwaters Health Network, Irongate Family Practice, Fidelis Care, Cancer Services Program of Warren, Washington and Hamilton Counties, American Cancer Society, American Academy of Dermatology and Glens Falls Hospital.

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### FOR MORE INFORMATION

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# Ellenville Regional Hospital Rural Health Network

## Rural Health Network Wellness Program

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### INITIATIVE DESCRIPTION AND GOALS

The goal of the Rural Health Network Wellness Program is to reduce the disparate rate of cardiovascular disease and other chronic health conditions in the community of Wawarsing using the evidence-based community health worker model. Ellenville Regional Hospital Rural Health Network created a wellness program that coincides with two New York State *Prevention Agenda* priority areas, “Prevent Chronic Diseases” and “Promote Health Women, Infants and Children.” These priority areas are being addressed by ensuring that every community member in the medically underserved Wawarsing community who is at risk of developing cardiovascular disease or has a child in the home who is at risk of becoming or is already overweight/obese, has access to a community health worker at no cost to them.

The community health worker helps these at-risk individuals navigate existing health services in Wawarsing and help them overcome the social determinant of health barriers that restrict their ability to lead healthy lives. This is done through one-on-one work between the community health worker and the at-risk individual and through open classes and programs available to all members of the community.

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### OUTCOMES

In 2019, Ellenville Regional Hospital Rural Health Network’s instructional physical activity classes, self-care classes and support groups were accessed more than 2,000 times by 567 unduplicated individuals. Additionally, its “Farmacy” provided 950 bags of produce (2,262 individuals’ worth of produce) to families in 2019. The network has also recruited 92 individuals at risk of heart disease and 13 families with children who are obese or at risk of becoming obese, into the Wellness Program. They have all been provided a community health worker to help them navigate the available health services in the area to ensure proper care and make it easier for them to access preventive health services.

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### LESSONS LEARNED

Throughout implementation of the Wellness Program, Ellenville Regional Hospital Rural Health Network has learned that participation and collaboration between many agencies is a key factor in ensuring the most community members possible are reached in a meaningful way. The organization has also learned that the ability to cater and adapt the program to the needs of each specific group of the target population is important when trying to keep the community engaged and stimulated.

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### SUSTAINABILITY

Ellenville Regional Hospital Rural Health Network plans to sustain and expand this program by acquiring available grants and exploring the future of billing for preventive services as the value-based care environment evolves. The program will also adapt and change as new health disparities emerge and a greater need for different focuses arises.

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### PARTNERS

The Institute for Family Health, Ulster County Department of Health and Mental Health, Cornell Cooperative Extension of Ulster County, Rose Women’s Care Service Community Resource Center, Ellenville Central School District, Ellenville/Wawarsing Youth Commission, Ulster County Office for the Aging, Ellenville Public Library and Museum, Ulster County Community Action Coalition, Catholic Charities Community Services of Orange, Sullivan and Ulster, The Food Bank of the Hudson Valley, Ulster County Correctional Facility and HealtheConnections.

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### FOR MORE INFORMATION

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# Ellis Medicine

## The Living Room

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### INITIATIVE DESCRIPTION AND GOALS

The Living Room is a community-based crisis diversion program designed to improve care and reduce costs by providing individuals in mental health crisis with an alternative to the hospital emergency department. These goals are consistent with Schenectady County's top *Prevention Agenda* priority area, "Promote Well-Being and Prevent Mental and Substance Use Disorders."

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### OUTCOMES

- The Living Room has served 517 people through 944 visits; these guests made only 26 behavioral health ED visits during the period, avoiding \$914,000 in costs.
- Guests reported a three-point reduction in stress levels (on a 10-point scale) resulting from their visit.
- The Living Room is focused on serving low-income people — 89% of visits were Medicaid enrollees or uninsured individuals.

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### LESSONS LEARNED

- The Living Room model is clinically and financially successful; patients report successful outcomes while costs are avoided.
- Collaboration and co-location are keys to success. Peer counselors help to offset staffing shortages, community referrals maximize patient engagement and the capacity for "warm hand-offs" adds value.

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### SUSTAINABILITY

Two regional not-for-profit managed care organizations representing nearly 24% of patient visits have engaged in discussions about sustaining the program through shared savings. This is a good start, but has not yet achieved sustainability.

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### PARTNERS

Ellis Medicine rehabilitation support services and the Alliance for Better Health.

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### FOR MORE INFORMATION

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# Erie County Medical Center

## Co-localization of Hepatitis C and Substance Abuse Treatment

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### INITIATIVE DESCRIPTION AND GOALS

More than 2.5 million people in the United States are living with the Hepatitis C virus, with those who inject drugs at the greatest risk for contracting and transmitting HCV. These individuals remain at risk if they do not receive adequate substance abuse treatment. At ECMC's Center for Hepatology, Anthony Martinez, MD, developed an innovative model for co-localized treatment of HCV and opiate dependence to manage both co-morbidities in a "treatment-as-prevention" approach.

This model has proven to be a highly successful treatment method that incorporates community outreach, substance abuse treatment and interventions designed to meet patients in their present state of health without judgment. Success at treatment initiation and completion of HCV medication have been far higher than national averages.

This program is directly in support of the New York State *Prevention Agenda* goal 4.1, "Increase the number of persons treated for Hepatitis C Virus" and supports interventions 4.1.1 (education) and 4.1.2 (provider knowledge).

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### OUTCOMES

Since 2012, ECMC's Center for Hepatology has treated nearly 3,000 individuals, including many actively using drugs. Currently, the program has a documented 85% treatment adherence rate and a 98% cure rate. The Center's program has resulted in a large uptake in initiation of medication-assisted treatment for opioid dependence.

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### LESSONS LEARNED

Providing a stigma-free environment supports a patient's predisposition to seek continued care. Treatment for HCV among people who use drugs can serve as a gateway to start medication-assisted treatment.

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### SUSTAINABILITY

This program receives funding through the New York State Department of Health with a grant specifically to link HCV patients to care. As a safety-net hospital for a city plagued by the opioid epidemic, ECMC remains strongly committed to this program.

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### PARTNERS

First Step Chemical Dependency Crisis Center, Stutzman Addiction Treatment Center, Alba de Vida, Jericho Road, Horizon Health, UB HEALS, Chautauqua Center – Jamestown/Dunkirk locations, Beacon Center, FLACRA, Erie County Probation/Holding Center/Jail, Niagara County Jail/Department of Health, Veterans Administration, Genesee/Orleans Council on Alcoholism, TLC Network, CARES of Olean, Horizon Health of Batavia, Best Self Outpatient/Primary Care, Turning Point, Summerset, Unity House, The Lighthouse, Cazenovia Recovery, Evergreen Health and Positive Directions and Endeavor.

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# Erie County Medical Center

## Increasing Community Breast Health Equity through Primary Care Navigation

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### INITIATIVE DESCRIPTION AND GOALS

The breast cancer mortality rate in Erie County, New York exceeds that of the entire state as a whole by 4.7%. Of particular concern is the minority population, whose mortality rate is much higher than that of the general population. As a safety-net hospital, Erie County Medical Center has learned that services provided, especially in a primary care setting, must go beyond reactionary medicine and instead focus on a wider approach to population health.

To address disparities, ECMC examined barriers to screening mammograms, including those created by internal systems. A needs assessment revealed 49% of women age 50 to 74 who were eligible for a mammogram had not been screened within the last 27 months. To understand these low screening rates, a survey was implemented for all new and returning patients to review social determinants of health. In October 2018, an initiative began to increase mammography screening in ECMC's primary care clinics. As of August 2019, mammography screening rates had increased to 58%, a 12% increase over the course of one year. The initiative supports the New York State *Prevention Agenda* priority area, "Maternal and Women's Health," objectives 1.1.1 and 1.1.2 (increase preventive care) and priority area, "Intervention," objective 1.1.1 (age-appropriate preventive healthcare).

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### OUTCOMES

- A 12% increase in the breast cancer screening rate was realized in the patient population studied over the course of one year (October 2018 to August 2019).
- Internal systems for supporting increased screening were developed and made part of the clinical workflow.
- Patient education was increased through one-on-one impact and a free educational breakfast series, with 104 in attendance. Linkage was provided during that time to on-campus screenings via a mobile mammography coach.

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### LESSONS LEARNED

- In a low-income area serving at-risk patients, transportation can be a major barrier to medical care. Developing systems to provide care without adding additional trips or stops can make a significant difference.
- Offering concierge-type assistance by focusing on the individualized needs of each patient encountered has significantly increased engagement and screenings, and has helped to change the perception of the hospital-based clinics.

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### SUSTAINABILITY

The main cost of the program was incurred with staff training and systems redesign at the outset. In reviewing 2019 project spending, costs associated with taxi service proved to be minimal, due to many patients receiving transportation through Medicaid. At this point, the program is sustaining without additional revenue required and has proven to be an effective means of increasing access to essential, lifesaving screening for the women of the community.

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### PARTNERS

ECMC mobile mammography coach, International Institute of Buffalo, Western New York Breast Health, Patient Voices Network, Buffalo Taxi and Erie County Health Department.

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# Flushing Hospital Medical Center

## A Healthier Community: Implementation of the National Diabetes Prevention Program



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### INITIATIVE DESCRIPTION AND GOALS

Flushing Hospital Medical Center designed this initiative to prevent chronic diseases; specifically, the onset of Type 2 diabetes. With the launch of the National Diabetes Prevention Program, FHMC strives to reduce the diagnoses of Type 2 diabetes in prediabetic participants. The program is a full-year course designed to educate patients on healthier eating, the importance of physical activity and ways to reduce stress. The goal 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%.

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### OUTCOMES

- To date, 62 participants completed the program and lost a total of 763 pounds.
- FHMC is currently running a course with three participants.
- Participants who have reached the program goals have reported reduced or normal levels of glycated hemoglobin and cholesterol.
- Follow-up calls with participants who have completed the program show that 12 continued to lose 75 pounds.
- 14 participants gained 89 pounds and 16 kept the weight off. Seven continue to be pre-diabetic, three developed Type 2 diabetes and 34 are no longer at risk of diabetes.

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### LESSONS LEARNED

- The camaraderie that develops during group sessions has proven a source of encouragement and accountability for participants to reach their goals.
- Use diagrams and visual aids to better communicate complex terms.
- Use supplemental data from past course materials to provide more comprehensive lessons.
- Reach out to group participants who have completed the program to continue accountability.

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### SUSTAINABILITY

To continue serving its community, the hospital will:

- maintain certification for its lifestyle coaches by facilitating programs annually (lifestyle coaches conduct outreach events by providing program brochures to recruit potential participants);
- uphold collaborations with in-house departments and partnering organizations for recruitment and optimal health in the community; and
- uphold full CDC recognition of this program by continuing to meet program standards.

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### PARTNERS

This program is made possible in collaboration with in-house departments including FHMC's information technology, food and nutrition department, primary care physicians of the ambulatory care clinic and the quality and technical assistance center; New York City Department of Health and Mental Hygiene; Shape Up NYC; and community faith-based organizations (First Baptist Church of Flushing, Boone Church of Oversea Chinese Mission, Myosetsuji Temple, YMCA, the Taiwanese Center, Young Women Christian Association and the St. George Episcopal Church).

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### FOR MORE INFORMATION

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# Greater Hudson Valley Health System\*

## GHVHS Warrior Kids

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### INITIATIVE DESCRIPTION AND GOALS

Greater Hudson Valley Health System’s mission is to improve the health of its community by providing exceptional healthcare. Chronic disease prevention is a priority in GHVHS’ Community Service Plan. More than a third of New York state school children are overweight or obese, but while state rates are declining, sadly, rates are increasing in the GHVHS hospital catchment area of Orange and Sullivan counties.

This issue is particularly concerning in Sullivan County, which ranks number 61 out of 62 in the Robert Wood Johnson County Health Rankings. Sullivan County’s rate of children either overweight or obese is an alarming 37.7% compared to 33.8% for the state. The GHVHS Warrior Kids program is a model to tackle childhood obesity in the ZIP Codes that have the highest obesity rates while using evidence-based strategies and partners with shared goals. Warrior Kids teaches children the “formula” for being a healthy Warrior Kid; “5-2-1-Almost None” gets them moving to music from around from the world.

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### OUTCOMES

- GHVHS total Warrior Kids participants since 2017: 1,500+. Summer and fall 2019 Warrior Kids participants: 707.
- A Warrior Kids challenge event to support the Boys and Girls Clubs: 167 participants and \$4,880 raised.
- Collaborative Warrior Kids/Children’s Dental Health Night: 182 participants, 20 dental health screenings:
  - minutes of physical activity: 84,840;
  - minutes of health and wellness education: 84,840;
  - percentage of children who shared intent to eat more fruits and vegetables: 94.4%;
  - children who shared intent to watch less screen time: 80.2%;
  - children who shared intent to be more physically active: 91.2%; and
  - children who shared intent to drink less sugar drinks: 85.2%.

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### LESSONS LEARNED

As healthcare looks further upstream at evidence-based prevention initiatives, quality programming to prevent the onset of poor health at an early age can have a positive impact into adulthood. Hospitals should prioritize community health programs that impact youth. Not only are these offerings deeply appreciated by the communities served, but they also have lasting impact on health outcomes.

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### SUSTAINABILITY

GHVHS Warrior Kids has attracted significant attention from numerous internal health system departments and external community partners. The program has earned an innovation award from the community foundation as well as a community partner award from the Boys and Girls Club. Work with partners is now in progress to create a Warrior Teens program where Teen Heart Health Ambassadors can be trained to teach back the 5-2-1-Almost None model to younger children, broadening reach and impact.

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### PARTNERS

American Heart Association; Bethel Parks and Recreation; Boys and Girls Clubs of Sullivan and Orange counties; Cornell Cooperative Extension; SNAP-ED (formerly Eat Smart New York); Studio Ayo Fitness Center; and School Districts including Fallsburgh, Liberty, Middletown, Monroe, Monticello and Pine Bush.

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***\*Greater Hudson Valley Health System  
is now Garnet Health***

# Hospital for Special Surgery

## The Leon Root, MD Pediatric Outreach Program

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### INITIATIVE DESCRIPTION AND GOALS

The Leon Root, MD Pediatric Outreach Program is a unique, community-based screening and education program that helps reduce the burden of chronic diseases and health disparities. POP detects and treats musculoskeletal conditions well before they can lead to chronic orthopedic disorders and provides education to reduce the risk of sports-related injuries. The program targets student athletes in middle and high schools located in culturally diverse, low-income neighborhoods in New York City.

With the overarching goal of improving access to high-quality and specialized care through free musculoskeletal screenings and education, POP's objectives are to:

- screen student athletes to detect musculoskeletal injuries and poor movement quality;
- educate student athletes on how to move properly; and
- educate coaches to identify and correct movement deficiencies known to increase anterior cruciate ligament injury risk.

POP's goal aligns with the state's *Prevention Agenda* priority area, "Preventing Chronic Disease." POP targets focus area 4.4: Chronic Disease Preventive Care and Management, which aims to increase the percentage of individuals with chronic conditions who have taken a course/class to learn how to manage their condition.

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### OUTCOMES

- HSS conducted 22 screenings, reaching 392 student athletes. POP referred 149 students for follow-up care due to musculoskeletal issues and primary care concerns, resulting in 44 clinical visits to HSS.
- Movement analyses revealed that students had inadequate lower extremity alignment when performing a double leg vertical jump (59.8%), and single right and left leg vertical jump (80.4% and 80.2%, respectively).
- Educational workshops showed a 0.8% increase in overall knowledge of proper movement techniques. Specifically, increases were seen in students identifying the correct movement techniques for performing a plank (46.6%;  $p \leq 0.05$ ), a lunge (14.6%) and for landing (8.3%).

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### LESSONS LEARNED

- Institutional commitment to the program from administrative and medical leadership is essential for success.
- Ongoing communication and commitment with the schools is important to facilitate appropriate planning and logistics for program implementation and to foster program continuity to improve student athletes' care. This includes effectively communicating program benefits to both student athletes and coaches.

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### SUSTAINABILITY

Sustainability is made possible by:

- collaborations with schools and support from hospital leadership;
- commitment from the medical team that volunteers their time;
- ongoing partnerships with athletic directors and coaches that reinforces their commitment to the program;
- donations from private, corporate and individual donors allowing for program operation and expansion; and internal awareness and support through HSS' employee activities committee.

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### PARTNERS

POP partners with middle and high public schools in underserved communities in New York City for program implementation. Partners include: P.S. 76 A. Philip Randolph School, East Harlem School-Exodus House, Harlem Village Academy Charter School, Urban Assembly Gateway School of Technology, A. Philip Randolph Campus High School, Fannie Lou Hamer High School, Columbia Secondary School for Math, Science, and Engineering, George Washington Educational Campus, The High School for Environmental Studies and Bard High School Early College.

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# Jamaica Hospital Medical Center

## The Jamaica Hospital Medical Center Volunteer Milk Depot

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### INITIATIVE DESCRIPTION AND GOALS

The Jamaica Hospital Medical Center Volunteer Milk Depot is a branch of the nonprofit New York Milk Bank. Strategically located in the community, the depot consists of a temperature-controlled freezer to store human milk deposits. A volunteer staff “manager” oversees its operation and ensures that milk donations are shipped out to the “parent” milk bank as per its policies.

Volunteer milk depots are a bridge between the donor and the milk bank. They are designed to ease the donor drop-off process, reduce expenses incurred by the donor and help the milk bank reduce operational costs so that the pasteurized human milk they produce is more affordable; hence, more accessible.

Staffed by volunteers at donated spaces with in-kind equipment, milk depots are valuable to the community. Establishing volunteer human milk depots increases access to donors, raises awareness and helps lower operational costs of producing pasteurized donor human milk. When donor milk is affordable and accessible, more infants can benefit from it. Increasing breastfeeding is goal 2.2 under the New York State *Prevention Agenda* priority area, “Perinatal and Infant Health,” under the “Action Plan to Promote Healthy Women, Infants and Children.”

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### OUTCOMES

- Establishing the Jamaica Hospital Medical Center Volunteer Milk Depot in approximately one year is a significant achievement of this project. The initial request to the New York Milk Bank was made in October 2016.
- During the first year of operation, the JHMC depot received milk deposits from 11 different donors. About 6,300 ounces of breast milk was donated. As of Oct. 11, 2019, there were 12 donors.
- Having the depot within the WIC program has been very beneficial and educational; the depot is located in the breastfeeding area.

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### PARTNERS

The New York Milk Bank, the Jamaica Hospital Medical Center WIC Program and staff, JHMC ambulatory care department, JHMC in-patient lactation consultant, JHMC obstetrics and gynecology department, JHMC ambulatory care pediatric clinic, JHMC legal department, JHMC planning department, JHMC engineering department, JHMC public affairs department, JHMC printing and shipping department and the Flushing Hospital inpatient lactation consultant team.

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# John R. Oishei Children's Hospital

## Children's Health Home of Western New York dba Oishei Healthy Kids

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### INITIATIVE DESCRIPTION AND GOALS

In 2016, John R. Oishei Children's Hospital established Oishei Healthy Kids, a Medicaid Health Home that provides care management services to Western New York children who have complex physical and/or behavioral health conditions.

Oishei Healthy Kids care managers promote communication among all of a child's caregivers, addressing the full spectrum of needs, including medical, mental health and social. They work to educate and empower the child/family/caregiver to self-manage wellness to improve quality of care and outcomes, reduce emergency room utilization and prevent duplicated or unnecessary services.

Oishei Healthy Kids aligns with the New York State *Prevention Agenda* priority area, "Promote Healthy Women, Infants, and Children" and the focus area, "Child and Adolescent Health," with the goal to support and enhance children and adolescent social-emotional development and relationships. Staff are trained to identify and address social-emotional development in children. This includes adverse childhood experiences such as abuse and neglect, parental mental illness and addiction, family separation and other traumatic experiences in a child's life.

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### OUTCOMES

- Oishei Healthy Kids had 860 enrollees at the end of 2017, 1,267 at the end of 2018 and today 1,445 children receive Oishei Healthy Kids services.
- In 2019, 57 Oishei Healthy Kids members were assessed at enrollment to be "high acuity" through the Child and Adolescent Needs and Strengths assessment. After six months of health home intervention, their assessment improved to medium and/or low acuity.
- In 2019, Oishei Healthy Kids outreach and enrollment staff participated in 77 community events reaching an estimated 2,420 individuals and resulting in 613 referrals.

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### LESSONS LEARNED

- Incorporate diversity in staff hiring and partnerships, including varied occupations, education, expertise and cultural and ethnic backgrounds.
- Oishei Healthy Kids staff are able to think "outside of the box" to meet the unique and specialized care needs of each child/family/caregiver.

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### SUSTAINABILITY

The success of Oishei Healthy Kids is due to its affiliation with the New York State Department of Health and John R. Oishei Children's Hospital, its diverse and highly committed staff and its strong community partnerships. Oishei Healthy Kids is the only hospital-affiliated Health Home specifically for children in Western New York, and its mission and partnerships contribute to its sustainability. Oishei Healthy Kids meets a growing community need for specialized care management for underserved children and their families/caregivers, resulting in improved health outcomes and lower costs.

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### PARTNERS

New York State Department of Health, John R. Oishei Children's Hospital specialty and primary care clinics, University of Buffalo Medical Group Cystic Fibrosis Clinic and Severe Asthma Clinic, Sickle Cell and Hemoglobinopathy Center of Western New York, Child and Family Services, Endeavor Health Services, Gustavus Family Services, Jewish Family Services, Native American Community Services, People, Inc., Say YES Buffalo, The Summit Center, The Arc Erie County, Tabernacle of Praise, Community Action Organization, Summit Pediatrics, St. Luke's Food Pantry, Helping Hands Ministry, Buffalo Public Schools, Enterprise Charter School, Tapestry Charter School, Blue Cross Blue Shield of WNY Amerigroup, Fidelis Care, Independent Health, UnitedHealthcare and YourCare Health Plan.

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# Long Island Community Hospital

## Buprenorphine in the Emergency Department

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### INITIATIVE DESCRIPTION AND GOALS

Opioid abuse is prevalent in our nation and specifically in Suffolk County, New York, where there were 373 fatal overdoses in 2018, according to the Suffolk County Police Department. In 2018, Long Island Community Hospital had 571 patients present to the emergency department with a diagnosis of opiate overdose. In addition, the hospital serves the areas of Mastic and Shirley, which have been heavily impacted with this deleterious disease. Long Island Community Hospital serves approximately 65,000 people in its ED each year and at least 25% of those treated are affected by opioid use disorder.

Patients who enter the ED present with a variety of symptoms directly and indirectly related to opioid misuse and abuse. In alignment with the New York State *Prevention Agenda* priority area of preventing substance abuse, the organization is strongly committed to identifying, assessing, treating and referring patients to the appropriate level of care. Providing the community with education about Narcan administration has been an important part of this community awareness program.

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### OUTCOMES

- Nine patients were induced on buprenorphine in the ED since June 2019.
- The hospital provided 189 certified recovery peer service visits (October to December 2019).
- A total of 242 Narcan kits were distributed to patients at risk and their families in 2019.

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### LESSONS LEARNED

Upon review of the program, it became apparent that all staff could have benefited from a basic course in substance abuse disorders prior to the inception of the program. The role of stigma and lack of community awareness about opiate use disorder has impacted a number of people seeking services, and as such the number of eligible patients who were receptive to treatment has been lower than anticipated.

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### SUSTAINABILITY

Long Island Community Hospital implemented the buprenorphine protocol in the ED daily workflow in alignment with its screening, brief intervention and referral to treatment process. Staffing and billing procedures are in place to sustain this program. Future plans are to continue ongoing education about evidence-based care for treatment of this population to the medical staff, residents and nursing staff. The hospital plans to offer community-based education about prevention and treatment of substance abuse disorder, including Narcan administration for overdoses.

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### PARTNERS

Long Island Community Hospital actively participates in the Suffolk County Medication Assisted Treatment Committee, a subcommittee of the Suffolk County Division of Community Mental Hygiene Community Service Board. This group has identified a listing of providers who are able to accept next-day referrals from emergency departments. Talbot House provides 24/7 service in Bohemia, BEST in Deer Park, Victory Recovery Partners in Farmingville and primary care providers through MYHealth Long Island.

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# Maimonides Medical Center

## Wellness Empowerment for Brooklyn: Participatory Action Research

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### INITIATIVE DESCRIPTION AND GOALS

Brooklyn residents experience greater inequalities in health outcomes, housing and employment than the rest of New York City and the nation. Though many have long understood that change is rooted in the hands, hearts and minds of the people, previous efforts to study and address inequities have been organized by those who do not experience nor encounter these challenges firsthand. Therefore, when strategically investing Delivery System Reform Incentive Payment program dollars in Brooklyn, Maimonides Medical Center worked to ensure that community voices were a key component of the decision-making process.

Supported by a workgroup of 100+ representatives from 70 labor, education, government, medicine and other community-based organizations, Maimonides led four participatory action research studies to learn how residents of Brooklyn communities perceive their health and their community's health, and what changes they believe will improve conditions. More than 3,000 surveys were collected by youth recruited from local high schools, colleges and urban planning graduate programs.

Findings and subsequent investments are linked to several *Prevention Agenda* priorities: Healthy Eating and Food Security; Physical Activity; Injuries, Violence and Occupational Health; Built and Indoor Environments; Child and Adolescent Health; Well-Being; and Mental and Substance Use Disorders Prevention.

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### OUTCOMES

- Engaged 3,000+ Brooklyn residents to gain insight into the experience of living in some of the city's most underserved communities and 170+ students in an educational program, earning them congressional awards, internships and leadership skills.
- Founded the Brooklyn Communities Collaborative, a community-led nonprofit improving health and wealth in Brooklyn and helped to organize the East Brooklyn Call to Action, a movement to mobilize residents to improve conditions in their communities.
- Provided fitness education and hydroponic farming in schools, implemented a farm-to-institution model in hospitals and distributed discount cards for produce.

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### LESSONS LEARNED

- Change is rooted in the hands, hearts and minds of the people. Including community voices and organizations at the decision-making table is essential to creating an effective strategy to improve population health.
- Success and change require time, patience and commitment by and among all groups invested.

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### SUSTAINABILITY

To continue the momentum of these studies and build a permanent, post-DSRIP home for this initiative, Maimonides has supported the formation of Brooklyn Communities Collaborative. BCC is a community-led, anchor institution-supported nonprofit organization focused on ensuring that Brooklyn's communities are healthy, economically sound, culturally vibrant and civically engaged.

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### PARTNERS

The Community Action and Advocacy Workgroup, which uses a consensus-based framework to plan and organize the participatory action research projects, consists of 115 individuals representing nearly 70 labor, medicine, education, social support, government and other organizations that strive to advance health and quality of life in Brooklyn. The participatory action research studies have also at various times received additional funds, space or support from the New York City Department of Health and Mental Hygiene, Kingsborough Community College (City University of New York), Medgar Evers College (CUNY), Brooklyn College (CUNY), Interfaith Medical Center, Kingsbrook Jewish Medical Center and New York Community Trust.

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# Mercy Hospital of Buffalo

## Stroke Support Group Partnership with Community Wellness Program

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### INITIATIVE DESCRIPTION AND GOALS

The New York State *Prevention Agenda* acknowledges preventing chronic diseases as a priority issue, with focus areas including healthy eating and food security, tobacco prevention and preventive care management.

The collaboration of the stroke support group and Heart Smart for Life Wellness program provides the socially, economically and culturally diverse community a comfortable, judgment-free setting to receive health and wellness education, in addition to skills to cope with the challenges of daily living.

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### OUTCOMES

The top three outcomes include weight reduction, a reduction in blood pressure and self-reported improvement in self-esteem. Participants have experienced additional or unexpected benefits from the program: volunteer opportunities within the organization and a desire to obtain formal education or training. Many are giving back to the group by returning and sharing the positive effects of the program. One participant loved the chair Zumba and became a certified Zumba instructor. Another participant from the surrounding neighborhood has become a volunteer and encourages her neighbors to attend. Seventy-six percent of participants had a post-program blood pressure reading of less than 140/90.

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### LESSONS LEARNED

Listen to the participants. Start slow and limit time of instruction to allow for engagement and feedback. Use the core program team to develop relationships and trust — know the participants by name!

Keep it simple, and reiterate the message delivered by each team member! Allow participants to share their stories.

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### SUSTAINABILITY

The sustainability of the program is the community itself, which is engaged and changing attitudes and practices because of the involvement with the group.

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### PARTNERS

Partners include the Astra Zeneca Foundation, FeedMore of Western New York, The Cornell Cooperative Extension, Fidelis Care of Western New York, Key Bank and Population Health of Western New York.

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# Nathan Littauer Hospital and Nursing Home

## Evidence-based Self-management Education Initiative

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### INITIATIVE DESCRIPTION AND GOALS

The Evidence-based Self-management Education initiative aims to improve self-management skills for people in the community with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes, prediabetes and obesity. The objective is to increase the percentage of adults with chronic conditions who have taken a course or class to learn how to manage their conditions. This initiative is aligned with the *Prevention Agenda* priority area, “Prevent Chronic Diseases,” and the focus area, “Preventive Care and Management.”

The *Prevention Agenda* calls for the expansion of access to evidence-based, self-management interventions. Nathan Littauer Hospital and Nursing Home has been doing this. The organization has increased the number of evidence-based interventions to include chronic disease, diabetes and chronic pain. Another measure is the number of patients referred to the EBSME initiative.

Nathan Littauer created a way to get electronic referrals from its providers directly. The organization has also measured the number of people who participated in the EBSME program and the percentage of those who completed it. The next goal is to launch the National Diabetes Prevention Program and continue to increase the number of people who participate in the EBSME initiative.

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### OUTCOMES

In a time when many other organizations struggled to fill chronic disease self-management workshops, Nathan Littauer consistently met the requirements for three years in a row. The organization was recognized as a rural health champion and was invited to sit on panels as experts in the delivery and sustainability of these self-management programs. Since beginning this initiative, Nathan Littauer has increased the number of certified peer leaders who can deliver workshops, the number of workshop site locations and the number of participants each year. There are also repeat attendees — people who take more than one of the chronic disease self-management programs — proving the public finds value in the classes.

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### LESSONS LEARNED

- Use of the hospital location, which is on the bus line, and choosing a time of day when a complimentary meal could be offered in an area where the poverty level and food insecurity is high is the kind of attention to detail that made this initiative a success.
- Treat people with respect and kindness. Be genuine and your participants will become your best source for recruitment and referrals for future workshops.

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### SUSTAINABILITY

The administration of this independent hospital has fully supported the initiative and believes in using evidence-based interventions to make New York the healthiest state in the nation. Nathan Littauer plans to continue to partner with other agencies and seek out opportunities for grant funding. The hospital will continue to work with fellow stakeholders toward getting commercial insurance companies to see the value of and begin reimbursing for self-management education. Ultimately, the hospital will fund its own initiatives, if needed.

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### PARTNERS

New York State Department of Health, Mohawk Valley Population Health Improvement Program, Adirondack Rural Health Network, Fulton County Public Health, Montgomery County Public Health, Fulton County Office for Aging, Montgomery County Office for the Aging, Johnstown Senior Center, Gloversville Senior Center, The Family Counseling Center, Lexington Center, the Greater Amsterdam School District and the Scotch Bush Herb and Tree Farm.

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# NewYork-Presbyterian Hospital

## NewYork-Presbyterian Community Naloxone Rescue Kit Trainings

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### INITIATIVE DESCRIPTION AND GOALS

The Community Naloxone Rescue Kit Trainings program is part of NewYork-Presbyterian Hospital's and Weill Cornell Medicine's response to the overwhelming rise in opioid overdose and associated fatalities in New York City. This project corresponds with the New York State *Prevention Agenda* priority area, "Promote Well-being and Prevent Mental and Substance Use Disorders," and goal 2.2, "Prevent Opioid and Other Substance Misuse and Deaths." The distribution of rescue kits and training of individuals to respond in an overdose situation is supported by the New York State Surgeon General and the New York City Department of Health and Mental Hygiene.

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### OUTCOMES

- The program has distributed 1,000 Naloxone rescue kits each year.
- Public awareness of and ability to identify and respond to opioid overdoses increased. This program enhanced the ability of individuals to recognize the signs of overdose and feel comfortable using the rescue kits to provide assistance.
- The stigma of opioid addiction and overdose was reduced by increasing familiarity and knowledge among individuals attending training sessions.

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### LESSONS LEARNED

- Rescue kits not only save lives, but provide an opportunity to connect individuals to treatment. By casting its net as widely as possible, NewYork-Presbyterian Hospital is able to bring more individuals into care.
- The hospital found that a portion of the public is very receptive to this program and are desperate for support. However, there remains significant work to be done in reducing the stigma of addiction.

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### SUSTAINABILITY

The hospital will maintain this program team due to the incredible demand from the community and continued need for the distribution of kits and training. Partnerships with various organizations around the city, including other health and outreach services as well as non-health-related businesses, such as bars and clubs, are strong. NewYork-Presbyterian Hospital is committed to continuing this important work in the face of growing need.

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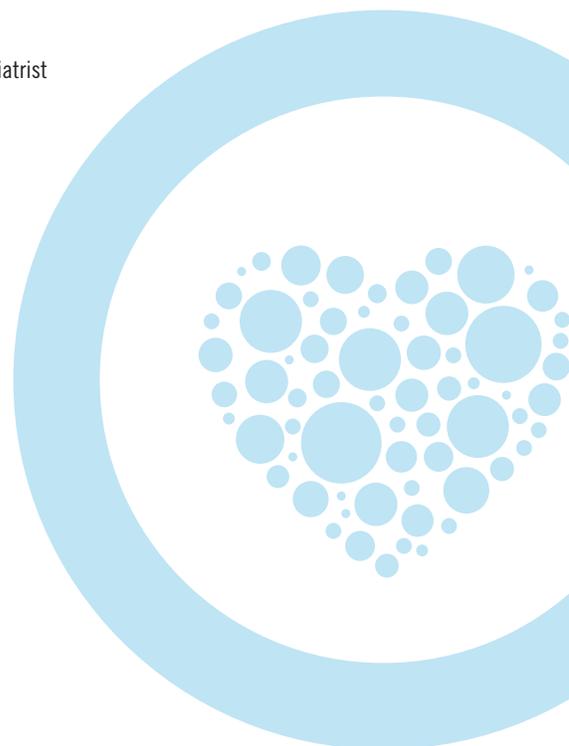
### PARTNERS

Urban Pathways, Roosevelt Island Police, House of Yes, Birch Wathen Lenox, Quest to Learn, Hunter College, Columbia University Graduate School of Journalism, Columbia School of Social Work and Columbia University School of Nursing.

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# NewYork-Presbyterian Hospital, Division of Community and Population Health, Ambulatory Care Network



## Food FARMacia

### INITIATIVE DESCRIPTION AND GOALS

Food FARMacia is a novel, community partnership-based intervention to reduce food insecurity among low-income families with children up to five years old. Together, NewYork-Presbyterian Hospital and West Side Campaign Against Hunger bring a food pantry on a state-of-the-art market truck to the underserved, predominantly Hispanic community of northern Manhattan where childhood obesity and food insecurity rates are high. Food FARMacia's mobile market parks adjacent to the Washington Heights Family Health Center twice a month. At each distribution, 45 families (200 individuals) select a free, three-day supply of healthy food, including 60% fresh produce. The program prioritizes dignity and choice. WSCAH intake counselors connect patients to social services toward reducing food insecurity long term.

Food FARMacia is expanding in 2020 as part of NYP's obesity prevention focus in alignment with the New York State *Prevention Agenda's* priority area, "Prevent Chronic Diseases." Combining WSCAH's expertise in emergency food provision with the hospital's ability to screen and identify high-need community members, Food FARMacia's success demonstrates the strength of community health system collaboration to address social determinants of health.

### OUTCOMES

Food FARMacia served 233 food-insecure individuals 22,902 pounds of healthy food over the program's first six months. Program attendance was high (78% on average) despite multiple demands on young families' time. Of 48 families eligible for the program at baseline, 79% remained enrolled after two months. Food insecurity prevalence, assessed using the Hunger Vital Signs™, was reduced over this brief period from 100% to 85%.

### LESSONS LEARNED

Less than a year after launching its social determinants of health screener, NewYork-Presbyterian Hospital was able to respond quickly and effectively to food insecurity by tapping into the expertise of an established, community-based organization. Clear and frequent communication with providers, administrators, patients and community members was essential to the program's success. Coupling emergency food with service connection and cooking demonstrations expanded the program's reach.

### SUSTAINABILITY

Food FARMacia's success is recognized across NewYork-Presbyterian's Division of Community and Population Health. Expansion to other pediatric practices in northern Manhattan as well as other NYP hospitals throughout the city is included in the hospital's Community Service Plan in 2020. As efforts continue toward preventing chronic disease, NYP's strategy will focus on combining community-based partners' expertise with patient and provider input to advance health equity.

### PARTNERS

West Side Campaign Against Hunger, NewYork-Presbyterian Hospital (Choosing Healthy and Active Lifestyles for Kids, Division of Community and Population Health, Ambulatory Care Network; Washington Heights Family Health Center Pediatrics) and Columbia University Irving Medical Center (Department of Pediatrics, Community Pediatrics Program; Division of Pediatric Gastroenterology, Hepatology and Nutrition and Jennifer Woo Baidal, MD).

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# NewYork-Presbyterian Queens

## HIV Peer-led Interventions

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### INITIATIVE DESCRIPTION AND GOALS

NewYork-Presbyterian Queens' HIV Peer-led Interventions project aims to increase access to testing, educate the community using health literate and culturally compliant methods and improve care compliance through peer mentorship for HIV patients.

Improving compliance with care instructions increases viral load suppression among patients, thus protecting patients' health, as well as providing community benefit by decreasing the rate of transmission and newly diagnosed patients. Providing newly diagnosed and noncompliant patients with a peer navigator improves their trust in the healthcare system and increases the likelihood they will reach viral load suppression. Peer mentors are integrated into the community and work closely with community partners to fluently navigate patients through the healthcare system.

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### OUTCOMES

The HIV Peer-led Interventions program has been a success, connecting 43 patients who tested positive for HIV into care with the assistance of a peer navigator to help guide them through the system. The program has also provided the community more than 800 outreach sessions and 192 health literacy sessions to educate the public and help reduce the stigma of HIV and AIDS.

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### LESSONS LEARNED

- Inter-institution collaboration: combining the expertise of the clinical team while engaging with partner community-based organizations is key to reaching people who would not be accessing healthcare otherwise.
- Peer-led programs have proven success rates. Allowing patients to speak with and develop a relationship with a peer makes healthcare more accessible. Creating a peer navigation program improves viral load suppression and reduces transmission of HIV in NYPQ's community.

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### SUSTAINABILITY

As a result of its success over the past two years, the peer-led program is being expanded through the NYPQ Community Service Plan to patients diagnosed with HIV. The goal of this expansion is to continue to engage patients who are newly diagnosed with HIV, as well as those who may have fallen out of care, to bring them to a state of viral load suppression using the peer model. NYPQ is committed to ensuring HIV-positive patients in the community have the support they need.

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### PARTNERS

NewYork-Presbyterian Queens Performing Provider System, Voces Latinas, AIDS Center Queens County, Brightpoint Health and NYPQ Special Care Center.

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# Northwell Health

## Food as Health

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### INITIATIVE DESCRIPTION AND GOALS

Food as Health dietitians counsel patients to avoid over-consumption of sugary drinks, work with patients to improve physical activity and health behaviors, provide fruits and vegetables to food-insecure patients and assess and enroll patients in Supplemental Nutrition Assistance Program benefits whenever eligible. The backbone of this program is a validated screener for food insecurity, which helps Northwell identify patients to assist with accessing services and benefits. A Food as Health dietitian helps each eligible patient access food resources in the community and enroll in benefits that will help provide the individual with long-term food security. The Food as Health program aligns well with the healthy eating and food security focus area of the New York State *Prevention Agenda*.

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### OUTCOMES

- Seventy-three percent of participants improved food security status.
- More than 97% of patients seen at the Food as Health center report that they are better able to manage their health conditions.
- A total of 96.3% of patients claim that the Food as Health program has helped them to reduce their food costs, allowing them to afford other necessities.

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### LESSONS LEARNED

- Don't re-invent the wheel! Develop and maintain community partner relationships that already provide quality resources to the community.
- Participant follow-up is extremely challenging, but key for evaluating program outcomes.

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### SUSTAINABILITY

The Food as Health program was originally funded through the Delivery System Reform Incentive Payment program, which ended in March 2020. For this reason, Northwell developed a path to sustainability for maintaining hospital-based Food as Health sites. Northwell's community health department funds the first year of contracting with community-based organizations, with the understanding that each hospital site housing the program will incur these costs on its own budget after year one.

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### PARTNERS

Island Harvest, Long Island Cares, God's Love We Deliver, Baldor and U.S. Foods.

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# NYC Health + Hospitals

## Food and Nutrition Services Bundle

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### INITIATIVE DESCRIPTION AND GOALS

The Food and Nutrition Services Bundle is a high-quality, coordinated and accountable food and nutrition services network connecting community-based food and nutrition services to critical healthcare and community access points. Food security specialists have a discussion with low-income New Yorkers around their food and nutrition needs using a coordinated intake and referral assessment tool to identify services in the community. The initiative supports the New York State *Prevention Agenda* priority area related to nutrition and food security.

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### OUTCOMES

A total of 1,598 participants provided consent and completed the full assessment between November 2018 and July 2019. These participants received 2,199 referrals. Fifty-seven percent (1,071) of referrals resulted in enrollment in services, benefiting 871 unique households.

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### LESSONS LEARNED

- Nutrition and food insecurity interventions should be brought as close as possible to the point of clinical service to make it easy for participants to engage with community providers. Yet, workflows are different in each specific setting, so engagement is critical for both healthcare partners and community providers.
- A strong, trusted backbone organization can support capacity, infrastructure and contracting, enabling diverse community-based organizations to participate.

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### SUSTAINABILITY

Once workflows and partnerships are established, food navigation models can be woven into healthcare through existing mechanisms that aim to facilitate access to community resources, such as health homes or managed care organizations' care management services.

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### PARTNERS

Food Bank for New York City, BronxWorks, God's Love We Deliver, Healthfirst and Unite US.

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# NYC Health + Hospitals

## OneCity Health Hospital Community Partnerships

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### INITIATIVE DESCRIPTION AND GOALS

The Bronx Asthma Peer Educator Project uniquely trains peers to recruit and support individuals with uncontrolled asthma and other social determinant of health-related needs in homeless shelters and New York City Housing Authority developments. Asthma was identified as high-risk at Bronx Health + Hospitals facilities as a catalyst for recurring visits to the emergency department. This pilot aims to improve health outcomes for individuals ages 18 to 39 with uncontrolled asthma by helping them to manage their asthma and link them to key services for co-conditions that impact their overall health. These services include food insecurity resources, health insurance coverage, connection to a primary care provider and mental health services, pharmacy services and health home enrollment.

Individuals targeted for this pilot have been hospitalized or have had an asthma-related emergency room visit within the past six to 12 months. This project aligns directly with the New York State *Prevention Agenda* focus area, “Chronic Disease Preventive Care and Management,” and addresses the goals of promoting evidence-based care to prevent and manage chronic diseases, including asthma (goal 4.3) and improving self-management skills of chronic diseases in the community (goal 4.4).

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### OUTCOMES

Data for this project are being collected; however, so far:

- Sixty-four percent of participants have connected to food security resources in the community.
- Twelve percent of individuals connected to a primary care physician.
- Twelve percent were connected to transportation services.
- Seven percent were connected to mental health resources.

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### LESSONS LEARNED

- Cross-sector collaborations are more likely to be successful when health systems work with community partner champions to engage vulnerable, hard-to-reach populations.
- Outreach to the homeless and all vulnerable populations requires time, trust and collaboration with community representatives who have existing relationships with the target community and population.

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### SUSTAINABILITY

The Healthcare Community Partnerships demonstration projects are DSRIP-funded through June 2020.

OneCity Health is currently meeting with various Medicaid managed care organizations across New York City with the goal of integrating the healthcare professionals’ borough-based interventions into a value-based arrangement for their managed care organization member populations and the community at large.

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### PARTNERS

Health People, NYCHA, OneCity Health, NYC Health + Hospitals/Lincoln, NYC Health + Hospitals/Community Care, Public Health Solutions and Community Service Society.

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# St. Mary's Healthcare

## Community Food Drop and Medical Mission

### INITIATIVE DESCRIPTION AND GOALS

The St. Mary's Healthcare Community Food Drop and Medical Mission began in October 2018 and was designed to improve food security and access to healthy food and beverages to vulnerable people across the St. Mary's Healthcare service area. While providing medical, social and spiritual social care to the underserved, the community outreach and population health teams identified food insecurity as a barrier to healthcare services. St. Mary's Healthcare also identified lack of access to healthy foods and beverages as a barrier to health for those patients at high risk for chronic diseases, including cancer and diabetes.

The Community Food Drop and Medical Mission targets rural and low-income populations with limited access to healthy foods and beverages as well as the population less engaged in healthcare. This initiative addresses the New York State *Prevention Agenda* focus area, "Chronic Disease Prevention and Healthy Eating and Food Security." Food insecurity is a social determinant of health with a significant impact on health status and quality of life. Lack of access to healthy foods adds to the root causes of poor health outcomes.

### OUTCOMES

In 2019, 5,840 people received food, and more than 500 men and women were referred to the breast and prostate cancer prevention and education program at St. Mary's Healthcare. Of the 500 men and women educated, more than 30% have been referred to primary care services. Additionally, 231 people completed diabetes risk assessments and six were referred to the St. Mary's Healthcare diabetes prevention program to address pre-diabetes.

### LESSONS LEARNED

As a result of this initiative, the staff at St. Mary's Healthcare now assess each patient for food insecurity using the evidence-based Hunger Vital Signs questionnaire. A resource list, including food pantries and community meals has also been developed to refer patients in need. To further address the need for food, the hospital created six food pantries called Mission Cupboards throughout the hospital campuses for patients who are in immediate need of food.

### SUSTAINABILITY

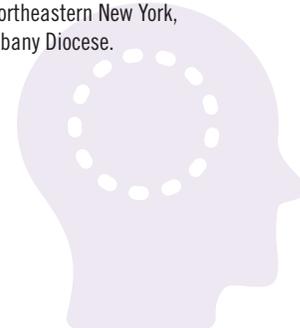
The initiative has been sustained through the combined resources of each valuable partner. Catholic Charities has named its program the Catholic Charities Mobile Outreach Vehicle Extension-CC Moves. The St. Mary's Healthcare logo is on the RV, and, through volunteering and staff donations, St. Mary's has generously provided just over \$33,000 of in-kind contributions to these community health initiatives.

### PARTNERS

Catholic Charities Mobile Outreach Vehicle Extension, HFM Prevention Council, Creative Connections Clubhouse, Montgomery County Cares, Office for the Aging, Regional Food Bank of Northeastern New York, Centro Civico and Catholic Charities of the Albany Diocese.

### FOR MORE INFORMATION

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# St. Peter's Health Partners

## St. Peter's Health Partners Farmers' Market

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### INITIATIVE DESCRIPTION AND GOALS

Focus area 1 of the New York State *Prevention Agenda* identifies the overarching goal of reducing obesity and the risk of chronic disease by increasing access to healthy and affordable foods, expanding knowledge to support healthy food choices and increasing food security. Objectives include decreasing the percentage of children and adults with obesity, decreasing the percentage of adults who consume less than one fruit and less than one vegetable per day, increasing the percentage of adults who buy fresh fruits and vegetables in their neighborhood and increasing the percentage of adults with perceived food security.

The St. Peter's Health Partners Farmers' Market brought the farm to the neighborhood, nestled in a healthcare setting, to not only increase access to healthy food but to link healthy food consumption to overall health awareness, behavior and outcomes. Once individuals and families understand the connection between healthy food consumption and health outcomes, they are better equipped to make changes that could enable them to live healthier lives. Education about health and nutrition, coupled with opportunity (access to healthy foods), is the best formula for reducing health disparities and advancing health equity; this was the ultimate goal of the SPHP Farmers' Market project.

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### OUTCOMES

- The SPHP Farmers' Market has increased access points to healthy and nutritious foods while connecting community members with nutrition instruction and healthcare education and screening opportunities, further emphasizing the link between good food and good health.
- The initiative has provided 1,915 community members the opportunity to purchase fresh, locally grown fruits and vegetables.
- Of the 416 Farmers' Market attendees who were screened, 249 received fresh produce vouchers worth \$10 each (247 were redeemed, a 99.2% redemption rate). Attendees also had opportunities to connect to community resources.

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### LESSONS LEARNED

- Paramount to choosing a community partner was identifying an organization whose mission aligned with SPHP.
- While efforts were made to screen all attendees at each market, SPHP learned that providing a pre-screen number to call allowed an additional and more discreet option to identify members of the population who may be experiencing food insecurity. Moving forward, SPHP will offer a "pre-screen" call number on Farmers' Market promotional materials.

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### SUSTAINABILITY

A continued partnership with the Regional Food Bank will sustain future SPHP Farmers' Market events. SPHP healthcare services staff will continue to participate in future Farmers' Market events, maintaining the healthcare link. SPHP will leverage internal and external relationships to enhance connectivity to social determinants of health resources, building on and creating relationships with community-based organizations that link people and families to education and assistance opportunities.

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### PARTNERS

Regional Food Bank of Northeastern New York, Healthy Together/Unite Us and Food Pantries for the Capital District.

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### FOR MORE INFORMATION

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# UHS Delaware Valley Hospital

## Integrating Tele-mental Health into Primary Care

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### INITIATIVE DESCRIPTION AND GOALS

This initiative integrates mental health services into primary care using an outside vendor and a secure video-conferencing platform. Through this model, Delaware Valley Hospital is able to connect area residents with vital mental health services without the healthcare professional having to move to a remote, rural location. This initiative is concentrated on the New York State *Prevention Agenda* focus area of strengthening the mental health infrastructure.

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### OUTCOMES

- Between January and December 2019, 119 patients had 698 visits, with one licensed clinical social worker and one non-physician provider working about 24 hours per week. In December, the hospital added an LCSW at 10 hours per week.
- Most patients have expressed very positive feelings about the program. Twenty-two patients completed a survey, 59% rated it a 5 (highest rating) and no one scored it below 3. All written comments have been positive: “I feel a good connection”; “Excellent way to communicate, very convenient.”
- Delaware Valley Hospital believes that having an additional referral source has eased the burden of the long waits for initial appointments, and one physician states that it’s “the single most valuable technology we have embraced during the more than two decades I have been here.”

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### LESSONS LEARNED

- Collaboration is key. It is imperative to identify and communicate with experts within the telehealth field and regulatory agencies. Their expertise is vital to ensuring pitfalls are avoided and the program creation process goes smoothly.
- The insurance credentialing process takes much longer than anticipated. Until telehealth becomes a more common mode of care, insurers’ representatives are struggling with their companies’ requirements for credentialing, especially when providers are off-site.

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### SUSTAINABILITY

A New York State Vital Access Provider grant has provided breathing room as the hospital navigates the many hurdles of credentialing telehealth providers with various insurance companies. Most of the adjustments were because the providers were not fully credentialed by the insurers at the time of service and the hospital cannot “back-bill” once credentialing is complete. This issue will be resolved as the enrollment process is completed.

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### PARTNERS

Sandeep Krishnan, consultant; Finger Lakes Community Health; United Health Services’ information technology, behavioral health, legal and provider enrollment departments; Delaware County Mental Health; Binghamton University; New York State Department of Health Healthcare Transitions Unit; and e-Psychiatry.com.

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### FOR MORE INFORMATION

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# University Hospital of Brooklyn

## Ready Set PrEPare

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### INITIATIVE DESCRIPTION AND GOALS

As expressed in the New York State *Prevention Agenda* 2018 progress report, New York remains at the center of the HIV epidemic in the United States, with more people living with HIV/AIDS than in any other state. Data from the New York City Department of Health and Mental Hygiene show that HIV prevalence in 2017 was highest in communities of Brooklyn like Brownsville, East New York and other Central Brooklyn communities. The Arthur Ashe Institute's Ready Set PrEPare work is at the epicenter of the AIDS epidemic in New York City and this work is closely aligned with the *Prevention Agenda* priority action plan to prevent communicable diseases — focus areas 2 and 3.

Specifically, University Hospital of Brooklyn's work addresses *Prevention Agenda* goal 2.2: increasing viral suppression by raising the awareness of and access to pre-exposure prophylaxis and post-exposure prophylaxis. This work also includes increasing health literacy such that affected community members understand the importance of treatment to achieve an “undetectable level” of HIV. This will help reduce the spread of HIV and assist in ending the epidemic in New York City.

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### OUTCOMES

- A total of 243 community members were directly trained and educated on HIV/AIDS prevention and risk management.
- This initiative achieved a 70.7% increase in knowledge in regard to whether “PrEP is considered a vaccine or not.”
- There has been a 61% increase in knowledge in regard to whether “If I take PrEP, I can stop using condoms when I have sex.”

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### LESSONS LEARNED

Hair establishments in the community play a significant role in community empowerment and health education and are not just for outward beautification. The awareness of HIV prevention is severely and more broadly needed throughout communities with similar demographics as those of this project. SUNY Downstate learned that there is still significant stigma around the subject of HIV and AIDS and there are barriers to prevention and treatment.

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### SUSTAINABILITY

University Hospital of Brooklyn believes that barbers and hair stylists everywhere can serve as mediators and trust-builders for educators, researchers and scientists who all have the same agenda: community empowerment, health and wellness. Community members as lay advocates, educators and community health workers can make improvements in health literacy and changing health behaviors far beyond the capacity of researchers, educators and healthcare establishments not grounded in the community.

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### PARTNERS

Arthur Ashe Institute for Urban Health, Brooklyn Health Disparities Center, Office of the Brooklyn Borough President, local hair establishments, including barbershops and hair salons and the Communities Together for Health Equity CBO consortium, which consists of 70 local community-based organizations located throughout the five boroughs of New York City.

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### FOR MORE INFORMATION

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# The University of Vermont Health Network – Elizabethtown Community Hospital

## Well Fed Collaborative: An innovative approach to food access

### INITIATIVE DESCRIPTION AND GOALS

The University of Vermont Health Network – Elizabethtown Community Hospital is now able to effectively screen for food insecurity. Once a disparity is identified, patients are supported through a referral process and connected with community resources to address barriers and determinants of food access and affordability. This initiative works collaboratively to connect people in need with the appropriate organizations, such as the Supplemental Nutrition Assistance Program and Supplemental Nutrition Program for Women, Infants and Children enrollment. It also provides referrals to programs such as Wellness Rx or food pantries, working with local farms, increasing consumption of fruits and vegetables and addressing food insecurity that has an adverse impact on the health of the population.

### OUTCOMES

Wellness Rx and Food Pantry Co-location were created to increase access to local, wholesome foods and goods; increase provider referrals to wholesome nutrition and food security; and reduce the stigma associated with food pantry use. A total of 51 referrals have been made to the Wellness Rx program, with 253 vouchers redeemed, totaling \$2,795.20 in produce purchased. Hosting a pantry in a health center has also greatly reduced the stigma surrounding utilization. After three months of operation, 83 unique families have accessed more than 3,983 pounds of food.

### LESSONS LEARNED

Team communication and role specifications were essential during the implementation of Wellness Rx into the health centers and community. Monthly meetings allowed for timely correspondence and decision making. Nutrition guidelines for the pantry are a crucial piece in the goal to help as many families in need as possible. Open access is a wonderful concept but can be overwhelming to staff who are primarily responsible for patient care. Volunteer recruitment provides flexibility with hours.

### SUSTAINABILITY

Sustainability is largely dependent on community and leadership support. The leadership within UVMHN – Elizabethtown Community Hospital embraces the population health approach to combating obesity in the region, ensuring financial backing for the prevention of disease. Future funding opportunities will continue to be explored through the collaborative, in addition to quarterly fundraising events throughout the community to ensure the pantry and Wellness Rx are available for years to come.

### PARTNERS

Adirondack Community Action Program, ADK Action, Adirondack Health Institute, Cornell Cooperative Extension, Essex County Health Department, Keeseville Farmacy and Pharmacy, local farmers, farm stands and markets, Mountain Lake Services, Hub on the Hill, Essex County WIC, Essex County OFA, Regional Food Bank of Northeastern New York, Church of the Good Shepard Food Pantry and area retailers.

### FOR MORE INFORMATION

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# Upstate University Hospital/Upstate Cancer Center

## We Matter

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### INITIATIVE DESCRIPTION AND GOALS

We Matter is a peer-to-peer community outreach program established in 2016 to reduce colon cancer disparities in low-income, primarily African American populations. Trained by Upstate University Hospital Cancer Center health professionals, peer advocates called “Resident Health Advocates” provide culturally appropriate colon health education and navigation to screening colonoscopy and at-home stool kits. The goal: to eliminate barriers, change behavior and make colon cancer screening a priority. We Matter addresses the New York State *Prevention Agenda* priority area, “Chronic Disease Preventive Care and Management.” Goal 4.1 focuses on increasing cancer screening rates:

- increasing the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (age 50 to 75 years) and increasing the percentage of adults with an annual household income less than \$25,000 who receive a colorectal cancer screening; and
- increasing the percentage of adults aged 50 to 64 who receive a colorectal cancer screening based on the most recent guidelines.

We Matter currently serves eight Syracuse public housing developments, benefiting some 1,400 people, 50 to 70 years of age who live in Syracuse’s poorest inner-city neighborhoods.

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### OUTCOMES

- From June 2016 to May 2019, 136 fecal immuno-chemical test stool kits were distributed and 39 were returned (29% return rate). Eight colonoscopies were completed in this period and three polyps were removed.
- In May 2019, the hospital switched the stool kit from FIT (three-day sample) to InSure (one-day sample); 56 kits have been distributed since then and 32 returned (57% return rate) — a nearly double increase. Three colonoscopies have been completed since May 2019 and no polyps removed.

- Through community events and hosting educational sessions, 185 people have signed up to be We Matter participants. We Matter participated in 44 community events in the 2018-2019 grant year and 34 so far in the 2019-2020 grant year.

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### LESSONS LEARNED

In addition to the change in kits, the We Matter program found that combining educational sessions with the already established She Matters program enhanced participation and attendance. Many participants have begun signing up for both programs. Often, if they are already a She Matters participant, they are scheduling their mammogram, and, after they complete their appointment, take a stool kit home with them.

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### SUSTAINABILITY

We Matter is grant funded by the Jim and Juli Boeheim Foundation. The grant covers monthly stipends, stool kit costs, promotional materials and incentives. In 2017, funding was approved for a full-time We/She Matter program coordinator paid for by Upstate Medical University and the Cancer Center. This funding displays Upstate’s passion and commitment to the Matter programs.

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### PARTNERS

Jim and Juli Boeheim Foundation, Syracuse Housing Authority, Onondaga County Cancer Services Program and American Cancer Society.

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### FOR MORE INFORMATION

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# UR Medicine

## Eat Your Colors

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### INITIATIVE DESCRIPTION AND GOALS

The New York State *Prevention Agenda* focus area 1.1 aims to create “community environments that promote and support healthy food and beverage choices and physical activity.” UR Medicine Thompson Health’s target population was daycare age children, pre-K and kindergarten students, along with areas of diversity and socio-economic challenged families within the county. Teaching children at such a young age about healthy food choices increases the chances of them being healthy eaters as they age. UR Medicine’s goal is to expose them to fruits and vegetables and get them excited about eating healthy foods.

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### OUTCOMES

- A total of 601 children participated in Eat Your Colors.
- Through educational skits, children learned to identify fruits and their colors.
- Youngsters were able to take educational material home with them to share with mom, dad and any siblings.

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### LESSONS LEARNED

- Be patient because things take time. It took two years from the time this program was envisioned to the delivery of the first show.
- Be sure the language is age-appropriate and the length of the skit is long enough to get your point across, yet short enough for their attention span.
- Be sure to add humor that the children will laugh at and understand.

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### SUSTAINABILITY

Once all the props were purchased, the only expenses are the educational materials that the hospital gives to the children. There is a small budget that helps with the educational materials. The staff time is part of the hospital’s community benefit hours and is one way to give back to the community.

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### PARTNERS

Canandaigua Elementary School, TLC Adventures in Child Care, Finger Lakes Community College Child Care, Victor Child Care, Salvation Army after-school program, Doodle Bugs, Montessori School, Jack and Jill, Jim Dooley Child Care Center, Our Children’s Place Head Start and Clifton Springs Head Start.

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### FOR MORE INFORMATION

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# White Plains Hospital

## Stop the Bleed

### INITIATIVE DESCRIPTION AND GOALS

Stop the Bleed is a national awareness campaign launched by the White House in 2015 with the goal of improving victim survival rates following acts of violence. STB helps create safer communities through educational programs that provide people with the skills they need to potentially save a life during an emergency. In 2018, White Plains Hospital formalized an STB training program that focused on two cohorts:

- Developing master trainers to sustain the program by educating and training others. The instruction included wound packing and tourniquet placement on high-fidelity mannequins in the White Plains Hospital simulation lab.
- Developing community champions by offering basic training to community members. This training, conducted at several off-site locations, included simulated wound packing and tourniquet placement on an artificial limb.

STB aligns with the New York State *Prevention Agenda* priority area, “Injuries, Violence and Occupational Health.” The goal is to reduce violence by targeting prevention programs to high-risk populations. STB correlates with efforts to increase school-based and community programs in conflict resolution, bystander interventions and healthy relationship building. STB reinforces this by helping participants safely intervene in a crisis.

### OUTCOMES

The hospital has implemented programs both within the facility and in the community, with more than 140 community members participating. This includes partnerships with more than 18 public schools, universities and community centers from Long Island to Westchester to Binghamton. Since the initial training, the White Plains School District has implemented annual competency requirements to ensure all trained staff continue to sharpen their skills – as well as train new staff. To help with this effort and to prepare the White Plains School District in the event of an emergency, the hospital donated STB kits to the schools. The kits include tourniquets and wound packing equipment.

### LESSONS LEARNED

When assessing the program’s efficacy, baseline data indicated there is a significant drop in retention after three months for the skillsets taught. WPH aimed to improve the program by introducing simulation and experiential learning to enhance outcomes. It ran a randomized control trial with 66 members of the White Plains School District and found an improvement of knowledge, comfort, skillset and retention with those that went through the experiential programming versus those who participated in static programming alone.

### SUSTAINABILITY

WPH formalized the STB program and collaborated with the schools to recruit and train new master trainers. WPH requires a second assessment three months later to measure retention of skills. This assessment ensures participants can effectively demonstrate the skills needed to save a life. WPH then developed a system where each of these trainers could join monthly training sessions and were encouraged to use WPH’s equipment to go into the community and certify others.

### PARTNERS

White Plains Hospital, Greenburgh Police Department and White Plains School District.

### FOR MORE INFORMATION

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# HANYS Celebrates Previous Community Health Improvement Award Winners



|      |  |      |  |
|------|--|------|--|
| 2019 | Montefiore Medical Center<br>Bronx<br><b>Healthy Food Initiative</b>   | 2007 | Rochester General Hospital Clinton<br><b>Family Health Center</b>  |
| 2018 | Unity Hospital, Rochester Regional Health<br><b>Healthy Moms</b>   | 2006 | Ellis Hospital/Northeast Health (Samaritan Hospital and Albany Memorial Hospital)/<br>St. Peter's Health Care Services/Seton Health System Schenectady/Albany/Troy<br><b>Seal a Smile: A Children's Oral Health Initiative</b> |
| 2017 | Schuyler Hospital<br>Montour Falls<br><b>Healthy Eating Active Living (HEAL) Schuyler</b>  | 2005 | Strong Memorial Hospital/University of Rochester Medical Center<br><b>SMILEmobile Dental Office on Wheels</b>  |
| 2016 | Strong Memorial Hospital, Highland Hospital (UR Medicine)/Rochester General Hospital, Unity Hospital (Rochester Regional Health)<br><b>High Blood Pressure Collaborative – Hospital Partners</b> | 2004 | NewYork-Presbyterian/Columbia University Medical Center<br><b>Breast and Cervical Cancer Screening Partnership</b>   |
| 2015 | Bassett Healthcare Network<br>Cooperstown<br><b>School-based Health/Oral Health Program</b>  | 2003 | St. John's Riverside Hospital<br>Yonkers<br><b>School-based Asthma Partnership</b>   |
| 2014 | Bassett Medical Center<br>Cooperstown<br><b>Cancer Screening Outreach – Medical Screening Coach</b>  | 2002 | Strong Memorial Hospital<br>Rochester<br><b>Project Link</b>   |
| 2013 | Arnot Health at St. Joseph's Hospital<br>Elmira<br><b>Chemung County School Readiness Project</b>  | 2001 | Canton-Potsdam Hospital/Claxton-Hepburn Medical Center<br>Potsdam and Ogdensburg<br><b>St. Lawrence County Health Initiative</b>   |
| 2012 | Sound Shore Medical Center<br>New Rochelle<br><b>Outpatient Pediatric Immunization Center</b>  | 2000 | Harlem Hospital Center<br>New York City<br><b>Injury Prevention Program</b>  |
| 2011 | Catholic Health Services of Long Island<br>Rockville Centre<br><b>The Healthy Sundays Program</b>  | 1999 | Women's Christian Association Hospital<br>Jamestown<br><b>Women's Health Initiative</b>  |
| 2010 | Brookdale University Hospital and Medical Center<br>Brooklyn<br><b>Live Light...Live Right Childhood Obesity Program</b>   | 1998 | United Health Services<br>Binghamton<br><b>Pediatric Asthma Program</b>  |
| 2009 | Strong Memorial Hospital/University of Rochester Medical Center<br><b>Health-e-Access Telemedicine Network</b>   | 1997 | St. Mary's Hospital/Unity Health System<br>Rochester<br><b>HealthReach Program</b>   |
| 2008 | Jamaica Hospital Medical Center<br><b>Palliative Care Collaborative</b>  |      |  |



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