# Connecting with Communities

## Community Health Initiatives Across New York State

2014 EDITION

HANYS Healthcare Association of New York State

# Community Health Initiatives Across New York State

### 2014 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER

**Bassett Medical Center**
Cancer Screening Outreach
Medical Screening Coach

### HONORABLE MENTIONS

**Hospital for Special Surgery**
Asian Community Bone Health Initiative

**NewYork-Presbyterian Hospital**
WIN for Health

The Healthcare Association of New York State (HANYS) is pleased to present the 18th edition of *Connecting with Communities: Community Health Initiatives Across New York State*, which highlights the winners and nominations for HANYS' 2014 Community Health Improvement Award.

Hospitals and healthcare systems are developing community benefit strategies to respond to the new demands of healthcare reform, including the movement toward population health management. Healthcare organizations are engaging key stakeholders to develop population and community health strategies to improve the overall health of their communities. They are creating new partnerships to address practical tools for developing effective multi-sector partnerships at the local, regional, and state levels to implement community health initiatives.

Many of New York's hospitals and health systems link their community benefit strategies to New York State's Prevention Agenda 2013-2017—to make New York State the healthiest state in the nation—and to the National Prevention Strategy, which was created under the Affordable Care Act to increase the number of Americans who are healthy at every stage of life.

HANYS is a leader in helping hospitals and health systems transition to patient-centered, integrated healthcare delivery models that emphasize preventive care and maintaining good health. HANYS is assisting members as they develop ways to manage population health through care coordination, education, behavioral interventions, and the evidence-based use of healthcare resources. To learn more, visit HANYS' Population Health website: www.hanys.org/population-health.

## About HANYS' Community Health Improvement Award

**HANYS created the Community Health Improvement Award in 1997 to recognize outstanding initiatives aimed at improving the health and well-being of communities. The award is presented to member facilities and programs that target specific community health programs, demonstrate leadership, collaborate among diverse groups, and most importantly, achieve quantifiable results.**

For more information on this award or about HANYS' community health agenda, contact Sue Ellen Wagner, Vice President, Community Health, at (518) 431-7837 or at swagner@hanys.org.

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## 2014 COMMUNITY HEALTH IMPROVEMENT AWARD WINNER



## HONORABLE MENTIONS



## NOMINATION PROFILES

# WINNER 2014
# COMMUNITY HEALTH IMPROVEMENT AWARD

# Cancer Screening Outreach Medical Screening Coach

## BASSETT MEDICAL CENTER, COOPERSTOWN

**YEAR INITIATIVE STARTED**

**2008**

**PARTNERS**

**New York State Department of Health Cancer Services Program**

**American Cancer Society**

**NYCM Insurance**

**SEFCU**

**Medical Coach, Inc.**

### PROGRAM DESCRIPTION AND GOALS

The Bassett Cancer Institute's mobile medical screening coach program recognizes that socioeconomic status, geography, and lack of effective public transportation impact the ability of residents to access information and services related to early detection of disease. Bassett's mobile vehicle is equipped with digital mammography and a self-contained clinical unit, and travels to a variety of community-based sites, enabling staff to reach more under-served people with mammograms, clinical breast exams, Pap smears, and colorectal cancer screenings.

Bassett's eight-county service area includes the federally designated Appalachian counties of Chenango, Delaware, Otsego, and Schoharie. Through the mobile medical coach, Bassett is helping address a *Prevention Agenda* priority of chronic disease prevention and a specific goal of increasing screening rates for breast, cervical, and colorectal cancer, especially among disparate populations.

### OUTCOMES

Early diagnosis of cancer means greater chance of survival. This program has significantly increased access to screenings for the under-served. Out of 679 cancer cases in the Bassett Cancer Center registry from 2008 to 2012:

- 91 were Stage 0;
- 296 were Stage 1; and
- 196 were Stage 2.

This screening outreach program:

- provided 10,096 mammograms over four years, 773 referrals for follow up, and 31 referrals for breast cancer treatment;
- reached 1,601 underinsured and uninsured individuals with screening mammograms; and
- provided 1,400 underinsured and uninsured women Pap tests—97 received abnormal results, and eight of those were diagnosed with cancer.

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# HONORABLE MENTIONS 2014

## COMMUNITY HEALTH IMPROVEMENT AWARD

# Asian Community Bone Health Initiative

## HOSPITAL FOR SPECIAL SURGERY, MANHATTAN

### YEAR INITIATIVE STARTED

**2011**

### PARTNERS

**Arthritis Foundation**

**New York City Department for the Aging**

**New York Chinatown Citizen Senior Center**

**Chinese-American Planning Council**

**LaGuardia Good Health and Happiness Senior Center**

**Mott Street Senior Center**

**New York Foundation for Senior Citizens**

**New York Golden Eagle Senior Day Care**

**Selfhelp Innovative Senior Center**

**Queens Library**

**Grand Street Settlement**

**Internal learning and training center**

**Community adult day centers**

### PROGRAM DESCRIPTION AND GOALS

The Asian Community Bone Health Initiative (ACBHI) offers culturally-relevant educational lectures focused on musculoskeletal health and doctor/patient communication, self-management education, yoga, and low-impact chair exercise programs. Its overall goal is to help Asian older adults better manage chronic musculoskeletal conditions while also increasing access to care in a medically under-served community.

ACBHI is an integral part of the Hospital for Special Surgery's Community Service Plan; it aligns with the Prevention Agenda's chronic disease priority and focuses on promoting the use of evidence-based care to manage chronic disease and culturally relevant chronic disease self-management education.

### OUTCOMES

ACBHI reached 530 older adults through its community-based programming since its inception in 2011. Results indicate knowledge attainment and increased self-efficacy, improved health status and balance, reduced health limitations and musculoskeletal pain, and less stiffness and fatigue:

- eighty-one percent of participants understood chronic disease self-management techniques;
- eighty-eight percent of participants indicated that the program increased their confidence in symptom management;
- participants who could climb several flights of stairs increased by 69%;
- participants who could bend, kneel, or stoop increased by 83%;
- fifty-nine percent fewer participants reported falling;
- forty-eight percent fewer participants had pain on a daily basis;
- participants reported their pain interfered significantly less with aspects of their quality of life, including walking ability and normal work;
- participants' mean pain intensity rating decreased significantly;
- participants feeling fatigue after the program dropped by 39%; and
- thirteen percent more took part in light physical activity such as walking.

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# WIN for Health

## NEWYORK-PRESBYTERIAN HOSPITAL, MANHATTAN

### YEAR INITIATIVE STARTED

**2006**

### PARTNERS

**Columbia University Medical Center**

**Northern Manhattan Improvement Corporation**

**Community League of the Heights**

**Fort George Community Enrichment Center**

**Dominican Women's Development Center**

### CONTACT

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### PROGRAM DESCRIPTION AND GOALS

WIN for Health is a hospital-community partnership designed to reduce the burden of chronic disease in a predominantly low-income, immigrant community. Bilingual community health workers (CHWs) support children with asthma and adults with Type 2 diabetes and their caregivers in a year-long care coordination program that offers comprehensive education, support, home visits, and referrals for clinical/social services. CHWs are based in partner community-based organizations, drawing upon a wealth of local resources. CHWs work as part of healthcare teams on pediatric inpatient units and community practices providing culturally appropriate support and information to patients.

WIN for Health is part of NewYork-Presbyterian Hospital's Regional Health Collaborative, which connects providers and coordinates care in a culturally appropriate manner to improve the overall health of the local community.

### OUTCOMES

**Fewer Asthma-Related Hospitalizations, Emergency Department Visits, Missed School Days:** The proportion of children hospitalized due to asthma fell from 40% to 14% upon graduation. The proportion of emergency department visits also fell from 81% to 37%, as did the proportion of missed school days due to asthma (82% to 49%).

**Enhanced Caregiver Self-Efficacy:** The proportion of caregivers who stated they felt in control of their child's asthma rose from a 63% rate at enrollment to 97% at graduation, a 35% increase.

**Improved Diabetes Self-Management:** Among graduates of the diabetes program, 55% of participants decreased their baseline A1C; 54% decreased their systolic blood pressure from baseline; 43% decreased their diastolic blood pressure; and 50% decreased their baseline low-density lipoprotein. Retention (includes those who are still active in the program, who have completed milestones and surveys, and who are in regular communication with the Community Health Workers) for the diabetes program was at 94% at the six-month mark and 96% at the 12-month mark.

**Improved Environmental Awareness:** The proportion of caregivers taking steps to reduce potential asthma triggers in the home increased by 22%, rising from 63% at enrollment to 81% at graduation.

# NOMINATED PROFILES 2014

## COMMUNITY HEALTH IMPROVEMENT AWARD

# Garden Ministry's Horticultural Therapy and Garden Education Program

## BON SECOURS CHARITY HEALTH SYSTEM, SUFFERN

### YEAR INITIATIVE STARTED

**2010**

### PARTNERS

**Jawonio**

**Rockland County Board of Cooperative Education Services (BOCES) Project SEARCH**

**Boy Scouts and Girl Scouts of Rockland and Orange Counties**

**New York Botanical Gardens**

**Catholic Community Services of Rockland**

**Christ Church of Ramapo Feeding Ministries**

### PROGRAM DESCRIPTION AND GOALS

Developed in 2010 on a foundation of innovation and accessibility, Bon Secours Charity Health System's Garden Ministry program delivers horticultural therapy, garden education, and horticulture vocational training at three campuses. Multi-sensory horticulture-based experiences are provided in Americans with Disabilities Act-accessible facilities and outdoor gardens. The Garden Ministry serves senior citizens, special needs students, residents, employees, and community groups.

The initiative provides patients, family members, and community visitors with opportunities to benefit from horticultural therapy and its physical, cognitive, and emotional benefits. It offers the therapeutic advantages of spiritual and social stimulation that occur when people connect with the gifts of the earth and community. It is staffed by a horticultural therapist and relies on volunteers and community members for ongoing sustainability.

The Garden Ministry provides lower-income community members with fresh fruits and vegetables—diets rich in fresh produce help reduce obesity.

### OUTCOMES

**Food donated:** 432 pounds of fresh produce in 2013.

**Increased participation in educational and therapeutic programming:** In 2012, there were 1,873 participants; in 2013, there were 2,459.

**Increased programming:** In 2012, there were 61 programs; in 2013, there were 81.

**Improved stress and mood levels:** *Before visit:* 41% were "happy"; 58% were "not happy nor sad"; and 84% had stress. *After visit:* 100% were "happy" or "elated"; 56% had "no" or "less" stress.

### CONTACT

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# Advance Cardiology Services

## BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER, PATCHOGUE

**YEAR INITIATIVE STARTED**

**2010**

**PARTNERS**

**Winthrop-University Hospital**

**Bellport Primary Care Centers (located in a federally recognized poverty-stricken community)**

**Health Hearts Spirit of Women Community Education Program**

**King Kullen Supermarkets**

### PROGRAM DESCRIPTION AND GOALS

Brookhaven Memorial Hospital Medical Center (BMHMC) developed this initiative to provide additional cardiology services to its community. BMHMC established a relationship with Winthrop-University Hospital and expanded the cardiac services available to bring life-saving interventional cardiac care and diagnostic procedures to 500,000 residents of the East End of Long Island.

The goal is to expand the breadth and scope of community members who have access to these services. Specifically, the program strives to achieve 100% success in meeting door-to-balloon time for all patients.

This project is providing care to patients who suffer from obesity and/or diabetes. Heart disease is prevalent among this patient population. BMHMC has coordinated the activities of its cardiology services, including community outreach, with its diabetes wellness program and bariatric and wellness center.

### OUTCOMES

BMHMC Advance Cardiology Services has:

- performed diagnostic catheterization procedures since 2002;
- performed 228 catheterizations; 64 percutaneous coronary interventions, including 20 patients with acute myocardial infarctions, since December 2013;
- the average door-to-balloon time is 57.25 minutes—the goal is to maintain this tremendous response time; and
- registered 2,500 residents in Health Hearts and provided more than 60 health and wellness lectures.

### CONTACT

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# Operation Rural Rescue

## CANTON-POTSDAM HOSPITAL, POTSDAM

**YEAR INITIATIVE STARTED**

**2012**

**PARTNERS**

**Community Health Center of the North Country (Cerebral Palsy Association)**

**Kinney Drugs, Inc.**

**United Helpers, Inc.**

**WITH ASSISTANCE PROVIDED BY:**

**Clarkson University**

**SUNY Upstate Medical University (Department of Pathology)**

### PROGRAM DESCRIPTION AND GOALS

Canton-Potsdam Hospital and its partners collaborated to safeguard hospital services in Gouverneur after the closure of its hospital. The partners created a sustainable quality program, conducted listening tours to determine needs, achieved Critical Access Hospital designation, provided guidance for expanding the laboratory menu, recruited new practitioners, and reopened most services. Health services are oriented toward primary and preventive care, and a plan exists to more fully integrate services to achieve efficiencies in alignment with the State Health Innovation Plan.

### OUTCOMES

- The laboratory and operating rooms (for minor procedures) were re-opened, serving the Gouverneur community.
- Critical Access Hospital designation was achieved, allowing optimal reimbursement.
- Services were stabilized through practitioner recruitment and retention, especially in primary care, through collaboration with the Community Health Center of the North Country.
- State approval was obtained for St. Lawrence Health System, a parent corporation within which Canton-Potsdam Hospital and the newly established Gouverneur Hospital can operate sustainably, creating a catalyst and model for consolidation in the high-need central St. Lawrence County sub-region.

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# Pediatric Obesity Initiative

## CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER, PLATTSBURGH

### YEAR INITIATIVE STARTED

**2010**

### PARTNERS

**Northern Adirondack Medical Home Pilot Program (including Benardot Pediatrics, Plattsburgh Primary, Plattsburgh Pediatrics, Rainbow Pediatrics, Mountain View Pediatrics)**

**Eat Smart New York**

**County health departments**

**Alice Hyde Medical Center**

**City of Plattsburgh Recreation Department**

**Wellness Center at PARC**

### PROGRAM DESCRIPTION AND GOALS

The Pediatric Obesity Initiative's vision is to create healthy kids and families in communities where they live, work, and play by focusing on lifestyle changes around diet, exercise, and education. The initiative is a collaborative effort between the Northern Adirondack Medical Home Pilot Program and its local pediatric practices. Reaching across rural Clinton, Essex, and Franklin counties in northern New York, the initiative provides nutritional support and counseling to patients and families; engages and empowers patients to strive for healthy lifestyle changes; and aids in the creation of a healthy community with long-term benefits, including the prevention of chronic diseases.

As part of the Medical Home model, the participating pediatric practices received National Committee for Quality Assurance (NCQA) recognition by meeting standards that focus on prevention, obesity, and asthma. The requirements to meet the measures for obesity are: providing education to the family and patient, patient monitoring and follow up, monitoring Body Mass Index (BMI) and lab work, and ensuring connections are made to community resources.

### OUTCOMES

- A multidisciplinary "Community Health Team" approach including the primary care physician, care manager, community resource advocate, and nutritionist allowed for collaboration and the breakdown of barriers that prevented patients from obtaining a healthier lifestyle.
- Data obtained for 2012-2013 showed 14% of the patients with a BMI greater than 85 experienced an improved BMI, dropping below the 85$^{th}$ percentile; this represents 277 out of 2,000 patients in the initiative.

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# Community-Based Care Transitions Program

## ELIZABETHTOWN COMMUNITY HOSPITAL, ELIZABETHTOWN

### YEAR INITIATIVE STARTED

**2012**

### PARTNERS

**Essex County Departments of Public Health, Social Services, Coordinated Care, and Financial Services**

**High Peaks Hospice and Palliative Care**

**Horace Nye Nursing Home**

**Champlain Valley Senior Living**

**Montcalm Manor Assisted Living**

**Neighborhood House Assisted Living**

**Interlakes Healthcare Medical Home**

**Southern Adirondack Independent Living Center**

**Ombudsman**

**Northern Adirondack Medical Home**

**Primary care clinics**

**The Alzheimer's Association**

**Third Day Adult Day Care**

**Veteran's Administration**

**HCR Home Care**

**Visiting Nursing Services**

**North Country Home Care**

### PROGRAM DESCRIPTION AND GOALS

Elizabethtown Community Hospital is exempt from any federal funding for care transitions programs due to its Critical Access Hospital (CAH) designation. The hospital has made a grassroots effort to develop and coordinate a care transitions program and community-based care transitions committee.

The care transitions program facilitates 24/7 post-discharge telephone calls to all patients; and a care transitions coach makes home visits for medication reconciliation and coordination of community services, etc.

The goal of the community-based care transitions committee is to ensure patients in the community are provided a full continuum of care upon discharge. The committee meets on a monthly basis and is comprised of 21 agencies that encompass five counties.

The initiative is aligned with the goals of the New York State Prevention Agenda and county efforts as it strives to provide high-quality chronic disease management in clinical and community settings.

### OUTCOMES

- Same diagnosis readmission rates decreased from 10% in 2012 to 4% in 2013. All-cause readmission rates decreased from 3% in 2011 to 1% in 2013.
- The number of referrals made for patients discharged home from an inpatient or swing bed stay increased from three referrals in 2011 to 64 referrals in 2013.
- The membership of community agencies has increased from representation from five agencies in 2012 to more than 20 in 2014.
- Community agency relationships have improved to become more collaborative, resulting in a smoother transition from the hospital and a supported continuum of care thereafter.

### CONTACT

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# Lifeline Mobile Mammography Coach Initiative

## ERIE COUNTY MEDICAL CENTER, BUFFALO

**YEAR INITIATIVE STARTED**

**2012**

**PARTNERS**

**First Niagara Bank**

**Buffalo Sabres Alumni Foundation**

**ECMC Lifeline Foundation**

**Buffalo Bills**

**Vivian Lindfield, M.D., ECMC, and WNY Breast Health**

**The National Witness Project®, Inc.**

**WNY Women's Imaging**

### PROGRAM DESCRIPTION AND GOALS

To provide mammography screenings in under-served and rural Western New York communities, Erie County Medical Center (ECMC) introduced a 45-foot, bright pink clinical office on wheels. The coach is the only type of its kind in the nation, with two state-of-the-art, full-field mammography systems in private suites. Certified technologists conduct the mammogram procedures and mammograms are read by board-certified radiologists.

This initiative focuses on chronic disease prevention through the improvement of breast health behaviors. The team works to reduce mortality rates associated with breast cancer and improve breast health behaviors through education and screenings. It promotes women's health, one of ECMC's priorities, advancing the Prevention Agenda through improving the health status of African American, Latino, refugee, and rural women. This public-private, multi-stakeholder partnership has achieved public health improvement.

### OUTCOMES

- In the first year (July 2012 to June 2013), 1,410 mammograms were performed, 110 women were flagged for secondary exams, and two positive results were found.
- The mobile unit provided services to more than 57 sites with returns to some sites on a monthly basis.
- In the first six months of year two, July 2013 to December 2013, 969 women received a screening mammogram, and 106 women were flagged for secondary exams.
- The coach visited 67 sites in the first six months of year two, some on a monthly basis.

### CONTACT

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# From Rehab to PRE-hab: Reducing the Incidence of Heart Disease in High-Risk Rural Upstate New York

## FINGER LAKES HEALTH, GENEVA

**YEAR INITIATIVE STARTED**

**2012**

**PARTNERS**

**The William G. McGowan Charitable Fund**

**New York Chiropractic College**

**Geneva YMCA**

**Geneva Community Center**

### PROGRAM DESCRIPTION AND GOALS

In many communities in rural upstate New York, heart disease is the number one cause of premature death. Intent on reducing that number, Finger Lakes Health developed *From Rehab to PRE-hab: Reducing the Incidence of Heart Disease in High-Risk Rural Upstate New York*. The program, directed by the chief of cardiology, consists of one evening session each week for ten weeks to educate at-risk patients.

Finger Lakes Health will focus on obesity and hypertension over the next three years. The program is an ideal format for the rural, close-knit nature of the counties the system serves.

### OUTCOMES

- Ninety-eight percent of participants had an increased knowledge of causes and risk factors of cardiac disease as measured by achieving improvement from pre- to post-survey.
- All participants understand how screening results (lipid profile, blood pressure, body mass index) reflect wellness, allowing them to knowledgeably follow up with a primary care practitioner.
- Ninety-eight percent of participants increased their ability to identify their own risk factors for cardiac disease as measured by an end-of-cycle post-test.
- Forty-three percent reported that they increased their amount of regular exercise.

### CONTACT

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# Healthier Families Program

## GOOD SAMARITAN HOSPITAL MEDICAL CENTER, WEST ISLIP

**YEAR INITIATIVE STARTED**

**2012**

**PARTNERS**

**Good Samaritan Hospital Medical Center staff**

**Bay Shore School District**

**Bay Shore Wellness Alliance**

### PROGRAM DESCRIPTION AND GOALS

The goal of the Healthier Families Program is to educate parents/guardians and students about the importance of adopting healthy lifestyles. The program underscores the importance of healthy nutrition and encourages daily participation in physical activities that can be enjoyable and fun.

The program targets students with a Body Mass Index (BMI) in the 85$^{th}$ percentile or above. Parents/guardians and students must demonstrate commitment to the program by attending nutritional sessions together. There is no enrollment fee. Meetings are held twice a week for ten weeks. Weight, height, and BMI are measured at the first session, midway, and at the conclusion of the program. Faculty participation and involvement is composed of a multidisciplinary team that includes Good Samaritan Hospital, Bay Shore schools, and the Bay Shore Wellness Alliance.

In 2013, Good Samaritan conducted a community health needs assessment, which showed that among the 115 respondents, being overweight and obesity were the most commonly health challenges. Guided by these data, the hospital selected chronic disease prevention through the provision of nutrition and weight management services as one of its priority focus areas. The Healthier Families Program is one of the strategies that the hospital employs to address this issue as part of its Prevention Agenda work.

### OUTCOMES

- At least 50% of participants demonstrated relevant improvement in weight and health as determined by BMI at the end of the ten-week period.
- By surveying both students and parents, more than 90% demonstrated greater knowledge and awareness of the importance of a healthy lifestyle and the need for its continuation.
- Parents expressed increased commitment to provide a home environment conducive to healthy living.
- Children report greater self-esteem at the end of the course.

### CONTACT

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# Improving the Quality of Life of the COPD Population in Our Community

## LONG ISLAND JEWISH MEDICAL CENTER, NEW HYDE PARK

### YEAR INITIATIVE STARTED

**2011**

### PARTNERS

**The national "Living Well with COPD" program**

**Fifty community physicians at more than 20 practices**

**Centers for Medicare and Medicaid Services**

**Sixteen sub-acute/rehabilitation facilities**

**Service Guild of Long Island Jewish Medical Center**

**Long Island Jewish Medical Center interdisciplinary inpatient care team**

**Care Solutions and Long Island Jewish Medical Center Home Health Agency**

### CONTACT

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### PROGRAM DESCRIPTION AND GOALS

Chronic obstructive pulmonary disease (COPD) is the third-leading cause of death in the United States. COPD cannot be reversed, but many treatments performed in the hospital for COPD can actually be performed in the community, at home, or in a physician's office at a much lower cost. This program's goal is to identify and collaborate with community partners to create access and coordinate care across the continuum for COPD patients through educational toolkits and a shared decision-making framework that will ultimately facilitate collaborative disease management choices.

Services include having community practice physicians meet patients in the hospital, scheduling follow-up/rehabilitation appointments before discharge, a local gym "credentialing" program, and expediting the transition from nebulizer to inhaler use to reduce costs.

### OUTCOMES

- Improvement in quality outcomes and an avoided admissions resulted in approximately $2 million in savings to the health system after the first program year.
- More than 1,600 cases of COPD have been treated since the program's start.
- Results include a 22% reduction in 30-day readmissions, a 50% reduction in in-hospital mortality rates, and a 64% reduction in intensive care unit use in the first program year.
- The program was accepted into the national Centers for Medicare and Medicaid Services (CMS) Bundled Payments for Care Improvement project: 13 patients were enrolled since January 1, 2014 with a 0% readmission rate; 100% of patients have been connected with a nurse practitioner navigator for a home visit; more than 200 high-risk patients have been tracked in a COPD database since 2011—90% were visited in the hospital by a pulmonary practice specialist during their stay, and 91% received a discharge phone call within 72 hours of discharge.
- StoryCorps grant: Three patient accounts of the care they received and their ability to manage their disease in the community were captured on film and housed in the Library of Congress as a testament to the program's impact and success.

# Project HOPE

## LUTHERAN MEDICAL CENTER, BROOKLYN

### YEAR INITIATIVE STARTED

**2012**

### PARTNERS

**Local schools, after-school programs, and summer camps**

**Local community-based and faith-based organizations**

### PROGRAM DESCRIPTION AND GOALS

Crisis counselors offered free, confidential, individual, and group counseling and resource linkages for New York City residents devastated by Superstorm Sandy. The goal of the program was to offer a range of counseling services at a time and place that worked best for storm survivors. Crisis counselors offered residents coping strategies to manage overwhelming emotions, allowing them to make decisions and move past the physical and emotional impact of the disaster.

### OUTCOMES

- Crisis counseling services were provided to 4,200 individuals and families.
- Lutheran Medical Center facilitated 275 resiliency social-emotional skills building groups in eight schools, ten after-school programs, and 14 summer camps.
- Lutheran Medical Center hired 18 staff that spoke nine languages to work in traditionally under-served communities, reaching more than 4,000 residents.
- This was the only Project HOPE team to have seven Arabic speakers who travelled in Queens, Brooklyn, and Staten Island to provide crisis counseling in Arabic.

### CONTACT

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# Home Care Geriatric Psychiatry Program

## MONTEFIORE MEDICAL CENTER, BRONX

**YEAR INITIATIVE STARTED**

**2004**

**PARTNERS**

**Naturally-occurring retirement communities**

**Nonprofit aging case management agencies**

**Local community hospitals and primary care providers**

### PROGRAM DESCRIPTION AND GOALS

Montefiore Medical Center's home healthcare and the psychiatry departments implemented an innovative program to identify and treat the homebound elderly with depression. Using Outcome and Assessment Information Set (OASIS) and screening tools, home care staff screen all home care patients for depression or other psychiatric symptoms. In communication with primary care providers, patients are referred to Montefiore's geriatric psychiatrist, who provides in-home consultations and treatment.

The program has further evolved to have Montefiore's geriatric psychiatrist embedded part time in the teaching hospital, allowing for follow-up of hospitalized home care patients. By integrating behavioral health into primary care, the program aims to provide care to a population that under-utilizes mental health services.

This program meets Montefiore's institutional goal to increase access to high-quality chronic disease preventive care and management in both clinical and community settings.

### OUTCOMES

- Provides access to mental health treatment for under-served, elderly, minority individuals (50% Hispanic and 31% African American).
- Evaluates and provides mental health treatment to homebound patients with depression/mood disorders that may have gone undiagnosed and untreated (65% were diagnosed and treated for a depressive or mood disorder).
- Provides timely mental health interventions (49% were evaluated within a week of referral; 78% within two weeks of referral).

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# The Pediatric Visiting Doctors Program

## THE MOUNT SINAI HOSPITAL, MANHATTAN

**YEAR INITIATIVE STARTED**

**2013**

**PARTNERS**

**A.I.R. Harlem**

**East Harlem Asthma Center for Excellence**

**The Little Sisters of the Assumption**

**School-based health centers**

### PROGRAM DESCRIPTION AND GOALS

The Pediatric Visiting Doctors Program at The Mount Sinai Hospital aims to provide patient, family, and community-centered care in the home for children in central and east Harlem. The Mount Sinai Hospital strives to decrease healthcare disparities by improving access to high-quality care; delivering care in the context of each child's home, school, and community environment; collaborating with local community-based organizations; and empowering patients, families, and communities to live healthier lives.

The Pediatric Visiting Doctors Program team is comprised of two physicians, a social worker, care coordinator, and patient navigator. This team provides comprehensive home-based primary care and care coordination in partnership with the Pediatrics Associates Clinic at Mount Sinai and with several community partners.

### OUTCOMES

**Patient Enrollment:** The program has enrolled 61 children and made more than 150 home visits.

**Community Partnerships:** The team has made more than 60 referrals to community partners.

**Patient Outcomes:** According to a preliminary analysis, there was a decrease in total emergency room visits in children with asthma who have been in the program for at least three months. Out of this subgroup of 28 patients, there were a total of 19 emergency room visits at the hospital three months prior to enrollment, which was decreased to a total of nine emergency room visits for the three months after enrollment, reflecting a 47% reduction in visits.

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# Moms Net™ Collaborative

## MOUNT SAINT MARY'S HOSPITAL, LEWISTON

**YEAR INITIATIVE STARTED**

**2008**

**PARTNERS**

**Two local universities**

**Several faith groups and charitable organizations**

**Niagara County Health Department**

### PROGRAM DESCRIPTION AND GOALS

The goal of the Moms Net™ Collaborative is to create an individualized education care plan for women and families based on specific needs and home environments. The education structure is seamless to the participant and is initiated by the participant's obstetrician/gynecologist. The model is offered to other local hospitals for replication in their facilities. The vision is that it can be readily deployed throughout the county for all pregnant women and their families, regardless of where they deliver.

Moms Net™ addresses Mount Saint Mary's Hospital's Prevention Agenda by identifying and treating chronic diseases early in pregnancy; educating new mothers on nutrition, exercise, and healthy behaviors; encouraging breast feeding to improve infant health; and improving infant wellness through compliance with well-baby visits.

### OUTCOMES

- This initiative has advanced collaboration among a wide array of community organizations.
- More efficient identification of moms at risk for postpartum depression/other issues.
- Establishment of support groups and information lines for real-time assistance.

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# Stepping On: Falls Prevention Initiative

## NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, GREAT NECK

### YEAR INITIATIVE STARTED

**2011**

### PARTNERS

**Local health and human services organizations**

**Local faith-based organizations**

**Local libraries**

**Naturally occurring retirement communities**

**Local senior centers**

**Local police departments**

### PROGRAM DESCRIPTION AND GOALS

Stepping On is an evidence-based community program that empowers independent older adults to manage fall risk. For seven weeks, trained leaders facilitate weekly small groups using adult education principles and storytelling strategies. The interactive classes empower participants to make better decisions and behavioral changes.

The program goals are to create a sustainable community health program that empowers older adults to use healthy behaviors that reduce fall risk, improve self-management, improve self-efficacy, maintain independence, and enhance quality of life.

This program is directly related to the New York State Prevention Agenda and is an integral component of the organization's community health education strategy.

### OUTCOMES

- The organization developed and implemented a sustainable, evidence-based community health prevention program.
- The *Stepping On: Falls Prevention Initiative* successfully engaged 19 community partners and fostered their ability to independently deploy the program in the communities they serve.
- Older adult hospital volunteers are having an innovative volunteer experience as leaders in the Stepping On program.
- The data have shown that participants significantly improve self-knowledge and risk reducing behaviors after completing the course. The data also demonstrate that risk reducing behaviors are sustained beyond the classes through the three-month follow-up.

### CONTACT

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# Improving Care for the Patient Presenting With Signs and Symptoms of Acute Coronary Syndrome

## OLEAN GENERAL HOSPITAL, OLEAN

### YEAR INITIATIVE STARTED

**2009**

### PARTNERS

**Cattaraugus County Emergency Services**

**Cattaraugus County basic life support and advanced life support agencies**

**Trans Am Services, Olean**

**Olean City, Weston Mills, Salamanca, Allegany, Randolph, Little Valley, Hinsdale, Franklinville, and Portville fire departments**

**Cattaraugus County Emergency Dispatch Services**

**Cattaraugus County Health Department**

**Southern Tier Healthcare Network**

### PROGRAM DESCRIPTION AND GOALS

In 2009, Olean General Hospital embarked on a journey to improve outcomes for patients presenting with signs and symptoms of acute coronary syndrome (ACS). It began with the development of the hospital's Chest Pain Center and coordination of processes for early recognition, diagnosis, and treatment of patients with ACS signs and symptoms. The second stage focused on community education and coordination of pre-hospital care.

The goal was to improve cardiac care through timely recognition of signs and symptoms, early activation, emergency medical services (EMS) response, appropriate pre-hospital care, and coordination of care within the hospital. In 2013, the hospital became one of ten in New York State accredited by the Society of Cardiovascular Patient Care. This initiative is linked with the cardiovascular care goals of the state's Prevention Agenda.

### OUTCOMES

- The initiative achieved a 50% reduction in the timeframe from onset of chest pain to a 911 call (120 minutes in December 2012, to 60 minutes in December 2013).
- The time from patient arrival to first electrocardiogram (EKG) read time was reduced by 50% during the first year, with median times below ten minutes sustained (20.3 minutes in April 2011, to six minutes in December 2013).
- The time from patient arrival to Troponin result was reduced by 72% (91.14 minutes in July 2012, to 35 minutes in December 2013).
- There was a 50% increase in pre-hospital EKG transmission by emergency medical services providers (22% of pre-hospital EKG's transmitted in January 2013, to 45% transmitted in December 2013).

### CONTACT

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# Primary Care Collaborative

## OSWEGO HEALTH, OSWEGO

**YEAR INITIATIVE STARTED**

**2009**

**PARTNERS**

**Northern Oswego County Health Services, Inc.**

**Oswego County Opportunities**

### PROGRAM DESCRIPTION AND GOALS

A successful primary care collaborative developed by Oswego Health and two former competitors—Northern Oswego County Health Services, Inc. and Oswego County Opportunities—led to improved physician recruitment and retention opportunities, updated healthcare facilities in rural Oswego County, and, most importantly, an improved health status of community members. This collaboration expanded the county's only Federally Qualified Health Clinic's (FQHC) scope of service from one location to six.

Oswego Health has taken a proactive role to improve access to primary care services in Oswego County. With this improved access, patients will more likely visit physicians for chronic disease care. Chronic disease prevention is one of the Prevention Agenda priorities on which Oswego Health is focused.

### OUTCOMES

- Six primary care clinics successfully transitioned to one FQHC.
- These six clinics have seen measurable health improvements in weight assessment in children followed by physical activity and nutrition counseling, which improved from 44% to 59%. Hypertension control in patients with diabetes improved from 59% to 75%. Usage of a tobacco use assessment tool increased from 84% to 99%. The FQHC has added patient smoking status to every form and 46% of these patients were either counseled or provided smoking cessation medication.
- Not one physician or mid-level provider resigned following the consolidation of the six health centers and most of the 80 employees were retained.
- The FQHC that operates the six clinics expects to break even in 2014.

### CONTACT

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# Redefining High Blood Pressure Care for a Hospital Outpatient Clinic

## ROCHESTER GENERAL HOSPITAL, ROCHESTER

**YEAR INITIATIVE STARTED**

**2010**

**PARTNERS**

**Ibero-American Action League (Project Hope)**

**Greater Rochester Health Foundation**

**Rochester Business Alliance**

**Finger Lakes Health Systems Agency**

### PROGRAM DESCRIPTION AND GOALS

Rochester General Hospital undertook a bold initiative and completely redesigned how patients with high blood pressure were cared for in the outpatient department, which serves a predominately African American and Hispanic patient population, and trains internal medicine residents. The goal was to achieve a 25% improvement in the percentage of hypertensive patients reaching their blood pressure goal. The initiative exceeded expectations and achieved a more than 30% increase.

Increasing the percentage of patients reaching their blood pressure goal is part of Rochester General Hospital's Community Service Plan, and is aligned with the hospital's Prevention Agenda goals.

### OUTCOMES

- Accuracy in obtaining blood pressure values increased 76%.
- Wait times for prescriptions decreased 42%.
- Wait times for appointments decreased 31%.
- There was a 30% increase in patients reaching their blood pressure goal.

### CONTACT

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# Community Alliance for Health Awareness

## ST. BARNABAS HOSPITAL, BRONX

**YEAR INITIATIVE STARTED**

**2006**

**PARTNERS**

**Thirty-four local schools**

**Sixteen community-based organizations**

**Seven faith-based groups**

**Three local grocery stores**

### PROGRAM DESCRIPTION AND GOALS

As part of its ongoing effort to educate and inform the Bronx community on various health topics and respond to community inquiries on health-related topics, St. Barnabas Hospital developed the Community Alliance for Healthcare Awareness (CAHA). This group unifies local community schools, community-based organizations, faith-based organizations, and childcare facilities. Members of CAHA meet at St. Barnabas Hospital on the last Wednesday of every month, share a light snack, and discuss various relevant health topics of interest for these organizations. It is also a perfect setting to voice their concerns and to share solutions on pertinent matters.

### OUTCOMES

**CAHA Results: Awareness of Key Health Issues**

| | RIGHT ANSWERS **PRE** TEST | RIGHT ANSWERS **POST** TEST |
|---|---|---|
| Chronic Diseases prevention | 68% | 86% |
| Obesity | 68% | 85% |
| Smoking Cessation | 47% | 69% |
| HIV Awareness | 59% | 69% |

### CONTACT

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# Care Transition Coalition

## ST. LUKE'S CORNWALL HOSPITAL, NEWBURGH

### YEAR INITIATIVE STARTED

**2012**

### PARTNERS

**Wingate Skilled Nursing Facility (SNF)**

**Hospice of Orange/Sullivan Counties**

**Orange County Department of Mental Health**

**Elant SNF**

**Willcare Home Health Agency (HHA)**

**Independent Living**

**Montgomery SNF**

**Premier HHA**

**Occupations, Inc.**

**Campbell Hall SNF**

**Good Samaritan HHA**

**Fresenius Dialysis**

**Center for Wound Healing and Hyperbaric Medicine**

**Greater Hudson Valley Family Health Center**

**Helen Hayes Hospital**

### PROGRAM DESCRIPTION AND GOALS

With healthcare reform emphasizing quality improvement, efficiency, better outcomes, and decreasing the fragmentation of care across settings, in July 2012, the Care Transition Coalition was established. The Coalition's goal is to use partnerships and knowledge to develop a new sustainable healthcare model. The overarching objective is to provide the right care in the right setting at the lowest cost and highest quality. This is accomplished through collaborative initiatives aimed at seamless transitions for post-hospital care, connections with needed community resources, and removing barriers to meet the needs of patients.

This work coincides with the hospital's Community Service Plan components related to chronic disease prevention.

### OUTCOMES

- Thirty-day heart failure readmissions were reduced.
- The number of hospitalizations from the emergency department decreased.
- More patients were received on weekends from the hospital setting to the SNFs.
- The number of behavioral health patients requiring transfer to a "Section 9.39" facility decreased.

### CONTACT

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# Concussion Education and Safe Return to School and Play Program

## ST. MARY'S HEALTHCARE, AMSTERDAM

### YEAR INITIATIVE STARTED

**2010**

### PARTNERS

**St. Mary's Healthcare Emergency Department and Speech Pathology Department**

**Greater Amsterdam School District**

**Broadalbin Perth High School**

**Gloversville High School**

**Johnstown High School**

**Mayfield High School**

**Fulton Montgomery Community College**

**Amsterdam Little Giants Football League**

### PROGRAM DESCRIPTION AND GOALS

Certified athletic trainers play a key role in concussion assessment and return-to-play management. In 2010, the Concussion Education and Safe Return to School and Play Program was developed in response to area coaches, parents, and physicians not understanding what a concussion was and returning athletes too quickly back to their normal routines. In order to play, athletes must go through the Return-to-Play program after sustaining a concussion.

Goals of the program include educating the community regarding concussions, increasing the number of athletes and coaches who report concussion symptoms, making sure the athletes are symptom-free prior to returning to sports, and decreasing the cognitive load placed on students when returning to school after a concussion.

### OUTCOMES

- Fifty-three athletes were diagnosed with concussions and went through the Return-to-Play program in the first year (2010-2011 academic year). Eight athletes were diagnosed in the previous academic year.
- Only six athletes (3%) who went through the Return-to-Play program since 2010 sustained a second concussion in the same sports season.
- More than 50 athletes go through the program each year.
- All coaches attend concussion education seminars each year.

### CONTACT

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# School-Based Asthma Care Program for Urban Youth

## STRONG MEMORIAL HOSPITAL/UNIVERSITY OF ROCHESTER MEDICAL CENTER

**YEAR INITIATIVE STARTED**

**2000**

**PARTNERS**

**Rochester City School District**

**American Lung Association's Regional Community Asthma Network**

**Children's Institute**

### PROGRAM DESCRIPTION AND GOALS

The School-Based Asthma Care Program for Urban Youth is an innovative preventive initiative to improve asthma care for high-risk Rochester City School District students. In conjunction with the children's primary care providers, the program helps ensure that children are prescribed guideline-based preventive asthma treatments, then facilitates the delivery of these treatments by school nurses while the children are at school. The schools also work with caregivers to ensure delivery of prescribed treatments at home.

Program goals are to:

- identify high-risk children in need of improved asthma care;
- improve delivery of care for these children in school and at home;
- decrease the burden of asthma in the community and reduce disparities; and
- develop sustainable models for asthma care that can be disseminated.

### OUTCOMES

- The program demonstrated that, during the peak winter season, children who received preventive medications through school experienced almost one symptom-free day per two weeks more than children in the control group. This translates into approximately 2.5 weeks of additional symptom-free days during a school year.
- Children receiving school-based care had fewer days with activity limitation (1.3 vs. 1.8 days/two weeks).
- Children in the treatment group also were less likely than those in the control group to have an exacerbation requiring treatment with prednisone (12% vs. 18%).
- Importantly, families have been supportive of the program. During qualitative interviews, parents shared: "A year ago, we were back and forth to the doctor and my son wasn't able to participate in sports as he can now. His asthma has improved and we are able to manage his care better," and "Educating me on maintenance medication was key."

### CONTACT

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# Center for Community Health Promotion and Wellness

## SUNY DOWNSTATE MEDICAL CENTER

**YEAR INITIATIVE STARTED**

**1996**

**PARTNERS**

**American Cancer Society**

**American Diabetes Association**

**American Heart and Stroke Association**

**New York City Department of Health**

**New York State Cancer Services Program**

### PROGRAM DESCRIPTION AND GOALS

The mission of this program is to address health disparities and empower communities by providing health education/prevention, early detection, and access to care.

This program is supported by a culturally diverse, multidisciplinary team that provides free community health education/prevention via lectures and workshops, health screenings, cancer services, flu vaccine immunization, prenatal and expectant family education classes, chronic conditions clubs (diabetes, stroke, kidney), as well as access to care. The staff operates daily, including evenings and weekends. The goal is to provide a comprehensive health education, awareness, and prevention program to urban and immigrant communities.

### OUTCOMES

- Cervical and pelvic exams increased from 11% in 2012, to 44% in 2013.
- Flu vaccine administration increased from 4% in 2012, to 37% in 2013.
- Clinical breast exams increased 3% in 2012, to 26% in 2013.
- SUNY Downstate's cardiac screening and education program showed a significant change in diet and adoption of increased physical activity, directly associated with a favorable change in weight. The clients who receive this service lost an average of 13 pounds with diet modification and lost an average of 9.4 pounds with increased physical activity.

### CONTACT

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# Get Up! Fuel Up!

## THOMPSON HEALTH, CANANDAIGUA

**YEAR INITIATIVE STARTED**

**2007**

**PARTNERS**

**Canandaigua YMCA**

**New York Wine and Culinary Center**

**Christa Tyson, Yoga Instructor**

**Salvation Army After-School Program**

**Ontario County school districts: Canandaigua City, Bloomfield Central, Red Jacket (Manchester-Shortsville), Naples Central, Honeoye Central, and Victor Central**

### PROGRAM DESCRIPTION AND GOALS

Thompson Health created the Get Up! Fuel Up! program to combat childhood obesity. It is a prevention-based program that relies on data analysis to continually improve. Thompson Health takes the program into schools, with three levels tailored to particular grade levels. The program is delivered with a positive, imaginative approach crafted to fully engage students and their parents. Children learn which foods are healthy and why, how the media and peer pressure affect choices, and how to be empowered regarding their health. The goal is to teach students to make healthy choices.

### OUTCOMES

From 2011 to 2013:

- Among 250 fifth-graders at Honeoye Elementary School, after completing the program there was a 43% increase in students who acknowledged that watching television during mealtimes can lead to overeating.
- Among 59 second-graders at Bloomfield Elementary School, there was a 58.2% increase in students who acknowledged that grains and vegetables should make up the largest portion of their dinner plate because they are the healthiest.
- Among 259 fifth-graders at Canandaigua Middle School, there was a 46% increase in students who acknowledged that people who skip breakfast eat about 200 more calories a day than people who eat breakfast.
- Among 250 fifth-graders at Honeoye Elementary School, there was a 43% increase in students who acknowledged that it takes 20 minutes to realize your stomach is full.

### CONTACT

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# Care Transitions

## UNITED MEMORIAL MEDICAL CENTER, BATAVIA

**YEAR INITIATIVE STARTED**

**2012**

**PARTNERS**

**P2 Collaborative**

**Office of the Aging**

### PROGRAM DESCRIPTION AND GOALS

Care Transitions is a 30-day program established for patients who suffer from congestive heart failure (CHF), chronic obstructive pulmonary disease, pneumonia, or diabetes, or someone who has been readmitted within 30 days. Within 72 hours of discharge, the Office of the Aging visits the patient to review discharge paperwork and medications, and set goals for the future of the patient's health and well-being. After the home visit, the case worker has three telephone conversations with the patient to ensure his or her transition is smooth. One goal of the program is to get a contract with commercial payers so more patients in the community can be served and can learn how to adapt a healthier lifestyle. Another goal is to have 14 patients go through the entire process each month.

### OUTCOMES

- The average acceptance rate has increased significantly over the past year. An increase in acceptance rates means that more "at-risk" patients are being served, taught healthier lifestyle changes, and ultimately reducing the likelihood of readmission into the hospital. The coaching visit empowers patients to take control of their own health and know what steps to take when they are not feeling well. The number of completed home visits in year one is 16. The number of completions in year two is 19, with five months left to go. Three patients have participated and completed the Care Transitions program for a second time.
- Year One Initial Acceptance Rate: 21%; Year One Final Acceptance Rate: 18%.
- Year One Completion Rate: 82%.
- Year Two Initial Acceptance Rate: 32%; Year Two Final Acceptance Rate: 31%.
- Year Two Completion Rate: 59%.

### CONTACT

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# Go Before You Show/Access to Care

## VASSAR BROTHERS MEDICAL CENTER, POUGHKEEPSIE

**YEAR INITIATIVE STARTED**

**2011**

**PARTNERS**

**Hudson River Healthcare**

### PROGRAM DESCRIPTION AND GOALS

The initiative began as a task force to improve early access to obstetrical care between community organizations. A media and social network campaign called "Go Before You Show" was created. As these partner agencies expanded their affiliation, it culminated in the transition of a population of under-served patients to a Medical Home model of care to better meet their complex medical needs and improve key health indicators. The agencies continue to collaborate to meet the specialty needs of the population while better utilizing their resources and clinical strengths.

Entry to prenatal care, which is predicated on ease in access to care, is addressed by Go Before You Show and is one of Vassar Brothers Medical Center's Prevention Agenda topics. Diabetes management is another Prevention Agenda and is addressed in the diabetic management program portion of the Medical Home model.

### OUTCOMES

- First trimester entry to prenatal care increased 13%.
- Access to Medical Home and specialty medical care is provided to 3,500 patients.
- Emergency department utilization decreased for shared agency patients.

### CONTACT

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# Annual Neighborhood Health Fair

## WHITE PLAINS HOSPITAL, WHITE PLAINS

**YEAR INITIATIVE STARTED**
**1977**

**PARTNERS**
**El Centro Hispano**

**The Thomas Slater Community Center**

**Calvary Baptist Church**

**The Junior League of Central Westchester**

### PROGRAM DESCRIPTION AND GOALS

The Annual Neighborhood Health Fair is a valuable community service in its 37th year, serving more than 500 adults and children annually. The day-long event includes screenings for diabetes, high blood pressure, asthma, breast and prostate cancers, eye, ear, stroke risk, HIV, sickle cell disease, and cholesterol. Experts provide information and answer questions on various health and wellness topics.

Preventing chronic disease by decreasing the percent of African Americans and Hispanics dying prematurely from heart-related deaths is one of the hospital's Prevention Agenda goals. Toward that end, the hospital continues to increase awareness of ways to maintain a healthy blood pressure and avoid heart disease. The Neighborhood Health Fair is the centerpiece in achieving this priority.

### OUTCOMES

- Increase self-assessment abilities through interactive learning experiences.
- Use of health screening information for early disease detection.
- Reassure and encourage participants to continue healthy behaviors.
- Promote effective use of community resources by encouraging cooperation among private, voluntary, and government sector groups.

### CONTACT

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# Falls Prevention Program

## WINTHROP-UNIVERSITY HOSPITAL, MINEOLA

**YEAR INITIATIVE STARTED**

**2009**

**PARTNERS**

**Project Independence: Town of North Hempstead (Westbury/New Cassel)**

**Restoration Village: Bethpage**

**St Paul's Field House: Garden City**

**Four-Part Series in Libraries: Malverne, Elmont, Uniondale, and Freeport**

### PROGRAM DESCRIPTION AND GOALS

The Falls Prevention Program consists of hospital- and community-based training and educational programs about risk reduction and fall prevention strategies, including risk assessments, exercises to enhance balance, and environmental modifications. Launched as a single lecture and balance exercise class, the program currently offers an interactive four-week series that includes lectures and exercise classes. The program goals are to raise community awareness about falls and reduce the senior citizen fall rate.

The hospital identified fall prevention in the elderly population as a public health priority for the region through the Prevention Agenda. In 2008, falls were identified as the leading cause of hospitalization for the elderly and listed under the category of "unintentional injury."

### OUTCOMES

- All participants reported that the program increased their knowledge of the risk of falls, fall prevention strategies, and need for exercise/balance.
- Seventy percent of participants have continued attending individual exercise classes more than once with stated improvement in balance.
- All participants want to be contacted about future classes.
- The program began with 360 participants in year one; year four had 1,908.

### CONTACT

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## PREVIOUS COMMUNITY HEALTH IMPROVEMENT AWARD WINNERS

**2013** **Arnot Health at St. Joseph's Hospital, Elmira**
Chemung County School Readiness Project

**2012** **Sound Shore Medical Center, New Rochelle**
Outpatient Pediatric Immunization Center

**2011** **Catholic Health Services of Long Island, Rockville Centre**
The Healthy Sundays Program

**2010** **Brookdale University Hospital and Medical Center, Brooklyn**
Live Light...Live Right Childhood Obesity Program

**2009** **Strong Memorial Hospital/University of Rochester Medical Center, Rochester**
Health-e-Access Telemedicine Network

**2008** **Jamaica Hospital Medical Center, Jamaica**
Palliative Care Collaborative

**2007** **Rochester General Hospital, Rochester**
Clinton Family Health Center

**2006** **Ellis Hospital/Northeast Health (Samaritan Hospital and Albany Memorial Hospital)/St. Peter's Healthcare Services/Seton Health System, Schenectady/Albany/Troy**
Seal a Smile: A Children's Oral Health Initiative

**2005** **Strong Memorial Hospital/University of Rochester Medical Center, Rochester**
SMILEmobile Dental Office on Wheels

**2004** **NewYork-Presbyterian/Columbia University Medical Center, New York City**
Breast and Cervical Cancer Screening Partnership

**2003** **St. John's Riverside Hospital, Yonkers**
School-Based Asthma Partnership

**2002** **Strong Memorial Hospital, Rochester**
Project Link

**2001** **Canton-Potsdam Hospital/Claxton-Hepburn Medical Center, Potsdam and Ogdensburg**
St. Lawrence County Health Initiative

**2000** **Harlem Hospital Center, New York City**
Injury Prevention Program

**1999** **Women's Christian Association (WCA) Hospital, Jamestown**
Women's Health Initiative

**1998** **United Health Services, Binghamton**
Pediatric Asthma Program

**1997** **St. Mary's Hospital/Unity Health System, Rochester**
HealthReach Program

*Profiles of past winners and nominees can be found on HANYS' website, www.hanys.org, by choosing "Awards" at the bottom of the page.*