Community Health Initiatives
Across New York State
2006-2007 Edition
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Hospitals’ commitment to their communities is evident in their tireless dedication to fulfilling their mission to provide quality care and essential services. Communities throughout the state benefit from this commitment, whether it means providing access to care to the uninsured, disabled, and elderly, or providing health education, outreach, and awareness programs.

Hospitals’ commitment to their communities is readily apparent in the 37 initiatives nominated for HANYS’ 2006 Community Health Improvement Award. This publication profiles these programs.

HANYS established its annual Community Health Improvement Award to recognize its members’ outstanding initiatives to improve the health and well-being of their communities.

HANYS presented its 2006 Community Health Improvement Award to a collaboration of hospitals in the Capital District—Ellis Hospital, Northeast Health (Samaritan Hospital and Albany Memorial Hospital), St. Peter’s Health Care Services, and Seton Health System—for their partnership on the Seal a Smile initiative. Seal a Smile is an oral health prevention and screening program for under-served children in Albany, Rensselaer, and Schenectady counties. The program provides dental care to at-risk children in the Capital District and expands access to health and dental care through enrollment of uninsured children in Medicaid or Child Health Plus.

HANYS awarded an Honorable Mention to Carthage Area Hospital for its Community Partners—Primary Care Network, a collaborative infrastructure of health care providers, schools, local government, civic organizations, and others that developed, implemented, and maintained needed access to basic primary health care and related education for medically under-served residents of northern Lewis, southern St. Lawrence, and Jefferson counties.

For additional information about HANYS’ Community Health Improvement Award or HANYS’ advocacy and support for community health initiatives, contact Sue Ellen Wagner, Vice President, Workforce and Community Health, at (518) 431-7837 or at swagner@hanys.org. Specific questions related to the programs profiled in this document should be directed to the contact person provided for each program.

For additional copies of this publication, contact HANYS’ Community Health Division at (518) 431-7890.

*Community Health Initiatives Across New York State* is also available to members on HANYS’ Web site at www.hanys.org/members_only/access/award.cfm.
Seal a Smile: A Children’s Oral Health Initiative
Ellis Hospital, Northeast Health (Samaritan Hospital and Albany Memorial Hospital), St. Peter’s Health Care Services, and Seton Health System

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Program Description and Goals
Established in 2003, the Seal a Smile program is an oral health program for underserved children in Albany, Rensselaer, and Schenectady counties. This school-based program provides oral health education, screenings, preventive measures, and sealants to children.

The goal of Seal a Smile is to improve preventive dental care to at-risk children in the Capital District and expand access to health and dental care through enrollment of uninsured children in Medicaid or Child Health Plus. Children in need of primary dental services are referred to an appropriate provider for further dental care.

Outcomes
In its first year of operation, the Seal a Smile team provided classroom oral hygiene education to 7,000 kindergarten and second-grade children in 31 schools, five Head Start programs, and a Boys and Girls Club. Of these, 2,402 children were seen and, as appropriate, given fluoride treatment, dental prophylaxis, and screening for evidence of decay. About 751 children with molars ready for sealants were seen a second time to have sealants applied.
Data collected indicated that 46% of the children had evidence of decay and that these children showed decay on an average of 3.6 teeth. Children who needed urgent care received a parental follow-up telephone call, letter, and outreach from school staff to emphasize the seriousness of the problem and to offer assistance with arranging a visit with a dentist. School satisfaction was demonstrated in surveys on five care quality indicators, with 44% of the scores excellent and 42% very good.

**Lessons Learned**

- Parents are important partners in improving their children’s oral health.
- School-based oral health services reduce barriers to children accessing oral health services.
- Engaging private dentists to serve children with government-sponsored health insurance is challenging.

**Ability to Sustain the Initiative**

Sustainability is enhanced through a broad partnership of providers and insurers. Enrollment in Medicaid and Child Health Plus through the Healthy Capital District Initiative-facilitated enrollment project enhances the program’s sustainability through reimbursement for services. The partners work effectively on initiatives, promote community education, provide technical assistance, and provide complementary medical services to enhance the success of Seal a Smile.
Community Partners—Primary Healthcare Network
Carthage Area Hospital

Partners
Partners in this initiative include the Town of Cape Vincent; Village of Cape Vincent; Town of Diana; Village of Sackets Harbor; Town of LaRay; Village of West Carthage; Economic Development Corporation of Carthage; North Country Healthy Heart Network; Rochester/New York State Oral Health Coalition; Northern New York Rural Health Alliance; Jefferson Community College; Jefferson County Public Health Department; Adams Chamber of Commerce; Clifton-Fine Hospital; American Cancer Society; Monroe Community College; Central New York Asthma Coalition; and the Edwards-Knox, Thousand Islands, Sackets Harbor, Harrisville, and Carthage schools.

Program Description and Goals
Carthage Area Hospital’s Community Partners—Primary Care Network is a collaborative infrastructure of health care providers, schools, local government, civic organizations, and others to develop, implement, and maintain opportunities to ensure needed access to basic primary health care and related education for medically underserved residents of northern Lewis, southern St. Lawrence, and Jefferson counties. Since the program’s inception in 2000, the hospital has successfully opened 12 primary care centers.

Outcomes
As the Carthage Area Hospital Community Partners—Primary Care Network evolved, the hospital experienced an increase in outpatient visits from 25,000 per year in 2001 to more than 100,000 visits during 2005. This increase is due to improved access to primary care services. During the past 12-month period, the hospital’s emergency services department continued to have nominal increases in utilization; however, the number of inpatient emergent admissions decreased from 932 to 804. In reviewing the data, staff determined the decrease is a result of improvements in access to basic and continued primary care services.

During the past year, hospital personnel have accomplished more than 6,000 health/wellness patient educational contacts through health fairs, screening events, and speaking engagements. The hospital was directly involved in 21 community health fairs during the past year. The hospital is being approached by two rural communities to open similar outreach services.

Lessons Learned
- Community leaders are willing to support projects and assist in the strategic development of new ideas to enhance health care services.
- Sharing information and resources with community leaders is vital and provides them with a sense of “pride of ownership.”
- People want to become aware of issues and share in the risks and goals for meaningful, long-term solutions.
- Through the primary care centers, high school students have opportunities to evaluate health care career mentoring opportunities. At least three students are enrolled in pre-medicine programs because of this initiative.

Ability to Sustain the Initiative
Carthage Area Hospital is able to financially sustain this program because each network member in the community is assisting with either direct or “in-kind” types of financial support. In addition, the hospital was fortunate to receive several large grants that provided needed cash for capital equipment and start-up costs. The hospital is generating a favorable operating margin for this network through the significant increase of revenue for ancillary services such as laboratory, radiology, and rehabilitation services.
The Uninsured Task Force
Adirondack Medical Center

Partners
Partners include: Adirondack Medical Center, Upper Hudson Primary Care Consortium, Healthcare Association of New York State, Excellus BlueCross BlueShield, Fidelis Care New York, the Franklin and Essex county departments of social services, Northern Adirondack Planned Parenthood, New York State Nurses Association, Trudeau Health Systems, Saranac Lake Central School, Lake Placid Central School, Saranac Lake Chamber of Commerce, Plattsburgh/North Country Chamber of Commerce, Essex County Business Council, ComLinks, Healthy Heart Network, St. Joseph's Rehabilitation Center, Children's Defense Fund, Iroquois Healthcare Alliance, New York State Department of Insurance, United Way, community members, and area clergy.

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Program Description and Goals
The Uninsured Task Force is a partnership of organizations, agencies, and businesses representing the full spectrum of health care providers and consumers working together to improve access to health insurance for residents in a targeted area of rural upstate New York. The group has grown to include representatives from health care providers, insurance companies, schools, businesses, chambers of commerce, and other agencies and organizations.

The Task Force has two goals:
- assure that all children in the defined area have health insurance; and
- reduce the number of uninsured adults in the defined area by 25%, from 12.6% to 9.5%.

The plan of action breaks down the issues into manageable and doable subsets including advocacy, enrollment initiatives, engaging the business community, and public awareness and education.

Outcomes
The results show that the rate of uninsured residents decreased between the original survey in 2003 and the resurvey in 2005. From the baseline 2003 Community Health Assessment Telephone Survey conducted by the State University of New York and the 2005 survey, the Task Force learned that 89% report having insurance, a 3.5% increase from 2003; 93.5% report having a spouse/partner with insurance coverage, a 6.2% increase from 2003; and 97% of residents with children age 20 or younger report their children are insured, a 1.8% increase from 2003.

Lessons Learned
- The uninsured are usually employed; they just cannot afford insurance.
- Many uninsured people, particularly children, qualify for existing programs.
- Despite the magnitude of the issue, when looked at from a local perspective, there is a chance to have an impact.
- Getting the stakeholders together, reinforcing their interest, and spreading out the work to the appropriately skilled partners keeps the partnership viable and energized.

Ability to Sustain the Initiative
The Uninsured Task Force does not support any paid positions and is a manageable size so that work can be distributed among the members. Each partner tries to contribute to initiatives where their expertise can be used. Directly witnessing the local impact of this project helps sustain the Task Force members' interest and enthusiasm.
Project MEDSCOPE
Albany Medical Center Hospital

Partners
Partners in this initiative include Koinonia Primary Care and Psychiatric Services, Interfaith Partnership for the Homeless, Albany City Mission, Equinox Shelter, and Unity House Battered Women’s Shelter.

Program Description and Goals
Project MEDSCOPE (Medical Student Community Outreach for Prevention and Education) offers medical students the opportunity to collaborate with community organizations and physicians to meet the health care needs of the underserved in the community. While providing important health care services, the medical students gain valuable experience interacting with a segment of the population many of them have never encountered before—the poor and disenfranchised. For those receiving these services, the program is often their only means of receiving regular health care. For many of the students, participation in the program constitutes a profound experience that provides them with greater compassion and sensitivity to those in need; and for some it even affects their career choices.

Outcomes
More than 1,700 medical students have participated in Project MEDSCOPE over the past 15 years. Through their efforts, numerous men, women, and children have been able to access medical care that would not have otherwise been available to them. Many other people have benefited from the educational programs and screenings that the students have offered. Elementary school students have also learned about the health risks associated with smoking and that seeking medical attention is not something to be feared.

It has become apparent that clients’ needs do not end with health care. Clients often lack basic items such as food, diapers, or a warm coat. Consequently, the medical students have been called upon to develop community outreach, including fundraisers, toy drives, baby food drives, hat and mitten drives, and book drives to provide ongoing assistance.

Lessons Learned
The students who participate in this program gain valuable clinical and interpersonal skills while they witness the reality facing the uninsured and underinsured. This program provides students with exposure to the many challenges of the “working poor” or uninsured such as domestic violence, mental illness, substance abuse, depression, and other health care issues.

Ability to Sustain Initiative
Under the umbrella of the Department of Family and Community Medicine at Albany Medical Center Hospital, Project MEDSCOPE has grown in the number of organizations served each year as well as the number of medical students who participate. It is positively transforming not just the lives of those it serves, but also the lives of those providing the services. Its continued growth after 15 years bodes well for both the community’s future and the future of Albany Medical Center Hospital.
Program Description and Goals

In New York City in 2004, 47,000 people were eligible for hospice care; however, only 16% took advantage of this vital service, as compared to 28% nationally, making New York City the most under-served major city in the United States. The goal of the Open Access Program is to remove the barriers to access and provide hospice care for all who qualify for and desire it.

Open Access entails widened admission criteria to allow many treatments not typically considered for hospice patients. Consequently, patients are referred and enroll earlier in the disease progression. More importantly, with proper end-of-life care, patients are more comfortable and experience a higher quality of life. To promote earlier and more frequent referrals from physicians, discharge planners, and other health care providers, as well as provide community education, the program implemented a multi-tiered strategy: education of health care professionals, outreach within the communities served, and developing a presence in hospitals and long-term care facilities to help identify patients in need.

Outcomes

By implementing the Open Access Program, Continuum Health Partners raised its patient daily census 460%, from 100 in 2002 (800 for the year) to 460 patients per day, or more than 2,750 patients and their families annually. The average length of stay has increased from 54 days to 61, and Continuum’s program is now the largest hospice in New York City, growing at a rate of 27% annually. Through medication management, medical crisis avoidance, and hospitalization prevention, Open Access hospice care saves the health care system an estimated $1,500 to $4,000 per patient.

Open Access generates many incalculable benefits:
- more patients have access to specialist-level end-of-life care, preventing many people from dying in isolation and pain;
- patients’ longevity is increased;
- patients’ and families’ quality of life and satisfaction with care are enhanced; and
- patients and their families adopt a more positive acceptance of death.

Lessons Learned

- There is widespread misinformation about hospice eligibility and benefits. Generally, a focus on the “good death” rather than on being kept alive, has resonated poorly in a culture that often denies the inevitability of death.
- End-of-life care can no longer be viewed as a “terrible choice” between excellent hospice care and continuing access to innovative therapies and treatments. A cultural shift that promotes death not as a failure, but as a natural part of life that should be respected and dignified, will be required to overcome the current mindset.
- Late referral is a major barrier to adequate end-of-life care.
Ability to Sustain the Initiative
Continuum has a stable reimbursement stream (87% of care is Medicaid and Medicare) and operates at a modest surplus. Through astute management and a viable business model, Continuum is able to deliver quality end-of-life care using Medicare and private reimbursement sources. In addition, about 3% of Continuum home care is provided free of charge to disadvantaged people and families who have no insurance. The program receives solid philanthropic support from thousands of individuals, as well as several local foundations and corporations.
Reweaving the Safety Net in Northeast Rochester
Rochester General Hospital

Partners
Rochester General Hospital’s partners in this initiative include the office of Assemblyman David Gantt, Finger Lakes Health Systems Agency, Monroe Plan for Medical Care, Rochester General Hospital Advisory Partners, City of Rochester, Daisy Marquis Jones Foundation, Excellus Blue Cross/Blue Shield, Monroe County, and Rochester City School District.

Program Description and Goals
In spite of considerable effort and resources invested, health care outcomes in the city of Rochester are worsening. The northeast quadrant of the city, which is economically disadvantaged, is experiencing the most serious health risk challenges. Health care disparities are increasing over time, escalating the Medicaid burden for all. The mission of the Safety Net program is to improve the health and well-being of the residents in the northeast quadrant of Rochester.

Specific goals include:
- reduce medical appointment “no-show” rates;
- reduce delays for appointments;
- improve patient outcomes in chronic disease, starting with diabetes;
- improve patient and staff satisfaction; and
- reduce non-urgent visits to emergency departments.

Outcomes
The primary pilot site, Clinton Family Health Center, in the heart of the Hispanic community, used re-engineering concepts like “just in time” and rapid cycle improvement to achieve “open access,” the ability of a clinical practice to consistently offer same-day appointments regardless of urgency. Patients responded with delight. The no-show rate fell from 45% to between 5% and 10% and non-urgent visits to area emergency departments decreased by 30%. This model was then applied to three additional practices.

The program has provided insight into how public and private institutions and individuals can work together to improve the quality of life for residents of the northeast quadrant. One of the most important aspects of this program is that its concepts and models are adaptable to many different health care situations.

Lessons Learned
- Organizational and practice level leadership, commitment, and responsiveness must be unwavering.
- This kind of transformation and its implementation have to be carefully fit into the specific practice and its unique attributes.
- Involvement and collaboration with community partners is essential to achieve success.
Ability to Sustain the Initiative
Rochester General Hospital has carefully considered the sustainability of this program and has secured funding through 2006. The hospital is working collaboratively with its partners to seek grant funding for additional years. The hospital expects that the volume and revenue enhancement generated by this project will continue and will aid in sustaining the program.

The hospital has developed and implemented multiple operational strategies to ensure the viability of the program. It has added a full-time position dedicated to expanding the initiative to other primary care practices. The hospital’s policies, procedures, position descriptions, and annual performance plans/objectives are being aligned with this program’s goals. In addition, the hospital is establishing payer reimbursement and incentives that support this work and desired outcomes.
Partners

Partners include the local chapter of the American Cancer Society, dozens of community-based organizations such as the local AARP, Latino Civic Association, Project Hospitality, New York Urban League, Business & Professional Women’s Association, Prevention on Wheels, Safe Harbor Health Care Service, and Visiting Nurse Association. Each of these groups was connected with a unique segment of the community and promoted the message of the importance of mammogram screening and follow-up services.

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Program Description and Goals

Staten Island University Hospital’s goal with this program is to address an evolving crisis in community health: the availability of quality breast health services. Access to breast health services in Staten Island reached a critical point in 2001. Multiple mammography screening sites had closed their doors, pushing wait times to over eight months. At Staten Island University Hospital, breast health services were offered at three sites before the initiative. Each site performed some combination of screening, diagnostic work-up, and image-guided biopsies, but the availability of services at each site was limited by equipment and staffing issues.

To address this need, Staten Island University Hospital’s trustees and clinical leadership made this initiative a priority. Following site visits and focus groups with stakeholders, a full-service breast imaging center was designed and opened in October 2002 adjacent to the hospital’s newly opened ambulatory surgery center. The center’s interior was designed in a home-like motif to minimize stress for patients and families, while behind the scenes providing an efficient workflow for staff.

Outcomes

■ Waiting times for screening mammography declined dramatically from an average of 30 weeks in 2002, to five weeks in 2003, and 3.5 weeks in 2004—an 80% reduction in wait times.
■ Using hazard analysis, the hospital estimates that about 90 lives will be saved because of the improvements from the first two years of the project. This estimate is based on improved detection rates, prompt biopsies, and treatments.
■ Overall, the screening rates of cancer detection increased from 3.2 per 1,000 patients in 2002, to 5.2 in 2003, and 6.3 in 2004.
■ The total number of cancers detected was examined for differences based on screening vs. clinical presentation. In 2002, 40.3% were detected by screening. In 2003, this increased to 58.1% and 65% in 2004.
■ Patient satisfaction showed measurable improvement.

Lessons Learned

■ Barriers to high-quality breast health care can be overcome by community partnerships, coordination of services, focus on quality outcomes, outreach for government resources, and development of well-trained and dedicated staff. These improvements can be achieved without excessive financial burden to the organization.
■ Technology must be used to leverage capacity to meet volume demand.
Lessons Learned (continued)

- External funding is available for high-profile community health issues and must be used to control cost and improve service access.
- The intangible concept of mission in meeting a community need can be a powerful motivating force for recruitment, retention, and development of qualified staff when service delivery such as breast health is the focus.

Ability to Sustain the Initiative

The data from the first half of 2005 show continued improvement in detection rates, detected cancers, and wait times. These results illustrate that the initiative is durable. The hospital governing board, medical leadership, and administration maintain an active and supportive role in resource allocation and emphasis on maintenance of high performance. The local chapter of the American Cancer Society is a major anchor for the program and with its support this program was able to obtain funding for a second digital mammogram machine and grant funding for the outreach coordinator.
The Senior Community Health Project
Beth Israel Medical Center

Partners
Partners in this collaborative have included the clinical staff of Beth Israel Medical Center, New York City Department for Aging, New York City Housing Authority, United Hospital Fund, United Jewish Appeal, and a large network of community-based organizations, settlement houses, and business and cultural organizations. Senior residents of the community guide the program with their wisdom.

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Program Description and Goals
By 2030, one out of five New Yorkers will be over the age of 65. Paying for and allocating health care, achieving economic security in retirement, and providing suitable housing for older adults have emerged as critical issues. Since 1999, Beth Israel Medical Center's Senior Community Health Project, in partnership with the communities the Medical Center serves, has engaged in a process to address these issues and support the creation of an "elder-friendly" community—a community that is a good place to grow old.

Beth Israel Medical Center is in an urban setting with a large concentration of residents who have "aged in place." These aging communities, where over 50% of the population is over the age of 60, are known as Naturally Occurring Retirement Communities (NORCs). Beth Israel's Senior Community Health Project serves as the health care partner for five of these programs, reaching more than 8,000 New Yorkers. The Senior Community Health Project supplies physicians, health educators, and on-site community health nurses, who provide care management services and coordinate health promotion activities within each NORC. The project sponsors free health assessments and screenings as well as disease management programs designed to help older adults cope with chronic health conditions and improve health outcomes.

Goals for the project include:

- healthy and engaged older adults who can remain vital members of their communities;
- expanded and positive relationships between health care providers and the aging community;
- coordinated access to primary and specialty care services;
- programs that promote healthy behaviors and build upon community need;
- cost-effective coordination across the continuum of care; and
- creation of a replicable and sustainable model.

Outcomes
Since its formation in 1999, the Senior Community Health Project has enabled older New Yorkers to become engaged and active partners in their health care. Members of the community have stopped smoking, lost weight, and have begun to exercise. Frail, homebound community members have received home-based health care and social services that reduce isolation and help them remain in their own homes.

The project demonstrates that an innovative, interdisciplinary, collaborative, and community-based model of care can improve health outcomes for older adults, enabling them to remain active, vital members of a healthier community while reducing costs.

ELDER CARE INITIATIVES

Program Description and Goals
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The project demonstrates that an innovative, interdisciplinary, collaborative, and community-based model of care can improve health outcomes for older adults, enabling them to remain active, vital members of a healthier community while reducing costs.
Lessons Learned
The Senior Community Health Project improves the health of the community through a partnership where all participants are vested in a common goal. The project illustrates what can happen when a health care system looks outside traditional boundaries and collaborates with the community to creatively address an emerging issue of concern.

Ability to Sustain the Initiative
Currently, NORC programs and the Senior Community Health Project are funded by a variety of city, state, foundation, and hospital funding. It is probable that this funding will continue for the near future. It is also encouraging that the Centers for Medicare and Medicaid Services is now seriously looking at the issue of post-acute care and what the health care provider, working in tandem with community agencies, can do to prevent re-hospitalizations.
Program Description and Goals

The Harry & Jeanette Weinberg Center for Elder Abuse Prevention is a comprehensive, regional elder abuse shelter that provides emergency short-term housing, legal advocacy, and support services to victims of elder abuse. The Weinberg Center also conducts extensive outreach and training. The Weinberg Center has been in operation since December 2004.

Outcomes

- The Weinberg Center has offered direct services to 65 individuals and has provided shelter service for 15 victims. The Weinberg Center referred 26 queries to other community and legal services. In addition, 24 referrals were appropriate but declined the services of The Weinberg Center.
- Education sessions have been provided to 35 community agencies contracted by the New York City Department for Aging to assist elder abuse victims.
- The Weinberg Center offers training sessions to elder law attorneys, registered nurses at a “Developments in Geriatrics” training session at Bellevue Hospital, and to 28 nurses and social workers at a seminar at New York University.
- A training session was provided to Bronx County judges, educating them on the needs of elderly victims waiting to make court appearances and the emotional issues of facing the alleged abuser in court.

Lessons Learned

- Though a great deal of outreach has been conducted to date, there is a small number of victims who choose to use the shelter service. Program staff continue to work with referring agencies regarding potential appropriate victims; however, some victims decline to use the service.
- The Weinberg Center team is learning that many of the victims entering the shelter do not want to pursue legal action. They are hesitant to press charges against a family member. It takes several interactions with the lawyer and social worker for the victim to be comfortable to begin discussing legal actions available to them.
- Collaboration is key to the success of this project. From its inception, the Center did not want to duplicate existing resources in the community and wanted to work within the existing framework of services. This has proven effective.

Ability to Sustain the Initiative

The Hebrew Home is committed to the Center. To sustain the initiative, the Home will make this program a part of its annual operation budget, allocating funds from its endowments and other fundraising initiatives.
The Center for Curative and Palliative Wound Care
Calvary Hospital

Partners
The Center's partners include the Visiting Nurse Service of New York, WADO Radio, New York Medical College, and Calvary Home Health Agency.

Program Description and Goals
The Center for Curative and Palliative Wound Care was established in 2005 and is committed to relieving the suffering of patients with chronic skin wounds.

Outcomes
One-hundred percent of those surveyed were very satisfied with the level of their care and 95% of respondents said that the Center's efforts had improved their quality of life. Patient referral has increased by 80% in 2005 and the Center now sees more than 60 patients per week.

Lessons Learned
The Center for Curative and Palliative Wound Care has witnessed the success of hands-on, low-tech, high-touch caring, and compassionate care with chronic wound care patients.

Ability to Sustain Initiative
Reimbursement for this type of care will not lead to a profit-generating center. However, it is possible to sustain operations through the current reimbursement methodology and through research grant funding.
Living Safer
Canton-Potsdam Hospital

Partners
Canton-Potsdam Hospital has collaborated with the St. Lawrence County Department of Public Health on this initiative.

Program Description and Goals
Living Safer is a program run in cooperation with the St. Lawrence County Department of Public Health through the hospital’s inpatient chemical dependency units targeting patients who have a higher risk of contracting Hepatitis B due to their lifestyle choices, including engaging in risky sexual practices. Since its inception in 1999, the program has provided free vaccinations for Hepatitis A and B to those patients for whom immunizations are appropriate.

The goal is to prevent incidence of Hepatitis A and B in an extremely vulnerable population whose lifestyle choices place them at particular risk.

Outcomes
The education, counseling, and assessment for Hepatitis screening/immunization is provided to more than 800 patients per year. In 2005, the program immunized 45 patients.

Lessons Learned
■ It is easier to engage chemically dependent people in a setting to which they have come willingly for treatment.
■ An inter-disciplinary team (medical, counseling, and nursing) has more potential to present a successful program than any one discipline.
■ Positive results can be seen when education is accompanied by actions that can be taken to reduce incidence of illness.
■ More can be accomplished with sister agencies than alone.

Ability to Sustain the Initiative
The program is self-sustaining through the provision of vaccines by the St. Lawrence County Department of Public Health as part of its initiative to prevent the spread of sexually transmitted diseases and through the hospital's procedure of screening and immunizing vulnerable populations present on the chemical dependency units.

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HEALTH EDUCATION, INFORMATION, OUTREACH, AND AWARENESS
Chenango County Healthy Heart Coalition
Chenango Memorial Hospital

Partners

Partners in this initiative have included: Chenango County Public Health Department; Chenango County Department of Social Services; Cornell Cooperative Extension; Chenango Health Network; Chenango Tobacco-Free Coalition; Finger Lakes Volkssport Club; Bullthistle Hiking Club; Perinatal Network of South Central New York; Chenango County Area Agency on Aging; Chenango County Child Care Coordinating Council; Opportunities for Chenango; Supplemental Nutrition Program for Women, Infants, and Children; Head Start; Board of Cooperative Educational Services; YMCA; American Heart Association; Chenango County Chamber of Commerce; Norwich School’s lunch program director; restaurants; nursing homes; dieticians; insurance companies; media companies; health care professionals; and consumers.

Program Description and Goals

Chenango County Healthy Heart Coalition began in 1998, when Chenango Memorial Hospital received funding from the Department of Health to become lead agency of a collaborative group of organizations and individuals concerned with the heart health of Chenango County.

In Chenango County, morbidity and mortality from heart disease and other chronic diseases are above New York State averages and obesity, sedentary lifestyles, and tobacco use are high. The Coalition’s goal is to make it easier for community members to adopt healthy lifestyles. The group accomplishes this goal through education, awareness, and policy and environmental changes. Activities include physical activity and nutrition interventions in schools, worksites, and the community. The group conducts awareness campaigns to promote healthy lifestyle choices and works to ensure people have the resources to make those choices.

Outcomes

Collaborating with town officials and local organizations, the Coalition has brought recreational opportunities to residents throughout the county and participation is high. Local media have noticed the healthy lifestyle messages and continue to promote them. Hundreds of residents participate in community-wide physical activity campaigns. Because of the “Just Ask Us” program, several restaurants have adopted heart healthy menu items and labeling. In addition, Chenango Memorial has opened a Heart Care Center headed by the doctor whose advanced cardiology training was funded partially by the Coalition.

Lessons Learned

- People are receptive to wellness messages and structured initiatives when they are interesting and fun.
- Initiatives such as this one contribute to community wellness in a very holistic sense. In several towns where initiatives were funded by the program, volunteers and organizations involved in them clearly are “community proud” and more closely-knit as a result.
- Employees will take advantage of worksite wellness programming and will use on-site physical activity facilities.
- Local media are happy to work on and present news and feature stories featuring positive health messages.
- The strength of a coalition is in its diverse expertise and experience and the individuals’ willingness to get involved. Their energy is a powerful, creative driver.
- Much of the work can be accomplished with a cadre of committed volunteers and some outside funding.

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Ability to Sustain the Initiative

Chenango Memorial Hospital is committed to its lead agency role and supports group facilitation, donates meeting and storage space, a telephone number, supplies, and other resources. Other organizations donate in-kind services and support objectives through outreach and involving their clients/patients/friends/spouses/ and/or co-workers. The Coalition engages other partners whose objectives are similar and who have funding resources.
Tuberculosis Surveillance and Treatment Unit
Elmhurst Hospital Center

Program Description and Goals
Established in 2002, Elmhurst Hospital Center’s Tuberculosis Surveillance and Treatment Unit (TSTU) identifies and treats all cases of tuberculosis at the hospital. Care is provided along a continuum, beginning when the client is identified for being at-risk for tuberculosis. Patients receive care in the hospital or at home under quarantine while actively contagious, and progress to community-based ambulatory care in the clinic when non-contagious. Treatment continues based on New York City Department of Health and Mental Hygiene guidelines. Contacts and individuals at-risk for developing tuberculosis are also offered treatment in the clinic based on primary, secondary, or tertiary care principles. The clinic, which operates at a deficit, is supported by the hospital’s mission to provide care regardless of ability to pay. The goal is the eradication of tuberculosis.

Outcomes

- There has been a consistent increase in the number of active and latent cases seen and treated since 2000.
- Using central surveillance and the Cultural Case Management Model, compliance rates and adherence rates for treatment are consistently better than the national average.
- The facility received American Nurses Credentialing Center Magnet Designation for Excellence in Nursing Service 2006, the first public hospital to achieve this designation.
- Elmhurst Hospital Center has the largest hospital-based tuberculosis clinic in New York.
- NYCDOH chose TSTU as the Model for Hospital Based Tuberculosis Clinic in 2004.
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recognized TSTU as the Model for Infection Control Best Practices in the Ambulatory Care Setting in 2003.

Lessons Learned
Elmhurst has learned that the following factors make TSTU effective:

- centralized surveillance to capture the majority of tuberculosis cases in the hospital;
- strong follow-through from identification of disease, treatment, and transition to clinic-based care;
- education of the house staff and nursing staff to “think TB” in all situations;
- staff fluency in Spanish, Korean, and Hindi and access to telephone interpreters for other languages;
- non-judgmental, non-stigmatizing health care providers;
- multi-cultural health literature and free treatment, tests, and medications;
- effective use of cultural case management principles; and
- assistance with entry into the health care system for primary care needs.
Ability to Sustain the Initiative
As long as tuberculosis is a public health threat, Elmhurst Hospital Center will provide comprehensive services to eradicate the disease while caring for members of the community.
Language Assistance Program
Faxton-St. Luke’s Healthcare

Partners
Partners in this program include Mohawk Valley Resource Center for Refugees, Resource Center for Independent Living, Independent Language Services, and the Multicultural Association of Medical Interpreters.

Program Description and Goals
Faxton-St. Luke’s Healthcare initiated the Language Assistance Program in November 2003 with the hiring of a language assistance coordinator, who, in collaboration with the local refugee resettlement center and other independent interpreter services, provides in-person interpreters around the clock, seven days a week, for the major languages used in the area. The primary language needs identified were Russian, Bosnian, Vietnamese, and Spanish.

The goals of the program are to ensure communication between the Limited English Proficiency (LEP) patients and hospital staff and foster communication along the health care continuum. The Language Assistance Program is the initial point of contact for the program, arranging appointments with clients, obtaining interpreters, and reviewing and writing documents to improve communication with clients. The program educated hospital staff and developed a curriculum to certify current employees in interpretation. The hospital also embarked on strategies to recruit employees from different ethnic and cultural backgrounds.

Outcomes
- In 2005, of about 205,000 patient encounters, 9,300 LEP patients were served; 39% of whom required interpreters.
- The hospital has seen positive patient satisfaction from surveys.
- More than 30 documents have been translated; some are available on the hospital Intranet.
- The hospital contracted with a national signage firm to improve informational signage in the hospital.

Lessons Learned
- There is a lack of programs for certification of potential interpreters and a need for increased numbers of interpreters in many other languages.
- The personal touch is preferred to telephonic services.
- There is a universal lack of translated documents.
- The hospital identified the need for more cultural diversity education.

Ability to Sustain the Initiative
Continuing work with sponsoring agencies that bring in refugees and immigrants from around the world ensure that the initiative will continue.
South Asian Women’s Health Services Initiative
Flushing Hospital Medical Center

Partners
Partners in this initiative include the American Cancer Society-Queens Region, Queens Healthy Living Partnership, South Asians of New York, Inc., and the Greater New York City Affiliate of the Susan G. Komen Breast Cancer Foundation.

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Program Description and Goals
Flushing Hospital Medical Center developed the South Asian Women’s Health Services Initiative in response to requests by members of the South Asian community. The goal is to eliminate the disparities in health care for women of the South Asian community by offering culturally appropriate health services and encouraging their use. During dialogues with members of South Asian community and faith-based organizations, the concept was developed for a weekly South Asian Women’s Health session staffed by providers who possess South Asian language skills. The session provides routine prenatal, obstetrical, and gynecological care services.

In addition, breast cancer awareness and education are conducted at many South Asian community and faith-based organizations in the community. At these outreach events, women are offered an appointment to the South Asian Women’s Health session at Flushing Hospital Medical Center for a breast examination and cervical cancer and mammography screenings.

The hospital is a designated Prenatal Care Assistance Program provider and a member of the Queens Healthy Living Partnership, which reimburses member hospitals and other providers for diagnostic services provided to patients with inadequate or no health coverage.

The Initiative is staffed by obstetricians/gynecologists, a breast cancer surgeon, nurses, a social worker, a health educator, and an outreach coordinator who provides translation services for staff who may not possess South Asian language skills.

Outcomes
During its first year of operation, the South Asian Women’s Health Services Initiative provided 1,104 visits to 583 South Asian women. Ninety women were enrolled in prenatal care. More than 2,000 individuals received information and education about breast cancer and 76 women received mammography examinations.

Lessons Learned
Collaboration throughout all stages of the project with the target audience is extremely helpful in assuring acceptance and ensuring a successful project.

Ability to Sustain the Initiative
The hospital will be able to continue this initiative because funding is provided through third-party reimbursement. This program did not result in any increased cost because it required only a rescheduling of staff to ensure culturally appropriate personnel were available for the weekly session. Funding for cervical cancer and breast cancer screening are reimbursed through the Healthy Women’s Partnership. The costs of the outreach program coordinator are grant-funded. When grant funds end, this position will be reduced to a part-time position and costs will be absorbed by the hospital.
**Program Description and Goals**

Geneva General Hospital has been successful in providing timely treatment to confirmed stroke victims. In light of new treatment standards, since 2003, the hospital began to focus on aligning systems and resources to address all aspects of stroke care and to provide the latest standard of care. In July 2005, Geneva General Hospital received official Stroke Center designation from the Department of Health. The hospital has the capability of meeting the needs of stroke patients through a continuum of urgent and rehabilitative services, including an acute rehabilitation unit accredited by the Commission on Accreditation of Rehabilitation Facilities.

The goal of the program is to provide expert and specialized care to patients suffering from an acute stroke from the initial treatment phase through to the recovery/rehabilitation phase. To achieve this goal, the following steps were adopted:

- Bi-annual education for nursing staff, emergency medical service (EMS) personnel, and physicians regarding types of stroke, stroke symptoms, and treatment;
- Implementation of pre-hospital EMS procedures to facilitate identification of potential stroke victims and timely notification of the emergency department;
- The formation of a designated stroke team to achieve a 15-minute bedside arrival time;
- Radiology services that maintain a qualified technician on-site;
- Protocols for the administration of Activase® in the event of an embolic stroke;
- Transfer policy and agreements for patients requiring interventions not available at Geneva General Hospital;
- An evidenced-based clinical care guide outlining care requirements for stroke patients;
- Access to an interdisciplinary team for assessment and management of continuing care needs;
- Measurement of patient outcomes including mortality and recovery scores; and
- Comprehensive education for patients, their families, and the public.

**Outcomes**

Results of the project include:

- Increased awareness of stroke symptoms among clinical staff;
- A stroke symposium attended by 51 health professionals;
- Educational presentations to 38 EMS professionals;
- Community health fairs held twice a year, with about 3,500 visitors per year;
- A stroke support group formed for stroke victims and their caregivers and families;
- Free screenings for diabetes, hypertension, and cholesterol; and,
- Community forum on childhood obesity.
**Lessons Learned**

- Focus groups and advisory committees provide input from the community, identify community needs, and invite collaboration.
- Information from a formal community needs assessment provides the foundation for addressing community health issues.
- Input, cooperation, and trust between medical staff specialists, hospital staff, and EMS professionals is essential to the continued success of the program.

**Ability to Sustain the Initiative**

The Excellence in Stroke Care and Prevention program was built and sustained with current staff by aligning current systems and resources. No new funding was needed. The initiative falls naturally into the mission and vision of the Finger Lakes Health System and the health system’s commitment to the community assures its continuation.
Program Description and Goals

In June 2002, several members of Good Samaritan Hospital Medical Center’s (GSHMC) Rehabilitation Services Department were discussing the challenges of getting their children’s car seats properly installed in their vehicles. A conversation that started out filled with frustration and concern quickly evolved into a dialogue about the opportunity that this situation presented for GSHMC to not only correct the problem, but to become a resource for the rest of the community. This was the start of the C.A.R.E.S. (Children Are Riding Everywhere Safely) program. The program began with four physical therapists attending a five-day training course offered by Suffolk Safe Kids and becoming certified as Child Passenger Safety Technicians by the National Highway Transportation Safety Administration (NHTSA).

The C.A.R.E.S. program started offering child safety seat installation instruction to GSHMC’s employees and expanded to the parents coming to GSHMC’s Rehabilitation Center and then to the community. GSHMC also started a program to do apnea testing for neonatal intensive care unit babies with respiratory problems because their breathing problems can be exacerbated when placed into an infant car seat. In addition, the C.A.R.E.S. program went to the West Islip elementary schools to educate the kindergarten and first-grade students on the importance of riding in a booster seat.

Outcomes

■ GSHMC has grown its C.A.R.E.S. program from educating a modest 67 families in the proper installation of their child safety seats in 2003 to more than 230 families in 2005. In 2006, more than 325 families are expected to be instructed.
■ C.A.R.E.S. has spoken at six elementary schools on the importance of booster seats, reaching 600 children.
■ In 2004, C.A.R.E.S. purchased six Spelcast child safety seats and six car beds that are regularly lent to the families of children leaving GSHMC with lower extremity casts that would prevent them from using standard child safety seats.

Lessons Learned

■ Of the more than 500 child safety seats that GSHMC’s C.A.R.E.S. team have checked, only two were installed without error. There is an immense disconnect between child safety seat manufacturers and automobile manufacturers, leading to poor compliance in the proper installation of the seats.
■ The overwhelming majority of parents and medical professionals are unaware that a child safety seat that has been involved in a significant motor vehicle accident is not to be used again.
■ There is a great deal of confusion among parents and medical professionals on how and when to progress a child from an infant seat to a convertible seat to a booster seat.
Ability to Sustain the Initiative

GSHMC is using a $10,000 grant from the Department of Transportation in 2006 to purchase child safety seats for any child who needs one. GSHMC’s C.A.R.E.S technicians see firsthand the devastating consequences that a motor vehicle accident has on children and their families and the facility is committed to the growth and development of the C.A.R.E.S program.
Program Description and Goals
The Highland Hospital Breast Care Center collaborated with Westside Health Services and the Anthony L. Jordan Health Center, two urban, community-based health centers in Rochester, to increase access to breast cancer education and screening for medically under-served women. The program bases outreach workers from the Highland Hospital Breast Care Center at three health clinics for 30 hours per week to provide on-site breast cancer education to individual women and to schedule women for mammography services at the Breast Care Center. The clinic-based outreach program also provides case management services to all women who are scheduled for mammography services, including guiding them through paperwork, sending confirmation letters, making reminder calls, answering questions, helping women access transportation services, and ensuring returns for follow-up care.

Outcomes
- The Clinic-based Breast Cancer Outreach program provided information on breast health to 350 women through information tables at two urban health fairs sponsored by Anthony L. Jordan Health Center and Westside Health Services.
- Outreach staff provided 70 women with individual breast health education as part of their annual gynecological exam.
- The outreach program provided breast self-examination shower cards to every woman receiving services at Anthony L. Jordan’s obstetrics/gynecology department.
- Outreach staff provided on-site mammogram scheduling and case management to 171 women.

Lessons Learned
- Health care providers must always strive to build trust with women by consistently demonstrating a culturally sensitive understanding of their fears and the socioeconomic, language, and personal barriers that prevent women from accessing care.
- Diligent communication is a key ingredient in bringing women into the Breast Care Center. Ensuring that mammography staff and health care providers understand the goals and objectives of outreach efforts will increase the quality of patient care.
- Educating the women to understand the connection between continued screening and their overall health will increase the chances that they will return annually for screenings.

Ability to Sustain the Initiative
The two health centers have committed to ongoing support by providing space for the project at each clinic, as well as some of the operating costs. A Susan G. Komen Breast Cancer Foundation grant and dedicated financial resources from Highland Hospital have been instrumental in sustaining this project. The project continues to seek other funding sources to provide future financial support.
Pediatric Outreach Program
Hospital for Special Surgery

Partners
Assisting with this initiative are the Charles B. Wang Community Health Center, New York City Public Schools, New York City Day Care Centers, Weill Medical College of Cornell University, NewYork-Presbyterian Hospital, and the Pediatric Coalition.

Program Description and Goals
Founded in 1987, the Pediatric Outreach Program (POP) screens New York City Public School children in medically under-served communities for musculoskeletal and primary health needs, providing access to free medical care that these children might not otherwise receive. The goal of this program is to eliminate health disparities by providing quality care and access to care for school-aged children in under-served communities. By detecting and treating incipient musculoskeletal conditions well before they can lead to chronic adult pathologies, POP sends highly trained orthopedic teams into schools in predominantly Hispanic and Asian American communities to screen more than 1,000 children annually.

Outcomes
- Since the start of the program, 3,565 children have been identified with orthopedic and non-orthopedic related conditions. Left untreated, these children could potentially develop musculoskeletal disabilities that affect their quality of life.
- Since 1987, the program has worked with more than 200 schools and daycare centers to provide free screenings. The program also brings together orthopedic experts and community clinicians who work together with the hospital and community health clinics.
- In the long term, POP will have a far-reaching positive effect on the musculoskeletal health of future generations of children by arming physicians-in-training with the cultural sensitivity skills needed to overcome the barriers to health care access and delivery faced by patients from diverse linguistic and cultural backgrounds.

Lessons Learned
Collaborating with partners within the community to provide free health care services is invaluable. The success of these partnerships supports the success of the program. As POP continues to expand to community clinics, the POP team manages the challenges of dealing with diverse cultures. To help bridge the gap in health disparities, the program offers full coverage for the first visit and travel reimbursement.

Ability to Sustain Initiative
POP began through a funded grant from the Department of Health under the auspices of State Senator Roy M. Goodman. The program continues to be sustained by grants from the Citicorp Foundation, Toys ‘R’ Us Children’s Foundation, Lehman Brothers, The Helen Hotze Haas Foundation, and the Hospital for Special Surgery’s Junior Committee and Employee Activities Committee.
**Program Description and Goals**

Lenox Hill Hospital’s Apple P.I.E program is a jointly shared program that is in operation at five New York City public elementary schools. The “Apple” represents The Big Apple (New York City) and “P.I.E.” is an acronym for Partners in Education. Lenox Hill Hospital and the elementary school teachers jointly share in the preparation of the science curriculum, which is being taught to fifth-grade students by the Lenox Hill Hospital medical residents. The goal is to impart health education to children in an enjoyable and easy way for them to digest, thereby making learning “as easy as Apple P.I.E.”

The presentation lessons cover topics including quality of air and water and asthma education, digestive system, diet, nutrition, childhood obesity, respiratory system and the effects of smoking and second-hand smoke, circulatory system and heart disease, muscular and skeletal system and the importance of exercise, reproductive system and puberty’s effect on the body, waste management and how water affects the excretory system, marine life and water’s relationship to supporting life on earth, human impact on the environment and its many effects on human well-being, and medical inventions that improve the quality of human life.

**Outcomes**

This is the first year that the hospital has assumed all responsibility for the Apple P.I.E. program. Prior to this, the program was operated under a grant. The measurable classroom test results indicate that the information taught to the students by the residents during the school year was well-received and retained. In addition, the demonstrative behavior of the students when attending to their personal hygiene and health has improved. This healthy behavior has also improved their attendance in school.

**Lessons Learned**

Having health care personnel teach health education as a component of the science curriculum can result in enhanced interest in learning. In the Apple P.I.E. presentations, the students actively took part in medical discussions of the anatomy and applied these lessons to their own bodies and taking care of themselves. These lessons covered preventive measures for taking care of the lungs by not smoking and trying to avoid second-hand smoke, eating nutritious foods to avoid problems of being overweight and/or obese, and controlling weight problems that could lead to diabetes and hypertensive diseases. Children took this information home to share with family members and friends. Thus, the children acted as emissaries promoting good practices in and out of school.

**Ability to Sustain the Initiative**

The program, funded by a grant from the Skirball Foundation, has been so successful, that the hospital is preparing to extend the model into the middle schools in the community to teach a unit on sexually transmitted diseases. In addition, the hospital has begun its own preparation for future operational costs and is seeking new funding sources. Lenox Hill Hospital is exploring ways to use the success of the program to create a “Turn-key” program that will allow the hospital to train other hospitals and staff to replicate this model.
“Healthy Kids, Happy Future”—Preventing Childhood Obesity
Long Beach Medical Center

Program Description and Goals
“Healthy Kids, Happy Future”—Preventing Childhood Obesity provides middle school students with the latest information on health, wellness, and disease prevention. Using educational materials including PowerPoint presentations, food models, typical fast food samples, and activities that are appropriate for the middle school classroom setting, the program:

- reinforces current health principles and practices that help prevent chronic disease;
- empowers young people at risk for Type 2 diabetes to take actions that decrease their risk;
- empowers all students regardless of diabetes risk to make healthful eating choices and to be physically active;
- tracks behavior change by implementing a student assessment form six months following the presentation; and
- educates parents on program information, offering helpful hints on behavior changes for the entire family.

The goal is to prevent Type 2 diabetes in children. A recent survey conducted by school nurses indicated that 43% of Long Beach Medical Center’s students are overweight—well above the national average. Studies predict that one in three children born after the year 2000 will develop Type 2 diabetes during their lifetime. The “Healthy Kids, Happy Future”—Preventing Childhood Obesity program strives to address the Type 2 diabetes epidemic.

Outcomes
Although this program was developed and advertised to schools in the school year 2004-2005, most schools could not make room for it in their existing curriculum. However, 17 schools expressed interest in this program and some worked it into their curriculum for 2005-2006. Long Beach Medical Center has received very positive verbal feedback from both the students and their parents.

Lessons Learned
- Middle school enrollment varies significantly. In some schools, middle school constitutes sixth, seventh, and eighth grade, while in other schools middle school is only seventh and eighth grade. In addition, the size of the schools varies. All of this needs to be taken into consideration in designing the program for each school.
- Parent involvement is key. Long Beach Medical Center learned early in the program that it needed to involve the parents to complete the loop in the educational process to ensure behavior change for the student and the family.

Ability to Sustain the Initiative
With the progression of graduating classes and a new body of students entering each year, this program will continue indefinitely. Both Long Beach Medical Center and Lions International are committed to sustaining the program.
**Program Description and Goals**

Long Island Health Network created its Tobacco Cessation Initiative in December 2004 to meet a documented need in the community for a program to help people stop using tobacco. A network-wide approach to promote smoking cessation was started for three high-volume diagnoses: acute myocardial infarction, congestive heart failure, and pneumonia. The goal is to provide tobacco cessation literature and appropriate referrals to hospital- and community-based programs for all patients requesting assistance in stopping their use of tobacco.

**Outcomes**

- Performance on the Hospital Quality Alliance quality measure for adult smoking cessation advice/counseling improved by 11.1%.
- The success of this program prompted Long Island Health Network to expand the initiative to all patients served by all member hospitals.
- The Fax-to-Quit program (New York State Quitline) shows an increase in the number of contacts from 2004 to 2005, with a quit rate of about 34%.

**Lessons Learned**

- There were many different tobacco cessation materials across the member hospitals. Standardization of materials meant patients benefit from one standard of care.
- Endorsement from top hospital administrators is key to success.
- The collaboration with community agencies provided insight on how to reach the desired population and the best practices to implement to effect behavioral change.
- Engaging the hospital “champions” helped facilitate the program.
- Education for all personnel had to be standardized to ensure consistency in the message and delivery.
- Hospital and community program information needs to be easily accessible. The Web site needs to be user-friendly and contain the telephone numbers necessary to get the needed information.

**Ability to Sustain the Initiative**

Public attention to quality and the Hospital Quality Alliance program will continue to focus on this type of initiative. There is network-wide support for and commitment to the program, which will ensure its future.
The Glaucoma Project
New York Hospital Queens

Program Description and Goals
In July 2003, New York Hospital Queens collaborated with the Friends of the Congressional Glaucoma Caucus Foundation, Inc. to conduct free glaucoma screenings and provided free follow-up care throughout the borough of Queens. This project is part of New York Hospital Queens’ commitment as a community hospital to extend care beyond its walls and into the community.

Outcomes
During the first year of the program (July 2003-July 2004), the hospital sponsored 20 community glaucoma screenings, serving 965 people. These screenings included eye pressure, visual acuity, visual field, blood pressure, and blood glucose testing. Of the 965 individuals screened, 595 (62%) were recommended for follow-up care. Of these 595 clients, 118 (20%) received follow-up care at New York Hospital Queens.

During the second year (August 2004-October 2005), the hospital participated in 27 community glaucoma screenings, serving 1,290 people. Of these 1,290 individuals, 741 (57.4%) individuals were recommended for follow-up care. Of these 741 clients, 134 (18%) received follow-up care at New York Hospital Queens.

Lessons Learned
The biggest lesson learned is that screening is not always enough—the hospital needed to develop a contingency plan for follow-up care and treatment. It was important for the program to be about more than just screenings—but also about caring for the patient after diagnosis. Through the hospital’s partnership with the Congressional Glaucoma Caucus Foundation, New York Hospital Queens has been able to provide extensive follow-up care through the hospital’s comprehensive Eye Center.

Ability to Sustain the Initiative
Community outreach programs at New York Hospital Queens, including The Glaucoma Project, are a vital part of the hospital’s strategic plan and are crucial to its success. All community outreach activities are fully supported by the hospital’s board of trustees and administration. Recognizing that some patients are unable to pay for their treatment, either through third-party coverage or their own resources, in 2004, the hospital extended free or charity care, inclusive of underpayments by governmental payers, of about $15.8 million.
This is Where I’ve Walked—A Healthy Heart Initiative
Nicholas H. Noyes Memorial Hospital

**Partners**
Partners include Nicholas H. Noyes Memorial Hospital Community Outreach, Livingston County Department of Health, Genesee Valley Health Partnership, Cornell Cooperative Extension, Englert Clinic, and Livingston County Coalition of Churches.

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**Program Description and Goals**

This is Where I’ve Walked is a ten-week program designed to promote increased physical activity and exercise levels among community members through area faith-based communities. The program encourages walking, physical activity, and/or exercise. The program kick-off event included a health fair where free screenings were provided for hypertension, obesity, heart disease, and diabetes. Participants also set individual walking and exercise goals. Heart healthy foods were part of the event to demonstrate healthy eating choices. The formation of teams and selection of a team leader was encouraged to promote peer support and friendly competition. Free incentives were used at different points in the walking program beginning with a pedometer at the kickoff event.

A program facilitator from Nicholas H. Noyes Memorial Hospital led a Community Partners Committee with representatives from the area county health agencies and the Livingston County Coalition of Churches. The Community Partners divided the county into five areas and identified contacts in each area faith community, enabling county-wide involvement.

**Outcomes**
The program’s positive impact is evident in the increased number of people reporting 30-minute walking and exercise sessions. At three months, the number of individuals not exercising decreased 4.5% and the number of individuals walking two to three days a week decreased 15.8%. Of significant note are data representing an increase of 2.2% in those walking three to four days a week and the increase of 15.5% in the number now walking or exercising five or more days per week. It is exciting to note that each event had participants from outside of the targeted area faith-based community who shared the concept with their own parishes.

**Lessons Learned**
- A leader needs to be identified in each faith-based community to assist with the coordination of the program, be a contact for members, and be a leader for the continuation of the program.
- Program participants, team leaders, and captains need individual packets that specifically outline the program and their key responsibilities.
- Incentives work, especially pedometers, in keeping participants motivated.
- Advertising needs to use all media including public service announcements on local radio stations, community partner Web sites, community group presentations, and paid advertising in key publications several weeks before the kick-off event.
- Many individuals exercise at night when it is dark.

**Ability to Sustain the Initiative**
This initiative began with a five-year grant but the initiative has taken on a life of its own among the churches in the community. There is strong support within the faith community for continuing this program to spread the message of exercise and better nutrition, as demonstrated by new and ongoing activities.
Program Description and Goals
In summer 2004, the Nassau County Police Activity League, Inc. (P.A.L.) approached North Shore-Long Island Jewish Health System’s (NS-LIJ) Department of Professional and Public Health Education to train about 1,000 P.A.L. volunteers in basic cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED) skills. P.A.L. provides organized sports, crafts, educational, and other programs to more than 40,000 youth within Nassau County. Beginning in November 2004, P.A.L. began a program to place 103 automated external defibrillators at school fields, clubhouses, and the local parks of Nassau County to safeguard the lives of children. NS-LIJ entered into a financial arrangement with P.A.L. whereby P.A.L. paid NS-LIJ discounted fees to cover program oversight, instructor stipends, program costs, and educational materials. Additionally, all programs were to be offered at local P.A.L. unit sites, allowing more volunteers to be trained by NS-LIJ emergency cardiac care certified instructors. Volunteers representing parents, police, coaches, trainers, and referees are trained/certified via the American Heart Association’s Basic Life Support curriculum as lay rescuers in CPR and use of an AED. This strengthens the “chain of survival,” giving possible victims of sudden cardiac arrest, including young athletes, the greatest chance of survival outside of a medical facility.

Outcomes
- This program provides an increase of nearly 1,000 community members trained in CPR and AED.
- Educating lay people in a short course in CPR and the use of an AED, which can provide early defibrillation, increases the possibility of a survival rate as high as 90% if defibrillation is delivered within one minute and 50% if defibrillation is provided in less than five minutes.

Lessons Learned
- Emergency medical response is a shared responsibility among health care professionals and the lay community.
- Collaboration with community/health/local government leads to more trained rescuers within the community, thus shortening the time between collapse and rescuer action.
- With faster recognition and prompt action, a large percentage of “outside of hospital” sudden cardiac arrests are potentially reversible with the early application of CPR and defibrillation.
Ability to Sustain the Initiative
Having trained and certified about 620 volunteers within the county, it is now feasible to expand the instructor pool within the P.A.L. volunteer group, granting an opportunity for ongoing basic life support education and recertification. Twelve instructor candidates satisfactorily completed the American Heart Association Heartsaver AED instructor course. Each began independent teaching in January 2006. Program costs will be minimized due to an internal instructor pool, the ability to “library” curriculum texts, and the availability of equipment when needed. Funding for the program will continue through monetary donations made by Nassau County residents to the P.A.L. organization.
Program Description and Goals
The Heart Healthy School Program provides classroom-based presentations about how the heart works and heart healthy practices to students from kindergarten through eighth grade. Presented by nurses from North Shore University Hospital’s cardiac service line, the goals of this initiative are to educate about basic anatomy of the heart and the modifiable risk factors for heart disease including smoking, lack of physical activity, poor nutrition, stress, and obesity. The program emphasizes how children can choose a healthy lifestyle and empowers them to influence their own heart health.

Outcomes
Since the beginning of the program in September 2000, the cardiac nurses have educated about 2,900 students in small classroom settings. This allows for individualized presentations, taking the students’ personal family experiences into account, and allows for role-playing and interaction between the students, their peers, and the nurses. Data collected from the students’ evaluations show a positive reaction. An article about this program, titled, “A Heart Healthy Habit A Day Helps Keep The Doctor Away,” was accepted for publication in the February 2002 issue of Pediatric Nursing.

Lessons Learned
- The Heart Healthy School Program demonstrates the dedication and commitment of North Shore University Hospital and the entire cardiac service line staff to the surrounding communities. The program has reached students in Nassau, Queens, and Suffolk Counties.
- The cardiac nurses gain as much from the experience as do the students. They come back to the hospital excited, with enhanced self-esteem. Many nurses receive letters of thanks from the school and some are personally requested back year after year.
- Keys to the success of the program are the nurses’ ability and willingness to consistently collaborate, remain flexible, and care about the community.
- Myths and misinformation can be corrected “real time,” enabling the students to make better heart healthy choices moving forward.
- One “heart healthy champion” (i.e., a principal, teacher, or school nurse) in a school can make a tremendous impact on the lives of many students.

Ability to Sustain the Initiative
The program is implemented with existing staff and the nurses volunteer their time. The program has demonstrated sustainability and has grown over the past six years. With the continued dedication of the cardiac nurses and support from North Shore University Hospital, the sustainability is unquestionable.
The Helen Hayes Hospital Outpatient Rehabilitation Center at Nyack Hospital
Nyack Hospital and Helen Hayes Hospital

Partners
Nyack Hospital committed to providing the physical space for this project and Helen Hayes Hospital contributed staffing and programmatic expertise. The Department of Health provided invaluable assistance in guiding and directing the Certificate of Need process in response to the community need identified by both organizations.

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Program Description and Goals
The goal of this project is to improve cost, quality, and access to outpatient rehabilitation services following acute hospitalization or as directed by the primary provider, in a convenient, local environment. To preserve scarce capital investment dollars, this project aims to provide these valuable services in a collaborative rather than duplicative manner.

Outcomes
- The outpatient rehabilitation center had 11,400 patient visits in the first year of operation (April 2004–March 2005).
- This program has greatly enhanced the continuity of clinical care, resulting in seamless transitions to inpatient or satellite outpatient services following acute hospitalization.
- Because of this successful collaboration, services have been expanded to include a cardiac wellness program and cooperation in the area of stroke care.
- Rehabilitation in-service training has improved staff skills at Nyack Hospital.
- A reduction in the out-migration of physicians for orthopedic surgery and post-acute follow-up care has benefited both organizations and the patients who can receive continuing care close to home.

Lessons Learned
- This collaborative effort highlights the commitment of both organizations to providing rehabilitation services to the community.
- This project reinforces the concept of collaboration on mutually beneficial programs, which can be explored in other aspects of the continuum of care.
- The value of having the insight and flexibility necessary to build “win-win” programs that truly serve their communities cannot be overstated.

Ability to Sustain the Initiative
Both organizations’ commitment to this project remains constant, as affirmed by board and hospital leadership. Utilization of the outpatient rehabilitation center’s services has grown in its second year. Expanding services and programs can capitalize on the model established through this joint venture and extend into new areas of service.
The CHAMP Program
Sisters of Charity Hospital

Program Description and Goals
The CHAMP (Choosing Healthy Activities through Mentoring and Play) program addresses student weight and body mass index (BMI), identified through the clinical assessment of middle school students. The program aligns with the requirements of the State Education Department’s health curriculum. The program's goal is to educate students to make better choices in food selection, to promote the importance of exercise in their personal lives, and to improve self-esteem and personal management skills.

Outcomes
- Thirty-six percent of student participants have demonstrated a reduction in BMI measurements from September 2005 to February 2006.
- This initiative has improved student, parent, and community awareness of the importance that nutrition and exercise play in health and wellness both in childhood and throughout life.

Lessons Learned
Initiating the school year with an introduction to physical activity introduced through enjoyable activities such as hip-hop dancing better framed the context in which to teach the principles of good nutrition. In this way, the relationship between exercise and better nutrition was shown as integral and complimentary.

Ability to Sustain the Initiative
This program is voluntary and dependent upon the alignment of the faith-based collaborators with a common mission. Nominal grant support has been sought for faculty in-service and student event costs.

Partners
Joining Sisters of Charity Hospital in this initiative are Catholic Health System’s primary care centers and community health division, FidelisCare New York, Niagara University, The Center for Excellence in Education, St. Aloysius School, Mary Queen of Angels School, Trinity Catholic School, Kolbe Catholic School, and Catholic Central School.
Mommy Project
Seton Health System

Program Description and Goals
The Mommy Project offers classes to teach teenage mothers how to balance the stresses of adolescence and parenthood. Upon completion of a set number of classes, participants receive “Baby Bucks” that can be exchanged for safety equipment and devices such as a new car seat or bassinet, baby monitors, outlet plugs, or cabinet locks.

The project’s goals are to:
- provide education to the expectant mother ranging in age from 14 to 22 years;
- provide safety information to help maintain a safe environment for mother and baby;
- increase father participation;
- increase breastfeeding rates; and
- assist teenage mothers with returning to school and/or employment.

Outcomes
- In three years, the facility had no incidence of shaken baby syndrome.
- There was an improvement in the breastfeeding rate from 59.5% in 2003 to 70% in 2005.
- The cesarean section rate decreased from 48% in 2002 to 22% in 2005.
- The mothers were able to demonstrate safe care of their infants.
- The Mommy Project has an 85% completion rate. This includes mothers who did not finish the series due to early delivery.
- There has been no incidence of Sudden Infant Death Syndrome or Shaken Baby Syndrome among class participants.
- Teens who attend the classes are better prepared for childbirth and have necessary services in place.
- At 14.3%, the cesarean section rate among class participants is lower than that of their peers.
- Women have linked with social services before delivering and therefore are not in crisis upon delivery.
- An interesting and unexpected effect of the classes is that teens are building a support network within the class. Many participants developed friendships and supportive relationships with one another. This has provided them with a larger support network on which to draw and has eased their sense of isolation. Most importantly, teens that have participated in this program report feeling better prepared for the challenges of parenthood and have a more positive view of their role as parents.

Lessons Learned
- Always include a support person if the father is unable to be included.
- There are advantages to including a social worker in the program. Outcomes were much better because the social component is addressed.
- The project’s success was partially due to the limitation of the age group. The teen population relates better with their age group in meetings.
Program Description and Goals

In 2003, St. Luke’s-Roosevelt Hospital Center Department of Government and Community Affairs began focusing on community outreach in the area of stroke-related education and screenings. It successfully involved medical professionals in conferences, workshops, and screenings and in 2005 received a $15,000 grant from the hospital’s associate trustees to conduct outreach with the faith-based network. Most of the work of the department’s outreach staff is free to the public.

The health education staff works closely with the staff of the hospital’s Comprehensive Stroke Center. The hospital’s community outreach specialists provide numerous free community health education and screening events throughout the year. In 2004 and 2005, daylong, free, stroke-related conferences were held in both the spring and fall, and will be held again in 2006.

Outcomes

St. Luke’s-Roosevelt Hospital Center’s outreach has improved outcomes by educating patients, their families, and the community about stroke risk factors, type of strokes, stroke prevention, and the symptoms of stroke. The hospital is planning a “Care for the Caregiver” conference in fall 2006 and will work with the Comprehensive Stroke Center, hospital psychiatrists, and members of the facility’s department of social work to help devise an appropriate format for this conference.

Lessons Learned

■ Caregivers were not at all prepared for their new roles. They were often the sole support and needed support themselves. They learned that the survivors of stroke could be very demanding and manipulative, sometimes suffering from depression.
■ Caregivers reacted favorably to basic information strongly supported by graphics. Words were not enough.

Ability to Sustain the Initiative

With the continued, committed, financial support of St. Luke’s-Roosevelt Hospital Center and the cooperation of the Stroke Center staff, as well as other hospital health care professionals, the Community Stroke Initiative will continue. The strong support and collaboration between the hospital and its network of faith-based institutions, elected officials, community-based organizations, and others continues to grow.
Women's Health Screening Outreach Initiative
St. Mary's Hospital, Amsterdam

Partners
Partners in this initiative include Healthy Women’s Partnership of Fulton and Montgomery County, Fulton and Montgomery County Public Health, Bellevue Woman’s Hospital, Nathan Littauer Hospital and Nursing Home’s HealthLink initiative, American Cancer Society, St. Johnsville Nursing Home and Rehabilitation Center, Cornell Cooperative Extension of Fulton and Montgomery County, the Farm Bureau, The Healthy Living Partnership, Fulton and Montgomery Partners in Cessation, Greater Capital District Asthma Coalition, and Fulton-Montgomery Wellness Coalition, media venues, businesses, churches, local towns, and committed community members.

Program Description and Goals
The goal of the Women’s Health Screening Outreach Initiative is to provide free breast cancer and cervical cancer screenings for women in rural communities where access to health care is often limited. The initiative provides free mammograms, clinical breast exams, pelvic exams, and Pap smear test screenings for uninsured or underinsured women in a rural community located within the hospital service area. St. Mary’s Hospital and its collaborating partners also offer services to community members at no charge including bone density screenings, glucose and cholesterol testing, reflexology, chair massage, healing touch treatments, an expert educational presentation, and various health information tables that focus on smoking cessation, diabetic health, cancer services, wellness, and community programs and services.

Outcomes
Data from last year’s event indicate that 73% of the women screened with a Pap test required further follow-up due to infection, pre-cancerous cervical lesions, or other gynecological issues. One case of breast cancer was found through the mammogram screening process. The average time since a woman had seen a medical provider was more than five years—some women over 12 years. Some women had never had a baseline mammogram. Eighty-seven percent of participants indicated their satisfaction with the location of the event, with 62% saying they would not have been able to be screened at another location.

Lessons Learned
The way to reach the targeted population is through local, grassroots outreach. Community partnerships and word of mouth are key in creating awareness and encouraging participation in screening events. More than 85% of the participants indicated that they heard of the screening event somewhere other than the newspaper. Responses indicated that the majority of participants learned about the program through their local business, town, employer, church, or farm bureau. Bringing services to the community rather than asking the community to travel provided the opportunity to welcome women in a familiar and comfortable setting to take advantage of vital, life-saving screenings.

Ability to Sustain the Initiative
Should the financial support of the Healthy Women’s Partnership that currently funds the mammograms, breast exams, and cervical screenings be withdrawn, there would be several ways the hospital would seek to sustain this screening initiative. First, the local Zonta, a group dedicated to the advancement and well-being of women, would be asked to provide funding. Secondly, the hospital would assist with financial options, insurance enrollment, or charity care for the participants to enable them to receive the same services.

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The Asthma School Pilot Project: A Group Education Model

**Program Description and Goals**

The Asthma School Pilot Project’s objective was to improve the asthma management of children in the Canandaigua community through a group-based asthma education program. It involved a study that included children 18 years of age and younger who were enrolled in an Excellus BlueCross BlueShield—Rochester Region—health insurance plan. The study measured specific outcomes for 56 children with asthma who were enrolled in an Excellus health plan from July 2003 through December 2004. Excellus provided clinical, operational, and funding support. Thompson Health provided the location, administrative support, and clinical staff to administer the program.

**Outcomes**

The Asthma School Pilot Project met all identified goals, exceeding some. During the study period:

- quality of life scores increased for 87% of the participants;
- rescue medication use decreased 77%;
- controller medication use increased 56%;
- asthma-related emergency department visits decreased 73%;
- asthma-related inpatient stays decreased 100%;
- an increase in asthma knowledge occurred for 97% of the participants; and
- an Asthma Action Plan was completed for 73% of the participants within six months of class completion.

**Lessons Learned**

- The hospital attributes part of the program’s success to the group education format of the Asthma School. The group dynamics of the class structure fostered peer support for the pediatric students and their families. Families reported that they felt like they were not alone in worrying about their child’s asthma care. Through group interaction, they learned that others also stayed up at night with a coughing child or missed family activities or work because of an asthmatic child’s illness.

- The success of the program was also attributed to forming relationships with the area schools and garnering support from the school nurses. It was apparent from the number of referrals that a letter from the school nurse had a more positive impact on the family than a letter from their health insurance company or the advice of their physician.

- The program was also successful because of its dedicated and certified asthma educator.

**Ability to Sustain the Initiative**

A group-based, multi-session asthma program that educates both children and caregivers has been proven a replicable model for improving asthma management in the pediatric population. Collaboration between community agencies, Excellus, area schools, physicians, and the Regional Community Asthma Network of the Finger Lakes, aids in both the participation of families in this education process and follow-up management of their asthma needs.
Child Passenger Safety Program
White Plains Hospital Center

Partners
White Plains Hospital Center’s partners in this program include Greenburgh Police Department, Westchester Safe Kids Coalition, Blythedale Children’s Hospital, New York State Governor’s Traffic Safety Committee, and the National Highway and Traffic Safety Administration.

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Program Description and Goals
The Child Passenger Safety Program provides parents of newborns at White Plains Hospital Center and parents in the community with basic and up-to-date child passenger safety information. By seizing a unique educational opportunity, the hospital has committed to assuring that newborns are properly restrained when riding for the first time. This establishes a pattern for continued compliance with a measure that can save children’s lives or prevent serious injury. As part of this initiative, a monthly Child Passenger Safety Class is offered to expectant parents who will be delivering their babies at the hospital, as well as interested families in the community who may be delivering at another facility. The class is designed to provide parents, grandparents, and caregivers information on child passenger safety and includes assistance in properly installing child safety seats in their vehicles.

Outcomes
Since the inception of this program, about 85% of the parents who attend the hospital’s Lamaze and parenting groups contact the Child Passenger Safety Program before their child is born to attend the seminar and have their seat installed. The inspection station was scheduled to be open the first and third Saturday of every month for three hours. Due to the overwhelming response at the station, it stays open for about six hours to accommodate the 60 to 80 people who attend each day.

Lessons Learned
In the process of forming this initiative, White Plains Hospital Center realized that there needed to be a coordinator who had the appropriate education and resources available to ensure a successful program.

Ability to Sustain the Initiative
The complex issues of child passenger safety will never go away: The reality is that there are just too many variables in the equation. The hospital, its community partners, and the government are dedicated to protecting children, despite these variables, through education and funding. The hospital is committed to providing this program indefinitely and has created policies and programs to ensure that the program remains a priority far into the future.
Bloodless Medicine and Surgery Program
Wyckoff Heights Medical Center

Program Description and Goals
Wyckoff Heights Medical Center established the Bloodless Medicine and Surgery Program (BMSP) to accommodate those individuals in the community who for religious or other reasons choose treatment options that do not include blood transfusions. As the vast majority of these individuals were traveling out-of-state for hospitalization, the primary goal was to establish non-blood treatment options closer to home and improve patient outcomes through optimal blood management.

Outcomes
In Wyckoff Heights Medical Center’s initial response to the unique needs of a religious community, a comprehensive range of education and information about the potential risks and side effects of blood transfusions and the alternatives to transfusion was made available. The information had an immediate and unexpected impact on communities at large, and today 50% of patients now enrolling in BMSP are non-Jehovah’s Witnesses. In a 24-month period, 568 patients enrolled in the program, requiring care ranging from surgeries, to deliveries, to medical and radiation oncology treatments.

Lessons Learned
- The lessons that physicians and other health care providers may learn from open and respectful communication with patients with unique health care needs can have a far-reaching and profound impact on advancements in medicine.
- Collaboration and cooperation between hospitals can produce services that are greater than the sum of their parts. Rather than “reinventing the wheel,” working together can achieve a better outcome.
- Reaching out to recognized clinical and non-clinical experts in the field is vital to producing a viable and credible program.
- With blood in dangerously short supply, decreasing transfusion utilization improves the availability of blood for critical cases.

Ability to Sustain the Initiative
BMSP is seamlessly integrated into the full scope of the Medical Center’s patient care services. It does not require separate funding and, in fact, produces measurable cost savings in a number of areas.
Program Description and Goals
Established in June 2003 within Alice Hyde Medical Center’s Education Department, In Touch with Health (ITWH) serves as a community focal point for health and wellness education for all ages and backgrounds, with interactive, engaging resources available for everyone. ITWH includes outreach programs, wellness education, health screenings, support groups, lectures, and seminars. ITWH is coordinated by a full-time community wellness specialist who delivers health and wellness information through presentations, screenings, informational tables, worksite outreach programs, radio shows, and public service announcements. The ITWH community wellness program encompasses the health promotion spectrum from prevention, to early detection and intervention, to disease management.

Outcomes
During its first two years, ITWH directly sponsored or participated in more than 500 wellness programs that included presentations and health screenings at six community adult centers, four health centers, schools, businesses, community groups, and health fairs. Participants complete program evaluations, which help Alice Hyde determine if the information presented is pertinent and useful, whether the adjunct materials enhanced the presentation, and whether the speaker was responsive to the audience. The evaluation also asks for suggestions for future programs.

Lessons Learned
- As ITWH approaches its third anniversary, Alice Hyde has learned that small interventions and projects can have a large impact.
- Community members have a multitude of health needs and each demographic requires different targeted information. One key to success is using a variety of media and methods to deliver health messages.
- Ease of access is required for an effective program. Alice Hyde offers programs throughout the community and at the medical center to maximize ease of access.
- Changing behavior is hard to do and education alone is not the answer. While awareness is a necessary first step to living more healthfully, the ITWH program is looking at the next step: helping people take action through behavior change and decision-making skills.

Ability to Sustain the Initiative
The community wellness specialist is a budgeted, hospital-supported position, considered an integral part of Alice Hyde’s health care services and the facility’s ongoing commitment to the community. The program’s sustainability is enhanced by its growth during its first two-and-a-half years, the support and vision of Alice Hyde’s administrators, and the community’s positive response.
Program Description and Goals
Girls on the Run (GOTR) is a fun, interactive program that teaches life lessons to enhance the physical, social, and emotional health of third-, fourth-, and fifth-grade girls. Female adolescents age 8-13 who are overweight, sedentary, and do not typically participate in organized school sports are the target population. GOTR provides girls with the tools and encouragement they need to eat right, manage their stress, feel good about themselves, and develop a lifetime love of being physically active.

Weekly lessons, coupled with training for a final celebratory community run/walk event, empower girls to make lifestyle choices to be more active and eat right, thus reducing key risk factors for diabetes and related chronic health conditions.

Outcomes
Evaluations of the program show significant improvement in self-esteem, body image, eating attitudes, and behaviors toward healthy foods. Four behavioral objectives specific to improved health status and the reduction of chronic disease risk factors were achieved at the end of the program:

- an increase in the number of girls who eat at least three vegetables a day;
- an increase in the number of girls who eat at least two fruits a day;
- an increase in the number of girls who are physically active most days after school; and
- fewer girls are preoccupied with weight.

GOTR helped the girls make healthier eating choices, have greater self-esteem and empowerment, be more active, and be less preoccupied with their body image. GOTR was recently recognized as one of eight programs statewide to receive funding from the Department of Health (DOH) for the prevention of Type 2 diabetes in children.

Lessons Learned
- GOTR is particularly inviting to girls not enrolled in organized sports.
- Young girls enthusiastically participate in after-school programming developed with their special needs and interests in mind.
- A well-organized curriculum based program can be accomplished successfully and inexpensively at schools.
- Local running clubs are natural partners in providing community-based physical activity opportunities for youth.

Ability to Sustain the Initiative
GOTR is currently funded by two DOH grants. With the national focus on obesity prevention expected to continue, ongoing pursuit of additional support is planned. Glens Falls Hospital is committed to remain accredited as a GOTR International Partner Council, in-kind beyond the expiration of program grant funding and school districts will be encouraged to incorporate GOTR-related expenses into their existing annual budgets.
**HealthLink Littauer: Wellness Education and Resources**  
Nathan Littauer Hospital and Nursing Home

**Partners**  
Nathan Littauer’s partners in this program include: local and regional health care organizations, county public health departments, local and regional hospitals, home care agencies, hospice, the Department of Health, human service agencies, Cornell Cooperative Extension, County Offices for Aging, Alcoholism and Substance Abuse Council, Catholic Charities, Community Action Agencies, Departments of Social Services, Latino services, mental health and counseling services, Office of Mental Retardation and Developmental Disabilities and Office of Mental Health day and residential services, senior clubs and organizations, pre-Kindergarten through community college schools, Hannaford Supermarkets, Littauer Occupational Alliance, local chambers of commerce and their member businesses, Alzheimer’s Association, American Cancer Society, American Lung Association, Arthritis Foundation, American Heart Association, and American Stroke Association.

**Program Description and Goals**  
HealthLink is Nathan Littauer Hospital’s community education and wellness center. Located in a local shopping mall, HealthLink’s goal is to increase community awareness about the benefits of wellness and provide resources for those wishing to make positive, healthy lifestyle changes.

Since opening its doors in 1989, HealthLink has offered over 4,500 free or low-cost programs to more than 118,000 people. Featured topics are chosen from community interests and needs, taking into account the most prevalent public health concerns. They include fitness, mind-body health, nutrition, childbirth preparation, parenting, smoking cessation, stress management, and disease prevention/management. Program highlights include an accessible resource center with on-site health professionals, a published monthly calendar of events, senior membership program, and special events such as an annual women’s wellness conference and community health fair. Other highlights include monthly health screenings, worksite wellness, and school-based programs.

**Outcomes**

- HealthLink Littauer has become a trusted community resource, a place to turn for health and wellness information or to support a healthy lifestyle change. In 1989, its first year, HealthLink held 128 programs with over 4,000 attendees; in 2005, 480 programs were held, with almost 8,000 participants.

- Often, the hospital becomes aware of success stories “after the fact.” For example, hospital staff may see a participant six months or a year later, and he or she says, “Because of you I started exercising, eating better, lost weight and now my glucose and cholesterol numbers are normal and I’ve lost over 60 pounds!”

**Lessons Learned**

- Nathan Littauer’s recipe for success has been working with other organizations and combining resources to achieve a common goal.

- The program’s title and where and when events are located do make a difference.

- To better measure its impact, benchmark before starting a program.

**Ability to Sustain the Initiative**  
The commitment of the hospital to the community enables the program to thrive. Only a modest amount of revenue (less than 25% of its operating budget) is generated from program fees, worksite wellness initiatives, program-specific grant reimbursement, and outright donations. The other equally important factor in sustaining the initiative is the ongoing quality and consistency of the programming.