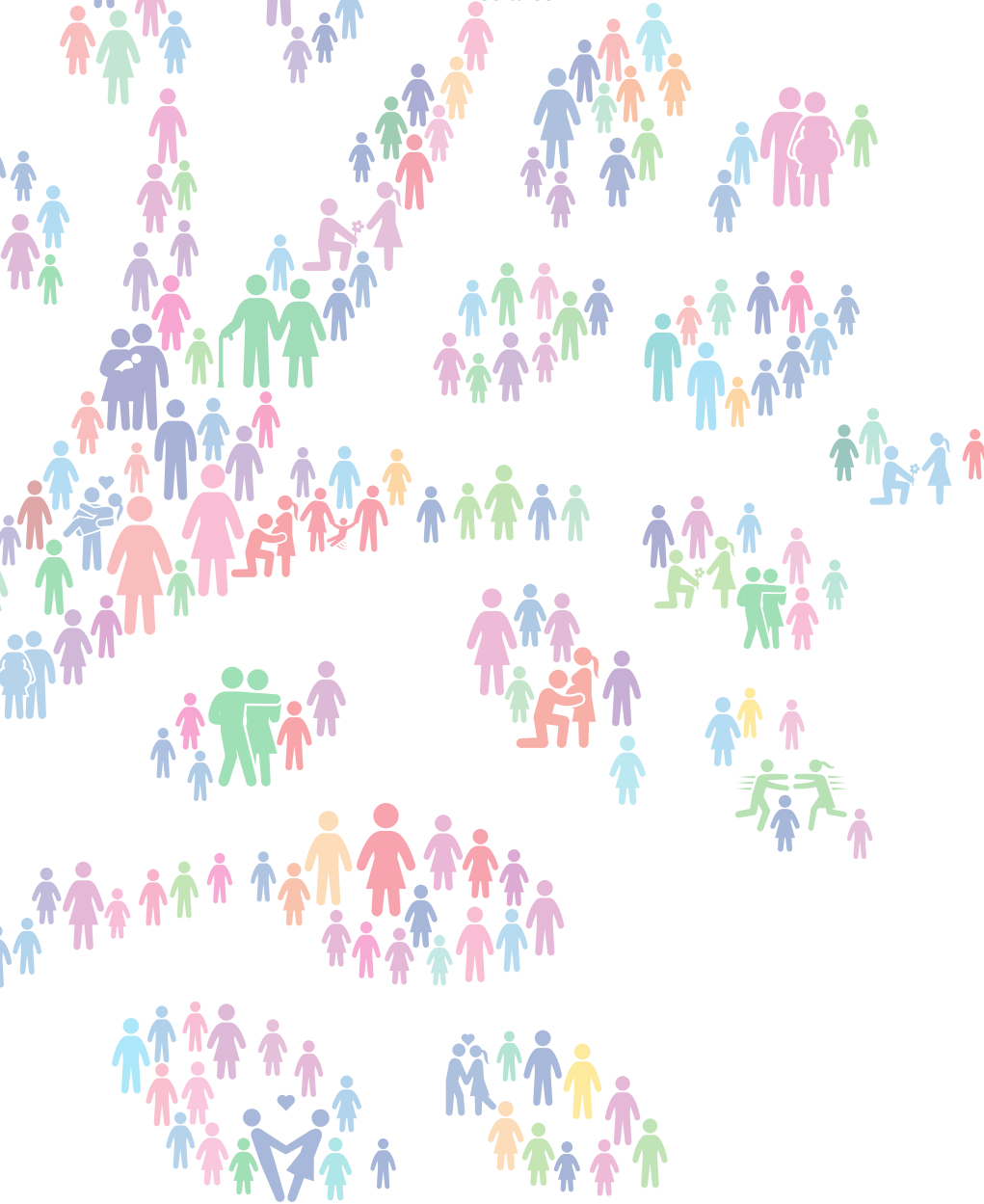




CONNECTING WITH COMMUNITIES:

Community Health Initiatives Across New York State



About HANYS' Community Health Improvement Award

HANYS established the Community Health Improvement Award in 1997 to recognize outstanding initiatives aimed at improving the health and well-being of communities. The award is presented to member hospitals and health systems for their programs that target specific community health needs related to the New York State *Prevention Agenda*, demonstrate leadership, collaborate among diverse groups and achieve quantifiable results.

Thank you to our 2022 reviewers

Sylvia Pirani (retired), former director, Office of Public Health Practice, New York State Department of Health

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

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



CONNECTING WITH COMMUNITIES: Community Health Initiatives Across New York State

HANYS is pleased to present the 26th edition of *Connecting with Communities: Community Health Initiatives across New York State*. This publication highlights the winner of and nominations for HANYS' 2022 Community Health Improvement Award.

The initiatives described in this publication are directly linked to New York state's *Prevention Agenda* priorities. The *Prevention Agenda* aims to make New York the healthiest state for people of all ages; it serves as a blueprint for local community health improvement.

Due to the COVID-19 pandemic, many hospitals had to put their existing community health initiatives on hold or take a different direction. Some of the initiatives in this publication describe what hospitals have done to address the effects of COVID-19 in their community. HANYS commends hospitals for their community health efforts during this challenging time.

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

**Questions about HANYS' Community Health Improvement Award?
Contact Kristen Phillips, director, trustee education and community
health policy, at 518.431.7713 or kphillip@hanys.org.**

2022 AWARDEE

**MOHAWK VALLEY
HEALTH SYSTEM**
Lead-Free and Healthy Homes
Mohawk Valley Coalition

INITIATIVE DESCRIPTION AND GOALS

The Lead-free and Healthy Homes Mohawk Valley Coalition formed when more than 40 community and agency partners, including Mohawk Valley Health System, united to address the high rates of childhood lead poisoning in Herkimer and Oneida counties.

Pregnant women, infants and children under the age of six are at the highest risk due to lead exposure and environmental health hazards from living in low-income neighborhoods with housing built before 1978 (when the use of lead paint was banned). More than 90% of Utica's housing was built before 1978 and more than half of the families living in Utica's high-risk target areas earn at or below the adjusted median income for the two-county region.

Through the Lead-Free and Healthy Homes Mohawk Valley Coalition, MVHS and community partners reduce lead poisoning and support access to healthy housing in Herkimer and Oneida counties to improve social determinants of health. The coalition aims to reduce the incidence of confirmed elevated blood lead level rate per 1,000 tested children aged <72 months, as shown by the New York State Community Health Indicator Reports.

The coalition provides LeadCare II testing units to local medical facilities to support this initiative. The City of Utica is a HUD Lead Hazard Reduction with Healthy Homes Supplemental Funds Grantee, which assists with this effort.



PARTNERS

The Coalition consists of more than 100 individuals from over 40 organizations representing health, government, legal, insurance, education, childcare, housing, construction and support services constituencies.

In addition to MVHS, partners on the steering committee include the City of Utica, Herkimer County, Oneida County, Cornell Cooperative Extension Oneida County, The Community Foundation of Herkimer and Oneida Counties, Green & Healthy Homes Initiative Utica-Oneida County, Utica Neighborhood Housing Services Home Ownership Center and Legal Services of Central New York. In addition, the Mohawk Valley Resource Center for Refugees provides interpretation services.

OUTCOMES

- State incidence ranking has improved. According to CHIRS, the Oneida County incidence of confirmed elevated blood lead levels was 26.7 for 2014-2016. The level lowered to 19.9 for 2016-2018, then again to 18.0 for 2017-2019 based on the most recent data. When the coalition started, Oneida County was ranked first, with the worst lead incidence rate in New York state; now the county ranks fifth.
- Lead hazard reduction interventions have produced 30 healthy, lead-safe housing units. The Home Ownership Center is on track to produce about 45 more units in Utica by the end of 2023.
- Using the healthy homes assessment process, enough air quality data was collected to show the need for and justify funding to initiate an asthma reduction pilot.

LESSONS LEARNED

Lessons learned that are contributing to the initiative's success include:

- a simplified enrollment process — a one-page intake sheet is given to interested parties to quickly pre-qualify households, and intake appointments are offered to every family that shows initial interest in partner programs;
- direct collection of necessary documents such as tax information and deeds by agency staff; and
- direct referrals between partner agencies.

SUSTAINABILITY

In addition to the multi-million-dollar, multi-year funding commitment from The Community Foundation of Herkimer and Oneida Counties through 2029, sustainability is improved by collaborating using the Green & Healthy Homes Initiative braided funding model to maximize the longevity of environmental health programming and to ensure that the residents most in need receive the services necessary to make their homes as safe as possible.

CONTACT

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- 2** Catholic Health Home Care
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- 3** Community Care of Brooklyn/Maimonides Medical Center
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- 4** Ellenville Regional Hospital Rural Health Network
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- 5** Erie County Medical Center Corporation
Transition of Care and Complex Care Management Program
- 6** Flushing Hospital Medical Center
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- 7** Glens Falls Hospital
Stroke Center Community Outreach to Reduce Stroke Reoccurrence and Decrease Long-term Disability
- 8** Hospital for Special Surgery
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BUFFALO NIAGARA MEDICAL CAMPUS

Food as Medicine

INITIATIVE DESCRIPTION AND GOALS

The BNMC Food as Medicine Initiative launched in 2015 to build a culture of local food procurement practices in healthcare and increase community access to healthy food. After seven years of successful culture building, the program has resulted in a spectrum of initiatives. These include population-level prevention programs like:

- creating and expanding farmers' markets and community-supported agriculture;
- eliminating deep-fat fryers at hospital cafeterias;
- launching a Harvest of the Month educational campaign;
- reducing portion sizes;
- nutrition labeling of retail foods;
- updating food and nutrition procurement policies; and
- making healthy food accessible after the cafeteria closes with a smart fridge vending program.

Individual-level initiatives include an insurance-sponsored lifestyle medicine program for both healthcare workers and patients, and offering healthy meals, nutrition education, cooking classes, mindfulness meditation and a mobile health coach. BNMC hosted the first annual Food as Medicine Symposium in 2021, engaging more than 100 stakeholders in discussions about culinary medicine, nutrition in medical school education and community-clinical partnerships. This program aligns with the New York State *Prevention Agenda* goal of preventing chronic disease through increasing access to healthy foods.

PARTNERS

Kaleida Health, Roswell Park Comprehensive Cancer Center, University at Buffalo, Metz Culinary, Pandion Optimization Alliance, Produce Peddlers, Eden Valley Growers, Healthcare Without Harm, Practice Green Health, Byte Technology, Blackman Farms, Urban Fruits and Veggies, African Heritage Food Co-Op, Healthy Living with Patti Green, Buffalo Public Schools, Cornell Cooperative Extension, Field and Fork Network, Buffalo Healthy Living, Farm to Institution North East, WIC, SNAP-Ed, DENT, SCORE, 716Fresh, Groundwork Market Garden, Grassroots Gardens of Western New York, Healthy Corner Store Initiative, American Heart Association, Buffalo Erie Food Policy Council and Riveter Design.

OUTCOMES

- BNMC operationalized the farm-to-hospital program so food service and communications teams can continue to implement the program without BNMC's technical assistance. This includes maintaining the Harvest of the Month campaign, tracking local food procurement metrics (16%), continuing the local food request for proposals and sustaining contracts with Healthcare Without Harm and Practice Green Health.
- The Farmhouse Fridge provides 24/7 access to healthy local foods to healthcare workers and patients. The program has sold more than 5,000 meals.
- The program secured \$240,000 to develop a medically tailored meal lifestyle medicine program with 125 healthcare workers and community members.

LESSONS LEARNED

- There is urgent need for provider and healthcare team education on how to:
 - treat disease using food, nutrition and culinary medicine;
 - screen for food insecurity;
 - refer out to community food resources; and
 - make food and nutrition prescriptions.
- It is important to collect data and metrics to demonstrate success.
- Continued research and advocacy are needed to push reimbursement for effective treatments like medically tailored meals and food prescriptions.

SUSTAINABILITY

The program has been sustained for seven years due to its unique approach of inclusive engagement and relationship building. The initiatives have been institutionalized into regular operations at the hospitals, including maintaining the Harvest of the Month, tracking local procurement, continuing the local foods RFP and smart vending program, sustaining contracts with Healthcare Without Harm/Practice GreenHealth, continuing to organize the farmers markets/CSA and maintaining policy/environmental changes.

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CATHOLIC HEALTH HOME CARE

Using Remote Patient Monitoring to Improve Medication Adherence and Efficacy in Patients with Asthma and COPD

INITIATIVE DESCRIPTION AND GOALS

Asthma and chronic obstructive pulmonary disease adversely impact patients, families, healthcare providers and healthcare payer systems. Adherence to prescribed medications, particularly inhalers, is essential for managing chronic restrictive lung disease. Integrating technology with education and support can improve outcomes within this population.

This initiative used a Propeller inhaler sensor, a small electronic device that attaches to the top of an individual's inhaler and programs the prescribed medication schedule. It uses Bluetooth technology to transmit data on medication utilization to the digital monitoring platform for clinician review and to an application downloaded onto a patient's or caregiver's smart device. The app sends electronic reminders if the inhaler is not activated at the prescribed time. The app also offers education to support information provided by clinicians, inclusive of trigger avoidance and medication education reinforcement.

Goals of the initiative include increasing disease self-management, patient and clinician satisfaction, adherence with prescribed inhaler medications and decreasing healthcare utilization.

PARTNERS

Asthma Coalition of Long Island (American Lung Association), Propeller (device vendor), Mother Cabrini Health Foundation (funded the inhaler sensors), Catholic Health hospitals, local community hospitals (Stony Brook University Hospital, NYU Langone Hospital), hospital and community physicians and providers, Good Samaritan Pediatric Pulmonology Clinic and Westbury Federally Qualified Health Center.

OUTCOMES

- The adherence rate for inhaler use improved when remote patient monitoring was incorporated into care planning.
- The organization identified subjective and objective improvements in disease management.

- High patient satisfaction lends itself to continued adherence and provider follow-up.
- High levels of clinician satisfaction resulted from increased clinician engagement with the initiative.
- Decreased healthcare utilization reduced strain on the individual, provider and healthcare system.

LESSONS LEARNED

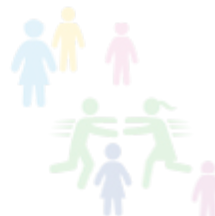
- Integrating remote patient monitoring of inhaler medications into the customary post-acute practice to support home care is beneficial to the management of chronic respiratory disease.
- The health management modality can be replicated among individuals with other chronic airway diseases using prescribed inhaler therapy. The organization is considering how to apply these lessons to individuals with residual effects of COVID-19.

SUSTAINABILITY

The use of remote patient monitoring to support adherence with prescribed medications offers individuals with limited access to healthcare a unique opportunity to receive the necessary support and follow-up between provider encounters. Integrating this population health approach to care can serve as a means to mitigate social determinants of health and provide access to care for those most in need.

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COMMUNITY CARE OF BROOKLYN/ MAIMONIDES MEDICAL CENTER

Testing Provider Partnership and Beyond — Combating the COVID-19 Pandemic in Brooklyn

INITIATIVE DESCRIPTION AND GOALS

New York City was hit hard at the onset of the COVID-19 pandemic. In response to the critical need to prevent communicable disease as outlined in the New York State *Prevention Agenda*, Community Care of Brooklyn performing provider system entered into a one-year program supported by the New York City Department of Health and Mental Hygiene in December 2020 to increase COVID-19 testing by 20% from the baseline period. Community Care of Brooklyn PPS is a network that facilitates relationships with community physician partners and is managed through Maimonides' department of population health.

Throughout the COVID-19 pandemic, CCB leveraged its relationships with more than 1,000 partners including hospitals, providers, community leaders and community-based organizations to meet the evolving needs of Brooklyn communities, provide on-the-ground support to groups most impacted by the pandemic, support vulnerable communities and ensure equitable distribution and deployment of COVID-19 tests and vaccinations.

Using a multi-pronged approach to maximize impact, CCB grouped its efforts into three main avenues of engagement: provider, community and patient.

PARTNERS

NYCDOHMH, Brooklyn Communities Collaborative, Brooklyn Health Home, Maimonides department of population health, Healthix, Amazon Web Services, 47 partner providers and 14 CBOs.

OUTCOMES

- CCB expanded testing by 20% over the baseline for six of the 12 grant-funded months.
- CCB's provider partners received 70,000 extra COVID-19 test kits and 550,000 units of personal protective equipment, and administered 366,000 tests during the 12-month Testing Provider Partnership program period.

- CCB sent 330,000 text messages encouraging testing and vaccination to at-risk community members while partner CBOs conducted vaccine outreach to tens of thousands of Brooklynites, supported over 100 community events and vaccination points of dispensing, and assisted 1,000 Brooklynites in scheduling vaccine appointments.

LESSONS LEARNED

Through analysis of community-level data via participatory action research, CCB discovered the need for better accessibility and efficiency of testing centers and identified 14 CBOs equipped to engage those most at risk. With support, primary care physicians and CBOs are strong assets in the fight against COVID-19. Leveraging community-level organizations and leaders allowed CCB to provide education to Brooklyn communities that are historically under-served and less likely to respond to traditional methods of education and engagement.

SUSTAINABILITY

The Delivery System Reform Incentive Payment program ended in March 2020, but CCB was able to effectively work beyond the DSRIP program and activate its network of partners to combat the COVID-19 pandemic. CCB and its partners have taken a multi-pronged approach to combat the pandemic, working during and beyond NYCDOHMH's testing-provider partnership program to address the needs of Brooklyn's providers, community members and CBOs. CCB will continue to leverage and expand its partnerships and community ties.

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ELLENVILLE REGIONAL HOSPITAL RURAL HEALTH NETWORK Wawarsing Wellness Program

INITIATIVE DESCRIPTION AND GOALS

Understanding that people in rural communities are at greater risk of chronic disease, the Rural Health Network at Ellenville Regional Hospital's mission is to continuously pursue healthier lives for everyone in the community. Using the chronic care and community health worker models, ERH offers a free wellness program to guide individuals through the prevention and management of chronic diseases. Members of the wellness program have access to a community health worker and a nutritionist who work collaboratively to provide personal health coaching tailored to each participant's needs through evidence-based goal-setting techniques such as motivational interviewing and brief action planning.

Through the Rural Health Network, ERH offers innovative approaches to preventive care such as coronary calcium scans and carotid artery ultrasounds cost-free regardless of insurance coverage. ERH's rehabilitation department also offers a free cardiac wellness program modeled after the existing cardiac rehabilitation framework for individuals at risk of a cardiovascular incident. In addition, the program offers free fitness classes, nutrition education and health education informative seminars to all members of the community.

PARTNERS

Ellenville Regional Hospital, The Institute for Family Health, Ulster County Department of Health and Mental Health, Cornell Cooperative Extension of Ulster County, Ellenville Central School District, Ellenville/Wawarsing Youth Commission, Ulster County Office for the Aging, Ulster County Community Action Coalition, Catholic Charities Community Services of Orange, Sullivan and Ulster, Food Bank of the Hudson Valley, Ulster County Correctional Facility, Rondout Valley Growers Association and Planned Parenthood of Greater New York.

OUTCOMES

Since 2018, ERH has engaged with community members by offering a variety of programs throughout the years. Outcomes include:

- 138 people have enrolled to work one on one with a community health worker;

- 60 individuals have enrolled in continuing (once a month or more) nutrition counseling;
- more than 1,000 people have accessed Network programming such as physical activity, nutrition and health education classes each year since its inception;
- 1,255 individuals have received a free calcium scoring CAT scan; and
- 208 individuals were screened for risk of heart attack or stroke using the CDC's heart age calculator at community events.

LESSONS LEARNED

ERH has found that being present in the community by promoting at local businesses and events has been beneficial to keeping the local population engaged. Making programs accessible in person and online has been critical to maintaining participation during the COVID-19 pandemic. Creating a sense of community among program participants has guided them to feel open to engaging with each other, attending new programs and leaning on each other for support.

SUSTAINABILITY

ERH Rural Health Network plans to sustain and expand this program by acquiring new grants and investigating the future of charging for preventive treatments as the value-based care system continues to advance. The program will also evolve and develop as future community needs assessments are performed and new problem areas are identified.

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ERIE COUNTY MEDICAL CENTER CORPORATION

Transition of Care and Complex Care Management Program

INITIATIVE DESCRIPTION AND GOALS

Erie County Medical Center's Transition of Care and Complex Care Management Program aims to eliminate health disparities, poor health outcomes and hospital readmissions through preventive and coordinated care management. This initiative uses an interdisciplinary team rooted in coordination, patient-centered access, transition management and community collaboration.

The World Health Organization attributes between 30% and 50% of health outcomes to the impact of social determinants of health, drawing a direct correlation between lower income and poor health outcomes. Unmanaged chronic conditions combined with SDOH have led to increased healthcare costs as a result of unnecessary emergency department and hospital utilization and readmissions from complications.

According to community needs assessment data, ECMC's patient population suffers from disproportionately high rates of asthma, chronic obstructive pulmonary disease, cardiovascular disease, diabetes and obesity; all exacerbated by a lack of access to care resulting from SDOH. These data align with the New York State *Prevention Agenda's* chronic disease preventive care and management focus area.

PARTNERS

Independent Health Association, General Physicians PC, ECMC Family Health Center, Internal Medicine Center, VIP Primary Care, Downtown Clinic for Behavioral Health Services, Best Self Behavioral Health, Community Health Center of Buffalo, Inc. and Jericho Road Community Health Center.

OUTCOMES

Through this initiative, ECMC:

- identified 47% of patients admitted to ECMC's hospital as high-risk for admission and requiring intervention;

- identified and successfully linked 36% of high-risk patients without a primary care provider to a transition of care visit post-hospital discharge; and
- successfully provided mental health counseling and bridging to follow-up mental health appointments to 38% of patients in need of behavioral health services post-discharge.

LESSONS LEARNED

- Through this program, healthcare providers have observed the impact of health disparities on preventive disease management and hospital readmissions. Patients were leaving the hospital without understanding changes to their health, disease state and medications and lacked the ability to obtain the resources to do so.
- Through an interdisciplinary, community-based approach, hospitals can support change through care coordination and by addressing disparities.

SUSTAINABILITY

Integrating an interdisciplinary team designed to assess and treat the "whole" person across the continuum of care provides the clinical social support necessary to address health disparities and foster a community of collaboration. Through the partnerships established within this program, ECMC has been able to and will continue to sustain the remarkable level of care provided to in-need patients.

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FLUSHING HOSPITAL MEDICAL CENTER

Successful Aging for Increased Longevity

INITIATIVE DESCRIPTION AND GOALS

The goals of the Successful Aging for Increased Longevity project were to provide integrated, destigmatized mental health services to an underserved older population. SAIL components included screenings, assessments and engagement activities such as English literacy, using gadgets, dance and movement activities, the use of Fitbits, a health literacy curriculum and onsite counseling.

In 2016, the Flushing Hospital Psychiatry and Addiction Services department and the New York City Department for the Aging collaborated to secure a \$1.5 million, five-year Partnership Innovation for Older Adults grant from the Office of Mental Health. Two full-time Chinese-speaking clinicians and a half-time coordinator were placed in a Chinese-speaking Older Adult Center in Flushing, Queens.

This initiative supported the following New York State *Prevention Agenda* priority areas:

- preventing chronic diseases by increasing skills and knowledge to support healthy food and beverage choices, increasing physical activities and improving self-management skills;
- promoting well-being and preventing mental illness, substance abuse, major depressive disorders and suicides; and
- promoting well-being across the lifespan.

PARTNERS

Flushing Hospital Medical Center's Department of Psychiatry and Addiction Services' chairperson and administrator, and the New York City Department for the Aging's director of geriatric mental health and senior research director.

OUTCOMES

- The program reached 236 participants; 1,490 Patient Health Questionnaire-9s and 1,461 Generalized Anxiety Disorder Screener-7s were completed: 55% scored 5-9; 31% >10; >5 needed for admission.

- Of 32 participants in the Fitbit program, a majority felt the device was very helpful (9 on a 10-point scale); 37.5% said the sleep component is helpful; 75% reported that step counts raised awareness; 50% appreciated the group.
- During the pandemic, 64% did not wear the Fitbit. A majority felt the Fitbit was helpful (7/10-point scale); 86% wore it seven days a week prior to the pandemic; 71.4% said step counts raised awareness; 35.7% continue to track steps on a phone and 28.6% on WeChat; 21.4% found the sleep component helpful; 57% appreciated the support group.

LESSONS LEARNED

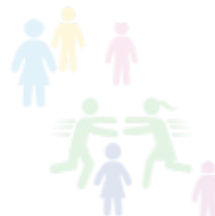
- The Fitbit component of the SAIL program is its most innovative aspect.
- Trust between funding agencies and collaborators is crucial. Collaborators that have track records with funders can secure additional grants that advance the SAIL concepts and implementation strategies that can bring equity to underserved populations. Trust takes time between funders and grantees, among collaborators, and between collaborators and potential participants.

SUSTAINABILITY

A major step toward sustainability was the strength of the collaboration among project leaders. The collaboration was awarded a \$1.5 million, five-year grant to promote aging in place for another underserved population using the same concepts and strategies as the original grant, including the Fitbit component. The hospital also anticipates referrals from the Older Adult Center to the Flushing Hospital Asian-American Mental Health Clinic, when appropriate.

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GLENS FALLS HOSPITAL Stroke Center Community Outreach to Reduce Stroke Recurrence and Decrease Long-term Disability

INITIATIVE DESCRIPTION AND GOALS

Nearly two million neurons die during an acute stroke event with every passing minute. Glens Falls Hospital identified that potential stroke patients arriving to the hospital via emergency medical services were able to be triaged and receive a CT scan much quicker than ambulatory patients. Reasons for this include waiting room delays and registration, check-in and assessment processes.

When a patient arrives via EMS their work-up has already begun in the ambulance and the hospital receives a pre-arrival report so hospital staff can be ready for the patient. To achieve faster arrival-to-CT scan times, GFH developed a plan to educate the community to dial 911 and arrive via EMS for acute neurological changes. The goal was to target existing community forums with this important educational initiative to improve patient outcomes.

The program uses evidence-based care and prevention outreach to address the New York State *Prevention Agenda* goals for chronic disease prevention and management. Chronic diseases such as cancer, diabetes, heart disease, stroke, asthma and arthritis are among the leading causes of death, disability and rising healthcare costs in New York state.

PARTNERS

Rotary Club, Washington County Office for Aging and the Conkling Center.

OUTCOMES

- GFH achieved a progressive decline of about 25% of ambulatory arrivals and increase of about 15% in EMS arrivals since beginning community outreach and education.

- There has been a nearly 15% increase in patients arriving in less than 4.5 hours since the onset of their symptoms. Thrombolytic therapy (the clot-busting medication for stroke) must be given within 4.5 hours of the start of symptoms to increase the medical team's ability to prevent long-term disability.
- During the three years and four months GFH has been a stroke center, the stroke recurrence rate has been 10.5% for patients who presented to GFH compared to the world-wide average of nearly 26% of patients having a second stroke within five years.

LESSONS LEARNED

- You can reach more individuals by partnering with local community organizations to provide stroke education on the importance of dialing 911 immediately when stroke symptoms are identified.
- GFH has learned the importance of ensuring that the outpatient post-hospital follow-up visit is scheduled before discharge and providing reminder calls to the patient for their upcoming visit.

SUSTAINABILITY

GFH established a director position to oversee the stroke program, coordinate community outreach and lead the organization in continuous quality improvement activities. In addition, the hospital created a stroke patient specialist position — a registered nurse who tracks inpatient metrics and performs 30-day follow-up calls.

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HOSPITAL FOR SPECIAL SURGERY

Aging with Dignity

INITIATIVE DESCRIPTION AND GOALS

Older adults face unique health challenges including physical and cognitive changes, social isolation, loneliness and lack of access to health services. A community health needs assessment identified social isolation, loneliness, pain and lack of education as needs among the older adult population. The Greenberg Academy for Successful Aging at the Hospital for Special Surgery developed Aging with Dignity, an initiative to support healthy aging in older adults.

Aging with Dignity offers weekly, phone-based support groups for older adults to discuss and share the challenges of aging in a safe environment. Workshops around web information literacy, journaling, music therapy and art therapy are hosted on Zoom. HSS created a multilingual resource guide (digital and print) to provide older adults with a listing of local and online resources for health and wellness.

The goals of the AWD program are to:

- provide a safe community for older adults to discuss the challenges of aging;
- educate older adults on how to manage healthy aging; and
- improve older adults' health and well-being by increasing social connectedness, decreasing stress and anxiety and improving energy and mood.

AWD aligns with the New York State *Prevention Agenda* priority area, “Promote Wellbeing and Prevent Mental and Substance Use Disorder.”

PARTNERS

Arthritis Foundation, 305 West End Assisted Living, Assembly Member Rebecca Seawright, Breaking Ground, Brookdale Senior Living, Bronx Health Link, Carter Burden Network, COHME, Creaky Joints, Integrity Senior Services, JASA, Lenox Hill Neighborhood House, Mother Cabrini Health Foundation, Mount Sinai Hospital, New York City Department of Health and Mental Hygiene, New York-Presbyterian, New York Public Library, *Our Town* newspaper, *Queens Ledger*, SelfHelp Innovative Senior Center, The Music Academy for Special Learners, Visiting Nurse Service of New York and *Woodside Herald*.

OUTCOMES

- The CHNA, which consisted of 23 community partner interviews and 18,248 survey responses, identified social isolation/loneliness, pain and lack of health education as major health needs.
- AWD has conducted 116 support groups and 13 workshops reaching 1,135 older adults. A majority of participants reported an increase in knowledge (92%) and self-management skills (84%), high program satisfaction (91%) and high likelihood to recommend the program to others (93%).
- Qualitative data indicated that AWD provides participants with tools to overcome challenges in aging, creates a sense of community and offers a calming, supportive and open environment to discuss shared experiences.

LESSONS LEARNED

- With the onset of COVID-19, AWD learned to be flexible and creative in adapting the program to reach multiple audiences. Specifically, in-person programs quickly shifted to conference calls and Zoom to accommodate those with differential access to technology.
- The Community-based Participatory Research model has been key to AWD's success. Continual engagement with community partners ensures programs remain relevant to and meet the changing needs of the community.

SUSTAINABILITY

Program sustainability is supported by:

- ongoing commitment of HSS staff and community partners;
- recruitment of HSS staff as program coordinators and speakers, lessening the funding burden;
- private and individual donations, allowing for program operation and expansion;
- continuous evaluation of community health needs to ensure program impact and efficacy; and
- virtual program formats (Zoom and phone) that allow for wider community reach.

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JAMAICA HOSPITAL MEDICAL CENTER

Violence Elimination and Trauma Outreach

INITIATIVE DESCRIPTION AND GOALS

The Violence Elimination and Trauma Outreach program is a Jamaica Hospital Medical Center partnership with King of Kings, Life Camp and the new Jamaica Hospital THRIVE (Trauma Healing & Recovery Integrative Violence Elimination) Survivor Center. VETO aims to provide comprehensive and coordinated healthcare to patient survivors while working to decrease trauma recidivism and address patients' social determinants of health in a culturally responsible and sensitive way. JHMC recognizes individual- and community-level trauma as an SDOH that impacts health behaviors and outcomes.

By expanding the program team, JHMC anticipates being able to increase patient participation and enrollment in the VETO program.

This collaborative program establishes additional community partnerships to link survivors to violence interruption groups and education, employment, legal aid, victim compensation assistance and housing resources.

PARTNERS

King of Kings and Life Camp.

OUTCOMES

- JHMC has advanced coordinated outpatient care.
- Trauma recidivism has decreased.
- VETO supports goals identified in the organization's SDOH evaluation.

LESSONS LEARNED

Many victims of violence lack coordination of their outpatient care, have social factors increasing their risk of violent harm and are at risk for trauma recidivism. With an integrative medicine approach, all aspects of care will be available including linkages to community organizations and violence interrupters with a focus on future violence-injury prevention.

SUSTAINABILITY

Under the VETO program, the THRIVE Center will coordinate with cure violence groups such as King of Kings and Life Camp to provide comprehensive care to victims of violence and reduce violence in the community.

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LONG ISLAND COMMUNITY HOSPITAL

Medication-assisted Treatment — Prescription Drug and Opioid Addiction

INITIATIVE DESCRIPTION AND GOALS

The goals of this project are to reduce opioid overdose deaths, decrease illicit opioid and prescription drug abuse, increase access to medication-assisted treatment and outpatient services and ultimately save lives. This is in direct alignment with the New York State *Prevention Agenda* priority area of decreasing the number of opioid deaths and providing education to the community about MAT.

In addition to efforts within the hospital's emergency department and medical units, this initiative provided Narcan training sessions within the community. LICH's participation with the HEALing Community Study enabled the hospital to partner and collaborate with myriad community agencies to assist with outreach and education about the positive aspects of treatment for opioid use disorder. The hospital was an active participant in social media campaigns designed to decrease the stigma surrounding treatment, in addition to highlighting easy access to treatment in its outpatient and inpatient services. LICH used partners, including its own outpatient chemical dependency program, to provide the necessary clinical and community services patients require.

LICH's outpatient chemical dependency program was able to increase access to care using telehealth, significantly easing some of the transportation barriers patients face. LICH promoted the use of telehealth through the hospital website and social media.

PARTNERS

Suffolk County Division of Mental Hygiene, Office of Addiction Services and Supports, HEALing Community Study through the National Institutes of Health, LICH outpatient chemical dependency program, Sun River Health Center and all OASAS Part 822 licensed outpatient programs.

OUTCOMES

- The initiative induced 15 patients on Suboxone between Sept. 30, 2021, and Aug. 31, 2022.
- Outpatient follow-up appointments were provided for all patients induced on Suboxone.
- Between Sept. 30, 2021, and April 30, 2022, LICH induced 20 patients (113% of the goal) and obtained outpatient appointments for all 20.
- All patients have remained in treatment at the six-month follow-up point.

LESSONS LEARNED

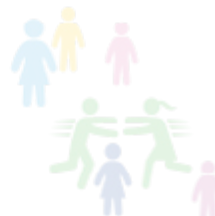
Addressing stigma with healthcare professionals is an ongoing initiative. Providers required basic education on substance use disorders and LICH held educational sessions with field experts, in addition to promoting the use of the provider clinical support system website. Recruitment for a certified recovery peer advocate was challenging; LICH contacted the regional OASAS liaison to assist with contracting with a community agency for help.

SUSTAINABILITY

LICH implemented the "Screening, Brief Intervention and Referral to Treatment" protocol in its ED several years ago and used that approach on medical units as well. LICH provided formal training on SBIRT to its care management and key nursing staff. Along with education, the hospital has ensured this is part of the ongoing assessment process for all patients requiring it.

CONTACT

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MONTEFIORE ST. LUKE'S CORNWALL Collaboration for Improving Behavioral Health

INITIATIVE DESCRIPTION AND GOALS

Montefiore St. Luke's Cornwall and its emergency department leadership developed a plan to provide mobile mental health services to emergency room patients presenting with behavioral health concerns. It was created in collaboration with Access: Supports for Living and the Orange County Commissioner of Mental Health. ASFL is a local agency committed to supporting the behavioral health needs of families and communities in the Hudson Valley.

When a patient with a behavioral health issue is admitted to the ED, a member of the healthcare team contacts ASFL to initiate an assessment by a trained counselor. This counselor is available 24 hours a day/seven days a week. The counselor shares findings with the ED provider and helps create a safe plan for the patient. The plan may include sending the patient home with confirmed local outpatient services or admission to a psychiatric facility. Providing local services, as appropriate, allows for long-term, local care within the grasp of a poverty-stricken, underserved community.

This ongoing project addresses the New York State *Prevention Agenda* behavioral healthcare priority areas.

PARTNERS

Access: Supports for Living and Orange County Commissioner of Mental Health.

OUTCOMES

Since the inception of the collaboration with ASFL in 2013, MSLC has seen positive quantitative outcomes. The hospital has assessed, identified and created a process to provide affordable, local mental healthcare to the community. The most recent data continue to prove its worth. In 2021:

- recidivism (return to ED within 120 days) was at a low 3%;
- 56% of mental health patients were discharged home with local, affordable care; and
- 79% of these patients had a government payer source (Medicaid or Medicare).

LESSONS LEARNED

All projects provide insight into best practices and opportunities but this one confirmed a lesson for the facility. Behavioral health is a complex, growing arena for healthcare and providers should partner with experts in the field for best outcomes. While a hospital ED can serve to maintain safety at the moment, a behavioral condition, like any other chronic condition, requires patient self-management and familiar local services to sustain healthy living and sequelae avoidance.

SUSTAINABILITY

A key to hardwiring any successful program lies in developing tactics to sustain the effort and embedding them in the everyday workflow. MSLC continues to meet quarterly with ASFL to identify barriers to care and opportunities for improvement, and maintain a professional relationship. The workflow of the ED staff includes a point of entry case manager who supports and facilitates conversations between hospital and ASFL staff.

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MOUNT SINAI HEALTH SYSTEM

The Public Health and Racial Justice Program for Black Youth

INITIATIVE DESCRIPTION AND GOALS

The Mount Sinai Department of Health Education's Public Health and Racial Justice Program is an innovative youth empowerment initiative for Black teens. This program explores the intersections of public health, social justice and community activism, all through a racial justice lens.

Community presenters share their firsthand experiences entering the field of public/community health, personal journeys, successes and challenges and barriers they've faced. Community guests often lead education and empowerment activities for our youth, building their civic engagement skills and incorporating creative expression. Connecting young people with community activists and organizations during such a formative period of their development helps build their self-efficacy and feelings of ownership and autonomy over their community's health.

Programming was founded in spring 2020 with the belief that change is most effectively, rapidly, radically and sustainably brought about when people of color are at the helm and when the root causes of racial injustice are addressed. This initiative explores the insidious impact of racism on public health in the United States while framing conversations in the context of inspiration, hope and the ways in which everyday individuals can be powerful agents of social change.

PARTNERS

Planned Parenthood of Greater New York, The New York City Department of Health and Mental Hygiene CATCH Program, Day One, The Mount Sinai Adolescent Health Center, The Trevor Project and many more throughout all iterations of programming.

OUTCOMES

Mount Sinai has seen increased knowledge and self-efficacy across all cohorts; results vary from cohort to cohort.

LESSONS LEARNED

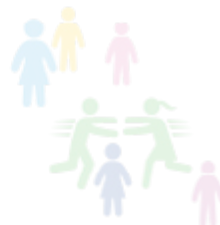
- "Zoom fatigue" was a serious barrier during the remote school year and this program is best facilitated during the summer while still in a virtual setting.
- Guest presenters must have previous experience presenting to and working with teens. The ability to meaningfully connect with and capture the interest of young people requires a unique set of skills and an understanding of how youth differ from adults in learning and engagement.

SUSTAINABILITY

Mount Sinai has already begun preliminary meetings with the city's summer youth employment team to discuss turning this program into a New York City placement site for teens in the summer of 2023. Mount Sinai is excited and optimistic about this opportunity for growth.

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NORTHERN WESTCHESTER HOSPITAL Senior Community Health Programs Then and Now — Mind, Body, Spirit

INITIATIVE DESCRIPTION AND GOALS

Northern Westchester Hospital's senior community health programs include:

- *Access to quality healthcare:* Offering vaccinations to the community provides access at a trusted location for those who may not otherwise seek vaccination. Additionally, NWH's virtual lectures on chronic disease management and in-person health screenings help seniors manage blood pressure and diabetes.
- *Chronic disease:* NWH provides lectures on chronic disease prevention and other issues affecting seniors as outlined in the New York State *Prevention Agenda*, including heart disease, cancer, stroke and diabetes.
- *Infectious disease:* NWH's comprehensive vaccination program slowed the spread of COVID-19 and protected vulnerable seniors. The hospital's community flu vaccination program provides seniors with high-dose flu vaccinations, providing protection during flu season.
- *Mental health and substance abuse:* The chair yoga program led by a holistic nurse incorporates mind, body and spirit. The frequency of classes and engagement with the instructor provide avenues for connection. Breathing and meditative exercises are correlated with positive mental health benefits.
- *Physical activity and nutrition:* NWH offers weekly, in-person and virtual chair yoga instruction and nutrition classes.

PARTNERS

Community Center of Northern Westchester, Heritage Hills, Bedford Hills Seniors, Pound Ridge Seniors, Fox Senior Center, Interfaith Food Pantry, Neighbor's Link, Pinecrest Manor, A-Home, North Castle Seniors, New Castle Seniors, Lewisboro Seniors, Lexington Center for Recovery, Bethel Baptist and Antioch Baptist Church.

OUTCOMES

- *Provided access to COVID-19 vaccination:* Our seniors always had protected spots for sign-up and we removed barriers for those identified as vulnerable with our community partners. We are proud to say that in the first six months of our vaccination clinic, we had zero-wasted doses, meaning we maximized our supply fully during the height of vaccine scarcity.
- *Increased engagement with the community through virtual programs:* Our virtual platform was accessible to all; we leveraged community partnerships and our live attendees in 2021 proved its success (over 2,000).
- *Provided safe access to flu vaccination in the community:* Our numbers increased from 500 pre-pandemic to 850 during the pandemic.

LESSONS LEARNED

NWH learned that the only way to reach its target groups was through already established, trusted relationships. The hospital leveraged partnerships with community organizations and maintained trusted instructors to ensure a feeling of stability and calm for participants. NWH's team thought deeply about barriers such as digital literacy and worked closely with partners to provide simplified access to these programs with instructions and special easy-to-use links.

SUSTAINABILITY

NWH has fully incorporated these virtual programs into its mission through a virtual platform, the Center for Healthy Living. This platform engages the community in free virtual content. All lectures and education, including chair yoga, are added to NWH's YouTube library. This is essential for those in the community with transportation and mobility challenges or those who are still cautious with in-person engagement. The partnerships that make this program possible have grown and strengthened from the pandemic and continue to flourish.

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NORTHWELL HEALTH

Addressing Food Insecurity by Leveraging Family Health Center Resources and Community Partnerships through the Nutrition Pathways Program

INITIATIVE DESCRIPTION AND GOALS

The Nutrition Pathways Program aims to increase food security and improve the health and well-being of the diverse and underserved patient population of Northwell Health's Dolan Family Health Center — 80% of whom are on Medicaid or uninsured — by increasing access to healthy food and supporting healthy lifestyles.

Results from Northwell's assessment showed great need for culturally sensitive, language- and health literate-appropriate education, outreach and care coordination to address food insecurity rates that were 50% higher than pre-pandemic rates, and related social issues.

Northwell and Island Harvest, Long Island's largest food bank, rolled out the evidence-based NPP to provide nutrition counseling, healthy food, weekly community food distribution and referrals for other resources to create long-lasting change to patients' food insecurity status. NPP includes culturally competent services by a bilingual (English/Spanish) nutritionist.

In alignment with the New York State *Prevention Agenda's* goal of preventing chronic diseases (increasing access to healthy and affordable foods and beverages, skills to support healthy food choices and food security), NPP has improved healthy food consumption, decreased unhealthy food consumption in meals eaten away from home, increased physical activity and improved clinical outcomes.

PARTNERS

Northwell Health – The Dolan Family Health Center, Island Harvest and its many referral partners.

OUTCOMES

NPP outcomes include improving food access, reducing food insecurity and improving lifestyle and clinical outcomes among participants. These outcomes were evaluated by:

- serving 134 unique individuals and their families;
- successfully enrolling at least 125 families in Supplemental Nutrition Assistance Program benefits and linking to other community resources;
- increasing intake of healthful food choices by 54%;
- decreasing intake of unhealthy foods by 67%;
- decreasing the number of meals consumed from restaurants by 26%; and
- increasing participant engagement in regular exercise by 44%.

In addition, 50% of participants reduced their body mass index, 36% reduced their blood pressure and 55% reduced their A1C.

LESSONS LEARNED

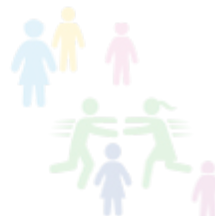
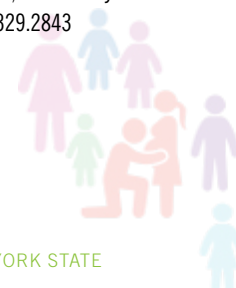
It is important to understand the unique needs of the target community and make sure that programmatic elements align with these needs. This includes culturally appropriate food choices and recipes; staff that mirror the community and speak their language(s); educational materials in appropriate languages and being able to help address the presenting problem, in this case food insecurity; and other underlying social needs.

SUSTAINABILITY

Northwell's leadership fully supports NPP and has a history of absorbing the cost of successful models that demonstrate community benefit. NPP will continue reducing food insecurity and health inequity through geographic and programmatic expansion guided by community-based participatory research. These expansions will allow for continued infrastructure development to provide sustainable access to healthy food, nutrition education, social need referrals and community engagement.

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NYC HEALTH + HOSPITALS/ELMHURST

Improving Diabetes Control in an Underserved, Low Literacy Community

INITIATIVE DESCRIPTION AND GOALS

NYC Health + Hospitals/Elmhurst identified that its patients who were diagnosed with diabetes and had a poor HgbA1c control rate were struggling to get it under control using the standard education and medication treatment.

The majority of the basic educational materials reflected the standard Western diet and were written at an advanced literacy level. Patients had difficulty understanding the material after leaving the clinic and were uninterested in adopting a Western diet. In response, Elmhurst created teaching materials written at a lower literacy level and translated them into its patients preferred languages (Bengali, Spanish, Nepali). The hospital also provided alternative nutritional suggestions that complemented the foods within each patient's culture.

This initiative supports the New York State *Prevention Agenda* priority area for preventing chronic disease; specifically, decreasing the percentage of adults with diabetes whose most recent HgbA1c level indicated poor control (>9%).

PARTNERS

New York City Department of Health and Mental Hygiene's Health Bucks, New York City Farmer's Green Market, local food pantries, including The Salvation Army in Woodside, Lutheran Church Food Pantry in Jackson Heights and St. Mary's Church in Woodside.

OUTCOMES

- As of December 2021, Elmhurst's adult primary care diabetic population had a diabetes control rate of 67% (A1C<8%), an improvement of over 11% from March 2021's baseline of 56%.
- Insurance-based inequity was reduced from a 4% control rate gap in March 2021 to a 2% control rate gap in December 2021.
- The hospital developed strong relationships with community-based organizations, including three food pantries that provide ongoing support and collaboration for its chronic disease programs.

LESSONS LEARNED

- Providers should assess patients for their barriers, needs and social determinants of health to identify care gaps.
- Working with patients and family members on education and nutritional adjustments made it easier for patients to follow the appropriate nutritional guidance while maintaining a satisfying cultural diet.
- Partnering with the city and local organizations to promote healthy eating options and access to food was key.

SUSTAINABILITY

Elmhurst's collaborative care for diabetes continues to connect patients with food pantries and other local organizations that provide access to healthy foods. For diabetic patients who need to get into or stay in control of their disease, Elmhurst hired clinical pharmacists and community health workers to further improvements, such as medication adjustments by PharmDs or CHWs, navigating social determinant gaps and supporting patients with food insecurities.

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ONEIDA HEALTH Fit Kids of Madison County

INITIATIVE DESCRIPTION AND GOALS

In 2013, a body mass index study showed that Madison County youth prevalence of obesity was increasing; 37% of children between the ages of 12 and 19 and 45% of kids ages two to five were classified as obese and/or overweight. Oneida Health and the YMCA created a collaborative program of fitness and nutrition education for middle school-aged children, modeled after the successful Fit Kids of Arizona program.

Oneida Health and the YMCA collaborated with school districts for referrals of potential program participants and transportation after school via bus to the YMCA campus in Oneida. In addition, the program engaged parents and caregivers in discussions on nutrition, cooking, portion control, physical activity and barriers to offering healthy meals to their children. This provided program staff opportunities to mold the program around barriers and issues that families and caregivers faced.

The Oneida Health Foundation held two annual fundraisers to specifically support the Fit Kids Program. They collaborated with DOH and other funders/donors to raise funds, and contracted with health insurance companies and community foundations to assist with overall costs.

PARTNERS

Oneida Health Foundation, Tri-Valley YMCA, Excellus BlueCross BlueShield, Central New York Community Foundation, Madison County Health Department, Oneida public school districts and community donors and stakeholders.

OUTCOMES

The top three outcomes of the program were:

- *Fitness/physical activities:* Increased the number of hours that youth are engaged in aerobic and physical fitness.
- *Nutrition:* Informed students and families/caregivers about the importance and long-term outcomes of eating nutritious and balanced meals as it relates to obesity, chronic illness and morbidity in youth over time.

- *Expanding the number of students/schools involved in program:* In 2013, 12 students were actively enrolled in the program. In 2019, 42. Now, Madison County is funding part of the program to increase the total in 2022-2023.

LESSONS LEARNED

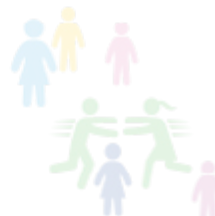
- Transportation is necessary for youth to participate in an after-school program in an area that is rural and facing poverty. Therefore, the school district or other forms of transportation should be secured.
- Obesity has a familial and generational tie. Therefore, it is imperative for the family to be engaged and involved to successfully aid the youth participants.

SUSTAINABILITY

Initial sustainability was driven by those who saw the need and built the program for the community. Since 2013, continued sustainability, expansion and growth came with proven documented data and outcomes regarding the health of the youth participating and through seeking additional funds through collaboration and external funding opportunities. This year, the Madison County Youth Bureau is providing funds to assist additional school districts in joining the program.

CONTACT

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ST. JOHN'S EPISCOPAL HOSPITAL Mobile Health Outreach Program

INITIATIVE DESCRIPTION AND GOALS

St. John's Episcopal Hospital launched the Mobile Health Outreach program in 2017 to improve community health by providing blood pressure screening, immunizations, nutritional counseling and sharing health-related resources. In 2020, the program successfully upgraded its mobile health unit and expanded services to include free cholesterol, glucose and lipid profile tests; COVID-19 vaccinations and prevention education; depression screenings; nutritional counseling; pre-diabetes risk tests; social needs screenings; and care referrals.

The clinical staff for the program include physicians, registered nurses, social workers, registered dietitians, patient navigators, community health workers and other healthcare providers. The program goals are to:

- address health disparities such as food insecurity and medical transportation;
- enhance access to care;
- improve vaccination rates;
- provide preventive screenings and tests; and
- offer health education, nutritional counseling and health-related resources.

The program directly supports the New York State *Prevention Agenda* focus area to prevent chronic diseases; specifically, to increase early detection of cardiovascular disease, diabetes, prediabetes and obesity.

PARTNERS

Five Towns Community Center, Ocean Bay CDC, New Hope Baptist Church, Services for the Underserved, Far Rockaway/Arverne Nonprofit Coalition and Church of God, RISE Life Services, New Hope Baptist Church, NHCC, Sheltering Arms, FBNYC, New York City Housing Authority-Hammel's, Carlton Manor, 54th Street, 41st Street, Redfern Hassock Street, REMA4US, Sickle Cell Awareness Foundation, Bethel AME Church, Macedonia Baptist Church, First Baptist Church, First Congregational Church of Rockaway Beach, The Child Center of New York, Epicenter, Relume Foundation, Challenge Charter School, Amani Men's Shelter, Police Athletic League, Far Rockaway Educational Campus, Peninsula Preparatory, The Campaign Against Hunger, Queens Defender, YMCA, Rockaway Development and Revitalization Corporation, Precinct 101, Rock Safe Street, Catholic Charities and Queens Royal Priesthood.

OUTCOMES

The Mobile Health Outreach program:

- administered pre-diabetes risk screening to 744 people, identified 110 individuals with risk of diabetes and pre-diabetes and provided them with resources and education to improve their literacy level, and made referrals to a primary care physician;
- provided blood pressure screenings to 1,100 people, identified 450 with high blood pressure and provided them with resources and education to improve their self-management skills to better manage their condition; and
- administered glucose, lipid and cholesterol tests to 247 people, identified 105 people at risk of cardiovascular disease and provided them with resources and education, and made referrals to further care.

LESSONS LEARNED

- Improving health literacy and helping people access and manage resources for their healthcare needs is essential to community health.
- Strategic partners who share a similar vision and mission are key to serving the community and improving health outcomes.

SUSTAINABILITY

The program's sustainability is supported by:

- increased collaboration with community-based organizations, precincts, schools and churches;
- strengthening partnerships with elected officials in the catchment area;
- identifying grant opportunities to expand the program;
- continued support of hospital leadership and donors; and
- addressing community needs by expanding services to include sickle cell and Hepatitis C screening, lifestyle medicine and hearing tests.

CONTACT

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SAINT JOSEPH'S MEDICAL CENTER Westchester County's Comprehensive Crisis Response Initiative

INITIATIVE DESCRIPTION AND GOALS

The Saint Joseph's Medical Center/St. Vincent's Hospital Westchester Division crisis prevention and response team collaborated with emergency services organizations and government agencies to develop and staff a Westchester-based suicide prevention and crisis response center. The response center handles Westchester calls to the 988 Suicide Prevention and Crisis Response Lifeline and the county's 911 diversion program.

The goal of the initiative is to create a comprehensive crisis response system that will connect New Yorkers to trained, local crisis counselors to provide emotional support and assistance for behavioral health crisis and suicide prevention, and provide connections to services in the community for support and recovery. This initiative supports the "Promote Well-Being and Prevent Mental and Substance Use Disorders" action plan of the New York State *Prevention Agenda*.

PARTNERS

New York State Office of Mental Health, Westchester County Department of Community Mental Health, Westchester Community Foundation, Westchester County Executive's office, Westchester Department of Public Safety, Westchester Department of Social Services and Westchester Department of Emergency Services.

OUTCOMES

The crisis prevention and response team:

- coordinates with local police and emergency services in "active rescue" situations to ensure the caller is located and transported to a hospital for follow-up: seven active rescues were completed from January to May 2022;
- provides follow-up to callers who request it: the team achieves an average of 70% of callers linked to community support; and

- expanded staffing to allow for coverage 24 hours a day, 365 days a year. Active recruitment is underway, but is challenging due to the impacts of COVID-19. The center is currently staffed by the crisis prevention and response team Monday through Sunday from 7:30 a.m. to 10 p.m., with St. Vincent's staff providing overnight telephone coverage.

LESSONS LEARNED

- The lifeline links anyone with a Westchester area code (914) to the CPRT, including callers who may be in other states or countries. The team has had to greatly expand its contacts to include police, emergency services and local crisis services in locations outside Westchester County.
- Recruitment challenges are ongoing. Active recruitment of licensed clinical staff, volunteers and interns is underway to support the suicide lifeline.

SUSTAINABILITY

New York state and Westchester County have demonstrated a significant funding and operational commitment to providing comprehensive crisis services. The medical center is optimistic that this model is sustainable.

CONTACT

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ST. MARY'S HEALTHCARE

Paid Time Off for Cancer Screening

INITIATIVE DESCRIPTION AND GOALS

The Cancer Prevention in Action initiative at St. Mary's Healthcare began in 2018 and works to prevent cancer in the community through organizational partnerships that promote policy, systems and environmental changes that take action against cancer. CPIA helps community partners adopt their own cancer screening paid time off to increase workforce health and reduce healthcare costs.

The program builds awareness that, through regular cancer screenings, breast, cervical and colon cancer can be found early or prevented. A cancer screening PTO benefit is offered to employees in addition to their regularly afforded time off. This program addresses the "Prevent Chronic Disease" priority area of the New York State *Prevention Agenda* by increasing cancer screening rates.

PARTNERS

Amsterdam Fire Department, Capital Region Chamber of Commerce, City of Gloversville, Resource Center for Independent Living, Gloversville Water Works, Centro Civico, Montgomery County Cares Coalition, Amsterdam Department of Public Works, Catholic Charities, HFM Prevention Council, FullMont Community Action, Wolf Hollow Brewing Company, Back Barn Brewing Company, City of Amsterdam, Schenectady Coalition for a Healthy Community, Fulton Montgomery Regional Chamber of Commerce, Schenectady County Public Health and the Gloversville Transit System.

OUTCOMES

- The CPIA program at St. Mary's Healthcare has successfully implemented eight PTO for cancer screening benefits programs with partner organizations.
- St. Mary's Healthcare is the first hospital in New York to offer the PTO for cancer screening benefit to its associates. The team has provided 53 educational sessions with 1,395 people in attendance and has had 75 pieces of earned media circulated with a reach of more than 300,000 community members.

LESSONS LEARNED

- Once the paid time off for cancer screening policy is implemented, it is critical to publicize and promote the benefit and provide educational materials on cancer screenings to encourage employee use of the new benefit.
- Obtaining information on employee benefit use or cancer screening rates can be challenging.
- The CPIA team learned to build partnerships early with human resource departments, payroll departments and health plans to assist with the impact on employer policies.

SUSTAINABILITY

A dedicated bank of time for regular cancer screenings improves workforce health, maintains staff engagement and retention, reduces healthcare costs and, most importantly, may save lives. Sustainability can be achieved by encouraging employees to use the new leave time and providing educational materials on breast, colorectal and cervical cancer screenings and the benefits of early detection.

CONTACT

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ST. PETER'S DIABETES AND ENDOCRINE CARE Diabetes Prevention Program

INITIATIVE DESCRIPTION AND GOALS

Type 2 diabetes increases your risk for complications from COVID-19. Since 2017, St. Peter's Diabetes and Endocrine Care has been a subgrantee of a CDC grant for scaling the national diabetes prevention program in underserved areas. Priority populations are men and participants who are 65 years of age and older.

The program is led by a trained lifestyle coach who provides a supportive, group atmosphere. During the year, the group learns how to eat healthier, fit activity into their daily life, cope with triggers and stress and much more.

The program aims to help participants lose 4% to 7% of their weight and increase activity to 150 minutes or more a week. These two goals have been proven to prevent or delay the onset of Type 2 diabetes in individuals who have prediabetes or who are at risk for Type 2 diabetes.

PARTNERS

St. Peter's Health Partners, St. Peter's Health Partners Medical Group, Innovative Health Alliance of New York and Albany County Department of Health.

OUTCOMES

- 57 participants have enrolled in the last six months.
- A total of 650 pounds have been lost.
- Partnerships formed with Innovative Health Alliance of New York providers and Albany County Department of Health have helped spread awareness.

LESSONS LEARNED

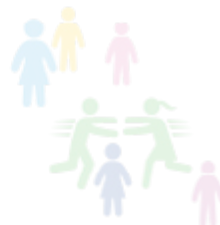
- Integrating the Diabetes Prevention Program into electronic medical records has increased referrals.
- Identifying and solving technology barriers has helped participants enroll and remain engaged.

SUSTAINABILITY

Medicare Part B beneficiaries are able to participate in the program at no cost and St. Peter's can receive revenue by providing the program. The hospital is also forming lasting relationships with community organizations to help scale and spread prevention of Type 2 diabetes.

CONTACT

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THE BROOKLYN HOSPITAL CENTER

Diabetes Care Management

INITIATIVE DESCRIPTION AND GOALS

The goals were to:

- improve HgbA1C compliance for the diabetic population;
- provide education and support to diabetic patients through a mindful program that provides easy access, chronic disease management and nutritional guidance; and
- reduce HgbA1C to 8 or below and, concurrently, positively affect weight, blood pressure and sustainability.

New means of engagement included virtual visits, preventive screenings and Zoom education.

PARTNERS

Patients, community advisory board, professional interdisciplinary staff and support staff.

OUTCOMES

- Out of 276 patients, 57 have graduated so far by successfully maintaining their hemoglobin below 8 for more than six months.
- Average weight loss was 5.2 pounds.
- Brooklyn Hospital Center was number one among HealthFirst participating hospitals for HgbA1C less than 9 for 2021.

LESSONS LEARNED

- Recording nutritional and education sessions for on-demand access made it easy for patients. Hosting virtual nutrition groups and having recordings expanded participation to other sites not yet active with the program.
- Interdisciplinary team huddles prior to the session start, outreach and engagement between visits and treating the endocrinology sessions as a shared medical appointment (individual physician visits and group education while waiting) were well received.

SUSTAINABILITY

Electronic medical record modifications, structured data fields, staff education, continuous monitoring, data collection and incorporating outcomes and results into a “report card” helped engrain the process into the culture.

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UNITED HEALTH SERVICES HOSPITALS

Hospital Care at Home

INITIATIVE DESCRIPTION AND GOALS

The Hospital Care at Home initiative was born from necessity in January 2021 as a result of the COVID-19 pandemic. United Health Services Hospitals determined that inpatient hospital capacity was critically low. An internal needs assessment revealed that capacity could be created within the hospitals by shifting the location of care for a certain cohort of patients to the outpatient community setting at home with the support of virtual healthcare. The model consists of a combination of provider and nurse navigation encounters delivered via virtual healthcare platforms to support the recovery process through medical management, as well as improve the ability of the patient to better self-manage their own future disease state within the home setting through education.

Since this program is targeted to adult-aged patients currently admitted to the hospital for an exacerbation of an underlying chronic disease, the health system is providing tertiary and quaternary public health prevention to the community by improving clinical outcomes, reducing associated sequelae and preventing over-medicalization by treating patients in the most appropriate care location.

This initiative supports the New York State *Prevention Agenda* priority area of preventing chronic diseases.

PARTNERS

In collaboration with Endwell Family Physicians, a non-affiliated community provider of primary care services, a model of community-based care was developed. Further, success was achieved through the development of an internal network of organizational resources provided by physician leaders, nursing care management, population health and medical education staff. The partnership and sharing of resources across independent reporting structures resulted in the ability to plan and implement the program in a matter of weeks. The inclusion of medical education, specifically the internal medicine residency program, allowed for program operational success and new physicians to gain hands-on training in the delivery of community-based care.

OUTCOMES

The larger vision for this program is for patients to better manage their own chronic diseases and reduce their need for hospitalization. Qualitative feedback provided by patients has been positive. Common themes include that they feel safer being back in their home post-hospitalization and better empowered to manage their chronic disease state moving forward. For those on the program, the rate of return to the emergency department was 2.5%, the rate of hospital readmission was 3.5% and the rate of 30-day readmission was 11.2%.

LESSONS LEARNED

- This initiative gave staff a renewed sense of intra-organizational collaboration for the benefit of patients and the community.
- Positive qualitative feedback from patients and the early quantitative findings are encouraging staff to continue to grow and develop this offering with a vision toward the future in which this program will be the routine pathway through which all patients from UHS hospitals are transitioned back to their home environment.

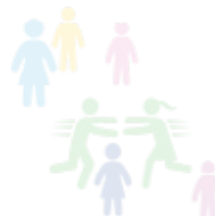
SUSTAINABILITY

This program is financially sustainable because it generates revenue through the virtual visits with providers. With the business case established, UHS can continue the program as long as clinical outcomes, population health level results and feedback from patients on their subjective experience of care remain favorable.

CONTACT

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UPSTATE CANCER CENTER

She Matters Increases Mammography Screening During COVID-19 Among Syracuse Public Housing Women of Color

INITIATIVE DESCRIPTION AND GOALS

She Matters was created in 2014 to promote health equity in Syracuse public housing communities that experience disparities. The peer-to-peer program provides a trusting connection and bridge between Syracuse Housing Authority residents and Upstate University Hospital.

The pandemic increased mammography screening delays due to job loss, lack of transportation options during stay-at-home orders and anxiety due to continually changing information about COVID-19. To combat these issues, She Matters implemented a wait list for first priority patients when screening resumed, including women whose annual appointments landed between March and July 2020, when the imaging center was closed.

She Matters continued to make personal phone calls to check in with patients and engage with the residents of Syracuse Housing Authority in different ways such as hosting virtual events, mailing newsletters and volunteering during pandemic relief efforts.

PARTNERS

Syracuse Housing Authority.

OUTCOMES

She Matters saw a 7.7% increase in mammography screening in 2021 compared to 2020. More than 30% of participants have demonstrated behavior change. New participants have increased each year, from 21 in 2019 to 26 in 2021.

LESSONS LEARNED

Trust and patience: The relationship with the community is what will ultimately make people feel safe enough during a pandemic to show up for appointments. You need to have the willingness to reschedule as many times as needed until they show.

SUSTAINABILITY

She Matters is grant-funded; Upstate has received funding for the past eight years and has funding covered until 2024.

CONTACT

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VASSAR BROTHERS MEDICAL CENTER Greater Poughkeepsie Community Care Team

INITIATIVE DESCRIPTION AND GOALS

More than a third of City of Poughkeepsie's residents are from historically marginalized populations. The COVID-19 pandemic has only amplified barriers to care and social determinants of health for the community's vulnerable populations. Over 50% of Community Care Team clients face substance abuse and/or mental health challenges, and 25% or more have complex medical conditions and/or struggle with homelessness.

The Poughkeepsie CCT leverages the power of a community-based anchor institution to mobilize cross-sector partnerships that collaboratively address multiple New York State *Prevention Agenda* priorities, including chronic disease prevention and management, prevention of substance misuse and death, and interventions that increase well-being and facilitate supportive environments that promote respect and dignity for at-risk populations.

The approach to care begins by identifying community residents in need of wraparound care services, either through frequent hospital emergency department services utilization or direct referral by CCT stakeholders. A signed release form authorizes CCT partners to share protected client health information to facilitate care planning at regularly scheduled meetings. A high-risk CCT navigator facilitates ongoing coordination of CCT care plans.

PARTNERS

Council on Addiction Prevention and Education of Dutchess County, City of Poughkeepsie Police Department, Dutchess County Department of Community and Family Services/Adult Protective Services, Dutchess County Department of Health, Dutchess County Mobile Crisis Team, Hudson River Housing, Hudson Valley Community Services, Mental Health America of Dutchess County, New York Medication for Addiction Treatment and Electronic Referrals, Nuvance Health, People USA/Dutchess County Stabilization Center, Sun River Health, Town of Poughkeepsie Police Department, Vassar Brothers Medical Center and 60+ additional partners.

OUTCOMES

- This initiative created a robust community framework for collaborative care planning for high-risk populations, enhancing hospital and community communication and collaboration, and strengthening data collection to inform and catalyze growth, innovation and cross-sector decision-making.
- The CCT fosters interdisciplinary collaboration with the hospital system to reduce internal/external treatment silos and strengthen the community's public health infrastructure.
- More than 40 collaborative care plans were created since October 2021, facilitating 18 CCT client connections to primary care, 15 to case management, 15 to behavioral health treatment and eight to substance abuse treatment.

LESSONS LEARNED

- Cross-sector collaboration is necessary to improve health outcomes and quality of life for at-risk community populations who do not improve with a traditional model of "episodic" care delivery.
- The CCT treatment model has proven successful in improving social determinants of health and health outcomes for vulnerable populations but must be tailored to existing community resources and needs to maximize stakeholder collaboration, coordination and impact.

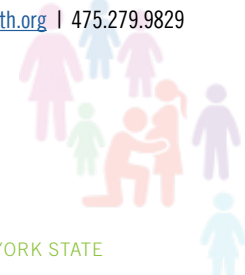
SUSTAINABILITY

Vassar Brother Medical Center strives to advance organizational sustainability through initiatives that improve the quality and efficiency of care while reducing unnecessary costs. In a healthcare era increasingly focused on prevention and population health, VBMC serves as a lead change agent in leveraging community resources, expertise and activities that improve health outcomes. CCT stakeholders promote cross-sector collaboration as the "new normal," ultimately enhancing each agency's identity, mission, success and long-term sustainability in pursuit of community health equity.

CONTACT

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WHITE PLAINS HOSPITAL

WPH Cares: Bridging the Gap in Care for Our Community

INITIATIVE DESCRIPTION AND GOALS

The mission of WPH Cares is to provide data-driven, innovative solutions that ensure patients have access to services when they need them. The program leverages hospital and community resources to decrease hospital readmissions and emergency department utilization by empowering patients to get proactive about monitoring and managing their health.

In addition, WPH Cares aims to improve patient access to primary care and ultimately improve patients' overall healthcare experience. WPH Cares looks to be a bridge between inpatient and ambulatory settings for patients discharged home, while also improving chronic disease management.

Through the WPH Cares model, the Clinical Outreach team coordinates with inpatient teams and follows high-risk patients with diagnoses such as congestive heart failure, chronic obstructive pulmonary disease and pneumonia. The team monitors and coordinates patient care with an ambulatory team, along with community partners and local organizations to prevent hospital readmissions.

WPH Cares aligns with the New York State *Prevention Agenda* "Chronic Disease Preventive Care and Management" priority area.

PARTNERS

The United Way, Grassy Sprains Pharmacy, White Plain's Hospital Family Health Center, Visiting Nurse Service of New York, Visiting Nurse Service of Westchester, EMPRESS Community Paramedicine, Scarsdale Volunteer Ambulance Corporation's community paramedicine division, Memorial Sloan Kettering transitional care and WPH inpatient care managers.

OUTCOMES

- The program has assisted Medicare readmission reduction from 14.8% in 2018 to 11.2% in 2022, as well as a total "all cause" readmission rate of 12.7% in 2018 to a current rate of 9.4%.
- CHF readmission rates for Medicare decreased from 20.4% in 2018 to 9.3% currently. Pneumonia readmission rates declined from 16.8% to 14.6% over the same time period.
- The tele-clinical pharmacy, initiated in 2021, enrolled 900 patients; compared to the match cohort, it found an 8.8% decrease in readmission and an 8.1% decrease in ED visits. Among patients with CHF, the decrease was more profound, demonstrating a 46.7% reduction in readmission and a 37.5% decrease in ED visits.

LESSONS LEARNED

- While some programs are built in silos, it became clear that resources need to be coordinated for maximal patient impact. This care coordination lesson was then directed at improving some of the most challenging chronic diseases.
- Regular meetings with community partners were essential to sharing key community resources and identifying barriers to care.

SUSTAINABILITY

The key to sustaining and expanding this program is through participation in the evolving value-based care model. Through this model, efforts at reducing hospital readmissions and ED visits have not only had a positive financial impact on the organization, but more importantly, have provided patients with the tools necessary to proactively manage their health.

CONTACT

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HANYS Celebrates Previous Community Health Improvement Award Winners

2021	Northwell Health <i>Advancing Health Equity through Community-based Partnerships to Fight COVID-19</i>	2008	Jamaica Hospital Medical Center <i>Palliative Care Collaborative</i>
2020	UR Medicine–Jones Memorial Hospital, Wellsville <i>Promotion of Healthy Life Styles</i>	2007	Rochester General Hospital, Clinton <i>Family Health Center</i>
2019	Montefiore Medical Center, Bronx <i>Healthy Food Initiative</i>	2006	Ellis Hospital/Northeast Health (Samaritan Hospital and Albany Memorial Hospital)/ St. Peter's Health Care Services/Seton Health System, Schenectady/Albany/Troy <i>Seal a Smile: A Children's Oral Health Initiative</i>
2018	Unity Hospital–Rochester Regional Health <i>Healthy Moms</i>	2005	Strong Memorial Hospital/University of Rochester Medical Center <i>SMILEmobile Dental Office on Wheels</i>
2017	Schuyler Hospital, Montour Falls <i>Healthy Eating Active Living (HEAL) Schuyler</i>	2004	NewYork-Presbyterian/Columbia University Medical Center <i>Breast and Cervical Cancer Screening Partnership</i>
2016	Strong Memorial Hospital, Highland Hospital (UR Medicine)/Rochester General Hospital, Unity Hospital (Rochester Regional Health) <i>High Blood Pressure Collaborative – Hospital Partners</i>	2003	St. John's Riverside Hospital, Yonkers <i>School-based Asthma Partnership</i>
2015	Bassett Healthcare Network, Cooperstown <i>School-based Health/Oral Health Program</i>	2002	Strong Memorial Hospital, Rochester <i>Project Link</i>
2014	Bassett Medical Center, Cooperstown <i>Cancer Screening Outreach – Medical Screening Coach</i>	2001	Canton-Potsdam Hospital/Claxton-Hepburn Medical Center, Potsdam and Ogdensburg <i>St. Lawrence County Health Initiative</i>
2013	Arnot Health at St. Joseph's Hospital, Elmira <i>Chemung County School Readiness Project</i>	2000	Harlem Hospital Center, New York City <i>Injury Prevention Program</i>
2012	Sound Shore Medical Center, New Rochelle <i>Outpatient Pediatric Immunization Center</i>	1999	Women's Christian Association Hospital, Jamestown <i>Women's Health Initiative</i>
2011	Catholic Health Services of Long Island, Rockville Centre <i>The Healthy Sundays Program</i>	1998	United Health Services, Binghamton <i>Pediatric Asthma Program</i>
2010	Brookdale University Hospital and Medical Center, Brooklyn <i>Live Light...Live Right Childhood Obesity Program</i>	1997	St. Mary's Hospital/Unity Health System, Rochester <i>HealthReach Program</i>
2009	Strong Memorial Hospital/University of Rochester Medical Center <i>Health-e-Access Telemedicine Network</i>		

