CONNECTING WITH COMMUNITIES:

Community Health Initiatives Across New York State

2024 EDITION

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Thank you to our 2024 reviewers

Rachael Brust, MBA, project manager, Advancing Healthcare Excellence and Inclusion, HANYS

Nancy Zuech Lim, director, community health improvement, Catholic Health Association of the United States

Priti Irani, MSPH (retired), former research scientist, Office of Public Health Practice, New York State Department of Health

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*, emphasize the importance of health equity, demonstrate leadership, collaborate among diverse groups and achieve quantifiable results.

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CONNECTING WITH COMMUNITIES:
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HANYS is pleased to present the 28th edition of *Connecting with Communities: Community Health Initiatives Across New York State*. This publication highlights the winner of and nominations for HANYS' 2024 Community Health Improvement Award.

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

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

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.

SBH HEALTH SYSTEM

SBH Health and Wellness Center

2024 AWARDEE

INITIATIVE DESCRIPTION AND GOALS

Severe health disparities persist in the Bronx at the borough and neighborhood level, fueled by structural barriers like unequal income, inadequate housing, food insecurity, limited safe spaces for exercise and safety concerns. To tackle these challenges, SBH Health System spearheaded an innovative project that transformed a parking lot into a health and wellness center.

The initiative addresses housing disparities by constructing low-income housing units and providing support services. It promotes health through an urban rooftop farm selling discounted produce, engaging students in healthy food and nutritional education, and offering affordable cooking classes. Additionally, the Center integrates healthcare with wellness initiatives, offering prevention programs and addressing chronic disease management. Collaborations with community groups and NFL teams enhance these efforts.

In addition, a gun violence prevention boxing program provides at-risk youth with a supportive environment for skill building and conflict resolution. These initiatives align with New York State *Prevention Agenda* goals focusing on chronic disease prevention, healthy environments and violence prevention.

PARTNERS

Bronx Partners for Healthy Communities, Bronx Rises Against Gun Violence, BronxWorks, Envision Architects, Food Bank For NYC, Good Shepherd Services, Healthplex Fitness, Hornig Capital Partners, L&M Development Partners, Lantern Community Services, New York Police Department, New York Giants, New York Jets, NK Architects, New York City Council, New York City Department of Health and Mental Hygiene, Office of the New York City Mayor, New York State Department of Health and Project Eats.

OUTCOMES

SBH Health System's initiatives have significantly impacted community health, reducing disparities and advancing equity.

- All 314 affordable housing units were fully occupied, with 94 units reserved for the formerly unhoused.
- Physical activity programs resulted in a 1.18 reduction in Body Mass Index and strength gains of 30% to 35%. Students demonstrated a 41% increase in nutrition understanding, leading to healthier food habits, including a 500% increase in fruit and vegetable consumption.
- Gun violence prevention participants showed a 280% increase in de-escalation skills within three months.

LESSONS LEARNED

Strategic partnerships with aligned organizations are vital for success. By collaborating with partners who possess specialized expertise, SBH was able to anticipate potential issues and approach problem solving in practical ways.

This initiative emphasizes the importance of engaging the community and participants as integral members of the team. SBH recognizes that people are most inspired to enact change when they personally believe in its importance.

SUSTAINABILITY

Patient engagement and teamwork are vital for initiative sustainability. SBH prioritizes ongoing involvement and collaboration among stakeholders to ensure lasting impact. Sustainable funding, from hospital budgets and value-based contracts, supports cost-effective approaches. Advocacy for policy reform, such as Medicaid reimbursement for wellness activities, promotes long-term success.

CONTACT

Alvin Lin, Vice President, Ambulatory Care Transformation and Innovation
alin2@sbhny.org | 718.960.6836

2024 SUBMISSIONS

2024 SUBMISSIONS

ALBANY MEDICAL CENTER

The Health Equity Project

INITIATIVE DESCRIPTION AND GOALS

The Health Equity Project aims to address issues regarding social determinants of health through resource connection. The health system works with partnered sites to screen families for SDOH and connect them with community resources, ultimately improving health outcomes. Families are screened for needs such as food security, housing, environmental concerns, transportation, counseling, insurance, clothing and tobacco cessation.

The initiative supports *Prevention Agenda* priority areas including "Prevent Chronic Diseases" (healthy eating and food security, tobacco prevention), "Promote Healthy Women, Infants, and Children" (perinatal and infant health, child and adolescent health) and "Promote Well-Being and Prevent Mental and Substance Use Disorders" (well-being of parents and children).

PARTNERS

Center for Law and Justice, Albany Medical Center General Pediatrics and Youth L.I.F.E Support Network, Inc. Additionally, Albany Medical College offers programs to expose medical students to community needs, emphasizing the role of community service in understanding and addressing social barriers to tailored care.

OUTCOMES

- From 2022 to 2023, referrals for health system navigation services drastically increased and issues related to housing concern increased by over 50%.
- In 2023, the Health Equity Project team reviewed 2,848 outpatient screening forms from families and individual community members who resourced the program collaborators for care.
- The project successfully contacted 74% of clients in 2023. The lost to follow-up rate decreased from 14% in 2022 to 8% in 2023.

LESSONS LEARNED

When working with vulnerable populations, it is essential to establish trust by empathizing with their perceptions of their needs, often setting aside organizational roles. While it's easy to assume needs out of good faith, this project consistently demonstrates that experience is the best teacher. It underscores the importance of listening and learning from those affected by SDOH to effectively address their needs.

Crucial work remains at the structural, state and federal levels to ensure SDOH are not only discussed but actively addressed through policies, systems and organizational efforts aimed at eradicating its impact.

SUSTAINABILITY

The project, funded by a philanthropic grant, is sustained by two full-time employees: the director of community engagement and service learning and an administrative coordinator. They work alongside medical students, School of Public Health interns, resident physicians and clinical staff to drive the initiative's goals, ensuring the program's sustainability.

CONTACT

Alice A. Antwi, Director, Service Learning and Community Engagement
antwia@amc.edu | 518.262.4765

ARNOT HEALTH

Arnot-Chemung County-EOP-LECOM Clinic

INITIATIVE DESCRIPTION AND GOALS

In 2017, Common Ground Health presented a community health assessment about the City of Elmira that highlighted concerns about the aging housing stock in the city, specifically in neighborhoods of concentrated poverty and racial diversity. Not surprisingly, Chemung County's lead exposure levels were among the highest in the state, with 11% of children showing elevated lead exposure as opposed to the 4% statewide average.

The significance of this level of lead exposure — which can lead to many health concerns, including decreased learning and cognitive abilities — was not lost on the Economic Opportunity Program, Inc. and Arnot Health. EOP's Head Start enrollment data showed that half of the area children enrolled in its program had not been tested for lead exposure.

Together, the organizations convened a broader coalition with Chemung County Public Health, Excellus BlueCross BlueShield, the City of Elmira and the Lake Erie College of Osteopathic Medicine, which had recently established an Elmira campus. The result was the formation of the Arnot-Chemung County-EOP-LECOM clinic.

The ACCEL Clinic, which held its ribbon cutting in November 2021, was initially developed to screen children and their family members for lead exposure and connect impacted individuals with appropriate medical interventions as quickly as possible to mitigate future adverse health outcomes.

PARTNERS

Chemung County Public Health, Excellus BlueCross BlueShield, the City of Elmira, LECOM and EOP.

OUTCOMES

Since May 2022, the ACCEL Clinic has:

- provided more than 872 total health screenings, including blood pressure screenings;
- screened 394 people for lead exposure;
- achieved lead exposure rates that are more aligned with overall New York state numbers, with a demonstrated drop from the clinic's first calendar year of operation, when nine of 135 individuals (6.5%) had elevated levels, to the current year-to-date total of 2.2% of those screened showing elevated levels;
- offered onsite access to lead screenings to 100% of EOP's Head Start enrollees;
- increased the percentage of children screened from 50% at the clinic's inception to nearly 75% as of January 2024; and
- expanded services to elementary-aged children (5-12 years old) in EOP's after-school program.

LESSONS LEARNED

The success of this endeavor is in large part attributable to EOP's well established reputation among Elmira's marginalized and low-income population. By offering lead testing through EOP, a site where families are accustomed to visiting for a range of services, the Clinic falls under EOP's "umbrella of trust."

With no ramp-up in credibility needed, and by taking a "build it where they already come" approach, the program has been able to introduce nutrition-based interventions and plan for other high-impact health screenings relevant to the target population.

SUSTAINABILITY

LECOM has reiterated its commitment to supply medical students to staff the Clinic. Since providing the Clinic's initial funding, Excellus has committed an additional $30,000 through its 2023 Health Equity Innovation Award to support continued operations.

DOH granted EOP $49,000 to increase education and outreach on COVID-19, nutrition, lead prevention, mental health and other SDOH strategies.

The ACCEL Clinic has also inspired and provided a proven platform for these and a number of other new community health initiatives.

CONTACT

Kenneth J. Roberts, System Director, Marketing, Communications and Community Relations
kenneth.roberts@arnothealth.org | 607.795.8105

BASSETT HEALTHCARE NETWORK

Ambulatory Intensive Pharmacotherapeutics: Improving the Health and Well-Being of Communities

INITIATIVE DESCRIPTION AND GOALS

Bassett Healthcare Network's Ambulatory Intensive Pharmacotherapeutics Program is an active and ongoing population health initiative that has evolved since 2016. Recognizing the need to reduce poor outcomes for patients involving medication management, the Bassett team provides reconciliation and optimization of complex medication regimes through chart reviews, patient consultations, provider support and guidance.

Staff education provides current and up-to-date information while promoting the team approach for patient management. The goals are to reduce hospitalizations and improve cost effectiveness of care while maintaining the primary focus of improving patient care across the health equity spectrum.

PARTNERS

Providers in over 28 primary care clinics, a certified home health agency, hospice and palliative care, care management, age-friendly work group, and the diabetes education and management clinic.

OUTCOMES

The AIP program has been operating in varying capacities since 2016. In 2020, the program received external funding through a partnership with a managed care provider, allowing the team to expand from one clinical pharmacist to three and add a dedicated data analyst. From 2016 to 2024, the following three measurable outcomes highlight the success of the AIP initiative:

- Staff reviewed 4,480 patient charts; of these, 2,517 resulted in 6,752 clinical pharmacy interventions.
- Of the 6,752 interventions sent to prescribers, 3,300 have been implemented so far.
- The program has saved an estimated $5.8 million (~$1,757 per intervention).

LESSONS LEARNED

The need for this service was not only the impetus for the program inception, but also one of the driving forces behind its success and continuation. The multipronged approach has proven to be extremely beneficial in the comprehensive care of patients within the communities Bassett serves. This is evident by the positive impact of medication interventions.

Another lesson is the provider support and relationship building the AIP team has accomplished. The team is a valuable resource in the management of patients.

SUSTAINABILITY

The ability to sustain this program relies on established relationships with Bassett's managed care partners, utilizing value-based processes and payments. In addition to continuing this revenue stream, the AIP team is exploring the ability to maximize billing through CMS for services rendered. Additional funding is being researched though grants and potential other funding streams.

CONTACT

Leonard Lindenmuth, Vice President, Population Health and Strategy
leonard.lindenmuth@bassett.org | 607.322.5150

CAYUGA HEALTH SYSTEM

Community Health Resource Network

INITIATIVE DESCRIPTION AND GOALS

As Cayuga Health has worked to grow its population health efforts, it became obvious that health-related social needs were a main driver of health outcomes. Cayuga Health has begun to build partnerships between its providers, community-based organizations, academic partners and local government to address health-related social needs. Its intention is to move beyond simple coordination with community partners to collaboration, with a goal of health and social care integration.

Cayuga Health's providers know that unmet social needs are major drivers of adverse health outcomes. They want to connect their patients with community resources but had not had an effective way to do this. Through patient focus groups and conversations with a community advisory board, the health system learned that patients believe that their providers are not aware of the factors that are influencing their health. They want their providers to ask about their social needs, offer support and adjust how they provide care.

Having a better understanding of both provider and patient perspectives, Cayuga Health was able to establish a commitment to standardize its approach to addressing unmet social needs among all patients by screening for and responding to health-related social needs. This program started a multi-year process in 2021, working closely with the internal medicine residency program, several CBOs and Cornell's Center for Health Equity. They used Health Leads' social needs screening toolkit to customize the health system's first standardized social needs screening tool.

Cayuga's aim was for it to be short, with eight questions that cover food, utilities, housing, childcare, finances, transportation, health literacy and social support. Cayuga also selected questions written at a fifth-grade reading level whenever possible. This universal screening was given to all patients at their annual well visit. The team also created a community resource brochure so that when patients identified an unmet social need on the screening form they'd know what is available and had a number to call.

While this screening tool and brochure were a significant improvement, Cayuga Health recognized that self-referrals were not as effective as warm hand-offs and supportive contacts. However, the practices did not have sufficient staff resources to provide this necessary level of support. The team knew that to support patients and connect them with needed services, the health system had to expand the pilot to facilitate direct referrals to CBOs.

Partnering with CBOs to receive direct referrals enabled Cayuga to design a new process and approach to addressing unmet social needs. They brought all stakeholders to the table to co-design the screening and referral process, which includes a web-based closed-loop referral system. The goal is to treat social needs referrals the same as any referral coming out of a primary care office.

PARTNERS

Human Services Coalition, Cornell Center for Health Equity, Cornell University Department of Public and Ecosystem Health, Cayuga Health Partners, Tompkins Whole Health, Advocacy Center, Family & Children's Services, FoodNet Meals on Wheels, Visiting Nurse Services, Cayuga Addiction and Recovery Services, LawNY, Child Development Council, Opportunities Alternatives Resources, Finger Lakes Independent Center, YMCA and REACH.

OUTCOMES

Cayuga Health has screened over 44,000 patients for health-related social needs, with 20% of patients screened indicating at least one unmet social need. Patients who indicate having an unmet need are referred via a warm hand-off to CBO partners. The CBO partners have a 100% outreach rate, with every person being contacted to offer support or connection to resources to meet their needs.

LESSONS LEARNED

Increasing the rates of referrals for patients is a top priority area. This requires a streamlined, automated process at each site, which will be developed by the multidisciplinary project team.

Cayuga Health actively collects data around screening for social needs, population health/quality data and demographic data. Enhancing, expanding and leveraging these data is key to developing actionable steps to improve outcomes. This includes improving the use of ICD-10 coding for social needs and better understanding how referrals improve or eliminate unmet needs and if access to care is improved.

SUSTAINABILITY

To further sustainability of the program, Cayuga Health was awarded a state transformation grant, which is supporting the creation of an integrated health and social care network.

CONTACT

Amy Carver, MBA, Assistant Vice President, Clinical Integration and Population Health
acarver@cayugamed.org | 607.252.3695

GARNET HEALTH

Food Farmacy

INITIATIVE DESCRIPTION AND GOALS

The Food Farmacy initiative, available to Garnet Health patients, is aimed at addressing health disparities within the community. The program seeks to alleviate hunger, promote healthy eating habits, bridge the gap between discharge and longer-term resources, and enhance overall health outcomes. Additionally, the program aims to empower participants through education and resources, enabling them to make informed choices about their diet and lifestyle.

The approach begins with a multidisciplinary team, initially led by community health staff who recognized the need for such a program. The steering committee, comprised of members from nursing, community health, quality, volunteer services, patient experience, courier services, food services and dietary, reflects a diverse range of expertise necessary to tackle the complex issues of food insecurity and health disparities.

Volunteer services and courier services play crucial roles in the logistics of distributing food to those in need throughout the system, while food services staff and dieticians provide expertise on nutrition and dietary requirements for Garnet's patient mix. The initiative's approach involved developing a workflow, establishing criteria for eligibility, selecting primary locations for distribution, identifying the target patient base and procuring necessary supplies.

With the use of social determinants of health screening questions collected by nursing staff, interns conducted surveys and interviews and then developed food bag composition guidelines. The guidelines show volunteers how to pack dietary restricted food bags. Bag types include standard bags, heart disease- and diabetes-friendly bags, renal-friendly bags and easy-access bags. These bags are incorporated into the discharge plan and care coordination to support a patient's transition to home, bridge the gap between other food resources and reduce the risk of readmissions.

The target population of the Food Farmacy program was initially one inpatient unit at each hospital in the Garnet Health system. Inpatients who express hardship on the SDOH screening questions received three days of shelf-stable items to take home upon discharge.

After a successful pilot period, Garnet rolled the initiative out hospital-wide for all inpatients and the oncology outpatient setting. The goal is to reach all inpatient, outpatient and emergency department settings by the middle of 2025.

Community collaborations have enabled the program to expand, tailor the bags and provide essential care items. After a year, Garnet applied to be a member of the Regional Food Bank, which has helped stock the pantry and expand program offerings to reach more patients in need.

In addition, United Way of Sullivan County's generous monetary donation enables the purchase of food, formula and/or clothing just prior to discharge if a mother expresses a hardship. United Way of Duchess-Orange Region has also provided comfort items to include in the food bags such as toothbrushes, toothpaste, shampoo, soap and other personal care items.

The Food Farmacy program aligns with the *Prevention Agenda* priority area, "Prevent Chronic Diseases" with a focus on healthy eating and food security. Through food and education, Garnet Health's Food Farmacy program strives to advance the health and well-being of the community and create lasting positive impacts on population health.

PARTNERS

Food As Medicine of the Regional Food Bank, United Way of Sullivan County, United Way of Dutchess-Orange Region and Garnet Health staff.

OUTCOMES

Food Farmacy has provided short-term security to over 200 patients and their families after their visit to Garnet Health while establishing links to longer term resources. To highlight a few successes:

- A new mother for a sixth time expressing concerns that she has many mouths to feed was able to leave with several bags of food to feed her family while she recovered from birth.
- Garnet Health Medical Center-Catskills, Harris Campus purchased formula and newborn clothing for an infant being discharged to a foster family.
- A patient who was being treated with chemotherapy and radiation recently lost her home and was living in a motel without appliances and eating only a continental breakfast for nutriment daily. Through Garnet's volunteer and patient navigator services this patient was able to shop the Food Farmacy for food and care essentials with the Garnet team to make sure suitable items were picked that she could tolerate while going through treatment.

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LESSONS LEARNED

- Reducing the stigma of food insecurity requires education. It took some time for the program to gain traction and attract participants. This wasn't due to staff negligence in asking the screening questions, but rather because patients were hesitant to answer honestly, if at all. To address this issue, the Magnet Nursing Committee implemented continuous education for the nursing staff on patient engagement. Nurses are now creating opportunities to ask questions multiple times during a patient's inpatient stay and advertise the Food Farmacy to patients regardless of their initial response.
- Garnet learned that the needs of patients change as the program expands to outpatient services. While there are dietary-restricted bags and "easy access" bags for patients who do not have appliances to cook, some patients' hardships go even deeper when different medical treatments are entered into the equation. This led members of the multidisciplinary team being available to answer the call when a more personal shop might be needed.

SUSTAINABILITY

- **Resource diversification:** Garnet's established partnerships have helped secure diverse funding sources and enhanced the program's sustainability.
- **Capacity building:** Investing in staff training and development ensures that the program's workforce remains equipped with the skills and knowledge necessary for effective implementation. Providing ongoing education on topics such as nutrition, cultural competence, SDOH and patient-centered care strengthens the program's sustainability.
- **Outcome monitoring and evaluation:** Regular monitoring and evaluation of program outcomes allow for evidence-based decision-making and optimization of resources.
- **Future plans:** Garnet will continue the relationship with the Food As Medicine Program of the Regional Food Bank and pursuing funding together if necessary. Garnet will purchase a refrigerator and is building toward a garden that will not only supplement the food bags with fresh fruits and vegetables but expand to address mental health needs through horticultural therapy.
- After one year of the program, Garnet believes it has achieved success. The partnership with the Food As Medicine program at the Regional Food Bank has allowed Garnet to further provide food and personal care items for patients in need.
- By reflecting on lessons learned, leveraging elements contributing to success and implementing sustainability mechanisms, Garnet Health can ensure the long-term viability and impact of its Food Farmacy initiative in addressing food insecurity and advancing community health. There is no doubt that this program will grow and stand the test of time.

CONTACT

Moira Mencher, MBA, Director of Planning and Community Relations
mmencher@garnethealth.org | 845.333.2632

HOSPITAL FOR SPECIAL SURGERY

Aging with Dignity

INITIATIVE DESCRIPTION AND GOALS

Hospital for Special Surgery's Greenberg Academy for Successful Aging developed Aging with Dignity, an initiative to reduce social isolation and support healthy aging in older adults. Social isolation among older adults is a national and local issue, evidenced by medical literature and the hospital's Community Health Needs Assessment.

Hospital for Special Surgery partners with senior centers in medically underserved and diverse communities to offer programs in-person and virtually on health education, computer literacy, journaling, music and art therapies. AWD also offers weekly phone-based support groups that allow participants to share the challenges of aging and provide social connectedness in a safe environment. The hospital developed a multilingual resource guide that provides older adults with a listing of local and online resources for health and wellness.

AWD's impact is measured through post-program surveys and telephone interviews. AWD aligns with the *Prevention Agenda* "Promote Well-being and Prevent Mental and Substance Use Disorder" priority area.

The goals of AWD are to improve older adults' health and well-being by:

- educating older adults on how to manage healthy aging;
- increasing social connectedness;
- decreasing stress and anxiety;
- providing a safe community for older adults to discuss the challenges of aging; and
- increasing awareness of and accessibility to healthcare resources.

PARTNERS

Breaking Ground, Breevort Senior Center, Brookdale Senior Living, Bronx Health Link, Carter Burden Network, Henry Street Settlement, JASA, Lenox Hill Neighborhood House, Mother Cabrini Health Foundation, Mount Sinai Hospital, New York-Presbyterian, New York Public Library, Raices Corona Senior Center, Self Help Innovative Senior Center, Soundview Senior Center, The Music Academy for Special Learners, Washington Lexington Senior Center and Assemblymember Rebecca Seawright.

OUTCOMES

- From March 2020 to date, AWD has reached 5,009 participants through 171 support groups, 50 workshops and 32 health education programs.
- Ninety percent of those who reported a high level of stress prior to the programs reported lower stress after the programs. Ninety-four percent indicated high program satisfaction and would recommend the programs to others.
- Zoom polls indicated that most participants strongly agreed/agreed that they felt connected to others after the programs.

LESSONS LEARNED

- Flexibility and creativity are essential in delivering education for older adults and to help this easily overlooked group stay as connected as possible.
- Experienced staffing is critical to creating a safe and non-judgmental environment, forming partnerships among many different sectors and pivoting when necessary.

SUSTAINABILITY

- The hospital continues outreach to the community to stay connected with current successful partners and to create new partnerships.
- The hospital continually seeks and secures grants and donations to expand these programs.
- Continuous evaluation of community health needs ensures program impact and efficacy.
- The hospital extends invitations to community partners to join other HSS programming to keep them connected and to allow for wider community reach.

CONTACT

Linda Roberts, LCSW, Manager, Greenberg Academy for Successful Aging
robertsl@hss.edu | 718.781.8182

JAMAICA HOSPITAL MEDICAL CENTER

Violence Elimination and Trauma Outreach

INITIATIVE DESCRIPTION AND GOALS

The Violence Elimination and Trauma Outreach program is dedicated to eliminating the cycles of violence endemic to the community by providing:

- bedside crisis response;
- comprehensive medical and therapeutic services;
- intensive case management;
- educational workshops; and
- linkage to wraparound services.

The VETO team approaches victims of gun violence and their families for enrollment and provides them with:

- development of a short-term goal plan;
- weekly follow-up calls;
- patient health navigation; and
- referrals to resources including education, employment, legal aid, housing, nutrition and mental health services.

The team documents assessments, program activities and patient communication in the electronic health record. Program enrollment is defined as the provision of informed consent to participate in the pilot and any post-discharge engagement with the team.

In its next phase, the VETO program will set a goal of expanding enrollment and the length of time it can support the patient. There is usually strong engagement in the first 90 days; after that it becomes more difficult to continue engaging an individual up to 12 months. A longer engagement period allows the VETO team to follow up with longer-term goals including educational and job attainment, which will further reduce the chances of violence recidivism.

PARTNERS

King of Kings Foundation, Wheelchairs Against Guns and Life Camp.

OUTCOMES

- Among those not completing the VETO program, the rate of post-intervention violent trauma reinjury was 6.5% ($n = 9$) versus only 1.3% ($n = 1$) for VETO program graduates.
- Those who were approached at the bedside versus by phone were significantly more likely to enroll in (odds ratio 7.63; $p < 0.001$) and complete (OR 3.59; $p < 0.001$) the VETO program.
- Before the trauma counselor joined the team in September 2023, the overall enrollment rate was approximately 60%. From their arrival to December 2023, the VETO program enrollment rate increased to 74%.

LESSONS LEARNED

The program proves that a patient-centered approach to healthcare is a successful strategy for reducing violent reinjury and improving social, economic and medical conditions among gunshot wound patients.

The pros include integrating departments, meeting the patients' unique needs, addressing their social determinants of health, and regular post-discharge engagement up to 12 months with the patients and their families, and longer if needed.

The cons include a lack of staff to meet with patients at the bedside outside of business hours and limitations to enrolling participants in social services, such as strict eligibility requirements and long waiting lists. JHMC is currently seeking philanthropic funding to expand the VETO team after hours.

SUSTAINABILITY

Gun violence is preventable. The VETO program leverages strategic partnerships and evidence-based strategies to overcome the economic, social and medical obstacles that increase the community's risk for firearm and other violence. The observation that more seriously injured patients were more likely to complete the program points to the need for further investigation of injury patterns and patient factors as tools for selecting patients.

Hospitals should engage in more nontraditional methods of patient outreach (like credible messengers). Further, it is crucial to address cultural sensitivity when engaging individuals with a criminal history and background. Co-locating cure violence partner organizations has also proven to be helpful in immediate follow-up and support of patients and family members.

CONTACT

Jessica Williams, Director, Development
jwilliam@jhmc.org | 718.206.8613

MOHAWK VALLEY HEALTH SYSTEM

Mohawk Valley Partnership for Healthy Lifestyles

INITIATIVE DESCRIPTION AND GOALS

The Mohawk Valley Partnership for Healthy Lifestyles addresses critical health disparities in Oneida and Herkimer Counties, targeting neighborhoods with elevated rates of stroke, hypertension and diabetes, particularly impacting low-income, minority and immigrant communities. MVPHL employs census tracking and hot spot mapping to pinpoint these health challenges and communities.

Inspired by successful COVID-19 vaccination efforts, MVPHL collaborates with diverse stakeholders, including healthcare providers, community organizations and advocacy groups. Its strategy integrates health education, chronic disease screenings and referrals to essential services with a focus on social determinants of health, enhancing healthcare access, education and community engagement.

MVPHL achieves significant outcomes through extensive community outreach, thousands of screenings and linkage to vital services, fostering tangible improvements in health outcomes and community trust. MVPHL's culturally sensitive approach positions it as a leading initiative in promoting health equity and community partnerships.

PARTNERS

The Center (Refugee Services), Rome Health, Rome and Utica branches of the NAACP, Mohawk Latino Association, Excellus Blue Cross Blue Shield, Fidelis Care, American Heart Association, Oneida County Health Department, Alzheimer's Association, Mohawk Valley Community Action Agency and the Community Foundation of Herkimer and Oneida Counties.

OUTCOMES

MVPHL's top outcomes include hosting 362 events in 2023, educating 16,070 individuals and conducting screenings for 5,573 people.

These efforts facilitated primary care connections for 272 individuals, assisted 5,003 with health insurance enrollment and provided 4,887 heart-healthy meals.

LESSONS LEARNED

MVPHL demonstrated the critical role of dedicated funding in ensuring sustained impact and attracting additional clinical support. Furthermore, partnerships with community-based organizations, alongside community navigators and faith-based communities, have been pivotal in fostering trust and deepening engagement within the target populations. These collaborations have significantly enhanced the overall effectiveness of MVPHL's outreach efforts in improving community health outcomes.

SUSTAINABILITY

MVHS, through its office of population health, remains committed to ongoing exploration of funding opportunities and leadership in community health activities with MVPHL. This commitment ensures sustained support for advancing health equity in the Mohawk Valley through collaborative partnerships with community-based organizations and faith-based groups.

CONTACT

Lisa Volo, Director, Population Health
lvolo@mvhealthsystem.org | 314.624.5677

NEWYORK-PRESBYTERIAN

Postpartum Doula Program

INITIATIVE DESCRIPTION AND GOALS

NewYork-Presbyterian's Postpartum Doula Program provides direct peer support through a community-clinical partnership model. It is an initiative within NYP's Maternal and Child Health Integrated Mental Health Program that delivers culturally attuned, peer-based, individualized interventions, designed to mitigate existing systemic communal and healthcare inequities. In the face of long-standing maternal and infant health disparities, the Postpartum Doula Program provides additional psychosocial support and health monitoring for high-risk mothers, building a foundation of integrated health and community care.

The Postpartum Doula Program operates at multiple locations in high-need, low-income neighborhoods of New York City. In each neighborhood, a designated community-based organization serves as the key partner in leading the initiative. The local CBO leads hiring and training of bilingual, certified doulas, drives programming and designs culturally attuned, grassroots interventions that reflect the diversity of patients served. Though employees of the local CBO, doulas are simultaneously integrated into NYP's healthcare response team, serving as a bridge between NYP and community-based services.

PARTNERS

Northern Manhattan Perinatal Partnership and Caribbean Women's Health Association.

OUTCOMES

In 2023, 519 patients were referred and 254 patients were enrolled in the program. As part of the MAC-IMP network, the program uses a centralized referral process that improved enrollment through personalized follow-up with eligible patients.

At the start of every visit, patients report a "stress thermometer" score. The average score dropped from 4.03 to 2.74 (1.15 points) from the initial visit to the final visit. This reduction is especially meaningful considering caregivers typically face an increase in stress in the postpartum period.

The third finding is breastfeeding uptake: At the initial visit, 9.6% of patients reported an interest in breastfeeding. At the final visit, 47.9% of patients report breastfeeding. This increase can likely be attributed to education and support embedded in the model.

LESSONS LEARNED

The co-design model employed by the Postpartum Doula Program allowed it to build relationships and programs that are durable and connect patients not only to programs and services within NewYork-Presbyterian, but also to the many resources in the surrounding community.

These strong relationships allow partners to quickly pursue new programming, coordinate closely, and increase program durability and longevity. This collaboration also helps foster trust between community members, CBOs and healthcare systems.

SUSTAINABILITY

With New York's Medicaid Section 1115 waiver, there will be greater support for hospitals and healthcare systems to address social determinants of health and improve integration of primary care, behavioral health and community-based resources. In this context, the Postpartum Doula Program's staffing model can be self-sustaining, allowing the program to improve maternal and infant health in a seamless web of integrated services for patients.

CONTACT

Emma Hulse, Program Director, MAC-IMP
emh9022@nyp.org | 347.931.2088

NORTH SHORE UNIVERSITY HOSPITAL, NORTHWELL HEALTH

Supermarket Education Tours Program

INITIATIVE DESCRIPTION AND GOALS

The Supermarket Education Tours Program, led by North Shore University Hospital, is a bilingual, five-week nutrition education program with two goals:

- Create a bilingual nutrition education program for vulnerable community members.
- Empower participants with the tools to create lifestyle changes to positively impact themselves and their families.

NSUH's mission is to measurably improve the health and well-being of its communities. This initiative aligns with the *Prevention Agenda* "Preventing Chronic Diseases, Healthy Eating and Food Security" priority area.

NSUH's senior community relations program manager and registered dieticians, under the leadership of the managing registered dietician, partnered with the regional Stop & Shop RD to provide a five-week nutrition education program for community members.

Participants with an interest in nutrition were identified by Our Lady of Fatima Church/Food Pantry. A five-week curriculum and handbook were developed and translated into Spanish. On week one, participants received a copy in their native language. The topics included: mastering the basics, how to read a food label, fats and oils, dietary fiber and hydration, and mindful eating. Each week, participants identified one impactful component from the previous week. Participants were surveyed after each session and 12 weeks after program completion.

PARTNERS

Our Lady of Fatima Food Pantry and Stop & Shop in Port Washington, NY.

OUTCOMES

The Supermarket Education Tours Program succeeded in creating a bilingual program that empowered participants with the tools to create lifestyle changes that impacted themselves and their families.

Post-program survey results indicated that participants have changed their eating habits and practice what they have learned (83%); have noticed positive change in both them and their family's eating habits (67%); and felt more confident reading and understanding food labels (100%).

LESSONS LEARNED

NSUH learned that community partnerships are essential for successful community health initiatives. Our Lady of Fatima's food pantry coordinator, Sister Kathy, earned the trust of her community and, by endorsing this program, encouraged the community to participate. Sister Kathy also understood the needs of her community and was able to assist the NSUH team regarding considerations surrounding language, culture, scheduling conflicts and location.

NSUH also learned that programs need to be community centered. Rather than coming in with a detailed plan for all participants, RDs designed a program to meet each individual where they were. For example, one participant was non-literate. The team revised its strategy to include more pictures, verbal explanations and verbal surveys to ensure that all individuals were able to get the most out of the experience.

When food costs were raised as an issue, NSUH developed a unit on healthy eating on a budget, understanding unit pricing and buying bulk items frozen so they last longer. Each week, participant feedback helped to guide future sessions and ensure that each participant was understanding the material. Every community is unique, so it is important to listen and solicit feedback regularly to ensure that program outcomes and participant needs are aligned.

SUSTAINABILITY

NSUH developed a strong working relationship with both Stop & Shop and Our Lady of Fatima, which will lead to future iterations of the program for the Manorhaven community and other communities that Northwell Health serves. This program has been shared with all community relations leads for Northwell's 23 hospitals. South Shore University Hospital is currently beginning its own program, specifically tailored to its community.

CONTACT

Christine Patti, Senior Community Relations Program Manager
cpatti@northwell.edu | 516.562.4715

NUVANCE HEALTH

VBMC Community Care Team

INITIATIVE DESCRIPTION AND GOALS

Vassar Brothers Medical Center implemented the Community Care Team in 2021 in response to needs identified in the City of Poughkeepsie. Consistent with the *Prevention Agenda*'*s* "Promote Well-Being" and "Prevent Mental and Substance Use Disorders" priority areas, the CCT seeks to prevent excessive alcohol consumption by adults, prevent opioid and other substance misuse and deaths, reduce the prevalence of major depressive disorders, prevent suicides and reduce the mortality gap between those living with serious mental illness and the general population.

The CCT treatment model improves care for at-risk populations through comprehensive wrap-around services facilitated by navigated collaboration between community stakeholders. Led by a VBMC high-risk navigator and comprised of hospital staff and community agencies, the CCT includes health centers, behavioral health and substance use treatment providers, city social service and municipal agencies, faith-based organizations, shelters and housing agencies, veterans' organizations, police departments, legal providers and food banks.

The team identifies high-risk clients and engages in community collaboration and care coordination to address health-related social needs and improve health outcomes.

PARTNERS

The CCT includes many more community agencies than are listed here, but regular participants include: Arms Acres, Council on Addiction Prevention & Education, Catholic Charities Community Services, City of Poughkeepsie Police Department, Dutchess County Department of Behavioral and Community Health, Dutchess County Department of Community and Family Services, Dutchess County Mobile Crisis Team, Dutchess County Stabilization Center, Dutchess Outreach, Empowerment Center, Grace Smith House, Hudson River Housing, Hudson Valley Community Services, Mental Health America, PEOPLE-USA, Recovery Centers of America, Sun River Health and Taconic Resources for Independence.

OUTCOMES

The CCT program improves health outcomes for the community's most vulnerable residents and strengthens Poughkeepsie's public health infrastructure through cross-sector collaboration and communication, fortified data collection and reduced community treatment silos.

In 2023, the CCT carried a caseload of 47 clients; helped 14 homeless people into housing; and facilitated 39 client connections to physical healthcare providers, 22 connections to behavioral healthcare providers and 18 connections to substance use providers. In total, the program has served 118 people, 23 people have been housed and ED utilization by CCT clients decreased 81%.

LESSONS LEARNED

VBMC has learned that by addressing social drivers of health, promoting prevention efforts and providing timely access to healthcare services, the CCT can reduce health disparities and enhance individual and overall community well-being. Benefits of this approach, with regard to community partners, include pooling resources, sharing experience and knowledge, more efficiently enhancing service delivery, supporting capacity-building and strengthening community engagement and empowerment.

SUSTAINABILITY

The CCT collaborative approach involves individuals, organizations and institutions working in partnership to leverage their strengths, resources and expertise toward common goals and sustainability. By uniting stakeholders with shared interests, CCT not only positively affects the identified individuals, but also influences local, regional and national policies to promote healthier systems of care and environments for all residents. The program also reduces healthcare expenses related to ED visits and hospital admissions, which contributes to its sustainability.

CONTACT

Dawn Myles, Vice President, Community Health
dawn.myles@nuvancehealth.org | 203.470.0674

NYC HEALTH + HOSPITALS / ELMHURST

Advancing Equity: Improving Access to Flu Vaccines by Bringing it to the Community

INITIATIVE DESCRIPTION AND GOALS

Based on the factors that NYC Health + Hospitals / Elmhurst identified that contribute to influenza vaccine disparity and inequity during the flu season, the hospital launched a campaign to get information about the flu vaccine out to the community. Although the hospital has served its community for years, many new immigrants in the area see it as a hospital and emergency department care facility and are unaware of the services NYC Health + Hospitals / Elmhurst offers in the ambulatory care setting.

The hospital conducted health fairs to educate the community by strategically partnering with organizations and local council members to provide free flu vaccines. It also offered the community information on access to affordable healthcare and other needed vaccines and screenings.

Patients at Elmhurst are offered a flu vaccine at any type of visit, both in primary and specialty care clinics. The hospital also expanded vaccination education and services to its employees and enabled staff to promote the benefits of the flu vaccine, along with their own testimonials on why they choose to get vaccinated. Providing fact sheet handouts in the waiting room and offering the flu vaccine across any care setting was helpful.

The interventions NYC Health + Hospitals / Elmhurst used align with the *Prevention Agenda's* Prevent Communicable Diseases Action Plan: Focus Area 1, and Vaccine Preventable Diseases: Objective 1.1.3: Increase influenza immunization rates of New Yorkers aged six months and older by 10% to 54.8%.

PARTNERS

Our Lady of Sorrow Church, Baptist Church of Corona, St. Mark's Episcopal Church, 34th Avenue Open Streets Coalition, Columbian Consulate, Department of Education and Council Member Francisco Moya.

OUTCOMES

- Elmhurst achieved a nearly 3% increase in the vaccination rate from the first quarter of 2023 (65.8%) to Q1 2024 (68.6%).
- The Black/African American flu vaccine rate reached a peak in January at 63%, up from 55% in October, an 8% increase.
- The Hispanic flu vaccine rate reached its highest in December at 71%, up from 63% in October, an 8% increase.

LESSONS LEARNED

- Quality improvement projects require multi-stakeholder analysis, cause and effect analysis and mapping processes to fit the normal workflow without creating additional burden on the frontline staff.
- This process includes continuous data analysis and monitoring, proactively outreaching populations that are known to have low vaccination rates with education, automated language concordant MyChart reminders, in-clinic counseling, community education and outreach.

SUSTAINABILITY

The interventions Elmhurst used to improve the flu vaccine rate are easily sustainable due to minimal changes to each individual staff workflow; some of the changes are as small as just adding an additional script promoting the influenza vaccine. As a hospital that is part of an overall safety net system, Elmhurst participates in many community events and health fairs, making it easy to connect with local community-based organizations to promote and offer free influenza vaccines.

CONTACT

Michelle Lam, Administrator for Ambulatory Care
lamm4@nychhc.org | 718.334.3603

ROCHESTER REGIONAL HEALTH

Culturally Responsive Treatment for Black Communities

INITIATIVE DESCRIPTION AND GOALS

To address ongoing racial disparities in mental healthcare, Common Ground Health, Rochester Regional Health and Rafiki Consortium, LLC came together to impact the longstanding problem of bringing culturally responsive practices to mainstream behavioral health services.

The key reasons for partnering for this initiative were:

- ongoing disparities for Black people in behavioral health;
- lack of Black clinicians;
- lack of general clinical capacity to provide culturally responsive/culturally specific services; and
- increased demand for culturally responsive services.

RRH developed an intensive 42-hour training program for clinicians. As part of this training, therapists introduce practitioners to modalities for family intervention rooted in African psychology and ancient Ayurvedic principles for healthy and sustainable living. Together, these philosophies lay the foundation for the self-actualization of healers and the healing capacity of individuals and families.

The primary pillars of the program that are covered are Homa therapy, enriched structural family therapy, NTU psychotherapy and anti-racist, culturally competent engagement.

To deliver a holistic and life-affirming intervention and modality, white clinicians undergo a reorientation to the function and purpose of treatment — one that clearly confronts, challenges and deconstructs the tenets of white supremacy and reframes the condition, needs and strengths of black and indigenous people of color.

Immersion, openness and commitment are essential for the willing practitioner. This includes ownership of one's privilege, dissecting and evaluating the history of racism in one's work, and an unwavering resolve to address trauma and prohibit re-traumatization at the hands of the practitioner.

PARTNERS

Common Ground Health and Rafiki Consortium, LLC, Baltimore, Maryland.

OUTCOMES

Qualitative remarks from clinicians who attended the training:

"For me it's been a journey toward self-healing as an African American that equipped me with the opportunity to assist more deliberately in the healing of others of all races, ethnicities and lifestyles; I think I feel more confident in understanding how cultural differences may show up at work and in relationships, not just for patients but for myself."

"I think my awareness and grasp of potential dynamics for Black/African American patients has grown significantly; I use something I learned from this training every single day!"

A recipient of services said:

"I know you always say that I am doing the work, and yes, I am, but I honestly would not have been able to do this without the seeds you planted within me. Your intelligence, cultural competence and dedication helped to reverse nearly a lifetime of self-doubt. Because of you, I am inspired to survive and thrive and improve others' lives. Your impact is genuinely changing the world, one person at a time."

Quantitative results from 2021 to 2023 are as follows:

- Total number of clinicians trained: 118.
- Total number of clients impacted (unduplicated and based on average caseload size for practitioners): 23,600.
- Total number of Black, indigenous and people of color clients impacted: 8,354.

LESSONS LEARNED

- Partnerships built on relationships are great but they need to evolve beyond the relationship.
- Partnerships are fragile and need to be tended to like a garden.
- Regular check-ins are a must!
- Be transparent with your partners from the start.
- Give yourself and others grace in the process.
- Stay open and flexible.
- Breathe!

SUSTAINABILITY

This training was brought to Rochester through funding obtained by Melanie Funchess of Common Ground Health from various foundations. RRH dedicated some funding to support the start-up and now contributes to each cohort to cover some of the costs for each participant. This is a valued training that RRH will continue to invest in.

CONTACT

Eve Hosford, LCSW-R, Vice President and
Chief Administrative Officer, Behavioral Health
eve.hosford@rochesterregional.org | 585.754.2694

ST. MARY'S HEALTHCARE

Addressing Health Disparities with ACT

INITIATIVE DESCRIPTION AND GOALS

St. Mary's Healthcare serves a rural community that ranks among the highest in New York on social determinants of health challenges. St. Mary's Healthcare's mission and values emphasize service to the poor and vulnerable, including the population targeted by its Assertive Community Treatment program: adults who have severe, persistent mental illness.

ACT is a mobile program staffed by a multidisciplinary team that provides comprehensive, coordinated, patient-centered care, including intensive treatment, rehabilitation and support services. Central to ACT's success are the numerous community partners who collaborate with St. Mary's Healthcare to meet clients' clinical, emotional and daily living needs — and to move them toward increasing independence.

In the six years since St. Mary's Healthcare launched ACT, only three clients have been readmitted. The rest have improved their health and quality of life and strengthened their connections to community.

ACT addresses four *Prevention Agenda* priorities: "Promote Well-Being and Prevent Mental Health and Substance Abuse Disorders," "Improve Health Status and Reduce Health Disparities," and, to a lesser extent, "Promote a Healthy and Safe Environment," and "Prevent Chronic Diseases." Progress on the main priority, improving mental health, has a positive ripple effect on the others.

PARTNERS

Catholic Charities, Creative Connections Clubhouse community center, Department of Social Services, DePaul Properties supportive housing, Helio Health supportive housing, local courts and correction facilities, local parole and probation departments, local pharmacies, local primary care providers, local police departments, Mental Health Association in Fulton & Montgomery counties, NYSED ACCES-VR (vocational rehabilitation), outpatient and inpatient substance use providers and U.S. Social Security Administration.

OUTCOMES

St. Mary's Healthcare has seen significant improvements in key indicators for clients who remain in the ACT program for three years.

- Psychiatric hospitalization rates declined from 42% for clients enrolled in ACT for six months to 15% for those enrolled for three years; psychiatric ER visits declined from 52% at six months to 18% at three years; and threat of self-harm decreased from 21% at six months to 3% at three years.
- Homelessness rates declined from 27% for clients enrolled in ACT for six months to 9% for those enrolled for three years.
- Forensic involvement rates declined from 18% for clients enrolled in ACT for six months to 6% for those enrolled for three years.

LESSONS LEARNED

Collaboration is key: ACT is built on longstanding partnerships. Any time St. Mary's Healthcare identifies a need, community partners step up to fill the gap and ensure that clients receive comprehensive, coordinated services.

Trust transforms: Trust does not come easily for ACT clients, so the team uses every interaction to help cement a positive, trusting connection. Over time, clients welcome and even request assistance. Equally important, they become more receptive to repairing or initiating other relationships.

SUSTAINABILITY

The successful ACT initiative is another example of St. Mary's Healthcare's determination to reduce health disparities and inequities among a very vulnerable population: adults with debilitating mental illness. St. Mary's Healthcare views ACT as an essential investment in the long-term health of program clients and the community. The health system's enduring commitment, along with that of its invaluable, continually expanding group of community partners, will help ensure ACT's long-term sustainability.

CONTACT

Margaret Brodie, Vice President, Mission Advancement and Patient Experience
brodiem@nysmha.org | 518.841.7135

UNITED HEALTH SERVICES HOSPITALS

Home Is Where the Healing Continues: An Integrated Care Team Approach

INITIATIVE DESCRIPTION AND GOALS

The Home Is Where the Healing Continues program brings together United Health Services Hospitals' inpatient case management, hospital care at home, home care services, population healthcare coordination and union volunteer emergency services/community paramedicine to provide comprehensive support for patients with complex medical conditions.

Through collaborative workflows and communication channels, the program aims to keep patients safe, healthy and thriving in their communities. By leveraging the expertise of each partner, patients receive tailored care plans that address medical, social and logistical needs, ultimately reducing hospital readmissions and emergency department visits while promoting overall well-being.

PARTNERS

Union Volunteer Emergency Squad, Broome County Health Department, Broome County Council of Churches, Office for the Aging, Medical Answering Services, Meals on Wheels and Southern Tier Independence Center.

OUTCOMES

- **Reduced ED utilization:** More than 83% of patients have been able to avoid emergency care in the community for a 30-day period post-discharge from the program.
- **Improving hospital throughput:** Reduced overall organizational inpatient length of stay (and thus, cost of care) by approximately 3.5 days per patient due to enrollment.
- **Improved access to ambulatory care:** 95% of patient enrollees are connected to preventive care at the time of graduation from the program.

LESSONS LEARNED

- **Prioritize communication:** A strong emphasis on communication among all stakeholders is critical. Regular information sharing via weekly meetings and EHR secure chat to coordinate care plans and discussion of issues or barriers was critical.
- **Don't wait:** Early collaboration is valuable. The program involves all partners to leverage expertise and resources. This allowed for better integration, identification of potential challenges and development of comprehensive care plans for patients.

SUSTAINABILITY

Sustaining this program requires a commitment to ongoing communication, information sharing and joint problem-solving. By fostering a culture of transparency, trust and mutual respect, partners can navigate challenges, leverage strengths and capitalize on opportunities for improvement.

CONTACT

Anne DePugh, System Director, Population Health Management
anne.depugh@nyuhs.org | 607.762.2862

UPSTATE UNIVERSITY HOSPITAL

She Matters

INITIATIVE DESCRIPTION AND GOALS

For the past 10 years, Upstate Medical University's outreach team has been engaged in health programming for the nearby underserved community. Programs are selected and developed based on needed assessments conducted in collaboration between Upstate and the Syracuse Housing Authority to gauge resident needs. Established in 2014, the most successful program includes a robust breast cancer education and screening initiative, She Matters.

Numerous early-stage cancers that otherwise may have gone undiagnosed have been detected and treated through this program. The success of the program is the result of the trust that has developed between Upstate, SHA and the residents. She Matters is effective because of its unique peer-to-peer approach, working with resident heath advocates who engage the community in all facets of program design, delivery and improvement.

She Matters staff not only assist women in scheduling annual mammograms but also educate and support women in other ways, often beyond breast health, helping them find the additional care they need while establishing trust in the medical system. The program's main goal is to educate, inform and encourage women 40 years of age and older who live in public housing to get annual screening mammograms. The second goal is to educate all women about breast health and breast cancer.

The program objective is to increase knowledge about breast cancer prevention and treatment, decrease fear associated with mammograms, identify barriers to mammography and increase breast health navigation to improve adherence to recommendations.

PARTNER

Syracuse Housing Authority

OUTCOMES

- Since 2014, the initiative has completed 1,113 mammograms.
- Since 2014, 10 cancers have been found and treated or are currently being treated.
- Since 2019, an average of 31% of participants navigated to mammography in this program have incorporated the behavior into their own health maintenance regimen, scheduling their next annual mammogram without reminders.

LESSONS LEARNED

- This population needs multiple reminders, transportation and sometimes to be scheduled multiple times before they complete a mammogram. UHS never gives up and sticks with people until they show up.
- Incentives will get participants to show up and to come back each year.

SUSTAINABILITY

Since 2014, the program has secured funding by applying for grants throughout the year. All grant funding currently goes directly to program expenses and stipends. In addition, a hospital foundation fundraising page provides an avenue for the community to support the program.

Upstate has illustrated its commitment to sustaining this program by providing funding for a full-time project coordinator since 2017. Additionally, substantial in-kind support to the program is provided on an ongoing basis, including project managers, mammography schedulers and imaging staff, clinical oversight and guidance, time commitments from medical directors and office space.

CONTACT

Rachel Osiecki, Project and Program Coordinator
ryanra@upstate.edu | 315.484.4237

HANYS Celebrates Previous Community Health Improvement Award Winners

2023 Catholic Health (Long Island)
Food is Care

2022 Mohawk Valley Health System
Lead-free and Healthy Homes Mohawk Valley Coalition

2021 Northwell Health
Advancing Health Equity through Community-based Partnerships to Fight COVID-19

2020 UR Medicine–Jones Memorial Hospital, Wellsville
Promotion of Healthy Life Styles

2019 Montefiore Medical Center, Bronx
Healthy Food Initiative

2018 Unity Hospital–Rochester Regional Health
Healthy Moms

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

2016 Strong Memorial Hospital, Highland Hospital (UR Medicine)/Rochester General Hospital, Unity Hospital (Rochester Regional Health)
High Blood Pressure Collaborative – Hospital Partners

2015 Bassett Healthcare Network, Cooperstown
School-based Health/Oral Health Program

2014 Bassett Medical Center, Cooperstown
Cancer Screening Outreach – Medical Screening Coach

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

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

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

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

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

2008 Jamaica Hospital Medical Center
Palliative Care Collaborative

2007 Rochester General Hospital, Clinton
Family Health Center

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

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

2004 NewYork-Presbyterian/Columbia University Medical Center
Breast and Cervical Cancer Screening Partnership

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

2002 Strong Memorial Hospital, Rochester
Project Link

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

2000 Harlem Hospital Center, New York City
Injury Prevention Program

1999 Women's Christian Association Hospital, Jamestown
Women's Health Initiative

1998 United Health Services, Binghamton
Pediatric Asthma Program

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

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