CONNECTING WITH COMMUNITIES:

Community Health Initiatives Across New York State

2025 EDITION

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Thank you to our 2025 reviewers

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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 29th edition of *Connecting with Communities: Community Health Initiatives Across New York State*. This publication highlights the winner of and nominations for HANYS' 2025 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 improve the health status of New Yorkers and reduce health disparities through a strong emphasis on prevention.

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. We were excited to receive a record number of award submissions this year – 35! The scores of the top-ranking initiatives were close this year, so we've identified the top five initiatives in this book.

All 2025 award submissions will be included in HANYS' Community Health Initiatives Tool available online at hanys.askflorence.org/data/chia. This searchable tool categorizes the initiatives by the domains and priorities of the *Prevention Agenda* framework. We hope members and their community partners will use this resource to inspire new ideas as they develop community health initiatives.

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.

2025 AWARDEE

NORTHWELL HEALTH
Northwell Health Street Medicine Program

INITIATIVE DESCRIPTION AND GOALS

Nearly 10,000 Long Islanders experience homelessness annually. This vulnerable community faces health disparities, higher rates of chronic illnesses, mental health and substance use disorders, and limited access to consistent healthcare. Northwell Health launched the Street Medicine Program to address these challenges. It aligns with the 2025 New York State *Prevention Agenda* "Health Care Access and Quality" priority area.

Northwell Health collaborated on this project with the Long Island Coalition for the Homeless, a trusted grassroots organization with more than 35 years of experience addressing homelessness. The initiative delivers essential healthcare and addresses social determinants of health directly in the community, embodying the principle, "Go to the People." It aims to provide high-quality, patient-centered clinical care to street homeless, develop programming emphasizing trust-building and inclusivity, and connect clients to comprehensive services, including housing and employment.

Through coordinated, compassionate care delivery and comprehensive support services, this strategic partnership improves outcomes for the most vulnerable community members.

PARTNERS

Long Island Coalition for the Homeless and New York Community Trust-Long Island.

OUTCOMES

The Street Medicine Program pilot, operating just one day a week for six hours, has achieved remarkable successes in a short span. From its inception in 2020 through Feb. 6, 2025, it has:

- served 54 unique patients through 103 patient encounters;
- assisted five patients in finding housing, with four more pending placements; and
- facilitated 19 patient referrals through patient access services to various specialists, including podiatry, OB-GYN and behavioral health.

These accomplishments are life-changing and instill a sense of hope for the most vulnerable Long Islanders who face significant challenges accessing healthcare and housing

LESSONS LEARNED

Building trust with the homeless is crucial. They feel unheard and betrayed. Weekly outreach with the Long Island Coalition for the Homeless helps bridge this gap. By using a client-centered approach, providing essentials and understanding individual needs, this program achieves successful outcomes.

The work is emotionally challenging.

Setbacks and losses require team-based support and regular debriefings. Celebrating small victories boosts morale and resilience, reinforcing Northwell's commitment to care despite challenges.

SUSTAINABILITY

Senior leadership support, New York Community Trust-Long Island funding, a volunteer-based structure and plans for a Street Medicine Residency program underscore Northwell's commitment to creating lasting community impact.

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2025 SUBMISSIONS

2025 SUBMISSIONS

ALBANY MEDICAL CENTER

Expanding Disability Awareness, Advocacy and Access in Clinical Settings

INITIATIVE DESCRIPTION AND GOALS

One in four adults in the U.S. has some type of disability, with the numbers expected to grow in coming years. Yet, medical students often lack formal education and clinical exposure to working with this patient population. This gap can result in discomfort, misunderstanding or inadequate care for patients with disabilities.

With this new initiative, medical students at Albany Medical College meet with disability self-advocates identified by the Center for Disability Services and Albany Medical Center physicians. The students hear firsthand how to better serve patients before they begin their clinical rotations. The curriculum introduces students to common issues facing patients with disabilities, with the goal of eliminating barriers to appropriate care.

This initiative supports the "Prevent Chronic Disease," "Promote a Healthy and Safe Environment" and "Promote Well-Being and Prevent Mental and Substance Use Disorders" priority areas of the New York State *Prevention Agenda*.

PARTNERS

Albany Medical College's Patient Safety and Clinical Competency Center, Center for Disability Services and self-advocate patients with disabilities.

OUTCOMES

- More than 435 medical students have participated in Albany Medical College's disability curriculum, which introduces common issues facing patients with disabilities, with the goal of eliminating barriers to appropriate care.
- Through interviews with disability self-advocates, hands-on use of adaptive equipment such as wheelchairs, and practicing lifting and moving people with limited mobility, these future physicians develop a critical eye to improving accessibility. After these sessions, the number of students reporting feeling confident caring for patients with disabilities nearly doubled.

LESSONS LEARNED

Twenty self-advocates said they felt fulfilled by their participation and benefited from meeting each other. Many shared resources or contacts to address care gaps and most asked to participate in future sessions. "It means so much to me to be able to give back and know I am impacting future doctors," said one participant with brain injury.

Students expressed a clear appreciation of the focus and reported they were impacted by reflecting on the care of this patient population and were questioning how they can adjust care settings to ensure their patients feel seen.

SUSTAINABILITY

Rich preclinical experiences create a strong foundation for further clinical exposure and enrichment. Albany Medical Center is working to increase visibility of the curriculum and create philanthropic interest to ensure continued funding of this program. Faculty time, administrative support, adaptive equipment and self-advocate pay have so far been funded by a National Inclusive Curriculum in Health Education grant from the American Academy of Development Medicine and Dentistry.

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BASSETT HEALTHCARE NETWORK/NEW YORK CENTER FOR AGRICULTURAL MEDICINE AND HEALTH

John May Farm Safety Fund

INITIATIVE DESCRIPTION AND GOALS

The John May Farm Safety Fund is operated by Bassett Medical Center's New York Center for Agricultural Medicine and Health. The program provides grant funding to farmers and agricultural operations to provide safety improvements to farms across the state. These safety improvements range from structural enhancements on farms to animal handling equipment and beyond. Small and medium size farms grossing less than $1 million per year and all New York dairy farms can apply for up to $5,000 in direct grants for projects that will be completed within one year.

The JMFSF partners with other organizations such as Cornell Cooperative Extension, Soil and Water Conservation District and Natural Resources Conservation to offer matching funds for larger projects and to spread the word to farmers about these programs. JMFSF has provided funding to private farms, nonprofit farm collectives, and schools and youth programs with livestock handling programs.

The program's primary goal is to improve farm worker safety on small and mid-sized farms. From there, the goal is to foster positive relationships with New York farmers. This benefits NYCAMH and other programs, many of which are research based and benefit from farmer participation. Finally, the program is a direct investment in the well-being and sustainability of New York agriculture, which undergirds so much of the statewide economy and the health of communities.

PARTNERS

Cornell Cooperative Extension, Soil and Water Conservation District, and Natural Resources Conservation Service.

OUTCOMES

- $1.4 million has been invested into 343 farms since 2016, improving safety environments, directly reducing harm on New York state farms and bolstering their strength and sustainability.

LESSONS LEARNED

JMFSF administrators have learned that word of mouth is the most effective advertising for this program, as farmers encourage other farmers to apply. Farmers do not often have time left in the day to research and identify support opportunities. Being encouraged by another farmer also builds a permission structure for farmers to reach out and ask for help.

It is important to maintain a stable flow of funds into the program, which requires good donor relations and positive government relations.

SUSTAINABILITY

Since its inception, JMFSF has grown steadily, bringing in both new sources of revenue and new grantees. Part of the reason is that it is a compelling story, motivating involvement from private donors and foundations. Another issue is that New York state also recognizes the importance of this program to the economic stability of rural New York. With the help of the broader NYCAMH and Bassett team, JMFSF is poised to grow its reach and benefit to the community for years to come.

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CATHOLIC HEALTH (LONG ISLAND)

Mission-driven Mobile Clinical Units

INITIATIVE DESCRIPTION AND GOALS

Catholic Health is in a geographically diverse area with pockets of underserved, uninsured individuals struggling to access healthcare. The goal of the Community Outreach Mobile Unit is to ensure equal access to care and to provide early detection and prevention of disease.

Aligning with the New York State *Prevention Agenda's* "Chronic Disease Preventive Care and Management" priority area, the COMU drives to underserved communities, offering free glucose and cholesterol screenings. This service promotes testing for pre-diabetes and reduces the risk for future diabetes in asymptomatic people with obesity and overweight and who have one or more additional risk factors for diabetes. In addition, using goal 4.2.1, Catholic Health is promoting strategies that improve the detection of undiagnosed hypertension by checking blood pressure and BMI, along with the previously mentioned screenings. COMU also offers flu and COVID-19 vaccines. The health system is expanding access to evidence-based self-management interventions for individuals with chronic disease whose conditions are not well controlled with guidelines-based medical management alone.

PARTNERS

The Town of St. Brigid's Catholic Church, Latina Sisters Support, Long Island Cares, Island Harvest, Smile Farms, The Long Island Health Collaborative, The Society of St. Vincent de Paul Long Island, Guatemala Consulate, local libraries, parishes, Pronto, Adelante, hospitals, YMCA, senior centers, elected officials, Gala supermarkets, Tanger Outlets, Bravo Market, senior apartments and Catholic Charities.

OUTCOMES

Top outcomes for the program include:

- number of people screened: 3,189;
- number of people with elevated BP/glucose/cholesterol: 149; and
- number of people referred to social work: 1,005.

The registered nurses record family history and existing health issues and use the CMS SDOH screening tool to identify needs and refer to social workers. Licensed bilingual social workers assist with a variety of issues ranging from medical interpretation to housing and prescription assistance. The top need was for medical interpreting (646 people) followed by help with scheduling a doctor appointment (448) and insurance assistance (410).

LESSONS LEARNED

First, it is crucial to foster a safe environment. The target population isn't comfortable sharing their personal information for fear of their security or receiving a bill. Others may mistrust healthcare, leading them to not answer truthfully. To overcome this, the team partners with established, trustworthy community-based organizations such as religious institutions.

Second, the team learned to seek areas of need using data to determine who can benefit most.

SUSTAINABILITY

Catholic Health's goal is to improve community health, enhance patient care and increase cost benefit by:

- addressing chronic disease (150 in immediate need of services/800 referred),
- aiding with insurance enrollment (435 without insurance), and
- reducing emergency department utilization (detection/disease management/ongoing care avoids ED visits).

Our COMU 2024 data demonstrates early detection/management of disease and connecting people to ongoing care/medication reduces unnecessary ED visits. We continue to adapt, adding staff and extending resources by partnering with nursing schools.

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ELLENVILLE REGIONAL HOSPITAL

Ellenville Regional Rural Health Network

INITIATIVE DESCRIPTION AND GOALS

This 2024 initiative's primary objectives were to enhance physical fitness, encourage healthy eating habits, reduce substance misuse and improve food security within the community.

To achieve these goals, Ellenville Regional Hospital, through the Ellenville Regional Rural Health Network, implemented targeted programs including fitness classes, personalized nutrition coaching, tobacco cessation support, harm reduction services and a Farmacy produce distribution initiative. The strategy prioritized accessibility, cultural competency and data-driven decision-making to ensure that the programs effectively reached and served vulnerable populations. This initiative aligns closely with the New York State *Prevention Agenda* priority area, "Preventing Chronic Diseases."

By providing essential resources and education, ERRHN empowered individuals to make healthier choices and reduce risk factors associated with chronic diseases.

PARTNERS

The Institute for Family Health; Cornell Cooperative Extension of Ulster County; Catholic Charities of Orange, Sullivan and Ulster; and the Ulster County departments of health and mental health.

OUTCOMES

This impactful initiative yielded three significant outcomes. Firstly, enhanced chronic disease management was achieved through personalized nutrition coaching, reaching 144 individuals. Impressively, this resulted in 23 participants experiencing lower A1C levels, 20 reducing their blood pressure and 21 achieving a lower body mass index. Secondly, the community's response to opioid overdoses was strengthened by training 444 individuals in Narcan administration. Finally, food security and nutrition access improved through the Farmacy program, which distributed 1,560 bags of fresh produce to families facing need. These measurable results underscore the initiative's comprehensive strategy towards promoting health equity, mitigating preventable health risks and fostering a more robust and healthier community.

LESSONS LEARNED

Personalized support, addressing specific needs and building trust, outperformed generalized approaches, fostering greater engagement and improved health outcomes. Collaborations with local organizations, healthcare providers and community leaders amplified the initiative's impact through resource sharing and culturally relevant interventions, empowering residents in their health and well-being for a holistic and sustainable approach.

SUSTAINABILITY

Sustainability is key to our initiative, driven by robust strategies for lasting impact. We build community capacity via training and education, empowering residents. Strong local partnerships ensure support and resource sharing. Integrating programs into healthcare guarantees service access. Diverse funding ensures stability, and data evaluation drives improvement and demonstrates impact. These strategies ensure our initiative's longevity, driving positive change and advancing health equity long-term.

CONTACT

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ELLIS MEDICINE

The Family Room: A Walk-in for Mental Healthcare for Adolescents and Teens

INITIATIVE DESCRIPTION AND GOALS

The Family Room is a first-of-its-kind walk-in mental health center for adolescents, providing immediate support in a welcoming, non-clinical environment. This initiative addresses the growing need for accessible youth mental health services, particularly post-pandemic. By diverting adolescents from emergency departments and connecting them to ongoing care, The Family Room is reducing overall healthcare costs and improving mental health outcomes in the community.

PARTNERS

Mother Cabrini Health Foundation, The Little Family Foundation, The Schenectady Foundation, local schools, healthcare providers and social service agencies.

OUTCOMES

- Eighty-five percent of The Family Room visitors avoided an ED trip, saving $357,900 in healthcare costs.
- Sixty-three percent of visitors presented with self-harm or suicidal ideation, underscoring the urgency of these services.
- There was a 32% average reduction in emotional distress levels among visitors.

LESSONS LEARNED

Low-barrier access points significantly improve mental health service utilization among youth. A welcoming, non-clinical setting fosters trust and engagement among adolescents in crisis.

SUSTAINABILITY

Continued community partnerships, grant funding from multiple local and statewide foundations, and expanded collaboration with school districts will help ensure long-term impact and sustainability.

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ERIE COUNTY MEDICAL CENTER

Hypertension Remote Patient Monitoring Program

INITIATIVE DESCRIPTION AND GOALS

ECMC's Remote Patient Monitoring Program addresses chronic disease prevention and management by improving hypertension awareness and control in socioeconomically disadvantaged populations. The initiative provides self-measured blood pressure monitoring, telehealth visits and pharmacist-led medication counseling to eliminate barriers to care such as transportation, cost and limited healthcare access.

Patients receive cellular tower-enabled blood pressure cuffs that sync with their mobile devices; those without phones are connected with social services for assistance. Through weekly remote monitoring, education and care coordination, the program empowers patients to self-manage hypertension, improve medication adherence and reduce cardiovascular risks.

Since its launch, hypertension control rates have increased from 24% to 73%, demonstrating the program's effectiveness in reducing health disparities, advancing health equity and aligning with the New York State *Prevention Agenda's* focus on chronic disease prevention.

PARTNERS

Buffalo Center for Health Equity, Independent Health Association, Highmark Inc., American Medical Association, American Heart Association and Univera.

OUTCOMES

- This initiative has enrolled more than 900 patients.
- Hypertension control compliance has skyrocketed from 24% in August 2022 to 73% in January 2025.
- In total, 88% of enrolled patients have seen an overall reduction in their systolic blood pressure, demonstrating the program's effectiveness in improving cardiovascular health.

LESSONS LEARNED

ECMC's RPM program taught two key lessons. First, addressing social determinants of health such as transportation and cost was critical to improving hypertension control. By providing free blood pressure cuffs and using telehealth, ECMC significantly increased patient engagement.

Second, patient-centered education and support were essential for long-term success. Weekly assessments, medication counseling and social work assistance helped patients better manage their hypertension and adhere to treatment plans, improving outcomes and engagement.

SUSTAINABILITY

ECMC and its partners intend to continue to use the impactful results of this program to ignite policy analysis, research, community engagement and payer reform to support the changes in the way healthcare is delivered that are necessary to reduce health disparities. The program's sustainability is also supported by an analysis of ED visits and inpatient admissions of primary care patients with hypertension at ECMC that shows the RPM Program's significant impact on reducing healthcare utilization and costs.

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FLUSHING HOSPITAL MEDICAL CENTER

Community-driven Approaches to Address Factors Contributing to Structural Racism in Public Health

INITIATIVE DESCRIPTION AND GOALS

Using culturally tailored interventions, provider training and policy advocacy, Flushing Hospital Medical Center's CDA initiative reduces stigma, language barriers and systemic obstacles preventing equitable mental healthcare. Key strategies include:

- embedding mental health services in primary care settings using telehealth and language-concordant providers;
- developing psychoeducational materials in multiple languages to increase patient empowerment;
- training primary care physicians to recognize and refer patients for mental health treatment; and
- advocating for Medicaid policy changes to remove barriers to integrated treatment.

Aligned with the New York State *Prevention Agenda's* "Promoting Well-Being and Preventing Mental Health Disorders" priority area, this initiative advances health equity by ensuring Asian American communities receive accessible, culturally competent mental healthcare. Through partnerships, advocacy and data-driven strategies, Flushing Hospital Medical Center is creating a sustainable, community-centered model for mental healthcare integration.

PARTNERS

Community Advisory Board, Coalition of Asian-American Independent Practice Association, Healthfirst, Nathan S. Kline Institute, New York State Office of Mental Health, New York City Mayor's Office on Community Mental Health, Asian American Federation, Jamaica Hospital Medical Center, NewYork-Presbyterian Queens Hospital, Tzu Chi Foundation, Garden of Hope, Rendr Care, Morehouse Medical College, CMS, Community Outreach Workers, advocacy groups, primary care physicians, legislators and policy advisors.

OUTCOMES

- First outpatient mental health encounters rose 138% overall, 152% for Asian patients and 433% for non-English-speaking Asian patients since the program's inception.
- Mental health session cancellations/no-shows decreased by 24% overall, 26% for Asian patients and 32% for non-English-speaking Asian patients.
- Successful connection to mental health services for internally referred patients improved 2.36 times in year 2, with increased physician referrals following targeted training programs.

LESSONS LEARNED

Providing language-concordant providers and culturally relevant materials significantly improved mental health service utilization and reduced stigma in Asian American communities.

Embedding mental health services in primary care settings and using telehealth solutions can make mental healthcare more accessible and acceptable for Asian patients, leading to higher referral rates and improved patient follow-through.

SUSTAINABILITY

Flushing Hospital Medical Center will ensure sustainability by integrating mental health services into primary care billable services, securing hospital and managed care partnerships, and advocating for policy changes to remove systemic barriers. Telehealth expansion, ongoing physician training and community collaborations will maintain accessibility. Grants and Medicaid reimbursement reforms will support long-term service delivery, ensuring continued mental health equity for underserved populations.

CONTACT

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HUNTINGTON HOSPITAL, NORTHWELL HEALTH

Huntington Hospital Food as Health

INITIATIVE DESCRIPTION AND GOALS

Huntington Hospital implemented a comprehensive program that provides immediate access to nutritious food and connects patients with community resources upon discharge. The target population includes children, women of childbearing age, older adults and minority groups, as they are disproportionately affected by food insecurity and experience more severe consequences. The Food as Health Program has given nurses tools to help patients navigate to more positive nutritional outcomes, which has led to a greater sense of comfort in the assessment of these patients.

This initiative, which aligns with New York State *Prevention Agenda* priorities, aims to reduce hospital readmissions due to food insecurity and poor nutrition, improve patient health outcomes by ensuring access to nutritious food, empower patients with the knowledge and skills for long-term food security and strengthen partnerships between hospitals and community organizations.

PARTNERS

The Townwide Fund, Town of Huntington, Town of Huntington Senior Center, Northwell Family Health Center, Family Service League, Island Harvest, Baldor Food Corp., US Foods, Casio Foods and CTown Supermarket.

OUTCOMES

The Food as Health program made a significant impact on the community's health, reducing disparities and advancing equity by:

- providing nutritious food to 378 patients who were food insecure: 176 in 2023 and 202 in 2024 (increase of 16%);
- connecting patients and families with food insecurity to the most appropriate community partner to sustain support; and
- identifying and prioritizing the five most important social determinants of health in the community.

These initiatives comprise a comprehensive strategy to combat food insecurity among patients. By addressing both immediate needs and long-term solutions, the initiative aims to improve patient health outcomes, break the cycle of food insecurity and empower people to maintain nutritional well-being beyond their hospital stay. This holistic approach recognizes that access to food is a fundamental determinant of health and that lasting change requires ongoing support and connection to community resources.

LESSONS LEARNED

It's crucial to understand community needs by actively listening to residents rather than making assumptions. This initiative emphasizes the importance of engaging the community and participants as integral members of the team.

Partnering with community-based organizations is essential for scaling the impact of these initiatives and ensuring they effectively address community needs. Strategic partnerships with aligned organizations and partners with specialized expertise are vital.

SUSTAINABILITY

Patient engagement and teamwork are essential. Northwell prioritizes ongoing involvement and collaboration among stakeholders to ensure lasting impact on the community. Sustainable funding is available from hospital budgets, value-based contracts and donations.

CONTACT

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MEDISYS HEALTH NETWORK

Lung Cancer Screening Pilot Project

INITIATIVE DESCRIPTION AND GOALS

MediSys Health Network initiated the Lung Cancer Screening Pilot Project to reduce lung cancer mortality through early detection. Targeting high-risk individuals aged 50 to 80 with smoking histories, the initiative addresses disparities in Queens and Kings counties by expanding access to low-dose computerized tomography screenings and overcoming barriers like cost, transportation and lack of awareness.

Key strategies include integrating LDCT into MediSys primary care, deploying bilingual patient navigators to assist with scheduling and logistics, and partnering with community organizations (e.g., faith groups) for culturally tailored outreach. The program aligns with New York State *Prevention Agenda* goals by prioritizing health equity, tobacco cessation and reducing late-stage diagnoses through timely screenings.

Collaboration with Memorial Sloan Kettering Cancer Center enhances clinical expertise and high-quality care for patients with positive low-dose CT results while local partners like Greater Allen AME Church host educational workshops. Provider education emphasizes screening eligibility and shared decision-making. The initiative has increased screening rates, improved follow-up care and empowered underserved populations to prioritize preventive health, advancing equitable cancer outcomes.

PARTNERS

Memorial Sloan Kettering Cancer Center, Jamaica Health Medical Center, Flushing Health Medical Center and Greater Allen AME Cathedral of New York.

OUTCOMES

- LDCT screenings increased to 33% (national average 5.7%) among high-risk groups within eight months, with 86% completing appointments via navigators addressing cost/transportation barriers. Screening disparities narrowed for Black/Hispanic populations, while provider referrals rose.
- Early detection reduced late-stage diagnoses, lowering mortality in underserved communities. The equity-focused model improved systemic access to care, creating a replicable framework for reducing health disparities.
- By uniting clinical expertise, community partnerships and patient-centered navigation, the project advanced health equity and set a sustainable precedent for cancer prevention.

LESSONS LEARNED

Involving community partners from the planning stage fostered buy-in and ensured the initiative addressed real needs. Adapting strategies based on feedback allowed for more effective outreach and service delivery, and regular data collection and analysis helped identify gaps and measure progress, ensuring continuous improvement.

SUSTAINABILITY

MediSys Health Network has committed to integrating LDCT screenings into routine care, ensuring ongoing funding and resources. Strong relationships with local organizations provide a durable network for continued outreach and engagement. Efforts to advocate for expanded insurance coverage and reimbursement for LDCT screenings aim to reduce financial barriers. The project's model can be replicated for other preventive services, leveraging existing infrastructure to address additional health disparities.

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MONTEFIORE NYACK HOSPITAL

Montefiore Nyack Community Chats

INITIATIVE DESCRIPTION AND GOALS

Montefiore Nyack Community Chats is a weekly health education resource program for the Hudson Valley community. Sessions are published on YouTube to make the information accessible to all who couldn't join the live sessions.

This program brings science-based health information and community resources to the public. It is a communication channel between the hospital and community members, where participants interact with presenters to learn about different health conditions and community resources, including those prioritized in the New York State *Prevention Agenda*.

PARTNERS

Albert Einstein School of Medicine, Alzheimer's Association, American Cancer Association, Haverstraw Collaborative, Highland Medical, Montefiore Advanced Care, Rockland County Department of Health, United Way, Volunteer Counseling Services and White Plains Hospital.

OUTCOMES

- This program has invited speakers from 79 organizations; all have been able to reach out to the community through this collaboration.
- 186 educational videos are now available on YouTube.
- 381 YouTube subscribers, 963 email subscribers, 6,621 registrations, 2,568 unique viewers and 3,997 total users.

LESSONS LEARNED

Choose your speakers well. Some professionals are very knowledgeable but are not comfortable presenting. Look for knowledgeable speakers with real-life experience that they can use in your talk and be entertaining, dynamic, fun and engaging.

Know your audience. It's helpful to let speakers know that their audience comes from all education levels, and the simpler they can explain concepts, the better. Speaking clearly and non-technically keeps the attendees engaged and at ease with asking questions.

Ask for feedback. In every flyer, the hospital shares where people can send comments and ideas for new topics. The hospital also sends satisfaction surveys. This helps the community feel included in the program, targets the webinars to their needs and makes the webinars more popular and valuable.

SUSTAINABILITY

The program budget is for a Zoom Pro subscription at $300 per year. Speakers present free of charge. Staff and/or volunteer time is required weekly to produce and promote the shows.

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MOUNT SINAI HEALTH SYSTEM

Mount Sinai Robert F. Smith Mobile Prostate Cancer Screening

INITIATIVE DESCRIPTION AND GOALS

Launched in 2022 with a $3.8 million donation, the mobile unit provides free prostate cancer screenings, education and referrals to treatment. By bringing healthcare directly to neighborhoods with high concentrations of Black men, the initiative eliminates barriers such as transportation, time constraints and lack of healthcare access.

The initiative's goals are to:

- increase screening rates among Black men, who are at higher risk for prostate cancer;
- lower prostate cancer mortality by improving early detection;
- raise awareness about prostate cancer and the importance of regular screenings; and
- provide access to follow-up care and treatment for those who need it.

This initiative aligns with the New York State *Prevention Agenda* priority area, "Reducing Health Disparities," by targeting a high-risk, underserved population, providing equitable access to preventive care and addressing health disparities in cancer outcomes.

PARTNERS

Local churches, health centers, community groups, street health expos and charity events.

OUTCOMES

- More than 4,400 men were screened in the first two years and 63% identified as Black men.
- 19% of those screened had an elevated prostate-specific antigen of 2.5 or higher, leading to referrals for follow-up care with a urologist.
- The mobile unit reached diverse neighborhoods, serving 25 to 30 men per visit. It expanded its outreach by visiting local churches and community events throughout New York City and beyond.

LESSONS LEARNED

Building trust within underserved communities is essential for the success of health initiatives. The initiative reached more individuals who might otherwise avoid screenings by partnering with local organizations and meeting people where they are.

Offering services in easily accessible locations, including weekends and evenings, improved participation. Addressing barriers like time off work and childcare was key to ensuring broader community engagement.

SUSTAINABILITY

The mobile prostate cancer screening program relies on continued funding and strong community partnerships to ensure sustainability. Robert F. Smith's $3.8 million donation provides a solid financial foundation, while ongoing collaboration with local churches, health centers and community organizations ensures long-term engagement and outreach. The initiative is expanding its services and continuously improving by incorporating feedback from community members, supporting its ability to adapt and thrive.

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NATHAN LITTAUER HOSPITAL AND NURSING HOME

Work Without Limits: Nathan Littauer and Transitions Neurodivergent Career Pathways

INITIATIVE DESCRIPTION AND GOALS

In rural communities, opportunities for individuals with autism and learning differences are often limited, leading to social isolation, anxiety and decreased overall well-being. Through this initiative, participants receive structured job training and three to six months of coaching, ensuring they gain confidence and independence. Hospital staff have embraced these individuals as valued team members, fostering a safe, supportive environment that encourages personal and professional growth.

This program benefits both the hospital and the community, providing reliable staffing in critical hospital roles while enhancing workplace diversity. This initiative supports the *Prevention Agenda's* "Advancing Health Equity and Promoting Mental Well-being" priority area, improving workforce integration and promoting mental well-being in the rural Adirondack region.

PARTNERS

Transitions (Gloversville) and ARC Lexington (Gloversville).

OUTCOMES

- Six neurodivergent individuals have been hired, with four more in the pipeline. Each new employee receives three to six months of coaching, ensuring a smooth transition and job success.
- Participants have demonstrated 100% attendance, providing consistent, dependable support in hospital departments such as environmental services, nutrition and patient care. Employees report increased confidence and independence, while staff embrace them as valued team members, fostering a more inclusive workplace culture.

LESSONS LEARNED

Two key lessons learned are the compassion of staff and the belief that everyone, regardless of where they are in life, can contribute meaningfully. The partnership with Transitions has provided invaluable productivity and staffing to Nathan Littauer Hospital, while helping individuals achieve their life's potential. Healthcare professionals have embraced new colleagues with kindness and the tailored coaching offered ensures participants receive the support they need to thrive in their roles.

SUSTAINABILITY

To ensure long-term sustainability, Nathan Littauer committed to maintaining a strong partnership with Transitions, which provides essential training and coaching for individuals with autism and other neurodivergent conditions.

Expanding the scope of roles and offering new opportunities — including internships, clerical positions and additional job pathways — ensures continued program growth and accessibility.

Ongoing coaching support for new employees ensures they receive the guidance needed to integrate successfully, reinforcing long-term success, workplace inclusion and professional development. This commitment strengthens both the workforce and the community, making sure that neurodivergent individuals have opportunities to thrive for years to come.

CONTACT

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NEWYORK-PRESBYTERIAN

Prevention and Education in Advanced Kidney Disease

INITIATIVE DESCRIPTION AND GOALS

The Prevention and Education for Advanced Kidney Disease program addresses disparities associated with chronic kidney disease in underserved communities. Launched in 2015, PEAK focuses on individualized support and education to empower patients with CKD. The program aims to improve outcomes by increasing preemptive kidney transplant rates, home dialysis rates, optimal vascular access and the initiation of dialysis in outpatient settings.

PEAK operates through an interdisciplinary team, language-concordant care, culturally competent support and data-informed outreach. It leverages an electronic medical record-based risk stratification model to target high-risk patients. This model has proven effective in improving patient engagement and reducing care gaps. In 2023, PEAK expanded to two additional sites in Northern Manhattan and the South Bronx, areas with high CKD prevalence and significant health disparities.

The program aligns with the New York State *Prevention Agenda* "Preventive Services for Chronic Disease Prevention and Control" priority area. By improving care coordination, expanding early interventions and increasing access to patient education, PEAK is a model for reducing CKD disparities and promoting health equity across underserved communities.

PARTNERS

Columbia University Vagelos College of Physicians and Surgeons Division of Nephrology, Rogosin Institute, Dalio Center for Health Justice at NewYork-Presbyterian, Food FARMacy, West Side Campaign Against Hunger, Renewal and the Center for Independence of the Disabled New York.

OUTCOMES

Among patients initiating kidney replacement therapy:

- ten percent received a preemptive transplant (vs. 3.1% nationally), which is the optimal therapy for end-stage renal disease patients and associated with improved survival;
- twenty-six percent chose home dialysis (vs. 5.6% NYC, 13.1% nationally), which is the optimal modality, allowing patient convenience and flexibility; and
- fifty-seven percent achieved an optimal dialysis start, which is associated with lower costs and reduced mortality.

LESSONS LEARNED

PEAK exceeded national averages in preemptive transplant rates, home dialysis rates and dialysis initiation without inpatient admission. High patient and clinician engagement was demonstrated through visit completion and referral rates. A key lesson learned was using an electronic medical record-based risk stratification model to focus on high-risk patients and prevent care gaps. Additionally, the use of telehealth enhanced care coordination, increasing the efficiency of weekly meetings and remote visits.

SUSTAINABILITY

The PEAK program is integrated into hospital clinical operations, ensuring long-term sustainability. Given its success, leadership has committed to maintaining it beyond the pilot. Key performance indicators are embedded in the electronic medical record, including a referral pathway and risk stratification model to monitor outcomes and optimize care. Continuous evaluation of impact, patient satisfaction and cost-effectiveness ensures ongoing program refinement and success.

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TOP 5

NEWYORK-PRESBYTERIAN HOSPITAL

Sexual Health Mobile Medical Unit

INITIATIVE DESCRIPTION AND GOALS

NewYork-Presbyterian Hospital's Sexual Health Mobile Medical Unit, part of the Division of Community and Population Health, serves as an Article 28 sexual health clinic that operates within the most vulnerable communities in the Bronx, Brooklyn, Queens and Manhattan. The mission of the SHMMU is to support New York state's End the HIV Epidemic initiative by providing broad HIV testing to people at risk, identifying people with HIV who are undiagnosed and linking HIV+ people who are out of care to the services they need.

The SHMMU provides access to and information about HIV and PrEP and PEP-two medications that are used to protect against HIV transmission. The SHMMU also offers comprehensive testing and treatment for sexually transmitted infections and hepatitis C, as these infections have been concurrent with the HIV epidemic.

The initiative focuses on the New York State *Prevention Agenda* priority of "Preventing Communicable Diseases," with a primary focus on reducing new HIV diagnoses and achieving viral suppression through linkage to ongoing care, while addressing sexually-transmitted diseases and hepatitis C.

PARTNERS

CAMBA, Mexican Coalition, Voces Latinas, Prospect Park Alliance, New York City Department of Health and Mental Hygiene, Project STAY, Brooklyn Community Pride Center, Medger Evers College, GMHC and Red Canary Song.

OUTCOMES

- The SHMMU tested 95% of its patients for STIs and 92% for HIV. Due to the high testing rates, the team offered PrEP access to all and was able to support 15% of patients seen in accessing PrEP.
- In 2024, the SHMMU operated in the Bronx 23 times, Brooklyn 38 times and Queens 11 times. Its mobility allows the SHMMU to support sites like the NYCDOHMH Sexual Health Center in Brooklyn, Voces Latinas (a community-based organization in Queens) and the Mexican Coalition in the Bronx.

LESSONS LEARNED

The most important lesson is the value of having staffing coverage that can help support the SHMMU roles. As a result of staffing shortages, the SHMMU was not able to go out to the field about 18% of scheduled times.

Since the SHMMU is out in the field, there are a variety of issues that can arise — from weather to the generator causing issues or the refrigerator not working. The lesson learned is to have a standard operating procedure so that people can refer to the document as a guiding point.

SUSTAINABILITY

The SHMMU aims to be fully sustainable by leveraging insurance revenue to support its operational costs. Hours of operation are currently four days a week; expanding to a seven-day schedule will maximize billing potential.

CONTACT

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NOYES HEALTH, UR MEDICINE

SDOH Focus: Food Insecurity

INITIATIVE DESCRIPTION AND GOALS

The initiative is simple: providing food and community resources to those in need so they can focus on their recovery once they return home from the hospital. Every patient admitted to the inpatient units, regardless of age, race, gender, socioeconomic status or health literacy, is screened on their social determinants of health. If a disparity is identified, the appropriate community resource is discussed and referred to the patient. Noyes Health's emergency food pantry aligns with the New York State *Prevention Agenda* "Economic Stability" priority area.

PARTNERS

Foodlink Inc. of the Rochester Area, Finger Lakes Rural Health Network, Livingston County Food Security Coalition, Noyes Memorial Hospital Core Team, Noyes Employees and anonymous donors.

OUTCOMES

- Noyes Health successfully supported 122 households and 251 individuals by giving 194 bags of food to those who most needed it in 2024.
- This was achieved by successfully screening 94% of all admitted patients and finding that 4.6% identified as having food insecurity.

LESSONS LEARNED

Patients who have extensive food allergies are apprehensive about food pantry items and will refuse them. Thus, the hospital has begun to tailor the items in each bag according to allergies or restrictions due to medical conditions.

People experiencing homelessness may need can openers, utensils and paper products. Therefore, the hospital keeps a supply to give when appropriate.

SUSTAINABILITY

Beginning with the end in mind is key to sustainability. Strong partnerships within the community and with Foodlink Inc. drive this success. The initiative has anonymous donors to fall back on and the ability to tap into the hospital's passionate employees to hold an internal can drive and host additional fundraisers if needed.

With the use of only non-perishable items, no refrigeration is required. This reduces waste and provides a longer shelf life.

Financially, the larger items are purchased, enabling future funding to go directly to items that are needed the most: food.

CONTACT

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NUVANCE HEALTH

Nuvance Health Food as Medicine Program

INITIATIVE DESCRIPTION AND GOALS

Review of Vassar Brothers Medical Center's recent Community Health Needs Assessments showed the impact of the intersection of chronic diseases like hypertension and diabetes with food and nutrition security among Dutchess County residents. Nuvance Health created a three-year strategic plan for the development, implementation, maintenance and refinement of the FAM Program. Through this program, patients with nutrition-sensitive chronic diseases such as hypertension are screened for food insecurity. Those who screen positive are offered a referral to one of two FAM Program grocery stores twice monthly and access to a registered dietician nutritionist and food preparation demonstrations.

PARTNERS

Dutchess Outreach and Culinary Institute of America.

OUTCOMES

- Forty-eight percent of program participants had five points or greater reduction in systolic blood pressure (48% improvement of systolic blood pressure by 5 mmHg or more for a total of 31 participants with at least 2 BP measurements).
- Fifty-four percent had four points of greater reduction in their diastolic blood pressure (54% improvement of diastolic blood pressure by 4 mmHg or more for a total of 31 participants with at least 2 BP measurements).
- A reduction in food and nutrition insecurity measures was revealed through patient-reported data.

LESSONS LEARNED

Sustainable behavioral change requires time, reinforcement and ongoing education. Simply providing access to healthy food is not enough — true impact comes from equipping individuals with the knowledge, skills and encouragement to integrate healthier habits into their daily lives.

Every individual's journey toward better health is shaped by their personal experiences, family traditions and cultural background. You must acknowledge and respect these factors to achieve meaningful change.

SUSTAINABILITY

Aligning the FAM Program outcome measures with strategic goals of the organization and community needs is necessary to demonstrate the return on investment in the form of decreased emergency department utilization and achievement of CMS targets around hypertension control and other key ambulatory conditions.

Additional opportunities supporting ROI include provider and payer (e.g., Medicaid) reimbursement for services provided through a medically tailored groceries program such as the FAM Program. To this end, it will be necessary to engage the Nuvance Health Community Benefits resources to offer input in the development of the FAM Program to further support organizational alignment and promote sustainability. New York's 1115 waiver is expected to offer additional funding sources. Grants and philanthropy continue to be sources of funding.

CONTACT

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NYC HEALTH + HOSPITALS

NYC Care

INITIATIVE DESCRIPTION AND GOALS

NYC Care is a healthcare access program that guarantees low-cost and no-cost services offered by NYC Health + Hospitals to New Yorkers who do not qualify for or cannot afford health insurance based on federal guidelines. NYC Care members can receive preventive care like vaccinations, routine screenings and mammograms to stay healthy. Support from a primary care team also includes nurses, medical assistants, social workers, pharmacists and nutritionists.

Its benefits can be felt across all focus areas of the New York State *Prevention Agenda*, including "Promote Well-Being and Prevent Mental and Substance Use Disorders," "Preventing Chronic Diseases," "Promote a Healthy and Safe Environment" and "Promote Healthy Women, Infants and Children." NYC Care touches each of these priorities in a way other programs do not. Primary and preventive care, specialty care and behavioral health are all significant efforts that are included in the NYC Care continuum of care.

PARTNERS

Academy of Medical & Public Health Services (now RaisingHealth), Adhikaar for Human Rights and Social Justice, AIDS Center of Queens County, Alliance for Positive Change, Arab-American Family Support Center, Center for the Independence of the Disabled, Center for the Integration and Advancement of New Americans, Council of Peoples Organization, DSI International, Emerald Isle Immigration Center, Jewish Community Council of the Rockaway Peninsula, Korean Community Services, La Jornada, Make the Road NY, Mixteca Organization, Metropolitan New York Coordinating Council on Jewish Poverty, Project Hospitality, Sauti Yetu Center for African Women, Single Stop USA, South Asian Council for Social Services, United Sikhs and Voces Latinas.

OUTCOMES

- 141,000+ current members, of which 65% percent are below 100% of the federal poverty level and 95% are below 200% FPL.
- Members have had over 669,000 primary and specialty care appointments, including more than 76,000 telehealth appointments. Members have sought specialty care in areas such as gynecology, cardiology, surgery, ophthalmology and podiatry.
- About 90,000 members have had U.S. Preventive Services Task Force-recommended cancer screenings.
- Fifty-three percent of members with diabetes enrolled in the program for at least six months have seen an improvement in their hemoglobin A1C readings.
- Similarly, 40% of members with hypertension who have been enrolled in the program for at least six months have seen an improvement in their blood pressure.

LESSONS LEARNED

NYC Care has provided pathways for New Yorkers to access affordable quality healthcare. NYC Care has learned that community-based partnerships, outreach and culturally-sensitive care create vital conduits for community members to achieve better health and well-being.

SUSTAINABILITY

Since NYC Care is not health insurance and individuals do not have to pay monthly fees, health services are available at a discount rate based on household size and income. The program is also supported by the New York City Office of the Mayor.

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NYC HEALTH + HOSPITALS/ELMHURST

Elmhurst Suicide Prevention in Youth

INITIATIVE DESCRIPTION AND GOALS

Elmhurst Suicide Prevention in Youth aims to establish a welcoming environment where adolescents from all walks of life have access to mental healthcare. ESPY is committed to serving adolescents between the ages of 12-24, focusing on marginalized youth who frequently encounter barriers to care.

The goal is to decrease stigma associated with mental health and suicide and offer vital services of education, community outreach, workshops and suicide screening to help empower young people to care for their mental health. We collaborate with community organizations and schools to provide programming to increase accessibility and outreach. SDoH screenings are conducted and linkages to resources (e.g., health insurance, primary health, education) are completed. Suicide screenings are conducted and referrals to counseling services are facilitated.

Recognizing the importance of family involvement, the hospital works with caregivers through educational sessions, counseling and presentations aimed at reducing suicide risk through prevention. The approach is comprehensive, satisfying acute mental health needs and long-term well-being by providing adolescents and their families with the tools, information and support networks they require to thrive.

PARTNERS

City University of New York, Common Point Queens, NYC Department of Health and Mental Hygiene, Forest Hills High School, Newtown High School, Queens High School for the Sciences at York College, I.S. 5, I.S. 141, I.S. 61Q, ATLAS/Newcomers High School, Colectivo Intercultural TRANSgrediendo, Voces Latinas, Elmhurst/Corona Family Enrichment Center, Vibrant Emotional Health, Talkspace/NYC Teenspace, Plaza Del Sol Family Health Center, MetroPlus, Venture House, 34th Avenue Open Streets, Queens Botanical Gardens, SAYA, TSINY, First Baptist Church of Corona, Ganesh temple, Assemblymembers Catalina Cruz, Steven Raga and Jessica Gonzalez Rojas, and City Council Member Shekar Krishnan.

OUTCOMES

- Feedback: Surveys from participants indicate increases in awareness of signs of suicide, coping strategies, resources and reported likelihood to seek help. Participants also report an increase in sense of community.
- Community engagement and outreach: In 2024, programming provided educational materials on suicide prevention/awareness and resources to 9,545 people.
- Education: 380 individual health education discussions; 2,990 youth/young adults engaged in groups on suicide prevention and community supports/resources.
- Workshops: 506 youth and parents participated in workshops on mental health and wellness, creative expression, mindful movement, etc.

LESSONS LEARNED

- Inclusivity and accessibility: Services and materials must be culturally sensitive and reflect the diversity of the community in language and preference of resources. Utilizing trusted partnerships to market programming and reduce stigma is essential.
- Building and deepening partnerships: Establishing working relationships with local clinics, schools and community-based organizations allows the program to maintain presence and support for the individuals it serves.

SUSTAINABILITY

- Engagement and feedback: Feedback surveys and successful programming (e.g., Block Party, Drag Story Hour) demonstrate enhanced awareness of suicide prevention and community solidarity.
- Cultural sensitivity: Our "Be Sensitive, Be Brave" certified trainers provide effective culturally relevant suicide prevention interventions that fortify our diverse populations with relevant resources.
- Referral networks: We have established sustainable referral pathways to mental healthcare.

CONTACT

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ONE BROOKLYN HEALTH SYSTEM

Roots to Wellness Food Box Program

INITIATIVE DESCRIPTION AND GOALS

Launched in 2023, the One Brooklyn Health Roots to Wellness Food Box Program aims to increase access to and improve affordability of locally grown produce by providing fresh fruit and vegetable bags through a community-supported agriculture model. In line with 2024 New York State *Prevention Agenda* priority area, "Prevent Chronic Diseases," it also addresses chronic diet-related illness and strengthens local food systems.

One Brooklyn Health has long recognized disparities in diet-related health outcomes such as obesity, diabetes and hypertension across communities served compared to neighboring areas. To address and alleviate the burden of social and structural drivers of health impacting the community, and with a deep understanding of the role of nutrition and lifestyle in preventing and managing disease, the system uses a "food as medicine" strategy to promote health for patients, staff and the community.

Offering a weekly opt-in allows more flexibility than a traditional CSA, eliminating upfront financial commitment for participants. To further increase access, the program provided a 50% subsidy on food bags ordered by health system patients. This work is rooted in principles of food justice, intended to bring fresh foods to the community, but also support local producers and promote community-led food systems.

PARTNERS

Brooklyn Packers LLC, Isabahlia Ladies of Elegance Farms, GrowNYC, Cultivating Justice LLC and Dreyfus Health Policy & Research Center.

OUTCOMES

- The program enrolled 571 participants over six months. It saw a 24% retention rate among participants and distributed more than 7,000 pounds of produce.
- 83% of survey respondents reported using all or most of the produce in their food bags.
- The program helped 54% of respondents save money, 51% save time to go to the grocery store, 41% reach health goals and 12% lower stress levels. 57% were influenced to try new produce, 54% ate more fruits and vegetables and 43% used new recipes.

LESSONS LEARNED

Program success is attributed to strong community partnerships, outreach, participant engagement and food justice. One Brooklyn Health looks forward to expanding its reach through increasing provider referrals, establishing partnerships with local businesses and community and faith-based organizations, and expanding an online presence for the program. As One Brooklyn Health expands its food as medicine infrastructure, it will consider referral pathways that meet individual needs related to, for example, transportation and means for food storage.

SUSTAINABILITY

One Brooklyn Health is seeking opportunities for funding and collaboration with local growers, community-based organizations and academic partners to grow the Roots to Wellness Program and expand its food as medicine initiatives. The health system will also explore opportunities for sustainability through New York's 1115 waiver to ensure access to a sustainable fresh food model.

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ONEIDA HEALTH

Behavioral Health Collaborative Care

INITIATIVE DESCRIPTION AND GOALS

This initiative aimed to improve behavioral health outcomes in rural Madison County and western Oneida County by integrating behavioral healthcare services in the primary care setting and increasing access to behavioral healthcare services for the target population. This initiative sought to increase the number of patients screened and referred, as appropriate, for behavioral health from primary care providers and developing care team skills using the evidence-based stepped model of behavioral healthcare integration.

PARTNERS

Madison County Mental Health, Bridges, Family Counseling Services of Cortland, Oneida Medical Services, Oneida Medical Practices and Oneida Health Systems.

OUTCOMES

- Care team skills were developed using the evidence-based stepped model of behavioral healthcare integration (collaborative care model selected).
- Data-sharing agreements were established between core partners.
- Patients in need of behavioral/mental health treatment were identified.
- By year four 80% of patients in primary care offices were screened using Patient Health Questionaire-2.
- Patients were referred to counseling and other behavioral/mental health treatment and social services as needed.
- Licensed professionals were embedded in primary care offices to see patients for intake, referrals and ongoing therapy.

LESSONS LEARNED

Be completely transparent with community partners. Given the rural nature of this community and past experiences they have had with the health system, people were reluctant to provide support initially. Historically, the hospital and its outpatient programs had not been engaged in community initiatives.

It was more important to have behavioral health professionals that had a good understanding of rural culture.

SUSTAINABILITY

Oneida Health will prioritize federal and state grant opportunities that align with its objective. To ensure financial targets are met, the Orion Behavioral Health Consortium will implement ongoing monitoring of revenue from patient volume, reimbursement and donations. Regular financial reviews led by the project director will allow ORION to adjust strategies as needed to meet budget goals. This monitoring process will include quarterly evaluations to assess the success of income-generating activities and the effectiveness of funding sources.

CONTACT

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PHELPS HOSPITAL, NORTHWELL HEALTH

Westchester Community Paramedicine

INITIATIVE DESCRIPTION AND GOALS

Westchester Community Paramedicine's mission is to revolutionize patient care by delivering high-quality medical services to people in their homes. Specially trained community paramedics from the Ossining Volunteer Ambulance Corps, working under physician supervision, provide care in the comfort of patients' homes.

The community paramedics screen, assess and treat patients who may not need emergency or hospital care. Leveraging telehealth services, the patients and community paramedics are connected to a physician in the Northwell Health Physician Partners Network or Northwell Emergency Telehealth Services, ensuring medical expertise is never far away.

Community paramedics have a front-row view of other social determinants of health, including loneliness and food insecurity, self-care routines and home safety, and will help make modifications and suggest referrals as needed to support the patient. With the ability to connect with social workers, Westchester Community Paramedicine, in partnership with Phelps Hospital's Community Partnership Program, provides holistic care to patients.

PARTNERS

Ossining Volunteer Ambulance Corps, Northwell Emergency Telehealth Services, Northwell's Center for Emergency Medical Services, Frank and Lisina Hoch Center for Emergency Education, Thomas E. and Alice Marie Hales Caregivers Center, Phelps Hospital Community Partnership Program, Family Services of Westchester, Neighbors Link, Hospice Care Network, Jansen Hospice & Palliative Care, LifeStance Health and PDI Health.

OUTCOMES

- The program demonstrated significant success in avoiding unnecessary hospital transports. 170 patients reported they would have gone to the hospital if the program had not been available.
- Satisfaction surveys focusing on communication, home healthcare management, teamwork and collaboration revealed 100% positive responses and a 100% program recommendation rate among respondents.
- The program facilitated end-of-life care by referring 18 palliative care patients to hospice services.

LESSONS LEARNED

The program design evolved from a single-agency focus to a scalable, geographically distributed model leveraging telehealth and coordinated emergency medical services. Early on, it was evident there needed to be close collaboration between the community paramedics, care coordinators and social workers. The initiative shifted from offering just medical evaluations, screenings and treatments to developing pathways for positive social determinants of health.

SUSTAINABILITY

Frameworks, handbooks and infrastructures allow for sustainability and future growth. Pending legislation to allow EMS agencies to be paid for "treat in place" encounters would enable funding to EMS agencies. As a leader in the field, the program is positioned to seamlessly integrate into the new payment model. With experience in developing the program through a hospital and EMS partnership, the program is positioned to aid others in the future program development.

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RICHMOND UNIVERSITY MEDICAL CENTER

Early Childhood Developmental Support Initiative

INITIATIVE DESCRIPTION AND GOALS

Richmond University Medical Center noticed long delays in connecting children — especially from underserved communities — to early intervention services. Wait times for physical, occupational and speech therapy often exceeded six months, risking long-term developmental impacts. Partnering with its rehabilitation department and community organizations, RUMC launched the Early Childhood Developmental Support Initiative, reducing wait times for these therapies to just three to four weeks. RUMC implemented standardized tools to identify high-risk children, including neonatal intensive care unit graduates.

By integrating screenings into well-child visits and streamlining referrals, the program ensures timely, equitable access to care, aligning with the New York State *Prevention Agenda's* "Child Health and Social-Emotional Development" priority area.

PARTNER

The Institute for Basic Research.

OUTCOMES

This initiative achieved three key outcomes:

- RUMC decreased the average wait time for physical, occupational and speech therapy from over six months to just three to four weeks, ensuring timely access to critical interventions.
- This initiative enrolled 1,500 children from birth to age three in therapy, giving them access to services during the most critical window of early development.
- Preliminary data show that a significant percentage of children who received early intervention demonstrated measurable improvements in developmental milestones within six months, highlighting the program's effectiveness.

These outcomes underscore the Early Childhood Developmental Support Initiative's success in addressing health disparities and advancing equity through early intervention and streamlined care.

LESSONS LEARNED

Early identification is crucial. Partnering with a community organization to conduct screenings as early as the neonatal stage allowed RUMC to detect developmental concerns sooner, leading to timely interventions and better outcomes.

Streamlined referral pathways significantly reduce delays. By embedding a direct referral system, this initiative reduced wait times, ensuring children receive critical therapies without unnecessary delays.

SUSTAINABILITY

The Early Childhood Developmental Support Initiative is sustainable through integration into routine pediatric care, which eliminates the need for additional visits, ensuring efficiency and reducing costs; strong partnerships with a community organization and health network, which provide ongoing expertise, trust and seamless access to services; institutional support and data-driven advocacy, which use measurable outcomes (e.g., reduced wait times, improved milestones) to secure continued funding and resources; expansion plans to reach 1,000 children annually by 2026, ensuring the program grows and adapts to meet community needs; and proven success in early identification and intervention, which strengthens the case for long-term support and equitable access for future generations.

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ROCHESTER REGIONAL HEALTH

Diversity in Healthcare Pipeline Program

INITIATIVE DESCRIPTION AND GOALS

The Diversity in Healthcare Pipeline Program offers students an educational journey leading to a career path to economic stability for this generation and the next.

This initiative also enables RRH to work on improving access to and quality of care by providing an opportunity for students to connect with healthcare professionals, ask questions and get a better understanding of what healthcare is, why it's important and how they can join the profession to help future efforts to improve care access and quality.

PARTNERS

Rochester Institute of Technology, Rochester City School District, Hackensack Pharmacist, Highland Hospital LPN and Black Physicians Network of Rochester.

OUTCOMES

- More than 420 participating students served, 2022-2024.
- 54 interactive healthcare workshops, 2022-2024.
- 108 volunteers from RRH and the community, 2022-2024.

LESSONS LEARNED

It is important to partner with internal team members to showcase the various careers available and embed the entry points to the health system into the program (Youth Action Project, volunteer, human resources) by sharing information and materials with school counselors and students.

Maximize the engagement with students by adding an educational icebreaker and world café-style career panel for the students to get one-on-one time with healthcare career volunteers.

It is important to restructure the program schedule to make it an interactive education opportunity for the youth.

SUSTAINABILITY

To sustain the program, RRH chose five area schools to work with for five years to measure impact. Working with a small group of schools allows the hospital to focus on middle school and high school students, determine what entry points the program is supporting most and develop a plan to expand programming with the RRH footprint.

The hospital is working with HR to identify and showcase high-demand careers to strategically target shortages due to the "silver tsunami" and other factors effecting the workforce.

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TOP 5

ST. JOHN'S EPISCOPAL HOSPITAL, EPISCOPAL HEALTH SERVICES

The Doula Care Program

INITIATIVE DESCRIPTION AND GOALS

St. John's Episcopal Hospital, Episcopal Health Services, launched the Doula Care Program in 2022 to address alarming rates of maternal mortality and morbidity among black and brown women. By providing continuous support before, during and after childbirth, the doulas have improved maternal and neonatal outcomes, aligning with the New York State *Prevention Agenda*.

The Doula Program's focus on social determinants of health ensures holistic care for expectant mothers, addressing economic hardship (i.e., listening to patients and providing the things that they need), food insecurity and transportation needs. The doula program gives free, culturally sensitive support to expectant mothers, leading to better birth outcomes. By integrating doulas into the labor and delivery units, St. John's has seen higher breastfeeding rates, fewer c-sections and less postpartum depression.

PARTNERS

ICARE Foundation, God's Love We Deliver, The Allied Foundation Diaper Bank, Love Nana and Ocean Bay Development Corporation.

OUTCOMES

- Improved mental health: A 50% reduction in high-risk Edinburgh Postnatal Depression Scale scores and nearly 100% of flagged mothers connected to behavioral health resources, reducing postpartum depression and anxiety rates.
- Higher breastfeeding exclusivity: Rates increased from 8% to 16% (a 50% increase), demonstrating enhanced lactation support and maternal education.
- Increased maternal education engagement: 65% of patients participated in childbirth education, the Centering Program or newborn care classes, improving maternal knowledge and confidence.

LESSONS LEARNED

Holistic maternal care improves outcomes. Integrating doulas with mental health screenings and social services led to improved maternal health, demonstrating the effectiveness of a comprehensive, patient-centered approach.

Community partnerships strengthen impact. Collaborations with local health organizations, social service providers and advocacy groups enhanced resource accessibility, ensuring long-term support for mothers beyond childbirth.

SUSTAINABILITY

The Doula Care Program is sustained through grant funding (Mother Cabrini Health Foundation, Elevance Health), Medicaid reimbursement, advocacy and workforce training partnerships. Embedding doulas into hospital workflows and expanding community collaborations ensures long-term financial viability and continued impact on maternal health disparities in underserved communities.

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ST. LAWRENCE HEALTH, ROCHESTER REGIONAL HEALTH

Chronic Disease Self-Management Programs

INITIATIVE DESCRIPTION AND GOALS

St. Lawrence Health, in collaboration with the St. Lawrence County Health Initiative and The Heart Network, is dedicated to increasing the number of adults with chronic conditions who participate in self-management programs. The Chronic Disease Self-Management Programs are designed for individuals living with cancer, heart disease, stroke, diabetes, arthritis and other chronic conditions, and their caregivers.

These evidence-based programs provide support, empowerment and practical strategies to enhance quality of life and promote effective disease management. Participants gain valuable tools to prevent complications, improve daily function and take an active role in their health.

This initiative aligns with the New York State *Prevention Agenda* "Prevent Chronic Diseases" priority area and offers programs including:

- Chronic Disease Self-Management Program;
- Diabetes Self-Management Program;
- Chronic Pain Self-Management Program; and
- Cancer: Thriving and Surviving Program.

By expanding access to these resources, St. Lawrence Health aims to empower individuals to take control of their health and enhance overall community well-being.

PARTNERS

St. Lawrence County Health Initiative and The Heart Network.

OUTCOMES

- Participants report better management of symptoms, including reduced pain, fatigue and emotional distress.
- Increased adherence to medication and treatment plans is leading to better disease control.
- There are fewer hospital visits and emergency room admissions, easing the burden on the healthcare system.

LESSONS LEARNED

Providing personalized resources, addressing the unique challenges of each condition and being flexible with program delivery (such as offering workshops in different formats) enhances engagement and outcomes.

Building and nurturing a peer support network within the program improves long-term engagement and helps participants feel less isolated in managing their chronic conditions.

SUSTAINABILITY

By using existing employees and volunteer community members to teach the programs, St. Lawrence Health, in collaboration with the St. Lawrence County Health Initiative and The Heart Network, can offer these classes at minimal cost to the health system, ensuring the sustainability of the initiative.

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ST. MARY'S HEALTHCARE

Open Access Counseling Services

INITIATIVE DESCRIPTION AND GOALS

St. Mary's Healthcare launched walk-in Open Access Counseling Services to meet the growing need for behavioral healthcare in its rural community. Before Open Access, patients in distress often had to wait months for an appointment. Some were so discouraged they gave up on seeking care. Now, patients ages 5 and up can come to the Open Access clinic and receive services the same day. Patients can also be more easily connected to follow-up care.

The Open Access Counseling Services initiative aligns with multiple New York State *Prevention Agenda* priorities, including "Economic Stability and Well-being," "Mental Well-being and Substance Use," "Safe and Healthy Communities" and "Healthcare Access and Quality."

PARTNERS

Amsterdam City Schools; Catholic Charities; Cities of Amsterdam and Gloversville; The Family Counseling Center; Fulton County; Fulton-Montgomery Community College; Helio Health; HFM Prevention Council; Hillcrest Spring Residential; Liberty ARC; Mental Health Association in Fulton and Montgomery Counties; Montgomery County; Montgomery County Family Court; Montgomery County Schools; Mountain Valley Hospice; New Dimensions in Living; Private Industry Council; St. Mary's Healthcare Primary Care Centers; and the towns of Amsterdam, Caroga, Mayfield, Root and St. Johnsville, and Village of St. Johnsville.

OUTCOMES

Through Open Access Counseling Services, St. Mary's Healthcare has:

- provided services at 3,842 Open Access visits, including serving 1,757 people who visited more than once — the number of patient visits increased by 25% from 2023 to 2024;
- made 888 referrals for patients to follow-up care and support services within and beyond the St. Mary's organization; and
- dramatically reduced delays in treatment, as patients who previously waited months for appointments now walk in and receive care the same day.

LESSONS LEARNED

Open Access works because of its patient-centered, collaborative approach. Walk-in care is available on patients' schedules. Coordinated community services address multiple patient needs and build trust.

Communication — with patients, among the care team and with community partners — is essential to ensure that behavioral health services are provided as seamlessly as possible. Internal and external partners are routinely alerted to modifications to care plans and changing patient circumstances.

SUSTAINABILITY

St. Mary's and its community partners are committed to sustaining Open Access. They have added staff and incentives for continuing education and collaborate with a local university on internships for students pursuing careers in social welfare. St. Mary's is adding Open Access services onsite in a local school, increasing case management services, and will begin surveying patients on satisfaction and opportunities for improvement. St. Mary's continues to forge new partnerships and strengthen existing ones.

CONTACT

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ST. PETER'S HEALTH PARTNERS

Food as Medicine

INITIATIVE DESCRIPTION AND GOALS

St. Peter's Health Partners' Food as Medicine programs seek to improve the health and mitigate social care needs of patients with chronic medical conditions and food insecurity.

The Type 2 Diabetes FAM Program is designed to lower participants' weight and HbA1C, and the Gestational Diabetes FAM Program is designed to improve birth outcomes including healthy newborn birth weight, reduce hypoglycemia in newborns and improve gestational age at birth. Participants in these programs receive a five-day supply of lean meats and proteins, low-fat dairy, fresh produce and healthy shelf-stable food for a 12-week period. They also receive individualized nutrition education from a registered dietitian and social needs screening and referrals if needed.

An emergency food bag program supports patients who come into the emergency department and outpatient practices and express an immediate food insecurity need. These patients are provided with a three-day supply of healthy, shelf-stable food. All patients given an emergency food bag receive social needs screenings and any identified needs are addressed by community health workers, social workers, SPHP's community resource directory or Unite Us.

PARTNERS

Regional Food Bank of Northeastern New York, Maria College, The Collaboratory, Project Dash – a division of DoorDash, Unite Us, Healthy Alliance, Mother Cabrini Foundation, Elevance Health, St. Peter's Health Partners Endocrine and Diabetes Program, St. Peter's Health Partners Obstetrical and Maternal/Fetal Medicine, St. Peter's Health Partners Pediatric Health Centers and Trinity Alliance.

OUTCOMES

- Since its inception, more than 800 patients and their household members have benefitted from St. Peter's Health Partners' FAM programs.
- Participants in the Type 2 diabetes program have seen an average weight loss of 10.3 lbs. and 3.1% decrease in HbA1C.
- In 2024, the program distributed 936 emergency food bags addressing patients' food insecurity need and provided additional social needs screenings and follow-up.

LESSONS LEARNED

By providing healthy foods and nutrition education, and addressing social needs, FAM programs lead to a positive change in physical health, such as weight loss and improved HbA1C. It is critically important to listen to patients' needs and concerns and provide them with individualized care to help them accomplish their healthcare goals.

SUSTAINABILITY

Short-term sustainability is ensured thanks to a three-year grant from the Mother Cabrini Health Foundation beginning in 2025 and the final year of a three-year grant from Elevance Health held by The Regional Food Bank of Northeastern New York. Long-term sustainability will be supported through third-party reimbursement, particularly through Medicaid as indicated in the state's 1115 waiver.

CONTACT

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SARATOGA HOSPITAL

Creative Community Health and Wellness Event

INITIATIVE DESCRIPTION AND GOALS

This initiative provided free, accessible healthcare services and outreach to creative professionals to promote chronic disease prevention and wellness. Creative professionals often have unique health needs due to the physical demands of their work, exposure to loud noises, frequent travel and the psychological pressure of performing. A collaborative approach made it possible for a variety of services to be offered to meet these needs, including blood pressure screening, insurance navigation, nutrition services, vision screening, custom-fitted ear plugs, Tai Chi demonstrations, cancer services and hepatitis C/HIV testing.

This event provides access to care by licensed professionals in a familiar and accessible setting, helping build trust between the creative community and the healthcare community. With established relationships, it is more likely that this community will continue to seek preventive and routine healthcare, leading to better disease management and better health outcomes.

This initiative addresses the following 2019-2024 New York State *Prevention Agenda* priority areas: "Prevention of Chronic Diseases," "Promote a Healthy and Safe Environment: Promote Well-Being" and "Prevent Mental/Substance Use Disorders."

PARTNERS

Hudson Headwaters Health Network, Caffe Lena, New York State Cancer Services Program, Sight and Sound Vision Care, and 1 of 1 Custom.

OUTCOMES

- Event participation has increased each year, with many attendees returning year after year.
- The following services/resources were provided: 113 vision exams; 40 custom-fitted ear plugs; more than 100 blood pressure screenings; more than 20 Narcan kits distributed; and several individuals connected to insurance.

LESSONS LEARNED

Take advantage of opportunities to improve event marketing and promotion to reach a wider audience.

It is critical to allow the event to evolve over time. Feedback has indicated a need for mental health, dental screening and lab services. Organizers plan to accommodate these needs by changing the event location to a clinical space for next year and engaging new partners.

SUSTAINABILITY

Event organizers are planning the fourth Creative Community Health and Wellness event in fall 2025. Because open and consistent engagement with stakeholders and partnering organizations is essential to the initiative's sustainability, organizers spend significant time and effort soliciting feedback from attendees, building relationships with volunteers and listening to the needs of the creative community they intend to serve.

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TOP 5

STONY BROOK EASTERN LONG ISLAND HOSPITAL

Food Rescue US North Fork

INITIATIVE DESCRIPTION AND GOALS

This initiative redistributes surplus food to vulnerable populations, reducing food insecurity and waste while promoting health equity and environmental sustainability. Tailoring the initiative to the specific needs of the North Fork community has been vital, and addressing the unique challenges of an aging population, low-income families and individuals in recovery ensures the program is impactful and inclusive.

The success of Stony Brook Eastern Long Island Hospital's Food Rescue US North Fork initiative lies in its strong partnerships. Public education and outreach campaigns about food insecurity and waste have been instrumental in engaging volunteers, social service organizations and local businesses.

PARTNERS

Community Action Southold Town, local restaurants and grocers, volunteer network and Suffolk County.

OUTCOMES

- More than 476 fresh, nutritious meals have been provided to food-insecure individuals and families, addressing immediate hunger.
- A total of 571 pounds of surplus food has been diverted from landfills, reducing waste and supporting environmental sustainability.
- Collaboration with local partners resulted in 30 successful food rescues, benefiting vulnerable populations and strengthening community ties.

These outcomes demonstrate measurable progress in reducing food insecurity and environmental harm while fostering collaboration within the North Fork community.

LESSONS LEARNED

Strong partnerships with local organizations, businesses and volunteers are essential for effective food rescue and distribution, ensuring the program's success and scalability.

Tailored approaches matter. Addressing the unique needs of vulnerable populations, such as seniors and low-income families, ensures the initiative is impactful and reduces systemic health disparities.

SUSTAINABILITY

The initiative ensures sustainability through strong community partnerships, including local businesses and organizations like CAST, which provide consistent resources and support. A dedicated volunteer network and focus on volunteer recruitment, retention and training ensures cost-effective operations, while diversified funding sources, such as grants and donations, strengthen financial stability.

The model is scalable and adaptable, allowing for replication in other regions or expansion to address more needs. The integration of technology, such as scheduling tools, ensures efficiency and scalability. SBELIH's institutional commitment and alignment with its mission further ensure long-term impact and scalability.

CONTACT

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SUNY UPSTATE MEDICAL UNIVERSITY

It Matters: A Community Mental Health Education Program

INITIATIVE DESCRIPTION AND GOALS

It Matters offers a comprehensive educational program for the under-resourced in the community aimed at reducing mental health challenges and getting the appropriate care for mental health needs before a crisis.

Leveraging the expertise of SUNY Upstate Medical University and its outreach department along with trained resident community health workers from Syracuse public housing, the program provides education, resources and access to psychiatrists for residents living in public housing. It also implements community outreach initiatives designed to correct misconceptions about mental health challenges by identifying warning signs and promoting the use of professional mental health resources. The outreach team has a strong and trusted relationship with housing residents due to the 11-year history of providing health education and services through cancer screening programs and chronic disease awareness.

PARTNERS

Upstate Medical University leadership, Upstate Medical Mental Health Services, Syracuse Housing Authority leadership and social work staff, Syracuse Housing Tenants Association and Syracuse Public Housing residents.

OUTCOMES

- Since December 2023, 51 people have completed the Mental Health First Aide class.
- Since December 2023, two participants have needed additional psychiatric assistance.
- Requests and interest to hold It Matters mental health first aid classes are increasing, with six more planned in 2025.

LESSONS LEARNED

Community member input is vital to the design and implementation of any community health program. With this input, programs have a higher chance of success.

Tracking outcomes is important to monitor success and answer the question: Is the effort that goes into community programs having the desired impact?

SUSTAINABILITY

To sustain health programs in the community, data from the program must demonstrate efficiencies and effectiveness, and show that the program is meeting its goals and securing community member input. The It Matters program does all of this by partnering and listening to community members from Syracuse public housing, securing outside grants and monitoring those who enter the program and those who need additional clinical services. Continual measuring and pivoting, when necessary, ensures sustainability.

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TOP 5

THE MOUNT SINAI HOSPITAL — ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI

KidsThrive Social Determinants of Health Screening Program

INITIATIVE DESCRIPTION AND GOALS

KidsThrive at Mount Sinai has served the East Harlem community since 2020. It includes an onsite food pantry; emergency supplies; infant formula bank; early literacy program; Supplemental Nutrition Program for Women, Infants and Children satellite office; medical-legal partnership; and integrated behavioral health program.

East Harlem families experience high rates of medical, developmental and psychosocial issues, poor living conditions and financial stress. Mount Sinai's research showed families struggle to complete referrals to address their social needs. KidsThrive's "one-stop shop" approach ensures needs can be addressed at one time, in a familiar environment staffed with trusted professionals. Working closely with the New York Common Pantry, Mount Sinai developed a workflow where NYCP contacts families, conducts intakes and enrolls them in services virtually. A curated resource database provides doctors and families with resources, and an onsite WIC office reduces barriers to WIC enrollment.

KidsThrive strives to improve economic well-being by decreasing poverty and promoting nutrition security. In the social/community context, the initiative provides access to healthy food and nutrition education materials to promote healthy eating.

PARTNERS

New York Common Pantry, Mount Sinai Medical Center Medical-Legal Partnership, Mount Sinai WIC Office and LSA Family Health Services.

OUTCOMES

- From 2022 to 2024, the KidsThrive onsite pantry distributed 4,300 packages of shelf-stable food and fresh produce and more than 2,000 infant formula packages. KidsThrive connected more than 350 families to the New York Common Pantry.
- A 12-month study with 125 families found that 71% had low/very low levels of household food security at baseline. Caregivers who successfully enrolled in NYCP had significantly better food security over time compared to those not enrolled.
- To comprehensively address needs, KidsThrive grew its program to provide free legal consultations, mental/behavioral health support, books/school supplies and help with WIC/SNAP enrollment.

LESSONS LEARNED

With an influx of families living in shelters, KidsThrive provided food and supplies compatible with limited cooking facilities. During the 2022 formula shortage, the program had to be flexible and respond by obtaining formula and establishing a distribution hub.

KidsThrive understands their needs and the barriers they face — by staying engaged. Knowing that families struggle to keep WIC appointments, KidsThrive partnered with WIC to offer a weekly clinic onsite to facilitate easier enrollment.

SUSTAINABILITY

Mount Sinai KidsThrive continues to apply for and receive grants and donations. The team continues to explore how to best leverage the Medicaid 1115 waiver to cover SDH-related services. Mount Sinai hopes to institutionalize aspects of the program and is leveraging inter-departmental partnerships and technology innovations to enhance and increase its ability to screen all clinic families and address their social needs.

CONTACT

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UHS CHENANGO MEMORIAL HOSPITAL

Improving Emergency Services Transitions of Care and Referrals for Health-related Social Needs

INITIATIVE DESCRIPTION AND GOALS

At UHS Chenango Memorial Hospital, historically, patients seen in the emergency services department have experienced challenges in arranging follow-up care.

As such, the hospital developed a strategic initiative to allow ESD staff to schedule follow-up care for patients treated and released but in need of near-term clinician reassessment. Of about 18,000 ESD annual visits from the greater service area, 1,200 patients need some type of assistance in care transitions. As part of the 2024 action plan, a care coordinator position was created in the ESD. In addition to assisting in directly scheduling follow-up appointments, the care coordinator also performs a health-related social needs assessment facilitated by the EHR.

Depending on the assessment's findings, the care coordinator will make referrals to community groups, hospital departments or to the larger health system to help patients get needed care. These HRSN-related assessments and referrals tie in with the *Prevention Agenda* priority areas, including "Economic Stability," "Social and Community Context," "Neighborhood and Built Environment" and Health Care Access and Quality."

PARTNERS

UHS, Chenango County Health Department, Chenango County Behavioral Health Services, Children and Youth with Special Health Care Needs, NY Connects, Catholic Charities, the United Way, Home Care, online and telephone tobacco cessation services, YMCA and the Food Bank of Central NY.

OUTCOMES

- The number of ESD patients directly scheduled for post-acute care visits increased. Using data from 2023 when this care coordination service was not available, the total doubled in comparison to when patients had to self-arrange a post-ESD visit.

LESSONS LEARNED

Ensure that the care coordinator has a room to schedule patients in primary and specialty care offices. Given existing access challenges in those areas, having to balance leaving sufficient openings on the schedule for post-acute visits versus allowing spots to be filled by either existing or new patients outside of the ESD remains a challenge. Further work is ongoing to analyze this.

Care coordination in an ESD is not limited to traditional daytime business hours. An additional support system is needed when the care coordinator is not onsite. That issue, too, is under review.

SUSTAINABILITY

The initiative has proven to successfully improve post-ESD care transitions and assess and close actionable HRSN gaps. Further, this direct scheduling and care coordination service has contributed meaningfully and beneficially to hospital revenue. Given the impressive benefits to date, considerations are underway to expand capabilities within the ESD and to create similar roles and processes for other hospital service lines.

CONTACT

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WHITE PLAINS HOSPITAL

See, Test and Treat

INITIATIVE DESCRIPTION AND GOALS

The See, Test and Treat program, in partnership with the College of American Pathologists, addresses health disparities in underserved populations by offering free cancer screenings to uninsured, low-income women, particularly those with limited English proficiency. The program aligns with the New York State *Prevention Agenda's* "Prevent Chronic Diseases" priority, Goal 4.1, focusing on early cancer detection.

Through local partnerships, including with El Centro Hispano and the Westchester County Department of Health, the annual, one-day initiative provides mammograms and cervical cancer screenings along with education and follow-up care. By fostering healthcare access, empowering participants with knowledge and offering resources for ongoing care, the See, Test and Treat initiative works to reduce health disparities and promote long-term well-being.

PARTNERS

American College of Pathologists, El Centro Hispano, Calvary Baptist Church, Westchester County Department of Health, LiveOnNY, Lion's Club, Family Services of Westchester County and Alpha Kappa Alpha Sorority.

OUTCOMES

- 28 out of 69 participants in 2024 had abnormal findings, leading to necessary follow-up appointments, including one cancer diagnosis and follow-up treatments at White Plains Hospital's Center for Cancer Care.
- The program reached underserved women, offering free cancer screenings and connecting them to ongoing care and resources including insurance options and primary care providers.
- Participants gained critical health education, fostering confidence in seeking proactive care and establishing long-term connections to the healthcare system.

LESSONS LEARNED

The success of the See, Test and Treat program highlights the power of community partnerships. By collaborating with local organizations, healthcare providers and community leaders, the program reached underserved populations and provided essential cancer screenings and follow-up care.

The program demonstrated that addressing financial, linguistic and logistical barriers to healthcare is essential for improving access. Offering screenings, educational resources and insurance enrollment support significantly impacted participants' ability to seek continued care.

SUSTAINABILITY

Program sustainability is ensured through ongoing community partnerships and continuous follow-up care. Regular data collection, outcome tracking and participant feedback further drive program improvements, ensuring long-term impact and future success.

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WMCHEALTH

Project ADAM New York

INITIATIVE DESCRIPTION AND GOALS

As New York's first affiliate of this national initiative, Project ADAM NY collaborates with Maria Fareri Children's Hospital physicians who provide medical expertise, lead cardiopulmonary resuscitation/automated external defibrillator training and support advocacy efforts.

Prioritizing underserved communities, PANY enhances access to lifesaving resources, including AED placements and training in English and Spanish. Its efforts align with the New York State *Prevention Agenda* by preventing chronic disease and promoting health equity. Through partnerships with schools, youth organizations and health agencies, PANY continues to expand its reach, bridging the gap between expert care and real-world emergency preparedness to make New York safer for young hearts.

PARTNERS

American Heart Association, Country Children's Center, Don Bosco Community Center, Dutchess County DBCH Superintendents, Greenburgh Youth Soccer League, Horsehead Central School District, In a Heartbeat, More George, Mount Vernon City School District, Boys & Girls Club of New Rochelle Parent Academy, New Rochelle School District, New York State Recreation and Park Society, Nightingale-Bamford School, Peekskill Woodside Elementary School District, Pointe of Praise Church, Poughkeepsie Cal Ripken/Babe Ruth Baseball League, Poughkeepsie Girls Softball League, Port Chester-Rye Brook EMS, Scarsdale School District, South Salem Day Care, Spackenkill Union Free School District, Westchester Department of Health and Winston Prep School.

OUTCOMES

- PANY was instrumental in passing New York state legislation mandating AED accessibility in youth sports and camps, ensuring life-saving equipment is available in high-risk settings.
- PANY secured a $30,000 state grant to support AED purchases, with funds to be administered in 2025 to enhance cardiac emergency preparedness in youth sports programs and camps.
- In 2024, PANY trained over 600 individuals in CPR and AED skills through more than a dozen hands-on events, hosted 10 community awareness events reaching about 3,000 attendees and conducted six professional presentations for 635 participants.

LESSONS LEARNED

Prioritizing underserved communities and collaborating with local organizations amplifies impact. By providing education, resources and support, PANY empowers communities with limited healthcare access to respond to cardiac emergencies. Partnerships foster trust and cultural competence, allowing tailored initiatives that improve preparedness, bridge health gaps and save lives.

SUSTAINABILITY

The health system ensures the sustainability of PANY by engaging a diverse team of physicians, nurses and resident volunteers from various specialties. These dedicated professionals contribute their time and expertise, often in their own communities, fostering a culture of involvement and shared responsibility. This approach is not only sustainable, but it is a model for preventing sudden cardiac arrest among youth for other states across the nation.

CONTACT

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HANYS Celebrates Previous Community Health Improvement Award Winners

2024 SBH Health System
SBH Health and Wellness Center

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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