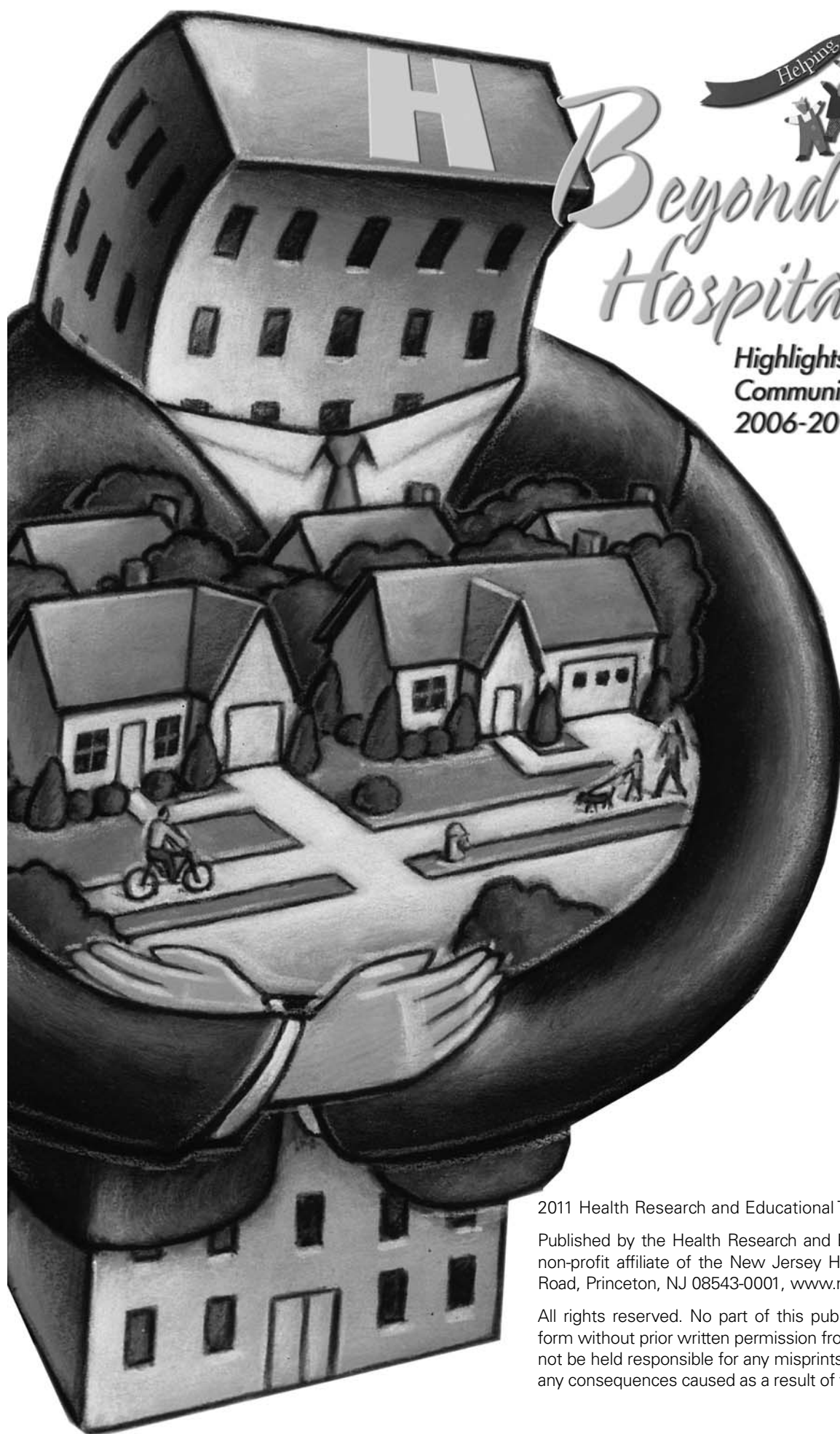


# Beyond Hospital Walls:

Highlights of N.J. Hospitals'  
Community Outreach Programs,  
2006-2010







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Highlights of N.J. Hospitals'  
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2011 Health Research and Educational Trust of New Jersey

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## *Beyond Hospital Walls:*

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# Preface

The Health Research and Educational Trust of New Jersey (HRET), a nonprofit affiliate of the New Jersey Hospital Association, is pleased to offer the second issue of *Beyond Hospital Walls: Highlights from the HRET Community Outreach Awards, 2006-2010*. This resource is a collection of community programs, which were established by hospitals throughout New Jersey between 2006 and 2010, and submitted as entries for HRET's Community Outreach Awards.

The Community Outreach Awards were founded on the belief that the partnerships between a hospital and its community are necessary to build and sustain health. The development of integrated "community care networks" enables hospitals to collaborate with communities to emphasize prevention and minimize illness. Through hospital community outreach programs, the infrastructure is created to bring about changes needed to attain improved health and well-being for the community.

NJHA is committed to proactively guiding hospitals and community leaders to develop partnerships that address the needs of their community members. HRET established the Hospital Award for Community Outreach activities in 1991 to recognize hospital-initiated programs that demonstrated prospective identification, creative response, active collaboration and successful fulfillment of community needs. HRET's Community Outreach Award Program seeks to publicly acknowledge hospital-community collaborative efforts leading to development of a shared vision of health.

This resource is available both in print and online, and it is being distributed to all New Jersey hospitals. We hope this collection of successful community programs will help hospitals and legislators learn about efforts being conducted throughout the state and encourage hospitals to consider replicating these programs or expanding their own programs in order to better serve their communities.

If you have any questions, need further information or would like an additional copy, please call the HRET Research Department at 609-275-4145 or [research@njha.com](mailto:research@njha.com).



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President and CEO  
New Jersey Hospital Association



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President and CEO  
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## *Acknowledgements*

**T**he Health Research and Educational Trust of New Jersey and the New Jersey Hospital Association would like to extend their deep appreciation to all of the New Jersey hospitals who reached beyond the walls of their institutions and focused their attention on the well-being of the greater community. HRET is especially grateful to those who submitted entries to the Community Outreach Awards Program and would like to recognize all entrants for their efforts to address major healthcare issues in our communities.

HRET would like to acknowledge further the contributions of our student intern, Geeta Kersellius, for preparing a standardized summary of all entries. We also would like to extend a special thanks to NJHA's Communications and Design and Print Departments for editing the entries and for the artwork and production of this resource. Last, and certainly not least, we extend our sincere thanks to the Research Department staff, Maria Mera and Kimberly Hewitson, for their dedication and hard work in preparing the indices and producing this directory.

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# Introduction

**HRET's Community Outreach Awards** are granted on an annual basis to recognize hospital programs that address major healthcare issues through community partnerships and innovative programs or services. Such partnerships are essential to assess and fulfill community needs, build healthy environments and bring about changes to improve the health of New Jersey's residents.

This resource, designed to showcase all Community Outreach Awards entries, is published in five-year intervals, and this second edition covers entries submitted to HRET from 2006 to 2010. The main body of the resource which presents descriptions of programs in a standardized format is organized by three major themes: Preventing Disease and Injury, Improving Access and Quality of Care and Reducing Healthcare Disparities. Within each theme, different population categories may be the target of health improvement interventions including children, the elderly and those with special needs, such as minorities, women, the uninsured or persons with disabilities, addictions or specific diseases such as cancer, HIV/AIDS or chronic conditions. Entries in each theme are arranged alphabetically by the title of the program. Each program's most recent contact information is included if you would like more information about a specific intervention.

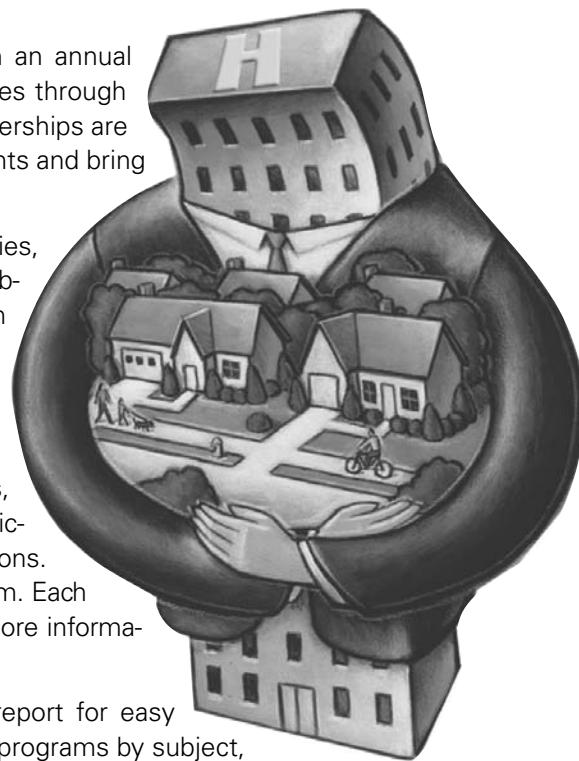
Community Outreach Awards winners are asterisked throughout the report for easy identification purposes. Several indices are provided to facilitate locating programs by subject, target population, hospital, year(s) of its submission for a Community Outreach Award and legislative district. Also provided is an index of award winning programs by their main theme and year of submission.

We hope that this directory will help to disseminate information about hospitals' community programs, and raise awareness about the types of innovative interventions being provided to New Jersey's residents to better their health and well-being. We also hope that this resource will encourage hospitals to develop plans to replicate these programs or foster ideas for development and implementation of new and innovative community programs and services. Such continued efforts on the part of hospitals ultimately will result in healthier communities throughout the state.

FIROOZEH VALI, PH.D.

*Vice President of Research*

*New Jersey Hospital Association/HRET*



*Beyond Hospital Walls:*

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# HOSPITAL COMMUNITY PROGRAMS

## *Preventing Disease and Injury*



# *AIDS Community Education - A.C.E.*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The AIDS Community Education Project - A.C.E is a four-session, HIV/AIDS prevention education program delivered annually to a minimum 1,000 at-risk Newark public school students and their teachers in grades 4-12.

## COLLABORATORS

Partnering community organizations included the Broadway House for Continuing Care, an affiliate of University Hospital/UMDNJ, Newark public school system, American Red Cross of Metro N.J., the United Way of Essex and West Hudson and the N.J. AIDS partnership.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program, which was developed in response to an identified community need, targets a vulnerable population of children and teens by increasing their sensitivity and knowledge regarding HIV/AIDS. The program aims to reduce unsafe sexual and substance abuse practices and prevent the spread of HIV/AIDS, which is a rising epidemic in New Jersey. The program teaches better decision making strategies and uses didactic training by the students' trained teachers on HIV/AIDS prevention health topics and on-site experimental education with Broadway House for Continuing Care staff and residents.

## EVALUATION/OUTCOMES/IMPACT

The program's positive outcomes have led to its expansion beyond the pilot phase. Standardization of the program's curriculum and materials has created opportunities for its replication statewide. The lack of HIV prevention education in Newark public schools and elsewhere in New Jersey, coupled with the rising incidence of HIV/AIDS, has made replicating this program a high priority.

**KEYWORDS:** *Adolescents; Children; Community Outreach; Health Education; HIV/AIDS; Prevention Education; School-based Outreach; Students*

SUBMISSION DATE: 2006, 2008

\* HRET Community Outreach Award Winner, 2008



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## *Beyond Hospital Walls:*

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## *Adult Community Nursing Center*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Adult Community Nursing Center at Saint Peter's University Hospital was designed to remove barriers and improve the quality of life for seniors by providing onsite health screenings and education.

### COLLABORATORS

Partnering community organizations included The Whittingham Homeowner's Association, Middlesex County Vo-Tech LPN Program and Monroe Township. The center also works in collaboration with a healthcare advisory committee.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The center offers one-on-one health assessments and treatments, counseling, health education, monthly newspaper articles, monthly health lectures, caregivers support groups, health fairs and flu shot clinics. The center also dresses wounds with a physician order, provides pneumonia immunizations, referrals for residents and their families, emotional support, first aid, injections, referrals for services at health, mental health and community agencies and is a first responder in times of emergencies. Lectures cover wellness, preparation for a senior's future healthcare needs as well as how to avoid crisis situations related to the aging process. Saint Peter's University Hospital also provides a van service for clients and their relatives in times of emergency.

### EVALUATION/OUTCOMES/IMPACT

Surveys were sent to the 1,200 residents who participated in the program and 48 percent of participants reported positive satisfaction with the program. Overall, 1,883 people were reached at the health fairs, 1,112 at lectures, 4,129 at flu shot clinics, 3,583 during emergencies, 46,777 made office visits and 34,044 made phone calls.

**KEYWORDS:** *Community Outreach; Elderly; Emergency Response Services; Health Education; Health Fairs; Health Screenings; Immunizations; Mental Health Services; Patient Education; Prevention Education; Referral Services; Support Services; Transportation Services*

SUBMISSION DATE: 2009

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# Bacharach Stroke Talks

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Stroke Talks offers a series of lectures at county nutrition sites to seniors, staff and residents of nursing homes to help them recognize the signs of stroke.

## COLLABORATORS

Partnering community organizations include Richard Stockton College.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Lectures are about stroke recognition and teaching the target population the importance of time when a stroke is suspected and the responsibility of the bystander to call 911. Talks are given to a variety of groups reviewing the warning signs and available treatment options. To ensure health literacy in the senior population, program implementers utilize a video entitled, "Know the Signs, Act in Time" from the National Institutes of Health. This engaging video demonstrates the proper response to a suspected stroke – call 911 and also clearly describes stroke symptoms. Following the video, there is a question and answer session. In addition, each attendee is given a bookmark with the signs of stroke listed on one side and stroke risk factors on the other, courtesy of the NIH. All NIH materials such as the video, brochures and stroke bookmark, also are available in Spanish.



## EVALUATION/OUTCOMES/IMPACT

In total, 75 Stroke Talks were given to 2,000 listeners. Overall, 86 lectures were provided to 1,994 people.

**KEYWORDS:** *Cardiovascular Diseases; Community Outreach; Crisis Response Training; Culturally Sensitive Education; Elderly; Health Literacy; High-risk Populations; Prevention Education; Stroke*

SUBMISSION DATE: 2008



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## *The Balance Center of Warren Hospital*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Warren Hospital Balance Center is an outpatient multidisciplinary center designed to evaluate and treat people with inner ear disorders, vertigo, stroke, Parkinson's disease, Multiple Sclerosis and the elderly who have a tendency to fall frequently. The program aims to improve the quality of life of seniors by improving their balance, gait, functional ability and reducing dizziness.

### COLLABORATORS

Partnering community organizations included the Balance Center at Warren Hospital and their team of care plan facilitators, a neurologist/medical director, community educators, physical therapists specializing in balance therapy, technicians who perform vestibular testing and ancillary office staff.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program included: education on fall prevention, screenings to identify individuals at risk for falls, medical evaluations focusing on balance and dizziness, diagnostic testing to identify location and type of disorder, customized treatment of all balance disorders, evaluation and diagnostic testing, personalized education to reduce fall risk, appropriate medical follow-up and collaboration with patients' primary care physician.

### EVALUATION/OUTCOMES/IMPACT

Since 2005, the center has held 17 free screenings for more than 800 people and treated more than 500 patients. From 2005 to 2006, 177 patients were evaluated and showed improvement in their balance scores and 14 percent increase in their confidence level with balance during function. For patients with dizziness, symptoms improved by 13 percent. Overall, these patients met an average of 81 percent of the program's goals.

**KEYWORDS:** *Balance Disorders; Diagnostic Testing; Ear Disorders; Elderly; Fall Prevention; Health Screenings; Multiple Sclerosis; Parkinson's Disease; Patient Education*

SUBMISSION DATE: 2008

# Basic Osteoporosis Nutrition Education & Screening - B.O.N.E.S.

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)



The Community Medical Center's Basic Osteoporosis Nutrition, Education and Screenings (B.O.N.E.S) project was designed to increase the knowledge of older adult women over the age of 50 in Ocean County about osteoporosis and the importance of calcium in their diets. The program also encouraged them to exercise, seek routine screenings, follow-up and treatment when necessary, in accordance with the National Osteoporosis Foundation guidelines.

## COLLABORATORS

Partnering community organizations included Advanced Wellness Consultants and the Arthritis Foundation – N.J. Chapter.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The project offered health screenings, exercise programs and other educational workshops to the community. It specifically offered three screenings each month coupled with a half-hour educational lecture, *Boning up on Osteoporosis*; a one-hour education program, *Calcium Counts*, given once a month to explain the importance of vitamins and minerals in decreasing the incidence of osteoporosis; and one screening per month was offered at different community locations. The project also offered a post-menopausal Tai Chi class and a nationally-recognized exercise program called *Healthy Bones*. Women also were provided with weight bearing exercise classes and referrals were made to outside resources when appropriate.

## EVALUATION/OUTCOMES/IMPACT

So far, Project B.O.N.E.S' exercise workshops and educational classes have attracted at least 20 participants each time and has screened 900 women since its inception in September 2004.

**KEYWORDS:** *Community Outreach; Health Screenings; Nutrition Education; Osteoporosis; Physical Fitness; Prevention Education; Referral Services; Weight Management; Women's Health*

SUBMISSION DATE: 2006

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Pro-Kids Program's goal is to partner with schools and help their students to develop healthy habits and effectively manage stresses in their lives. In addition, the program also provides a resource for school personnel to obtain the most current information about specific health topics and services available at the hospital.

### COLLABORATORS

Partnering community organizations include Trinitas School of Nursing, Madison School and Head Start.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Schools are invited to participate, and if interested, to contact the hospital's child life specialists to schedule a presentation at their school. When schools contact the hospital, the school nurses, guidance counselors and social workers are asked about their school's specific needs and the program is adjusted to meet those



needs. Presentations are interactive, using discussion and creative activities. Each student is given a booklet to take home that contains the key points from the presentation. Besides classroom presentations, Pro-Kids also offers hospital tours. These tours enable the children to become familiar with and understand what happens in hospitals. The aim is to lower the anxiety associated with going to a hospital if the child becomes ill or has an accident. Other tours are geared towards acquainting students with the health professions field.

### EVALUATION/OUTCOMES/IMPACT

The Pro-Kids Program reaches over 1,000 students per year.

**KEYWORDS:** *Career Building in Healthcare; Children; Health Behavior Modification; Health Education; Low-income Populations; School-based Outreach; Stress Management; Students*

SUBMISSION DATE: 2006



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# Childhood Obesity Initiative

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The program has two approaches for combating childhood obesity; be a Smarty & Eat like Marti and the Cardiac (Children at Risk for Cardiac Disease) Kids program.

## COLLABORATORS

Partnering community organizations include the Center for Prevention and Counseling, Sussex County School Nurses Association and the state Department of Health and Senior Services.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The Be a Smarty & Eat like Marti program provides an opportunity for skill development and modeling behavior by providing a relaxed environment that asks for responses from children and uses a clown as a model. The program also addresses Goal 4 in the N.J. Obesity Prevention Action Plan which is to mobilize and empower public and non-public schools to take local action steps to help families raise healthier children and increase the number of schools that view obesity as a public health issue. The program teaches children about hunger, fullness cues, caloric awareness, reading food labels, portion control and healthy snacking. A jeopardy game is played at the end to reinforce concepts. In addition to Marti, Cardiac Kids measures lipid profiles and blood glucoses of children and lets parents know if their children have any abnormalities which require follow-up care.

## EVALUATION/OUTCOMES/IMPACT

The Cardiac Kids program identified 30 percent of children with one or more abnormal results. Be a Smarty & Eat like Marti program was offered to 3,300 children.

**KEYWORDS:** *Cardiovascular Diseases; Cardiovascular Health; Children; Families; Health Behavior Modification; Health Screenings; Nutrition Education; Obesity Prevention; Obesity, Childhood; Prevention Education; School-based Outreach; Students*

SUBMISSION DATE: 2009



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# *Chronic Disease Self-Management*

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## **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

The Chronic Disease Management Program is an evidence-based empowerment program for people suffering from various chronic health conditions. The goal of this project is to help people maintain a higher degree of independence as they age.

## **COLLABORATORS**

Partnering community organizations include the state Department of Health and Senior Services, the Cape May County Department of Aging and the Cape May County Department of Health.

## **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

The program consists of free workshops held once each week for six weeks. The workshops are held in senior housing facilities and churches and community settings. The program gives clients action plans, problem solving, brainstorming and other modalities to deal with healthy eating, exercise, emotions, communication and other lifestyle issues. Healthcare professionals with Master's degrees train peer leaders to help run the workshops.

## **EVALUATION/OUTCOMES/IMPACT**

The program offers four peer leader courses which certified 61 peer leaders. The master trainers and/or peer leaders held 19 workshops. The workshops helped clients make significant lifestyle changes resulting in improved physical and mental health, enhanced quality of life, more effective health utilization and reduced healthcare expenditures. The Chronic Disease Self-Management Program was completed by 245 people. Future goals include holding six additional workshops for 90 people.

**KEYWORDS:** *Chronic Diseases; Chronic Disease Management; Community Outreach; Elderly; Faith-based Outreach; Health Behavior Modification; High-risk Populations; Nutrition Education; Physical Education; Self Care*

SUBMISSION DATE: 2010

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# Community Diabetes Screening Program

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Community Diabetes Screening Program was designed to identify adults with pre-diabetes and potentially prevent additional cases of Type 2 diabetes and to assist those with diabetes in better managing their disease for a better quality of life.



## COLLABORATORS

Partnering community organizations included Kennedy Health System, Shop-Rite, American Diabetes Association and representatives from LifeScan (Johnson & Johnson).

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Free diabetes screenings were held at area supermarkets to raise awareness about the importance of screening and education. Shop-Rite provided the location for the screenings. Store pharmacists provided free product samples. Kennedy provided Certified Diabetes Educators to perform the screenings and give education and/or referral information as well as screening supplies, medical information wallet cards and follow-up communication when necessary. The American Diabetes Association provided informational tables, and LifeScan staff provided free testing equipment, strips and sticks for each screening. When necessary, referrals were made for additional testing and/or education regarding lifestyle change and prevention and for people with previously diagnosed diabetes who needed additional education and assistance with self-management.

## EVALUATION/OUTCOMES/IMPACT

The program's first screening reached 74 residents. To date, 18 screenings were held with 953 South Jersey residents screened. Overall, eight percent of those screened were outside of the normal range, with 90 percent scoring in the pre-diabetes range.

**KEYWORDS:** *Chronic Disease Management; Community Outreach; Diabetes; Early Detection; Health Education; Health Screenings; Medical Services; Prevention Education; Referral Services; Self Care*

SUBMISSION DATE: 2008



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## *Doctor Bernard and the Pawsitive Action Team*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Doctor Bernard and the Pawsitive Action Team is an educational program designed to teach children up to 10 years of age about healthy eating, active playing, safety and good character habits.

### COLLABORATORS

Partnering community organizations included the K. Hovnanian Children's Hospital and Meridian Health.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Doctor Bernard worked with nurse educators at schools and community events to educate children about safety, nutrition, fitness and respect. With approval from the child's parent, children could register to become a Pawsitive Action Pal. Once registered, each child received a birthday card, an activity book, a member ID card and invitations to fun events held throughout the year. The Web site, doctorbernard.com, also provided additional games and learning modules to help reinforce key messages to the children. Once approved, additional focus groups will be held with parents.

### EVALUATION/OUTCOMES/IMPACT

To date, Doctor Bernard's section of the Web site has had over 5,000 page views, accounting for 15 percent of all page views for the hospital site. Since the program's inception, Doctor Bernard has visited more than 60 elementary schools, campuses and libraries and delivered presentations to over 7,800 children and 700 teachers. In addition, the program held 35 community events reaching more than 18,000 community members. Within one year of the program, 2,800 people enrolled through the Web site.

**KEYWORDS:** *Children; Families; Health Behavior Modification; Multimedia Outreach; Nutrition Education; Obesity Prevention; Obesity, Childhood; Physical Education; School-based Outreach; Students; Technology Use in Healthcare*

SUBMISSION DATE: 2010

# Give Kids a Smile

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Give Kids a Smile program provides free oral and dental healthcare services for children from low-income families. The goal of the program is to raise awareness about childhood tooth decay and provide dental services for children under the age of 12 that do not have regular access to dental care.

## COLLABORATORS

Partnering community organizations included the Chair of Dental Services, LibertyHealth-Jersey City Medical Center, American Dental Association, general and pediatric dentists, oral surgeons and local schools.



## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

General dentists and oral surgeon residents began the educational process with parents and their children. The children were screened and treatment was provided as necessary. Children also were given a comprehensive dental exam, oral healthcare instruction, fluoride treatments and free dental materials including toothbrushes, floss and toothpaste. If further treatment was required, a follow-up appointment at the Health Center was provided. Fun-filled activities such as clowns and entertainment were incorporated into the program to reduce children's fears related to receiving dental services.

## EVALUATION/OUTCOMES/IMPACT

To date, the center has screened over 1,000 children. In addition, more than 400 children were treated for serious tooth decay and an additional 300 children for preventive tooth loss through root canals, fillings and cleanings. Forty-three children also received follow up treatment.

**KEYWORDS:** *Children; Dental Services; Families; Health Behavior Modification; Low-income Populations; Oral Health Education; Patient Education; Prevention Education; Referral Services*

SUBMISSION DATE: 2010



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## *Healthy Kids/Fit Kids*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Healthy Kids/Fit Kids reduced obesity in children grades K-8 by providing them with the education and knowledge necessary to make healthy choices regarding their nutritional and fitness status.

### COLLABORATORS

Partnering community organizations included the Freehold YMCA, Freehold Borough School District, CentraState's Family Medicine Residency Program, The Rugby School, Keansburg and Neptune School Districts, Red Bank Charter School, St. James School and Belmar Elementary School.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Program implementation included the Kids in Control project, a nutrition and exercise program developed to teach children to manage their weight. In addition, the Student Health Awareness Center programs addressed healthy eating, making appropriate choices and integrating physical activity. A partnership with UMDNJ Family Medicine Residency program offered aerobic exercises, strength and flexibility training and fun fitness games to children. Finally, 22 staff attended the Train-the-Trainer at a school for children with physical and emotional challenges.

### EVALUATION/OUTCOMES/IMPACT

For the Star & Barry Tobias Health Awareness Center programs, a total of 1,087 children from nine schools were reached. The Kids in Control programs and the YMCA reached a total of 32 children. Medical assessments showed that 12 children had a slowed rate of weight gain and 20 children improved their food choices. Nearly 60 percent consumed more fruits and vegetables and 65 percent increased their physical activity.

**KEYWORDS:** *Children; Health Behavior Modification; Health Education; Nutrition Counseling; Obesity, Childhood; Physical Fitness; School-based Outreach; Students; Weight Management*

SUBMISSION DATE: 2009

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# Healthy Schools, Healthy Children

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Healthy Schools, Healthy Children program addresses the high rates of childhood obesity in Atlantic County by empowering schools to promote healthy eating, physical activity, and positive body image through education, activities and policy changes, ultimately enhancing the health of students and their families and preventing childhood obesity.

## COLLABORATORS

Partnering community organizations include Atlantic County's School Nurses Association and Public Health Department, Atlantic City Health Department and Rutgers Cooperative Extension.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The initiative works with area schools and community partners to increase healthy behaviors among the youth by: holding quarterly meetings and sharing best practices that highlight the work of partnering schools; hosting community events and educational sessions that reinforce key healthy lifestyle messages; helping schools complete CDC's School Health Index; providing culturally appropriate educational resources; offering staff training and continuing education opportunities around wellness topics; delivering monthly promotions supporting student and family participation in healthy behaviors; and providing physical activity resources. In addition, AtlantiCare staff liaisons assist schools in policy reforms, Wellness Policy implementation efforts and wellness programming design.

## EVALUATION/OUTCOMES/IMPACT

To date, more than 38 K-12 schools in Atlantic County have partnered with AtlantiCare for this initiative. These efforts have resulted in 20 percent of area students (207 of 1,035) reporting positive behavior changes during the 2008-2009 school year.

**KEYWORDS:** *Children; Culturally Sensitive Education; Families; Health Behavior Modification; Nutrition Education; Obesity Prevention; Obesity, Childhood; Physical Education; Physical Fitness; School-based Outreach; Students*

SUBMISSION DATE: 2008, 2010

\* HRET Community Outreach Award Winner, 2010



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## Beyond Hospital Walls:

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Heart Safe Hudson County: CPR Anytime*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Heart Safe Community Program was developed to decrease mortality from sudden cardiac arrest as well as to assist community members in determining how prepared they were to respond to a cardiac arrest in the community. The program also encouraged community organizations to have a specified number of individuals trained to provide HeartSaver CPR and first aid.

### COLLABORATORS

Partnering community organizations included the LibertyHealth – Jersey City Medical Center, the American Heart Association, the Hispanic Pastoral Association and local public schools.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Prior to program implementation, the JCMC Emergency Medical Services (EMS) staff provided 60 pastors and parishioners from different churches who possessed bilingual instruction in Basic Life Support and instructor courses. Six Spanish speaking instructors were employed to conduct the trainings. In addition, 44 Hispanic pastors were trained. Training for seventh graders was repeated every year to capture all students that moved from the sixth to the seventh grade. Both the parishioners and the students were given CPR Anytime Kits containing a personal, inflatable CPR mannequin, a skills practice DVD and accessories for families and friends to learn CPR.

### EVALUATION/OUTCOMES/IMPACT

Since the program's inception, the EMS staff has trained 740 seventh graders in Jersey City and 150 seventh graders in Secaucus in CPR and first aid.

**KEYWORDS:** *Cardiac Arrest; Cardiovascular Diseases; Children; Community Outreach; CPR Education; Crisis Response Training; Faith-based Outreach; Families; First Aid Education; Latino Communities; Minorities; School-based Outreach*

SUBMISSION DATE: 2010

# Inspire for Women

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Inspire for Women is a comprehensive health and wellness program designed to prevent disease, increase physical activity and knowledge about medication and vaccines among women over the ages of 35. Program objectives include addressing the physical, emotional, mental, social and educational needs of its members.

## COLLABORATORS

Partnering community organizations include Nature's Remedy, YM-YWHA of North Jersey and the Health Barn USA. Inspire partnered with Nature's Remedy, Wayne YMHA, local gyms and a church to increase fitness and reduce stress in women.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Program activities include health screenings, exercise classes, safety classes, health education, workshops, social events, aromatherapy, massage, guided meditation, education about how food affects your mood and physician-led lectures focusing on heart disease, stroke, diabetes, memory, autism, food allergies, pregnancy and cancer. Nutrition classes taught participants about healthy eating habits and how to buy and prepare healthy meals for themselves or their families. To increase awareness of the program, Inspire sends out a bi-annual newsletter.

## EVALUATION/OUTCOMES/IMPACT

To date, 1,351 women have been "inspired" to participate in this program. Surveys indicate that participants reduced their stress; increased energy; improved flexibility; heightened awareness; increased body strength; improved balance, breathing, coordination and posture. In addition, new members are constantly joining the program, with over 130 new members added from September to December 2007.

**KEYWORDS:** *Autism; Cancer; Cardiovascular Health; Community Outreach; Diabetes; Health Behavior Modification; Health Education; Health Screenings; Medication Management; Nutrition Education; Physical Fitness; Prevention Education; Stroke; Women's Health*

SUBMISSION DATE: 2008



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## Beyond Hospital Walls:

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Kids Under Construction*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Kids Under Construction was a comprehensive eight-week nutrition education and exercise program for overweight and obese children ages 10 to 14.

### COLLABORATORS

Partnering community organizations included the Abbot Nutrition, Nature's Remedy and Health Barn.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program provided nutrition education, self-esteem and image education, exercise classes, interaction and support from peers and parental support and guidance. Major activities of the program included: nutrition and fitness education classes developed by certified health education specialists; a registered dietitian and an exercise physiologist; a parent education program presented by a pediatrician, registered dietitian and exercise physiologist; a participant back pack that included weekly health education handouts, walking log and personal pedometer to encourage activity; weekly private weigh-in and motivational reinforcement through a raffle of a Nintendo Wii and Wii Fit. Each week, participants attend a one half-hour educational session and two one-hour exercise session. To encourage exercise even on days when classes were not held, participants were given monthly walking logs and pedometers with the recommended number of steps to achieve. The program charged \$25, which was returned at completion in the form of a gift card to a local farmer's market.

### EVALUATION/OUTCOMES/IMPACT

The program had 15 participants; 10 had lost weight, four gained weight and one stayed the same. The average weight loss was 1.38 pounds. In addition, 17 parents/guardians attended the parent education program.

**KEYWORDS:** *Children; Families; Health Behavior Modification; Health Education; Nutrition Counseling; Nutrition Education; Obesity, Childhood; Physical Fitness; Self Care; Students; Support Services*

SUBMISSION DATE: 2009



# Love Does Not Hurt/ El Amor No Hierde

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Love Does Not Hurt/ El Amor No Hierde theater program addresses domestic violence among New Brunswick's medically underserved and minority populations through education and outreach. The program aims to connect female survivors with local domestic violence resources so that they can be supported in living a violence-free life.



## COLLABORATORS

Partnering community organizations include the Domestic Violence Awareness Coalition, the Center on Violence Against Women and Rutgers School of Social Work.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program consists of vignettes that represent real-life situations where domestic violence occurs. These vignettes are provided in English and Spanish to address many different aspects of domestic violence by showing the impact on children, families and communities. The performance utilizes several theatrical effects to convey powerful messages about domestic violence. Following the skits, a certified domestic violence counselor provides participants with additional information about the different types of violence, warning signs of abusive behavior and the dangers of domestic violence. At this point, participants also are informed of local domestic violence resources that are available to survivors such as emergency shelters and restraining orders.

## EVALUATION/OUTCOMES/IMPACT

Since 2005, 559 community residents participated in the program. In 2006, 228 community members were reached through presentations and 95 percent of respondents rated the program as excellent or good.

**KEYWORDS:** *Community Outreach; Domestic Violence; Families; Latino Communities; Mental Health Services; Minorities; Prevention Education; Preventive Services; Referral Services; Social Services; Support Services; Theater; Medically Underserved Populations; Uninsured and Underinsured; Women's Health*

SUBMISSION DATE: 2009

## Beyond Hospital Walls:

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



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## Mayor's Weight Loss Challenge

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Marlboro Mayor's Weight Loss Challenge was an initiative designed to combat the community's obesity epidemic. The primary goal of the program was to encourage positive lifestyle changes in terms of weight management and physical inactivity.

### COLLABORATORS

Partnering community organizations included CentraState Healthcare System and Marlboro Mayor Robert Kleinberg. Additional partners included the Township of Marlboro, The Marlboro Township Recreation Department, local restaurants, Pathmark and ShopRite of Marlboro, students in the Culinary and Hospitality Management Program at the Freehold High School and Marlboro Township Seniors.



### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Program implementation included an opening ceremony, screenings for body mass index, blood pressure and body fat; 10 weekly nutrition and exercise education sessions; six walking sessions; four supermarket tours; local restaurant collaborations; cooking demonstrations; and a closing ceremony with prizes.

### EVALUATION/OUTCOMES/IMPACT

The program registered 311 people with 105 active participants. Participants who completed the program had an average weight loss of 6.3 pounds and 61.7 percent of active participants lowered their blood pressure. The total weight loss for the program was 523 pounds. This initiative helped Marlboro residents lose weight, lower their blood pressure and increase their level of physical activity. Due to positive feedback from this program, requests were made to create a five-week follow-up program, which was implemented in 2007.

**KEYWORDS:** *Community Outreach; Health Education; Health Screenings; Nutrition Education; Obesity; Obesity Prevention; Physical Education; Physical Fitness; Self Care; Weight Management*

SUBMISSION DATE: 2008

# Pedestrian Injury Prevention Partnership



## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Pedestrian Injury Prevention Partnership (PIPP) addressed a significant public health issue in urban areas: increasingly dangerous travelling by foot and pedestrian injuries and fatalities due to motor vehicle crashes.

## COLLABORATORS

Partnering community organizations included a coalition formed in 2006 by the New Jersey Trauma Center of the UMDNJ University Hospital in Newark.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Urban minority populations, especially children, experience the highest rates of these injuries and fatalities, mainly due to environmental and socioeconomic factors, such as proximity of housing to busy streets and insufficient care and supervision. Since its inception, the program has assessed its strengths, weakness, opportunities and threats and developed a model to collaboratively address the key "E's" of pedestrian safety for children - Engineering/ Environment; Enforcement (of traffic safety); and Education.



## EVALUATION/OUTCOMES/IMPACT

This model has led to several measureable improvements. They include mapping injury "hot spots" throughout the city; installing safety cameras on city streets; implementing a school-based pedestrian initiative; and conducting pedestrian safety special events including international Walk to School Day. Currently, PIPP is evaluating its overall success through a three-year longitudinal study sponsored by the Division of Highway Traffic Safety and the Department of Human Services.

**KEYWORDS:** *Children; Injury Prevention; Minorities; Pedestrian Safety; Prevention Education; Preventive Services; Traffic Safety*

SUBMISSION DATE: 2009

\* HRET Community Outreach Award Winner, 2009

## Beyond Hospital Walls:

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Project P.I.E.S. is part of the HIV/AIDS Services Department of Saint Michael's Medical Center. The program is designed to halt the spread of HIV in Newark using preventive strategies such as community outreach, direct education, counseling, rapid HIV testing and referral, prevention case management and prevention messages integrated into the HIV clinical visit.

### COLLABORATORS

Partnering community organizations include the SMMC's HIV outpatient clinics, City of Newark Department of Health's Homeless Healthcare Program, area homeless shelters and service providers, and clients from affiliated agencies through Catholic Health and Human Services, Catholic Charities of the Archdiocese of Newark.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Services are offered at hospital and community sites, such as homeless shelters and food kitchens, and include increased access for those who are HIV positive or at high HIV risk (minority women and people in poor mental health) to HIV rapid testing and HIV risk reduction and prevention. The program links people to quality HIV care and treatment through direct referral and identifies HIV positive people out of care and brings them back to care through outreach.

### EVALUATION/OUTCOMES/IMPACT

The program has made more than 2,000 outreach contacts per year and tested 600 homeless persons, using the Center for Disease Control Advancing HIV Prevention models for intervention and outreach.

**KEYWORDS:** *Community Outreach; Early Detection; Health Screenings; High-risk Populations; HIV/AIDS; Homeless People; Medical Services; Minorities; Prevention Education; Referral Services*

SUBMISSION DATE: 2006

*\* HRET Community Outreach Award Winner, 2006*

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# *Reaching Out: Suicide Prevention in Action*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The program consisted of two suicide awareness and prevention workshops, "Reaching Out: Suicide Prevention in Action" and "Dying to Know: Inside Teen Suicide." The workshops were designed to educate school personnel about the signs of depression and suicidal ideation and provide educators with the tools and resources necessary to encourage communication and problem solving with students as well as enhancing their comprehension of the complexities of depression and suicide.



## COLLABORATORS

Partnering community organizations included the NJ Society for the Prevention of Teen Suicide, CentraState Student Health Awareness Center Advisory Committee, CentraState's Youth Emergency Assessment Services, Monmouth County Board of Education, UMDNJ Family Residency Program at CentraState, Monmouth County's Traumatic Loss Coalition and the NJ Youth Suicide Prevention Council.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The "Reaching Out: Suicide Prevention in Action" workshop was tailored for clinically-oriented school professionals. This workshop trained these professionals to provide at-risk teens with assistance needed to cope with their depression and prevent potential suicide. The second workshop, "Dying to Know: Inside Teen Suicide," was designed to empower school personnel with interventions and resources to decrease student suicide.

## EVALUATION/OUTCOMES/IMPACT

In 2005, four workshops were presented reaching 200 people. After completion of the program, approximately 92 percent of attendees reported being highly satisfied with the program and felt an increased self-efficacy to implement the skills and strategies they obtained in the workshops.

**KEYWORDS:** *Adolescents; Behavioral Health Services; Depression; High-risk Populations; Prevention Education; Professional Education; Students; Suicide Prevention*

SUBMISSION DATE: 2006

## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*

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# 22 Shapedown

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## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Shapedown is a 10-week family lifestyle change program developed to prevent childhood obesity among Mercer County children who are at risk for developing Type 2 diabetes. Shapedown aims to screen and identify children who are at risk for developing Type 2 diabetes, teach members of the community about the dangers of being overweight and offer children and their families the Shapedown program.

## COLLABORATORS

Partnering community organizations included Bristol-Myers Squibb, the Hamilton Township School District, the Trenton School District and Hamilton Pediatric Associates.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Shapedown is an exercise and nutrition program that includes fitness components and nutrition education and was offered 10 times (sessions) per year. The program offered 800 student in-school screenings, distributed bilingual materials, held 25 student assemblies and health fairs and provided one-on-one family lifestyle assessments, one-on-one family nutritional assessments and support groups.

## EVALUATION/OUTCOMES/IMPACT

Since the start of the program in 2001, over 2,000 children were screened, more than 3,000 children and adults in the community were educated about the dangers of childhood obesity and over 150 families were educated via the Shapedown program. Shapedown decreased children's unhealthy eating habits, blood pressure, body mass index, waist size, number of cans of soda consumed weekly, hours spent watching TV, playing video games or on a computer. In the future, RWJ Hamilton seeks to expand the duration of Shapedown to 12 weeks, introduce a pilot program called Family Intervention Today (F.I.T.) and offer Shapedown in Trenton.

**KEYWORDS:** *Children; Diabetes; Early Detection; Families; Health Behavior Modification; Health Education; Health Fairs; Health Screenings; High-risk Populations; Nutrition Counseling; Nutrition Education; Obesity Prevention; Obesity, Childhood; Physical Education; Physical Fitness; School-based Outreach; Students*

SUBMISSION DATE: 2008



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## SOMERSET MEDICAL CENTER

### *Breast Cancer Education Program – Pink Parties*

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#### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Somerset Medical Center Breast Cancer Education Program – Pink Parties is a breast cancer education initiative that promotes the importance of breast cancer screenings and increased mammography rate among women ages 60-75.

#### COLLABORATORS

Partnering community organizations include Sanofi-Aventis U.S. Breast Cancer Program and the Community Health Department.

#### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Breast education programs are held at senior housing centers, community groups and retirement communities. Lectures include the presentation of age-appropriate information about the importance of annual mammograms, self-breast examinations and early detection. Sessions include a pre- and post-test as well as take home materials. At the end of each class, participants are given the opportunity to schedule a mammogram at Sanofi-Aventis U.S. Breast Cancer Program at the Steeplechase Cancer Center as well as a letter requesting a prescription from their physician. Within one month, the program educator follows up with participants. In addition, special incentives such as a raffle ticket for a gift certificate to the Sanofi-Aventis Wellness Boutique are given to each participant who gets a mammogram.

#### EVALUATION/OUTCOMES/IMPACT

To date, seven Pink Parties have been held reaching more than 550 seniors.

**KEYWORDS:** *Breast Health; Cancer, Breast; Cancer Prevention; Cancer Screenings; Community Outreach; Early Detection; Elderly; Health Education; High-risk Populations; Mammogram Services; Medically Underserved Populations; Women's Health*

SUBMISSION DATE: 2010

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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





# *Sports Breast Health Recognition and Action Program (SBHRAP)*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The purpose of SBHRAP is to provide education about breast health and the importance of early detection of breast cancer for female high school athletes.

## COLLABORATORS

Partnering community organizations include Saint Peter's University Hospital, the Central and South Jersey Affiliate of Susan G. Komen for the Cure and N.J. high school athletics programs.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program is staffed by nurse educators that teach female athletes how to protect themselves against breast cancer through early detection. Nurses talk about risk factors and emphasize the importance of receiving regular clinical breast examinations from healthcare providers, performing breast self exams and having annual mammograms beginning at age 40. The education sessions are held at practices or before games and are presented to both the home and visiting teams. Players receive an information kit and self-exam shower cards as well as shoelaces, makeup bags, combs, pens and other items—all in pink. Teams also receive pink practice balls. All students are required to complete a post-session questionnaire, which is reviewed by the nurse educators to ensure the students grasped the take-away message of early detection.

## EVALUATION/OUTCOMES/IMPACT

SBHRAP has reached approximately 8,000 young women. The program also had increased its total coverage to 110 schools that participate in the Greater Middlesex, Skylands, Colonial Valley and Shore athletic conferences.

**KEYWORDS:** *Breast Health; Cancer Prevention; Cancer, Breast; Early Detection; Health Education; Prevention Education; School-based Outreach; Student Athletes; Women's Health*

SUBMISSION DATE: 2010

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# Stroke Education and Screening Program

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Stroke Education and Screening Program assesses stroke risk factors and provide strokes education to those individuals with a family history of stroke or those with high blood pressure, diabetes or obesity. The target population also includes individuals who have lower income, the elderly and African Americans. Overall goals are to increase community awareness of stroke by teaching individuals to recognize the warning signs of stroke and the urgency of immediate action if they occur.

## COLLABORATORS

Partnering community organizations include the Atlantic Neuroscience Institute at Overlook Hospital, the Community Health Department of Overlook Hospital, senior centers, corporations, faith-based organizations, low-income housing and municipal health departments, libraries and clubs/YMCA.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

During the program, bilingual health educators are available and participants are screened for blood pressure, cholesterol, blood glucose, carotid bruit and apical pulse check. After each screening, individuals meet with a healthcare professional to discuss screening test results and an analysis for stroke risk factors, stroke warning signs and actions. All screened participants with a positive result in any of the five tests are referred for follow-up care.

## EVALUATION/OUTCOMES/IMPACT

On average, 24 stroke screenings are held per year or two community-based stroke education/screenings per month. The program has received positive feedback from physicians and community members.

**KEYWORDS:** *African Americans; Community Outreach; Diabetes; Elderly; Early Detection; Faith-based Outreach; Health Screenings; Low-income Populations; Minorities; Obesity; Preventive Services; Referral Services; Stroke; Support Services*

SUBMISSION DATE: 2008

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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Success through Exercise, Physical Fitness and Sharing Information (S.T.E.P.S.)*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

S.T.E.P.S. is a 12-week educational program designed to combat childhood obesity among students ages 8 to 12 with a body mass index at or above the 85th percentile, those who attend an inner city elementary school or a bilingual middle school or those with a highly disadvantaged background. The program assists children and their families in making healthier lifestyle choices by identifying environmental, behavioral, dietary and physical activity factors contributing to obesity.

### COLLABORATORS

Partnering community organizations include South Jersey Hospital, Cumberland, Cape Atlantic YMCA, the Vineland School System and pediatricians.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

S.T.E.P.S. provides children and their parents/guardians with nutrition and exercise information from professionals such as physicians, school nurses, registered dietitians, psychologists and exercise psychologists. This information guides families toward leading healthier lifestyles. The program is offered in both English and Spanish.

### EVALUATION/OUTCOMES/IMPACT

As of December 2007, 13 children completed the STEPS program. Evaluation surveys showed that children exhibited an increase in self-esteem and a sense of accomplishment as a result of the program. The retention rate for the class was 84 percent. Averages for the class were: increase in height by 0.5 inches, increase in weight by 1.78 pounds, decrease in BMI by 0.05, decrease in waist by 1 3/8 inches, step test -34.5 heart beats, sit ups +18.6 and push ups +15.5.

**KEYWORDS:** *Children; Culturally Sensitive Education; Families; Health Behavior Modification; Health Education; Nutrition Counseling; Obesity Prevention; Obesity, Childhood; Physical Education; School-based Outreach; Students*

SUBMISSION DATE: 2008

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# Teen Breast Health Education Partnership

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Teen Breast Health Education Partnership program was developed to make teens aware of the importance of self breast examination (SBE). The program encouraged young women to begin examining their breasts to identify how it should look and feel when normal in order to ensure they can recognize when abnormal changes occur in the future.

## COLLABORATORS

Partnering community organizations include the N.J. Interscholastic Athletic Association and the Susan G. Komen Foundation.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Program objectives were met by utilizing teen breast models and qualified nurse educators along with posters, informative literature and incentives. Visits were made by the Community Mobile Health Services staff to scheduled school sporting events. An educational presentation was given to both teams by the nurse educators. All participants received educational materials, incentives and a short quiz. Each team received pink soccer balls, volleyballs, tennis or field hockey balls and pink shoe laces.

## EVALUATION/OUTCOMES/IMPACT

Presentations were held at 20 different sporting/school events. Breast education was provided to 1,228 student athletes as well as coaches, family members and school staff. Quizzes were used to assess the program and the results showed that students did learn more about breast health.

**KEYWORDS:** *Adolescents; Breast Examination; Breast Health; Cancer Prevention; Families; Health Education; Mobile Health Services; Preventive Education; School-based Outreach; Student Athletes; Women's Health*

SUBMISSION DATE: 2008

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## Think Positive Helmet Safety

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Think Positive Helmet Safety program is an injury prevention program that promotes helmet use, the prevention of brain injury and possibly death among children under the age of 17 that engage in wheeled sports without a helmet.

### COLLABORATORS

Partnering community organizations include the LibertyHealth-Jersey City Medical Center, N.J. Division of Highway Traffic Safety, Trauma Injury Prevention Program, Brain Injury Association of N.J., Hoboken Police Department and local vendors.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The Think Positive Helmet Safety program is based on the goals of the state Division of Highway Traffic Safety Safe Communities and it rewards children for compliance with the New Jersey Helmet Safety Law. The program was implemented through the following action steps: Hoboken police routinely patrol the parks and other



high traffic areas observing wheeled sports. A child observed wearing a helmet is issued a summons which reads "Congratulations! You have been caught using your head. Remember to always wear your helmet." The summons can be redeemed at one of two local retail shops for an Italian Ice or an ice cream sundae. Children observed not wearing helmets are issued a helmet and parent education material.

### EVALUATION/OUTCOMES/IMPACT

Overall, police have distributed 150 helmets and issued 250 summons. A follow-up observational exercise revealed an increase of 23.6 percent in helmet use rate.

**KEYWORDS:** *Children; Health Education; Families; Injury Prevention; Prevention Education*

SUBMISSION DATE: 2010

# *Tobacco Dependence Treatment Program / Institute for Prevention*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Tobacco Dependence Treatment Program was established to increase the success rate of individuals who are attempting to quit smoking. The program serves Essex, Union, Monmouth and Ocean counties, and it was designed to increase the number of youth and adult tobacco users who initiate treatment, reduce the overall number of New Jerseyans who smoke, decrease exposure to environmental tobacco smoke and reduce disparities related to tobacco use and its effects among different populations. The program targeted lower income individuals, the elderly, Hispanic, Orthodox Jews, pregnant women/women with young children, hospital patients, mentally ill/chemically addicted, business and industry.

## COLLABORATORS

Partnering community organizations include the Saint Barnabas Behavioral Health Network and the state Department of Health and Senior Services, and the Office of the State Epidemiologist Comprehensive Tobacco Control Program.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offered assessment, behavioral therapy and pharmacotherapy. Key program activities included: onsite tobacco treatment programs in local companies, weekly groups for patients and employees of the Saint Barnabas Hospital System, onsite groups at doctors' offices and daily outreach efforts to the target communities. Upon entering the program, participants received a bio-psychosocial assessment, clinical counseling, meeting with a tobacco specialist and pharmacotherapy.

## EVALUATION/OUTCOMES/IMPACT

Since the program's inception, over 2,000 individuals have quit smoking successfully.

**KEYWORDS:** *Behavioral Health Services; Community Outreach; Elderly; Healthcare Access; Hospital Patients; Low-income Populations; Mentally-ill Populations; Minorities; Preventive Services; Referral Services; Smoking Cessation Support*

SUBMISSION DATE: 2008

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## *Toward a Healthier You*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Toward a Healthier You improves the general health status of underserved children in grades two, four and six by providing them with education and knowledge about the nutrition and fitness needed for healthy transitions into adulthood.

### COLLABORATORS

Partnering community organizations include the Lakewood School District, the Keansburg School-based Program and the Ann Earle Talcott Family Foundation.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Toward a Healthier You was undertaken as a three-year project that tracks the same children from second, fourth and sixth grades through third, fifth, and seventh and into fourth, sixth and eighth grades. To date, only the first year of the project has been completed and the second year is underway. The program consists of a one-hour interactive health education session conducted by staff from CentraState's Student Health Awareness Center and a one-hour visit to the center. Topics covered during these lectures are selected by the center's educators and meet the N.J. Core Curriculum Standards for Health, Physical Education and Science. Grade level specific pre- and post-tests are given to students to measure comprehension. During the second and third year of the program, nutrition lessons will be reinforced to the same group of students who transition to the next grade.

### EVALUATION/OUTCOMES/IMPACT

The program held 29 classes for 912 students.

**KEYWORDS:** *Children; Health Education; Low-income Populations; Medically Underserved Populations; Minorities; Nutrition Education; Physical Education; School-based Outreach; Students*

SUBMISSION DATE: 2010

## TRINITAS REGIONAL MEDICAL CENTER

### *Stroke Awareness Program - Creating a Stroke Smart Community*



#### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Trinitas Hospital Stroke Awareness Program is designed to comply with the state Department of Health and Senior Services' requirements for State Licensed Stroke Programs on provision of ongoing community education regarding prevention, recognition, diagnosis and treatment of acute stroke. The goal is to educate the community about the signs of stroke and rapid activation of Emergency Medical Services (EMS) as well as prevention methods such as healthy lifestyles and recognition of stroke risk factors.

#### COLLABORATORS

Partnering community organizations include the American Stroke Association, DHSS' Office of Minority and Multicultural Health, EMS and other community organizations such as senior housing centers and radio talk shows.

#### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The target audiences include church groups and senior housing residents with emphasis on minority, poor and vulnerable populations. Lectures provided to EMS use the American Stroke Association's guidelines on EMS' role and rapid response.

#### EVALUATION/OUTCOMES/IMPACT

The program was offered at 18 different community events on stroke education for more than 800 people in Union County throughout 2009, including health fairs and community gatherings or seminars, and provided screenings for blood pressure, cholesterol, glucose and stroke. The health fairs targeted towns and populations with different backgrounds and socio-economic status. The stroke screens alone accommodated a total of 63 attendees with 60 percent of them being African American and Hispanic.

**KEYWORDS:** *African Americans; Community Outreach; Crisis Response Training; Early Detection; Elderly; Faith-based Outreach; Health Education; Health Fairs; Health Screenings; High-risk Populations; Minorities; Preventive Services; Stroke*

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SUBMISSION DATE: 2010

\* HRET Community Outreach Awards Winner, 2010

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## *Women's Heart Center at St. Joseph's*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Women's Heart Center at St. Joseph's was designed to improve the cardiovascular health of women in northern New Jersey, mainly focusing on high-risk women from ethnic minorities living in Passaic county and surrounding areas. The program's goal was to increase women's awareness of heart diseases risks/symptoms/diagnosis/ treatment options to reduce their cultural, racial, linguistic and economic barriers and assist them with immediate access to appropriate quality care.

### COLLABORATORS

Partnering community organizations included OB/GYN physicians, internists, family practitioners, community- and business-based organizations such as religious and corporate leaders.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program provided educational outreach to women of all ages, ethnicities and socio-economic backgrounds, and assisted with identification and treatment of women at risk for heart disease. Thirty- to 60-minute presentations were held, discussing women and heart disease, at no cost. Through these sessions, health fairs and local advertising, women were encouraged to undergo a cardiovascular screening. Comprehensive cardiovascular examinations and risk screenings were offered by an APN during a 45- to 60-minute visit and included: family history review; body fat and body mass index analysis; waist-to-hip and height ratios; auscultation of the heart, lungs and major blood vessels; and point-of-care testing, which evaluated total cholesterol, LDL, HDL, triglyceride and glucose levels.

### EVALUATION/OUTCOMES/IMPACT

To date, more than 6,500 women have attended the educational programs and more than 1,800 have undergone the screening evaluations.

**KEYWORDS:** *Cardiovascular Diseases; Cardiovascular Health; Early Detection; Faith-based Outreach; Health Fairs; Health Screenings; Healthcare Access; High-risk Populations; Minorities; Prevention Education; Preventive Services; Women's Health*

SUBMISSION DATE: 2008, 2009

\* *HRET Community Outreach Awards Winner, 2009*



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# HOSPITAL COMMUNITY PROGRAMS

*Improving Access and Quality of Care*





## Breast Cancer Navigation Service

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Breast Cancer Navigation Service improved healthcare coordination and information flow between providers; offered a single point of contact; improved patient access to support services; provided rapid access to information and minimized anxiety and fear for patients.

### COLLABORATORS

Partnering community organizations included the American Cancer Society, Jewish Family and Children's Service and N.J. CEED-Camden County.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program was implemented in two phases/pilot programs. In phase I, an OB/GYN practice was provided with a referral coordinator for patients with abnormal mammograms to help them get immediate consultation with a breast surgeon. The second pilot assigned an oncology-certified nurse to serve as a personal navigator for newly-diagnosed breast cancer patients. The nurse navigator also planned conferences for cancer specialists to discuss the best course of treatment for patients. Following these conferences, the navigator would implement this care plan. The navigator also educated patients on treatment options and helped them schedule appointments with specialists.

### EVALUATION/OUTCOMES/IMPACT

Over 400 women were reached through phase I's referral coordinator service. Phase II's Navigator Service followed 59 patients. Virtua evaluated the program by tracking 15 metrics such as timeliness of care, communication effectiveness and patient and physician satisfaction with the service. To date, 13 of the 15 metrics are at benchmark or better.

**KEYWORDS:** *Breast Health; Cancer, Breast; Care Coordination; Mammogram Services; Medical Services; Patient Education; Patient Navigator; Professional Education; Referral Services; Support Services*

SUBMISSION DATE: 2008

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# *Cancer Program Support Services*

## **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

The Cancer Program provides state-of-the-art cancer care, including the latest in diagnostic and treatment services.

## **COLLABORATORS**

Partnering community organizations included the American Cancer Society, the Susan G. Komen Foundation and the Lourdes Medical Center of Burlington County.

## **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

The program staff provides emotional, spiritual and physical support to cancer patients. Elements of the support services include: a patient navigator program, a caring boutique, a cancer resource center, an ongoing breast cancer support group, a personal wellness foundation, a Look Good... Feel Better Program and the development of lectures and programs supported by the Susan G. Komen Foundation. The Patient Navigator program offers cancer patients access to a nurse who can help them navigate through the healthcare system to acquire quality care. The Caring Boutique is a service specifically for women. The Education Resource Center provides access to information related to cancer. The SpeakEasy Breast Cancer Support Group gives patients an opportunity to connect in a safe and open environment; and the Personal Wellness Foundation offers workshops for cancer patients. The Look Good...Feel Better Program aims to help women cope with their appearance and teaches them how to regain self-confidence and control over their lives.

## **EVALUATION/OUTCOMES/IMPACT**

In 2007, more than 200 people utilized these cancer support services. In particular, the patient navigator follows 111 patients.

**KEYWORDS:** *Cancer, Breast; Diagnostic Testing; Patient Education, Patient Navigator, Support Services*

SUBMISSION DATE: 2008

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## *Center for CPR and Public Access Defibrillation*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Hunterdon Medical Center's (Center for CPR and Public Access Defibrillation) was designed to minimize the time of emergency response and increase the chance of survival for cardiac arrest, thereby affecting the quality of life for cardiac arrest survivors in Hunterdon County and surrounding areas.

### COLLABORATORS

Partnering community organizations included the local schools, groups and businesses.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

This was accomplished by placing automated external defibrillators (AEDs) in community sites with trained/skilled lay first responders. Using the N.J. Public Access Defibrillation (PAD) Law and national AED implementation guidelines, the center developed resources, references, tools and training for physicians and community site personnel. The center acts as an advocacy leader and works in tandem with the community site's trained personnel to establish and maintain compliant and supported PAD programs, thus improving emergency response to cardiac arrest victims and increasing their chances of survival. The center's uniqueness is in its depth and range of expertise and services focused on the ongoing needs, risk assessments and facilitation of communication between the prescribing physician and risk personnel.

### EVALUATION/OUTCOMES/IMPACT

The center has driven this placement from two to 250 AEDs in the field in nine years.

**KEYWORDS:** *Cardiac Arrest; Cardiac Complications; Community Outreach; Crisis Response Training; Defibrillation; Emergency Response Services; First Aid Education*

SUBMISSION DATE: 2009

*\* HRET's Community Outreach Awards Honorable Mention, 2009*

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## CENTRASTATE

### *Multiple Sclerosis Center*

#### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The CentraState Multiple Sclerosis Center was developed to improve the well being and medical management of the Multiple Sclerosis population.

#### COLLABORATORS

Partnering community organizations included CentraState Medical Center (CSMC).

#### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offers clients access to a full-time registered nurse with advanced Clinical Certification in Multiple Sclerosis treatment. Utilizing this care model has proven to be patient friendly and clinically effective. Yearly, the CSMC's Multiple Sclerosis programs offer over 100 hours of free community education to the central N.J. population. The Multiple Sclerosis School is offered quarterly at CSMC in Freehold and regularly has over 50 attendees. The school topics cover both traditional and non-traditional approaches to disease management. Recent topics included cognitive issues, exercise and using the Internet as a medical education tool.

#### EVALUATION/OUTCOMES/IMPACT

The CentraState Multiple Sclerosis Center has served over 500 patients in the central N.J. area. The center had an immediate impact on the admission days for Multiple Sclerosis patients. For example, in 2003, the center had over 200 admission days with the primary diagnosis being Multiple Sclerosis. However, in 2004, that number dropped to 17 days and has been at zero for the past three years. Overall, the CentraState program has proven to be a cost effective patient-focused model.

**KEYWORDS:** *Chronic Disease Management; Health Education; Multiple Sclerosis; Patient Education*

SUBMISSION DATE: 2008

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CENTRASTATE

## *Spine Rehabilitation Center*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The CentraState Spine Rehabilitation Center treats patients suffering from low back pain.

### COLLABORATORS

Partnering community organizations included CentraState Medical Center.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program adapted an outcome benchmarking system to measure patient's function and performance. The Focus on a Therapeutic Outcomes system was one of four such programs approved by the Center for Medicare and Medicaid Services as an outcome measurement tool. Prior to integration of the benchmarking system, the Rehabilitation Department averaged 14 visits for treatment of low back pain. Since the adoption of the system in 2005, the number of average visits dropped to just over six with extremely high levels of functional return and patient satisfaction. These improvements were accomplished by utilizing the Fear Avoidance Module. Incorporating the Fear Avoidance Module into the Focus on Therapeutic Program produced profound improvements in both outcomes and length of treatment.

### EVALUATION/OUTCOMES/IMPACT

Since the program's inception, 750 patients were treated using the new model with approximately 4,500 visits to the center. Analysis of former treatment patterns indicated that approximately 6,000 visits were avoided translating into huge healthcare savings.

**KEYWORDS:** *Benchmarking System; Low Back Pain; Outcomes Measurement Tools; Rehabilitation Services*

SUBMISSION DATE: 2008

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## CHILDREN'S SPECIALIZED HOSPITAL

### *Development Screening Clinic:*

#### *An Evidence-Based Model for Autism Early Identification*

#### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Children's Specialized Hospital Developmental Screening Clinic (CSH-DSC) provides training to community healthcare providers and clinic-based developmental screening for children ages 12-48 months with any suspected developmental issue. The program also seeks to improve access to early identification, reduces wait times for specialized evaluation appointments and encourages early intervention leading to better functional outcomes.

#### COLLABORATORS

Partnering community organizations include the N.J. Governor's Council for Medical Research and Treatment of Autism and the Children's Specialized Hospital.

#### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program utilizes evidence-based tools, incorporating history and physical examination with observation of behaviors seen in young children with Autism Spectrum Disorders (ASD). Clinic staff is bilingual Advanced Practice Nurses (APNs) who receive specialized developmental and autism-specific training. APNs not proficient in Spanish use translation services for families with limited English proficiency.

#### EVALUATION/OUTCOMES/IMPACT

Since the program's inception, 542 children were screened, with 44 percent found at risk for autism and the remaining children found to have other developmental concerns such as receptive-expressive language disorder, attention deficit hyperactivity disorder or general delay. The program receives positive feedback from national autism experts, community healthcare providers, early childhood educators and families. Overall, CSH-DSC meets the goals to improve access to early identification and intervention for the target population.

**KEYWORDS:** *Autism; Children; Developmental Screening; Early Detection; Language Services; Prevention Services*

SUBMISSION DATE: 2010

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## *Clara Cares: Home-Based Healthcare for Seniors Program*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Clara Cares is a comprehensive residence-based medical service program for frail, low-income, urban seniors who are homebound and therefore have limited access to healthcare.

### COLLABORATORS

Partnering community organizations include the Clara Maass Medical Center, the Healthcare Foundation of N.J., Hillcrest Management, Bailey Hoyt, Concord Tower, Orange Senior, Branch Brooke, Wesley Towers, Ballantyne, Kearny Senior and South End Gardens.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Clara Cares offers residence-based comprehensive healthcare assessments, preventive care and chronic disease management. The program is staffed by two doctors, a nurse practitioner, a medical assistant and a pharmacist that visit seniors monthly to oversee their treatment and assist with discharge planning and coordinate follow-up home care. The staff provides house call treatment services, medication review, screenings, health education, insurance counseling, transportation to medical appointments and coordination of any required hospital-based testing. In addition, the program offers clients specialist referrals, balance and fall assessments as well as access to educational materials.

### EVALUATION/OUTCOMES/IMPACT

The Clara Cares program has made 72 senior housing site visits reaching 193 elderly men and women. The program has increased access to key medical services by providing 106 laboratory tests, 56 imaging services, 31 cardiac services, 38 rehab services and 97 referrals to specialists.

**KEYWORDS:** *Care Coordination; Chronic Disease Management; Elderly; Financial Counseling; Geriatric Care; Health Screenings; Healthcare Coverage; Home Visits; Low-income Populations; Medication Compliance; Patient Education; Post Discharge Services; Preventive Services; Referral Services; Transportation Services*

SUBMISSION DATE: 2010



# Community Vision Services Outreach

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Community Vision Services Outreach was developed by the Princeton Healthcare System's Community Education and Outreach Program (PHCS/CEOP) following a major community need regarding a shortage of vision services for the area's uninsured and underinsured populations.

## COLLABORATORS

Partnering community organizations included the Latin American Task Force and the N.J. Commission for the Blind Project Prevention Unit and Lens Crafters Gift of Sight Program.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

During community health fairs, they found vision exams were the most sought after services offered and that no resources were available for free eyeglasses for people who received prescriptions at vision screenings. The program put together a coordinated plan with the help of area faith-based groups and social service organizations to take vision screenings out to the uninsured and underinsured.

## EVALUATION/OUTCOMES/IMPACT

Through screenings held during 2006 and 2007, over 700 people were screened and about 300 eye glasses were delivered. Also, many individuals suspected of having glaucoma were identified and referred to appropriate service sites. As a result of this vision screening program, PHCS became the only N.J. Commission for the Blind fixed site in Mercer County.

**KEYWORDS:** *Community Outreach; Diagnostic Testing; Faith-based Outreach; Health Fairs; Referral Services; Uninsured and Underinsured; Vision Services*

SUBMISSION DATE: 2008

\* HRET Community Outreach  
Award Winner, 2008



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## *Comprehensive Health Evaluation for Children (CHEC)*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Comprehensive Health Evaluation for Children (CHEC) program ensures that all children entering the care of the Division of Youth and Family Services (DYFS) have access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services as well as mental health/developmental evaluations.

### COLLABORATORS

Partnering community organizations include DYFS, Child Health Unit, state Division of Medical Assistance and Health Services, regional staff nurses and Totowa Pediatrics.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The Center for the Protection of Children established a CHEC clinic enabling children with an out-of-home placement to have better access to quality healthcare. The program offers a mental health screening by a psychologist and a comprehensive physical examination by pediatricians and nurses to identify medical, developmental and mental issues. Based on these visits, reports are sent to DYFS and the caregivers indicating any recommendations and requests for referrals for follow-up care with DYFS, resource/foster parents or primary care providers.

### EVALUATION/OUTCOMES/IMPACT

Since the program's inception in 2007, 54 CHEC evaluations were conducted. All 54 reports were provided on schedule. It was estimated that the CHEC site would provide services to 70 children per year. Overall, the program has improved immunization status, referrals for dental and ophthalmology care, identification of cognitive impairment, language delays and symptoms of trauma.

**KEYWORDS:** *Children; Developmental Screenings; Diagnostic Testing; Early Detection; Health Screenings; Immunization; Mental Health Services; Referral Services*

SUBMISSION DATE: 2008

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# *Coordinating Health Services for School-Age Children in Need*

## **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

The Coordinating Health Services for School-Age Children in Need program was designed to provide essential healthcare services for school-age children in need to allow them to enter school in a timely manner.

## **COLLABORATORS**

Partners in this program include the regional Health Officer, the Public Health Registered Nurse, the School Nurse Coordinator, Medical Education and Family Practice of Overlook Hospital and the Community Health Department of Overlook Hospital.

## **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

The program uses the help of school nurses to identify those students who need help accessing healthcare services. Once these children are identified, they are provided with vision and hearing screenings and scheduled for a follow up appointment to receive all other healthcare services (i.e. immunizations, complete physical examination, etc.) Healthcare services are provided at no cost to students by Public Health nurses, a physician and a nurse practitioner at a local school on the Community Health Department's "Healthy Avenues" van. Also, once the child is seen by the Family Practice, the children as well as their families become the Practice's primary care patients.

## **EVALUATION/OUTCOMES/IMPACT**

To date, 12 children have been identified and seen on the "Healthy Avenues" van. Of those seen, one child was referred for a primary care follow-up and one child was referred for a dental clinic follow-up. Overlook Hospital plans to continue offering these services as long as the regional Public Health Officer and the Summit school nurse coordinator identify children in need.

**KEYWORDS:** *Children; Health Screenings; Healthcare Coverage; Hearing Screenings; Immunizations; Low-income Populations; Mobile Health Services; Primary Care; Referral Services; Students; Uninsured and Underinsured; Vision Services*

SUBMISSION DATE: 2009

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## *Diabetes Basic Skills Program*

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### **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

The Diabetes Basic Skills program provides diabetic patients from Capital Health System's (CHS) Family Health Center with basic diabetes education, teaches patients skills and tools to manage diabetes and encourages the target population to practice daily self-care and keep routine appointments.

### **COLLABORATORS**

Partnering community organizations include the Capital Health System Foundation.

### **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

The program is two hours, free of charge and held monthly. As an incentive, refreshments are provided for participants as well as free monitors to check blood glucose and additional 100 matching glucose strips. A Certified Diabetes Educator who also is a registered nurse and a registered dietitian, teaches the program. The educator uses a variety of teaching methods including a display board, food models and group discussions. Before the program begins, participants' glucose and blood pressures are measured. These results are given to participants who can refer to them throughout the program as they are being educated about the significance of those values. Participants are encouraged to ask questions during the program and attend the annual CHS Diabetes Fair to obtain additional health screenings (foot and kidney) and to learn more about diabetes. Participants also receive medication prescription assistance.

### **EVALUATION/OUTCOMES/IMPACT**

Within the first year of the Diabetes Basic Skills Program, 106 patients completed the program.

**KEYWORDS:** *Chronic Disease Management; Diabetes; Health Fairs; Health Screenings; Low-income Population; Nutrition Education; Patient Education; Prescription Assistance; Self Care; Skills Building; Uninsured and Underinsured*

SUBMISSION DATE: 2008

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## *Geriatric Services – Adult Day Care*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Geriatric Services – Adult Day Care program at Warren Hospital was designed to meet the special needs of the elderly population through outpatient assessment, case management, wellness and specialized inpatient acute care. In addition, Warren Hospital has created the Comfort Zone program to address the physical and emotional needs of senior citizens.

### COLLABORATORS

Partnering community organizations include the Balance Center, Warren County Division of Senior Services, Jersey Assistance for Community Care and Warren County Transportation.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program provides senior assessment services, senior future focus, education, screenings, advance directives and shuttles for outpatient services and adult day care. The Comfort Zone offers a structured comprehensive program for people over 60 who require health, social and support services in a protective setting. The Center provides services to patients suffering with dementia, Alzheimer's disease, depression, cerebrovascular accident, congestive heart failure, Parkinson's Disease and diabetes. Diagnostic and therapeutic modalities used or provided by the center include blood pressure monitoring and education, glucometer testing, medication management and treatments, blood work, specimens collected, rehabilitative services, toileting and incontinence management, memory impairment groups, supervised activities and crafts, nutrition counseling and guidance, behavioral modification and meals-feeding assistance.

### EVALUATION/OUTCOMES/IMPACT

The center can accommodate 40 patients at a time.

**KEYWORDS:** *Alzheimer's Disease; Behavioral Health Services; Dementia; Depression; Diabetes; Elderly; Geriatric Care; Health Screenings; Heart Failure; Medical Services; Medication Management; Mental Health Services; Nutrition Counseling; Outpatient Services; Parkinson's Disease; Patient Education; Rehabilitation Services; Support Services; Transportation Services*

SUBMISSION DATE: 2008



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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Gero-Psychiatry Community Outreach*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Gero-Psychiatric Community Outreach program provides extensive psychiatric services for homebound seniors over the age of 65 who are (and their caregivers) dealing with complex psychiatric conditions.

### COLLABORATORS

Partnering community organizations included the Grotta Foundation, Union County Division on Aging, Jewish Family Services, visiting physicians, visiting nurse practitioners, social workers, Union County Mobile Psychiatric Outreach Program and Trinitas psychiatric inpatient, outpatient and Psychiatric Emergency Services departments.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program improves access to quality psychiatric healthcare thus reducing psychiatric hospitalization and preventing premature institutionalization. The program is conducted by a nurse practitioner who is trained in both geriatrics and psychiatry. The nurse practitioner makes free home visits and provides clients with evaluations, testing, treatment (pharmacological and non-pharmacological), patient and caregiver education and extensive case management services. The program assists clients and their caregivers to obtain grants and programs, elder care attorneys, support groups, visiting medical physicians, visiting nurses, aides and social workers, social and medical day care centers, assisted living facilities, living wills, global options, guardianship and nursing home placements.

### EVALUATION/OUTCOMES/IMPACT

The Gero-psychiatry Outreach program's nurse practitioner provides over 600 psychiatric house calls per year to homebound seniors. More than 50 percent of patients treated psychopharmacologically showed a reduction in psychopathology.

**KEYWORDS:** *Assisted Living Services; Care Coordination; Elderly; Geriatric Care; Health Screenings; Home Visits; Housing Services; Mental Health Services; Patient Education; Psychiatric Services; Support Services*

SUBMISSION DATE: 2010

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## *Healthcare on the Road, The "Healthy Avenues" Van*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Healthcare on the Road, the Healthy Avenues Van program, was developed by Overlook Hospital to deliver comprehensive health screenings and education to residents from 23 towns in Union and Morris County.

### COLLABORATORS

Partnering community organizations included the Summit School System, Summit Area YMCA, Community Health Committee, Schering Plough Corporation and Overlook Family Practice.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program was staffed by members of the Department of Health who utilized the van to provide participants with free and low-cost health screenings. The Healthy Avenues Van project used the Closing the Loop program to screen and educate participants as well as schedule physician appointments for those individuals whose test results were abnormal. Participants were asked if they would agree to be contacted via phone to ensure they received the needed services. If individuals were uninsured, they were referred to one of Overlook's Family Practice offices. With the addition of a larger van in 2007, the program now gives physical examinations to children in underserved areas whose families cannot afford a pediatrician. This allows children who otherwise could not begin school without a physical to enter school on time.

### EVALUATION/OUTCOMES/IMPACT

The program's goal was to reach 10,000 individuals in 10 years. Since September 2009, the program has exceeded its expectations by screening and educating over 140,000 people.

**KEYWORDS:** *Children; Community Outreach; Health Education; Health Screenings, Low-income Populations; Mobile Health Services; Referral Services; Uninsured and Underinsured*

SUBMISSION DATE: 2008, 2010



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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *HIV/AIDS Testing / Counseling at the Atlantic County Jail*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The HIV/AIDS Testing / Counseling at the Atlantic County Jail program was developed through a partnership with the AtlantiCare Mission HealthCare (MHC) to provide HIV/AIDS testing to all consenting inmates of the Atlantic County Gerard L. Gormley Justice Facility (ACGLGJF) as well as education, counseling and referral options for treatment for those who test positive for HIV/AIDS.

### COLLABORATORS

Partnering community organizations included MHC, AtlantiCare Regional Medical Center ID Ambulatory Clinic, N.J. Department of Health and Senior Services- HIV/AIDS Services, ACGLGJF, Center for Family Guidance and UMDNJ/Robert Wood Johnson Medical Services.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

MHC offers HIV/AIDS prevention, care and counseling services to inmates at ACGLGJF while inmates are incarcerated and upon their release into the community. MHC tested inmates on site, provided referrals to the ID Clinic upon testing positive and referred inmates to the MHC as their medical home. A case manager also is available to deliver risk-reduction strategies to inmates engaging in high-risk behaviors. If the person requires medication while incarcerated, MHC gives assistance through its 340b pharmacy program until the person is released. The collaborative team also obtained a lab license designation for the ACGLGJF with UMDNJ as the custodian resulting in an increased number of inmates tested.

### EVALUATION/OUTCOMES/IMPACT

To date, the project has tested 763 inmates with a total of 788 visits.

**KEYWORDS:** *Chronic Disease Management; Counseling Services; Criminal Justice Partnerships; Diagnostic Testing; High-risk Behaviors; High-risk Populations; HIV/AIDS; Patient Education; Prescription Assistance; Preventive Services; Referral Services*

SUBMISSION DATE: 2010



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## *Hooray for Five a Day*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The primary mission of the Hooray for Five a Day outreach program is to address the issue of childhood obesity in first and second graders by providing them with nutrition messages. The program aims to encourage students to eat five fruits and vegetables every day.

### COLLABORATORS

Partnering community organizations include the Summit YMCA, The Connection for Women and Families, The Red Cross, the Recreation Commission and Summit public schools.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Program implementation included presentation of nutrition topics, a reward aspect and a Bingo game. In addition, families were given a take-home exercise to track their child's consumption of fruits and vegetables for the next week. When those forms were returned to teachers, a small prize was given to each child for their participation. Families were also provided with an interactive Internet site with prizes from participating vendors. Families were given contact information for a health professional at Overlook Hospital so they could call if they had any questions.

### EVALUATION/OUTCOMES/IMPACT

In conjunction with five community agencies, the program has reached 36 schools and 3,350 students. In 20 out of the 36 schools in the project, students' BMIs decreased. Future plans include a program with a fitness component that will incorporate contests between schools within the same town.

**KEYWORDS:** *Children; Families; Health Behavior Modification; Nutrition Education; Obesity Prevention; Obesity, Childhood; School-based Outreach; Students*

SUBMISSION DATE: 2008

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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Hunterdon County Medications Access Program*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Hunterdon County Medications Access Program was developed to improve access to prescription medications for the county's uninsured and underinsured residents, thereby improving their health and minimizing excessive and avoidable use of emergency healthcare services. The program utilizes a nurse educator to coordinate needed services and provide these residents with access to affordable prescription medications and health education.

### COLLABORATORS

Partnering community organizations include the Hunterdon County's physician practices, health departments, office of senior services, congregations and social and human service agencies to refer patients and support the activities of this program.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Through this program, nurse educators provide assistance to patients in accessing prescription medications via pharmaceutical company patient assistance programs, help patients incorporate positive behavior changes into their lifestyle; provide medication and disease specific information to each patient; and coordinate refills of the prescription with the treating physician, patient and the pharmaceutical company.

### EVALUATION/OUTCOMES/IMPACT

Currently, over 200 patients are enrolled and approximately \$600,000 of free medicine was provided to county residents. The program has reduced hospital total emergency department visits or admissions by 30 percent among program participants. This program's streamlined process has been used as a best practice model for other counties developing their own medical access program.

**KEYWORDS:** *Care Coordination; Health Behavior Modification; Medication Compliance; Medication Management; Prescription Assistance; Uninsured and Underinsured*

SUBMISSION DATE: 2010

*\* HRET Community Outreach Award Winner, 2010*

# *Improving Access and Quality of Care for the Uninsured, Underinsured and Minority Groups in Hightstown*



## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Improving Access and Quality of Care for the Uninsured, Underinsured and Minority Groups in Hightstown is a community outreach and education program offered by Princeton Healthcare System that aims to provide traditionally underserved residents in Hightstown with the information they need to prevent serious medical illness.

## COLLABORATORS

Partnering community organizations include local community leaders, clergy, nurses and community service organizations.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

By providing access to free and culturally sensitive education and screening programs in this community, the program generated awareness about health risks, screened participants, and as needed, referred them for treatment of hypertension, diabetes and other serious health problems. With direction and assistance of community partners, the program rolled out a series of screenings, lectures and health fair-type activities in 2005 that were designed to reduce health risks in the Latino and African American populations. The program focused on improving cardiovascular health as well as detecting and preventing diabetes, which are the two conditions that create higher risks for Latinos and African Americans.

## EVALUATION/OUTCOMES/IMPACT

Last year the program effectively organized 12 events, provided more than 320 screenings and 100 referrals for follow-up treatments.

**KEYWORDS:** *African Americans; Cardiovascular Health; Community Outreach; Culturally Sensitive Education; Diabetes; Health Education; Health Fairs; Health Screenings; Hypertension; Latino Communities; Minorities; Prevention Education; Referral Services; Uninsured and Underinsured*

SUBMISSION DATE: 2006

\* HRET Community Outreach Award Winner, 2006

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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Kidney Transplant (KT) Classroom*

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### **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

The Saint Barnabas Health Care System (SBHCS) created a two and a half hour live interactive videoconference called the Kidney Transplant (KT) Classroom for central and northern N.J. students. This educational outreach program aims to educate students about organ donation, promote life-saving measures through organ donation, expose young people to the health professions field as well as teach them about healthy lifestyle choices.

### **COLLABORATORS**

Partnering community organizations include the Liberty Science Center (LSC), the New Jersey Sharing Network and Roche and Becton Dickinson.

### **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

During the program, two surgical teams perform live kidney donor and transplant surgeries while teaching and interacting with students in the Liberty Science Center's amphitheater. A special School Aid Fund was established to assist schools with transportation or LSC admissions fee issues. The program also offers students five-minute summaries from a healthcare practitioner about healthcare careers including education and experience requirements as well as a question/answer session. Health career brochures also are provided for students.

### **EVALUATION/OUTCOMES/IMPACT**

Overall, the program was offered 12 times each school year. Sixteen KT classroom events were conducted for 1,200 high school and middle school science students from 29 schools. Nine of the 16 programs were broadcast from the SBMC operating rooms to students in the LSC amphitheater. To date, two schools have used the School Aid Fund.

**KEYWORDS:** *Career Building in Healthcare; Children; Health Education; Kidney Transplantation; Organ Donation Counseling; School-based Outreach; Students; Technology Use in Health*

SUBMISSION DATE: 2006

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## *Korean Long Term Care*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Korean Long Term Care program was created to meet the social and healthcare needs of the Korean senior population of Bergen County. However, this program also accepts residents from throughout N.J. and metropolitan N.Y. The facility provides traditional long term care as well as skilled, sub-acute medically complex care, IV, respiratory and rehabilitation therapy. Additional services include specialized programs in wound care, pain management, hospice and respite care.

### COLLABORATORS

Partnering community organizations include Eden HealthCare, Korean American Association of N.J., Milal World Wheat Mission, churches and local Korean politicians.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

There is a full range of Korean staff available to provide Korean elders with long term care services in a traditional Korean setting without disrupting their lifestyles. Clients have access to newly designed resident care units, food services, recreational programming and alternative health and medical options, including acupuncture and massage therapy. The staff also connects residents in the facility with local community organizations.

### EVALUATION/OUTCOMES/IMPACT

To date, there are 125 residents in the Korean Long Term Care program from the original 20. However, with the continued need for long term care and other health-care services for the elderly, the program expects to include 150 residents in the future. Positive feedback was received from residents, family members, staff and the community.

**KEYWORDS:** *Complimentary/ Alternative Medicine; Elderly; Geriatric Care; Hospice; Korean Communities; Medical Services; Pain Management; Rehabilitation Services; Respiratory Therapy; Respite Care*

SUBMISSION DATE: 2006, 2008

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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Latino Healthcare Initiative of Hunterdon Healthcare System*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Latino Healthcare Initiative of Hunterdon Healthcare System improved access to healthcare services for Latino communities through minimizing/eliminating barriers to accessing care.

### COLLABORATORS

Partnering community organizations included the Hunterdon County Health Department, Hunterdon Pediatrics, Phillips Barber Family Health Center, the New Jersey Cancer Education and Early Detection Program, Hunterdon County Division of Social services, Hunterdon Pediatric Association, YMCA and United Way.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The initiative includes five programs: 1) Latino Well Child Clinics in a Medical Home in Lambertville and Flemington; 2) Latino Prenatal Health Literacy Initiative; 3) Latino Patient Education and Nutritional Counseling Program; 4) Hunterdon Regional Cancer Center Latino Outreach Program, and 5) Hunterdon Regional Community Health Latino Outreach Program. These programs provided a wide range of services, including well child visits, financial assistance, language services, prenatal care, education on childbirth and infant care, weight management seminars, nutrition education and a number of health screening services.

### EVALUATION/OUTCOMES/IMPACT

The successful outcomes of these programs included: over 700 well child visits; increased awareness of Latino communities about available services; increased enrollment of Latino children in Medicaid and NJ FamilyCare; improved appointment compliance; reduced language/transportation barriers; increased use of prenatal care; improved weight loss management and daily exercise and reduced diabetes complications; increased cancer screenings and timely linkages to follow-up services; and improved trust and quality care experience for Latino communities.

**KEYWORDS:** *Cancer; Cancer Screenings; Childbirth/Infant Care; Community Outreach; Diabetes; Health Literacy; Healthcare Coverage; Language Services; Latino Communities; Medical Home; Patient Education; Prenatal Education; Primary Care; Referral Services; Transportation Services*

SUBMISSION DATE: 2008

*\* HRET Community Outreach Award Winner, 2008*

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# Lourdes Center for Public Health

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Lourdes Center for Public Health is a community-based participatory research program designed to meet the need for population-based studies about health promotion and disease prevention in Camden, Trenton and Newark.

## COLLABORATORS

Partnering community organizations include academic (Drexel and Princeton University) and community partners to identify critical public health challenges, design and implement research and develop intervention strategies.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Through this program, graduate level public health students and undergraduates participate in fieldwork in underserved communities. By engaging in public health studies and activities in the community, these students evaluate healthcare status, access and delivery and make recommendations for improvement to Lourdes Health System. Students gain valuable exposure to these communities' challenges as well as experience in public health research and healthcare settings.

## EVALUATION/OUTCOMES/IMPACT

To date, more than 23 students have completed over 20 projects in a wide variety of topics, with interest continuing to grow. Through this student research program, the center addresses the increasing need for community-based participatory research. In addition, the center helps to connect, motivate and educate future healthcare workers in public health practice and exposes them to career opportunities available in public health. Recommendations have the potential to impact 30,000 inpatients, 80,000 emergency department patients and 300,000 outpatients per year in the Lourdes Health System hospitals.

**KEYWORDS:** *Career Building in Healthcare; Health Services Research; Population-based Research; Public Health Research; Students*

SUBMISSION DATE: 2009



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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Matheny Center of Medicine and Dentistry*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Matheny Center of Medicine and Dentistry was established to provide outpatient services to people with a wide range of disabilities. In particular, clients receive a range of medical and dental services as well as access to therapy care.

### COLLABORATORS

Partnering organizations included the Delta Dental Plan of NJ Foundation, the Merck Corporation and the NJ Health Initiatives Program of the Robert Wood Johnson Foundation as well as the Ethicon Inc. and SJP Properties. In addition to funds from these partners, Matheny created two fund-raising events, Miles for Matheny and the Matheny Golf Classic, to support the program. The program's main service delivery partners are UMDNJ-NJ Dental School, UMDNJ-NJ Medical School and Merck. Merck enabled the center to provide seating and mobility services. Matheny has several community partners such as the Spectrum for Living, the Arcs of Morris and Somerset counties, Midland School and Adult Services and Community Hope.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program allows people with all kinds of disabilities to obtain routine medical, dental and therapy care including specialty evaluations such as developmental pediatrics, evaluation of swallowing dysfunction, urology, women's health, dysphasia/speech therapy and seating and mobility evaluations.

### EVALUATION/OUTCOMES/IMPACT

The Matheny Center of Medicine and Dentistry experienced 1,806 outpatient visits (1,355 adult patients; 451 pediatric patients) from 12 New Jersey counties.

**KEYWORDS:** *Dental Services; Developmental Disabilities; Developmental Screenings; Medical Services; Outpatient Services; People with Disabilities; Rehabilitation Services; Women's Health*

SUBMISSION DATE: 2006, 2008



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# Newark Homeless Community Support Services

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Newark Homeless Community Support Services (NHCSS) project was an HIV secondary prevention project undertaken by the Broadway House and St. Bridget's Residence/Catholic Charities. The project aims to improve healthcare access and quality of care for HIV positive individuals who are homeless or at risk of becoming homeless by strengthening use of primary healthcare, maintaining housing stability and reducing behaviors that increase their risk of contracting HIV/AIDS.

## COLLABORATORS

Partnering community organizations include the St. Bridget's Residence/Catholic Charities, the Community Food Bank of NJ, UMDNJ and Broadway House.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offered social services entitlement/referral assistance, life skills training, housing assistance, medical and medication counseling, social service counseling (individual), HIV support group, individual and group mental health counseling and individual and group substance abuse counseling. Implementation of the program included assessing the client's housing, medical and psychotherapeutic needs, developing a monitor care plan, making referrals, follow-up care and providing a six-module Discharge to Life: Life Skills Training. The program also provides weekly individual and group medical and medications adherence training, individual and group mental health and substance abuse counseling, weekly two-hour HIV support groups and developing/monitoring HIV risk reduction plans.

## EVALUATION/OUTCOMES/IMPACT

To date, 46 of the 65 2008-2009 project clients have been enrolled, 15 additional drop-in clients also were served. A total of 416 clients were reached.

**KEYWORDS:** *Care Coordination; Case Management; HIV/AIDS; Homeless People; Housing Services; Life Skills Training; Medication Compliance; Mental Health Services; Preventive Services; Referral Services; Substance Abuse Counseling; Support Services*

SUBMISSION DATE: 2009

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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## Observant Jewish Outreach Program

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Englewood Hospital and Medical Center established a program to better accommodate the religious needs of the Orthodox/Observant Jewish community during their hospital stay. The medical center offers targeted services and amenities that improve access and quality of care to Observant Jewish patients.

### COLLABORATORS

Partnering community organizations include the Moriah School, The Congregation Ahavath Torah, the Keshet Synagogue, local Jewish Federations, Jewish Community Centers, Jewish healthcare agencies as well as the Jewish press and media.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Through this program, amenities and services are provided to Orthodox/Observant Jewish patients and their relatives. Clients also have access to a Sabbath Elevator, a Kosher Kitchen and a Hospitality Room. Jewish holidays are appropriately observed in accordance with Jewish customs. For instance, on Rosh Hashanah, all Jewish patients were given gift bags containing traditional items. Furthermore, a local Orthodox synagogue used the medical center to conduct religious ceremonies which allowed physicians, staff, patients and visitors to join in the prayers. For Sukkot, the medical center erected a Sukkah in the garden. Each night of Chanukah, a different community partner was invited to the medical center to join in the nightly lighting of the Menorah candle. In addition, regular patient visits were conducted by a liaison and community volunteers.

### EVALUATION/OUTCOMES/IMPACT

The program created meaningful and innovative initiatives to improve healthcare for Observant Jewish patients.

**KEYWORDS:** *Culturally Sensitive Care; Faith-based Outreach; Faith-based Practices/Services; Jewish Communities*

SUBMISSION DATE: 2008

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# *One Minute Can Save Your Life- Prostate Cancer Screening Program*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Recognizing the disproportionate burden of prostate cancer among minority populations, One Minute Can Save Your Life program increased needed screenings among New Brunswick's medically underserved minority men.

## COLLABORATORS

Partnering community organizations include Mt. Sian AME Church and the Puerto Rican Action Board to design outreach strategies based on best practice models. It established strong relationships with church-based men's groups, barber shops, local mail carriers, school coaches, health ministries and other groups to market the event and encourage participation. Robert Wood Johnson University Hospital implemented a three-night screening program held annually in September. It uses community partnerships, outreach, and education to highlight the importance of annual prostate cancer screenings.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The screenings were offered after work hours at The Cancer Institute of New Jersey. Participants received a PSA test and a digital rectal exam, and were provided with transportation, free parking and a light dinner. Those who needed further evaluation were sent a letter with their test results, and medical resources if uninsured, and the UMDNJ RWJMS Urology Department coordinated follow-up services. The program also provided interpreter and translation services during the screenings and follow-up visits.

## EVALUATION/OUTCOMES/IMPACT

Since its inception, more than 3,663 men have participated in the program's annual screenings; about 400 each year. In 2008, 54 percent of participants were men of color and other minorities.

**KEYWORDS:** *Cancer, Prostate; Cancer Prevention; Cancer Screenings; Care Coordination; Community Outreach; Faith-based Outreach; Health Screenings; Language Services; Medically Underserved Populations; Men's Health; Minorities; Referral Services*

SUBMISSION DATE: 2010

*\*HRET Community Outreach Award Honorable Mention, 2010*

## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*

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## *Pancreas Transplant Program*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Newark Beth Israel Medical Center (NBIMC) established a Pancreas Transplant Program to educate African American and Latino patients with Type 1 Diabetes and end stage renal disease (ESRD) about the advantages of pancreas transplantation and the importance of organ donation.

### COLLABORATORS

Partnering community organizations include the Healthcare Foundation of New Jersey to conduct outreach to local dialysis units, provide in-service education at the medical center and outreach to various community groups.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offered a bilingual education module to incorporate into the Renal Transplant education program for patients and their families with ESRD and Type 1 diabetes. Site visits also were made to dialysis units and educational sessions were conducted. Dialysis patients were visited and dialysis staff members were educated. Patients were evaluated for simultaneous Pancreas-Kidney and Pancreas after Kidney transplants. Brochures were created to market the program and an educational symposium was provided in Spanish about the options for transplantation, including the new pancreas program.

### EVALUATION/OUTCOMES/IMPACT

As a result of the Pancreas Transplant Program, education sessions were conducted at 16 dialysis units, over 200 patients and families attended the bilingual education program, 165 patients on dialysis were visited, 70 dialysis staff members were educated in formal continuing education presentations and 10 patients were evaluated for simultaneous Pancreas-Kidney and Pancreas after Kidney transplants.

**KEYWORDS:** *Culturally Sensitive Education; Diabetes; Health Education; Kidney Diseases; Minorities; Organ Donation Counseling; Patient Education; Transplantation Education*

SUBMISSION DATE: 2006

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## PASCACK VALLEY HOSPITAL

### *Community Outreach Van Service*



#### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Pascack Valley Hospital Community Outreach Van Service provides free transport northeastern Bergen County residents who cannot access healthcare due to physical challenges and financial burden.

#### COLLABORATORS

Partnering community organizations include the Historical 1985 Stillman Ford, Emerald Management and the Bergen County Community Transplantation, the program meets the physical as well as social needs of its clients. Implementation of this program was fully funded by the Pascack Valley Hospital.

#### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offers individuals access to medical and support services such as physical therapy, cardiac services, oncology treatments and hospital physician appointments. On any given day, five of the hospital vehicles are on the road; one is a standard van, another is a 12-seat bus with one wheelchair space, two are 10-seat buses with two wheelchair spaces, and one is a five-passenger automobile.

#### EVALUATION/OUTCOMES/IMPACT

Results from documentation indicate that the program has increased patient use of cardiology, radiation oncology and the Diabetes Center. The target population now is able to obtain more preventive care and treatment. The Pascack Valley Hospital's program serves 26 towns with a population of 225,000 people. The program reached 192 low-income residents who are 60 years of age or older.

**KEYWORDS:** *Cardiac Services; Care Coordination; Case Management; Elderly; Low-income Populations; Medical Services; Oncology Treatment; Physical Therapy; Support Services; Transportation Services*

SUBMISSION DATE: 2006

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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Patient Concierge Service*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Patient Concierge Service Program was designed to provide post-discharge services to patients of all ages, particularly those with comorbidities, the frail, elderly or those with little or no support system. The program fosters continuity of care and facilitates compliance with discharge plans and follow-up during the transition from hospital to home.

### COLLABORATORS

Partnering community organizations include the Saint Barnabas Health Care Link, the program increases preventative health behaviors and promotes more cost-effective healthcare. Additionally, working with community agencies such as Ocean Ride, Inc. and Meals on Wheels has enhanced access to vital social services.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offers physician referral services, schedules follow-up lab, radiology and physician appointments and coordinates transportation, meals and home medical supplies. The concierge staff meets one on one with patients prior to discharge to establish a rapport, offer assistance, share information about hospital services, programs and educational opportunities. The staff arranges follow-up appointments, and patients receive reminder calls for all appointments as well as confirmation letters outlining dates, times and locations of scheduled appointments.

### EVALUATION/OUTCOMES/IMPACT

To date, the Patient Concierge Service has reached more than 1,100 patients, secured 200 clients and arranged more than 250 follow-up events. Overall, the program has improved access to medical, health and wellness services and enhances the quality of care provided to its clients.

**KEYWORDS:** *Care Coordination; Elderly; High-risk Populations; Low-income Populations; Medical Services; Patient Education; Post Discharge Services; Referral Services; Support Services; Transportation Services*

SUBMISSION DATE: 2010

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# *Prevention of Catheter-Associated Bloodstream Infections*

## **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

The Children's Hospital of NJ's Prevention of Catheter-Associated Bloodstream Infections program was designed to eliminate catheter-associated bloodstream infections (CA-BSI) in the Pediatric Intensive Care Unit (PICU). Program goals included standardizing practice, collecting and sharing information to help in the development of strategies to eradicate CA-BSI by appropriate care during insertion and maintenance of catheters.

## **COLLABORATORS**

This was a national initiative that the hospital collaborated with 30 other units including the National Association of Children's Hospitals and Related Institutions.

## **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

The program utilized an improvement model of structure-process-outcome. Structure included the training of staff and enforcement of policies as it relates to quality care. Process included execution of ideal insertion and maintenance practices for the central catheters placed in patients. Outcome was measured by the amount of CA-BSIs that occurred. With the use of the Centers for Disease Control and Prevention's guidelines for proper hand hygiene, staff was able to reduce CA-BSIs. The program also created check lists to remind staff of the insertion and maintenance policies for central catheters.

## **EVALUATION/OUTCOMES/IMPACT**

Previously, the PICU had approximately 21 infections per 1,000 catheter days. However, since the program's inception, there has been only one infection per 171 catheter days, which is equal to 5.8 infections per 1,000 catheter days. This translates into huge reductions in mortality, morbidity and healthcare costs.

**KEYWORDS:** *Care Process Improvement; Care Standards Training; Catheter-associated Bloodstream Infections; Children; Infection Prevention; Patient Safety Improvement; Pediatric ICU; Prevention Education*

SUBMISSION DATE: 2008

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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Projects for Assistance in Transition from Homelessness (PATH-Homeless Program)*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The East Orange General Hospital (EOGH) established the Projects for Assistance in Transition from Homelessness (PATH) program to provide comprehensive mental health and housing services for adults 18 years of age and older who are homeless, at risk of becoming homeless, have a mental health diagnosis and/or co-occurring substance abuse illness.

### COLLABORATORS

Partnering community organizations include East Orange General Hospital.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offers a comprehensive array of services and information that include case management, supportive counseling, links to medical, financial, educational/vocational opportunities and substance abuse services. PATH also offers clients links to community agencies, food pantries and shelters.

### EVALUATION/OUTCOMES/IMPACT

Approximately 800 people benefited from this program by receiving words of encouragement, assistance with housing, mental health, medical, vocational and/or rehabilitation services. The program enrolled 131 individuals who received case management services, 27 individuals were placed into permanent housing, 15 individuals received rental subsidies and were subsequently placed in other housing programs within the organization, 25 individuals were placed into temporary housing while on the waiting list for rental subsidy and 36 individuals were linked to mental health services. In addition, the program provided 24 housing units located on the hospital's campus. All individuals placed into housing received monetary assistance along with continuous supportive housing services.

**KEYWORDS:** *Case Management; Financial Counseling; Homeless People; Housing Services; Mental Health Services; Rehabilitation Services; Substance Abuse Counseling; Support Services; Vocational Trainings*

SUBMISSION DATE: 2008



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# *Reaching Out to Help Care for Cape May County*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Cape Regional Medical Center's Parish Nurse Program sets up parish nurse programs in churches, provides education for parish nurses and assists in providing health screenings and education/prevention programs to these churches.

## COLLABORATORS

Partnering community organizations included the Robert Wood Johnson Foundation, South Jersey Council for Health and Wholeness Ministries, Atlantic Cape Community College, Cumberland County Community College, Thomas Jefferson University, South Jersey Ethics Alliance, Cape May County Department of Health, Cape Assist, Aids Alliance, Family Service Association, New Jersey Department of Health and Senior Services and Cape May County Department of Aging.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program hired a parish nurse coordinator, started new parish nurse programs in churches, supported parish nurses through education and networking opportunities, assisted with education and screening programs in churches and referred people to classes and support groups. A need to expand the program resulted in the development of the Center for Lifestyle Management which offers health education classes, wellness programs and information on healthcare services to participants.

## EVALUATION/OUTCOMES/IMPACT

Forty-eight churches in Cape May County have a Parish Nurse Program and 104 parish nurses. Thirty-six health fairs were held in 2006, 26 held in 2007, with a total of 5,587 people screened. Ninety-five health education classes were held in 2006, 90 in 2007, for 4,776 people. In 2007, eight classes were held for 114 seniors.

**KEYWORDS:** *Community Outreach; Faith-based Outreach; Health Education; Health Fairs; Health Screenings; Support Services*

SUBMISSION DATE: 2008



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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



# 65★ *Rolling Out the Red Carpet*

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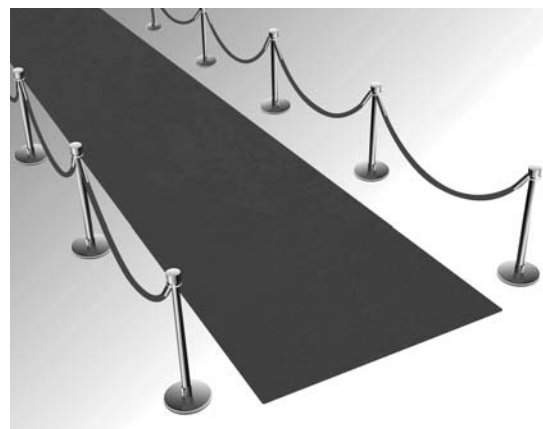
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## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Rolling Out the Red Carpet program helped improve access for black men to prostate screenings, regardless of health insurance or ability to pay. Mercer County is the fourth leading county for prostate cancer in the state, and there is a larger disparity in mortality rates and late stage diagnosis for black men.



## COLLABORATORS

Partnering community organizations included area businesses, local media, radio, and television stations.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Capital Health System offered free comprehensive prostate screenings over a three-month period, following American Cancer Society screening guidelines. The screenings were provided during the day, evening and weekend hours at many locations throughout the community in an innovative manner. Through a five-week multimedia campaign, (print, radio, billboards and television) the public was informed that CHS was “rolling out the red carpet for their screen” similar to Hollywood’s red carpet for a movie screen. Men were empowered in humorous and positive ways to sign up for the screenings. They registered through an 800 number and an interactive Web site that offered prostate cancer education.

## EVALUATION/OUTCOMES/ IMPACT

Out of 531 men registered, 310 attended one of the 11 screenings, which included a prostate-specific antigen blood test, rectal exam, fecal occult blood test and blood pressure. Over 15 percent were referred for further prostate cancer evaluation and three percent were recommended for a colonoscopy. About 40 percent with abnormal blood pressures received counseling on lifestyle changes and the need for medical interventions.

**KEYWORDS:** *African Americans; Cancer Prevention; Cancer Screenings; Cancer, Prostate; Community Outreach; Counseling Services; Health Screenings; Men’s Health; Multimedia Outreach; Preventive Services; Technology Use in Healthcare*

SUBMISSION DATE: 2009

\* HRET Community Outreach Award Winner, 2009

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# *Serving Uninsured and Underinsured in the Princeton Area*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

University Medical Center at Princeton's Outpatient Clinic is a full-service facility offering primary and specialty care in 13 clinical areas to the uninsured and underinsured in Princeton as well as comprehensive case management and links to community resources.

## COLLABORATORS

Partnering community organizations included UMDNJ-Robert Wood Johnson Medical School, Woman Space, Corner House, Latin American Task Force, Princeton Department of Health, Medicaid and the Susan G. Komen Breast Cancer Foundation. The collaborators held a joint Hispanic health fair, give diabetic eye screenings, mammography screenings and offer breast health education.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Program implementation included health education programs, screenings, clinical care, support services, prenatal classes, case management and pharmacy services. To ensure healthcare literacy, educational materials are available in both Spanish and English, staff are bilingual/bicultural, translation services coordinators also are available as well as volunteer interpreters. In addition, clinic staff assists patients with completing applications for medical coverage and follow up with government and healthcare agencies. Clinic staff ensures patient compliance with recommended treatments by calling patients, scheduling consultations and appointments, sending patients letters and when appropriate, making personal home visits.

## EVALUATION/OUTCOMES/IMPACT

There was an 87 percent increase in visit volume over the past 10 years, a total of 16,377 visits, 200 successful deliveries performed and 14,290 prescriptions filled for charity care patients.

**KEYWORDS:** *Care Coordination; Case Management; Health Education; Health Fairs; Health Screenings; Home Visits; Language Services; Latino Communities; Medical Services; Minorities; Prenatal Education; Prescription Assistance; Primary Care; Support Services; Uninsured and Underinsured*

SUBMISSION DATE: 2006



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*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Sharing Stories/Compartiendo Historias Breast Cancer Awareness Theater Program*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Sharing Stories/Compartiendo Historias Breast Cancer Awareness Theater Program was developed by the Robert Wood Johnson University Hospital in 2001 as an innovative way to reach out to New Brunswick's medically underserved minority women. The community needs assessment showed that minority women experience a higher death rate from breast cancer than Caucasian women, and that African American and Latino women get mammograms and clinical breast exams at a lower rate than Caucasian women.

### COLLABORATORS

Partnering community organizations included the Cancer Institute of New Jersey and the Middlesex County Health Department.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

This initiative used theater and education to highlight the importance of mammograms and raise awareness about breast health. Through the use of storytelling, the program addressed the cultural values and health beliefs of minority women and encouraged open discussions about these issues including fear, cultural differences, language barriers and economic challenges. The bilingual presentations were performed throughout the city in locations like schools beauty salons, laundromats, women's shelters, adult learning centers, churches and health fairs. All places where women feel comfortable and could be encouraged to participate.

### EVALUATION/OUTCOMES/IMPACT

Since the program's inception, more than 2,000 city residents have participated in the theater presentations and approximately 570 women received free mammograms.

**KEYWORDS:** *Breast Health; Cancer Prevention; Cancer, Breast; Cancer Screenings; Community Outreach; Culturally Sensitive Education; Health Education; Mammogram Services; Medically Underserved Populations; Minorities; Theater; Women's Health*

SUBMISSION DATE: 2006

*\*HRET Community Outreach Award Winner, 2006*

## SOMERSET MEDICAL CENTER'S

# *Implementation of Induced Therapeutic Hypothermia in Pre-Hospital Setting*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Somerset Medical Center established a program to provide induced therapeutic hypothermia treatments to all Mobile Intensive Care Unit (MICU) patients that suffer from sudden cardiac arrest. The program was later expanded to also treat any inpatient that experienced a cardiac arrest while in the hospital.

### COLLABORATORS

Partnering community organizations include the Somerset Medical Center, the emergency department, the MICU, Overlook Hospital, University Hospital at Princeton, St. Peters Medical Center, Robert Wood Johnson Hospital, JFK Medical Center, Morristown Hospital and Hunterdon Medical Center.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program was implemented by utilizing pre-hospital, in-hospital and re-warming protocols to increase survival rates among patients who were resuscitated after a cardiac arrest and also to minimize brain damage. Following a successful resuscitation, a patient with a return of spontaneous circulation but no eye opening to painful stimulation received Induced Therapeutic Hypothermia treatments. The pre-hospital protocol drops the patient's temperature to 33 degrees C while preventing shivering. The in-hospital protocol maintains the patient's temperature at 33 degrees C while preventing shivering and the re-warming protocol helps return the patient to a normal body temperature.

### EVALUATION/OUTCOMES/IMPACT

The center responds to 7,500 calls per year and since the program's inception, three out of four patients treated have experienced full neurological recoveries post-cardiac arrest.

**KEYWORDS:** *Cardiac Arrest; Cardiac Complications; Cardiovascular Diseases; Inpatient Services; Medical Services; Preventive Services; Therapeutic Hypothermia Induction*

SUBMISSION DATE: 2010

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*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## SOMERSET MEDICAL CENTER'S *EMT Training Class*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The EMT training program was developed to train high school students to support rescue squads with new recruits and ensure ambulance resources are available when necessary.

### COLLABORATORS

Partnering community organizations include the Somerset County Board of Chosen Freeholders, Somerset County Vocational and Technical High School, Somerset County EMS Chief Officers Association, Raritan Valley Community College and volunteer first aid squads in Somerset County.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Students are bussed to the Somerset County Vocational and Technical High School three days a week for a total of 140 hours. During those classes, students are taught anatomy and physiology, disease processes and traumatic treatment protocols for a variety of healthcare emergencies. Students also are given hands on skills practice in preparation for the National Registry Certification Examination. Once students complete the program, they are awarded six fully transferable college credits from Raritan Valley Community College and can sit for the final certification exam. As a result of this program, local rescue squads are adding new members to their agencies increasing access to healthcare for the entire community. Another benefit of this program is that students become immediately employable with the EMT certification.

### EVALUATION/OUTCOMES/IMPACT

Eighteen students completed the 16-week class. Eleven graduates of the class now serve on volunteer rescue squads.

**KEYWORDS:** *Career Building in Healthcare; Crisis Response Training; Health Education; Mobile Health Services; Professional Education; School-based Outreach; Students*

SUBMISSION DATE: 2010

## Spa for the Spirit

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Spa for the Spirit provides complementary therapies and beauty/relaxation for women receiving chemotherapy or radiation treatment to reduce stress and feel better physically and psychologically.

### COLLABORATORS

Partnering community organizations include AquaMedica, The Women's Council and the Leon Hess Cancer Center.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

AquaMedica, a day spa, hosts the program Spa for the Spirit. AquaMedica Spa clears its schedule for between 15 and 30 patients at a time and provides an inviting and supportive environment for these women. AquaMedica offers cancer patient services such as facials, manicures, pedicures, massages, Reiki, reflexology sessions and counseling with a nutritionist at a reduced rate. A healthy lunch also is served to women who spend the entire day receiving treatments at the Leon Hess Cancer Center.

### EVALUATION/OUTCOMES/IMPACT

Spa for the Spirit has provided days of rejuvenation and relaxation to more than 200 women undergoing active cancer treatment at the Leon Hess Cancer Center. AquaMedica also held a separate spa day during the Breast Cancer Awareness Month for women receiving breast cancer treatment. This special day provided free spa services to an additional 50 women.

**KEYWORDS:** *Cancer; Cancer, Breast; Chemotherapy Stress Reduction; Complementary/ Alternative Medicine; Radiation Stress Reduction; Support Services; Women's Health*

SUBMISSION DATE: 2010



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## Beyond Hospital Walls:

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Special Care Center*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Special Care Center (SCC) is a redesigned ambulatory care practice focusing on reducing healthcare costs and improving health outcomes for low-income patients with chronic conditions such as diabetes, congestive heart failure, hypertension and cardiovascular disease who need a medical home to provide comprehensive care.

### COLLABORATORS

Partnering community organizations include Local 54, Horizon Insurance, the Health Technology Center and Mercer Health and Benefits and the Unite Here Welfare Fund.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The center offers patients educational tools and personal empowerment to help them better manage their conditions. The center also offers clients easier access to care, reduced costs, personalized care as well as focus groups, home visits and self-management skills. The SCC reduces barriers to ideal care by waiving co-payments for visits and prescription medications, and other services such as an on-site pharmacy, 24/7 access to a medical provider and bilingual medical professionals to personally coach patients and guide them with lifestyle changes. Finally, the center provides integrated behavioral healthcare to address issues of depression and stress.

### EVALUATION/OUTCOMES/IMPACT

Since the program's inception in 2007, SCC has focused on the health outcomes of 800 patients and provided over 5,000 home visits. Program outcomes indicate an improvement in health, patient satisfaction and a reduction in overall cost of care.

**KEYWORDS:** *Behavioral Health Services; Bilingual Professionals; Cardiovascular Diseases; Care Coordination; Case Management; Chronic Disease Management; Depression; Diabetes; Healthcare Coverage; Heart Failure; Home Visits; Hypertension; Low-income Populations; Medical Home; Patient Education; Prescription Assistance; Self Care*

SUBMISSION DATE: 2009



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# Statewide Clinical Consultation and Training (SCCAT)

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Statewide Clinical Consultation and Training (SCCT) is a hospital affiliated mental health and behavioral outreach team providing crisis response to individuals diagnosed with mental illness and developmental disabilities.

## COLLABORATORS

Partnering community organizations include the Division of Developmental Disabilities, Division of Medical Assistance and Health Services, Psychiatric Screening Centers and the N.J. Association of Community Providers.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

SCCAT offers clients clinical support, psycho-education and skills-building. The program addresses primary healthcare needs by improving access to appropriate and effective mental health treatment. SCCAT also helps to maintain the community placements of individuals and avoid institutionalization and unnecessary psychiatric hospitalizations. This system preserves community placements through follow-up treatment, consultation and monitoring individuals. The SCCAT team operates 24 hours a day, seven days a week to assist individuals, families and agencies in dealing with psychiatric and behavioral crises.

## EVALUATION/OUTCOMES/IMPACT

SCCAT has provided over 1,500 clinical interventions to individuals in 2007 throughout 21 counties in N.J. SCCAT also has provided more than 90 training programs, 500 referrals and over 365 face-to-face visits to the homes of the target population, group homes, day programs or screening centers throughout the state. Over 88 percent of the clients served have remained in community placements. In addition, 42 clients were diverted from screening centers, 60 diverted from inpatient hospitalizations and 27 diverted from state hospitals.

**KEYWORDS:** *Behavioral Health Services; Community Placement – Mentally Ill; Crisis Response Training; Developmental Disabilities; Home Visits; Mentally-ill Populations; Patient Education; Referral Services; Skills Building; Support Services*

SUBMISSION DATE: 2008

*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



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## *Student Family Health Care Center (SFHCC)*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Student Family Health Care Center (SFHCC) is a biweekly volunteer free clinic that provides medical care to the uninsured population in Newark. It is staffed by New Jersey Medical School students and all services are supervised by University Hospital board-certified physicians, NJMS faculty and alumni.

### COLLABORATORS

Partnering community organizations included the Student Health Advocates for Resources and Education, the Newark Department of Health, Super Neighborhoods Community Covenant and Family Intervention Services Inc.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

SFHCC provides general physical examinations, pre-employment physical examinations, school physical examinations, gynecological care, psychosocial counseling, acute and chronic disease management and any necessary laboratory services. The clinic also provides flu vaccinations, pedometers, smoking cessation support, appropriate healthcare screenings and thorough patient education through counseling and literature. SFHCC gives patients referrals to the School of Public Health's Tobacco Cessation Program, charity care, subspecialty clinics, radiological services and healthcare screenings (e.g. colonoscopies, mammograms and pap smears). Patients are referred to neighborhood pharmacies to obtain free and discounted medications. Patients have access to medical translation services and a full time translation telephone service. Patients can get assistance to deal with homelessness, substance abuse and legal immigration status.

### EVALUATION/OUTCOMES/IMPACT

Approximately 346 students volunteered 4,236 service hours specifically to patient care. Overall, 865 patients were seen equaling more than 18,000 community service hours.

**KEYWORDS:** *Care Coordination; Case Management; Chronic Disease Management; Gynecological Services; Health Screenings; Homeless People; Language Services; Low-income Populations; Medical Services; Mental Health Services; Prescription Assistance; Preventive Services; Referral Services; Smoking Cessation Support; Substance Abuse Counseling; Support Services; Uninsured and Underinsured*

SUBMISSION DATE: 2009

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## *ThinkLikeAPancreas.com*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The BD Diabetes Center for Children and Adolescents created *ThinkLikeAPancreas.com* as an Internet-based educational program for adolescents with Type 1 diabetes.

### COLLABORATORS

Partnering community organizations included the American Diabetes Association, the Canadian Diabetes Association and the TeenHealthFx Web sites. Funding partners included the Warner Fund Inc., the Hoopapalooza Inc. and the Ladybug Fund.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offers online, interactive teaching modules for teens on living with and treating diabetes, along with teaching life skills and disease self-management. In addition, each learning module contains self-tests to measure comprehension. The Web site incorporates multimedia technology including photographs, three-dimensional images, flash animation, video and voice overs.

### EVALUATION/OUTCOMES/IMPACT

The Web site went live in August 2005, and has since logged over 10,000 visits from adolescents all over the world. In the seven months since the Web site went live, there have been over 12,500 visits from 9,500 unique visitors. Positive feedback confirmed that many U.S. diabetes centers are utilizing this program to promote diabetes education. Currently, data is being collected on how the Web site has influenced emergency department visits and control of blood sugars for the target population. Future plans include updating the site to reflect topics such as Type 2 diabetes and insulin adjustment techniques as well as possibly creating an interactive CD version of *ThinkLikeAPancreas.com*.

**KEYWORDS:** *Adolescents; Community Outreach; Diabetes; Life Skills Training; Multimedia Outreach; Patient Education; Technology Use in Health*

SUBMISSION DATE: 2006



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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



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# HOSPITAL COMMUNITY PROGRAMS

## *Reducing Healthcare Disparities*



# AtlantiCare Health Services - Healthcare for the Homeless



## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

AtlantiCare Health Services - Healthcare for the Homeless was established in 2003 by AtlantiCare as a federally qualified health center to provide primary care services to the homeless of Atlantic County. The initiative was developed to further AtlantiCare's commitment to community health improvement and equitable health-care and was funded by grants from the Health Resource Service Administration.

## COLLABORATORS

Partnering community organizations included AtlantiCare and local agencies and businesses.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The primary care needs of the homeless were identified through the Homeless Assessment Resource Team over a five-year period. The team found chronic conditions such as hypertension, diabetes and respiratory diseases were going undetected and resulting in higher rates of hospitalizations and comorbidities. The initiative developed a comprehensive primary and preventive care facility, which has seen more than 4,000 unduplicated patients and provided more than 24,000 visits. Patients' cultural and linguistic needs were addressed by staffing ratios of bilingual professionals and increased access to care for the homeless.

## EVALUATION/OUTCOMES/IMPACT

The center's accomplishments include: reduction of waiting days for an appointment to zero (adopting the IHI model of advanced access); opening of an ambulatory detoxification drug treatment program that admitted over 200 patients each year; development of a system continuum that provided seamless care from the acute setting to outpatient services; national recognition in the Health Disparities Collaborative Diabetic Project; and state recognition in the pharmacy 340B program, which purchases medications for the homeless.

**KEYWORDS:** *Bilingual Professionals; Chronic Diseases; Culturally Sensitive Care; Culturally Sensitive Education; Homeless People; Language Services; Outpatient Services; Preventive Services; Primary Care*

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SUBMISSION DATE: 2006

*\*HRET Community Outreach Award Winner, 2006*

## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *The Beth Challenge: A Wellness Program for Newark Beth Israel Medical Center and the Community it Serves*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Beth Challenge is a worksite wellness program that fosters lifestyle changes for improved health and well-being through nutrition and exercise education and support.

### COLLABORATORS

Partnering community organizations included the Clear View Baptist Church.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program consisted of three rounds per year, each containing 12-week cycles for competition for largest percentage of weight loss and other personal fitness goals. The Beth Challenge created its own Web site, bulletin board and blog to encourage and guide participants in their journey. The program also changed the employee cafeteria menu to include affordable healthier food options. In addition, the program provided access to physical activity within the facility and suggestions for options in the greater Newark area. Additional rewards and recognition were provided through periodic Pep Rallies and at closing ceremonies after each round was completed. The church has approximately 1,000 parishioners and volunteers who were designated to monitor weight and conduct blood pressure screenings at initial enrollment. The initial weight loss contest expanded into a year round wellness and lifestyle improvement program.

### EVALUATION/OUTCOMES/IMPACT

Overall, 30 percent of contestants lost weight. Other contestants reported changing their dietary behaviors and increasing their exercise time, lowering their blood pressure and reducing or discontinuing their medications for obesity-related outcomes.

**KEYWORDS:** *Faith-based Outreach; Health Behavior Modification; Health Education; Health Screenings; Nutrition Counseling; Obesity Prevention; Physical Fitness; Support Services; Weight Management*

SUBMISSION DATE: 2010

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## Breast Health Outreach

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Breast Health Outreach program helped increase knowledge about breast health, clinical breast exams, self breast exams and promoted mammography screenings. Ultimately, the program helped increase earlier detection of cancer which will improve cure rates in African American women.

### COLLABORATORS

Partnering community organizations include the Cancer Center at Mountainside Hospital, the Community Health Department, Work First, Safe House, 7th Day Adventists, local churches, back-to-work programs, shelters and youth organizations.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program is conducted by an African American breast health educator who also is a retired teacher and a breast cancer survivor. The breast health educator was trained by the hospital's oncology clinical nurse specialist to provide informative sessions for one to two hours on breast health in churches, local battered women's shelters, back-to-work programs, parks and other venues where African American women meet. The health educator stresses the importance of self-exam, clinical exam and yearly mammograms. She teaches breast self exam skills and discusses how her regular exams detected warning signs early.

### EVALUATION/OUTCOMES/IMPACT

To date, the program has reached more than 100 women. Outcomes included referrals of women with problems to appropriate resources and positive feedback from partners about the quality of the program.

**KEYWORDS:** *African Americans; Breast Examination; Breast Health; Community Outreach; Faith-based Outreach; Health Education; Mammogram Services; Minorities; Women's Health*

SUBMISSION DATE: 2009



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## Beyond Hospital Walls:

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





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## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

ClubSib I and ClubSib II are recreation groups offering peer support for healthy/normal children with siblings who suffer from physical or developmental disabilities, autism or brain injuries. The program focuses on the participant's advocacy skills, coping mechanisms and information.

## COLLABORATORS

Partnering community organizations included the Children's Specialized Hospital's Psychology Department, Marketing Department, Recreational Therapy Department and a Child Life Specialist.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

Participants in the program engage in activities that include self-expression, pure silliness and heartfelt discussions while interacting with other children who also have a sibling with a special need. The original ClubSib or ClubSib I was open to children ages 6 to 12. However, due to a new need to also help teenagers, ClubSib II was opened for children ages 13 to 17. Children who are not eligible to participate in either program are offered resource materials and private consultation. Following the program, parents are given suggestions to assist their children to effectively cope with having a sibling with special needs.

## EVALUATION/OUTCOMES/IMPACT

ClubSib has provided a venue for the siblings of children with special needs to feel important; to know that there are others who are going through the same things they are; to understand that their parents don't love them any less; and that in reality, their parents are experiencing issues as well.

**KEYWORDS:** *Adolescents; Autism; Children; Developmental Disabilities; Families; Health Behavior Modification; Support Services; Support Services*

SUBMISSION DATE: 2006



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# *Have a Healthier Life: Reduce Your Cardiovascular Risk*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Have a Healthier Life: Reduce Your Cardiovascular Risk program attempted to reduce cardiovascular risk factors by providing prevention techniques, nutrition and exercise education to a group of 15 Latino men and women ages 18 to 62 from the Iglesia Familia De Dios Church.

## COLLABORATORS

Partnering community organizations included the Community Health Department at Morristown Memorial Hospital and the Iglesia Familia De Dios Church.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

To be included in this program, participants had to be a member of the church, uninsured, have a language barrier, low literacy, lack transportation and complete a health risk survey. After eligibility was checked, participants were screened for weight, cholesterol levels, blood pressure, diabetes, BMI and physical fitness. Those with abnormal values were included in the program. The program lasted for six months and was led by a bilingual health educator. Participants were offered health screenings and educational sessions about cardiovascular risk, nutrition and exercise. The church provided a vehicle to transport participants. All programs and educational materials were in Spanish.

## EVALUATION/OUTCOMES/IMPACT

At the completion of a post test, all 15 participants demonstrated improvement in health status. For instance, cholesterol levels decreased by 40 percent, blood pressure decreased by 80 percent, glucose decreased by 66 percent, BMI decreased by 44 percent, weight decreased by 26 percent and exercise increased by 53 percent.

**KEYWORDS:** *Bilingual Professionals; Cardiovascular Diseases; Cardiovascular Health; Faith-based Outreach; Health Education; Health Screenings; Language Services; Nutrition Counseling; Physical Education; Preventive Services; Uninsured and Underinsured*

SUBMISSION DATE: 2008



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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Healthy Aging in Jersey City*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Healthy Aging in Jersey City held at Christ Hospital Counseling and Resource Center, aims to prevent alcohol and drug abuse and reduce depression among the elderly population, specifically targeting persons age 60 or older who are at risk for drug or alcohol abuse.

### COLLABORATORS

Partnering community organizations include The Philippine American Friendship Committee, Shield of Faith Ministries, the Jersey City Housing Authority, local clergy, civic groups and politicians.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

This project offers easy access to medical information, medical treatment when needed and medication monitoring for its target population through weekly health screenings, wellness workshops and educational programs. Healthy Aging also gives clients the opportunity to discuss personal medical issues with trained healthcare professionals, referrals for mental and physical health services, and counseling for depression, bereavement issues, addictions and nutrition.

### EVALUATION/OUTCOMES/IMPACT

In one year, this project has already exceeded its target objective of serving 75 clients per year by more than 300 percent with 240 clients. Preliminary data as measured by the Geriatric Depression Scale, renamed Feelings Scale, indicated a 23.9 percent decrease in depression and an 11.1 percent increase in the Life Satisfaction Index.

**KEYWORDS:** *Depression; Elderly; High-risk Populations; Mental Health Services; Referral Services; Substance Abuse Counseling; Support Services*

SUBMISSION DATE: 2006

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# *Healthy Choices = Healthy Communities*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The East Orange General Hospital (EOGH) developed Healthy Choices = Healthy Communities to provide continuous health and wellness promotion/education, disease prevention and health screenings as well as to strengthen and increase viable community partnerships for residents of East Orange, Orange, Irvington, Newark and surrounding areas.

## COLLABORATORS

Partnering community organizations include the American Heart Association, Robert Wood Johnson Foundation, EOGH physicians, local and county health departments, libraries, schools, colleges, community-based providers, service provider organizations, local business owners, local media, local clergy associations and local congregations.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program offers free health screenings and healthcare services through the use of a Mobile Health Unit (MHU), which is staffed with Community Outreach Nurse Volunteers and/or other professional medical staff. EOGH also utilizes Express Vans for patient transportation. Clients have access to multi-lingual staff and educational materials written in English, Creole and Spanish. Clients in need may be referred for financial counseling. The program also provides a monthly diabetes support group.

## EVALUATION/OUTCOMES/IMPACT

During 2006-2007, the program served 2,400 residents through hospital-based health fairs, MHU served 1,200 residents through weekend health fairs and reached 150 residents during weekly events held by nurse volunteers. Senior-focused events served 750 individuals, and 100 people attended the Community Health Education Workshops.

**KEYWORDS:** *Bilingual Professionals; Community Outreach; Culturally Sensitive Care; Faith-based Outreach; Health Education; Health Screenings; Healthcare Access; Language Services; Minorities; Mobile Health Services; Prevention Education; Referral Services; Support Services; Transportation Services*

SUBMISSION DATE: 2008

## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



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## *Heart Failure and Tel-Assurance Home Monitoring*

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South Jersey Healthcare's (SJH) Heart Failure and Tel-Assurance Home Monitoring program's goal was to improve care for heart failure, a highly prevalent condition among immigrant and minority populations in the hospital's catchment area. They achieved this goal through education, screening and care management interventions.

### COLLABORATORS

Partnering community organizations include Home Care, Pharos, Casa Prac, Community Health Care Inc., various churches, senior citizens centers and community nutritional services. SJH, along with nine other hospitals, worked with NJHA's Institute for Quality and Patient Safety to implement the project as part of New Jersey Health Initiative's Cardiac Excellence Grant and to reduce disparities in cardiac care.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

This program provided education to minority patients and the community on disease processes and self-management of heart failure regarding weight; nutrition and medication; informed patients of available community resources to assist in wellness maintenance; provided a smooth transition of patient care from hospital to home; and introduced a home monitoring system. SJH utilized a nurse liaison native to the community to gain the trust of community members, allowing for the implementation of culturally appropriate education, screening and care management interventions.

### EVALUATION/OUTCOMES/IMPACT

Through these interventions, over 500 individuals were screened and educated. Acute care recidivism for heart failure patients decreased 17.6 percent and inpatient length of stay for acute cardiac care decreased 21.7 percent.

**KEYWORDS:** *Cardiovascular Diseases; Chronic Disease Management; Culturally Sensitive Care; Culturally Sensitive Education; Heart Failure; Medication Compliance; Minorities; Nutrition Education; Self Care; Weight Management*

SUBMISSION DATE: 2010

\* *HRET's Community Outreach Awards Winner, 2010*

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# *The Heart Failure Center*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Ethnic Minority Heart Failure Program at St. Joseph's Regional Medical Center (SJPMC) is a comprehensive, multi-disciplinary inpatient and outpatient disease management program serving ethnic minority heart failure patients in Paterson. The primary goal of the program is to fulfill SJPMC's mission to provide ethnic minority heart failure patients with optimal medical, social and community support throughout the continuum of their life so as to improve the quality of their life, mitigate disease progression, avoid hospitalization and prolong duration of life.

## COLLABORATORS

Partnering community organizations include SJPMC and the Paterson City Council's president.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program provides full support for ethnic minority heart failure patients and healthcare access for inpatient and outpatient services through the use of a physician champion directed-Cardiac Nurse Practitioner Heart Failure Advocate-managed model of care. Clients also can contact an NP for additional support via the Heart Failure Hot Line.

## EVALUATION/OUTCOMES/IMPACT

Since the program's inception in 2007, a total of 44 interventions were provided for 11 patients. Prior to the program, these 11 patients had 18 admissions during a six-month period of time. However, since their participation in the program, admissions have decreased to four admissions in three patients. In addition, 109 patients were visited by one of the program's NPs.

**KEYWORDS:** *Chronic Disease Management; Healthcare Access; Heart Failure; Home Visits; Hospital Patients; Inpatient Services; Minorities; Outpatient Services; Support Services*

SUBMISSION DATE: 2008



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## Heart Failure Program

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Heart Failure Program's primary goal is to identify reasons for healthcare disparities and utilize strategies for improvement.

### COLLABORATORS

Partnering community organizations include the Robert Wood Johnson Foundation and the Camden Coalition of Health Care Partners support this program.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program staff collected information regarding each admitted patient's race, ethnicity and primary language and ensured that Spanish translators were available to provide education and discharge instructions. The program established a system to ensure that patients fill discharge prescriptions, initiate and sustain daily weights post-discharge and provide specific appointment dates and times for outpatient follow-up visits. The program also offered educational sessions focusing on diet, shopping, cooking, portion control, label reading and medications for all inpatients and their families. Follow-up phone calls provided continued reinforcement of the diet/medication lessons learned. In addition, detailed heart failure education was provided to home care service providers, which increased the percentage of heart failure patients discharged with appropriate home care services.

### EVALUATION/OUTCOMES/IMPACT

Overall, 2,581 patients visited the hospital, 1,133 were inpatients with the discharge diagnosis of heart failure and 70 percent of these patients were visited/educated by a registered nurse heart failure coordinator, contacted by phone and/or attended education follow-up classes.

**KEYWORDS:** *Chronic Disease Management; Counseling Services; Discharge Instructions; Heart Failure; Home Visits; Language Services; Medication Compliance; Nutrition Education; Patient Education; Preventive Services*

SUBMISSION DATE: 2009

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# *In the Pink: Bring the Women in Your Life*

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Bring the Woman in Your Life program was designed to inform, promote and educate Girl Scouts and their friends and relatives about the benefits of developing a healthy lifestyle, the importance of early detection of breast cancer and to provide intergenerational education and service opportunities focusing on breast health awareness.

## COLLABORATORS

Partnering community organizations include the Community Health Department, Breast Center and the Carol G. Simon Cancer Center of Overlook Hospital, the Susan G. Komen Race for the Cure and the Girl Scouts Heart of New Jersey.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The project provided education and awareness to Girl Scouts between the ages of 11 to 17 who must earn the In the Pink Interest Project award. Girl Scouts receive this award after completing a program such as the Bring the Woman in Your Life program, which focuses on breast health and breast cancer. Girl Scouts could invite an important woman in their life to also attend the program. The program lasted for two and a half hours and included refreshments and speakers such as physicians and nurses and a breast cancer survivor. After program's completion, the girls received their In the Pink Interest Project award.

## EVALUATION/OUTCOMES/IMPACT

Over the past three years, five programs were held reaching a total of 217 participants.

**KEYWORDS:** *Breast Health; Cancer Prevention; Cancer, Breast; Early Detection; Health Education; Minorities; Women's Health*

SUBMISSION DATE: 2009, 2010

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## *Beyond Hospital Walls:*

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## *KidsFit Newark: A Comprehensive Wellness Program for Kids and Those Who Love Them*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The KidsFit Newark: A Comprehensive Wellness Program for Kids and Those Who Love Them is a pediatric obesity program that was established to address the prevalence of overweight and obese children in the greater Newark area. The program's goal is to help the community's children and families to overcome this pressing health and social issue.

### COLLABORATORS

Partnering community organizations include the Pediatric Health Center, the outpatient pediatric clinic at Newark Beth Israel Medical Center as well as area healthcare agencies.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

As a group, the collaborators estimate that 35 percent of their pediatric patients are overweight or obese. This program reaches children ages 7-18 and provides them with realistic, health-focused and life-changing programs to teach them to make healthier choices about food and show them how to integrate exercise into their day-to-day lives. It uses a multidisciplinary model that reaches all aspects of the obesity problem in the inner city environment and addresses the needs not only of children, but families and caregivers as well. With a small group composed of peers along with professional guidance from a pediatrician, nutritionist, an exercise physiologist and social worker, children set personal diet and exercise goals and received coaching to help them meet their goals.

### EVALUATION/OUTCOMES/IMPACT

The need for this program is so great that children are referred through the Pediatric Health Center's Obesity Clinic and also the surrounding community. Future plans include bringing the program to local schools and increasing the number of participants as funding permits.

**KEYWORDS:** *Children; Families; Health Behavior Modification; Health Education; Nutrition Counseling; Obesity, Childhood; Physical Education*

SUBMISSION DATE: 2009

\* *HRET Community Outreach Award Winner, 2009*



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# *Korean Outreach Program*

## **PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)**

Englewood Hospital and Medical Center's Korean Outreach Program promotes healthy living, prevention and detection of serious health conditions and ensures that those in need of medical care always have access to appropriate treatment.

## **COLLABORATORS**

Partnering community organizations include the Englewood Hospital and Medical Center, Robert Wood Johnson Foundation and the Friends of Grace Seniors (FGS).

## **PROGRAM IMPLEMENTATION PLANS/ACTIVITIES**

These partnerships resulted in free and low-cost monthly health screenings and diabetes management classes that are staffed by Englewood Hospital employees and held at a familiar community setting. Additionally, the medical center holds monthly health screenings at Korean churches, purchasing Korean-language advertising, utilizing on-staff patient-physician translators, participating in Korean community events, offering Korean language forms and patient education classes. Korean translators also are available to assist patients and their families. Forms and educational materials as well as patient education classes, including Lamaze, are available in Korean. Korean language print and radio advertising notifies the Korean community of healthcare services offered at the medical center.

## **EVALUATION/OUTCOMES/IMPACT**

It is estimated that 200 people a month attend the screenings with approximately 2,400 Korean individuals per year being reached.

**KEYWORDS:** *Chronic Disease Management; Diabetes; Faith-based Outreach; Health Screenings; Korean Communities; Language Services; Minorities; Patient Education; Preventive Services*

SUBMISSION DATE: 2008



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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Open Arms for Healthy Moms and Babies*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Open Arms for Healthy Moms and Babies is a perinatal initiative that addresses health disparities in birth outcomes. Current health statistics show increasing and significantly high rates of infant mortality in Cumberland County with Hispanic and African American newborns disproportionately affected.

### COLLABORATORS

Partnering community organizations include South Jersey Healthcare Regional Medical Center, Community Health Care (federally qualified health center) and the Women Centers of Bridgeton and Vineland to address this problem and target its root causes.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The complex social, economic and healthcare needs of these women are addressed through a carefully crafted network of providers and services, including easy entry to prenatal care and comprehensive medical/dental/pharmacy services. The program addresses problems of teen pregnancy, substance abuse and other issues through culturally competent outreach, education and support. Women are encouraged to seek early prenatal care, be compliant with prenatal tests and visits and return after the birth for postpartum and pediatric care.

### EVALUATION/OUTCOMES/IMPACT

The program has provided comprehensive obstetrical care to approximately 1,500 medically underserved women annually, as well as care for poor and uninsured families that are predominantly African American, Hispanic and farm workers. There has been a dramatic impact in the community, including unprecedented increase in attendance at family centers as well as increasing number of mothers seeking post-partum care for their families.

**KEYWORDS:** *Childbirth/Infant Care; Culturally Sensitive Education; Dental Services; Low-income Populations; Medical Services; Medically Underserved Populations; Minorities; Prenatal Education; Prescription Assistance; Support Services; Uninsured and Underinsured; Women's Health*

SUBMISSION DATE: 2008

*\* HRET Community Outreach Award Winner, 2008*

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## PALISADES MEDICAL CENTER'S *Community Outreach Program*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Palisades Medical Center's Community Outreach Program provides health education, screenings, testing and treatment referrals for Latinos on the PMC campus and in local religious centers, schools and other community organizations.

### COLLABORATORS

Partnering community organizations include the North Hudson Community Action, participating schools (Christ Hospital School of Nursing), employers, civic organizations, religious congregations and at community events throughout the area. In addition, PMC partnered with the Cancer Education and Early Detection programs in Hudson and Bergen County to provide comprehensive education about breast health and to care for the areas medically underserved, largely Hispanic, uninsured or underinsured populations.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The PMC program consists of community health screenings, physician seminars and community health fairs. The program provides healthcare screenings, testing and treatment referrals with a particular focus on early detection of breast cancer, obesity, asthma, heart disease and diabetes. If physicians presenting at the seminars are not bilingual, on site translation services are available. Pamphlets and educational materials are provided to all attendees and free transportation assistance also is provided to local residents.

### EVALUATION/OUTCOMES/IMPACT

Overall, the program has given screenings to more than 5,400 community members, administered 10,000 individual tests and referred more than 850 people for treatment to area clinics or local physicians. A series of 22 lectures were offered and more than 950 residents participated.

**KEYWORDS:** *Chronic Diseases; Diagnostic Testing; Faith-based Partnerships; Health Education; Health Fairs; Health Screenings; Language Services; Latino Communities; Medical Services; Patient Education; Preventive Services; Referral Services; Uninsured and Underinsured*

SUBMISSION DATE: 2010

*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Partner In Health (PIH) initiative was designed to address disparities in access to care and healthcare services of local minority groups. In 2008 PIH efforts were focused on providing culturally-tailored community health education programs on heart disease and stroke and improving access to healthcare services for African American and Latino communities.

### COLLABORATORS

This program is led by a council of representatives from engaged community groups, including American Health Association, Red Bank Men's Club, National Council of Negro Women, North Jersey Shore Chapter Continentals, Ocean Chapter of Drifters, Asbury Park/Neptune NAACP, Central Jersey Club, NANBP-WC, as well as fraternities (Omega Psi Phi and Alpha Phi Alpha) and sororities (Alpha Kappa Alpha and Delta Sigma Theta).

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

In 2008, the initiative offered Heart & Soul Gospel Fest, a night of inspirational gospel performances while raising awareness of heart disease and stroke among African Americans in recognition of Black History Month and American Heart Month. It also hosted It Takes A Village to Address Health Disparities, a program designed in response to request from diverse community members interested in getting to know more about physicians of color in the area. Community members participated in a dialogue with a panel of Meridian physicians regarding local community health issues faced by the minority communities in the area.

### EVALUATION/OUTCOMES/IMPACT

Overall, in 2008 this initiative drew the participation of over 1,000 community members combined for its Heart & Soul Gospel Fest and It Takes A Village to Address Health Disparities programs (700 and 300 respectively). Meridian Health plans to continue offering similar programming as part of its community outreach and cultural diversity activities.

**KEYWORDS:** *African Americans; Cardiovascular Diseases; Community Outreach; Health Education; Latino Communities; Minorities; Stroke; Theater*

SUBMISSION DATE: 2009

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## *Reducing Language Barriers and Achieving Excellence at All Levels of Clinical and Supportive Care for Spanish- Speaking Patients Diagnosed with Cancer*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

Trinitas Comprehensive Cancer Center addresses the challenges of cancer prevention, diagnosis and treatment for the Hispanic and Latino community by providing them with culturally and linguistically appropriate care.

### COLLABORATORS

Partnering community organizations include the American Cancer Society, National Cancer Institute, Susan G. Komen for the Cure, Josephine's Place: A Space for Women, YMHA-YWHA and a local certified Spanish translator for printed and web-based content.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The center increases availability of language services to reduce barriers to health-care. The program provides every staff member with training in patient contact and access to the CyraCom Language Line Interpretation phone service; the center's Web site ([www.trinitasccc.org](http://www.trinitasccc.org)) was translated into Spanish; Spanish-speaking valet, concierge, medical secretary and receptionists were hired. In addition, bilingual billing staff was hired; health educators were utilized for outreach to the community and to teach about breast health and partnerships were developed with local organizations to promote cancer prevention and organize cancer support groups. The program also provides patients with psychological services in Spanish, bilingual nurses and nursing assistants, Spanish survivorship programs and complementary medicine services and transportation by bilingual staff.

### EVALUATION/OUTCOMES/IMPACT

The center provided cancer care in Spanish to over 480 patients who spoke little or no English. This translates into over 7,200 clinical patient visits and over 1,150 psychological patient visits.

**KEYWORDS:** *Bilingual Professionals; Breast Health; Cancer Prevention; Complimentary/Alternative Medicine; Culturally Sensitive Care; Health Education; Language Services; Psychological Services; Support Services; Transportation Services*

SUBMISSION DATE: 2008

*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*



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## *Salem County Cardiovascular Health Initiative*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Salem County Cardiovascular Health Initiative helps reduce the high rates of mortality and hospitalizations from cardiovascular disease complications among Salem County residents, through a comprehensive chronic disease management and prevention program.

### COLLABORATORS

Partnering community organizations include the Salem Health and Wellness Foundation, the Salem County Chapter of the American Cancer Society, the Salem County Health Department and the Puerto Rican Action Committee.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program provides early screenings/assessments, health education and awareness of cardiovascular disease risk factors, health management counseling and access to primary care physicians and specialists in two phases. In phase one, the project offers the community monthly four-hour health information fairs providing screenings conducted by qualified medical practitioners (including weight, BMI, HDL (cholesterol), blood pressure and glucose levels) as well as patient education/awareness workshops. Patients found at risk for complications are referred to an appropriate practitioner. Phase two offers four, 30-minute health management and educational sessions involving exercise, diet and smoking cessation targeting weight and blood pressure management.

### EVALUATION/OUTCOMES/IMPACT

Overall, the program has screened 376 residents, approximately 50 percent at-risk participants were identified with cardiovascular disease and 16 were enrolled successfully in counseling. Following the project's completion, Cooper University Hospital plans to analyze its effectiveness by comparing baseline and post-project hospital/ED admissions data.

**KEYWORDS:** *Cardiovascular Diseases; Cardiovascular Health; Chronic Diseases; Chronic Disease Management; Counseling Services; Health Education; Health Fairs; Health Screenings; High-risk Populations; Primary Care; Referral Services*

SUBMISSION DATE: 2006

# Senior Wellness Action Team (SWAT)

## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

SWAT was designed to improve the quality of life of low-income African American and Hispanic senior citizens in the community. It empowered them to try and prevent disease and manage chronic illnesses via health education, treating acute illness and improving access to healthcare.

## COLLABORATORS

Partnering community organizations include the Healthcare Foundation of NJ, the NJ Foundation on Aging and the Wallenstein Foundation.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

SWAT offered health education programs and screenings and was staffed by a team of three peer leaders and a nurse practitioner. The team identified and assisted at-risk seniors, educated seniors about available medical and community resources and made referrals for follow-up care. SWAT also offered exercise classes and workshops on a variety of issues; such as nutritional management of diseases, responsible sexual activity (HIV/AIDS) and tobacco cessation. At these education sessions, participants also were offered the opportunity to have a health screening.

## EVALUATION/OUTCOMES/IMPACT

As of 2005, SWAT has conducted over 95 health education programs, 123 exercise classes and reached 2,417 seniors. The SWAT team has helped to facilitate enrollment in the Newark Beth Israel Medical Center senior membership program and decrease the number of emergency department visits, all of which directly caused an increase in the number of visits to Center for Geriatric Health Care.

**KEYWORDS:** *Elderly; Health Education; Health Screenings; HIV/AIDS; Low-income Populations; Nutrition Education; Physical Education; Physical Fitness; Prevention Education; Preventive Services; Smoking Cessation Support*

SUBMISSION DATE: 2006

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*Beyond Hospital Walls:*

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## *Shelter Plus Care Program*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Shelter Plus Care Program helps to address the need for housing and supportive services on a long-term basis for its local homeless population (18 and over) with disabilities, primarily those with serious mental illness, chronic substance abuse problems and AIDS or related complications. East Orange General Hospital (EOGH) alone serves 1,377 homeless mentally ill individuals annually.

### COLLABORATORS

Partnering community organizations include the City of East Orange, Essex County Welfare, Social Security Administration, LaFerrara Properties and local food pantries to connect patients with support services and ensure stable housing.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program provides a wide range of supportive services such as case management, behavioral health counseling, transportation, financial counseling and medical evaluations and referrals. Case managers and other support personnel help to assess the needs of every participant to determine an individualized plan that provides housing, education and job training opportunities and treatment options.

### EVALUATION/OUTCOMES/IMPACT

Since its inception in 2003, Shelter Plus Care has provided stable housing and support services to over 60 consumers. In 2008, the program awarded 30, one-bedroom units for homeless individuals.

**KEYWORDS:** *Case Management; Financial Counseling; Counseling Services; Homeless People; Housing Services; People with Disabilities; Referral Services; Substance Abuse Counseling; Support Services; Transportation Services*

SUBMISSION DATE: 2010

*\* HRET Community Outreach Awards Honorable Mention, 2010*



# *The Special Care Center (SCC)*



## PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The SCC is a patient-centered medical home for individuals with chronic conditions such as diabetes and heart disease, intentionally designed to maximize successful management of those conditions and lead to lower hospitalization, better clinical outcomes and better quality of life.

## COLLABORATORS

Partnering community organizations include H.E.R.E. International Union Welfare Fund, Local 54, Trump Casino properties and AtlanticCare.

## PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The Center offers not only primary care providers but also a team of health coaches who match the cultural and linguistic diversity of the patient population and provide self-management education and healthcare navigation. The center offers clients easier access to care, reduced costs, personalized care as well as focus groups, home visits and self-management skills. The SCC reduces barriers to ideal care by waiving co-payments for visits and prescription medications, providing on site pharmacy services, providing 24/7 access to a medical provider, and providing bilingual medical professionals to personally coach patients and guide them with lifestyle changes.

## EVALUATION/OUTCOMES/IMPACT

To date, the SCC has enrolled more than 1,000 members and has achieved greater than 90th percentile performance on chronic condition clinical outcomes and patient satisfaction. In the past year, the SCC has decreased hospitalizations and emergency department visits as well as increased enrollment and new accounts.

**KEYWORDS:** *Bilingual Professionals; Cardiovascular Diseases; Chronic Diseases; Chronic Disease Management; Culturally Sensitive Education; Diabetes; Healthcare Coverage; Home Visits; Language Services; Low-income Populations; Medical Home; Patient Education; Primary Care*

SUBMISSION DATE: 2010

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## *Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *The High Risk Intervention Via Education Program (THRIVE)*

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### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The THRIVE program was designed to slow the progression of kidney disease, provide education about the disease and available treatment options, improve compliance and outcomes and facilitate adjustment to dialysis for patients diagnosed with chronic kidney disease.

### COLLABORATORS

Partnering community organizations include Trinitas Regional Medical Center and the National Kidney Foundation's Kidney Early Evaluation Program.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

THRIVE focuses on medication and dietary management and early identification of psychological issues. The program enables patients to be evaluated to determine their need for dialysis. Following the evaluation, a nurse educator discusses the dialysis process and the available treatment modalities. THRIVE also offers patients anemia management and access to arteriovenous grafts and arteriovenous fistulas. In addition, the program gives annual screenings to high-risk kidney patients. Services provided at the screenings include blood glucose, hemoglobin, serum creatinine, glomerular filtration rate, lipid panel, calcium test and phosphorous test.

### EVALUATION/OUTCOMES/IMPACT

Since the program's inception, 30 patients were evaluated resulting in the following statistics: 346 visits for anemia management, over 400 counseling sessions for anemia management, dietary and social services, 14 patients received arteriovenous fistulas or arteriovenous grafts. Two of the participants transitioned to dialysis.

**KEYWORDS:** *Chronic Disease Management; Healthcare Access; Health Screening; Kidney Diseases; Medication Compliance; Medication Management, Nutrition Counseling; Patient Education*

SUBMISSION DATE: 2010

## UMDNJ-NJMS/UH

# *Cancer Center Clinical Research Program*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The UMDNJ-NJMS/UH Cancer Center provides cancer care to the underserved minority population from Newark and Essex County.

### COLLABORATORS

Partnering community organizations include IMPACT N.J., Robert Wood Johnson Medical School and the Susan G. Komen Foundation of N.J.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The center employs a multidisciplinary program to provide cancer care to these patients. One of the key elements of their cancer care is the opportunity to participate in the National Cancer Institute (NCI) clinical trials, which provide the best and latest treatment opportunities to patients. The center developed a multi-pronged approach, obtained external funding for educational and navigator programs and systematically queried patients regarding obstacles to enrollment in NCI-approved clinical trials. The center also created a culturally competent educational video told by patients involved clinical trials to give their perspective of the clinical trials experience. The center adapted a patient navigator program to provide education, information, foster comfort and trust of the cancer care team and help patients navigate the clinical care system. The goal of the navigator program was to increase screening and enrollment rates of minority patients into the NCI-approved clinical trials.

### EVALUATION/OUTCOMES/IMPACT

The center experiences 1,100 new cancer patients each year and cares for more than three times that number. To date, 126 patients have been enrolled in the NCI-approved prevention and treatment program.

**KEYWORDS:** *Cancer; Cancer Screenings; Culturally Sensitive Education; Medical Services, Minorities, Patient Education; Underserved and Uninsured*

SUBMISSION DATE: 2009



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*Beyond Hospital Walls:*

*Highlights of N.J. Hospitals' Community Outreach Programs, 2006-2010*





## *Women's Heart Awareness*

### PROGRAM PURPOSE (SIGNIFICANCE/GOALS/OBJECTIVES)

The Women's Heart Awareness program delivered information about risk factors and symptoms of cardiovascular disease and its devastating effects on women's health. Program goals were to teach the community to be heart healthy, save lives and assist physicians in the prevention, detection and treatment of heart disease and myocardial infarctions through evidence-based standards of care.

### COLLABORATORS

Partnering community organizations include the American Heart Association, the Liberty Science Center and Nordstrom's.

### PROGRAM IMPLEMENTATION PLANS/ACTIVITIES

The program included presentations given by a person who has survived two heart attacks and is able to speak to many audiences about how heart disease has changed her life. Presentations were given to seniors, at corporation luncheons, lunch and learn sessions, churches and synagogues, for student nurses and at health fairs. The program also offered monthly screenings and information sessions at Nordstrom's. In addition, there was a Women's Heart Day held at the Liberty Science Center, which offered screenings and education conducted by volunteer Cardiac Care Unit nurses. At the program, participants could schedule physician appointments and with the participant's permission, follow-up was implemented.

### EVALUATION/OUTCOMES/IMPACT

To date, over 5,300 women have heard the program's message, over 625 screenings were conducted and over 200 referrals were made for further medical care. Information was disseminated to approximately 35,000 women in the community.

**KEYWORDS:** *Cardiovascular Diseases; Community Outreach; Health Education, Health Screenings, Prevention Education; Women's Health*

SUBMISSION DATE: 2006

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# *Indices*



# 1. Programs by Subject

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Immunizations .....	2, 41, 42
Infection Prevention .....	62

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Injury Prevention .....	19, 28
Inpatient Services .....	68, 83
Jewish Communities .....	57
Kidney Diseases.....	59, 96
Kidney Transplantation .....	51
Kidney Transplantation Education ( <i>see Transplantation Education</i> )	
Korean Communities .....	52, 87
Language Services .....	38, 53, 58, 66, 73, 75, 79, 81, 84, 87, 89, 91, 95
Latino Communities .....	14, 17, 50, 53, 66, 89, 90
Life Skills Training .....	56, 74
Low Back Pain .....	37
Low-income Populations.....	6, 11, 25, 29, 30, 39, 42, 43, 46, 60, 61, 71, 73, 88, 93, 95
Mammogram Services .....	23, 67, 77
Medical Home .....	53, 71, 95
Medical Services .....	9, 20, 33, 44, 52, 55, 60, 61, 66, 68, 73, 88, 89, 97
Medically Underserved Populations .....	17, 23, 30, 58, 67, 88
Medication Assistance ( <i>see Prescription Assistance</i> )	
Medication Compliance.....	39, 49, 56, 82, 84, 96
Medication Management.....	15, 44, 49, 96
Men's Health .....	58, 65
Mental Health Services .....	2, 17, 41, 44, 45, 56, 63, 80
Mentally-ill Populations .....	29, 72
Minorities .....	14, 17, 19, 20, 25, 29, 30, 31, 32, 50, 58, 59, 66, 67, 77, 81, 82, 83, 85, 87, 88, 90, 97
Mobile Health Services .....	27, 42, 46, 69, 73, 81
Multimedia Outreach .....	10, 65, 74
Multiple Sclerosis .....	4, 36
Myocardial Infarction ( <i>see Cardiac Arrest</i> )	
Nutrition Counseling .....	12, 16, 22, 26, 44, 76, 79, 86, 96
Nutrition Education.....	5, 7, 8, 10, 13, 15, 18, 22, 30, 43, 48, 82, 84, 93
Obesity.....	18, 25
Obesity Prevention .....	7, 10, 13, 18, 22, 25, 26, 48, 76
Obesity, Childhood .....	7, 10, 12, 13, 16, 22, 26, 48, 86
Oncology Treatment.....	60
Oral Health Education .....	11
Organ Donation Counseling.....	51, 59

Orthodox Community ( <b>see</b> <i>Jewish Communities</i> )	
Osteoporosis .....	5
Outcomes Measurement Tools .....	37
Outpatient Services .....	44, 55, 75, 83
Pain Management .....	52
Pancreas Transplantation Education ( <b>see</b> <i>Transplantation Education</i> )	
Parkinson's Disease .....	4, 44
Patient Education .....	2, 4, 11, 33, 34, 35, 39, 43, 44, 45, 47, 53, 59, 61, 71, 72, 74, 84, 87, 89, 95, 96, 97
Patient Navigator .....	33, 34
Patient Safety Improvement .....	62
Pedestrian Safety .....	19
Pediatric ICU .....	62
People with Disabilities .....	55, 94
Physical Education .....	8, 10, 13, 18, 22, 26, 30, 79, 86, 93
Physical Fitness .....	5, 12, 13, 15, 16, 18, 22, 76, 93
Physical Therapy .....	60
Population-based Research .....	54
Post Discharge Services .....	39, 61
Prenatal Education .....	53, 66, 88
Prescription Assistance .....	43, 47, 49, 66, 71, 73, 88
Prevention Education .....	1, 2, 3, 5, 7, 9, 11, 15, 17, 19, 20, 21, 24, 27, 28, 32, 50, 62, 81, 93, 98
Preventive Services .....	17, 19, 25, 29, 31, 32, 38, 39, 47, 56, 65, 68, 73, 75, 79, 84, 87, 89, 93
Primary Care .....	42, 53, 66, 75, 92, 95
Professional Education.....	21, 33, 69
Prostate Cancer ( <b>see</b> <i>Cancer, Prostate</i> )	
Psychiatric Services .....	45
Psychological Services .....	91
Public Health Research .....	54
Radiation Stress Reduction .....	70
Referral Services .....	2, 5, 9, 11, 17, 20, 25, 29, 33, 39, 40, 41, 42, 46, 47, 50, 53, 56, 58, 61, 72, 73, 80, 81, 89, 92, 94
Rehabilitation Services .....	37, 44, 52, 55, 63
Religious Practices ( <b>see</b> <i>Faith-based Practices/Services</i> )	

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Respiratory Therapy .....	52
Respite Care .....	52
School-based Outreach .....	1, 6, 7, 10, 12, 13, 14, 22, 24, 26, 27, 30, 48, 51, 69
Self Care .....	8, 9, 16, 18, 43, 71, 82
Senior Care ( <i>see Geriatric Care</i> ) .....	
Skills Building.....	43, 72
Smoking Cessation Support .....	29, 73, 93
Social Services .....	17
Stress Management .....	6
Stroke .....	3, 15, 25, 31, 90
Student Athletes .....	24, 27
Students.....	1, 6, 7, 10, 12, 13, 16, 21, 22, 26, 30, 42, 48, 51, 54, 69
Substance Abuse Counseling .....	56, 63, 73, 80, 94
Suicide Prevention .....	21
Support Services .....	2, 16, 17, 25, 33, 34, 44, 45, 56, 60, 61, 63, 64, 66, 70, 72, 73, 76, 78, 80, 81, 83, 88, 91, 94
Technology Use in Health.....	74
Technology Use in Healthcare .....	10, 51, 65
Teens ( <i>see Adolescents</i> ) .....	
Theater .....	17, 67, 90
Therapeutic Hypothermia Induction.....	68
Traffic Safety.....	19
Transplantation Education .....	59
Transportation Services.....	2, 39, 44, 53, 60, 61, 81, 91, 94
Uninsured and Underinsured.....	17, 40, 42, 43, 46, 49, 50, 66, 73, 79, 88, 89, 97
Vision Screenings ( <i>see Vision Services</i> ) .....	
Vision Services.....	40, 42
Vocational Trainings .....	63
Weight Management .....	5, 12, 18, 76, 82
Women's Health.....	5, 15, 17, 23, 24, 27, 32, 55, 67, 70, 77, 85, 88, 98

## 2. Programs by Target Population

Adolescents .....	1, 21, 27, 74, 78
African Americans .....	25, 31, 50, 65, 77, 90
Children .....	1, 6, 7, 10, 11, 12, 13, 14, 16, 19, 22, 26, 28, 30, 38, 41, 42, 46, 48, 51, 62, 78, 86
Elderly .....	2, 3, 4, 8, 23, 25, 29, 31, 39, 44, 45, 52, 60, 61, 80, 93
Families .....	7, 10, 11, 13, 14, 16, 17, 22, 26, 27, 28, 48, 78, 86
High-risk Populations .....	3, 8, 20, 21, 22, 23, 31, 32, 47, 61, 80, 92
Homeless People .....	20, 56, 63, 73, 75, 94
Hospital patients .....	29, 83
Jewish Communities .....	57
Korean Communities .....	52, 87
Latino Communities .....	14, 17, 50, 53, 66, 89, 90
Low-income Populations .....	6, 11, 25, 29, 30, 39, 42, 43, 46, 60, 61, 71, 73, 88, 93, 95
Medically Underserved Populations .....	17, 23, 30, 58, 67, 88
Men .....	58, 65
Mentally-ill Populations .....	29, 72
Minorities .....	14, 17, 19, 20, 25, 29, 30, 31, 32, 50, 58, 59, 66, 67, 77, 81, 82, 83, 85, 87, 88, 90, 97
People with Disabilities .....	55, 94
Student Athletes .....	24, 27
Students .....	1, 6, 7, 10, 12, 13, 16, 21, 22, 26, 30, 42, 48, 51, 54, 69
Uninsured and Underinsured .....	17, 40, 42, 43, 46, 49, 50, 66, 73, 79, 88, 89, 97
Women .....	5, 15, 17, 23, 24, 27, 32, 55, 67, 70, 77, 85, 88, 98



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### *3. Programs by Hospital*

AtlantiCare Regional Medical Center .....	13, 47, 71, 75, 95
Bacharach Institute for Rehabilitation .....	3
Bergen Regional Medical Center .....	52
Broadway House for Continuing Care .....	1, 56
Cape Regional Medical Center .....	8, 64
Capital Health System .....	43, 65
CentraState Healthcare System .....	12, 18, 21, 30, 36, 37
Children's Hospital of New Jersey at Newark Beth Israel Medical Center .....	62, 86
Children's Specialized Hospital .....	38, 78
Chilton Hospital .....	15, 16
Christ Hospital .....	80
Clara Maass Medical Center .....	39
Community Medical Center .....	5
Cooper Health System, The .....	84, 92
East Orange General Hospital .....	63, 81, 94
Englewood Hospital and Medical Center .....	57, 87
Hunterdon Medical Center .....	35, 49, 53
K. Hovnanian Children's Hospital .....	10
Kennedy Health System .....	9
Kimball Medical Center .....	61
LibertyHealth – Jersey City Medical Center .....	11, 14, 28
Lourdes Health System .....	54
Lourdes Medical Center of Burlington County .....	34
Matheny Medical and Educational Center .....	55
Meridian Health System .....	90
Monmouth Medical Center .....	70
Morristown Memorial Hospital .....	74, 79
Mountainside Hospital .....	77
Newark Beth Israel Medical Center .....	59, 76, 93

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Newton Memorial Hospital .....	7
Overlook Hospital .....	25, 42, 46, 48, 85, 98
Palisades Medical Center .....	89
Pascack Valley Hospital (closed as of 11/2007) .....	60
Robert Wood Johnson University Hospital .....	17, 58, 67
Robert Wood Johnson University Hospital – Hamilton .....	22
Saint Barnabas Health Care System .....	29, 51
Saint Clare’s Health System .....	41
Saint Michael’s Medical Center .....	20
Saint Peter’s University Hospital .....	2, 24, 27
Somerset Medical Center .....	23, 68, 69
South Jersey Healthcare - Regional Medical Center .....	26, 82, 88
St. Joseph’s Regional Medical Center .....	83
St. Joseph’s Wayne Hospital .....	32
Trinitas Regional Medical Center.....	6, 31, 45, 72, 91, 96
University Medical Center at Princeton.....	40, 50, 66
UMDNJ – University Hospital .....	19, 73, 97
Virtua .....	33
Warren Hospital.....	4, 44

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## *4. Programs by Year of Entry for Community Outreach Award*

2006 .....	5, 6, 20, 21, 50, 51, 52, 55, 59, 60, 66, 67, 74, 75, 78, 80, 92, 93, 98, 5; 7; 13; 16; 17; 18; 19; 21; 33; 38; 40; 55; 57; 65; 67; 68; 69; 71; 72; 82; 96; 101; 102; 106; 111; 118; 120; 121; 124; 125; 131; 132; 146; 152; 154; 159; 160
2008 .....	1, 3, 4, 9, 13, 15, 18, 22, 25, 26, 27, 29, 32, 33, 34, 36, 37, 40, 41, 43, 44, 46, 48, 52, 53, 55, 57, 62, 63, 64, 72, 79, 81, 83, 87, 88, 912; 7; 17; 27; 32; 34; 40; 44; 49; 51; 54; 59; 60; 70; 73; 79; 84; 88; 89; 102; 115; 118; 119; 122; 128; 129; 140; 145; 147; 148; 156; 157; 163
2009 .....	2, 7, 12, 16, 17, 19, 32, 35, 42, 54, 56, 65, 71, 73, 77, 84, 85, 86, 90, 97, 3; 8; 9; 11; 20; 24; 25; 30; 34; 39; 47; 52; 61; 62; 71; 97; 104; 108; 109; 114; 123; 126; 127; 130; 134; 139; 143; 160; 161
2010.....	8, 10, 11, 13, 14, 23, 24, 28, 30, 31, 38, 39, 45, 46, 47, 49, 58, 61, 68, 69, 70, 76, 82, 85, 89, 94, 95, 96, 1; 4; 6; 7; 17; 23; 26; 29; 31; 34; 36; 37; 45; 46; 50; 56; 58; 74; 77; 78; 80; 84; 85; 86; 87; 90; 91; 92; 93; 94; 103; 114; 115; 117; 135; 136; 137; 144; 150; 152; 155; 162

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## 5. Programs by Legislative District

DISTRICT 1 .....	8, 26, 64, 82, 88
DISTRICT 2 .....	3, 13, 47, 71, 75, 95
DISTRICT 3 .....	26
DISTRICT 4 .....	9
DISTRICT 5 .....	9, 54, 84, 92
DISTRICT 6 .....	9, 33
DISTRICT 7 .....	33, 34, 54
DISTRICT 8 .....	33
DISTRICT 9 .....	N/A
DISTRICT 10 .....	5, 90
DISTRICT 11 .....	10, 70, 90
DISTRICT 12 .....	12, 18, 21, 30, 36, 37
DISTRICT 13 .....	N/A
DISTRICT 14 .....	22
DISTRICT 15 .....	40, 43, 50, 65, 66
DISTRICT 16 .....	55, 68, 69
DISTRICT 17 .....	2, 17, 24, 27, 58, 67
DISTRICT 18 .....	N/A
DISTRICT 19 .....	N/A
DISTRICT 20 .....	6, 31, 45, 72, 91, 96
DISTRICT 21 .....	25, 38, 42, 46, 48, 78, 85, 98
DISTRICT 22 .....	N/A
DISTRICT 23 .....	4, 35, 44, 49, 53
DISTRICT 24 .....	7
DISTRICT 25 .....	41, 74, 79
DISTRICT 26 .....	15, 16





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DISTRICT 27 .....	29, 51
DISTRICT 28 .....	39
DISTRICT 29 .....	1, 19, 20, 56, 59, 62, 73, 76, 86, 93, 97
DISTRICT30 .....	61
DISTRICT 31 .....	11, 14, 28
DISTRICT 32 .....	80, 89
DISTRICT 33 .....	N/A
District 34 .....	63, 77, 81, 94
District 35 .....	83
District 36 .....	N/A
District 37 .....	57, 87
District 38 .....	52
District 39 .....	60
District 40 .....	32

## 6. List of Award Winning Programs by Theme

### PREVENTING DISEASE AND INJURY

2006 SAINT MICHAEL'S MEDICAL CENTER	
<i>Project PIES (Prevention Intervention &amp; Education Services)</i> .....	20
2008 BROADWAY HOUSE FOR CONTINUING CARE – NEWARK AIDS CONSORTIUM	
<i>ACE - AIDS Community Education</i> .....	1
2009 ST. JOSEPH'S WAYNE HOSPITAL	
<i>Women's Heart Center at St. Joseph's</i> .....	32
2009 UMDNJ - UNIVERSITY HOSPITAL *	
<i>Pedestrian Injury Prevention Partnership</i> .....	19
2010 ATLANTICARE REGIONAL MEDICAL CENTER	
<i>Healthy Schools, Healthy Children</i> .....	13
2010 TRINITAS REGIONAL MEDICAL CENTER *	
<i>Trinitas Regional Medical Center Stroke Awareness Program</i>	
<i>"Creating a Stroke Smart Community"</i> .....	31

\* Program selected as a winner in this theme for programs with a budget less than \$50,000.

\*\* Program selected as an honorable mention.

### IMPROVING ACCESS AND QUALITY OF CARE

2006 UNIVERSITY MEDICAL CENTER AT PRINCETON *	
<i>Improving Access and Quality of Care for the Uninsured,</i>	
<i>Underinsured, and Minority Groups in Hightstown</i> .....	50
2006 ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL	
<i>Sharing Stories/Compartiendo Historias Breast Cancer Awareness Theater Program</i> .....	67
2008 UNIVERSITY MEDICAL CENTER AT PRINCETON *	
<i>Community Vision Services Outreach</i> .....	40
2008 HUNTERDON MEDICAL CENTER	
<i>Latino Healthcare Initiative of Hunterdon Healthcare System</i> .....	53
2009 HUNTERDON MEDICAL CENTER **	
<i>Center for CPR and Public Access Defibrillation</i> .....	35

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2009	CAPITAL HEALTH SYSTEM - MERCER CAMPUS	
	<i>Rolling Out the Red Carpet</i> .....	65
2010	HUNTERDON MEDICAL CENTER	
	<i>Hunterdon County Medical Access Program</i> .....	49
2010	ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL **	
	<i>One Minute Can Save Your Life-Prostate Cancer Screening Program</i> .....	58

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\* Program selected as a winner in this theme for programs with a budget less than \$50,000.

\*\* Program selected as an honorable mention.

## REDUCING HEALTHCARE DISPARITIES

2006	ATLANTICARE REGIONAL MEDICAL CENTER	
	<i>AtlanticCare Health Services - Healthcare for the Homeless</i> .....	75
2008	SOUTH JERSEY HEALTHCARE - REGIONAL MEDICAL CENTER	
	<i>Open Arms for Healthy Moms and Babies</i> .....	88
2009	CHILDREN'S HOSPITAL OF NEW JERSEY AT NEWARK BETH ISRAEL MEDICAL CENTER	
	<i>KidsFit Newark: A Comprehensive Wellness Program for Kids and Those Who Love Them</i> .....	86
2010	SOUTH JERSEY HEALTHCARE - REGIONAL MEDICAL CENTER	
	<i>Heart Failure and Tel-Assurance Home Monitoring</i> .....	82
2010	East Orange General Hospital **	
	<i>Shelter Plus Care Program</i> .....	94

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\* Program selected as a winner in this theme for programs with a budget less than \$50,000.

\*\* Program selected as an honorable mention.



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