

Impact THE 2015 REPORT



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We

We're pleased to present this 2015 Impact Report highlighting some of our work.

Notable accomplishments during the year included publication of the first Rural Broome Counts Needs-Assets Assessment, development of a new Strategic Plan, growth of the Food and Health Network, and initiating population health work with HealthlinkNY and other Rural Health Networks in the region.

The Board of Directors and staff have worked to position the Rural Health Network SCNY for future growth so that we can be more effective in advancing the health and well-being of rural people and communities.


Work in 2015 laid the foundation for increased capacity and staffing of Mobility Management of SCNY in 2016.

Our active participation and advocacy in the Medicaid redesign initiative known as DSRIP (Delivery System Reform Incentive Program) helped to inform and guide the process to consider the unique needs of rural residents and communities.

Community Health Services

"Community Health Services helped me out big time! My family got food stamps and Medicaid. They gave me information and help with who to call for cleaning supplies and mattress covers to improve sleep, health, and home safety for my family."

Renew Health Client, age 54


91%
of Chronic Disease Education participants graduated from the program in 2015

Community Health Services' programs include:

- **Health Care Access** uses an intake process to assess rural household supports, identify barriers, and navigate consumers to community resources to improve their quality of life and health outcomes. Referrals include access to health insurance enrollment, prescription assistance, and vision/dental programs.
- **Renew Health Case Management** provides individual assessment using research validated screening tools, care plans including self-management goals, and home or office visits to engage rural adults with chronic health conditions in health care services.
- **Chronic Disease Education** is a small group intervention that teaches people with chronic health conditions how to better manage their health.

New York's Delivery System Reform Incentive Program (DSRIP) is a Medicaid Redesign initiative intended to reduce avoidable hospitalizations and emergency room utilizations by 25% by 2020. Medicaid providers and community based organizations have formed networks known as Performing Provider Systems. Care Compass Network is the regional entity covering nine Southern Tier counties. Eleven projects will improve the quality of health care, patient satisfaction and reduce costs through care coordination, disease management, and behavioral health strategies. Several RHNSCNY staff are contributing expertise to planning and implementing better practices in population health, cultural competency, health literacy, chronic disease education, and addressing social determinants of health that impact rural Medicaid members.

www.rhnsncy.org/programs/community-health-services



Rural Health Service Corps (RHSC) is an AmeriCorps National Service Program. RHSC provides meaningful service and learning opportunities for people committed to improving the health of those living in south central New York.

RHSC members address the broad community health needs of South Central NY, with a focus on health access and education, increasing food security, and supporting independent living for the elderly, homebound, and people with disabilities.

During the 2014-2015 AmeriCorps program year:

36 AmeriCorps Members
Provided 34,465 Hours of Service
(the equivalent of 862 weeks of full-time service)

29 AmeriCorps Members
Completed Service and Received
Education Awards Valued at
\$136,534



Zech, Ramp it Up, Broome County Council of Churches

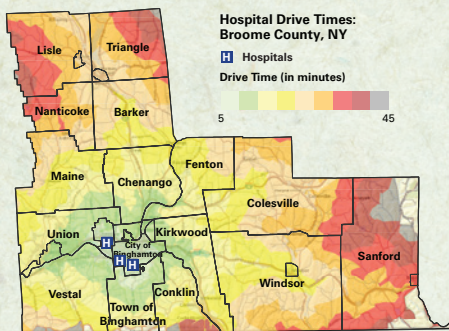
"I was making a difference I could actually see. I can see myself, a bit of me, in every single one of these ramps. Making a difference in people's lives — I'd say that's what the real attraction to AmeriCorps is."

Watch the videos and hear from Zech and other Service Corps Members including Leslie (CHOW, Broome County Council of Churches), Brianna and Kristen (Rural Health Connections, Mothers & Babies Perinatal Network), and Isaiah (VINES).

www.ruralhealthnetwork.org/ameri corps

RURAL BROOME COUNTS

The Rural Broome Counts Needs-Assets Assessment Project grew directly from challenges faced by the Rural Health Network SCNY and other organizations in advocating for resources and services to address the health related needs of rural Broome County residents. The project was established as a way to highlight the strengths and challenges facing rural Broome County residents and possible ways to address any service gaps we discovered. Our main goal was to collect and report on data most relevant to rural Broome County that will help to more equitably distribute resources, plan services, and inform policy decisions.



"One of the most important lessons the Rural Broome Advisory Committee taught me is that there is no one "perfect solution" for meeting a service need. For example, each time I found a new piece of data or talked to a different person about transportation, my perspective on how to best ameliorate that set of challenges would shift. I realized how important it is to think creatively when budgets are tight, but needs are high."

Rebecca Chandler,
VISTA member,
Project Manager
for Rural Broome
Counts



The August 2015 Rural Broome Counts report is available online. It is an initial assessment that will be updated every three years to track the status of rural Broome County and provide information for other planning efforts.

www.rhnsctny.org/programs/partnerships/rural-broome-counts



The Food and Health Network of South Central New York is a collaborative effort that aims to improve the quality of life in our region by supporting practices, projects, and policies leading to increased use of nutritious, locally produced food.

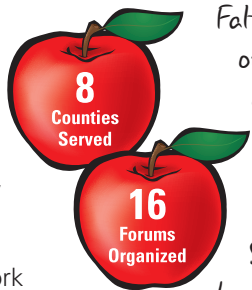
Food and Health Network projects include regional food assessments, facilitation of collaborative food system projects, summer food service program assessment and promotion, farm to school initiatives, and advocacy and public policy work.

"The Food and Health Network provides great opportunities for networking and collaboration.

FaHN members are supportive of one another's programs and work together on grant opportunities rather than compete for limited resources. FaHN's Food System Assessment has also been tremendously helpful.

One could spend hours searching for the most reliable sources of up to date statistics and now I can get the information I need within a matter of minutes."

Amelia LoDolce, Executive Director, VINES and Rural Health Network Board member



www.foodandhealthnetwork.org



The Health Action Priorities Network (HAPN) is a regional initiative of the NYS Department of Health's Population Health Improvement Program (PHIP). HAPN is led by HealthlinkNY and seeks to promote population health and to reduce health disparities in Broome, Chenango, Delaware, Tioga, and Tompkins Counties.

Rural Health Network of South Central NY, as a subcontracted organization, implements HAPN in Broome, Delaware, and Tioga Counties. Beginning in June 2015, PHIP Coordinators engaged 135 stakeholders across health and human services sectors in those 3 counties, and conducted 12 consumer focus groups to better understand challenges and barriers contributing to health disparities.

The next step will be to examine capacity building and technical assistance opportunities for two identified priority areas: Transportation/Access and Mental Health

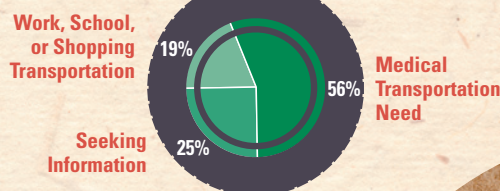
<http://www.healthlinkny.com>



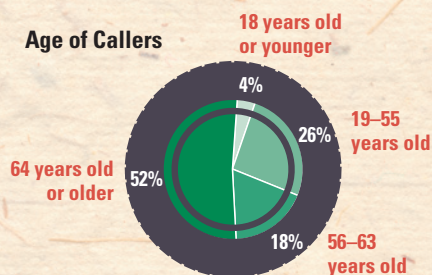
Mobility Management of South Central New York has established itself as a leading partner for transportation planning efforts at the county and regional level by contributing our expertise in mobility management, healthcare access, and capacity building. Current MMSCNY services for consumers include the GetThere Call Center and Connection to Care.

The **GetThere Call Center** provides transportation information, free trip planning, travel training, and transportation education services. **Connection to Care** provides financial assistance and transportation planning for non-Medicaid low income rural residents in need of non-emergency transportation to health care services.

Reason for Calling



Age of Callers



The National Center for Mobility Management has released *Integrating Services Across Transportation Modes*, a brief in the "Promising Practices of Mobility Management" series. Connection to Care was one of five programs cited for innovative collaboration, coordination, and integration of transportation services across modes.

http://nationalcenterformobilitymanagement.org/wp-content/uploads/2015/01/Promising-Practices_Integrating_Services_Across_Transportation_Modes.pdf

www.rhnsny.org/programs/mmscny



Connection to Care

assisted 110 individuals in securing 43,357.8 miles of transportation through volunteer transportation programs, public transportation, fuel cards, and private contracted services. CTC made 1,660 trips possible at an average cost of 50 cents per mile.



Debbie C., Mt. Upton, NY

"It is a relief to know that this part of my medical issue – the transportation issue – has been taken care of, at least for the moment. And it gives me relief to think about other things – peace of mind. There are many people in my area who could benefit from this program. I'd like to help get the word out about it."



of South Central New York, Inc.

Mission: Advancing the health and well-being of rural people and communities

www.rhnsny.org

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It may not seem that chronic disease, food security, mobility and transportation, and service learning have much in common. Yet, each of our programs address the unique characteristics of rural communities and issues that impact public health. Rural Health Network Staff and Board Members are available to speak to your group. We would welcome the opportunity to share why we have a rural focus and what we do by presenting to your service club, staff meeting, coalition, or social organization.