Appendix 10
CHISP Work Plan

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	North Country Healthy Heart Network	Champlain Valley Family Services
Planning Report Liaison	Dan Hill, Heidi Bailey	Jessica Darney Buehler, Elizabeth Terry	Julie Tromblee, Amanda Whisher	Ann Morgan	Dana Bushy Isabella
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults) Target 23.2% Baseline 32.2% Baseline Year 2016 Data Source BRFSS Data Level State (by sex, age, race/ethnicity, income educational attainments, disability and region), county	Access - The rural setting limits individuals from accessing services and programs outside of their communities.	Intervention 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program. Recommended components include: • Educating and informing through classes, distributing written information or utilizing educational software. • Conducting activities that target thoughts and social factors to influence behavior change. Examples include individual or group behavioral counseling, skill-building activities, providing rewards, and building support systems among co-workers and family members. • Changing physical or organizational structures that reach the entire workforce and make the healthy	Number of individuals utilizing services	UVMHN-Elizabethtown Community Hospital increased access for physical activity to include both the Elizabethtown and Ticonderoga campuses in addition to Elizabethtown Community Health Center. Both inpatient and outpatient physical therapy facilities are open access with a buddy system for employees.	The hospital will investigate expanding hours of operation for staff to utilize the facility. Recruitment for staff members trained in CPR to volunteer in Physical Therapy to allow for extended patient use. ECH will also develop and implement a workplace Take Off Pounds Sensibly (TOPS) program to be offered to ECH employees by January 2021.	Should the TOPS program be successful the hospital will open the program up to community partners by September 2021. The possibility of physical activity classes such as yoga will be made available for staff to attend, dependent on space.	Hospital	ECH will maintain documentation of enrollment in both the physical activity and nutrition programs. Resources: https://www.cdc.gov/workplacehealthpromotion/index.html https://www.tops.org/tops/TOPS/About_TOPS.aspx
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.4 - Increase the number of schools that improve nutrition policies and practices in at least 3 of 11 school districts in Essex County in an effort to reduce childhood obesity rates from 21% to the NYS Prevention Agenda benchmark of 16.7% by December 2021.	Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores).	Collaborate with local school districts to implement multi-component school-based obesity prevention interventions to include policy and environmental changes that target physical activity and nutrition (PA&N) before, during and/or after school.	*Input measures: provide assessment, targeted technical assistance to school wellness committees to support their efforts to improve, communicate and implement their school wellness policies. *Output measures: Three school districts will demonstrate improved implementation of policies and practices in three areas: 1) Nutrition Standards for Competitive Foods and Other Foods and Beverages; 2) Physical Education and Physical Activity; 3) School Wellness Promotion and Marketing (assessment tool: NYS DoH CHSC Building Assessment) *Short-term Outcome: Number of school districts with Wellness Committees meeting 3 x per year with goals related to implementation and having complete pre-assessments. *Intermediate Outcome: Number of school districts with improved implementation of policies and practices related to PA&N having completed post-assessments. *Long-term Outcome: reduction in overweight and obese school-aged children in the three targeted school districts.	Creating Healthy Schools & Communities in Clinton and Essex Counties (CHSC) will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of policies and practices to increase PA&N.	Creating Healthy Schools & Communities in Clinton and Essex Counties (CHSC) will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of implement policies and practices to increase PA&N. Essex County Health Department (ECHD) will offer technical assistance to school districts located outside of the CHSC catchment by creating and distributing a survey based on the School Building Assessment survey with the intention of analyzing results, providing feedback, and recommending resources needed for improvement. Results of the survey and recommendations for improvement will be provided to schools and will be available for communities and potential partners.	ECHD will offer technical assistance to school districts located outside of the CHSC catchment by creating and distributing a survey based on the School Building Assessment survey with the intention of analyzing results, providing feedback, and recommending resources needed for improvement. Results of the survey and recommendations for improvement will be provided to schools and will be available for communities and potential partners.	K-12 School	School district Wellness Committees and administrative leaders meet regularly with CHSC and/or ECPH specialists to review and enact recommendations (provided through assessment) to improve implementation of school wellness policies.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	Objective 1.9 Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults) Target 29.6% Baseline 31.2% Baseline Year 2016 Data Source BRFSS Data Level State	Socioeconomic (Income) - Target ALICE families to participate in the program.	Intervention 1.0.5 Increase the availability fruit and vegetable incentive programs Systematic evidence reviews find that financial incentive programs can increase affordability, access, purchases, and consumption of fruits and vegetables. Incentive programs for the purchase of fruits and vegetables have also been shown to increase sales and use of food assistance benefits (e.g., SNAP or WIC) at farmers' markets. Financial incentives can be a dollar-for-dollar match or a set amount per dollar spent (i.e., $2 for every $5 spent). Local health departments, hospitals, health centers, insurers, businesses, CBOs, hunger prevention advocates and other stakeholders can collaborate with local agencies to increase the availability and/or provide matching funds for low-income persons to purchase healthy foods, especially fresh fruits and vegetables.	Number of participants and Number of vouchers redeemed	Wellness RX was a program developed by Elizabethtown Community Hospital to address the dietary crisis in our community. Designed as a referral based program, Wellness RX is open to all patients of the UVMHN-ECH network. Participants are required to attend monthly education sessions with a diabetic educator or nutritionist in exchange for vouchers that can be redeemed for fruits and vegetables at local grocers and farmer's markets. There are currently eight redemption sites throughout the county.	The hospital will maintain established relationships with community partners and remain active in the county led Well Fed Collaborative. ECH will increase the total number of participating redemption sites by at least four and will continue to promote the Wellness RX program. ECH will have at least 55 participants by December 2020.	The hospital will continue to develop the program and identify sustainment activities. Physical activity will be incorporated to the program by September 2021.	Hospital	ECH will maintain documentation of participation and progress for statistical calculations. Resources: https://www.wholesomewave.org/ https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/fruit-vegetable-incentive-programs
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	1.0.6 - Increase the number of health practices that screen for food insecurity and facilitate referrals to supportive services in at least 5 Essex County health practices by December 2021.	Socioeconomic (Income) - Target ALICE families to participate in the program.	Intervention 1.0.6 Screen for food insecurity, facilitate and actively support referral Effective systems for referral are necessary to help individuals and families access services and benefits for which they eligible. Screening for food insecurity in clinical settings has been recommended by several national organizations, as food insecurity can adversely impact a patient's health outcomes. Some studies have shown that screening for food insecurity is feasible and adds minimal time to the appointment. Screening can ensure timely referral to public health nutrition programs such as WIC, SNAP, CACFP and Commodity Supplemental Food Program (CSFP), and, if necessary, local emergency food services. Screening and referral alone, however, may not be sufficient. Successful case studies have included additional information technology (IT), systems and/or staff resources to facilitate connection, application, and enrollment in the appropriate public health nutrition and/or community program(s). Local hospitals, health centers, businesses, and other stakeholders can partner with CBOs and governmental or private human services organizations to: • Promote and support screening of pediatric patients	Number of individuals screened for food secuity and Pounds of food provided Input Measures: # of technical assistance meetings held, # of screening tools shared Output Measures: # of health networks engaged Short-term Outcome: implementation or improvement plans created, # new food insecurity screening policies/procedures adopted Intermediate Outcome: Patients are being screened for food security during medical appointments. Long-term Outcome: Food insecurity screening procedure is in place, patients are being screened and referred to nutrition incentive programs as needed.	UVMHN-Elizabethtown Community Hospital established a co-located food pantry in the Crown Point Health Center. A food secuirty screening is being designed to be added to the EHR. Invidviduals and families who screen positive for food insecurity will be referred to the Crown Point Health Center food pantry where they will be given a five day supply of food and offered referrals to additional recources throughout the community, for exam SNAP navigation. Essex County Health Department (ECHD) will reach out to Adirondack Medical Center (AMC), University of Vermont Health Network - Elizabethtown Community Hospital (UVHN - ECH) , and Hudson Headwaters Health Network (HHHN) to determine current practice of screening for food insecurity for patients in the health center and hospital settings.	ECH will submit an application to join the regional food bank. If approved the cost reduction of purchasing food will allow for the sustainability of the pantry. ECHD will work with interested health practices on brainstorming potential options (based on evidenced based practices) to add food insecurity screening questions onto existing medical records or assist in creating an additional policy/procedure to screen patients and refer patients in need to public health nutrition programs such as SNAP, WIC, local food pantry services, and other nutrition programs when applicable.	ECH will continue to established relationships throughout the community to further connect individuals in need. The hospital will continue to have representation at Well Fed Collaborative meetings. ECHD will provide health practices with a list of nutrition incentive programs and resources to make referrals. ECHD will also work with participating health networks on gathering data on how many people received food insecurity screening and how many referrals were made to nutrition incentive programs. ECHD will also reach out to Essex County Mental Health (ECMH), Mental Health Association of Essex County (MHA), and St. Joseph's Addiction Treatment Center to access current food security screening and referral process to provide assistance if necessary.	Hospital	ECH will maintain documentation of screenings completed and amount of food distributed. ECHD - Assist in identifying possible screening tools/methods, share nutrition incentive programs and resources, gather data for reporting. UVHN-ECH, AMC, HHHN, ECMH, MHA - Access current practice, implement policy/procedure to screen for food security, screen patients for food security and make referrals to nutrition incentive programs as necessary. Resources: https://hungerandhealth.feedingamerica.org/explore-our-work/community-health-care-partnerships/addressing-food-insecurity-in-health-care-settings/

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Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.1 - Increase (or maintain) % of medical and behavioral health provider systems serving Essex County residents that have adopted Public Health Service (PHS) guideline concordant policies for treatment of tobacco addiction to at least 75% (Medical Baseline: 100%; Behavioral Baseline: 33%) by December 2021.	Health Care Access	Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers. Evidenced Based Intervention - Treating Tobacco Use and Dependence - Public Health Services Guideline (2008 edition)https://www.ahrq.gov/prevention/guidelines/tobacco/index.html	Number of patients who quit and sustained smoking cessation. Input Measures: Administrative presentations offered; Improvement process trainings offered; Planning meetings held; Model policies shared Output Measures: # presentations/trainings offered; # Memorandum of understanding (MOU); # planning meetings held Short-term Outcome: # policy development, implementation or improvement plans created; # new policies/standards of care adopted Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication) Long-term Outcome: Decrease in prevalence of adult tobacco use	Identify medical and behavioral health systems serving Essex County residents and assess current PHS guideline concordant policy adoption status. Establish baseline measures for quality improvement that focuses on increasing provider delivery of an advice statement per evidence-based guidance.	Provide technical assistance for adoption of PHS guideline concordant policy to at least one behavioral health system. Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. Standing orders followed and administered by health center clinical staff.	Provide technical assistance for adoption of PHS guideline concordant policy to remaining medical and behavioral health systems where policies have not yet been adopted. Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. Implement and maintain workflow to ensure all essential providers are screening for tobacco use.	Providers	Providers adopt and implement PHS guideline concordant policies. Health Systems for a Tobacco Free NY contractor (Year 1 - North Country Healthy Heart Network) provides technical assistance and patient and/or provider education materials to all health system providers in the county. Health system grantee will provide support on policy implementation and the development of standards of care as the Lead for this intervention. Franklin County Public Health Department will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the county and connect to healthcare resources.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.3 - Engage at least 3 health providers (medical and behavioral health) in Essex County in the Talk to Your Patients Campaign by December 2021.	Economic Stability, Health & Health Care	Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment. Evidenced Based Intervention: https://talktoyourpatients.health.ny.gov/	Number of media and marketing outreach encounters. Number of providers participating in smoking cessation campaigns. Input Measures: Planning meeting structure Output Measures: # Meetings held; Implementation Plans created; campaign materials distributed Short-term Outcome: % tobacco using patients "advised" to quit tobacco increases Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication) Long-term Outcome: Decrease in prevalence of adult tobacco use	Identify medical health system to pilot implementation of campaign. Establish baseline measures for quality improvement that focuses on increasing provider delivery of an advice statement per evidence-based guidance.	Provide technical assistance for implementation of Talk to Your Patients campaign in at least one medical provider system. Recruit at least two behavioral health systems to implement campaign in Year 3.	Provide technical assistance for implementation of Talk to Your Patients campaign in at least two behavioral health systems. Provide ongoing support for continued implementation of Talk to Your Patients campaign in health systems that began implementation in year 2.	Providers	Providers participate in campaign implementation planning process; then monitor implementation. Health Systems for a Tobacco Free NY contractor (Year 1 - North Country Healthy Heart Network) provides technical assistance and campaign materials to participating provider systems.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%. Target 60.1% Baseline 53.1% Baseline Year 2017 Data Source NYS ATS Data Level State (race/ethniity, gender, SES, NYC/ROS)	Socioeconomic - Medicaid Recipients	3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.	Number of individuals screened for tobacco use and Number of individuals who participate in tobacco cessation	EHR modifications have been completed to capture patients who use tobacco products. A policy has been developed to refer patients who are positive for tobacco use to tobacco cessation specialist (ECH currently has two.)	A third cessation specialist will be identified and trained. Their presence at health fairs and community events will increase by 10%. Community engagement will expand to include social centers, fire houses, and additional health fairs. Hosting public forums with partners to increase community awareness.	ECH will offer tobacco cessation services in community event space (eg. Essex County Fair.) Health fairs will expand to health center locations.	Hospital	ECH will maintain documentation of referrals to tobacco cessation and the number of individuals screened throughout the year. Resources: https://talktoyourpatients.health.ny.gov/
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3 Eliminate exposure to secondhand smoke	3.3.1 - 25 additional apartment units will receive 100% smoke-free multi-unit housing certification though policy adoption by December 2021.	Economic Stability, Neighborhood & Built Environment	Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents using evidence-based strategies. Evidenced Based Intervention - https://www.hud.gov/program_offices/healthy_homes/smokefree	Input Measures: Planning meetings held Output Measures: # Meetings held, draft policies created, campaign materials created and distributed Short-term Outcome: # of landlords/property managers engaged in smoke-free housing program increases Intermediate Outcome: # of apartments with 100% smoke - free housing policies adopted and implemented increases Long-term Outcome: % of people exposed to second hand smoke decreases	Essex County Health Department (ECHD) and Champlain Valley Family Center Advancing Tobacco Free Communities (ATFC) met to discuss potential goals and possible collaboration opportunities.	CVFC ATFC will research current multi-unit housing options in Essex County to establish a baseline for smoke - free housing policies. CVFC ATFC will also increase multi-unit housing that has 100% smoke free policies by 10 units in Essex County.	CVFC ATFC will increase multi-unit housing that has 100% smoke free policies by 15 units.	Housing	CVFC ATFC - Facilitate and support smoke free housing policy planning and implementation. Landlords/Property Managers - Adopt and implement smoke free housing policies.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3 Eliminate exposure to secondhand smoke	3.3.2 - Increase the number of smoke-free parks, beaches, playgrounds and other public spaces by 2 additional locations by December 2021.	Neighborhood & Built Environment	Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces using evidence-based strategies to reduce exposure to second hand smoke. Evidenced Based Intervention - http://tobaccopolicycenter.org/tobacco-control/tobacco-free-outdoor-areas/	Input Measures: Planning meetings held Output Measures: # Meetings held, draft policies created, campaign materials created and distributed Short-term Outcome: # of municipal leaders/organizational decision makers engaged in smoke-free communities program increases Intermediate Outcome: # of parks, beaches, playgrounds, and other public spaces with 100% smoke - free policies adopted and implemented increases Long-term Outcome: % of people exposed to second hand smoke decreases	ECHD and CVFC ATFC met to discuss goal and possible collaboration opportunities.	Establish baseline and increase by one municipal and one public (NCCC)	Increase by one municipal and one public (Essex Centers)	Other (please describe partner and role(s) in column D)	CVFC ATFC - Facilitate and support tobacco free grounds policy planning and implementation. Municipal leaders/Organizational Decision Makers - Adopt and implement smoke free parks, beaches, playgrounds, and other public spaces policies
	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years)	Income, Access, Disability	4.1. Systems change for cancer screening reminders	Number of patients reached through patient reminder system and compliance with Cancer screening guidelines.	Review current practice for reliability and timeliness to ensure reminders are being sent by all providers	Continue to track patient reminders	Continue to track patient reminders	Community-based organizations	Health system grantee will parnter and support this intervention. Franklin County Public Health Department will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the county and connect to healthcare resources.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4% Baseline 75.9% Baseline Year 2016 Data Source BRFSS Data Level state (by race/ethnicity, gender, and region), and by county 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program.	4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts).	Number of individuals screened for colon and/or breast cancer	Preventative outreach is currently in the form of a letter or post card. Feedback received has challenged the staff of ECH to develop a new way of connecting with individuals in need. Care coordination has began using phone calls as an opportunity to open the conversation about cancer screening. Reminder alerts are added to the EHR on individuals who may be overdue. A relationship has been established with Exact Science, a vendor for cologuard, the order form has been added into the EHR and generates once the provider adds the order.	ECH will develop a patient centered approach to preventative care outreach. Patient and Family Advisors will be involved in development of new outreach.	ECH will offer an increased number and locations of screening events throughout the year. Continued collaboration with the Cancer Screening Program and joint patient engagement will allow for positive patient outcomes. At least four events per year will hightlight cancer screening education.	Hospital	ECH will maintain documentation of outreach and a total number of individuals screened. Resources: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/https://www.thecommunityguide.org/topic/cancer

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Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.3 - Increase colorectal cancer screening rates in Essex County from 66.9% to at least 68.5% to meet upstate NY colorectal cancer screening rate by December 2021.	Health Access, Education, Economic Stability Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.3 Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand.	Number of social media posts related to cancer screenings Input Measures: # of cancer screening social media posts, ads, and campaigns created Output Measures: # of cancer screening social media posts, ads, and campaigns posted/printed/promoted Short-term Outcome: increased cancer screening health communications Intermediate Outcome: increased # of residents who engage in cancer screening campaign/communications and # of locations materials were distributed. Long-term Outcome: increase in cancer screening referrals and screening events	ECH has an active social media presence where posts directed at cancer screening can be completed. Essex County Health Department collaborated with the Cancer Services Program (CSP) of Northeastern NY and International Paper for a 'Movember' awareness campaign in November, 2019, . Educational flyers were distributed in public locations to raise awareness of the risks factors and how to prevent prostate and testicular cancers. The importance of regular screening was also highlighted. Materials on the Cancer Screening Program of Northeastern NY were distributed to assist employees that are uninsured or under insured. Essex County Health Department will also establish a baseline by researching social media logs and ad campaigns to determine current cancer screening campaign efforts.	ECHD and ECH will complete media campaigns together to address the need for cancer screening. Post cancer screening health messaging on the Essex County Health Department Facebook page to remind people of the importance of prevention and early detection. Create and print newspaper ads promoting the importance of cancer screening including targeted cancer screening public health observances (E.g. March - Colorectal Cancer Awareness). Collaborate with the CSP of Northeastern NY on awareness campaigns and assist in promoting scheduled screening events.	A calendar of events will be created an published for the public to plan screening on their availability. Post cancer screening health messaging on the Essex County Health Department Facebook page to remind people of the importance of prevention and early detection. Create and print newspaper ads promoting the importance of cancer screening including targeted cancer screening public health observances (E.g. March - Colorectal Cancer Awareness). Collaborate with the CSP of Northeastern NY on awareness campaigns and assist in promoting scheduled screening events.	Media	ECHD - collaborate with CSP Northeastern NY on creating educational materials using evidence-based interventions assist in distributing though various media outlets. CSP Northeastern NY - collaborate with ECHD on creating educational materials using evidence-based interventions and assist in distribution, collaborate with health networks to schedule and offer screening events Media - publish ads and disseminate information to Essex County residents. ECH w… provide community outreach and education. Resources: https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4% Baseline 75.9% Baseline Year 2016 Data Source BRFSS Data Level state (by race/ethnicity, gender, and region), and by county 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) Target 80.0%	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.4 Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance (Provider Assessment and Feedback).	Number of individuals screened for colon and/or breast cancer	Due to expectations of the Accountable Care Organization and National Committee for Quality Assurance, ECH maintains month values of breast and colon cancer screenings that are provided to the provider quarterly.	ECH will increase provider awareness through the completion of monthly education and review of provider standings.		Hospital	Resources: https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4% Baseline 75.9% Baseline Year 2016 Data Source BRFSS Data Level state (by race/ethnicity, gender, and region), and by county 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) Target 80.0% Baseline 68.5%	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.	Number of individuals screened for colon and/or breast cancer	ECH currently offers screening events at the Elizabethtown and Ticonderoga sites at a minimum of four times per year.	ECH will expand cancer screening events and will continue to work with partner organizations to increase awareness.	ECH will work with Cancer Screening services to promote screening within the health centers.	Hospital	ECH will keep documentation on the number of screenings. Resourc… https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4%	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.6 Ensure continued access to health insurance to reduce economic barriers to screening.	Number of insured vs uninsured patients	Elizabethtown Community Hospital welcomes organizations such as Adirondack Health Institute on site to assist patients in identifying and securing health insurance.	Increase the number of locations representatives are present.	Increase the number of days annually representation is on site.	Hospital	ECH will maintain a record of dates and locations partners were on site for insurance navigation. Resources - https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Target 71.7% Baseline 68.3% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, income, and region), and by county Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting.	4.2.1 Promote strategies that improve the detection of undiagnosed hypertension in health systems	Number of individuals screened for HTN Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote referrals of patients to chronic disease wellness coaches. Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote referrals of patients to chronic disease wellness coaches.	Both emergency departments are linked to The University of Vermont Health Network via high-tech telemedicine capabilities. During a stroke or other critical care case, physicians confer with trauma teams at the UVM Medical Center, a level 1 trauma center with specialists in all major medical and surgical fields available to assist when needed. Utilize electronic health records and HIXNY to gather patients lists to identify individuals with undiagnosed hypertension and pre-diabetes	ECH will expand health screenings to all eight sites. There will be increased attention to public education pertaining to stroke. Policies/practices in place for providers,nurses and medical office assistants to promote and detect chronic diseases	Identify chronic disease self management educator and host education session. ECH will increase the number of screening events completed annually. ECH will be recognized as an Acute Stroke Ready Hospital by Joint Commission.	Hospital	Health system grantee will provide staff time to support practice enhancement activities aimed at increasing identification and diagnosis of pre-diabetes offer practice facilitator staff time to support use of registry and staff time to support development. Will also support with funds to pay for patient education material. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for chronic disease wellness coaching.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Target 71.7% Baseline 68.3% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, income, and region), and by county	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting.	4.2.2 Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.	Number of individuals screened for diabetes and Number of referrals to diabetic education	Certified Diabetic Educator (CDE) actively sees patients in primary care health centers for ECH in addition to the Elizabethtown and Ticonderoga sites and advocates for all patients. CDE has excellent working relationship with providers. Certified Diabetic Educator (CDE) attends at least 50% of health fairs and promotes pre-diabetes screening. The CDE provides education and educational materials at time of screening.	Promotion of the Diabetic Education will continue. Support groups will be held monthly at both ECH and Ticonderoga campuses.	The hospital will continue to develop the program and identify opportunities to increase the access to diabetic education for patients of health centers where transportation is a barrier.	Hospital	Resources - https://www.cdc.gov/sixeighteen/diabetes/index.ht m
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Target 71.7% Baseline 68.3% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, income, and region), and by county	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting. Income, Access, Care Coordination.	4.3.1 Promote a team-based approach (which may include pharmacist, community health worker, registered dietitian, podiatrist, and other health workers) to chronic disease care to improve health outcomes.	Number of patients referred to the Diabetes Prevention Program. Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote # referrals of patients to chronic disease wellness coaches.	Patients who are identified to have the diagnosis of diabetes or prediabetes will be referred to the care team for further management. Identify undiagnosed pre-diabetic through electronic health records. Monitor patients with quality dashboard.	Individuals identified will be referred to appropriate programs (wellness program, wellness Rx, Diabetic Education, or Diabetes Prevention Program). Conduct in-service education to medical staff for further expansion of chronic disease prevention program.	Referrals to available programs will increase by ten percent. Increase access to chronic disease wellness coaches to schools and worksites.	Hospital	Health system grantee will partner and support this intervention with staff time to support practice enhancement activities aimed at increasing referral of patients to DPP program. Additionally, assist with funds for patient education and DPP facilitator training. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for diabetes prevention program. ECH will maintain records of individuals screened and referred to programs.
	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)	Income, Access, Care Coordination	4.3.5 Promote referral of patients with prediabetes to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 5% to 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week.	Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote # referrals of patients to chronic disease wellness coaches.	Identify undiagnosed pre-diabetic through electronic health records. Monitor patients with quality dashboard.	Conduct in-service education to medical staff for further expansion of chronic disease prevention program.	Increase access to chronic disease wellness coaches to schools and worksites.	Community-based organizations	Health system grantee will partner and support this intervention with staff time to support practice enhancement activities aimed at increasing referral of patients to DPP program. Additionally, assist with funds for patient education and DPP facilitator training. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for diabetes prevention program.

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	North Country Healthy Heart Network	Champlain Valley Family Services
Planning Report Liaison	Dan Hill, Heidi Bailey	Jessica Darney Buehler, Elizabeth Terry	Julie Tromblee, Amanda Whisher	Ann Morgan	Dana Bushy Isabella
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class how to learn how to manage their condition.	Income, Access, Disability	4.4.2 Expand access to chronic disease self management	Number of patients who participate in NDPP. Number of patients who complete NDPP. Number of educators certified. Number of locations to hold NDPP classes.	Chronic disease wellness coaches certified to administer NDPP classes in 2020.	Track number of patients. Additional locations sites identified to increase access to classes.	Continue to track number of patients. Additional locations sites identified to increase access to classes.	Local health department	Health system grantee will provide staff time to support establishment and/or maintenance of DPP programs. This includes facilitator training, stipends and participant materials. Health System grantee will also assist with data collection and reporting, as required by CDC to maintain recognition. Franklin and Essex County Public Health Department will promote NDPP classes to their population.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class how to learn how to manage their condition. 4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition Target 10.60% Baseline 10.1% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, age, race/ethnicity, income), and by county	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting.	4.4.3 Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.	Number of participants in the DPP program Number of patients who participate in NDPP. Number of patients who complete NDPP. Number of educators certified. Number of locations to hold NDPP classes.	An identified staff member will complete DPP training to become a certified life coach.	ECH will continue to develop and enhance a DPP program. Screening events will continue to be held regularly at various sites.	A DPP program will be developed and put into place by January 2021.	Hospital	ECH will maintain a total number of participants in the DPP program as well as results following the completion of the patient's participation. Health system grantee will provide staff time to support establishment and/or maintenance of DPP programs. This includes facilitator training, stipends and participant materials. Health System grantee will also assist with data collection and reporting, as required by CDC to maintain recognition. Franklin and Essex County Public Health Department will promote NDPP classes to their population.

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	Schroon Lake Pharmacy	The Prevention Team	Essex County Sheriff
Planning Report Liaison	Dan Hill, Heidi Bailey	Linda Beers	Julie Tromblee, Amanda Whisher	Rebcca Doyle	Doug Turbeek	David Reynolds
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2.3 Reduce the adult New Yorkers with incomes between $15,000 to $74,000 New Yorkers reporting frequent mental distress during the past month by 10% to no more than 21.8% Target 21.8%	Access - The rural setting limits individuals from accessing services and programs outside of their communities.	1.1.4 Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education	Number of Specialty services added	Continue to build upon the medical village in Ticonderoga. Primary Care to be available by 2021.	ECH will continue to explore Dental, Opthalmology and Gynecology in the Ticonderoga campus.	ECH will work with the Care Delivery Optimization Team	Hospital	https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	Achieve Health System goal of becoming an age friendly institution with the 4M's framework from IHI; Reduce the percentage of adults 65+ New Yorkers reporting frequent mental distress during the past month by 10% to no more than 13%.	Income, Access, Disability	1.2.3 Policy and program interventions that promote inclusion, integration and competence (Age Friendly)	Number of patients with advance care planning in place, number of patients with who have had fall risk screen using STEADI assessment on all patients over 65 and referred to PT as needed.Number of patients over age 65 screened for depression using PHQ-9 assessment	Implement policy and procedure within the Emergency department. Implement structured fields in hospital electronic medical records to assess 4M's- Mentation, Medication, What Matters and Mobility	Complete assessment of health centers and identify needs. Create a plan for implementation of Age Friendly initiative and work with Nurse Manager to build annual wellness assessment to include the 4 M's. Work with medical staff to incorporate what Matters into their progress note.	Review the assessment data to ensure proper documentation is completed. Speak with staff about the effectiveness and workflow while entering assessments. Review and revise assessments and documentation based on feedback from patients and staff.	Local health department	Mercy Care for the Adirondack will support by communicating efforts to the region, provide expertise. Franklin County Public Health will provide support and help identify seniors at risk of negative health outcomes that can benefit from hospital services. Franklin and Essex County Office of the Aging will further provide expertise, referrals and assistance with programming to improve well-being.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1 Prevent underage drinking and excessive alcohol consumption by adults	2.1.1 Reduce the percentage of youth in grades 7-12 reporting the use of alcohol within the past 30 days by 10% from 25.8 in 2018 to 23.22% in 2020 .	Education , Social & Community Context	2.1.2 Implement School based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors	Input: The Prevention Team will pilot Life Skills 3-6 Curriculum in four of the ten school they are providing services in. Output: Approximately 50 - 100 students will receive this training by December 2021. Short term: students will complete a Pretest prior to the Life skills Curriculum to assess current knowledge Intermediate: The Essex County Prevention Team will train four (4) school educators in the Life Skills 3-6 Curriculum Long-term: Students will complete a posttest measuring knowledge gained	The Essex County Prevention Team will train four (4) school educators in the Life Skills 3-6 Curriculum. The Prevention Team will pilot Life Skills 3-6 Curriculum in four of the NINE (9) school they are providing services in.	The Essex County Prevention Team will implement Life skills Curriculum in 5 out of the 9 nine schools	The Essex county Prevention Team will Implement life Skill in 9 out of the 9 schools.	Community-based organizations	The Prevention team will provide the Life skills training Schools will provided time in their Curriculum
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.1.2 Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% to no more than 16.4%	Access - The rural setting limits individuals from accessing services and programs outside of their communities.	2.1.5 Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) Electronic screening and brief interventions (e-SBI) using electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI	Number of positive screens	All health centers nursing staff have been trained on SBIRT.	ECH will continue to screen patients annually and make the necessary referrals for treatment.	Number or referrals to the care team will increase. Complex cases to be dicussed during care team meetings to explore necessary interventions.	Hospital	St. Joseph's Outpatient Rehabiliation
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Strengthen opportunities to build well-being and resilience across the lifespan	2.1.2 Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% to no more than 16.4%	Socioeconomic Access - Having the ability to educate patients outside of the healthcare setting.	2.1.6 Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration	Dates of trainings offered and number of attendees	Trauma informed care training to be offered to hospital and health center providers.	Medical officer to extend formal invitation to providers to attend offered training events.	Training will be expanded to nursing and clinical staff.	Hospital	AHI & UVHN
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.2 Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.8 per 1,000 population. Baseline: 36.5 per 1,000	Socioeconomic Access - Having the ability to educate patients outside of the healthcare setting.	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	Number of MAT prescribers	ECH has two providers currently able to prescribe for MAT.	ECH will increase the number of providers to three.	ECH will explore the option of having physician assistants become x-waivered to be able to prescribe MAT.	Hospital	NYSDOH
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.4 Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population	Socioeconomic Access	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	Number of kits provided. Number of opioid ED encounters referred to open access clinic, number of users prescribed Buprenorphine. Number of provider education classes taken. Number of prescription drugs obtained in safe disposal boxes.	Narcan kits are availble for community members at the Ticonderoga and Elizabethtown campuses. Narcan available at all Emergency Departments and Health Centers. Safe Disposal site located on campus.	Evaluate the number of kits dispensed to community members. Complete another Public Information advertisment to ensure community is aware of the service. Provide annual medical staff in service education.	Evaluate the number of kits dispensed. Advertise availability. Have a clinical staff member present and dispense at our annual Community Fair. Provide annual medical staff in service education.	Hospital	Alliance for Positive Health St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.4 Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population	Access	2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations	Number of opioid prescriptions	Opioid stewardship	Prescribing patterns will be analyzed and education provided. Pharmacy to be included during health fairs to provide education to the community regarding opioid prescribing guidelines.	Attend Essex county Heroin and Opioid Taskforce (ECHO).	Hospital	NYS Bureau of Controlled Substances. ECHO
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any drug from the Essex County rate 18.4/100K to the North Country rate of 11.3/100K or better.	Socioeconomic Access Social and Community	2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	Number of sites and dates of take backs Input: *Identify a location in Southern Essex County that will install a medication drop box. *Identify location sites for take back days Output: *Increase the number of medication drop boxes in the southern part of Essex County by at least one (1). * Schedule take-back days Short- term: The pharmacy will track utilization and report back. On social media we will count the views and engagement of the take back campaign Intermediate: Increase the amount of medication reported to have been dropped in box by pharmacy Create a media campaign to raise awareness of the new drop box as well as all existing Drop Boxes. Increase awareness off take back day events count the amount of views and engagement. Long-term: Risk reduction by removing the unwanted medication from households we will : Reduce the percentage of youth in grades 7-12 reporting the use of alcohol within the past 30 days by 10% from 25.8 in 2018 to 23.22% in 2020 .	Take back dates will now be listed during health fairs to promote the bins located in the lobby at both the Ticonderoga and Elizabethtown campus. ECHD will meet with (1) Southern Essex County Pharmacy . ECHD will contact the DEC and become educated on medication drop box Pilot Pharmaceutical Take-Back Program.	Social media highlights will be present to increase utilization of the safe disposal sites. ECHD will support the pharmacy in arranging for the delivery and installation of the medication drop box. The pharmacy will design a schedule in which medication is removed from the box and prepared for shipment to the DEC for incineration. The pharmacy will quantify the medication being shipped in a report to the ECHD. ECHD will design a media campaign to alert the public of the new drop location. Views and engagement will be tracked. ECHD will support the Prevention Team and the Sheriffs office with a social media campaign to promote drug take back days in April and December.	Evaluate the need for safe disposal sites at outlying health centers due to lack of transportation. The pharmacy will increase the quantity of the medication being shipped in a report to the ECHD. ECHD will collect data on the media campaign to alert the public of the new drop location and all existing ones. Views and engagement will be tracked. ECHD will support the Prevention Team and the Sheriff's office with a social media campaign to promote drug take back days in April and December. Views and engagement will be tracked.	Hospital	Schroon Lake Pharmacy- Drop box location Essex County Health Department- Media Campaign Essex County Sheriff dept. Take back event The Prevention Team supports Take Back event. NYSDEC.

Name of County - Organization(s) **2019 Workplan**	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	Schroon Lake Pharmacy	The Prevention Team	Essex County Sheriff
Planning Report Liaison	Dan Hill, Heidi Bailey	Linda Beers	Julie Tromblee, Amanda Whisher	Rebcca Doyle	Doug Turbeek	David Reynolds
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner ***(Please select one partner from the dropdown list per row)***	Partner Role(s) and Resources
		Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%	Income, Access, Disability	2.6.2 Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes.	Number of mental health patients referred to tobacco cessation counselor, number of tobacco users referred to mental health counseling.	Established on-site Open Access Clinic with St. Joseph's Addiction Treatment Center.			Hospital	St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.

Name of County - Organization(s) Adirondack Health | Essex Coutny Health Department
2019 Workplan

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Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal and Infant Health	Goal 2.1: Reduce infant mortality and morbidity	Increase the percentage of women receiving early prenatal care by 4% (currently 71.4%) to 75.4% .	Adult literacy and higher educational attainment, transportation and annual household cost	Apply the Home Visiting Evidence of Effectiveness (HOMVEE) review to the current Essex County Health Department (ECHD) Family Health (FH) Home visiting program.	Input measures - HOMVEE review by FH staff and the Director of the Preventive Services (DPRevS) . Output measures - FH staff and DPrevS completed HOMVEE review and documented comparison with ECHD FH program and next steps. Short-Term Outcome - Develop recommendations for ECHD FH program improvement to better meet HOMVEE model of implementation. Intermediate Outcome - Update FH client educational materials, including childbirth education (CBE) and visitation format to best match evidence based program. Long-term outcome - identify gaps and barriers to home visiting services.	The DPrevS attended the 11/15/19 Home Visiting Summit hosted by the Birth to 3 Collaborative. The 5 counties represented worked in groups to brainstorm priorities for the North Country region to submit to the NYSDOH Division of Family Health. This input is planned to be applied to the statewide needs assessment to inform our Title V Maternal and Child Health Services Block Grant program, which focuses on improving the health and well-being of mothers and children, including children and youth with special health care needs, and their families.	Continue to work with the Birth to 3 Collaborative to identify barriers and gaps in home visiting services. Collaborate with Adirondack Health to provide access to childbirth classes in Essex County.	Develop/revise an Essex County Resource List for expectant families and families with children ages birth to 3 and develop a plan to engage providers and community agencies with case management and referral to home visiting programs and other resources, such as lactation consultation and childbirth education classes and access to various methods of birth control.	Community-based organizations	Referral of eligible families to home visiting programs and other resources, such as WIC, Children's Services, ACAP Early Head Start and Head Start and Childbirth Education classes.
Promote Healthy Women, Infants and Children	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)	Goal 3.3: Reduce dental caries among children	Increase the percentage of children ages 1-17 years who had one or more preventive dental visits in the past year by 10% to 85.4%.	Poverty, transportation and built environment (access to Medicaid dental providers).	Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.	Input measures - ASTDD Oral Health Educational Resources for Home visitors and Families, and Best Practice Approach Reports. Output Measures - FH staff and DPrevS document evidence based measures best suited to align with Essex County WIC, Adirondack Community Action Program (ACAP) Head Start (HS) and Early Head Start (EHS) and ECHD Children's Services (CS) programs. Short Term Outcomes - WIC, ACAP EHD and HS and CS programs document # of children ages 0 to 5 years accessing a dental provider. Intermediate Outcomes - # of participants accessing evidence based measures, including a list of available dental providers and dental referral assistance as indicated. Long-Term Outcomes - Increase in the % of children served by ACAP HS and EHS, WIC and CS programs that access a dental provider.	No activities projected to be completed by the end of 2019.	Reach out to the New York State Department of Health (NYSDOH) Bureau of Child Health to collaborate on oral health messaging and outreach materials. Collaborate with ACAP, WIC and CS to assess current oral health strategies and those evidence-based strategies that can compliment or supplement what is currently being used.	Assess dental health of all participants in the ACAP, WIC and ECHD CS programs and provide referrals to dental providers as indicated	Community-based organizations	ACAP, WIC and Children's Services attend annual meeting with ECHD FH staff and DPrevS to determine current resources, best match evidence based resources, method of data collection and referral system.
Promote Healthy Women, Infants and Children		Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	4.1 - Increase and enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families through bi-monthly (12 meetings total) coalition meetings through December 2021.	Healthcare Access	Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course using evidence-based interventions.	Input Measures: # of community based partners invited Output Measures: # of community based partners engaged Short-term Outcome: # of coalition meetings scheduled Intermediate Outcome: # of collaborations with partners that address social determinants of health impacting women, infants, children, and families. Long-term Outcome: Identify racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	The Essex County Breastfeeding Coalition will re-brand to be more inclusive of other SDOH priority areas and issues currently impacting the health of women, infants, children, and families.	The coalition will review community health assessment data to determine priority areas and create a work plan based on identified objectives. Coalition members will provide bi-monthly updates on work plan objectives.	The coalition will review 2020 work plan data and provide input on objectives. The coalition will update the work plan based on progress and newly identified priorities.	Community-based organizations	ECHD - Schedule and facilitate coalition meetings in addition to the roles listed below. Elizabethtown Community Hospital (ECH), ACAP, Creating Breastfeeding Friendly Communities (CBFC) grant, Essex County WIC, Essex County Health Department - Children's Services Unit, and other community partners - assist in gathering data, provide input on priority areas, assist in completing identified work plan objectives to target identified disparities and barriers to addressing services to address SDOH.