Appendix F.1

Essex County [Public] Health Department Community Health Improvement Plan 2014-2017 Summary Report 2014-2016

Priority & Focus Areas 2013

Chronic Disease Prevention was the priority selected.

Focus areas were 1) reducing obesity in children and adults, and
2) increasing access to chronic disease preventive care management in clinical & community settings.

Outcome Summary (Overarching Objectives)

The color of the 2016 Assessment indicator numeric value indicates an improvement (green) or deterioration (red) for the indicator from the 2013 to 2016 assessment; it does not indicate whether the 2017 benchmark target was met.

Priority 1: Reducing Obesity in Children & Adults Overarching Objectives	2013 Assessment	2017 Benchmark Target	2016 Assessment
Reduce the percentage of children who are obese • WIC children (ages 2-4 years); and • among public school children	 15.5%* 18.8%	 NA* 16.7%	 **17.1%** **16.6%**
Reduce the percentage of adults ages 18 years and older who are overweight or obese.	64.3%	59.3%	**68.6%**
Reduce the percent of adults ages 18 years + who are obese.	24.9%	23.0%	**32.2%**

* Data reported in the Community Health Assessment Essex County, NY 2103 for this indicator was reported as 46.5% with a benchmark of 45.7%. Between the 2013 and 2016 assessments the criteria used to meet the definition of obesity changed. Therefore the data as currently reported for that previous time period is currently reported as 15.5%. Source: http://www.health.ny.gov/statistics/chac/general/g72_15.htm

Priority 2: Increasing Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings Overarching Objectives	2013 Assessment	2017 Benchmark Target	2016 Assessment
Reduce the rate of All Cancer deaths (/100K)	263.9	204.1	**244.0**
Reduce the rate of Diseases of the Heart deaths (/100K) from 263	262.9	243.6	**258.3**
Reduce the rate of Diseases of the Heart premature deaths ages 35-64) (/100K) from 263	110.4*	NA	**115.3**
Reduce the rate of Diabetes deaths (/100K)	28.7	17.7	**31.6**

** Data reported in the Community Health Assessment Essex County, NY 2103 for this indicator was reported as 45.3 with a benchmark of 32.2. The rate as currently reported for that previous time period uses a different comparison population (crude rather than age adjusted) therefore reflecting a different rate. Current data still demonstrates an increase in premature deaths due to diseases of the heart when comparing 2013 to 2016 points in time. Source: http://www.health.ny.gov/statistics/chac/mortality/d5_15.htm

Obesity Prevention Goal Specific Objectives

1. Create **community environments** that promote and support healthy food and beverage choices and physical activity. *Communities of lower income will be targeted as a means of addressing the income disparity for food and activity access.*		
Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Increase visibility and access to affordable, nutritious foods and/or beverages through store layout and displays.	2	4 Store layout/display improvements plus 10 buy local racks with recipe cards. *Creating Healthy Places Grant*
Increase the number of municipalities that have passed local complete streets resolutions or policies.	10	14 Policy Adoption: Essex County; Chesterfield; Elizabethtown; Essex; Lewis; Minerva; Moriah; Village of Port Henry; Newcomb; North Hudson; Schroon; Westport; Willsboro; Wilmington. 2 Language in Comp Plans: North Elba; Ticonderoga. *Creating Healthy Places Grant*

2. Create **school environments** that promote and support healthy food and beverage choices and physical activity. *Schools with high percentages of free and reduced lunches will be targeted as a means of addressing the income disparity.*		
Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Increase the number of school districts with adopted competitive food policies and practices that meet or exceed the Institute of Medicine recommendations for competitive foods or sugar sweetened beverages.	2	2 Wellness Policy Updates to meet the Healthy Hunger Free Kids Act (HHFKA) standards: Elizabethtown-Lewis Central School; Crown Point Central School. 1 District with policy revisions under way: Moriah Central *NYS Health Foundation CHIP Grant*
Increase the number of school districts that meet or exceed NYS regulations for physical activity.	2	1 District exceeds the Required Instruction frequency for pupils in grades K-3 (participate in PE on a daily basis) by achieving K-5 daily PE: Elizabethtown-Lewis Central School. *District PE Instructor*

3. Expand the role of **health care and health service providers and insurers** in obesity prevention.
** As there are no birthing hospitals in Essex County, ECPH will strive to partner with hospitals outside of Essex County where babies are born.*
***This objective and data is found under the Healthy Mother, Infants and Children though included here for its role in obesity prevention. Because WIC is an income dependent program and provides access to a lactation consultant, this objective addresses income and access disparities.*

Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Increase the percentage of infants born in hospitals who receive any breast milk in delivery hospital.*	71.0%	80.1% '11-'13 ECHD staff assessed breastfeeding friendly policies for 3 local birthing hospitals (Champlain Valley Physician's Hospital, Glens Falls Hospital and Adirondack Medical Center) and Elizabethtown Community Hospital (non-birthing hospital) and their affiliate health centers. The Breast Feeding Friendly (BFF) Hospital designation is reported by the birthing hospitals as difficult to achieve due to expense and documentation. However they all 3 describe practices that follow the 10 steps to meet criteria for being Breastfeeding Friendly. All 3 hospitals also have designated breast pumping areas for staff and provide support ranging from available pumps to break time allowed. Elizabethtown Community Hospital adopted a BFF policy that includes the hospital & affiliate health centers as being breast feeding friendly & installed provided wall-art and table stands with images of women breastfeeding & stating, "Breast feeding welcome here.". *Adirondack Rural Health Network, Prevention Agenda Project*
Increase the percent of WIC women who breastfeed at 6 months. **	39.7%	19.9% WIC has 1 Certified Lactation Counselor. 1 ECHD RN became a Certified Lactation Counselor (CLC®) and sat for the International Board Certified Lactation Consultant® (IBCLC®) exam in October 2016. *Adirondack Rural Health Network, Prevention Agenda Project*
Increase the number of provider practices that use electronic health records to cue for counseling for overweight and obesity.	1	3 1 Hudson Headwater practices – Ticonderoga Health Ctr. 2 Adirondack Health practices – Keene & Lake Placid Health Centers *Obesity Prevention in Pediatric Health Care Setting Grant*

4. Expand the role of **public and private employers** in obesity prevention.
Patients, residents & others impacted by organizational nutrition are identified as having limited access to nutritionally valuable foods & beverages.

Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Establish a Learning Collaborative around organizational nutrition to build knowledge and practices of evidenced based strategies that create healthy foods and beverage policies, systems & environments.	NA	ECHD did not pursue the Learning Collaborative because Designing a Strong & Healthy New York (DASH NY) initiated a Learning Collaborative that served the same purpose. *NYSDOH*

Chronic Disease Prevention and Management Goal Specific Objectives

1. Increase **screening rates** for breast, cervical and colorectal cancers, especially among disparate populations. *Men and women without health insurance are the target for this goal thereby addressing the income disparity.*		
Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Increase percent of breast cancer (mammography) screening within the last 2 years	79.7%	83.0% An outreach plan to reach those without health insurance was developed & implemented. Screening rates for low-income women is still unavailable. *Cancer Screening Program Grant*
Increase the screening percentages for colorectal cancers (through sigmoidoscopy or colonoscopy) within the last 10 years	62.9%	68.3% An outreach plan to reach those without health insurance was developed & implemented. Screening rates for low-income women & men is still unavailable. *Cancer Screening Program Grant*

2. Improve availability, accessibility and use of chronic disease **self-management education**. *Self-Management opportunity locations will be targeted to those communities with income and access disparities.*		
Objective	Target	Performance/Status as of December 2016 *Resources/Partner*
Develop a promotion plan for existing chronic disease self-management (CDSM) opportunities (diabetes self-management, living with a chronic condition, others) and ensure on-going opportunities.	3	>=3 Diabetes Self-Management Series & Diabetes Support Group Cardiac Rehabilitation Programs Living Healthy with Chronic Conditions series Pulmonary Rehabilitation Program Alzheimer's Disease Third Age Adult Day Center & Care-giver Support Group Assessment of existing opportunities completed 2015. It included topic-specific programs (diabetes, arthritis, etc.) and different types of programs (lectures, community based, clinically based, independent learning/self-help, etc.). Completion of promotion plan anticipated by end of 2016. *SUNY Plattsburgh Nursing Internship Program*
Develop a promotion pan for existing internet (web or phone) application self-management support systems and promote systems.	1	1 Web and phone-app based opportunities assessment started. Completion of promotion plan anticipated by end of 2016. *SUNY Plattsburgh Nursing Internship Program*

Appendix F.2
Adirondack Health Community Health Needs Assessment & Community Service Plan

2016 CSP Summary Report
December 2016

2015-2016 Activities

Throughout 2015, Adirondack Health has continued nurturing partnerships at the core of our strategic plan to provide the foundation for improving the health of all our residents in our Adirondack communities.

In addition to providing the highest quality care for patients at our primary locations, we at Adirondack Health aim to apply our clinical strengths to support the health needs of the broader community throughout the Adirondack Region.

Through the Community Health Needs Assessment and the partnerships outlined in our Community Service Plan, we seek to create a platform for evidence-based health promotion and disease prevention at the community level, fostering healthy behavior change and reducing risk factors for disease.

Aligning with New York State, our three-year Community Service Plan (2013-2015) takes a child- and family-centered approach to our first focus of reducing risk factors for obesity in children and adults; and the second focus area of increasing access to high quality chronic disease preventive care and management in both clinical and community settings.

Progress

Adirondack Health continues with increased participation and progress with the following:

- Participating in DSRIP (Delivery System Reform Incentive Payment) with seven projects all of which are part of a comprehensive program to reduce hospital admissions and Emergency Department admissions by 5% per year over the next five years, In our service area alone, over 800 homes will benefit from initiatives to provide healthcare in the home via either telemedicine by the patient themselves or with the assistance of home healthcare workers; and education and lifestyle changes for disease prevention. Project teams have been established and initial data analysis have been submitted to meet milestones. Projects have moved into the performance phase in 2016 and tools have been developed and implemented to determine benchmarks of patient healthcare status. To date all deliverables have been met. DSRIP funds are continuing to flow into these projects which are an investment in Population Health as the system ramps up to value based payment. Our projects align with the prevention agenda and Chronic Disease continues to be a focus area, with an emphasis on palliative care; as well as integration of behavioral health into primary care, among others.

- Our partnership with Adirondack Health Institute (AHI) helps us to expand regional collaboration among healthcare and social service providers serving the Adirondacks. AHI's goal is to help members and their communities navigate the ever changing health care industry through partnerships and collaboration. We are active in Medical Home through the ACO and considering Health Home as our next initiative.

- Using the National Diabetes Prevention Program as a model, Adirondack provided a pre-diabetes program for all Adirondack Health employees which has been proven to be successful and is just

about completing Phase II of the program. To date there is low participation rate and efforts are being taken to increase awareness of the program and move it out into the community on a larger scale.

- Adirondack Health's obstetrical department is currently participating in the NYS Breastfeeding Quality Improvement in Hospitals Collaborative through February of 2016. In 2014 the Stafford New Life Center submitted a Peak of Excellence project on "Exclusive Breastfeeding Practices Quality Improvement Initiatives". The department was recognized for its ongoing efforts in promoting breastfeeding. Adirondack Medical Center's Stafford New Life Center continues to excel in promoting breastfeeding in the Adirondack park of NYS. A recent comparison study of all NYS hospitals rated our hospital 9th in the state in meeting Healthy People 2020 goals of Exclusive breastfeeding rates of at least 70% and any breastfeeding goal of 82%. As of October 2015 Adirondack Health's exclusive breastfeeding rate is@ 75.5% and any breastfeeding rate is @ 84.9%.

- Participating in a NYS grant from DOH with Clinton County Obesity Prevention in Pediatric Health Care Settings (OPPHCS), which provides for education materials and supplies for physical activity for pediatric providers. Educational materials are available in all four clinics for primary care providers to use when providing information on prevention of obesity in children. A Healthy Lifestyle Quiz has been incorporated into the EMR which allows for good data collection which is submitted to the County. Data analysis are sent to us monthly by County showing marked improvement and progress by each of our providers which provides nutrition, physical activity and screen time measures.

- Four community forums were held in late 2015 conducted by our CEO to convene community stakeholders to engage in robust discussions on emerging healthcare trends. Adirondack Health is committed to listen and learn to gain a shared understanding of the impact that health and healthcare has on the community. Further dialogue was encouraged by both Adirondack Health and the community. For 2016, four informational lectures to inform everyone about how changes and trends might impact hospitals; and are being held as part of the endeavor to prompt community engagement and provide information as to how stakeholders can influence the hospital programs and processes.

- In late 2014, Adirondack Health began meeting with transgender advocates in the community as a result of them not feeling welcome at our facility. At that time, representatives of administration began meeting with the LGBTQ community members to put a plan together for education of staff and physicians, in order to respectfully treat LGBTQ patients in our system. During 2015, several educational programs were held with employees and physicians to educate them on the issues that LGBTQ patients face, their specific healthcare needs, and how AH had made changes to policies/protocols to assure that members of the LGBTQ community were treated respectfully and appropriately at AH. This was a huge success, and in 2016, more educational programs will be conducted in the community to continue educational efforts.

- The creation of a Women's Health Center is underway which will utilize our Women's Health Navigator, along with our published guidebook established in 2015-16 to help women navigate the intricate healthcare system and provide the necessary information for access to all women need throughout their lives and the lives of their family.

Appendix F.3

THE University of Vermont HEALTH NETWORK

Elizabethtown Community Hospital

Community Service Plan 2015 Update

To address needs identified in the community health needs assessment, Elizabethtown Community Hospital worked toward developing strategies and tactics independently through healthcare-based initiatives and also by engaging key community partners in implementing particular strategies. Acknowledging that many organizations and resources are already in place to address certain health needs within the community, Elizabethtown Community Hospital has strategically reviewed both internal and external resources to best meet the goals of the community service plan (CSP).

Many of the strategies and activities address risk factors associated with multiple health problems. For example, strategies to reduce obesity will affect heart disease and diabetes. These strategies also might have a positive impact on mental health, as will strategies to reduce substance abuse. Some strategies and activities outlined below have been in coordination with Essex County Public Health, or other health-oriented organizations in the area. Many of these strategies aligned with those of other community-based organizations, and other stakeholders have been engaged.

1. New York State Prevention Agenda Priority: Prevent / Manage Chronic Disease

Community Health Need: **The rate of diabetes in Essex County is increasing.** Many residents are at risk for developing diabetes or have poorly controlled diabetes. **Heart disease is the leading cause of death in Essex County.** Both of these issues contribute to emergent visits and hospitalizations. This is expected to increase as the population ages.

Priority	Goal	Intervention	ECH	Partner	Measurement
Prevent & manage chronic disease *By promoting evidence-based care.*	Improve access to primary care through PCP recruitment / establishment of community-based health centers.	Active recruitment of PCP and addition of hospital-owned, community-based health centers.	Human Resources Department, ECH medical staff & planning staff	Essex County Public Health - to help inform Essex County residents.	Addition of one primary care provider and one additional health center by 2015. Completed – Added community-based health center in Au Sable Forks, NY
	Increase the number of patients at the ECH network of community-based health centers.	Advertising strategies, and information provided to community organizations.	ECH Marketing department	Essex County Public Health.	Increase number of newly established adult patients at all ECH health centers by 10% by 2015. Completed- As of EOY 2014, this had been increased by 26%.
	Reduce the long-term effects of diabetes on patients of the hospital's community-based health centers.	Encourage patients with diabetes to take part in training by the hospital's CDE.	Medical & other clinical staff at ECH-owned health centers.	Cornell Cooperative Extension Adirondack Medical Home Project	Increase the number of patients taking part in the program by 15% by 2015. 2015- 138 Completed
	Ensure that patients from the hospital's service area receive cardiac rehabilitation after experiencing a cardiac issue.	Encourage patients to attend cardiac rehabilitation by increasing physician referrals.	ECH medical staff ECH Manager of Outpatient Services	CVPH Fletcher Allen Health Care	Increase the number of patients that take part in the program by 15% by 2015 62 took part in 2012 2013 = 32 2014= 62 2015=60
	Ensure that qualified patients from the hospital's service area receive pulmonary rehabilitation as required.	Encourage patients to attend pulmonary rehabilitation by increasing physician referrals.	ECH medical staff ECH Manager of Outpatient Services	CVPH Fletcher Allen Health Care	Plan and develop program. Aim for 15 patients each year by 2015. Program in place 2013 = 5 participants 2014= 7 2015= 6

2. New York State Prevention Agenda indicator: Obesity

Community Health Need: **Obesity contributes to chronic disease prevalence** in Essex County. **Almost 25% of adults are obese** (2008-09); **as are 12.5% of children** (2008-10).

Priority	Goal	Intervention	ECH	Partner	Measurement
Reduce Obesity in Children & Adults *By expanding the role of health care and providers in obesity prevention.*	Increase the number of new pediatric patients at the ECH community-based health center in Elizabethtown so that they can be under a physician's care; especially with regard to achieving / maintaining a healthy BMI.	Pediatrician assesses BMI at each well child visit; offers information regarding healthy eating, portion control and snack options.	ECH Marketing department. Elizabethtown Community Health Center ECH pediatrician	Essex County Public Health. Hudson Headwaters Health Network Local schools	Newly established pediatric patients at ECHC in 2012 = 79 Increase that by 10% to 87 by 2015. New ped pts: 2013 = 115 2014= 49 2015= 72 Completed
	Improve food options served at ECH for patients. Review and alter vending options for staff and visitors, as appropriate.	Assess food choices at ECH, in terms of vending options. Also assess and alter patient meals as appropriate to ensure healthy options.	ECH planning, nursing, food service, medical director.	Local vendor. Adirondack Community Action Program	Rise in patient satisfaction scores, in terms of quality of meals. Patient satisfaction score (quality of meals) in 2012 = 72.6% 2013 = 87.6% 2014= 80% 2015= 80% Completed
	Endeavor to become a Weight Watchers site for the local communities.	Search for group leader. Enlist physician support	ECH Clinical Services & Marketing Department. Funding organization (TBD)	Weight Watchers organization. Program leader (TBD). Organization to provide funding (TBD). Various organizations to solicit participants	Track number of participants and total weight loss of participants. Have not implemented this initiative. Could not get a representative to come to this area. Many attempts and meetings were had but it was not sustainable.
	Develop an employee wellness incentive program tied to the hospital's health insurance.	Take advantage of the Blue4U program through Excellus.	ECH Human Resources	Excellus	50% staff (who receive insurance from ECH) participation in the program by 2015. Started this program as of January 2014 and still in effect. 58% of staff that take health insurance participates in the wellness incentive.

Health Disparity: Access to care

Disparity	Goal	Intervention	ECH	Partner	Measurement
Access to care *Increase access to care for those in surrounding communities in terms of both opportunity and cost.*	Increase access to primary care in communities throughout Essex County	Increase number of primary care providers. Increase number of hospital-owned health centers	Planning. Medical Director. ECH marketing	Essex County Public Health News organizations	Increase number of newly established adult patients at all ECH health centers by 10% by 2015. Completed 2014= As of EOY 2014, this had been increased by 26%.
	Host 4 health fairs each year. Offer basic health assessment at each Involve ECH staff in the health fair organized by the certified diabetes educator to offer BMI, EKG, A1C	Make referrals to physicians within (close to) the participants' home communities.	ECH medical & clinical staff. ECH Marketing department	Essex County Public Health; Essex County Office for the Aging; Fidelis; Cornell Cooperative Extension; Cancer Screening Services Program of Essex and Franklin Counties; news organizations	Increase the number of total participants by 15% by 2015. There were 100 participants in 2012 Total participants: 2013 = 95 2014= 117 2015= 110
	Increase number of patients at ECH's community-based health centers that have access to a CDE	Hire a diabetes educator; ensure that health centers are accredited.	ECH nursing & planning departments.		Establish DSME program at health centers by 2015 Hired CDE to work for ECH and take referrals from community physicians and providers as well as health centers.

Appendix F.4

Moses Ludington Hospital
Community Service Plan Update
Summary of 2015

The Moses Ludington Hospital community service plan identifies the community health needs. Moses Ludington Hospital worked toward developing strategies and tactics independently through healthcare-based initiatives and also by engaging key community partners in implementing particular strategies. Acknowledging that many organizations and resources are already in place to address certain health needs within the community, Elizabethtown Community Hospital has strategically reviewed both internal and external resources to best meet the goals of the community service plan (CSP).

Many of the strategies and activities address risk factors associated with multiple health problems. For example, strategies to reduce obesity will affect heart disease and diabetes. These strategies also might have a positive impact on mental health, as will strategies to reduce substance abuse. Some strategies and activities outlined below have been in coordination with Essex County Public Health, or other health-oriented organizations in the area. Many of these strategies aligned with those of other community-based organizations, and other stakeholders.

Moses Ludington Hospital has attempted many tactics to reduce obesity in children and adults with minimal success in 2014, and 2015. Moses Ludington Hospital also has attempted to achieve tactics related to increasing access to high quality chronic disease preventative care and management in both the clinical and community setting. It should be noted Moses Ludington Hospital has been experiencing frequent leadership position changes relate to the financial future of the organization. The organization has experienced difficult financial distress in the last three years without improvement. In addition several programs were eliminated as a cost saving measure related to the financial distress of the organization.

New York Prevention Agenda
Results for 2014-2015

Priority: Reduce Obesity in Children and Adults

Goal	Intervention	MLH	Partner	Measurement	Intervention Status	Results
Expand the role of health care and health service providers and insurers in obesity prevention.	Dietary vendor, Unidine, will develop a plan for our café whereby the nutritional values of the main meals have been calculated and are on display for customers. A healthy option entitled OHSO Good™ will be available at each meal.	Director of Support Services	Unidine Corporation	Track how many meals purchased in our café are OHSO Good™. Aim for **15%** of purchased meals are OHSO Good™ Tracked monthly through specific cash register designation.	Program started **2015 UPDATE: OHSO Good meals are offered in the Café daily. Sales are not being tracked.**	OHSO Good Tracking Log.xlsx On average for 2014, 5.2% of the meals served in our café were OHSO Good™ option.
Expand the role of health care and health service providers and insurers in obesity prevention.	Promote internally and externally the free "MyFitnessPal" application for personal electronic devices.	Director of Clinical Services	Resource: www.myfitnesspal.com	Information provided in **100%** of employee benefits packages. Information provided in **100%** of health fair carry-bags provided to guests.	MLH had a health fair on October 21, 2014 with 25 exhibitors and 60 participants. This information was not included in the carry bags. MLH held its Annual Benefits Fair on November 14, 2014. This information was not provided at that event.	**2015 UPDATE: No information provided to staff/public.**
Expand the role of health care and health service providers and insurers in	Host educational programs for parents on limiting computer and TV time and use it as a reward for family exercise time.	Public Relations Committee	Hudson Headwaters Health Network	Host two healthy lifestyles lectures.	MLH did not host any healthy lifestyles lectures in 2014. **2015 UPDATE:**	

obesity prevention.	Function as "host site" for healthy lifestyles lectures.		Essex County Public Health		**No lectures held in 2015.**	
Expand the role of health care and health service providers and insurers in obesity prevention.	Offer onsite aerobics or Zumba classes for a minimal fee.	Director of Support Services	TiNY Wellness Center	Offer aerobics or Zumba classes **1 night/week**. Track attendance.	Our partner for this initiative no longer has available instructors to offer classes on our campus. We have, however, asked if our employees could purchase reduced priced monthly memberships to the Wellness Center through our HR department. We are still working through that arrangement. **2015 UPDATE: No Classes being offered @ ILH. Discount not currently available.**	
Expand the role of health care and health service providers and insurers in obesity prevention.	Continue to offer use of our Therapy Department's gym equipment in the off-hours to employees for $5.00/month. Promote this benefit.	Therapy Department Human Resources	Moses Ludington Hospital	Provide information in **100%** of employee benefits packages. Track monthly membership. Membership tracked by Therapy Department	This benefit continues to employees. Additionally, we offer wellness gym membership to patients who have completed their outpatient rehab sessions for $5/month for three months, after which	Employee Gym Memberships 2014: Jan 11 Feb 5 Mar 6 Apr 4 May 0 June 1 July 0 Aug 5 Sept 0

					they can renew for another 3 months with physician approval. This benefit was included in the Employee Health Benefits Fair on November 14, 2014. **2015 UPDATE: This information continues to be offered to employees and rehab patients for $5/month. 2015 #'s – Employees:** **Jan. 3** **Feb. 6** **Mar. 3** **Apr. 2** **May 2** **June 2** **July 4** **Aug. 2** **Sept. 6** **Oct. 7** **Nov. 8** **Wellness:** **Jan. 21** **Feb. 20** **Mar. 20** **Apr. 23**	Oct 3 Nov 2 Dec 1 Wellness Gym Memberships 2014 Jan 11 Feb 11 Mar 12 Apr 15 May 15 June 17 July 22 Aug 20 Sept 21 Oct 18 Nov 13 Dec 15

					May 25 **June 23** **July 35** **Aug. 39** **Sept. 28** **Oct. 27** **Nov. 27**	
Expand the role of health care and health service providers and insurers in obesity prevention.	Provide Eat Smart NY information to Emergency Department patients and others.	Director of Clinical Services	Cornell Cooperative Extension	Distribute brochures in **100%** of the carry-bags provided to health fair guests.	This information was not distributed in the Health Fair carry bags. Our partner, Cornell Cooperative Extension advised their grant had expired leaving them unable to conduct community outreach. They were unable, therefore, to attend our Health Fair. **2015 UPDATE: Eat Smart New York/SNAP-Ed program representatives were at the ILH Health Fair on October 28th.**	

Priority: Increase Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings

Goal	Intervention	MLH	Partner	Measurement	Intervention Status	Results
Increase screenings rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	Undertake educational campaign promoting mammograms and other cancer screenings.	Director of Clinical Services	Cancer Services Program Essex County Public Health	Provide educational materials at annual health fair. Publish ad in local newspaper during Breast Cancer Awareness Month.	Information was provided to the public at our Health Fair. Cancer Services of Essex/Franklin Counties had a booth along with Essex County Public Health. Free mammograms were offered by the Cancer Services Program and five exams were performed that day. During October an ad was placed in the local paper, "Times of Ti" for breast cancer awareness month. **2015 UPDATE: Cancer Services and Essex County Public Health at 2015 ILH Health Fair. Free mammograms offered in partnership w/Essex County Cancer Services**	

					during October 2015 Health Fair. Ad placed in Times of Ti for Breast Cancer Awareness Month.	
Promote evidence-based care	Make referrals to the NY State Smokers' Quitline.	Director of Clinical Services	NY State Smokers' Quitline North Country Healthy Heart Network	Track number of referrals to NY State Smokers' Quitline. Query our HIS regarding cessation.	All ED patients are asked their smoking status and it is documented in our HIS. Patients identifying themselves as smokers are referred to the NY State Smokers' Quitline but we are not currently tracking those referrals. Data gleaned from our HIS for ED patients reporting changes in smoking status throughout the course of 2014:- Current Every Day Smoker →Former Smoker = 39 patients	
Promote culturally relevant chronic disease self-management education.	Invite a Pulmonologist to do a community presentation hosted by the hospital.	Administration	Fletcher Allen Healthcare Glens Falls Hospital	A Pulmonologist does a community presentation hosted by the hospital.	MLH is in talks currently with a Pulmonologist to provide services in our outpatient clinic. We have not yet arranged for a	

					community presentation. **2015 UPDATE: To date, unable to secure a Pulmonologist s for our Outpatient Clinic.**	