Executive Summary

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Introduction

The purpose of the Essex County, NY Health Community Health Assessment (CHA) 2019 and Community Health Improvement/Service Plan (CHISP) 2019-2021 is to demonstrate an ongoing understanding of the significant health needs of Essex County residents and actions necessary to address these needs.

Needs were identified through a comprehensive analysis of multi-source data, community perceptions, and a solid historical knowledge of the region, cultivated after years of interacting with individuals and families in the county by the service agencies referenced in this report.

Partnerships

Essential to the development of this assessment and planning effort was the use of a collaborative process model – the **County Health Rankings and Roadmaps** Take Action Cycle – which emphasizes communication and working together with broad representation of community sectors.

Identified as ***Essex County Health Partners (ECHP)*** are Essex County Health Department (ECHD), University of Vermont Health Network – Elizabethtown Community Hospital (UVMHN-ECH), and Adirondack Health – Adirondack Medical Center (AH-AMC). To achieve effective collaboration, ***ECHP*** frequently engaged with each other and with the Adirondack Health Institute (AHI) Adirondack Regional Health Network (ARHN), as participants of a seven (7) county multi-stakeholder coalition. ARHN's purpose is to coordinate data collection, conduct regional stakeholder surveys, inform analysis and prioritization methods, and set regional priorities and initiatives.

Essex County Health Partners maintained this effort on a scale focused in Essex County to engage local partners in further isolating trends, issues, and concerns most important to constituents. Informing this process through the expertise of a broad cross-section of representation from various sectors in the community are the members of the following six committees/coalitions: Population Health Committees at both ECH and AMC, the Public Health Advisory Committee (PHAC), Essex County Human Services Committee (sub-committee of the Essex County Board of Supervisors), Community Service Board, and the Adirondack Community Action Program (ACAP) Human Services Coalition. The longstanding relationships, ongoing communication, and collaboration on shared initiatives between the local health department (LHD), hospitals, community based organizations (CBOs), and stakeholders helped refine CHA data and led to clear asset determination and selection of partners that best fit the interventions chosen in the CHISP.

Data Sources

The data used to draw health needs conclusions and advise strategy development originated from multiple primary and secondary sources. Secondary data included a regional survey containing responses from 129 different Essex County stakeholders, launched and reviewed by ARHN, resulting in a final report evaluated by ECHP. Additional secondary data included ARHN Health Indicator and Community Profile Data Sheets, compilations and analyses of hundreds of data indicators from various sources.

Essex County Health Partners advanced a deliberative process to generate new primary data and to refine secondary data through distributed focus group surveys, community surveys, asset matrix conceptualization, and the evaluation and synthesis of reports from various local agencies. The distributed focus group initiative involved five (5) groups of stakeholders, totaling 49 individuals. The community survey garnered 354 responses, and the asset matrix categorized over 100 individual organizations, agencies, programs, or services that could be called upon to support ***ECHP*** interventions.

Locally Identified NYS Prevention Agenda Priorities & Disparities

Following an iterative process of: reviewing and analyzing the data described above; conducting a regional and local prioritization process via utilization of a matrix to flesh out need/feasibility perceptions; sharing preliminary findings and requesting follow-up input from local stakeholders and community members, a final scope emerged.

Working within the 2019-2024 New York State Prevention Agenda framework of five action areas, the following three action areas were selected by ***ECHP***:

- Prevent Chronic Disease
- Promote Healthy Women, Infants, and Children
- Promote Well Being, Prevent Mental Health and Substance Use Disorders

Disparities were identified within the CHA report for specific health indicators in Section 1 and within sub-areas of each domain of Section 2. These include, age, gender, specific geography/communities, and socio-economics.

Access to healthcare was identified as a cross-cutting disparity for Essex County residents with barriers being provider shortages, geography, and transportation.

The two remaining Prevention Agenda action areas <u>not selected</u> for CHISP integration are:

- Promote a Healthy and Safe Environment and
- Prevent Communicable Disease.

Though not captured in the CHISP, it is important to note that activities, programs, and initiatives are being delivered in these areas.

Locally Identified Interventions to Address Priorities & Disparities

The process to select strategies that address the priorities and disparities identified above occurred by leveraging existing hospital/ECHD committees, and convening priority area workgroups with other community partners.

Committees and workgroups were presented with the CHA findings, a preliminary analysis of the data relevant to the issue, and a list of potential evidence-based solutions to consider. The groups further assessed data using partner expertise gained from working within the priority area being evaluated. The discussions centered on drilling down to the true root cause(s) that lead to poor health outcomes and disparate health indicators in certain communities, groups, locations; evaluating existing assets/programs/initiatives; and selecting the strategies that are most likely to result in measurable health gains; address the disparities identified; and be implemented successfully among partners.

A summary of the CHISP interventions are listed in the tables below.

Focus Areas	Intervention	Lead	Partners
PRIORITY: CHRONIC DISEASE			
Healthy Eating & Food Security	Worksite nutrition & physical activity programs	UVHN-ECH	
	School-based obesity prevention	ECHD	Schools
	Increase the availability of fruit & vegetable incentive programs	UVHN-ECH	ECHD
	Food insecurity referral	ECHD / UVHN-ECH	AMC
Tobacco Prevention	Facilitate medical / behavioral practices in delivering tobacco treatment	NCHHN	UVHN-ECH/AMC
	Health communications & marketing to promote tobacco use treatment	ECHD / UVHN-ECH	Media
	Encourage healthcare provider involvement in patient quit attempts	NCHHN	UVHN-ECH/AMC
	Promote smoke-free housing	CVFC	
	Increase smoke-free parks/playgrounds	CVFC	
Chronic Disease Prevention & Care Management	Systems change for cancer screening reminders	UVHN-ECH/AH	
	Media to build community demand	UVHN-ECH/ECHD	Media
	Provider assessment & feedback on screening services	UVHN-ECH	
	Remove barriers to screening	UVHN-ECH	
	Access to health insurance to increase screening	UVHN-ECH	
	Improve detection of undiagnosed hypertension	UVHN-ECH	
	Promote testing for pre-diabetes/diabetes	UVHN-ECH/AH	
	Team approach to chronic disease outcomes	UVHN-ECH/AH	
	Referral for those with pre-diabetes to DPP	AH	NCHHN
	Expand access to CDSM	AH	
	Expand access to NDPP	UVHN-ECH/AH	NCHHN

Focus Areas	Intervention	Lead	Partners
PRIORITY: WELL-BEING/MENTAL HEALTH/SUBSTANCE USE DISORDER			
Promote Well-Being	Social/emotional support across a lifespan	UVHN-ECH	
	Resilience for people living with chronic conditions (LEAD)	ECHD	
	Promote inclusion, integration and competence	AH	
Mental and Substance Use Disorder Prevention	School based prevention: Life Skills Training	Prevention Team	Schools
	Trauma-informed approaches into prevention programs (BRIEF/MindUp)	EC Mental Health	
	SBIRT	UVHN-ECH	
	Integrate trauma-informed approaches and responses	UVHN-ECH	
	Availability/access to MAT	UVHN-ECH	
	Availability/access to OD reversal	AH	St. Joseph's
	Prescriber education regarding opioid guidelines/limits	AH/UVHN-ECH	
	Safe disposal sites & take-back days	AH/Alliance for Positive Health	
	Integrated nicotine / mental health treatment	AH	

Focus Areas	Intervention	Lead	Partners
PRIORITY: HEALTHY WOMEN, INFANTS, CHILDREN			
Maternal & Women's Health	Health insurance enrollment	AH	
	Reproductive goal setting in routine health visits	AH	
	Capacity and competencies of local maternal and infant home visiting programs	ECHD	
Child & Adolescent Health	Oral health messaging in programs serving WIC	ECHD	ACAP/Media
Cross-cutting WIC	Collaborate to address social determinants of WIC (Maternal Health Agenda)	ECHD	AH/UVHN-ECH

Evaluating Impact

Interventions in the CHISP include an array of strategies to improve population health for people of all ages including:

- Coalitions and other community planning efforts;
- Policy, systems and environmental changes;
- Public health marketing and campaigns;
- Outreach, education, training and technical assistance;
- Delivery of early detection and guideline-concordant health care; and
- Application of new technologies in healthcare and improved care coordination.

Examples of Process Measures included in the CHISP are:

- Number of trainings provided
- Number of media campaigns & engagement
- Number of policies revised and updated
- Number of health practices screening and referring
- Number of smoke-free housing unit, parks and playgrounds
- Implementation of updated guidance related to priority areas
- Implementation of new technologies for care delivery
- Number of programs offered & residents served

Essex County Health Partners and the community-based organization partners engaged in the planning of the CHISP have pledged on-going commitment to the health and well-being of Essex County residents. Minimally, ***Essex County Health Partners*** will meet quarterly to:

- assess progress on activities,
- identify barriers to the implementation of activities, and
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success.

The Lead Partner for each activity will document progress through quarterly work plan updates and a representative of ***Essex County Health Partners*** will submit a quarterly update to NYSDOH.