PART III: COMMUNITY HEALTH IMPROVEMENT/SERVICE PLAN 2019-2021

Executive Summary

PART I: Introduction

PART II: Community Health Assessment 2019

PART III: Community Health Improvement/Service Plan 2019-2021

PART IV: Dissemination Plan

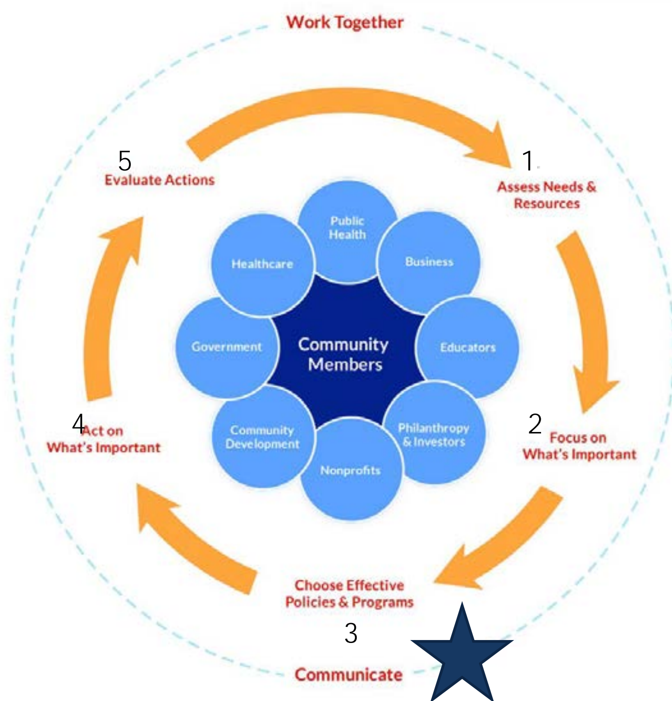
Part V: Appendices

Continuation of the Take Action Cycle

Part I, the Introduction and Part II, the Community Health Assessment, provide the basis for Part III, the Community Health Improvement/Service Plan (CHISP).

Selecting interventions and identifying appropriate lead and partner organizations would not be possible without a sound understanding of the county profile, health data, social determinants of health, and assets and challenges that the health of the region is predicated upon. A CHISP that results in collective progress and measurable health improvements is rooted in this foundational work.

Take Action Cycle



Take Action Cycle Steps 3-5 are included in this Part III: CHISP of the full report.

Step 3: Choosing Effective Policies & Programs

Planning was informed through long-standing relationships between ECHD, hospitals, community based organizations and stakeholders. This includes ongoing collaboration and communication directly between and among community based partners and stakeholders.

The process to select strategies that address the three (3) priorities and disparities occurred through the convening of Priority Area Workgroups with other community based organizations/partners.

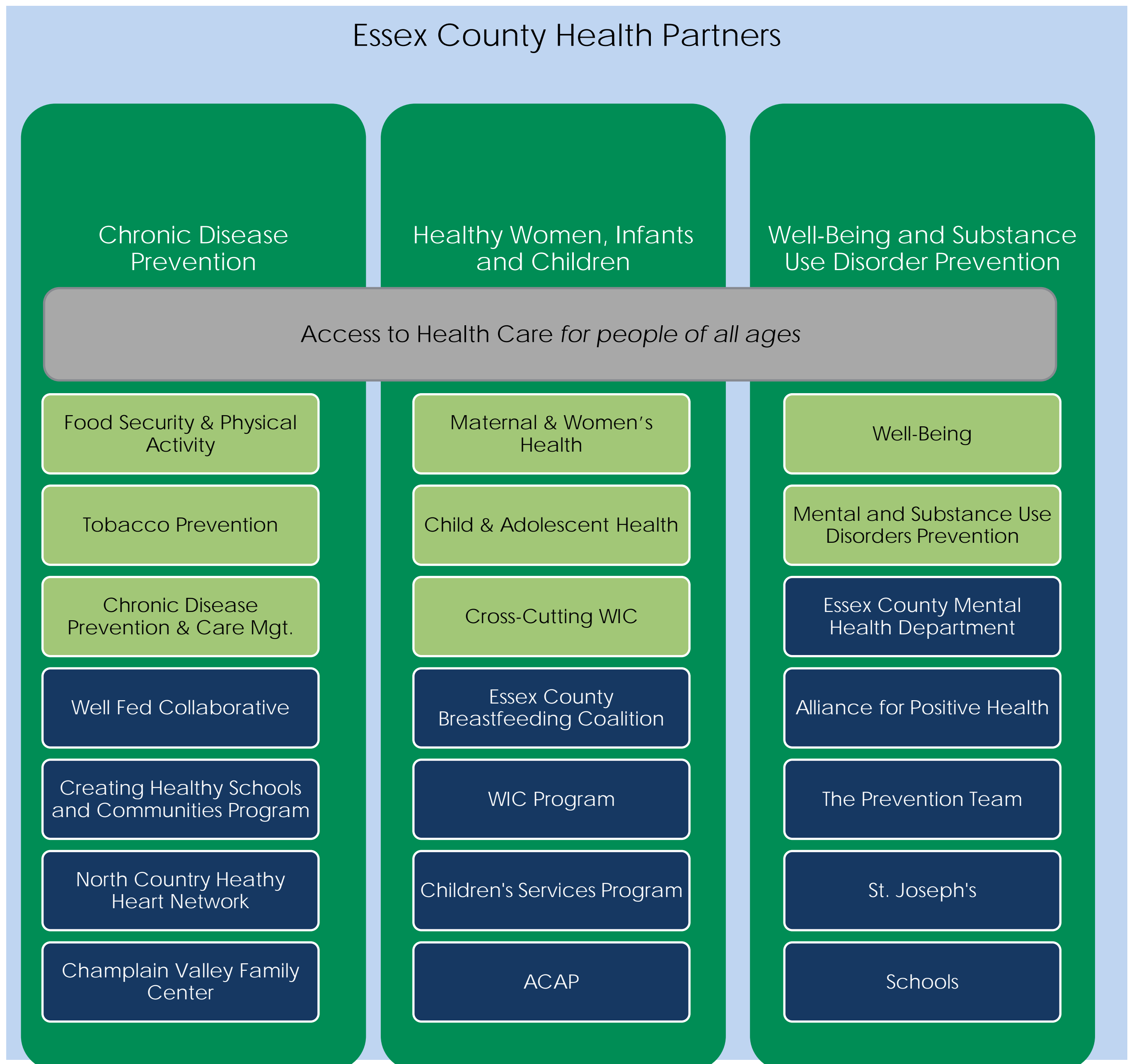
Workgroups started with a sound understanding of the county profile and considered:

- Data leading to these the priority areas
- Disparities experienced by sub-categories of populations within these priority areas
- Social Determinants of Health contributing to priority outcomes and disparities
- Evidenced-based interventions as directed by NYDOH Prevention Agenda
- Assets that may be mobilized to address health needs
- Lead organizations for specific interventions and community based partners essential to intervention success

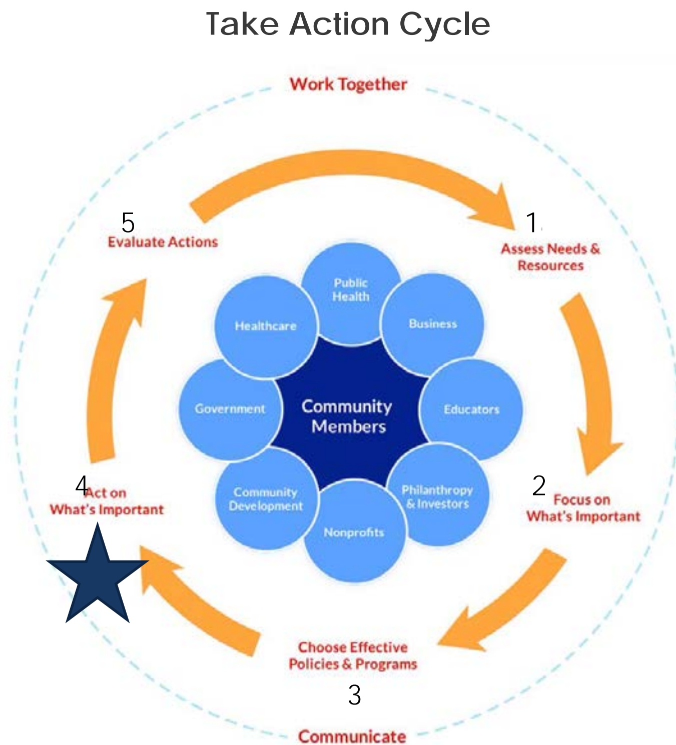
Workgroups further assessed data with partner expertise gained from working within the priority area. Discussions centered on:

- drilling down through contributing factors 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.

The graphic on the following page depicts that Essex County Health Partners (in light blue) oversaw the identification of three (3) health priorities (in green) and focus areas (in light green) with the cross-cutting disparity of Access to Healthcare (in grey). It also demonstrates the engagement of community based organizations, programs and partners (in dark blue) in the development of interventions.


Essex County Health Partners
Chronic Disease Prevention
Healthy Women, Infants and Children
Well-Being and Substance Use Disorder Prevention
Access to Health Care for people of all ages
Food Security & Physical Activity
Tobacco Prevention
Chronic Disease Prevention & Care Mgt.
Well Fed Collaborative
Creating Healthy Schools and Communities Program
North Country Heathy Heart Network
Champlain Valley Family Center
Maternal & Women's Health
Child & Adolescent Health
Cross-Cutting WIC
Essex County Breastfeeding Coalition
WIC Program
Children's Services Program
ACAP
Well-Being
Mental and Substance Use Disorders Prevention
Essex County Mental Health Department
Alliance for Positive Health
The Prevention Team
St. Joseph's
Schools

Step 4: Acting on What's Important



Interventions in this CHISP include an array of strategies to improve population health 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.

The following elements are included in the CHISP Work Plan (Attachment 10).

NYSDOH Prevention Agenda Identified:

- Priority
- Focus Area
- Goal

Locally Identified:

- Objectives
- Disparities
- Interventions
- Family of Measure for Evaluation
- 3 Years of Planned Activities
- Partners
- Partner Roles and Resources.

Examples of Process measures included:

- Number of trainings provided
- Number of media campaigns and 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
- Number of programs offered and residents served

A summary of the CHISP interventions are listed in the tables following. These tables demonstrate the commitment of ***Essex County Health Partners*** and community based organizations in both taking the lead with interventions and working collaboratively on interventions.

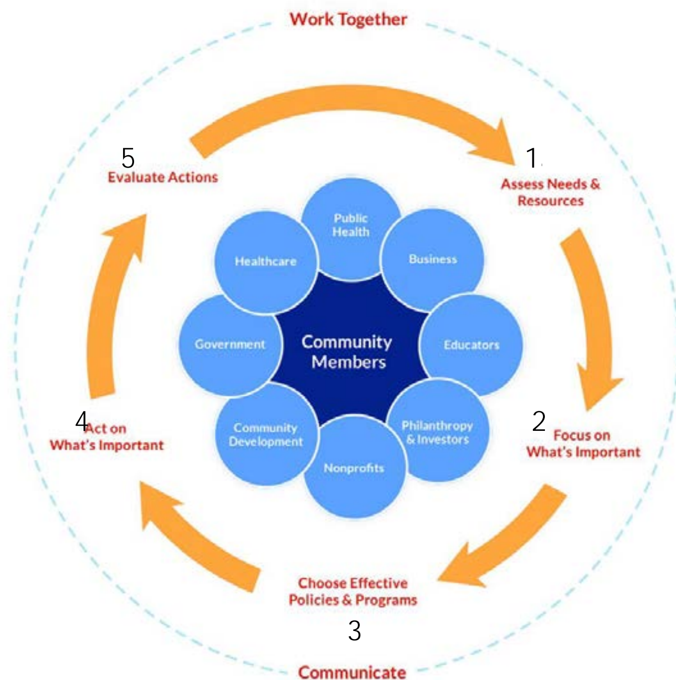
Priority and Focus Areas	Intervention	Lead	Partners
CHRONIC DISEASE			
Healthy Eating & Food Security	Worksite nutrition & physical activity programs	UVHN-ECH	
	School-based obesity prevention	ECHD	Schools
	Increase the availability of fruit & vegetable incentive programs	UVHN-ECH	ECHD
	Food insecurity referral	ECHD / UVHN-ECH	AMC
Tobacco Prevention	Facilitate medical / behavioral practices in delivering tobacco Tx	NCHHN	UVHN-ECH/AMC
	Health communications & marketing to promote tobacco use Tx	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

Priority and Focus Areas Focus Area	Intervention	Lead	Partners
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 Tx	AH	

Priority and Focus Areas Focus Area	Intervention	Lead	Partners
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

Essex County Health Partners will share the CHISP with the ARHN Forum to facilitate regional planning and identification of additional regionally-based activities.

Step 5: Evaluating Actions



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 activities through work plan (Appendix 10) updates on a quarterly basis.

A representative of ***Essex County Health Partners*** will submit a quarterly update to NYSDOH.

Description of these Steps 3-5 of the Take Action Cycle concludes this Part III: Community Health Improvement/Service Plan (CHISP) 2019-2021 of the full report.