Essex County Public Health

Community Health Improvement Plan

2014-2017

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Introduction

ESSEX COUNTY PUBLIC HEALTH
is a Local Health Department
of NYS Department of Health &
Essex County, NY Government.

Join us as we continue our mission to support the health of our communities by promoting health and preventing disease, injury, and disability.

Public health may best be described by field pioneer, Charles-Edward Winslow as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals."

In collaboration with our partners we have developed this **Community Health Improvement Plan (CHIP)** based on our ***Community Health Assessment—Essex County, NY 2013 (CHA)***.

Community Health Assessment Synopsis and Priorities

Essex County is located in the North Country region of New York State and completely within the Adirondack Park. We enjoy the largest share of tourism dollars in the North Country with a long history of being a haven for pure air and starry skies, striking mountains, rambling rivers and serene lakes.

We are the second most geographically large and third least densely populated county in NY. Our population is distributed in community pockets of 18 towns and 4 villages surrounded by large spans of public and private lands and water. Our population is aging with decreasing numbers of children and young adults.

A succinct community profile description of findings documented in our ***CHA*** identified challenging characteristics of our county all of which play a role in the health of our population- aged or lacking public infrastructure and broadband availability; health care provider shortages; and lower education and income attainment levels.

The ***CHA*** also details population data in a Dashboard of Health Indicators including the broad categories:
Improve Health Status & Reduce Disparities;
Promote a Healthy & Safe Environment;
Prevent Chronic Diseases;
Promote Healthy Women, Infants & Children;
Prevent HIV/STDs, Vaccine Preventable Diseases & Healthcare Associated Infections;
Promote Mental Health and Prevent Substance Abuse.

Identified Priorities and disparities are:

Prevent Chronic Disease:

1. Reduce obesity in children & adults.

2. Increase access to chronic disease preventive care and management in clinical & community settings.

Disparities: Income and Access to Care.

Taking Action

This plan follows the **Take Action Cycle**[1] designed with the understanding that each community has its own unique set of resources and capacities, and acknowledging that improving community health requires people from multiple sectors to work collaboratively on a variety of activities to achieve a common goal – improving the health of our citizens.

Everyone has a role to play in improving the health of communities. As we move from data to action, it's critical that diverse stakeholders are engaged as we can yield better results working together.

We invite you to join us on our journey by participating in some capacity to address the focus areas within the plan so that we can improve the health of individuals, families, and our community.

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[1] Robert Wood Johnson Foundation. County Health Rankings and Roadmap. Take Action Cycle. Retrieved from http://www.countyhealthrankings.org/resources/take-action-cycle

Working Together & Communicating

Essex County Public Health (ECPH) has been engaged with collaborative community health planning facilitated by Adirondack Rural Health Network (ARHN) since 2002. ARHN facilitates regional health planning through the Community Health Planning Committee (CHPC) that includes stakeholders from the eight county region of Essex, Clinton, Franklin, Fulton, Hamilton, Saratoga, Warren and Washington Counties.

Representatives include each local health department, hospitals and community based organizations. A complete CHPC list of representatives may be found in the ***CHA*** *Appendix B*. Essex County partners are Essex County Public Health, Adirondack Health, Elizabethtown Community Hospital & Inter-Lakes Health.

The ARHN provides neutral guidance and technical assistance through which key stakeholders throughout the region can plan, facilitate and coordinate the activities necessary to complete their required community health assessment and planning documents, and strategize on a regional level to address common health care concerns.

The group is further comprised of subcommittees developed to address areas specific to hospital, public health and data-specific requirements. Regular meetings of each subcommittee and the full CHPC have resulted in a systematic approach to community health planning and the development of local and regional strategies to address health care priorities.

Collaboration and communication are essential components of advancing population health improvement strategies. Partners are identified throughout this report in the pages that follow. ECPH will remain a CHPC member and take advantage of facilitated discussions provided through ARHN. ECPH will also maintain its role of facilitator or participant in committees, task forces and the like through formal and information communication.

ECPH will distribute this plan through mailing and notice of web availability to:

- New York State Department of Health (NYS DOH)
- Essex County Public Health Advisory Committee
- Rural Health Networks and other locally operating NYS DOH or federally funded programs
- Local Government – County Manager, Board of Supervisors
- Hospitals and Other Health Care Providers
- Schools and libraries
- Community Based Organizations – such as those identified as Partners in the Plan and/or members of the Healthy Communities Coalition of Essex County.

Assessment Process

ECPH participated in data planning, collection and analysis conducted through an 8-county collaborative process facilitated by ARHN.

The Community Health Planning Committee (CHPC) formally met 5 times in 2012 and 4 times in 2013. A complete list of CHPC partners and meeting schedules may be found in the ***Community Health Assessment-Essex County, NY 2013*** Appendix B. Essex County Public Health and Hospital partners (Adirondack Health, Elizabethtown Community Hospital and Inter-Lakes Health) met an additional 4 times in 2013.

Subcommittees of the CHPC included Public Health, Hospital, Data, and Survey. Both Public Health and Hospital subcommittees met to review requirements and progress, develop templates and network. The Data subcommittee was responsible for quantitative data collection; the Survey for qualitative data collection. Resources and Asset data was collected at the local level.

Quantitative Data

The Center for Health Workforce Studies at the University at Albany School of Public Health was subcontracted by ARHN and the CHPC to assist in quantitative data collection. Multiple state and national sources were used and local data was included as supplemental data in the CHA. This subcommittee was also responsible for providing/recommending a prioritization tool that members could elect to use.

Qualitative Data

The Center for Human Services Research at the University at Albany School of Public Health was subcontracted by ARHN and the CHPC to assist in community input through qualitative data collection. A stakeholder survey was developed and conducted throughout the 8-county region where CHPH members identified local stakeholders. Representatives of health care, service providing agencies and other community based organizations were asked for input on overall needs and priorities

All data combined was used in informing priorities, goals, objectives and interventions.

Prioritization Process

The CHPC agreed that due to the large area of the 8-county region it would be most beneficial to allow counties and their hospital partners to examine the data and address prioritization at a more local level. Local health departments used county boundaries and hospitals used their service areas to determine with which county or counties they would select priorities.

Community Stakeholder Discussion Meetings

Data presentations and community stakeholder discussion meetings were conducted 6 times during 2013 to present data, collect additional input and assess partnership commitment in addressing potential priorities.

Inter-Lakes Health Community Forum	May 2, 2013
Community Services Board Annual Retreat	May 8, 2013
Healthy Communities Coalition of Essex County	June 11, 2013 & September 10, 2013
Essex County Human Services Coalition	July 11, 2013
School Nurse In-service	October 8, 2013

Essex County Public Health and Hospital Partners Meetings

ECPH and hospital partners met 4 times in 2013 (June 4; July 23, 2013; July 31; and August 21) to review data, discuss community stakeholder input and use the prioritization tool described below to establish priorities.

Prioritization Tool

The prioritization tool developed by the Data subcommittee allowed for prioritization of the Focus Areas of the Prevention Agenda. Weighted scores ranging from 0.5-2.0 were applied to eight (8) items in three (3) scoring categories: Need, Feasibility and Impact. The 8 items included: quartile/severity score; stakeholder survey; perceived need for additional resources; funding availability; evidenced-based intervention availability; stakeholder capacity to implement interventions; effectiveness of current strategies; and whether multiple health benefits may be achieved through intervention.

Prioritization Rationale

Final priority scores as completed by the Essex County group ranged from 8-46. ECPH and hospital partners used stakeholder discussion meeting input, the prioritization worksheet, and professional knowledge to select priorities. The completed ARHN Prioritization Worksheet may be found in the ***CHA*** *Appendix I*.

Preventing Chronic Disease included the highest priority scores of the Prevention Agenda areas.

Reducing obesity in children and adults had the highest priority score (46).

Increasing access to chronic disease preventive care and management in clinical & community settings had the second highest priority score (39).

Income and Access to Care were identified disparities in Essex County.

Other focus areas also had high priority scores though were not selected for reasons described below.

- Built Environment
- Tobacco Use & Secondhand Smoke Exposure
- Healthy Mothers, Infants & Children
- Substance Abuse and Mental, Emotional, & Behavioral Health

Built Environment is addressed in this Plan under the first priority and objective of creating community environments that support physical activity (see page 11).

Tobacco Use and Second Hand Smoke Exposure was not selected as partners believed evidenced-based interventions to be employed to the fullest extent possible given existing and shrinking resources.

Maternal and Infant Health was not selected as hospital partners did not identify appropriate interventions best fitting their capacities and given the strong ECPH Maternal and Child Health program.

Promoting Mental Health and Substance Abuse was not selected due to lack of knowledge of existing activities/interventions and the identified need for capacity building in this area before appropriate interventions could be identified with partners.

This Plan briefly addressed goals and objectives for these areas on pages 22-25.

Priorities

Chronic Disease Prevention

1. Reduce obesity in children & adults.

2. Increase access to chronic disease preventive care and management in clinical & community settings.

Disparities: income and access to care.

1. Reduce obesity in children and adults; and

	Public Health	Hospitals
Goal 1.1: Create **community environments** that promote and support healthy food and beverage choices and physical activity.	x	
Goal 1.2: Prevent childhood obesity through **early child-care and schools**.	x	
Goal 1.3: Expand the role of **health care and health service providers** and insurers in obesity prevention.	x	x
Goal 1.4: Expand the role of **public and private employers** in obesity prevention.	x	x

2. Increase access to high quality chronic disease preventive care and management in clinical & community settings.

	Public Health	Hospitals
Goal 2.1: Increase **screening rates** for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	x	x
Goal 2.2: Promote **evidence-based care** to manage chronic diseases.		x
Goal 2.3: Promote culturally relevant **chronic disease self-management education**.	x	x

Choosing Effective Policies & Programs

Choosing effective interventions for Essex County were based on these considerations:

- using recommendations described in the New York State Prevention Agenda
- availability of evidenced-based or promising practices;
- existence of community assets (resources & programs);
- collaboration partners (existing or potential);
- targeting multiples levels of the Health Impact Pyramid[2]; and
- engaging multiple Sectors of the Public Health System.

Acting on What's Important

This Plan covers 2014-2017 with some intervention efforts already underway and others that start throughout the 2014-2017 timeframe.

The following pages describe in detail Essex County's plan for action –priorities, addressing disparities, goals, objectives, partners and performance measures.

Baseline percent/rates are those found in the ***CHA***. Targets are set based on benchmark data availability: 2017 Prevention Agenda Benchmark > Upstate NY > New York (NY) State.

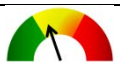
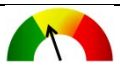
[2] The Health Impact Pyramid is a 5-tiered display describing the potential level of impact for public health interventions. Interventions focusing on lower levels of the pyramid have broader impact and tend to be more effective. Implementing interventions at each of the levels is recommended to achieve maximum and sustained public health benefit.
Frieden, TR. A framework for public health action: the health impact pyramid.
Am J Public Health. 2010 April; 100(4): 590–595. doi: 10.2105/AJPH.2009.185652
Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/

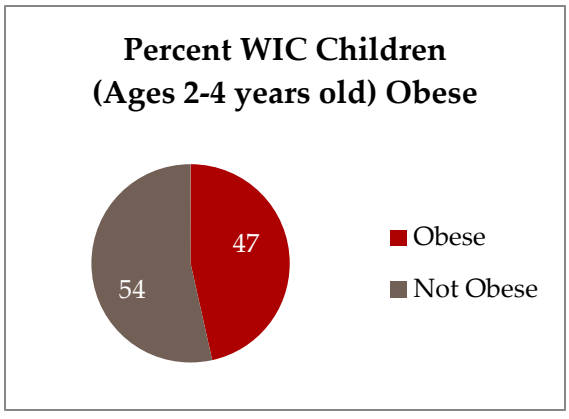
Defining the Problem

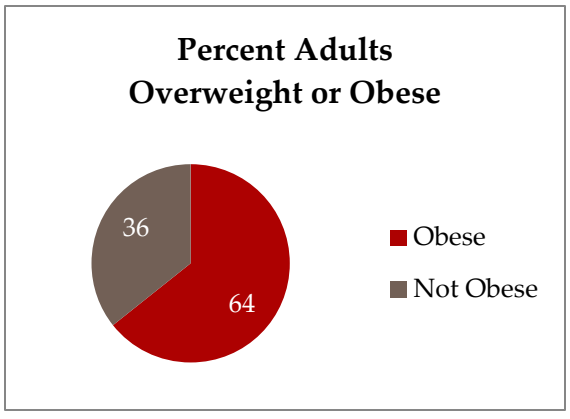
Obesity and overweight is the second (to tobacco) leading cause of preventable death in the US with significant impacts on quality of life and longevity.[3]

Increased health care expenditures attributed to overweight and obesity are well documented. Overweight and obesity are strongly correlated with other chronic conditions such as diabetes, cardiovascular disease, cancers and asthma. Equally important are the negative emotional and social experiences that frequently accompany overweight and obesity.

Essex County has higher percentages of obesity for all groups compared to benchmarks as demonstrated in the table and graphs below.

	Comparison Essex to Benchmark	Essex County % or Rate	Benchmark % or Rate	Benchmark Source
Weight/Obesity				
Percent of WIC Children Ages 2-4 Obese '08/'09		46.5%	45.7%	Upstate NY
Percent of Public School Children Obese '10-'12		18.8%	16.7%	Prevent NY
Percent of Age Adjusted Adults (Ages 18+) Overweight or Obese '08/'09		64.3%	59.3%	NY State
Percent of Adults (Ages 18+) Obese '08/'09		24.9%	23.0%	Prevent NY





[3] New York State Department of Health. Prevention Agenda. Retrieved from http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/focus_area_1.htm#sector

Overarching Objectives

Overarching objectives are based on those described in the NYS DOH Prevention Agenda.[4]

Baseline percentages for Essex County and targets percentages are based on data collected and found in detail in the ***Community Health Assessment – Essex County, NY 2013***.

Reduce the percentage of children who are obese

- among WIC children (ages 2-4 years) from 46.5% baseline to 45.7% (Upstate NY benchmark);
- among public school children from 18.8% baseline to 16.7% (Prevention Agenda benchmark).

Reduce the percentage of adults ages 18 years and older who are overweight or obese
from 64.3% baseline to 59.3% (NY State benchmark).

Reduce the percent of adults ages 18 years and older who are obese
From 24.9% baseline to 23.0% (Prevention Agenda benchmark).

Goal Specific Objectives

The reduction of the percent of children and adults who are overweight or obese will be addressed through goal specific objectives in four categories:

- **Community Environments**
- **School Environments**
- **Health Care Settings**
- **Public and Private Employers**.

For each of these goal specific objectives targets, partners and performance measures are described in the following pages.

Additional Interventions displayed using the Population Pyramid are activities that Essex County Public Health and community partners expect to use as resources permit. Specific measurements are not set for these interventions.

[4] New York State Department of Health. Prevention Agenda 2013-2017. http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Goal 1.1 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.*				
Objectives	Baseline	Target	ECPH Program/Staff & Partners	Performance Measure
1.1.a Increase visibility and access to affordable, nutritious foods and/or beverages through store layout and displays.	Unknown	2	Creating Healthy Places Coordinator Corner stores/other food outlets Cornell Cooperative Extension/ Adirondack Harvest Farmers Media	Assess the number of store layout and displays by December 2014 Target stores, create change and re-assess 2015-2017
1.1.b Increase the number of municipalities that have passed local complete streets • Resolutions or policies • Land use planning • Projects • Education & encouragement activities.	6	8	Creating Healthy Places Coordinator Senior Public Health Educator Essex County Healthy Communities Coalition Community Resources/Planning DPW Transportation Town Planning, Zoning & Full Boards Trail Groups Media	Document existing complete streets policies and practices by December 2014 Develop a method to assure communication and practice of existing policies 2014-2015 Share policy templates with all municipalities by December 2014 Target communities with which to develop policies and practices by December 2015 Conduct on-going assessment of policies and practices 2014-2017

Goal 1.2 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.*				
Objectives	Baseline	Target	ECPH Program/Staff & Partners	Performance Measure
1.2.a Increase the number of school districts that have policies that meet or exceed the Institute of Medicine recommendations for • competitive foods or • sugar sweetened beverages.	Unknown	2	Senior Public Health Educator Essex County Public Schools Healthy Schools NY Coordinator	Assess the number of districts with such policies & practices by June 2015 Target districts by June 2016 Continue working with districts to develop policies and practices 2016-2017
1.2.b Increase the number of school districts with wellness policies that support multiple opportunities for physical activity such as through: • Physical Education classes • active recess; • walking/bicycling to and from school.	Unknown	2		

Goal 1.3

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.*

*** Related data is found in the CHA 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.

Objectives	Baseline	Target	ECPH Program/Staff & Partners	Performance Measure
1.3.a Increase the percentage of infants born in hospitals who receive any breast milk in delivery hospital.*	69.3%	71.0%	Maternal & Child Health Program Hospitals Providers	Assess hospital policies and commitment to breastfeeding by December 2014 Develop policies & re-assess 2015-2017
1.3.b Increase the percent of WIC women who breastfeed at 6 months.**	20.0%	39.7%	WIC Program Maternal & Child Health Program Media	Develop breastfeeding promotion strategy for pregnant women by December 2017 Implement & re-assess strategy 2015-2017
1.3.c Increase the number of provider practices that use electronic health records to cue for counseling for overweight and obesity.	Unknown	1	Pediatric Obesity Grant Coordinator Senior Public Health Educator Health Centers Providers	Assess practices using EHR to screen & counsel by December 2015 Initiate EHR policies and practices 2015-2017

Goal 1.4 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.*		
Objectives	ECPH Program/Staff & Partners	Performance Measure
1.4.a Establish a Learning Collaborative (LC) around organizational nutrition to build knowledge and practices of evidenced based strategies that create healthy food and beverage policies, systems & environments including • structure for LC; • platform to host (such as a web-based location to collect and share resources); & • an increase by at least two (2) the number of organizations that have adopted a policy or practice (such as food procurement, preparation and vending policies) that support healthy food and beverage environments.	Senior Public Health Educator Hospitals Residential health care facilities Group residential homes (The ARC) Vending companies ACAP Hudson Mohawk Area Health Education Center (AHEC) ARHN Local Health Departments NYS DOH	Initiate Learning Collaborative by December 2014. Identify areas of work in which partners are interested by June 2015. Define the structure for the LC by June 2015. Rolled out the platform and initiate partner use by December 2015. Define targeted organizations, policies & practices by December 2015. Adopt & refine policies & practices 2016-2017.

Additional Interventions

Health Impact Pyramid Level	Reduce Obesity in Children and Adults - Interventions
Counseling & Education	Assure access to breastfeeding education and lactation counseling and support.
	Increase awareness of poor nutrition, lack of physical activity and obesity as risk factors for chronic disease.
	Refer to programs, providers and services that support healthy eating and active living.
	Host, co-host and/or promote educational programs (such as a screening of the PBS Weight of the Nation program at area hospitals, schools or other venues).
Clinical Interventions	Promote • and/or provide education, training and technical assistance for health care service provider capacity to implement prevention, screening & treatment for overweight & obesity in clinical settings; • adoption of Great Beginnings/Baby-Friendly breastfeeding policies in hospitals.
Long-Lasting Protective Interventions	Promote • educational opportunities for administration and food service workers on nutrition & wellness.
	Provide education, training and technical assistance for • institutions, communities or others that have integrated policies and practices that promote obesity prevention; • streetscapes and community designs that are conducive to physical activity; • community gardens; and • organizational adoption of healthy food and beverage policies and practices.
	Advocate for • funding and/or provide technical assistance for trails, complete streets, safe routes to school and active transportation infrastructure and programs; and • funding allocation to maintain or improve parks, trails, recreation facilities and active transportation infrastructure.

Changing the Context to make individuals' decisions healthy	Use social marketing messages (such as through Facebook) to promote breastfeeding, nutritious eating & active living as norms.
	Promote • availability and benefits of farm-fresh produce at farms, farm stands and farmers markets; • availability and use of parks, trails, recreation areas and other fitness venues.
	Provide technical assistance for [and promote] • the adoption of lactation accommodation policies at worksites and other public venues; • the adoption of food and beverage policies and practices in organizations and residential facilities; • community advocates for healthy environments, opportunities for physical activity and access to healthy food choices; • the establishment of joint use policies to improve access to public places to be physically active.

Socioeconomic Factors	Maintain and/or expand public-private partnerships and community mobilization efforts that directly or indirectly support obesity prevention.
	Pursue creating a food hub for locally-grown and produced goods.

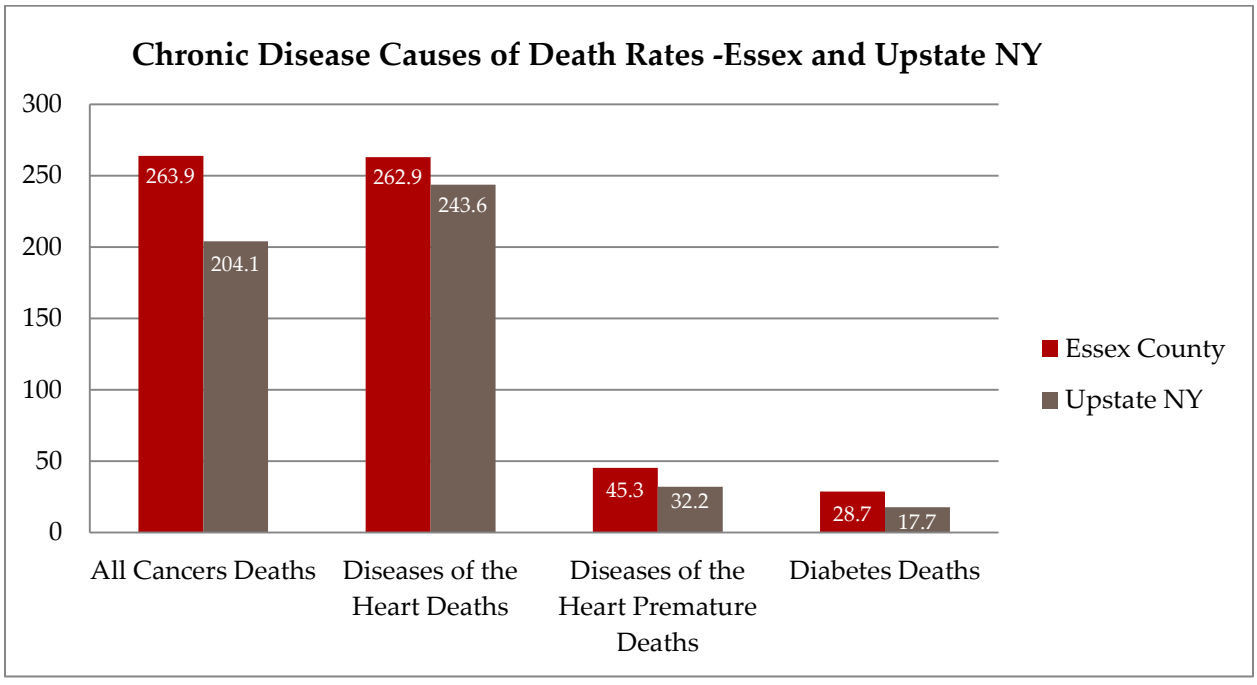
Partners

Essex County Public Health
Clinton County Public Health –
Pediatric Obesity Grant Program;
Healthy Schools NY Grant Program
Adirondack Community Action Program
Cornell Cooperative and Adirondack Harvest
WIC
Providers
Hospitals
Day Care Providers
Schools
Farmers Markets
Corner stores/other small food outlets
Employers
Essex County
Healthy Communities Coalition
Community Resources/Planning
DPW
Transportation
Town Planning, Zoning & Full Boards
Media
NYS DOH

Defining the Problem

Cancer is the leading cause of death in Essex County followed closely by heart disease. Rates for cancer, heart disease, and diabetes hospitalizations and premature deaths are higher in Essex County than benchmarks as demonstrated in the table below. The figure below shows chronic disease causes for death in Essex County as compared to Upstate NY.[5]

	Comparison Essex to Benchmark	Essex County % or Rate	Benchmark % or Rate	Benchmark Source
Chronic Diseases				
Rate of All Cancer Deaths (/100K) '07-'09		263.9	204.1	Upstate NY
Rate of Diabetes Deaths (/100K) '08-'10		28.7	17.7	Upstate NY
Rate of Diseases of the Heart Premature Deaths (Ages 35-64) (/100K) '08-'10		45.3	32.2	Upstate NY



[5] Essex County Public Health. ***Community Health Assessment-Essex County, NY 2013***

Living health-fully supports quality of life and longevity potential. Improved nutrition, adequate activity levels, healthy weight and tobacco-free living can prevent chronic conditions and improve outcomes for those diagnosed with a chronic condition. Objectives and interventions as described in the obesity prevention priority above will have a positive impact on chronic disease indicators.

Additionally, screening tests, preventive care and case management are important means of early detection and best management for chronic conditions. Essex County falls below benchmarks for many screenings and preventive care related to cancer, cardiovascular, heart disease and diabetes. Clinical care and management and community based supports are necessary to support individuals living with chronic conditions to best manage their condition and improve their quality of life.

Overarching Objectives

Overarching objectives are based on those described in the NYS DOH Prevention Agenda.

Baseline percentages for Essex County; targets percentages in this section are all based on the Upstate NY benchmark as found in the ***Community Health Assessment-Essex County, NY 2013***.

Reduce the rate of All Cancer deaths (/100K) from 263.9 baseline to 204.1.

Reduce the rate of Diseases of the Heart deaths (/100K) from 262.9 baseline to 243.6.

Reduce the rate of Diseases of the Heart premature deaths (ages 35-64) (/100K) from 45.3 baseline to 32.2.

Reduce the rate of Diabetes deaths (100K) from 28.7 baseline to 17.7.

Goal Specific Objectives

Increasing access to chronic disease preventive care and management will be addressed through goal specific objectives in two categories:

- **Screening**
- **Self-management education.**

For each of these goal specific objectives targets, partners and performance measures are described in the following pages.

Additional Interventions displayed using the Population Pyramid are activities that Essex County Public Health and community partners expect to use as resources permit. Specific measurements are not set for these interventions.

Goal 2.1 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.*				
Objectives	Current	Objective	ECPH Program/Staff & Partners	Performance Measures
2.1.a Increase percent of breast cancer (mammography) screening within the last 2 years *for those without health insurance*	79.5% unknown	79.7% NY State By ≥5%	Cancer Screening Coordinator Providers Hospitals Media	Develop outreach plan by December 2014 Annually re-assess outreach plan 2014-2017 Annually track participation 2014-2017
2.1.b Increase the screening percentages for colorectal cancers (through sigmoidoscopy or colonoscopy) within the last 10 years *for men & women without health insurance*	59.1% unknown	62.9% Upstate NY By ≥5%	Cancer Screening Coordinator Providers Hospitals Media	Develop outreach plan by December 2014 Annually re-assess outreach plan 2014-2017 Annually track participation 2014-2017

Goal 2.2 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.*				
Objectives	Current	Objective	ECPH Program/Staff & Partners	Performance Measures
2.3.a Develop promotion plan for existing chronic disease self-management (CDSM) opportunities (diabetes self-management, living with a chronic condition, others) and assure on-going opportunities.	Unknown	3	Senior Public Health Educator Eastern Adirondack Health Care Network Cornell Cooperative Extension Hospitals Providers Office for the Aging Adirondack Rural Health Network	Identify existing opportunities by June 2014 Develop a plan to bridge gaps by December 2014 Use the CDC 1-2-3 Approach to Provider Outreach to engage providers in referrals to CDSM opportunities Assure ongoing opportunities & initiate promotion plan 2014-2017
2.3.b Develop promotion plan for existing internet (web or phone) application self-management support systems and promote systems.	Unknown	1	Senior Public Health Educator Eastern Adirondack Health Care Network Cornell Cooperative Extension Hospitals Providers Office for the Aging Adirondack Rural Health Network	Research existing web and phone app. self-management support systems by December 2014 Develop promotion plan by December 2015 Implement promotion plan 2016-2017

Additional Interventions

Health Impact Pyramid Level	Interventions
Counseling and Education	Promote • Importance of mammography, colonoscopy & other cancer screenings • web based and phone application opportunities for individuals to individually manage their chronic condition(s) • face-to-face chronic disease self-management opportunities
Clinical Interventions	Explore the use of electronic health records to aid providers in addressing chronic disease screenings and self-management care.
Long-Lasting Protective Interventions	Collaborate with providers to • assure providers are aware and practicing screening guidelines for chronic conditions • refer to chronic disease self-management opportunities and other community resources
	Collaborate with chronic disease self-management providers, community based organizations and others to • identify underserved groups and improve access to screening and chronic disease self-management opportunities • assure chronic disease self-management opportunities use health literacy guidelines and culturally appropriate materials
Changing the Context to make individuals' decisions healthy	Promote importance of and opportunities for • ways to prevent chronic conditions • chronic disease screenings • chronic disease self-management
	Promote • Recommended screenings for chronic conditions • Self-management opportunities
Socioeconomic Factors	Maintain and/or expand public-private partnerships and community mobilization efforts that directly or indirectly support chronic disease prevention and care.

Partners

Essex County Public Health
Cancer Screening Program
of Franklin & Essex Counties
Eastern Adirondack Health Care Network
Adirondack Rural Health Network
North Country Asthma Coalition
Hospitals
Providers
Cornell Cooperative Extension
Essex County Human Services Coalition
Media
New York Academy of Medicine-Designing a Strong and Healthy NY (NYAM-DASH)
NYS DOH

As described earlier in this report, the following additional four focus areas were identified as areas of need in Essex County. They are included here to allow this Plan to serve as a working document for all community stakeholders such that recommended goals, objectives and strategies may be identified, shared and targeted by stakeholders to improve population health.

Built Environment

The Prevention Agenda area of Promoting a Healthy and Safe Environment includes core areas impacting health such as the air we breathe, water we drink, the built environment, injuries and occupational health. Addressing the built environment will contribute other priorities (obesity and chronic disease prevention) described in this Plan.

Goals and Objectives

Improve the design and maintenance of the built environment to promote healthy lifestyles, sustainability and adaptation to climate change by:

- increasing the number of Towns that have taken the *Climate Smart Communities* pledge;
- increasing the number of communities that have some written form of commitment to pedestrian and bicycle infrastructure such as through complete streets resolutions or policies, comprehensive plans, zoning ordinances, etc.
- improving pedestrian and bicycling access, infrastructure and networks, especially in low-income communities; and
- improving access to affordable fruits and vegetables especially in low-income communities.

Partners

Essex County Public Health
Essex -County Department of Public Works
Essex County Department of Transportation
Essex County IDA
Essex County Office of Community Resources; Planning
Healthy Communities Coalition of Essex County
Towns – Supervisors; Boards; Planning Boards
Cornell Cooperative and Adirondack Harvest
Day Care Providers
Schools
Farmers Markets
Corner stores/other small food outlets
Employers
Media
NYS DOH

Tobacco Use and Secondhand Smoke Exposure

Tobacco use and second hand smoke exposure falls under preventing Chronic Diseases. It remains the number one actual cause of death in the US and remains a concern for Essex County residents. Essex County Public Health is committed to collaborating with partners to meet the New York State Prevention Agenda goals and objectives.

Goals and Objectives

Prevent initiation of tobacco users by youth and young adults, especially among low socioeconomic status (SES) populations.

Promote tobacco use cessation, especially among low SES populations & those with poor mental health by:

- increasing the number of health care practices that use electronic health records to address tobacco with patients & refer to the NYS Smokers Quitline; and
- increasing the number of unique callers to the NYS Smokers' Quitline.

Eliminate exposure to second hand smoke by increasing the number of [and strengthening of existing] tobacco-free policies.

Partners

Essex County Public Health
Essex County Tobacco Policy Committee
North Country Healthy Heart Network
Adirondack Tobacco Free Network
Providers
Schools
Towns
Businesses
Health Care Organizations
Hospitals
Media
NYSDOH

Healthy Women, Infants and Children

The health and well-being of mothers, infants and children determine the health of future generations and predicts public health challenges for families, communities and the health care system.

Improving health outcomes for women, infants and children remain a great concern for Essex County. As described in the Community Health Assessment Essex County residents have limited access to medical providers (including OB/GYNs and Pediatricians). Public health therefore continues to contribute in meeting the needs of mothers, infants and children through strategic use of resources and evidenced based interventions.

Goals and Objectives

Improve Maternal and Infant Health by:

- reducing the percent of pre-term births in Essex County and for those with Medicaid;
- increasing the percent of women with prenatal care on the first trimester of pregnancy;
- decreasing the percent of WIC Women with Gestational Diabetes;
- decreasing the percent of WIC Women with Gestational Hypertension;
- increasing the percentage of infants born who receive any breast milk in delivery hospital; and
- increasing the percent of WIC women who breastfeed at 6 months.

Improve Child Health by:

- increasing the percent of children with
  - health insurance;
  - well visits as recommended;
  - receiving immunizations as recommended; and
  - at least 2 screenings for lead by 36 months.

Improve Reproductive, Preconception and Inter-Conception Health by
reducing the rate of unplanned pregnancies and unplanned adolescent pregnancies.

Partners

Essex County Public Health
Hospitals
Providers
Adirondack Health Institute
Cornell Cooperative Extension
Employers
Schools
Media
NYS DOH

Substance Abuse and Mental, Emotional, and Behavioral Health

Mental, emotional and behavioral (MEB) health are interwoven with substance abuse and physical health and essential to overall well-being. Essex County Public Health recognizes the importance of strong MEB health promotion and aims to collaborate with experts in these fields of to promote MEB well-being in communities.

Goals and Objectives

Promote MEB Well-being in communities by:

- supporting the collaboration of public health, field experts and other community organizations to strengthen infrastructure across systems; and
- Increasing the use of evidenced-based policies, systems, environments and programs grounded in the healthy development of youth and adults.

Prevent MEB Disorder and Substance Abuse by:

- preventing and reducing recurrence of MEB disorders in youth and adults; and
- preventing under-age drinking, excessive alcohol consumption [in adults] and non-medicinal use of prescription medications and associated accidents and hospitalizations.

Partners

Essex County Public Health
Essex County Mental Health and Community Services Board
Essex County Mental Health Association
Prevention Team
Families First
St. Joseph's Rehabilitation
Youth Centers
Schools
Towns
Hospitals
Providers
Sexual Assault Services and Stop Domestic Violence
Essex County Drug Court
Media

Evaluating Actions

Interventions described above include short and long term performance measures aimed at ongoing evaluation. Evaluation of interventions will be achieved through local monitoring of actions and ongoing larger-scale community health assessment.

Essex County Public Health will conduct internal quarterly meetings and facilitate quarterly meetings of the Healthy Communities Coalition, and other sub-committees or task groups formed to address these priorities, to measure progress interventions and determine if alteration or revision is required.

Ongoing formal and informal communication and progress monitoring with partners will contribute to the success of meeting goals and objectives.

Conclusion

Where we live, work, learn and play significantly impacts our health. The community health approach creates environments, policies, systems and programs that support people in engaging in behaviors leading to a great quality of life and longevity.

We all play a role in making our families and communities healthy. Community health is influenced by the entire public health system that works to assure the conditions in which people may be healthy.

The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations.[6]
- YOU!

[7]

[6] Centers for Disease Control and Prevention. The Public Health System and the 10 Essential Public Health Services. Retrieved from http://www.cdc.gov/nphpsp/essentialservices.html

[7] New York State Department of Health. Make New York the Healthiest State. Publication 8075 (8/13)

Contact Information

For questions about the Community Health Improvement Plan or
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