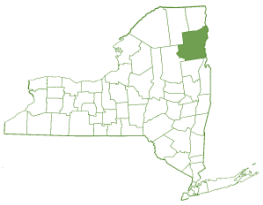
Essex County Community Health Improvement & Service Plan 2016-2018

2018 PROGRESS/FINAL REPORT

December 2018



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Report Overview

This report is a 2018 Progress Report to the *Essex County Community Health Improvement & Service Plan 2016-2018*. That Plan was the shared responsibility of the Health Department and Hospitals and relied on community engaged for success. The Plan was extensive and optimistic most especially given the rapidly changing landscape of healthcare and public health systems during this time.

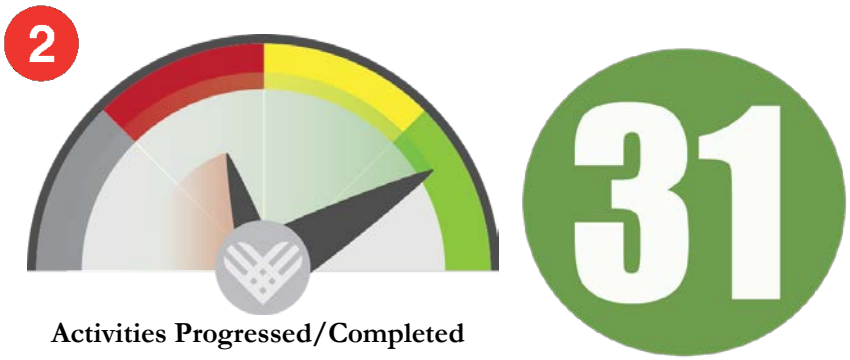
Priority and Focus Areas Summary

Chronic Disease Prevention & Control

- *Reducing Obesity*
- *Chronic Disease Management*
- *Tobacco Use and Secondhand Smoke Exposure* [added in 2017 is also captured in this report].

Tracking the progress of these activities documents interventions that shift culture and will support population health improvement over the long term. There were 31 original activities set in 2016 and 2 additional activities set in 2017.

Partners are pleased to report 2 activities were not progressed/dropped; 31 activities were progressed/completed.



Activities Progressed/Completed

The remainder of this report provides a detailed report out of goals and activities under this priority.

Priority: Chronic Disease Prevention

Focus Area 1: Reduce Obesity in Children and Adults

Goal: Reduce the percent of school-age children and adults who are obese to meet 2018 NYS Prevention Agenda Benchmarks.

	THEN	NOW	GOAL
School Age Children:	19.2%	21.4%	16.7%
Adults:	32.2%	32.7%	23.2%

Strategy 1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.

Intervention: Improve retail availability of nutritious foods and beverages & educate consumers on how to select the healthiest options.

Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
1. Improve offerings at small stores; improve visibility and access through store layout & displays by implementing *Better Choice Retailer* or other similar on-site marketing/cues for healthier choices.	Income Target communities that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program.	• Public Health – outreach/coordination; grant application; policy template • Small store operators – policy adoption & retailer displays • ARHN – Prevention Agenda support funds Creating Health Schools & Communities (CHSC) grant program small store operators grocery stores Community Action Program (CAP) participants Office for the Aging (OFA) existing social groups (faith, parent, senior)	7 stores achieved/maintain Better Choice Retailer standards	1. Keeseville Farmacy 2. Willsboro Meat Market 3. Ernie's Market-Westport 4. Mammie & Pops-Minerva 5. Denton's Bear Necessities- Lewis 6. Ticonderoga Natural Foods Coop 7. Mineville Rexall 10 recruitment packets sent to additional retailers.	Stores are happy to support local famers/farms by stocking their products & realize that the process to achieve & maintain the Better Choice Retailer standard is fairly easy & worth doing for their communities.	Stores are concerned about the time commitment. Small mom & pop stores have trouble staying open. A 1-pager to best answer "What's in it for me?" was created & has been successfully used to recruit businesses.
~~2. Educate consumers about food shopping assistance systems (such as NuVal or the Stars Program) to encourage purchase of healthier options when shopping in grocery stores.~~ DROPPED	Income & Aging Population Target education to income-eligible Community Action Program (CAP) participants and OFA senior clients.			Price Chopper and Tops Markets discontinued participation in NuVal Program. Hannaford Supermarket is still participating in the Stars Program though there are no Hannaford stores in Essex County.		The lack of food shopping assistance systems being used at local markets would require considerable changes in the scope of this activity. Essex County Health Department discontinued this activity.

Intervention: Adopt, strengthen & implement local policies & guidelines that facilitate increased physical activity for residents of all ages & abilities.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
3. Adopt, improve or implement *Complete Streets* principles through: • policies or resolutions • land use planning (comprehensive; local use local law) • projects • education & encouragement activities.	<u>Income</u> Target low-income communities for policy adoption, land use planning and projects to ensure residents of these neighborhoods are afforded living conditions that follow complete streets principles. <u>Income & Aging</u> Ensure housing developments/units that serve low-income and aging populations are well-served through complete streets projects.	<u>Public Health</u> • CHSC Grant program – Outreach/education, funding of projects. • Local Government - Outreach/education • Office for the Aging (OFA) • Trail Groups • Essex County Highway Superintendent Association	0 new policies adopted	2 towns-Moriah & Ticonderoga conducted walking audits that are being used to develop concept plans for improvements. Existing policies include: 1 County – Essex 1 Village – Saranac Lake 11 Towns- • Elizabethtown • Essex • Lewis • Minerva • Moriah • Newcomb • Schroon • Ticonderoga • Westport • Willsboro • Wilmington	CHSC grant funds help provide resources & incentive to engage towns in advancing progress.	Maintaining strong relationships in towns with a part time & out of county position is a challenge. Efforts are being made to connect towns with staff at the local health department. Target communities that don't have a policy: Chesterfield & Keene.

Strategy 1.2: Prevent childhood obesity through early child care and schools.						
Intervention: Increase the number of schools that establish strong nutritional standards for all foods & beverages sold and provided through the school.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
4. Partner with public schools to update school wellness policies and practices to include: • School meals • Concessions • Fundraising.	Income Target schools that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program. Target additional schools that meet similar socio-economic standards	Public Health with- • Creating Health Schools & Communities (CHSC) grant program • Public schools • Farmers and farm groups • Parent groups	2 of 3 CHSC districts updated their Wellness Policies to include highest standards in school meals, concessions & fundraising.	3 CHSC school districts • Ticonderoga • Moriah • Elizabethtown – Lewis met general best practices in 2016-2017. 2 additional districts • Westport • Ausable Valley are engaged with policy revision for compliance with Final Rule.	Throughout 2018, all 3 CHSC School Districts have had strong Wellness Committees that meet regularly and include participation of Administrative leadership. All 3 have achieved goals related to increasing access to healthy foods at school. 2018 activities have included the introduction and expansion of school gardens (Ti and Moriah) and the introduction of growing nutritious greens in the classroom to be added to school meals and expand students' appetite for healthy greens (ELCS).	Schools are challenged to find the time and staff to monitor and enforce all aspects of their wellness policies. Some schools are not confident that the community would support the limitation on concessions and fundraisers to healthy options. ECHD will continue to resource the schools with technical assistance and mini grants, as well as build relationships with stakeholders at schools to better ensure sustainability after the CHSC grant ends in 2020.
Intervention: Increase the number of schools that meet NYSED regulations to increase activity before, during & after the school day.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
5. Partner with public schools to update school wellness policies and practices to include: • active recess • classroom activity breaks.	Income Target low-income communities for policy adoption, land use planning and projects to ensure residents of these neighborhoods are afforded living conditions that follow complete streets principles. Income & Aging Ensure housing developments/units	Public Health with- • Creating Health Schools & Communities (CHSC) grant program • Public schools • Farmers and farm groups • Parent groups	2 of 3 CHSC districts updated their Wellness Policies to include highest standards.	3 CHSC school districts • Ticonderoga • Moriah Elizabethtown – Lewis updated wellness policies and have Comprehensive School Physical Activity Programs in place. Each district has designated a Comprehensive School Physical Activity Program (CSPAP) Champion. CSPAP training was provided in September.	3 districts are achieving goals related to increasing access to physical activity at school. 2018 activities have included the CHSC purchase of new physical activity equipment, such as desk cycles (all 3), bikes (ELCS), nature trail restoration (Moriah) and pickle ball (Ticonderoga).	In a recent survey, teachers expressed that they would like to provide more opportunities for physical activity in classroom, but they are limited by time. Some schools are not able to promote active transportation because of road safety concerns. ECHD will continue to resource the schools with technical assistance and mini grants, as well as build relationships with stakeholders at schools to

	that serve low-income and aging populations are well-served through complete streets projects.					better ensure sustainability after grant ends in 2020.

Intervention: Increase the number of and awareness of day breastfeeding friendly child care providers.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
6. Partner with the CAP to: • encourage breastfeeding friendly child care providers • update breastfeeding friendly provider lists.	<u>Access & Income</u> Target child care providers to ensure breastfeeding friendly providers are available across geographic areas & provider fee ranges.	<u>Public Health</u> with- • Adirondack CAP • WIC • Creating Breastfeeding Friendly Communities grant (CBFC)	7 child care practices achieved breastfeeding friendly: Ticonderoga – 1 Lake Placid – 2 Westport – 2 Moriah -1 Lewis - 1 NYSDOH website updated with these provider practices.	Breastfeeding Friendly Provider Practice training was provided in partnership with ACAP 11/14/2018. 21 Day Care Provider practices attended. All providers completed a pre-assessment that will be used for follow-up to help them progress through becoming designated practices.	Strong partnership with ACAP made scheduling & conducting the training easy. ACAP required child care practices to attend the mandatory training to ensure participation. The Essex County Breastfeeding Coalition (ECBC) was established in 2017 and conducted quarterly trainings in 2018. NYDOH website issues previously experienced are now resolved and updated with all 7 practices.	Steps to achieving the designation are involved and cannot be accomplished at just 1 training. Follow up is required and will be conducted by ACAP & CBFC grant & local health department staff. ACAP as the CACFP provider is engaged and supports advancing the practices as breastfeeding friendly. The Breastfeeding Friendly Coalition will also help advance this work.

Strategy 1.3: Expand the role of health care and health service providers and insurers in obesity prevention.						
Intervention: Link health care with community-based programs and services for breastfeeding counseling and support.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
7. Partner with health care providers on the adoption of breastfeeding friendly clinic practices & environmental supports.	Access Target provider practices across the geographic region.	Public Health with – • Hospitals (All) • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • Creating Breastfeeding Friendly Communities grant (CBFC)	UVHN-Elizabethtown Community Hospital (ECH) and 5 ECH clinics adopted a Breastfeeding Friendly Clinic policy, practices & environmental supports.	Essex County Health Department has 1 IBCLC & 1 Lactation Consultant; Essex County WIC has a Lactation Peer Counselor. Hudson Headwaters Health Centers in Ticonderoga and Moriah both have Certified Lactation Counselors on staff.	Essex County Breastfeeding Coalition (ECBC) met quarterly. The Essex County Breastfeeding Coalition merged 3 resources (ECHD, WIC, and CBFC) into 1 comprehensive list. That list is provided to all families with newborns.	Regionally located birthing hospitals cite financial barriers to gaining NYSDOH BFF designation, but are all following the 10 steps for BFF hospitals and have BFF policies for clients. Face to face meeting are most beneficial though hard to schedule & achieve good attendance. ECHD will leverage connection of the Public Health Director to continue to make a connection with Hudson Headwaters clinics.
8. Conduct Public Health Detailing with primary care providers regarding locally available breastfeeding counseling and support resources including the Certified Lactation Consultant (CLC) available to WIC participants and Internationally Certified Lactation Consultant (IBCLC) available through the LHD to anyone in the county.	Income Assure providers are aware of resources available to WIC-eligible families and all families in Essex County.		2018: Approximately 209 births; 158 received educational information from ECHD. ECHD conducted 33 newborn home visits; 23 of those were for breastfeeding moms. WIC has a participant population of approximately 700 per year. Of those approximately 125-150 receive breastfeeding services.	2018: Family health program sent packets to all providers in June 2018: Pediatrics, OB/GYN, birthing hospitals. Breastfeeding resources guide given at 2 primary care provider meetings		WIC is income based so can only reach their participants. The IBCLC though ECHD is able to work with anyone in need of services. Reaching outside of counties for birthing hospitals; none in Essex County. Hospitals offer their own services; rarely refer to ECHD resources. ECHD transitioned from working on referral by fax only to referrals from HCS Newborn Screening Program.
9. Provide a Women's Health Navigator, reprint Women's Guidebook and operate the associated phone line.	Access Target women and provide necessary information for any and all health needs for her and her family.	Hospital Adirondack Health • Hospital-owned health centers	Adirondack Health experienced 80 births and 30-40 referrals in 2017; anticipates 220 in the 2018 and increased referrals.	Baby Box Program has grown from the women's health center where the Navigator provides service. Continues to refer patients	New OB/GYN and Nurse Midwife will provide more access for all services for many more women	Getting mothers to come for their pre-natal visits. Navigator will coach and introduce telehealth

Intervention: Increase the capacity of primary care providers to implement screening, prevention and treatment measures for obesity in children and adults.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
10. Expand access to and consistency of primary patient care to implement screening prevention & treatment for obesity.	Access Construct a new primary care center in an underserved area and add a mid-level provider.	Hospital UVHN Elizabethtown Community Hospital	Staffing CPHC with male and female providers to draw more patients to the new health center. Referrals from local Emergency departments for local patients with no primary care. Currently recruiting for a new MD	238 new patients in 2018 and 2718 visits in 2018	Being part of the University of Vermont Health Network provides access to the academic medical school in addition to the family residency program at Champlain Valley Physicians Hospital.	Physicians are difficult to recruit to the area. Currently using multiple tactics to recruit physicians for Primary Care, media sources, search firms, etc.
11. Conduct Public Health detailing with primary care providers regarding locally available chronic disease self-management and other community-based prevention programs and opportunities to assist with patient measure to reduce weight.	Access & Age Ensure community opportunities are geographically accessible. Ensure age-appropriate opportunities are available & promoted.	Public Health and Hospitals (All) with – • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers	2018: Providers sent email about CDSM sessions. 2017: 3 sessions & 22 providers reached through public health detailing sessions.	Provider locations: • UVHN-ECH –All • Moriah Health Center • Schroon Lake Health Ctr • Ticonderoga Health Ctr	Sessions were well attended & providers were receptive to the information.	
12. Providers at primary care clinics will document patient BMI, develop a plan with the patient & document in the patient EMR.	Access Target population will have discussion with provider and referral to community-based opportunities.	Hospital UVHN Elizabethtown Community Hospital	2018 All Primary Care wellness visits include a BMI, all patients receive discharge instructions related to lifestyle change if BMI is >25.	Rate of documentation by the Provider the education was given to the patient is only 62%.	BMI calculations have been added to the EMR. All patients at all visits in primary care have documented BMIs. Educational materials are automatically generated by the EMR	Providers need education on the BMI calculator and their role to educate the patient or make a referral to the dietician for guidance. Education for providers on their role and referral to a dietician for all medical Home patients will occur in 2019.

Strategy 1.4: Expand the role of public and private employers in obesity prevention.						
Intervention: Strengthen business practices that align with the NYS Labor Law to support breastfeeding at work.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
13. Increase the number of employer sites that have policies and practices to support breastfeeding friendly work environments.	Income Target lower-wage employers.	Public Health with- • WIC • Small business owners • Franchise owners	6 worksite adopted policies	Recruitment packets sent. 1. International Paper 2. ACAP 3. CV Tech-Mineville 4. Mountain Lake Services Homes/Sites 23	Mini-grant funds have been made available to support environmental supports and lactation room improvements.	Worksite in Essex County are small-under 50 employees. Employers are interested in becoming worksites but time constraints limit their amount of engagement.

		• Creating Breastfeeding Friendly Communities grant (CBFC)		5. Ray Brook Correctional Facility 6. Mental Health Association		2 work sites have started but haven't followed through with policies. This activity is part of the Breastfeeding Coalition work plan.
Intervention: Increase adoption of food procurement and vending policies based on the Dietary Guidelines for Americans.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
14. Partner with local farmers on a farm to employer initiative to allow employees to pre-order goods to be delivered to worksites for pick-up.	<u>Access</u> Target large employers to increase access to farm-fresh produce and goods.	<u>Hospital</u> UVHN Elizabethtown Community Hospital and MLH with- • Farmers • Farmer organizations/representatives • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill)	# employers that implemented a farm to employer initiative In 2018 the previous vendor for farm to employer was no longer offer the option. The hospital offered a variety of farm to employer options from vegetables to meat and bread. Only 12 participants took advantage of the options. The options were also expanded to the new Ticonderoga campus after corporate change with no participants at that campus	*Meet the Farmers* and sign up for CSA event conducted at the county complex on 4/11/2018.	Staff interested in learning about CSAs & farm to employer. Payroll deductions for payment as an option for employees of the hospital. Deliver of CSA products to other ECH owned sites was offered as an option	Process to offer payroll deduction through Essex County government is challenging/prohibitive. Plan to expand to the MLH campus is on hold until corporate change is completed. The previous farm CSA notified ECH late, Took time to secure another vendor. The costs were a little higher. Addressing the challenges we will be planning earlier with increase communications to/from the farm and to the employees.
15. Improve vending options at hospitals, health centers & employers to support employee health & wellness and role modeling for patients and visitors.	<u>Aging</u> Provide consistent messaging for aging patients.	<u>Public Health and Hospitals (All)</u> with- • Health care systems (FQHCs; others) • Local vending company • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill)	# hospitals/health care systems/employers that have improved vending options.	Ticonderoga campus (formally- MLH) has more vending options with healthy choices of snacks and sandwiches. Wellness policy for meeting menu adopted at the Ticonderoga campus.	7 additional worksites identified through CHSC grant: 1. UVHN-Ticonderoga 2. UVHN-ECH E-town Health Center 3. North Country Community College 4. Elizabethtown Library 5. Ticonderoga Library 6. Essex Co Attorney's Office 7. Essex Co DA Office	Elizabethtown Community Hospital is a designated CHSC worksite. CHSC will be reaching out again soon to see if they are interested. Larger volume of use with more people on campus better turn-over of vending inventory. Access to larger vending supplier for healthy vending choices. Prestige vending is the operator.

16. Offer lifestyle modification workshops to local employers to prevent obesity.	Partner with community employers to offer on-site lifestyle modification workshops.	Hospital UVHN Elizabethtown Community Hospital and MLH	0 worksites have taken part in program.	ECHD received a mini grant to be able to provide lifestyle modification classes to employees after work.	Employees were surveyed for interest & highest responses pursued. Yoga and dance series scheduled for 2019.	Organizing, staffing & working around insurance issues are limitations. Coordinating with a CBO for location & insurance has made classes possible.

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

Goal: Reduce morbidity & mortality due to chronic conditions including cardiovascular disease, diabetes and cancers to meet or be less than Upstate NY comparisons:

	THEN	NOW	GOAL
Cardiovascular Disease, Premature (Ages 35-64) Deaths/100,000	127.2	124.1	<=96.8
Diseases of the Heart, Premature (Ages 35-64) Deaths/100,000	115.3	115.9	<=79.9
Diabetes Deaths/100,000	31.6	24.8	<=19.6
Cancer Cases/100,000	664.8	697.2	<=610.5

Strategy 2.1: Increase screening rates for chronic conditions, especially among disparate populations.						
Intervention: Use media and health communications to build public awareness and demand.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
17. Use paid and earned print media, social media and community outreach to raise awareness of need and demand for screening for chronic conditions.	Income Target those without health insurance/eligible for the Cancer Services Program.	Public Health & Hospitals (All) with- • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries	4 social media posts; 1077 people reached; 53 engagements. Outreach conducted at multiple community events/open clinics 18 served thru CSP 0 cancer identified	This program transition from being housed at the ECHD to the Adirondack Community Action Program (ACAP) & now is housed under UVHN-CVPH. It us currently the Cancer Services Program of Northeastern NY.	Falling under the umbrella of UVHN creates ease of connecting patients to screenings & services.	It has been historically challenging to find uninsured individuals to direct to the program. The program has changed parent organizations 3 times in recent years which can make it difficult for people to find. Staff person is dedicated to same duties in Clinton, Essex & Franklin counties.

Intervention: Ensure consumer access to screening, intervention and coverage for chronic disease.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
18. Offer cancer screening events at least twice per year at different locations in the county.	Income, Access & Aging Target people eligible for the CSP to ensure screening is available to those ages 50+ without health insurance.	Public Health & Hospitals (All) with- • Franklin & Essex Cancer Screening Program • Media • OFA/NY Connects • Food pantries	1 event offered 12 individuals served	Ladies Night at UVHN-ECH on 11/7/2018	Grant transitioned to new lead agency in 2018. Staff works under UVHN-CVPH in Clinton County; serves Clinton, Essex, Franklin. Is able to dedicate more time to similar activities in the region.	Grant contact is out of county Employee falls under the healthcare system which is likely a better fit and is dedicated full time to this program regionally.
19. Offer diabetes screenings at community health events	Access Target those without health insurance and increase ability of diabetes screening	Hospital UVHN Elizabethtown Community Hospital and MLH	2018- 5 Events 78 screened Diabetes-14 Fall Prevention-10 Hunter's Health-32 Ticonderoga Health Fair-6 Women's Health Night-16	Free health fairs were offered to the public where diabetes screening was completed: ECH -4 Ticonderoga - 1	Primary Care completes intake questions geared at screening for chronic disease through National Committee on Quality Assurance, specifically the patient-centered medical home measures for chronic disease like diabetes, hypertension, and cancer. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/ Marketing of health fairs reaches all of Essex County and we have a wide-area of participants when mailing results. Physician reviews results for recommendations. Referral to local primary care if participant currently needs a physician	It has been a challenge to consistently get people to free screening events. A different approach has been taken for 2019 with consistency with offerings at ea health screening including at both areas of the county (Elizabethtown and Ticonderoga) in case travel is a barrier. Only one CDE and her time is limited with patient conseling and health fairs. Have identified and started the initial clinical shadow hours for an additional CDE.
20. Screen all adult patients with a history of tobacco use for COPD.	Patients will complete tobacco use survey. Spirometry testing will be available at each health center for those identified as 'at risk' by survey.	Hospital UVHN Elizabethtown Community Hospital	100% of patients in all 6 health centers are screened.	14 referrals have been sent for Tobacco cessation education	EMR changes built for screening-hard stop of all patients seen in primary care. ECH secured two tobacco cessation specialists for referral services within the area.	Identifying those ready to have a lifestyle change from tobacco cessation many have smoked since they were teenagers. Important to educate the benefits to quitting smoking as an overall picture. Address education needs through nursing survey to assist patients.

Intervention: Expand the use of health information technology to remind clinicians to screen for pre-diabetes and diabetes.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
21. Use public health detailing to increase the number of health care practices that adopt policies and a system for identifying & referring patients with pre-diabetes & diabetes.	Access & Income Adoption of policies and systems ensures universal screening and referral.	Public Health & Hospital UVHN Elizabethtown Community Hospital Diabetes Educator at ECH	0 practices adopted a policy for identification and referral system for care.	Detailing & policy adoption was not pursued in 2018.	Policy would make for systematic patient assessment.	Provider practices are overwhelmed with the amount of mandated screenings, assessments, etc. that they are requested to conduct working thru the EMR. Will pursue referral thru the Referral and Care Coordinators.

Strategy 2.2 Promote evidence-based care to manage chronic diseases.						
Intervention: Establish clinical-community linkages that connect patients to self-management education and community resources.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
22. Establish an Outreach Coordinator position & a Chronic Disease Care Coordinator position to facilitate care & link of patients to care & community resources.	Access Facilitate access to care & community resources for patients.	Hospital UVHN Elizabethtown Community Hospital & Public Health	Positions established & filled.	Chronic Disease Outreach Coordinator position established at ECHD. It was filled, vacated & refilled. Chronic Disease Care Coordinator (Pulmonary/Cardiac Rehab Care Coordinator) position was created/filled at UVHN-ECH.	These positions ensure progress on priorities in Essex County & facilitates collaboration of health systems partners.	Additional initiative – Tobacco 21 – was not identified as an activity for the CHIP though has become a big initiative. Tobacco will be added as a focus area to this Plan.
23. Offer at least two (2) Better Breathers program to community annually.	Access ALA sponsored pulmonary exercise and education program.	Hospital UVHN Elizabethtown Community Hospital	2 programs provided	Two Better Breather programs held Spring and Fall with the additional opportunity of exercise continuation for patients with COPD.	No other pulmonary rehab in the county. Currently the only pulmonary rehab in 2 counties	Getting patients to finish the program is difficult because of fragile health. Had multiple referrals for 2 classes since the classes at CVPH Medical Center closed the pulmonary program. Only had one MD with limited time. Have identified another Pulmonologist willing to participate.

24. Establish a system for identifying & referring patients for Smoking Cessation.	Access, Income Universal screening likely to identify income-limited patients eligible for smoking cessation services.	Hospital UVHN Elizabethtown Community Hospital	Referral built into GE (EMR).	Completed in 2018 to track smoking and determine if a patient is ready to quit. Referrals automatically reflex to the referral coordinator to schedule an appt. with a tobacco cessation specialist	One trained tobacco cessation is a licensed social worker. LSW works with the outpatient primary care patients in all six health centers	Many times patients are identified and decline referral to tobacco cessation despite education on the risks of smoking and benefits of quitting. The change in the law to purchase tobacco products to 21 will assist with future populations. Additional collaboration with businesses to assist in the battle to combat smoking will be a must for alternate solutions together.
25. Offer cardiac or pulmonary rehab to any patient who qualifies.	Access, Income Universal screening likely to identify income-limited patients eligible for smoking cessation services.	Hospital UVHN Elizabethtown Community Hospital	Cardiac Rehab had 725 visits in 2018. Pulmonary had 8 participants for the 2 times a week for 6 weeks program		Strong cardiac rehab program and pulmonary rehab program for patients to benefit with education on self-management. Includes sessions on diet, exercise, and medications	Insurance companies have set high co-pays and deductibles for these services many times people find a gym membership is cheaper. No solutions except promote the classes and offer free screenings or lifestyle classes.

Strategy 2.3 Promote culturally relevant chronic disease self-management education.						
Intervention: Develop infrastructure for widely accessible, readily available lifestyle intervention professionals and opportunities.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
26. Ensure instructors for chronic disease self-management (CDSM) classes are trained.	Access, Aging, Income Provide classes at no or low cost	Hospital UVHN Elizabethtown Community Hospital, MLH, & Public Health with- • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects Low-income housing facilities	6 active instructors 4 new instructors trained; 2 maintained certifications	Multiple agencies have staff trained: 2 Office for the Aging 1 Cornell Cooperative Extension 1 Essex County Health Department 1 Mental Health Association 1 UVHN-ECH	Peer leader meeting to coordinate trainers July 2018. All trainers have agreed to work together to schedule sessions throughout Essex County. Training expenses were covered by Eastern Adirondack Healthcare Network grant funds.	The original lead agency, Eastern Adirondack Healthcare Network, is no longer coordinating. It is challenging to coordinate the trainers that work for multiple organizations within the community. ECHD Chronic Disease Outreach Coordinator has agreed to lead coordination of series. Goal for 2019 is to create a prescription pad of dates & locations for 2019 so providers can more easily refer patients.
27. Provide CDSM classes at least twice per year in Essex County.	Access, Aging, Income Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	Hospitals (All) & Public Health • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers	2 CDSM classes conducted 2 Sessions of Adults Swim	Westport & Lake Placid Moriah	The series is conducted through collaborative efforts of trainers, locations, providers, etc. Classes planned for 2019: Winter-Ticonderoga Spring-Willsboro & Schroon Lake Summer-Keene Fall-TBD. Swim sessions had regular attendees of target population (seniors). Grant funds allowed for the purchase of accessible stairs that improved ability for people of all abilities to swim.	Recruiting enough participants & having participants complete the series. Offer classes at locations where people are already congregating & increase provider referrals. Identify agency that will maintain the license for conducting classes & reporting info. Older population prefers to swim during the day, but school is in session making this not possible. Unable to sustain adult swim with school budget restrictions
28. Ensure trained lifestyle intervention professionals are available in clinical and community settings.	Access, Aging, Income Provide classes at no or low cost.	Hospitals (All) & Public Health • Hospital-owned health centers	6 professionals trained	2 Office for the Aging 1 Cornell Cooperative Extension	Staff trained from various agencies in both clinical & community settings creates a variety of scheduling	Challenging to coordinate across all agencies. ECHD has platforms (Google Drive or

	Target low-income/high risk communities. Target seniors.	• FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers		1 Essex County Health Department 1 Mental Health Association 1 UVHN-ECH	options for trainers and locations.	Basecamp) to help coordinate.

Intervention: Establish clinical-community linkages that connect patients to self-management education and community resources.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
29. Maintain a community resource list of Chronic Disease Self-Management (CDSM) opportunities including multi-session education series, support groups, etc.	<u>Income</u> Assure there are no or low cost options available. <u>Access, Income</u> Assure opportunities are easily accessible to those with limited income & transportation. <u>Aging</u> Assure opportunities are offered at times and locations and content is targeted for the aging population.	<u>Public Health</u> with- • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects • Low-income housing facilities	Updating the guide to a simplified version that can be more easily accessed electronically.	The Guide was distributed throughout Essex County communities in the winter/spring of 2017.	Resources listed in 1 area. Clinical & community providers were cooperative in sharing their contact information & providers were accepting of using the Guide with patients.	The guide was unable to be shared electronically because of the amount of data/size. The chronic disease groups and programs listed change often so the information needs to be updated frequently. The ECHD Chronic Disease Outreach Coordinator will ensure the Guide is updated annually & made available electronically on the ECHD website.
30. Use public health marketing & communication to share opportunities for CDSM in the community setting.	<u>Income</u> Target community outreach efforts to those with limited income or transportation.	<u>Public Health</u> with- • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries Low-income housing facilities	2 ECHD Facebook posts reaching 273 and 17 engagements 10 Community/Targeted Outreaches	2018 Targeted Outreach: • Ti Chamber • Ti Churches • ECH ladies night • Diabetes support group • Health Centers distribution • Provider outreach • Emailed to providers • Mailed to food pantries • OFA • Adk Wellness Connections	CDSM was put together in an attractive brochure and community partners were receptive to helping distribute.	It is difficult to assess the impact of the outreach & whether people took action to participate in any of the opportunities. Started tracking where people are getting info – FB identified as having best reach.

				Community Outreach to: • Fairs/Picnics Included with annual Provider Packet to Essex County providers.		
31. Use public health detailing to increase the number of health care practices that adopt policies and a system for identifying & referring patients to chronic disease self-management opportunities in the community setting.	Access & Income Adoption of policies and systems ensures universal screening and referral.	Public Health and Hospitals (All)	1 hospital system & health centers (5) have an established system in place.	UVHN-ECH has a system in place for either referral or Care Coordinators to follow-up with patients following provider visits.	The ECHD Chronic Disease Outreach Coordinator is working on updating the guide for CDSM with follow-up actions of placing the resource on the ECHD website and conducting detailing with Referral and Care Coordinators at healthcare systems.	It is unknown how Hudson Headwater clinics conduct referral and care coordination services for their patients. The Director of Preventive Services at ECHD will contact Hudson Headwaters to inquire and see how the Health Department can connect with this system to keep them appraised of community based opportunities.

Focus Area 3: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.

Goal: Maintain/improve prevention of initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations to meet or be less than Upstate NY:

	THEN	NOW	GOAL
Vendor Sales to Minors	1/53	2/61 (sales to minors/outlets)	
Adults who Smoke	16.6% to	16.8%	<=15.0%

Strategy 3.1: Increase the number of municipalities that restrict the sale of tobacco products to minors.						
Intervention: Pursue policy adoption of sales restrictions to prevent the initiation of tobacco use by youth (people under the age of 21).						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
32. Initiate the Essex County Tobacco 21 (T21) committee and develop a county-wide policy/ campaign to prevent the sale of tobacco products to those under the age of 21.	Income Children comprise the highest percent of Essex County residents living in poverty	Public Health with- • Essex County: Board of Supervisors, Mental Health, DSS • NYSDOH district office • PHIP program • UVHN-ECH • Hudson Headwaters • Healthy Systems for a Tobacco Free NY grant • Public Schools • St. Joseph's Rehab. ALL – committee participation, policy development & adoption	Establish local committee Establish local policy 2018: Monthly committee meetings 2 public hearings 1 lunch & learn – BOS Local law passed 9/4/18 Law into effect 1/1/19.	2018: Working on a vender campaign and public notice. ECHD participated in the North Country Tobacco Use Reduction Task Force a project of the Population Health Improvement Program. Multi-organizational media campaign conducted Spring 2017 by ARHN. .	Partner engagement. Initiative led by Public Health Director. Board of Supervisor championed the effort to advance. There is a regional effort to adopt T21 policies & it is a project of the PHIP providing shared learning, resources & experiences.	Vendor campaign – vape shops not covered under ETUPA law. Vaping products/nicotine covered in policy but they aren't covered under tobacco law. Perception of individual liberties and potential negative economic impact. Education is being conducted in numerous ways – one-on-one meetings, information sheets, meetings, etc. to shift perceptions to reality.

Goal: Maintain/improve tobacco use cessation, especially among low SES populations and those with poor mental health to meet or be less than Upstate NY comparisons:

Adults who Smoke **16.6%** to **<=15.0%**

Strategy 3.2: Promote tobacco use cessation, especially among low SES populations and those with poor mental health.						
Intervention: Improve access to, promotion of and use of local tobacco cessation services.						
Activity	Disparity & how it is being addressed	Partners AND Roles	Performance Measure/ Progress to date	Progress Notes	Strengths	Challenges AND How they will be addressed
33. a. Ensure locally trained tobacco cessation specialists; & b. Establish policy/procedures and practices to facilitate	Access to Care Improve local provider access where currently none exists	Hospitals – UVHN-ECH	2 trained Tobacco cessation specialists within the UVHN Hospital and 6 health centers.	14 referrals to the tobacco cessation specialist as of November 2018. Referral process is complete, evaluated and revised.	Team collaboration with the health center group to provide the patient with services to improve or maintain chronic disease status	Referral to tobacco cessation comes from the Provider. Will implement referrals from case manager, care coordinator or nursing staff since education is also provided by them to the

access to & use of tobacco dependence treatment.						patient population that smoke, and screened on intake visit at the health centers to improve the percentage.

Crosswalk of Other Initiatives of Essex County Health Partners with CHIP/CSP Priorities, Emerging Issues & Disparities

This section serves to identify how other initiatives of Essex County Health Partners align with Priorities & Disparities identified in the CHIP/CSP. These initiatives support, not supplant, efforts to achieve shared community health improvement goals.

Initiatives

		CHIP/CSP Priorities		Emerging	Disparities			Essex County Health Partners			
TYPE	DESCRIPTION	Obesity	Chronic Disease	MEB/SA	Income	Aging	Access	AH	ECH	MLH	ECHD
DSRIP	2ai Integrated Delivery System	X	X		X		X	X	X	X	
	2aii Advancing Primary Care	X	X		X		X	X	X		
	2aiv Medical Village		X		X	X	X			X	
	2bviii Hospital-Home Collaboration Solutions	X	X		X	X		X			
	2di Patient Activation	X	X	X	X	X	X	X			X
	3ai Integrate Behavioral Health with Primary Care		X	X	X		X	X	X		
	3aii Crisis Stabilization				X		X				
	3aiv Withdrawal Management				X		X				
	3gi Integrate Palliative Care into the PCMH Model			X	X	X		X			
	4aiii Mental Health & Substance Abuse Infrastruct.			X	X		X				X
	4bii Chronic Care: COPD		X		X	X	X	X	X		X
Grants	Vital Access Providers (VAP) Program						X	X	X	X	
	MAX Program: Medicaid Accelerated eXchange Series				X		X	X			
	Essential Provider Medical Village Grant		X			X	X		X	X	
	Creating Healthy Schools & Communities Grant										X
	Linking **I**nterventions **F**or **T**otal (LIFT) Population Health grant (pending approval/funding)	X	X		X		X		X	X	X
	Well Fed Essex County Collaborative	X	X		X		X		X	X	X
Community Benefit	Diabetes Self-Management Program	X	X				X	X	X		
	Diabetes Support Group	X	X		X		X		X		
	Integrative Healthcare (Yoga, meditation, etc.)		X	X				X			
	Walk/Run Health Events	X		X				X	X		
	Chronic Disease Self-Management Resources List		X		X	X	X	X	X	X	X
	Health Symposiums, Monthly Community Health Outreach Series, Screening & Other Health Events	X	X	X	X	X	X	X	X	X	X
	Women's Guidebook & Navigator						X	X			
	Respecting Choices Palliative Care			X				X			
	Employee Wellness Programs/Open Enrollment Ed.	X	X				X	X	X	X	X
	Tobacco 21		X		X		X		X		X

Emerging Issues Summary

Though not identified as priority issues, there were 2 emerging issues identified in the 2016 assessment –

- *Mental, Emotional, Behavioral Health and Substance Abuse and*
- *Climate Change and Human Health.*

Mental, Emotional, Behavioral Health and Substance Abuse

The Essex County Health Department fostered the establishment of the Essex County Heroin & Opioid (ECHO) Prevention Coalition in 2015 that has endured through 2018; all Essex County Health Partners have been engaged. The Coalition was established to develop the community-wide infrastructure needed to approach to the emerging issue of opioid and heroin abuse.

The work of the Coalition was supported by a private grant of the New York State Health Foundation. That funding supported 12 major activities all of which have documented successes and continue traction. See Attachment 1 for more details.

Climate Change and Human Health

Essex County Health Partners continue to meet through the Health Emergency Preparedness Coalition to plan for, exercise and respond to emergencies such as extreme weather that impact human health. All partners received grant funds through the NYS DOH Office of Health Emergency Preparedness to support these activities.

The Health Department conducted a survey in 2018 of libraries to establish the capacity for libraries to serve as designated Cooling Centers. The survey was conducted in partnership with the Clinton-Essex-Franklin Library System and will support public notice of Cooling Center availability in Essex County for the first time ever starting 2019.

Tick-borne disease have increased in Essex County leading the Health Department to take additional efforts in reaching community members and providers to conduct education about prevention and early detection of tickborne-diseases. This is accomplished through a dedicated work plan and updated annually.

Attachment 1

ECHO Coalition Goal Matrix

Assigned | Started | Significant progress | Complete/Continuing

	Prevention			Intervention					Treatment			Recovery	
Partner	Community-based awareness campaigns	Develop/ dissemiate educational materials	Provider education - pain management & prescribing practices	Implement SBIRT	Increase use of Narcan	Rx Take Back Days	Permanent drop box locations	Expand role of pharmacists in providing Rx education	Improve linkage between PCPs, SA/Mental Health via SBIRT	Develop Substance Abuse Resource Navigator	SIM or LEAD	Establish/ enhance peer support networks	Cultivate supported recovery environment
Essex County (EC) Public Health													
EC Mental Health													
EC District Attorney													
EC Transportation													
EC Courts													
EC DSS													
EC Probation Office													
EC EMS													
EC Town Supervisors													
EC Sheriff's Office													
Local PD's													
NYS Police													
ECH													
HHHN													
AHI													
The Prevention Team													
Alliance FPH													
MHA													
St. Joe's													
Faith-based Comm.													
NCCC													
FEH BOCES													
Schools													