

Franklin County Combined CHA-CHIP-CSP  
2017 Update

Completed by: Erin Streiff

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NOTE: Adirondack Health Update Submission Separate

| Priority                 | 2017 Progress to Date                                                                                                                                                                                                                                                                                                                                                                                                                           | Implementation Partner<br>(Please select one partner from the dropdown list per row) | Partner Role(s)                                     | Strengths                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Challenges? How will they be addressed?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Focus Area                            | Goal                                                                                                           | Objectives                                                                                                                      | Disparities | Interventions/<br>Strategies/Activities                                                                                                                                                                                                                                                                                                                                                               | Family of Measures                                |
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| Prevent Chronic Diseases | AHMC hosted the Third Annual Color Your Hyde Run on 5/6/17 at the Franklin County Fairgrounds and The Great Inflatable Race on 9/30/17 at the Malone Rec Park. AHMC also had evening Fun Runs for children every Wednesday throughout the summer. There were 900 participants in the color run and 750 in the inflatable race.                                                                                                                  | Hospital                                                                             | Leadership                                          | A number of selected activities were part of the strategic focus for the "leading" organization identified, adding to its importance (example- 5k, walking trail, employee wellness). Strong communication strategies to drive participation were identified. There is significant organizational focus around the selected initiatives. Substantial grant dollars have been received from the healthy heart network. Initiatives were selected that had prior traction which facilitated the 2017 process (example- breast feeding, maternal education and support). | Identifying and securing funding sources can create unanticipated delays. Significant effort is put into seeking new and innovative funding sources and applying for available dollars. Organizations are short staffed leaving challenges in identifying leaders to spearhead initiatives, see planned activities through. In addition, AHMC has had a difficult financial situation over the past few years which has limited funding opportunities. Consistency in data reporting and collection is a challenge. As much as possible, CHA/CSP leaders work with partners to assure measures are identified ahead of time and data being collected meets program needs and LHD/hospital reporting requirements. Agency alignment with LHD and hospital NYS requirements for CHNA and CSP is challenging. Trying to crosswalk initiatives and meet competing priorities is essential. | Reduce obesity in children and adults | Create community environments that promote and support healthy food and beverage choices and physical activity | OBJECTIVE 1.1.2:<br>Increase the percentage of adults ages 18 years and older who participate in leisure time physical activity |             | Establish joint use agreements to open public areas and facilities for safe physical activity (IOM Nutrition Standards in Schools; IOM Obesity Prevention; HP 2020; CDC Community Strategies) and for the implementation of programs to increase access to leisure time activities for members of the community: Host 5K Run/Walk for local community.                                                | Number of Participants                            |
|                          | Maps distributed to library, chamber of commerce, public health, Alice Hyde Hospital, and local outdoor apparel business. Six individuals completed challenge in 2016                                                                                                                                                                                                                                                                           | Other (please describe partner and role(s) in column D)                              | Malone Complete Streets Advisory Board (Leadership) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       |                                                                                                                |                                                                                                                                 |             | (Intervention removed for 2018)                                                                                                                                                                                                                                                                                                                                                                       |                                                   |
|                          | Two walking trails on the AHMC campus were established - one at the main hospital campus and one at the Alice Center (Nursing Home). Both are marked with signage and are available to employees 12 months of the year. In addition, a grant was secured for \$20,000 through NYS DOH Healthy Heart Network and a majority of those funds were used to purchase exercise equipment, yoga mats and educational videos for use by AHMC employees. | Hospital                                                                             | Leadership                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       |                                                                                                                |                                                                                                                                 |             | Open public areas and facilities for safe physical activity (IOM Nutrition Standards in Schools; IOM Obesity Prevention; HP 2020; CDC Community Strategies) through the implementation of walking trails on the Medical Center campus. Implement hospital Employee Wellness Committee to promote wellbeing for health professionals, partially through the usage of the Medical Center campus trails. | Establishment of walking trails in two locations. |

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|          | A feasibility study revealed that it would be a challenge to implement an employee fitness center. Hence, AHMC worked with The Healthy Heart Network to apply for and receive \$20,000 in grant funding. Dollars will be used in part to create water drinking stations throughout the campus as well as a fitness equipment room for employees. | Hospital                                                                             | Leadership      |           |                                         |            |      |            |             | Implement practices to reduce overconsumption of sugary drinks, such as make clean, potable water readily available in public places, worksites and recreation areas, and explore the feasibility of implementing an employee fitness center. (IOM Nutrition Standards in Schools; IOM Obesity Prevention; CDC Community                                                                                                                                                                                                  | Completion of feasibility study to determine if fitness center can be implemented. If yes, implementation in subsequent years |
|          | AHMC established an Employee Wellness Team and conducted events throughout 2017. In total, eight events and approximately 130 participants occurred. In addition, a weekly newsletter was developed that contains wellness information on nutrition and exercise. This newsletter is sent to 800 employees each week.                            | Hospital                                                                             | Leadership      |           |                                         |            |      |            |             | Adequately invest in proven community-based programs that result in increased levels of physical activity and improved nutrition (Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities) by conducting general education for health professionals on diet and exercise. ( <a href="https://www.thecommunityguide.org/stories/investing-worksite-wellness-employees">https://www.thecommunityguide.org/stories/investing-worksite-wellness-employees</a> ) | Number of employee wellness events conducted.                                                                                 |
|          | Franklin County Public Health Facebook posts reach approximately 500 people per month, and engage approximately 100 people per month. Each obesity prevention post reaches approximately 70 people, and obesity-targeted posts are scheduled 2-3 times per month.                                                                                | Local health department                                                              | Leadership      |           |                                         |            |      |            |             | Increase awareness of obesity as a risk factor for chronic disease by using Facebook to promote awareness of key obesity prevention strategies/practices. CDC encourages the strategic use of Facebook to effectively and inexpensively reach individuals with personalized and targeted health information. <a href="https://www.cdc.gov/socialmedia/tools/facebook.html">https://www.cdc.gov/socialmedia/tools/facebook.html</a>                                                                                        | Number of pertinent posts to Franklin County Public Health Facebook page per quarter                                          |

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|          | The Malone Complete Streets Advisory Committee implemented five of its approved projects (town approved update to sidewalk code including ADA provisions, construction sidewalk by middle school, completion of park sidewalk renovation, change in parking permission by middle school to protect pedestrian traffic, and grant approval to build sidewalk on St Rt 11 to Walmart), and two approved projects continue to be pending action by the Village Board (State Street Sidewalk, Village Code Update). The North Country Healthy Heart Network continues to work with Saranac Lake and Brushton on Complete Streets Policies. Other engaged partners include Franklin County Government, the Town and Village DPW offices, The Highway Department, Franklin County Traffic Safety Advisory Board, and the Malone Central School District. Saranac Lake, Fort Covington, Hogansburg, and Brushton also have complete streets and or healthy space projects supported by the North Country Healthy Heart Network. | Community-based organizations                                                               | Advisory        |           |                                         |            |                                                                                                 | OBJECTIVE 1.1.3:<br>Increase the number of municipalities that have passed Complete Streets policies.                                                                                                                                             |             | Adopt, improve, or implement Complete Streets principles: Support and strengthen local complete streets policies and guidelines and implement Complete Streets projects.                                                                                                                                                                                                                                  | Number of projects implemented                                                                                  |
|          | All AHMC Primary Care practice have BMI automatically calculated within the EMR, as well as a discussion/plan template built in for patients who are above/below healthy range. AHMC has approximately 12,350 patients that fall into category of BMI greater than or equal to 25 and 2017 year to date (Jan 1-November 30) there have been approximately 2,461 patients that have received some type of follow up specifically related to obesity.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Hospital                                                                                    | Leadership      |           |                                         |            | Expand the role of health care and health service providers and insurers in obesity prevention. | OBJECTIVE 1.3.1:<br>Increase the percentage of children and adults with an outpatient visit with a primary care provider or obstetrics/gynecology practitioner during the measurement year who received appropriate assessment for weight status. |             | Increase the capacity of primary care providers to implement screening, prevention and treatment measures for obesity in children and adults through quality improvement methods and other training approaches, reimbursement and payment incentives (IOM Obesity Prevention). Providers at primary care practices will document patient BMI, develop a plan with the patient and document in the patient | Number of patients with BMI ≥26 with documented discussion with provider regarding plan for overweight/obesity. |
|          | The pediatric obesity program ended in August 2016 and the practice is not currently participating in any other obesity-specific initiative. However, the practice continues to closely monitor BMI and recommend appropriate diet and exercise to all patients. Information is provided during visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Hospital                                                                                    | Leadership      |           |                                         |            |                                                                                                 |                                                                                                                                                                                                                                                   |             | Increase the capacity of pediatric providers to implement screening, prevention and treatment measures for obesity in children through quality improvement methods and other training approaches, reimbursement and payment incentives (IOM Obesity Prevention). Develop a Childhood Obesity Initiative to be implemented in Pediatric Primary Care practice.                                             | Program developed and implemented in Pediatric Primary Care practice                                            |

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|          | There were 42.8% of patients exclusively breastfed at discharge which is an increase over the baseline.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Hospital                                                                             | Leadership      |           |                                         |            |      | OBJECTIVE 1.3.2:<br>Increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization. |                | Link health care based efforts with community based programs and services for breastfeeding counseling and support: Continued participation in Great Beginnings, NY                                                                 | Breastfeeding rates at discharge.                                                                               |
|          | There is currently 1 pediatric practice that is certified as a NYS breastfeeding friendly practice.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Hospital                                                                             | Leadership      |           |                                         |            |      |                                                                                                                                              |                | Encourage adoption of breastfeeding friendly policies in hospital owned practices.                                                                                                                                                  | Number of practices certified as NYS Breastfeeding Friendly Practices.                                          |
|          | Monthly meetings attended by both Franklin County Maternal Child Health Nurses. Additional partners include Alice Hyde Hospital, WIC, Catholic Charities, Clinton County Health Department, Child Care Coordinating Council of the North Country. Family picnic coordinated by WIC held for breastfeeding mothers and families during awareness week in August, WIC developed guide to facilitate ordering breastfeeding pumps for ObGyn offices, Alice Hyde Medical Center Administration working on allocating a breastfeeding room and implementing a worksite breastfeeding policy with guidance from Clinton County Public Health. | Hospital                                                                             | Leadership      |           |                                         |            |      |                                                                                                                                              | Low Income     | Continued participation in Breastfeeding Council of Malone                                                                                                                                                                          | Attend Meetings                                                                                                 |
|          | Every patient in the OB practice receives information about breastfeeding in all trimesters. Chart reviews showed 95%, 70%, and 82% due to documentation challenges. Two staff members were sent for additional training on lactation counseling in 2017. The practice does a follow up call after delivery to identify those who continue breastfeeding after discharge.                                                                                                                                                                                                                                                               | Hospital                                                                             | Leadership      |           |                                         |            |      |                                                                                                                                              | Access to Care | Ensure access to breastfeeding education, lactation counseling and support: Implement lactation support program, including availability of Certified Lactation Counselors, and prenatal breastfeeding education in OB/GYN practice. | Number of Certified Lactation Counselors Trained<br>Number of women who receive lactation support or education. |

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|          | All learning sessions completed. Franklin County Public Health built a breastfeeding room available to all Franklin County Workers and the general public. Public Health worked with Personnel Department on county-wide breastfeeding in the work place guidance, formally adopted and distributed to department heads in November of 2016. | Local health department                                                              | Leadership      |           |                                         |            |      |            |                | Participate in NY Academy of Medicine Breastfeeding Community of Practice Advancing Prevention Project                                                                                                                                                                                                                          | Number of Learning Sessions Attended<br><br>Strategic plan resulting from program specific consultation                                         |
|          | Franklin County maternal child health nurse obtained CLC certification; updated brochure distributed to hospital advising mothers that free counselor services available through public health. Home visit offered to every child born in Franklin County. 136 of 276 breastfeeding mothers reached by telephone.                            | Local health department                                                              | Leadership      |           |                                         |            |      |            | Access to Care | Provide support to Breastfeeding mothers through Franklin County Public Health Nurse Home Visiting Program; Healthy Families NY Program, and JCEO Early Head Start                                                                                                                                                              | Number of phone calls made to breastfeeding mothers<br><br>Number of home visits made to breastfeeding mothers                                  |
|          | There have been six Childbirth Classes in 2017 with approximately 60 participants.                                                                                                                                                                                                                                                           | Hospital                                                                             | Leadership      |           |                                         |            |      |            |                | Establish Childbirth Classes to provide education to new mothers. Ensure access to breast feeding education, lactation counseling and support.<br>( <a href="https://mchb.hrsa.gov/maternal-child-health-topics/maternal-and-womens-health">https://mchb.hrsa.gov/maternal-child-health-topics/maternal-and-womens-health</a> ) | Number of classes held.<br><br>Number of participants in classes.                                                                               |
|          | A feasibility study was conducted that determined that given AHMC's current financial standing, there is not a great enough need to implement this program at this time. The program was launched but there were only 4 interested participants. All staff were trained for the program.                                                     | Hospital                                                                             | Leadership      |           |                                         |            |      |            | Access to Care | Determine the feasibility of the implementation of a pre-natal Centering program.<br>INTERVENTION WILL BE REMOVED FOR 2018 (SEE COMMENTS)                                                                                                                                                                                       | Completion of feasibility study to determine if it makes sense to move forward with implementation. If yes, implementation in subsequent years. |

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|          | In 2016 the Eastern Adirondack Health Care Network trained a total of five (5) new peer leaders to deliver the Chronic Disease Self-Management Program, locally known as the Living Healthy workshop. Please note three (3) leaders were from Malone and two (2) leaders were from SRMT Hogansburg. In 2017 a total of six (6) peer leaders trained: Three (3) leaders were from SMRT Hogansburg. Workshops delivered in 2017: A total of twenty two (22) participants completed the workshop. (Complete means that they met the requirement of attending at least 4 out of 6 sessions. Breakdown as follows: February, Out of eight (8) participants who enrolled, seven (7) completed the workshop; April, Out of eight (8) participants, seven (7) completed the workshop; May, Out of nine (9) participants, eight (8) completed the workshop. | Other (please describe partner and role(s) in column D)                              | Eastern Adirondack Health Care Network; Leadership |           |                                         |            | Promote culturally relevant chronic disease self management education. | OBJECTIVE 3.3.1:<br>Increase the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. |             | Develop a sustainable infrastructure for widely accessible, readily available self-management interventions: Assure instructors for chronic disease self management (CDSM) classes are trained.                                                                                                                 | Number of instructors trained.                                                        |
|          | For the period of 1/1/17-4/30/17, Tai Chi for Health was offered at various community locations. Approximately 60 people participated on a regular, weekly basis. In addition, one Living Healthy with Chronic Conditions Program was offered. Nine participants completed the program. There is a Diabetes Self-Management Program offered, through individual sessions. 180 new individuals were enrolled and 450 individuals that were participants in a previous year self-management program were seen with follow-up visits.                                                                                                                                                                                                                                                                                                                 | Hospital                                                                             | Leadership                                         |           |                                         |            |                                                                        |                                                                                                                                                                                            |             | Provide evidence based interventions (EBIs) for Chronic Disease Self Management at least twice per year in Franklin County. IE: CDSMP – Living Healthy with Chronic Conditions, CDC National Diabetes Prevention Program, Diabetes Self Management Program, Tai Chi for Health, Arthritis, and Fall Prevention. | Number and type of EBIs offered.<br>Number of participants in EBIs offered.           |
|          | Community Connections, local CBO, provides CDSM classes for Franklin County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Community-based organizations                                                        | Leadership                                         |           |                                         |            |                                                                        |                                                                                                                                                                                            |             | Assure trained lifestyle intervention professionals are available in clinical and community settings.                                                                                                                                                                                                           | List of CDSM professionals is developed and given to case managers and care managers. |

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|          | Regular Participants to monthly meetings include Behavioral Health Services, Community based organizations, Federally Qualified Health Center, Health Insurance Plans, Housing, Law Enforcement, Local Health Department, Office for the Aging, Social Services, Transportation, Joint Council for Economic Opportunity, United Way, Regional DSRIP Performing Provider System. County-wide service guide developed and distributed to all staff at partner agencies. An additional pocket sized service guide is indevelopment to be provided to NYS Troopers to be given to individuals who require guidance on community services. | Community-based organizations                                                        | Leadership      |           |                                         |            |      |            | Access to Care | Participate in Franklin County Community Connectins Coalition, based on the FSG Collective Impact Approach: Common Agenda, Shared Measurement, Mutually reinforcing activities, continuous communication, backbone organizations. The goal of the coalition is to share details of activities/interventions so that agencies do not duplicate work, and the group can identify gaps in service and collaborate to ensure individuals with MEB disorders and chronic diseases receive the wrap-around services they need to remain in the community. <a href="https://www.fsg.org/ideas-in-action/collective-impact">https://www.fsg.org/ideas-in-action/collective-impact</a> | List of participating agencies and community based organizations.<br>List of programs/services offered by partner organizations. |
|          | Single presentation completed in July 2017 to County Manager and 7 County Legislators. Unable to schedule presentation to St. Regis Mohak chief. Presentation reviewed RWJ Foundation County Health Rankings Data, emphasised the "social determinants of health," and explained the rationale behind the health in all policies approach. Presentation well recieved, with follow up data on Franklin County Health reports requested and submitted to meeting attendees.                                                                                                                                                            | Local governmental unit                                                              | Transactional   |           |                                         |            |      |            |                | Support a "health in all policies" approach to legislation: Present to County Legislators, County Manager, and Tribal Leadership on County Health Rankings and the impact of policymaking on health outcomes. The health in all policies approach is supported by the CDC, WHO, and public health institute as a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. <a href="https://www.cdc.gov/policy/hiap/index.html">https://www.cdc.gov/policy/hiap/index.html</a>                                                                                       | Number of individual meetings held with county policymakers.                                                                     |
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                      |                 |           |                                         |            |      |            |                | remove intervention                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Create and make available to clinicians and the public a list of community-based CDSM opportunities.                             |

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|                                                   | See evidence based intervention activity above.                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                 |                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                          |                                                                                                                                                                                                           |                                                                                                                                                                                                                                |                | Adopt policies and a system for identifying and referring patients to CDSM opportunities in the community setting. IN 2018, WE WILL BE REMOVING THIS INTERVENTION AS IT IS DUPLICATIVE OF ANOTHER INTERVENTION THAT WAS IDENTIFIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | System developed and adopted.                                                              |
| Promote Mental Health and Prevent Substance Abuse | The Crisis Stabilization Unit is located in the former Nursing Home space at AHMC, allowing patients to go directly from the ED or walk-in. An open house and ribbon-cutting ceremony were held with Citizens Advocate on August 28, 2017. From Aug 28 to Sept 30, there were 12 patients moved directly from the ED to Crisis Stabilization. There were 23 patients that avoided the ED and went right to the Crisis Unit. | Hospital                                                                                    | Leadership      | There is a community commitment to allocation of resources to combat crisis based on the significant need that has been identified. DSRIP dollars were received to help fund the Citizens Advocate project. | The community need for substance abuse and other MEB disorders exceeds current resources. Timelines that are out of the control of the LHD and hospital are challenging. This is especially true for activities that involve infrastructure and establishment of new services. Competing priorities and limited resources among lead organizations is a challenge. Partner organizations do change course and activities formally featured in plan may or may not be seen through. | Strengthen infrastructure across systems | Support collaboration among leaders, professionals, and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention treatment and recovery. | OBJECTIVE 3.1.1: Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost effectiveness strategies for integration and coordination, and the impact of interventions. | Access to Care | from governmental agencies, health care and community based organizations, schools, etc. to serve on an interdisciplinary team to address the specific MEB issues in the community that includes an approach that balances promotion, prevention, treatment and maintenance: Partner with Citizen Advocates in the creation of a Crisis Stabilization Unit on Medical Center campus. Develop policies and procedures to identify patients that need referrals to the unit. ( <a href="https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/overview.htm">https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/overview.htm</a> - The creation of a Crisis Stabilization Unit was a DSRIP initiative, hence this intervention is a best practice.) ( <a href="https://www.samhsa.gov/co">https://www.samhsa.gov/co</a> | Program established; Policy In Place for Referrals; Number of patients referred to program |

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|          | Regular Participants to monthly meetings include Behavioral Health Services, Community based organizations, Federally Qualified Health Center, Health Insurance Plans, Housing, Law Enforcement, Local Health Department, Office for the Aging, Social Services, Transportation, Joint Council for Economic Opportunity, United Way, Regional DSRIP Performing Provider System | Community-based organizations                                                               | Leadership      | Cross-sector collaboration and networking | Public health is not the lead agency; can suggest but not dictate interventions/strategies/approaches |            |      |            | Access to Care | Participate in Franklin County Community Connectins Coalition, based on the FSG Collective Impact Approach: Common Agenda, Shared Measurement, Mutually reinforcing activities, continuous communication, backbone organizations. The goal of the coalition is to share details of activities/interventions so that agencies do not duplicate work, and the group can identify gaps in service and collaborate to ensure individuals with MEB disorders receive the wrap-around services they need to remain in the community. <a href="https://www.fsg.org/ideas-in-action/collective-impact">https://www.fsg.org/ideas-in-action/collective-impact</a> | Measure: Number of organizations collaborating on an initiative; Number of meetings held |
|          | Annual 2-day training and conference held; Post Vention Plan Developed with facilitation by NYS OMH rep. Participating Agencies include Behavioral Health Services, Franklin County Community Services, School Districts, Community Based Organizations, Faith Based Organizations, Local Health Department, YouthPower!, Social Services, Students                            | Local governmental unit                                                                     | Leadership      |                                           |                                                                                                       |            |      |            | Access to Care | Participate in Franklin County Suicide Prevention Taskforce monthly meetings; follow task force strategic plan approved by NYS OMH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Participating Agencies                                                                   |

Franklin County Combined CHA-CHIP-CSP  
2017 Update

Completed by: Erin Streiff

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NOTE: Adirondack Health Update Submission Separate

| Priority | 2017 Progress to Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Implementation Partner<br>(Please select one partner from the dropdown list per row) | Partner Role(s)                                    | Strengths | Challenges? How will they be addressed? | Focus Area | Goal | Objectives                                                                                               | Disparities | Interventions/<br>Strategies/Activities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Family of Measures                                                                       |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------|-----------|-----------------------------------------|------------|------|----------------------------------------------------------------------------------------------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
|          | Participants include Behavioral Health, Social Services, Faith Based, Law Enforcement. Participants agree to be interviewed by MS student to explore feasibility of implementing needle exchange project with linkage to rehabilitation care, to be completed January 2018. Subcommittee developed survey to be administered to community members to determine educational needs for planning future projects; survey to be distributed February 2018 throughout Franklin County. Subcommittee participating in "Neurobiology of Stress" presentation discussing Trauma Informed Care Approaches. Subcommittee planning community screening of "Chasing the Dragon," a documentary detailing the impact of opioid addiction. | Other (please describe partner and role(s) in column D)                              | North Star Behavioral Health Services - Leadership |           |                                         |            |      |                                                                                                          |             | Participate in Franklin County Prevention Taskforce Opioid subcommittee to address and prevent opioid addiction using Project Lazarus model. Model consists of:<br>Community Education to improve the public's capacity to recognize and avoid the dangers of misuse/abuse of prescription opioids. Provider Education to support screening and appropriate treatment for mental illness, addiction, and pain. Hospital ED Policies to encourage safe prescribing of controlled substances and provide meaningful referrals for chronic pain and addiction. Diversion Control to reduce the presence of unused medicines in society. | Taskforce development and number of organizations or agencies who commit to participate. |
|          | AHMC continues to work with Citizen Advocates and other community partners to explore opportunities to integrate behavioral health into the existing primary care practices. Behavioral health screenings are part of the care provided to patients of the primary care practice and referrals are made as appropriate to behavioral health specialists.                                                                                                                                                                                                                                                                                                                                                                     | Hospital                                                                             | Leadership                                         |           |                                         |            |      | OBJECTIVE 3.1.4:<br>Support efforts to integrate MEB disorder screening and treatment into Primary Care. |             | Support a collaborative care model in primary care settings: Integrate behavioral health into primary care practice.<br>( <a href="https://www.kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicare-models/">https://www.kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicare-models/</a> - Evidence of this being best practice.)                                                                                                                                                                                                             | Number of patients receiving behavioral health services.                                 |
|          | There were 9,055 PHQ-9 screenings done from Jan 1, 2017-Nov. 30, 2017 and 243 referrals made to Behavioral Health providers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Hospital                                                                             | Leadership                                         |           |                                         |            |      |                                                                                                          |             | Integrate mental health screening into primary care . It is an ACO MSSP Quality Measure to perform depression screenings at Annual Wellness Visits. Therefore, AHMC Primary Care practices have screening templates built into EMR and are conducting.<br>( <a href="https://www.kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicare-models/">https://www.kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicare-models/</a> - Evidence of this being best practice.)                                                                           | Number of patients screened                                                              |

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NOTE: Adirondack Health Update Submission Separate

| Priority | 2017 Progress to Date                                                                                                                                                         | Implementation Partner<br><i>(Please select one partner from the dropdown list per row)</i> | Partner Role(s) | Strengths | Challenges? How will they be addressed? | Focus Area | Goal | Objectives | Disparities | Interventions/<br>Strategies/Activities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Family of Measures                                                                             |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------|-----------|-----------------------------------------|------------|------|------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
|          | Due to AHMC's current financial situation, this project has been placed on hold. AHMC is evaluating space options that fit into the financial framework for the organization. | Hospital                                                                                    | Leadership      |           |                                         |            |      |            |             | Expand AHMC Primary Care building, developing a coordinated, multi-disciplinary approach that includes behavioral health. Co-locate behavioral health providers into new space for primary care.<br>( <a href="https://www.kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicare-models/">https://www.kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicare-models/</a> - Evidence of this being best practice, particularly the co-location piece.) | Business Plan Approval.<br>CON Submission.<br>CON Approval.<br>Construction completed in 2018. |