

Essex County Community Health Improvement & Service Plan 2016-2018: 2017 PROGRESS REPORT

This report is a 2017 Progress Report to the *Essex County Community Health Improvement & Service Plan 2016-2018*; hereafter referred to as the Plan. That Plan describes priorities, strategies and activities strategically selected by Essex County Partners [Essex County Health Department; University of Vermont Health Network-Elizabethtown Community Hospital and Moses Ludington Hospital; and Adirondack Health, Adirondack Medical Center].

As described in this Report, Partners have made substantial progress on most activities in that extensive and optimistic Plan. Given the circumstances of numerous staff changes at partner organizations, the transition of organizational leadership at Moses Ludington Hospital to the UVHN, and additional major projects including DSRIP and additional grant projects, Partners are proud to report on achieved progress for the 2017 year.

This Report uses the original Plan tables with the addition of four (4) columns:

- Performance Measure Progress to Date;
- Progress Notes;
- Strengths [encountered in working on each activity]; &
- Challenges [encountered while working on each activity] and how they will be addressed.

This Report includes documentation of activities for a third priority area - Tobacco & Second Hand Smoke Exposure not included in the Plan as originally written. However Essex County Partners have been engaged in activities to address this priority and find this Report an appropriate location to capture such activities.

Contacts for this Report are:

**Essex County Health Department
Public Health Unit**

Susan Allott
518-873-3514
sallott@co.essex.ny.us
and
Jessica Darney Buehler
518-873-3518
jdbuehler@co.essex.ny.us

**University of Vermont Health Network
Elizabethtown Community Hospital
Moses Ludington Hospital**

Julie Tromblee
518-873-3013
jtromblee@ech.org
and
Heather Reynolds
518-873-3038
hreynolds@ech.org

**Adirondack Health
Adirondack Medical Center**

Bonnie Ohmann
518-897-2439
bohmann@adirondackhealth.org
and
Matthew Scollin
518-897-2431
mcollin@adirondackHealth.org

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:

School age children: 19.2% to 16.7%
Adults: 32.2% to 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
Improve offerings at small stores; improve visibility and access through store layout & displays by implementing <i>Better Choice Retailer</i> or other similar on-site marketing/cues for healthier choices.	<u>Income</u> Target communities that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program.	<ul style="list-style-type: none"> Public Health – outreach/coordination; grant application; policy template Small store operators – policy adoption & retailer displays ARHN – Prevention Agenda support funds 	<p>3 stores that have improved offerings</p> <p>3 stores that have improved visibility & access</p>	Keeseville Farmacy Willsboro Meat Market Ernie’s Market	Stores were happy to support local farmers/farms. ARHN provided Prevent Agenda mini-grant funds to give stores display racks for healthier options.	Stores want to better understand benefit to them. We will create a 1-pager to best answer “What’s in it for me?” to describe benefits to patrons and businesses.
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.	<u>Income & Aging</u> <u>Population</u> Target education to income-eligible Community Action Program (CAP) participants and OFA senior clients.	<p>Creating Health Schools & Communities (CHSC) grant program</p> <p>small store operators</p> <p>grocery stores</p> <p>Community Action Program (CAP) participants</p> <p>Office for the Aging (OFA)</p> <p>existing social groups (faith, parent, senior)</p>	<p>0 education sessions offered.</p> <p>0 participants reached.</p>	Price Chopper and Tops Markets have 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 will not continue this activity at this time.

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
Adopt, improve or implement <i>Complete Streets</i> principles through: <ul style="list-style-type: none"> • 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> <ul style="list-style-type: none"> • 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 policies or resolutions adopted. 0 land use planning documents impacted.	Chronic Disease Outreach Coordinator and CHSC gave 1 presentation at the Essex County Highway Superintendent Association meeting on 10/31/17. Topics included were status of communities with policies & technical assistance available thru the Health Department	Complete Streets 1-pager was created to educate the Highway Association on past projects and project ideas. Department has identified 2 target communities for 2018-Chesterfield and Schroon Lake.	Staffing changes in both the CHSC grant position and the Chronic Disease Outreach Coordinator positions have caused delay in this activity. It is anticipated that progress will be made in 2018 given staffing position stability.

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
Partner with public schools to update school wellness policies and practices to include: <ul style="list-style-type: none"> • School meals • Concessions • Fundraising. 	<u>Income</u> 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	<u>Public Health</u> with- <ul style="list-style-type: none"> • Creating Health Schools & Communities (CHSC) grant program • Public schools • Farmers and farm groups • Parent groups 	0 districts with updated wellness policies that meet target criteria.	3 CHSC school districts <ul style="list-style-type: none"> • Ticonderoga • Moriah • Elizabethtown – Lewis are in the process of revising their policies to meet USDA Final Rule requirements. 2 additional districts <ul style="list-style-type: none"> • Westport • Ausable Valley are engaged with policy revision for compliance with Final Rule. 	CHSC are granted additional incentive through funds to enhance environmental supports.	Schools are unaware of many of the new requirements. ECHD and CHSC are providing schools with a 1-pager that outlines the requirements and the Department will seek face-to-face meetings.
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
Partner with public schools to update school wellness policies and practices to include: <ul style="list-style-type: none"> • active recess • classroom activity breaks. 	<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> with- <ul style="list-style-type: none"> • CHCS Grant program • Local Government • Office for the Aging (OFA) • Trail Groups 	3 districts with updated wellness policies that meet target criteria.	3 CHSC school districts <ul style="list-style-type: none"> • Ticonderoga • Moriah Elizabethtown – Lewis updated wellness policies and have Comprehensive School Physical Activity Programs in place.	CHSC are granted additional incentive through funds to enhance environmental supports.	Schools are unaware of many of the new requirements. ECHD and CHSC are providing schools with a 1-pager that outlines the requirements and the Department will seek face-to-face meetings.

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
Partner with the CAP to: <ul style="list-style-type: none"> 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- <ul style="list-style-type: none"> Adirondack CAP WIC Creating Breastfeeding Friendly Communities grant (CBFC) 	4 child care providers have completed Breastfeeding-Friendly Child Care designation through NYSDOH.	<ol style="list-style-type: none"> Renee Anderson (Little Champs Daycare) - Port Henry Melissa Rider- Lewis Erika Kuhl – Ticonderoga Vesta Bill- Westport Information has been received and a breastfeeding-friendly childcare provider list will be developed and distributed in the upcoming months.	An Essex County Breastfeeding Coalition (ECBC) has been created. The first meeting is scheduled for January 2018. This activity has been added to the ECBC work plan.	Many providers are breastfeeding friendly but have not completed the official designation. ECHD will be working with daycare providers outside of the CBFC grant catchment area to help daycare providers who are interested in obtaining designation. NYDOH has experienced issues with their website and the designation process. CBFC grant will partner with NYSDOH to resolve.

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
Partner with health care providers on the adoption of breastfeeding friendly clinic practices & environmental supports.	<u>Access</u> Target provider practices across the geographic region.	<u>Public Health</u> with – <ul style="list-style-type: none"> Hospitals (All) Hospital-owned health centers FQHCs Other health care outpatient facilities/centers Creating Breastfeeding Friendly Communities grant (CBFC) 	0 provider practices that have adopted breastfeeding friendly policies and implemented environmental supports.	CBFC grant is working with Essex County. Ticonderoga Health Center and Moriah Health Center both have Certified Lactation Counselors on staff.	ECHD is spearheading the development of Essex County Breastfeeding Coalition (ECBC). The first meeting is scheduled for January 12, 2018. All Essex County primary care offices/hospitals have received an invitation to participate. This activity has been added to a ECBC work plan.	Providers identify time required for designation as a barrier. ECBC will continue to advance environmental supports & policy development even if practices do not achieve all requirements for designation. There are currently 3 resource guides (ECHD, WIC, and CBFC). The ECBC will work on 1 comprehensive list.
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	<u>Income</u> Assure providers are aware of resources available to WIC-eligible families and all families in Essex County.		1 public health detailing (PHD) session with providers Approximately 240 births; 177 received educational information from ECHD & 22 received visits from MCH nurses for one-on-one breastfeeding support.	Aug 2017 Provider PHD: <ul style="list-style-type: none"> OBs (none in Essex County) Primary care practices in Essex County Birthing hospitals (none in Essex County). 		

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Certified Lactation Consultant (IBCLC) available through the LHD to anyone in the county.			WIC has a participant population of approximately 700 per year. Of those approximately 125-150 receive breastfeeding services.	Public Health Detailing sessions are scheduled for January, July 2018	ECHD educational information packets are provided to all families with newborns; referrals from HCS Newborn Screening Program.	WIC is income based so can only reach their participants. However, 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 us. ECHD transitioned from working on referral by fax only to referrals from HCS Newborn Screening Program.
Provide a Women's Health Navigator, reprint Women's Guidebook and operate the associated phone line.	<u>Access</u> Target women and provide necessary information for any and all health needs for her and her family.	<u>Hospital</u> 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
Expand access to and consistency of primary patient care to implement screening prevention & treatment for obesity.	<u>Access</u> Construct a new primary care center in an underserved area and add a mid-level provider.	<u>Hospital</u> UVHN Elizabethtown Community Hospital	Complete the move of the health center into new building. Number of new patients served.	The new Crown Point Health Center was opened in May of 2017. As of December 2017 there have been 748 new patients established.	The space was a much needed addition to grow the practice and expand primary care services.	None foreseen.
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.	<u>Access & Age</u> Ensure community opportunities are geographically accessible. Ensure age-appropriate opportunities are available & promoted.	<u>Public Health and Hospitals (All)</u> with – • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers	3 sessions & 22 providers reached through public health detailing sessions.	Provider locations: • UVHN-ECH –All • Moriah Health Center • Schroon Lake Health Ctr	Sessions were well attended & providers were receptive to the information.	Not all providers attend meetings where detailing is conducted. It is difficult to determine how many providers are utilizing the resources that are distributed. Plan for 2018 is to continue sending email info to providers but to also conduct public health detailing with Referral and Care Coordinators for the health centers.

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Providers at primary care clinics will document patient BMI, develop a plan with the patient & document in the patient EMR.	<u>Access</u> Target population will have discussion with provider and referral to community-based opportunities.	<u>Hospital</u> UVHN Elizabethtown Community Hospital	Number of patients with BMI >25 with documented discussion with provider twice yearly regarding plan for overweight/obesity.	EMR modification to add BMI calculator and screening was initiated in beginning of 2017 through the accountable care organization measures as a joint improvement project. All patients at all visits in primary care have documented BMIs.	The EMR was modified to include BMI calculations at every visit with a reminder to the Provider to address a plan to assist the patient to reduce BMI. The EMR provides the plan for patients and is documented 90% at present.	Education to all health center staff on the measure for documentation in education of the patient in referral as appropriate. Limited resources in the area to assist the population in changing the lifestyle behaviors. Efforts will be made in 2018 to improve collaboration of ECHD & Chronic Disease Resources List with Referral and Care Coordinators.
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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
Increase the number of employer sites that have policies and practices to support breastfeeding friendly work environments.	<u>Income</u> Target lower-wage employers.	<u>Public Health</u> with- <ul style="list-style-type: none"> • WIC • Small business owners • Franchise owners • Creating Breastfeeding Friendly Communities grant (CBFC) 	4 worksites have adopted breastfeeding friendly policies and practices	1. Essex Co Sheriff Dept 2. Essex Co Health Dept 3. Ticonderoga Chamber of Commerce 4. Mountain Lake Services (various sites) The WIC Unit shared a list of worksites that they have worked with in the past.	Essex County has an existing policy. This may be modified for improvements and the consistency of putting the policy into practice better monitored through the ECBC.	Agencies are interested in becoming worksites but time constraints limit their amount of engagement. This activity has been added to our ECBC work plan to address potential worksites that fall out of the CBFC catchment area.

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
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- <ul style="list-style-type: none"> • Farmers • Farmer organizations/representatives • Employers (potential employers include schools, Mountain Lakes 	1 employer has implemented a farm to employer initiative.	UVHN-ECH established payroll deduction for CSA farm shares was implemented with 42 employees participating.	Delivery to hospital. Payroll deduction. Providing easy access to healthy foods.	Plan to expand to the MLH campus is on hold until corporate change is completed.

		Services, Ticonderoga Mill)				
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- <ul style="list-style-type: none"> • Health care systems (FQHCs; others) • Local vending company • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill) 	0 hospitals/health care systems/employers that have improved vending options.	Elizabethtown Community Hospital is a designated CHSC worksite. CHSC will be reaching out again soon to see if they are interested. 2018 goal to improve vending choices as MLH cafeteria closes.	7 worksites identified through the CHSC grant that will focus on improving food options offered in cafeterias and vending machines: 1. Elizabethtown Community Hospital 2. Mountain Lake Services (8 residences) 3. Essex Co Sheriff Dept 4. Essex Co Health Dept 5. Essex Co Transportation 6. Essex Co Office for the Aging 7. Essex Co DSS Coordinated Care/Adult Protective Services CHSC grant allows funding available to purchase incentives for worksites within their catchment area.	Worksites identify time constraints prevent engagement in this area.
Offer lifestyle modification workshops to local employers to prevent obesity.	Partner with community employers to offer on-site lifestyle modification workshops.	<u>Hospital</u> UVHN Elizabethtown Community Hospital and MLH	0 worksites have taken part in program. Extend to MLH campus as it comes under ECH (projected for 2017).	Not Completed	This would unite work places with options for healthy living education.	Employee with special skill set moved on, leaving a vacancy. Plan to address in 2018.

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:

Cardiovascular Disease, Premature (Ages 35-64) Deaths/100,000	127.2 to	<=96.8
Diseases of the Heart, Premature (Ages 35-64) Deaths/100,000	115.3 to	<=79.9
Diabetes Deaths/100,000	31.6 to	<=19.6
Cancer Cases/100,000	664.8 to	<=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
Use paid and earned print media, social media and community outreach to raise awareness of need and demand for screening for chronic conditions.	<u>Income</u> Target those without health insurance/eligible for the Cancer Services Program.	<u>Public Health & Hospitals (All)</u> with- <ul style="list-style-type: none"> Franklin & Essex Cancer Screening Program (CSP) Media OFA/NY Connects Food pantries 	4 media and outreach activities conducted. 20 individuals served through the CSP	This program transition from being housed at the ECHD to the Adirondack Community Action Program (ACAP). The Franklin County Health Department maintained activities in the interim.	New staff person hired by ACAP. ECHD has met to collaborate & anticipate open communication.	The Essex County sub-contract for the CSP grant moved from ECHD to ACAP.
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
Offer cancer screening events at least twice per year at different locations in the county.	<u>Income, Access & Aging</u> Target people eligible for the CSP to ensure screening is available to those ages 50+ without health insurance.	<u>Public Health & Hospitals (All)</u> with- <ul style="list-style-type: none"> Franklin & Essex Cancer Screening Program Media OFA/NY Connects Food pantries 	2 events offered. 6 individuals served through screening events.	ACAP collaborated with ECH and MLH to provide two cancer-screening events: 1. Ladies Night at ECH on 11/8/17 2. Moses Ludington Hospital 10/25/17	New staff person hired by ACAP. ECHD has met to collaborate & anticipate open communication.	The Essex County sub-contract for the CSP grant moved from ECHD to ACAP.
Offer diabetes screenings at community health events	<u>Access</u> Target those without health insurance and increase ability of diabetes screening	<u>Hospital UVHN</u> Elizabethtown Community Hospital and MLH	4 events 105 screenings Extend to MLH campus in 2017/2018.	Free health fairs were offered to the public where diabetes screening was completed: ECH -3 MLH - 1	Early identification of diabetes risk and referral/education for intervention. Offered to high risk group that does not typically have health insurance.	Goal is to hold more free health events at MLH but this is contingent upon corporate change.
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	<u>Hospital UVHN</u> Elizabethtown Community Hospital	770 new patients and current patients screened.	Tobacco screening is at 100%- all patients that smoke are screened- total of 770 screenings completed.	Identifying COPD and referring for treatment and education earlier.	Participation in the pulmonary rehab program is usually low.

	center for those identified as 'at risk' by survey.			PFT's performed on 15 patients.	Respiratory therapist as part of health team. Obtaining new PFT equipment at health centers.	Smokers are often not willing to quit. Continued screening & provider recommendation.
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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
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.	<u>Access & Income</u> Adoption of policies and systems ensures universal screening and referral.	<u>Public Health & Hospital</u> UVHN Elizabethtown Community Hospital Diabetes Educator at ECH	0 practices adopted a policy for identification and referral system for care.	Policy adoption was not pursued in 2017.	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
Establish an Outreach Coordinator position & a Chronic Disease Care Coordinator position to facilitate care & link of patients to care & community resources.	<u>Access</u> Facilitate access to care & community resources for patients.	<u>Hospital</u> UVHN Elizabethtown Community Hospital & <u>Public Health</u>	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.
Offer at least two (2) Better Breathers program to community annually.	<u>Access</u> ALA sponsored pulmonary exercise and education program.	<u>Hospital</u> UVHN Elizabethtown Community Hospital	2 programs provided 2017 year.	Two pulmonary rehab programs were held (Spring/fall).	No other pulmonary rehab in the county.	Getting patients to finish the program is difficult because of fragile health. Obtaining referrals is difficult.

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<p>Establish a system for identifying & referring patients for Smoking Cessation.</p>	<p><u>Access, Income</u> Universal screening likely to identify income-limited patients eligible for smoking cessation services.</p>	<p><u>Hospital</u> UVHN Elizabethtown Community Hospital</p>	<p>Referral built into GE (EMR).</p>	<p>In process</p>	<p>Two new Tobacco Treatment Specialists trained through UMass Medical.</p>	<p>Working on designing workflow for primary care and specialists.</p>
<p>Offer cardiac or pulmonary rehab to any patient who qualifies.</p>	<p><u>Access, Income</u> Universal screening likely to identify income-limited patients eligible for smoking cessation services.</p>	<p><u>Hospital</u> UVHN Elizabethtown Community Hospital</p>	<p>23 patients served through these programs.</p>	<p>36 patients started the programs and 23 actually made it to completion.</p>	<p>Respiratory Therapist on staff. New exercise physiologist hired.</p>	<p>Getting patients to finish the program is difficult because of fragile health. Obtaining referrals is difficult. Early detection of COPD & management is key. Health Center staff screen smokers for COPD through spirometry. Referral to Pulmonary Rehab & COPD team initiative begun to assist in the challenges Continue to offer classes and possibly expand to the southern end of county at MLH.</p>

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
Ensure instructors for chronic disease self-management (CDSM) classes are trained.	<u>Access, Aging, Income</u> Provide classes at no or low cost	<u>Hospital UVHN</u> Elizabethtown Community Hospital, MLH, & <u>Public Health</u> with- <ul style="list-style-type: none"> • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects Low-income housing facilities	At least 3 instructors trained. Extend to MLH campus in 2018.	2 instructors trained in Essex County from: <ul style="list-style-type: none"> • ECH • Mental Health Association 	Training expenses covered through Eastern Adirondack Healthcare Network	1 additional person was trained and vacated the position leaving only 2 instructors. Newly hired Chronic Disease Outreach Coordinator at ECHD will be taking the Chronic Disease Self Management Training in the Spring of 2018.
Provide CDSM classes at least twice per year in Essex County.	<u>Access, Aging, Income</u> Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	<u>Hospitals (All) & Public Health</u> <ul style="list-style-type: none"> • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers 	2 classes conducted and 13 participants completed the series	2 classes were offered at UVHN-ECH.	The series is conducted through collaborative efforts of ECH, Eastern Adirondack Healthcare Network and trained instructors. The series garnered enough participants to conduct & most completed the series.	Though offered twice, the series was only offered in 1 location. For 2018 ECHD will work on ensuring the series is offered in at least 1 additional location. The targeted community is Ticonderoga.
Ensure trained lifestyle intervention professionals are available in clinical and community settings.	<u>Access, Aging, Income</u> Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	<u>Hospitals (All) & Public Health</u> <ul style="list-style-type: none"> • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers 	3 lifestyle intervention professionals were trained in 2017.	1 – ECHD 1 – UVHN-ECH 1 – Mental Health Association (MHA)	Newly hired Chronic Disease Outreach Coordinator at ECHD will be taking the Chronic Disease Self-Management Training in the Spring of 2018.	

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
Maintain a community resource list of Chronic Disease Self-Management (CDSM) opportunities including multi-session education series, support groups, etc.	<p><u>Income</u> Assure there are no or low cost options available.</p> <p><u>Access, Income</u> Assure opportunities are easily accessible to those with limited income & transportation.</p> <p><u>Aging</u> Assure opportunities are offered at times and locations and content is targeted for the aging population.</p>	<p><u>Public Health</u> with-</p> <ul style="list-style-type: none"> • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects • Low-income housing facilities 	1 comprehensive Chronic Disease Self-Management Guide was created and made available to clinicians & the public.	The Guide was distributed throughout Essex County communities in the winter/spring of 2017.	Clinical & community providers were cooperative in sharing their contact information & providers were accepting of using the Guide with patients.	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.
Use public health marketing & communication to share opportunities for CDSM in the community setting.	<p><u>Income</u> Target community outreach efforts to those with limited income or transportation.</p>	<p><u>Public Health</u> with-</p> <ul style="list-style-type: none"> • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries • Low-income housing facilities 	<p>Number of marketing/communications promoting CDSM in the community:</p> <p>3 ECHD Facebook posts 8 Community outreach Targeted Outreach</p>	<p>Targeted Outreach:</p> <ul style="list-style-type: none"> • Health Centers • Churches • Food Pantries • Office for the Aging Meal Sites & Meals on Wheels <p>Community Outreach to:</p> <ul style="list-style-type: none"> • Fairs/Picnics <p>Included with annual Provider Packet to Essex County providers.</p>	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.
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.	<p><u>Access & Income</u> Adoption of policies and systems ensures universal screening and referral.</p>	<p><u>Public Health and Hospitals</u> (All)</p>	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 apprised 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:

Vendor Sales to Minors 3.8% to <=5.5%

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
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.	<u>Income</u> Children comprise the highest percent of Essex County residents living in poverty	<u>Public Health</u> with- <ul style="list-style-type: none"> 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 – established & conducting monthly meetings Adopt a T21 Policy – draft policy developed & under review.	ECHD has 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 activities to inform stakeholders of the initiative and request support & contribution to local policy development & adoption.	Essex County has experience working on tobacco policy with the county through policy development and adoption previously (2012-2013) for the county campus. There is a regional effort to adopt T21 policies & it is a project of the PHIP providing shared learning, resources & experiences.	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
a. Ensure locally trained tobacco cessation specialists; & b. Establish policy/procedures and practices to facilitate access to & use of tobacco dependence treatment.	<u>Access to Care</u> Improve local provider access where currently none exists	<u>Hospitals</u> – UVHN-ECH	Staff trained as tobacco cessation specialists System of referral to tobacco cessation established	2 staff trained as tobacco cessation specialists Development of referral process is underway.	Working on designing workflow for primary care and specialists.	None to report at this time.

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

TYPE	DESCRIPTION	CHIP/CSP Priorities		Emerging	Disparities			Essex County Health Partners			
		Obesity	Chronic Disease	MEB/SA	Income	Aging	Access	AH	ECH	MLH	ECHD
DSRIP	2ai Integrated Delivery System	X	X		X		X	X	X	X	
	2aai 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		
	3aai 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	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 Interventions For Total (LIFT) Population Health grant (pending approval/funding)	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	