Schuyler County
Community Health Improvement Plan: 2016-2018

Finalized: 10.26.2016

Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives **Taken directly from NYSDOH Prevention Agenda Outcome Objectives*	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#1.4 Expand the role of public and private employers in obesity prevention.	**Objective 1.4.1:** By December 31, 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities. Baseline to be determined.) (Data Source: NYSDOH Healthy Heart Program Worksite Survey)	Implement nutrition and beverage standards in public institutions, worksites, and other key locations such as hospitals.	Number and type of key community locations that adopt and/or implement nutrition and beverage standards. Number of adults that have access to key community locations that adopt and/or implement nutrition and beverage standards.	Schuyler Hospital to adopt and implement nutrition and beverage standards in Hospital cafeteria. Schuyler Hospital and Public Health to pursue acquiring a calorie counting machine for use with implementing nutrition standards. Public Health to identify and potentially recruit additional worksites. S2AY RHN/Regional Worksite Wellness Committee to assist PH and partners in worksite wellness efforts.	- Public Health commits 0.2 FTE/year - Schuyler Hospital commits 0.01 FTE/year. <u>Additional Community Partners</u> Regional Worksite Wellness Committee / S2AY RHN: $2,475 for CHIP Cycle

Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings.					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☒ Yes ☐ No *Disparity is addressed through increasing percentage of individuals who receive screening with an annual income of <$25,000.					
Goal	Outcome Objectives **Taken directly from NYSDOH Prevention Agenda Outcome Objectives*	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
#3.1 Increase screening rates for cardiovascular diseases, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	**Objective 3.1.1:** By December 31, 2018[a], increase the percentage of women aged 50-74 years with an income of < $25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), by 5% from 76.7% (2010) to 80.5%. (Data Source: NYS BRFSS) (Health Disparities Indicator) (Also, see: Focus Area - Preconception and Reproductive Health)	a. Use media and health communications to build public awareness and demand. (Guide to Community Preventive Services [Community Guide]) b. Foster collaboration among community-based organizations, the education and faith-based sectors, independent living centers, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive services. (National Prevention Strategy) c. Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability literacy and providers' cultural competence. (Community Guide) d. Expand use of health information technology to remind, provide feedback and incentivize clinicians and health care systems. (Community Guide; National Prevention Strategy) https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/index.htm#cde31	Number of patients navigated to and/or through screening. Number of events held, promoted and attended. Number of media alerts. NYS Cancer Service clients screened.	Schuyler Hospital to conduct screenings. Schuyler Hospital to work on the development of tools and process to allow Hospital to track individual patient screenings. Public Health, and Schuyler Hospital to facilitate any screening event with willing partners for example (Office for the Aging, Catholic Charities – Food Pantries, Local Churches etc.) Group to establish and participate in a Preventative Health Coalition.	- Schuyler Hospital commits 0.01 FTE/year. - Public Health commits 0.2 FTE/year Additional Community Partners -Any community partner willing to hold and or conduct screening event.

	Objective 3.1.3: By December 31, 2018, increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or a sigmoidoscopy in the past 5 years and a blood stool test in the past 3 years or a colonoscopy in the past 10 years) by 5% from 68.0% (2010) to 71.4%. (Data Source: NYS BRFSS) (Data Availability: state, county), HP 2020 (C-16) target: 70.5% (all adults) By 5% from 68.0% (2010) to 71.4% for all adults. Note! In November 2015, a revised target of 80% was set for 2018. By 10% from 59.4% to 65.4% for adults with an income <$25,000. (Data Source: NYS BRFSS) (PA Tracking Indicator; Health Disparities Indicator)	a. Use media and health communications to build public awareness and demand. (Guide to Community Preventive Services [Community Guide]) b. Foster collaboration among community-based organizations, the education and faith-based sectors, independent living centers, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive services. (National Prevention Strategy) c. Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability literacy and providers' cultural competence. (Community Guide) d. Expand use of health information technology to remind, provide feedback and incentivize clinicians and health care systems. (Community Guide; National Prevention Strategy) https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/index.htm#cde31	Number of patients navigated to and/or through screening. Number of events held, promoted and attended. Number of media alerts. NYS Cancer Service clients screened.	Schuyler Hospital to conduct screenings. Schuyler Hospital to work on the development of tools and process to allow Hospital to track individual patient screenings. Public Health, and Schuyler Hospital to facilitate any screening event with willing partners for example (Office for the Aging, Catholic Charities – Food Pantries, Local Churches etc.) Group to establish and participate in a Preventative Health Coalition.	- Schuyler Hospital commits 0.01 FTE/year. - Public Health commits 0.2 FTE/year <u>Additional Community Partners</u> -Any community partner willing to hold and or conduct screening event.

	Objective 3.1.4: By December 31, 2018, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. (Data Source: NYS BRFSS)	a. Use media and health communications to build public awareness and demand. (Guide to Community Preventive Services [Community Guide]) b. Foster collaboration among community-based organizations, the education and faith-based sectors, independent living centers, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive services. (National Prevention Strategy) c. Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability literacy and providers' cultural competence. (Community Guide) d. Expand use of health information technology to remind, provide feedback and incentivize clinicians and health care systems. (Community Guide; National Prevention Strategy) https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/index.htm#cde31	Number of patients navigated to and/or through screening. Number of events held, promoted and attended. Number of media alerts. Number of individuals who have received a blood sugar test at a screening event.	Schuyler Hospital to conduct screenings. Schuyler Hospital to work on the development of tools and process to allow Hospital to track individual patient screenings. Public Health, and Schuyler Hospital to facilitate any screening event with willing partners for example (Office for the Aging, Catholic Charities – Food Pantries, Local Churches etc.) Group to establish and participate in a Preventative Health Coalition.	- Schuyler Hospital commits 0.01 FTE/year. - Public Health commits 0.2 FTE/year and additional: *Grant Funds in the amount of $6,313* <u>Additional Community Partners</u> -Any community partner willing to hold and or conduct screening event.

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives **Taken directly from NYSDOH Prevention Agenda Outcome Objectives*	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#3.2: Promote use of evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90	Participation in regional blood pressure registry. Use Electronic Medical Record to remind providers and patients about managing blood pressure.	Schuyler Hospital to work with Public Health and FLHSA to become a member of the blood pressure registry. Number of patient's hypertension rates submitted to registry.	PH, and Schuyler Hospital to work with adopting procedure to connect with the FLHSA blood pressure registry and submit patient numbers PH and S2AY to reach out to currently participating providers after bi-annual numbers are released to follow up and offer trainings to providers. Schuyler Hospital to submit data to FLHSA registry once EMR is capable and expand EMR system to remind providers and patients about management of blood pressure. FLHSA to provide registry data on a bi-annual basis to participants.	- Public Health commits 0.2 FTE/year - Schuyler Hospital commits 0.015 FTE/year. <u>Additional Community Partners</u> - Finger Lakes Health System Agency: In kind contribution. - S2AY Rural Health Network: $2,475 for CHIP Cycle

Priority: Promote Healthy Women, Infants and Children					
Focus Area 2: Child Health					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives **Taken directly from NYSDOH Prevention Agenda Outcome Objectives*	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#2.2 Reduce prevalence of dental carries among children.	**Objective 5-3:** By December 31, 2018, increase the proportion of NYS children who receive regular dental care by at least 10%.	Link children and families to dental services. Support the delivery of oral health screening and preventative dental services through school based clinics and programs with a focus on evidence-based practices. Promote the use and availability of Varnish Fluoride training through PCP's and Dentists.	Number of school based dental health sites. Number of children screened who received preventative dental services through school-based dental health sites in the past year. Number of practitioners that are present during Varnish Fluoride application presentation.	Schuyler Hospital Primary Care Providers to create referral system to dental care providers. Schuyler Hospital and Public Health to promote the use and education of Varnish Fluoride application. RPCN to provide school and Head Start based dental clinics. Refer Medicaid individuals to the eligible FQHC dental services. Regional Dental Steering Committee/S2AY RHN to assist and support PH with coordination of evidence based programs and education.	- Public Health commits 0.2 FTE/year. - Schuyler Hospital commits 0.015 FTE/year. <u>Any Additional Community Partners</u> - Rochester Regional Primary Care Network - Finger Lakes Community Health - Schools - Head Start -Dental Steering Committee/S2AY RHN: $2,475

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives **Taken directly from NYSDOH Prevention Agenda Outcome Objectives*	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
#2.1 Prevent underage drinking and non-medical use of prescription pain relievers by youth.	Objective 2.1.1: December 31, 2018, reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days to no more than 34.6%. (Baseline: 38.4 per 100, 2011 YRBS) - Tracking Indicator Objective 2.1.2: December 31, 2018, reduce the percentage of youth ages 12-17 years reporting the use of non-medical use of painkillers. (Baseline: 5.26% 2009-2010, NSDUH, Target: 4.73%) - Tracking Indicator	- Implement evidence-based programs in all high risk and underperforming schools to increase positive social development and healthy lifestyles. - Reduce stigma regarding substance use disorder and addiction. - Advocate for addressing the common protective factors, such as poverty and exposure to violence and protective factors, such as parent engagement and social connectedness. - Promote screening and early intervention such as SBIRT for youth. - Educate health care providers about the warning signs of substance abuse. - Support and promote Naloxone trainings - Support and promote drug take-back events and the 24/7 drop box - Consider evidence based strategies to reduce underage drinking.	-Number of changes in local laws and ordinances to reduce youth alcohol use such as passage of Social Host liability laws, restrictions on hours and days of alcohol sales, happy hour and drink promotions, outlet density and alcohol advertising restrictions, prohibitions or controls on alcohol use at community events or in public areas (parks, beaches). -Percent of youth between grades 7 – 12 who report drinking alcohol in the last 30 days. -Percent of youth between grades 7 – 12 who report non-medical use of prescription pain relievers in the last 30 days. -Percent of youth between grades 7 – 12 who report binge drinking in the last 30 days. -Approximate incidence of opioid overdose as reported by the Schuyler County Sheriff's Office, the Watkins Glen Village Police, Schuyler Hospital, FLACRA, and EMS. -Number participating in take-back events and safe storage education -Pounds of prescription drugs collected through take-back events and drop boxes -Number of participants in Naloxone trainings	SCCUDD to educate and organize the community to pursue local laws and ordinances aimed at reducing youth alcohol use Public Health, Schuyler Hospital, and SCCUDD to provide education around SBIRT and the warning signs of substance use for practitioners. FLACRA to provide Naloxone trainings Sheriff's Office to conduct drug take-back events and maintain the 24/7 drop box	- Public Health provides $250,000 funding allocated for 2017 and 2018 which includes 1 FTE. - Schuyler Hospital commits 0.01 FTE/year. <u>Any Additional Community Partners</u> The Schuyler County Coalition on Underage Drinking and Drugs (SCCUDD) includes a variety of organization such as: - Finger Lakes Addiction Counseling & Referral Agency (FLACRA) - Council on Alcoholism and Additions of the Finger Lakes - Cornell Cooperative Extension -Schuyler County Sheriff's Office -Watkins Glen Village Police