

Leveraging assets, reducing barriers, and strengthening the public health infrastructure to improve the health of all residents in Jefferson, Lewis and St. Lawrence Counties in New York State.

Regional Community Health Improvement Plan

2014-2017

An Initiative of the North Country Health
Compass Partners

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Overview

In April 2013, the Fort Drum Regional Health Planning Organization (FDRHPO) was awarded a New York State Rural Health Network Development Grant. One of the grant's key objectives is to facilitate a regional Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) that includes chronic disease, behavioral health, maternal and child health, and dental health. The health improvement plan's target population resides in the rural counties of Jefferson, Lewis and St. Lawrence Counties in New York. FDRHPO therefore established a steering committee (North Country Health Compass Partners) as a collaborative group with representation from public health agencies, hospitals, and community-based organizations within the tri-county region. The North Country Health Compass Partners is comprised of individuals who volunteer their time and expertise to advise and govern the development, implementation and evaluation of the regional health improvement plan.

This regional Community Health Improvement Plan was designed to be responsive to the identified community health needs, while incorporating data on available population health indicators. The plan's strategies are grounded in evidence and designed to maximize regional collaborative efforts. To facilitate implementation and monitoring, the North Country Health Compass partners will leverage existing capacity for marketing, advocacy, policy development, grant support (i.e. technical assistance) and partnership building. Progress will also be monitored using the North Country Health Compass website (www.ncnyhealthcompass.org), a web-based source of population data and community health information for Jefferson, Lewis and St. Lawrence Counties.

Priority Setting

The Action Plan (*see page 11*) contains initiatives and objectives that are tailored specifically to the population in our region, while remaining aligned with the most current version of the New York State health improvement plan (The Prevention Agenda 2013-2017¹). The Prevention Agenda maintains a vision of "New York as the healthiest state in the nation," and our Action Plan is designed to assist the state in achieving that vision.

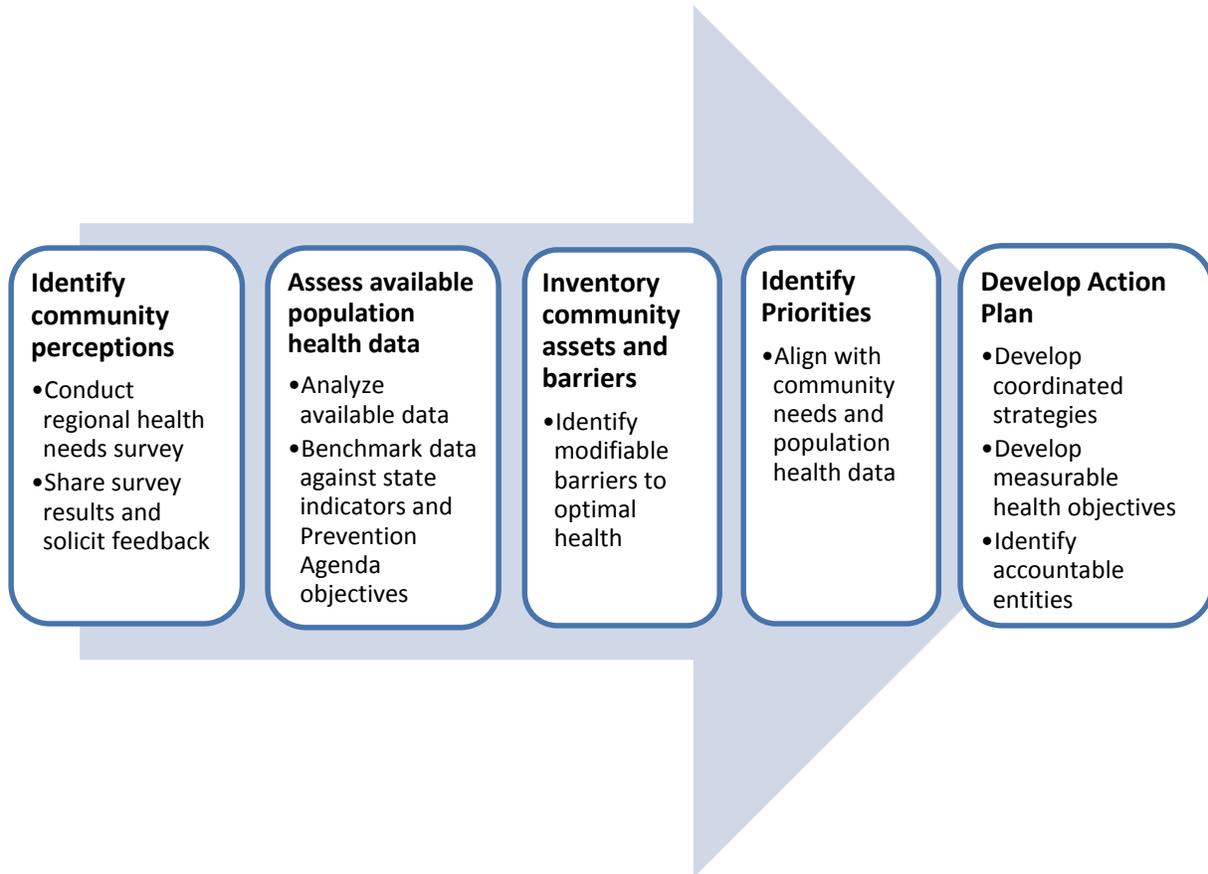
The Prevention Agenda serves as a catalyst for action as well as a blueprint for improving health outcomes and reducing health disparities. For the 2013-2017 period the state has identified five Priority Areas for intervention and monitoring:

- Prevent Chronic Diseases
- Promote Healthy and Safe Environments
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections

¹ Additional information on the New York State Prevention Agenda 2013-2017 can be found online at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Selection Process

To achieve meaningful, sustainable impact the New York State Department of Health (NYSDOH) recommends that communities “identify at least two priorities” from the Prevention Agenda 2013-2017². The North Country Health Compass Partners employed a systematic approach to identify priorities and develop the Action Plan as outlined in the flowchart below:



The regional priorities were selected after carefully evaluating community health needs, population health data, regional assets, and regional barriers. The process of identifying the regional priorities involved input from 28 stakeholders including hospital CEOs, hospital administrators, public health employees (directors, health planners, nurses and educators), and representatives from community-based organizations across the three counties. Stakeholders ranked Prevention Agenda priorities and goals using an online survey tool which displayed health indicators related to each priority.

² Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf

Selection Criteria

The selection of priorities and goals for regional health improvement was based on expressed community health needs and population health data indicating the health issues that were of greatest concern. To be selected for steering committee consideration, a priority should address:

- health outcomes that did not meet state benchmarks
- health outcomes that were regional (not county-specific) priorities
- at least one health disparity

Stakeholders were also encouraged to consider the following when making an informed decision about which priorities should be selected:

- impact on other health outcomes
- resources available
- impact on the physical and social environment
- ease of implementing solutions
- leadership support available
- importance to the public health system

Identification of Priorities

The survey results (*see Appendix 1*) indicated that the leading regional goals (ranked 1-10) were clustered into three Prevention Agenda priorities. These three priorities were:

- Prevent Chronic Diseases
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse

Participating Organizations

The development of this regional health improvement plan was governed by the North Country Health Compass Partners. The collaborative is comprised of members of diverse agencies and organizations. Committee members represent:

Public Health Agencies

- Jefferson County Public Health Service
- Lewis County Public Health Agency
- St. Lawrence County Public Health

Hospitals

- Canton-Potsdam Hospital
- Carthage Area Hospital
- Claxton-Hepburn Medical Center

- Clifton-Fine Hospital
- E.J. Noble Hospital
- Lewis County General Hospital
- Massena Memorial Hospital
- River Hospital
- Samaritan Medical Center

- Fort Drum MEDDAC (CLINIC)

Community-Based Organizations

- Excellus BlueCross BlueShield
- Fort Drum Regional Health Planning Organization
- Jefferson County Community Services
- Lewis County Community Recovery Center
- Lewis County Community Services
- North Country Family Health Center³
- North Country Prenatal/Perinatal Council
- St. Lawrence County Community Services
- St. Lawrence County Health Initiative

While developing an inventory of regional assets, regional barriers, protective factors, contributing factors and gaps related specifically to the identified regional priorities (*see Appendix 2*), the North Country Health Compass Partners developed ad hoc work groups. These groups had representation from the North Country Health Compass Partners with additional organizations (listed below) being engaged in this process.

Prevent Chronic Diseases

- Cornell Cooperative Extension of Jefferson County
- Office for the Aging (Jefferson County)
- YMCA (Jefferson County)

Promote Healthy Women, Infants and Children

- A Woman's Perspective
- Benchmark Family Services
- Care Net
- Cornell Cooperative Extension of Jefferson County
- Department of Social Services (Jefferson County)
- Jefferson-Lewis Childcare Project
- Medical Examiner (Jefferson County)
- North Country Family Health Center – WIC
- Planned Parenthood of NCNY
- Victims Assistance Center of Jefferson County
- Women's Way to Wellness (Carthage Area Hospital)

Promote Mental Health and Prevent Substance Abuse

- ACR Health (formerly AIDS Community Resources)
- Behavioral Health Clinic (Carthage Hospital)
- Children's Home of Jefferson County
- CREDO Community Center
- Family Counseling Service of Northern NY
- Jefferson County Alcohol and Substance Abuse Council
- Mental Health Association
- North Country Behavioral Healthcare Network
- Suicide Prevention Coalition (Jefferson County)
- Transitional Living Services of Northern NY
- Watertown Veteran's Center

³ Federally Qualified Health Center

Stakeholder Engagement

The North Country Health Compass Partners have held monthly meetings since April 2013. These meetings will continue and involve strategic planning sessions aimed at developing, implementing and evaluating the regional health improvement plan. Additional efforts to engage stakeholders included:

- The online survey tool to engage stakeholders in the selection of Prevention Agenda priorities and goals was open from July 29, 2013 to August 15, 2013.
- The “Promote Mental Health and Prevent Substance Abuse” ad hoc work group session which was held on September 9, 2013.
- The “Prevent Chronic Diseases” ad hoc work group session which was held on September 9, 2013.
- Meeting with the sole regional pediatric dentist (Dr. Andrew Beuttenmuller) to brainstorm strategies to address oral health issues affecting children on September 13, 2013.
- The “Promote Healthy Women, Infants and Children” ad hoc work group session which was held on September 16, 2013.
- Meeting with the FDRHPO Provider Executive Committee (PEC), comprised of physicians within the region, on September 25, 2013.

The individual counties (Jefferson, Lewis, and St. Lawrence) are also actively engaged in developing county-specific health improvement plans. The plans outlined within this document complement those ongoing activities and engage many of the same partners.

Data

Our priority setting process was guided by an analysis of community health needs survey responses (primary data) and available county health indicators (secondary data).

Community Health Needs Assessment

The North Country Community Health Survey (NCCHS) was open to residents of Jefferson, Lewis, and St. Lawrence counties from June 1 through July 1, 2013. The instrument was distributed using an online survey tool, facilitating collection of 1,379 completed surveys. A vast range of health related topics were covered, including specific diseases and conditions, health risks, access to care, prevention, and community health needs. The data most impactful to the priorities that were selected, is **summarized** below:

Top 5 Health Problems Affecting the Household and Community

Household	%	Community	%
High blood pressure	42	Abuse of prescription drugs or illegal drugs	79
Overweight/Obesity	38	Cancer	74
Arthritis	33	Overweight/Obesity	74
Lack of physical activity	27	Behavioral problems in children	70
Diabetes	22	Depression/other mental illnesses	70

*Top 5 Community Concerns**

Cost of insurance

Mental health access

Primary care access

Absence of specialists

Quality of care

** Based on 202 unique responses to the open-ended question "Please provide any additional comments or other health related needs for your community that you feel are important but have not been addressed in this survey."*

County Health Indicators

A review of over 180 available health indicators revealed several health outcomes that required regional attention. Data relevant to each of the five NYS Prevention Agenda 2013-2017 priorities was collated for each county and benchmarked against values for the entire state, with reference to the Prevention Agenda 2017 objective (where available). The indicators presented are those that did not meet the state benchmark related to each of the **3 selected priorities**.

Indicators	Jefferson	Lewis	St. Lawrence	NY State	Objective	Data Years	Source
Prevent Chronic Diseases							
Adult obesity (BMI > 30)	31.6%	29.0%	32.0%	23.2%	23.2%	2008-2009	BRFSS
Pregnant women in WIC who were pre-pregnancy obese	28.0%	31.6%	27.1%	23.4%		2008-2010	NYSDOH
Child & adolescent obesity (BMI > 95 th percentile)	19.2%	18.7%	24.4%	17.6%	16.7%	2010-2012	NHANES
Adults with diagnosed diabetes	10.7%	10.4%	10.8%	9.0%		2008-2009	eBRFSS
Pregnant women in WIC with gestational diabetes	6.5%	6.6%	6.7%	5.5%		2008-2010	NYSDOH
Adult smokers	28%	20%	27%	18%	15%	2011	BRFSS
Lung and bronchus cancer mortality rate (per 100,000)	53.9	45.0	66.0	42.8		2007-2009	NYSDOH
Colorectal cancer screening (adults 50-75 years)	61.1%	55.6%	64.1%	66.3%	71.4%	2008-2009	BRFSS
Colon and rectum cancer mortality rate (per 100,000)	19.2	18.1	19.1	15.7		2007-2009	NYSDOH
Heart attack hospitalizations (per 10,000)	21.5	17.4	18.7	15.5	14.0	2010	SPARCS

Indicators	Jefferson	Lewis	St. Lawrence	NY State	Objective	Data Years	Source
Promote Healthy Women, Infants and Children							
Federally insured children with recommended level of care	53.4%	45.8%	48.4%	69.9%	76.9%	2011	NYSDOH
Children ages 3-6 years	74.2%	68.5%	71.2%	82.8%	91.3%	2011	NYSDOH
Children ages 12-21 years	45.9%	35.8%	41.6%	61.0%	67.1%	2011	NYSDOH
Third-grade children with untreated tooth decay	29.5%	51.4%	39.5%	24.0%	21.6%	2009-2011	NYSDOH
Children (ages 19-35 months) with complete immunizations	45.5%	70.7%	61.7%	47.6%	80.0%	2011	NYSDOH
Elevated blood lead level rate (per 1,000 children < 6 years)	5.6	8.1	7.2	5.3		2008-2010	NYSDOH
Promote Mental Health and Prevent Substance Abuse							
Indicators	Jefferson	Lewis	St. Lawrence	NY State	Objective	Data Years	Source
Adult binge drinking	18.9%	22.7%	21.8%	20.4%	18.4%	2008-2009	BRFSS
Self-inflicted injury hospitalization rate (per 10,000)	9.0	6.0	10.6	5.1		2008-2010	SPARCS
Suicide death rate (per 10,000)	11.0	16.0	12.0	6.8	5.9	2008-2010	NYSDOH

Selection Rationale

In consideration of the data, the steering committee selected priorities and interventions that seek to address the existing gaps in access to care, while complementing ongoing public health efforts. The selected interventions are designed to leverage and strengthen regional assets (especially interagency collaboration) and address recognized regional barriers to optimum health.

The leading modifiable barriers and contributing factors related to each priority were identified. These factors helped to inform the development of the community health improvement plan and are as follows:

- **Prevent Chronic Diseases**
 - *Regional barriers:* low health literacy; absence of preventive care
 - *Regional contributing factors:* unhealthy environment (policy, market forces); absence of early intervention
- **Promote Healthy Women, Infants and Children**
 - *Regional barriers:* health professional shortages (especially for dental health and behavioral health); poor support of wellness and breastfeeding
 - *Regional contributing factors:* low awareness of available services; lack of prenatal care
- **Promote Mental Health and Prevent Substance Abuse**
 - *Regional barriers:* scant resources; lack of collaborating services
 - *Regional contributing factors:* absence of early intervention; substance abuse (contributing to poor mental health)

The dominant disparity emerging from work group sessions was poverty. Within the tri-county region, poverty levels exceed state averages. The following table underscores the steering committee's effort to focus on disadvantaged populations while designing the regional health improvement plan.

Indicator	Jefferson	Lewis	St. Lawrence	NY State
Population living below the poverty line ¹	17.4%	12.1%	18.8%	16.1%
Children (under 18 years) living in poverty ²	26.3%	20.3%	25.0%	22.8%

1. *Small Area Income and Poverty Estimates, retrieved from the Health Indicators Warehouse [http://healthindicators.gov/]*

2. *American Community Survey (ACS), retrieved from the Health Indicators Warehouse [http://healthindicators.gov/]*

Action Plan 2014-2017

The Action Plan outlines goals, objectives, improvement strategies and performance measures with time-framed targets for the 2014-2017 period. These activities align with National priorities (as indicated) and all relate to the selected NYS Prevention Agenda priorities and goals as follows:

- **Prevent Chronic Diseases**
 - Increase colorectal cancer screening rates among disparate populations.
 - Prevent initiation of tobacco use by youth and young adults.
 - Promote use of evidence-based care to manage cardiovascular disease and diabetes.
- **Promote Healthy Women, Infants and Children**
 - Increase the proportion of children who receive comprehensive well-child care in accordance with American Academy of Pediatrics (AAP) guidelines.
 - Reduce the prevalence of dental caries among children.
- **Promote Mental Health and Prevent Substance Abuse**
 - Support collaboration among professionals and strengthen infrastructure.

PRIORITY AREA: Prevent Chronic Diseases
GOAL #1: Increase colorectal cancer screening rates among disparate populations within Jefferson, Lewis and St. Lawrence Counties, NY.

PERFORMANCE MEASURES		
How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
<i>By December 2015, increase by 10% the number of adults (50-75 years) receiving colorectal cancer screenings through the Cancer Services Program of Lewis and Jefferson County, and through the Cancer Services Program of St. Lawrence County. (baseline to be established using cumulative 2013 data)</i>	<i>Cancer Services Program of Lewis and Jefferson County, Cancer Services Program of St. Lawrence County</i>	<i>Annually</i>
<i>By December 2015, increase the number of active patients that receive reminders about recommended colorectal cancer screenings, via electronic health records, to 10%. (baseline to be established using cumulative 2013 data)</i>	<i>FDRHPO</i>	<i>Annually</i>
Long Term Indicators	Source	Frequency
<i>By December 2017, increase the percentage of adults (50-75 years) receiving colorectal cancer screenings in each county to 70.0%. (2009: Jefferson = 61.1%, Lewis = 55.6%, St. Lawrence = 64.1%)</i>	<i>BRFSS</i>	<i>Annually</i>
<i>By December 2017, decrease the colon and rectum cancer mortality rate for each county by 5%. (2009: Jefferson = 19.2 per 100,000, Lewis = 18.1 per 100,000, St. Lawrence = 19.1 per 100,000)</i>	<i>Cancer Registry</i>	<i>Annually</i>
<i>By December 2017, increase the number of active patients that receive reminders about recommended colorectal cancer screenings, via electronic health records, to 20%. (baseline to be established using cumulative 2013 data)</i>	<i>FDRHPO</i>	<i>Annually</i>

OBJECTIVE #1: By December 2015, increase by 10% the number of adults (50-75 years) receiving colorectal cancer screenings using small media interventions.					
BACKGROUND ON STRATEGY					
Description: Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences.					
Source: Colorectal Cancer Screening Intervention Programs (http://rtips.cancer.gov/rtips/rtips_search.do?topicid=6&cg=2&choice=cguide)					
Evidence Base: <i>"Increasing Cancer Screening: Small Media Targeting Clients"</i> recommended by <i>The Guide to Community Preventive Services</i>					
Policy Change (Y/N): N					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/Organization	Anticipated Product or Result	Progress Notes
Establish baseline (2013) screening rates through the Cancer Services Program of Lewis and Jefferson County, and St. Lawrence County	January 2014	Staff time	FDRHPO (in collaboration with the Cancer Services Program)	Baseline data on screening rates through the Cancer Service Program	
Procure small media (patient engagement tools) targeting colorectal cancer screening	March 2014	Staff time	North Country Health Compass Partners	Small media (brochure, newsletter)	
Distribute small media to stakeholders for client/patient engagement	May 2014	Staff time, travel	North Country Health Compass Partners	Small media appropriate for mailing to patients/clients	

OBJECTIVE #2: By December 2015, increase the number of active patients that receive reminders about recommended colorectal cancer screenings, via electronic health records, to 10%.					
BACKGROUND ON STRATEGY					
Description: Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that the client is overdue for screening (called a "recall"). The reminders can be provided in different ways, such as in client charts or by e-mail.					
Source: Cancer Prevention and Control: Provider-Oriented Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening (http://www.thecommunityguide.org/cancer/screening/provider-oriented/index.html)					
Evidence Base: <i>"Increasing Cancer Screening: Provider Reminder and Recall Systems"</i> recommended by <i>The Guide to Community Preventive Services</i>					
Policy Change (Y/N): N					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/Organization	Anticipated Product or Result	Progress Notes
Establish baseline (2013) data on clinicians utilizing electronic health records to send patient reminders	February 2014	Staff time	FDRHPO (in collaboration with the Provider Executive Committee)	Baseline data on electronic health record utilization rates	
Provide technical assistance to regional providers to encourage utilization of reminder systems	December 2015	Staff time, travel	FDRHPO North Country Health Information Partnership	Increased utilization of patient reminder systems	

OBJECTIVE #3: By December 2014, foster collaboration among community-based organizations, educational institutions, faith-based communities, independent living centers, businesses and clinician to identify underserved groups and promote colorectal cancer screening services.

BACKGROUND ON STRATEGY

Description: Evidence-based preventive services (e.g. screening tests) are effective in reducing death and disability, and are cost-effective. Collaboration between diverse stakeholders can serve to promote interventions and improve access to preventive services.

Source: <http://www.surgeongeneral.gov/initiatives/prevention/strategy/preventive-services.pdf>

Evidence Base: "Clinical and Community Preventive Services" recommended by The National Prevention Strategy

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Establish partnerships between existing regional collaborative (North Country Health Compass Partners) and the school- and faith-based communities	March 2014	Time, travel	North Country Health Compass Partners	Enhanced collaboration	
Promote existing Cancer Screening Programs and small media interventions	June 2014	Time, travel	North Country Health Compass Partners	Improved access to preventive services	

PRIORITY AREA: Prevent Chronic Diseases

GOAL #2: Prevent initiation of tobacco use by youth and young adults.

PERFORMANCE MEASURES

How We Will Know We are Making a Difference

Short Term Indicators	Source	Frequency
<i>By December 2014, adopt an anti-tobacco marketing policy.</i>	<i>TPACC of Jefferson and Lewis County, TPACC of St. Lawrence County, MVPS-RC</i>	<i>Once</i>
Long Term Indicators	Source	Frequency
<i>By December 31, 2017, decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students by 5%. (baseline: unknown)</i>	<i>TPACC of Jefferson and Lewis County, TPACC of St. Lawrence County, MVPS-RC</i>	<i>Annually</i>

OBJECTIVE #1: Pursue policy action to reduce the impact of tobacco marketing to youth and young adults in the region.					
BACKGROUND ON STRATEGY					
Description: Sufficient evidence indicates the effectiveness of interventions —such as stronger local laws directed at retailers, active enforcement of retailer sales laws, and retailer education with reinforcement—in reducing youth tobacco use and access to tobacco products from commercial sources.					
Source: http://www.thecommunityguide.org/tobacco/communityinterventions.html					
Evidence Base: “Interventions to Restrict Minor’s Access to Tobacco Products” recommended by <i>The Guide to Community Preventive Services</i> ”					
Policy Change (Y/N): Y					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Meet with regional stakeholders to identify policy options	February 2014	Time, travel	North Country Health Compass Partners	Collaborative approach to policy development	
Policy research and development	June 2014	Time	TPACC of Jefferson and Lewis County, TPACC of St. Lawrence County, MVPS-RC	Anti-tobacco policy	
Policy approval	December 2014	Time	Board of Legislators (each county)	Policy approval	

PRIORITY AREA: Prevent Chronic Diseases
GOAL #3: Promote the use of evidence-based care to manage cardiovascular disease and diabetes.

PERFORMANCE MEASURES		
How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
<i>By December 2015, increase the number of participants in the Chronic Disease Self-Management Program (CDSMP) by 10% (baseline: unknown)</i>	LCPH, Office of the Aging (Jefferson, Lewis), NRCIL	Annually
<i>By December 2015, increase the number of participants in the NYS Diabetes Prevention Program (DPP) by 10% (baseline: unknown)</i>	YMCA, LCPH	Annually
Long Term Indicators	Source	Frequency
<i>By December 2017, decrease the heart attack hospitalization rate by 5%. (2010: Jefferson = 21.5 per 10,000, Lewis = 17.4 per 10,000, St. Lawrence = 18.7 per 10,000)</i>	SPARCS	Annually
<i>By December 2017, decrease the number of adults with physician-diagnosed diabetes by 2%. (2009: Jefferson = 10.7%, Lewis = 10.4%, St. Lawrence = 10.8%)</i>	eBRFSS	Annually

OBJECTIVE #1: By December 2015, increase by 10% the use of the Chronic Disease Self-Management Program (CDSMP) by individuals with cardiovascular disease.					
BACKGROUND ON STRATEGY					
<p>Description: The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.</p> <p>Source: http://patienteducation.stanford.edu/programs/cdsmp.html</p> <p>Evidence Base: http://patienteducation.stanford.edu/bibliog.html</p> <p>Policy Change (Y/N): N</p>					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/Organization	Anticipated Product or Result	Progress Notes
Raise awareness among health care providers and the general public about the benefits and availability of the program.	June 2014	Time, patient engagement tools	North Country Health Compass Partners, Office for the Aging, NRCIL	Marketed intervention with sustained enrollment	
Provide technical assistance and quality improvement training to healthcare organizations and providers to improve utilization of electronic medical records	Ongoing	Time, technical expertise, travel	FDRHPO's North Country Health Information Partnership	Regional health information technology utilization	

OBJECTIVE #2: By December 2015, increase by 10% the use of the Diabetes Prevention Program (DPP) by individuals with pre-diabetes.					
BACKGROUND ON STRATEGY					
<p>Description: The NYS Diabetes Prevention Program is an evidence-based lifestyle change program designed for people diagnosed with pre-diabetes or who are at risk of developing diabetes. Trained Lifestyle Coaches facilitate 16 one-hour weekly sessions and help participants set and achieve personal lifestyle goals.</p> <p>Source: https://www.ceacw.org/programs/dpp</p> <p>Evidence Base: http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/</p> <p>Policy Change (Y/N): N</p>					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/Organization	Anticipated Product or Result	Progress Notes
Raise awareness among health care providers and the general public about the benefits and availability of the program.	June 2014	Time, patient engagement tools	Public health (each county), North Country Health Compass Partners, YMCA	Marketed intervention with sustained enrollment	
Provide technical assistance and quality improvement training to healthcare organizations and providers to improve utilization of electronic medical records	Ongoing	Time, technical expertise, travel	FDRHPO's North Country Health Information Partnership	Regional health information technology utilization	

PRIORITY AREA: Promote Healthy Women, Infants and Children

GOAL #1: Increase the proportion of children who receive comprehensive well-child care in accordance with American Academy of Pediatrics (AAP) Guidelines

PERFORMANCE MEASURES

How We Will Know We are Making a Difference

Short Term Indicators	Source	Frequency
<i>By December 2015, increase the number of active pediatric patients that receive reminders about recommended well-child visits, via electronic health records, to 10%. (baseline: unknown)</i>	FDRHPO	Annually
Long Term Indicators	Source	Frequency
<i>By December 2017, increase the percentage of Federally-insured children who receive comprehensive well-child care by 10%. (2011: Jefferson = 53.4%, Lewis = 45.8%, St. Lawrence = 48.4%)</i>	NYSDOH Office of Patient Quality and Safety	Annually
<i>By December 2017, increase the percentage of children (ages 19-36 months) with a complete immunization series by 10%. (2011: Jefferson = 45.5%, Lewis = 70.7%, St. Lawrence = 61.7%)</i>	NYSDOH	Annually

OBJECTIVE #1: By December 2015, increase the number of active pediatric patients that receive reminders about recommended well-child visits, via electronic health records, to 10%.

BACKGROUND ON STRATEGY

Description: Client reminder and recall interventions involve reminding members of a target population that visits are due (reminders) or late (recall). Most reminder systems involve a specific notification for a specific client, and may be accompanied by educational messages regarding the importance of comprehensive care.

Source: <http://www.thecommunityguide.org/vaccines/clientreminder.html>

Evidence Base: "Client Reminder and Recall Systems" recommended by The Guide to Community Preventive Services.

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Provide technical assistance to regional providers to encourage utilization of reminder systems	December 2015	Staff time, travel	FDRHPO North Country Health Information Partnership	Increased utilization of patient reminder systems	

OBJECTIVE #2: By December 2014, engage partners across child-serving systems, including early child care organizations, to promote access to preventive health care services.

BACKGROUND ON STRATEGY

Description: Evidence-based preventive services are effective in reducing morbidity, and are cost-effective. Collaboration between diverse stakeholders can serve to promote interventions and improve access to preventive services.

Source: <http://www.surgeongeneral.gov/initiatives/prevention/strategy/preventive-services.pdf>

Evidence Base: The American Academy of Pediatrics (AAP) and Centers for Disease Control and Prevention (CDC) recommend well-child visits as a vehicle for delivery of preventive care and promotion of general health and development.

Policy Change (Y/N): N

ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Establish partnerships between existing regional collaborative (North Country Health Compass Partners), pediatricians, schools and early child care organizations	March 2014	Time, travel	North Country Health Compass Partners	Enhanced collaboration	

PRIORITY AREA: Promote Healthy Women, Infants and Children
GOAL #2: Reduce the prevalence of dental caries among children

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
<i>By December 2015, increase the number of regional school-based dental sealant programs by 5%. (baseline: unknown)</i>	<i>Public health departments (each county), Carthage Area Hospital, North Country Family Health Center</i>	<i>Annually</i>
Long Term Indicators	Source	Frequency
<i>Decrease the proportion of third-grade children with untreated tooth decay by 5%. (2011: Jefferson = 29.5%, Lewis = 51.4%, St. Lawrence = 39.5%)</i>	<i>NYSDOH</i>	<i>Annually</i>

OBJECTIVE #1: By December 2015, increase the number of regional school-based dental sealant programs by 5%.
<p>BACKGROUND ON STRATEGY</p> <p>Description: School-based dental sealant delivery programs increase the number of children who receive sealants at school, resulting in a significant reduction in tooth decay among school-aged children (5 to 16 years of age).</p> <p>Source: http://www.thecommunityguide.org/oral/schoolsealants.html</p> <p>Evidence Base: "Preventing Dental Caries: School-Based Dental Sealant Delivery Programs" recommended by <i>The Guide to Community Preventive Services</i></p> <p>Policy Change (Y/N): N</p>

ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess the best-practices of dental sealant programs offered by Community Health Center of the North Country (CHCNC, St. Lawrence County) and Carthage Area Hospital	March 2014	Time, travel	North Country Health Compass Partners, North Country Family Health Center	Best-practices related to school-based dental sealant programs in rural communities	
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Collaborate with stakeholders to facilitate (via advocacy/grant support) regional access to school-based dental sealant programs.	December 2015	Time, travel	North Country Health Compass Partners	Increased access to school-based dental sealant programs	

PRIORITY AREA: Promote Mental Health and Prevent Substance Abuse
GOAL #1: Support collaboration among professionals and strengthen mental health infrastructure.

PERFORMANCE MEASURES		
How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
<i>By December 2014, increase the number of regional meetings of suicide prevention coalitions throughout Central and Northern New York from one meeting per year to quarterly meetings.</i>	<i>Jefferson County Suicide Prevention Coalition</i>	<i>Annually</i>
<i>By December 2015, pilot-test a telemedicine mental health program between regional providers and mental health care services outside the region.</i>	<i>FDRHPO</i>	<i>Once</i>
<i>By December 2015, develop a sustainable education, recruitment and retention initiative focused on increasing access to mental health care.</i>	<i>FDRHPO</i>	<i>Once</i>
Long Term Indicators	Source	Frequency
<i>By December 2017, decrease the regional suicide death rate by 10%. (2010: Region = 12 per 100,000 population, Jefferson = 11, Lewis = 16, St. Lawrence = 12).</i>	<i>NYSDOH</i>	<i>Annually</i>

OBJECTIVE #1: *By December 2014, increase the number of regional meetings of suicide prevention coalitions throughout Central and Northern New York from one meeting per year to quarterly meetings.*

BACKGROUND ON STRATEGY

Description: Collaboration enhances information sharing and increases training opportunities for providers and behavioral health professionals.

Source: <http://www.afsp.org/preventing-suicide/key-research-findings>

Evidence Base: *“Educating the Medical Community to Recognize and Treat Depression” recommended by The American Foundation for Suicide Prevention*

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Develop a meeting schedule and research collaborative training opportunities.	December 2014	Time	Jefferson County Suicide Prevention Coalition	Meeting schedule, training schedule	

KEY

ASAC – Alcohol and Substance Abuse Council of Jefferson County

TPACC – Tobacco Prevention Awareness Cessation Coalition

FDRHPO – Fort Drum Regional Health Planning Organization

LCPH – Lewis County Public Health

MVPS-RC – Mountain View Prevention Services, Reality Check Program

NRCIL – Northern Regional Center for Independent Living

Maintaining Engagement

The North Country Health Compass Partners have been in existence for the past six months and the members are highly engaged. The collaborative group meets on a monthly basis to achieve the mission of developing, implementing and evaluating a regional health improvement initiative through research, data analysis, community engagement and collaboration among public health departments, hospitals and community-based organizations.

The regional Community Health Improvement Plan will be posted on the websites of the local health departments, hospital partners, the North Country Health Compass Partners and affiliated organizations. To improve community engagement, the plan will be promoted during a regional public launch of the North Country Health Compass website (www.ncnyhealthcompass.org) in early 2014.

Furthermore, the recently awarded Rural Health Network Development Grant has a separate patient engagement objective which aligns precisely with several of the strategies outlined in this Action Plan. That additional grant objective is “to develop and implement a patient engagement plan utilizing both electronic and paper tools to facilitate improved outcomes for patients with chronic disease.”

The steering committee will track progress through the North Country Health Compass website and with meeting progress reports. In the event that a particular strategy becomes unsuccessful, mid-course corrections will be made by the steering committee in consultation with the relevant subject-matter experts.

Appendix 1

Ranking of Prevention Agenda Priorities and Goals: Survey Results

A total of 28 surveys were completed by representatives at regional hospitals, public health agencies, and community-based organizations. The results are displayed below in rank order. Note that the priorities, focus areas, and goals are adopted from the NYS Prevention Agenda 2013-2017. The top three priorities were then selected as the regional priorities for the development of the community health improvement plan. As shown, “Prevent Chronic Diseases” was ranked as the top priority.

PRIORITY	FOCUS AREA	GOALS	Rating (1-10)	RANK* (1 - 44)
Prevent Chronic Diseases <i>(Cumulative rating = 8.2)</i>	Increase access to preventive care <i>(Cumulative rating = 8.7)</i>	Increase screening rates (CVD, diabetes, cancer)	9.08	2
		Promote evidence-based care	8.83	4
		Promote self-management education	8.20	10
	Reduce tobacco-related illness/death <i>(Cumulative rating = 8.3)</i>	Prevent initiation by youth & young adults	8.92	3
		Promote cessation (esp. among low SES populations)	8.52	6
		Eliminate secondhand smoke exposure	7.42	24
	Reduce obesity in children and adults <i>(Cumulative rating = 7.8)</i>	Create healthy community environments	8.17	11-T
		Prevent childhood obesity through daycare/schools	8.12	14-T
		Expand the role of health care, providers, insurers	8.08	16
		Expand the role of employers	6.80	29-T
Promote Healthy Women, Infants & Children <i>(Cumulative rating = 7.9)</i>	Child health <i>(Cumulative rating = 9.0)</i>	Increase % of children receiving comprehensive care	9.23	1
		Reduce prevalence of dental caries	8.72	5
	Preconception and reproductive health <i>(Cumulative rating = 7.9)</i>	Increase utilization of preventive services among women	8.07	17
		Reduce rate of adolescent and unplanned pregnancies	7.70	22
	Maternal and infant health <i>(Cumulative rating = 7.1)</i>	Increase breastfeeding	7.96	18-T
		Reduce premature births	7.55	23
		Reduce maternal deaths	5.84	40
Promote Mental Health & Prevent Substance Abuse <i>(Cumulative rating = 7.9)</i>	Strengthen infrastructure across systems <i>(Cumulative rating = 8.3)</i>	Support collaboration among professionals	8.35	8
		Strengthen infrastructure	8.28	9
	Promote Mental, Emotional, Behavioral Health	Promote MEB well-being in communities	7.93	20
	Prevent substance abuse and disorders <i>(Cumulative rating = 7.7)</i>	Prevent underage drinking, prescription drug abuse	8.15	13
		Prevent occurrence of MEB disorders	8.12	14-T
		Prevent suicides	7.96	18-T
		Reduce tobacco use among adults with poor mental health	6.46	35-T

*The “-T” designation indicates that a particular goal had a rating score that tied with another goal. A total of 44 goals were rated and ranked.

PRIORITY	FOCUS AREA	GOALS	Rating (1-10)	RANK* (1 - 44)	
Prevent HIV/STDs, Vaccine Preventable Diseases Hospital Acquired Infections	Vaccine-preventable diseases <i>(Cumulative rating = 7.36)</i>	Improve childhood/adolescent immunization rates	8.50	7	
		Educate parents about importance of immunizations	7.81	21	
		Decrease burden of pertussis disease	6.96	28	
		Decrease burden of disease caused by HPV	6.80	29-T	
		Decrease burden of influenza disease	6.71	32	
	Sexually transmitted diseases <i>(Cumulative rating = 6.86)</i>	Decrease STD morbidity	7.15	27	
		Healthcare Associated Infections <i>(Cumulative rating = 6.95)</i>	Reduce Clostridium difficile infections	7.36	25
			Reduce infections caused by multidrug organisms	7.20	26
			Reduce device-associated infections	6.30	38
		Hepatitis C Virus (HCV)	Increase and coordinate HCV prevention and treatment	6.54	34
		Human Immunodeficiency Virus (HIV) <i>(Cumulative rating = 5.5)</i>	Increase early access to/ and retention in HIV care	5.80	41
			Decrease HIV morbidity	5.20	43
Promote a Healthy & Safe Environment <i>(Cumulative rating = 6.31)</i>	Injuries, violence, occupational health <i>(Cumulative rating = 7.13)</i>	Reduce fall risks amongst vulnerable populations	8.17	11-T	
		Reduce occupational injury and illness	6.77	31	
		Reduce violence through violence prevention programs	6.46	35-T	
	Water quality <i>(Cumulative rating = 6.50)</i>	Reduce risks associated with drinking/recreational water	6.59	33	
		Increase % of residents receiving fluoridated water	6.40	37	
	Built environment <i>(Cumulative rating = 5.91)</i>	Improve design and maintenance of built environment	6.28	39	
		Improve design and maintenance of home environment	5.54	42	
	Outdoor air quality	Reduce exposure to outdoor air pollutants	4.29	44	

*The “-T” designation indicates that a particular goal had a rating score that tied with another goal. A total of 44 goals were rated and ranked.

Appendix 2

Summary of the Main Issues highlighted during Ad Hoc Work Group Brainstorming Sessions

Priority: Prevent Chronic Diseases			
Regional Assets	Regional Barriers	Protective Factors	Contributing Factors
Interagency collaboration	Poverty	Evidence-based medicine	Genetics
School-based health initiatives	Low health literacy	Social environment supporting health	Poverty
State & Federal funding for screenings	Rural area (food deserts, long commutes)	Environmental laws [CAA, CWA, CIAA]	Unhealthy environment (policy, structure)
Rural (health-supporting) environment	Absence of family/social support	School-based health promotion	Marketing and market forces
Electronic health records	Absence of preventive care		Absence of early intervention
			Culture (unhealthy behaviors)
Priority: Promote Healthy Women, Infants & Children			
Regional Assets	Regional Barriers	Protective Factors	Contributing Factors
Case management and home visit services	Culture (autonomy; unhealthy norms)	Community-based organizations	Poverty, "working poor"
North Country Prenatal/Perinatal Council	Health professional shortage (Dental, MH, SA)	Health education	Low awareness of services
School-based health initiatives	Insurance information deficit, coverage gaps	Facilitated enrollment in insurance plans	Lack of prenatal care
Interagency collaboration	Geographic isolation	Home visiting programs	Unplanned pregnancy
	Poor support for wellness, breastfeeding	Religious and service organizations	Geographic isolation
		Medicaid and supplemental programs	Family and social environment
			Nutritional status
Priority: Promote Mental Health and Prevent Substance Abuse			
Regional Assets	Regional Barriers	Protective Factors	Contributing Factors
Interagency collaboration	Unfunded mandates	Early identification and intervention	Absence of early intervention
Engaged service providers	Low Medicaid reimbursements	Family and social support	Genetics and family history
Improved tri-county housing	Scant resources, high resource turnover	Community collaboration	Any form of trauma or abuse
Treatment and prevention resources	Limited access (long wait lists)	Healthy leisure activities [MH]	Substance abuse [MH]
St. Lawrence Psychiatric Center	Lack of collaborating services [MH]	Continuum of Care (CoC) housing [MH]	Social isolation [MH]
Peer-to-peer groups	Culture (unsupportive community)	Rapid response task force [SA]	Situational stressors [MH]
	Poverty	Evidence-based education in schools [SA]	Lack of self-management [MH]
		Legislation limiting access to substances [SA]	Co-occurring disease, mental illness [SA]
		Society and workforce re-integration [SA]	Ease of access and availability [SA]
		School policies and interventions [SA]	Unemployment [SA]

(Key: CAA - Clean Air Act; CBO - Community-Based Organization; CIAA - Clean Indoor Air Act; CWA - Clean Water Act; MH - Mental health; SA - Substance abuse)