# NYS 2016-18 Community Health Assessment and Community Health Improvement Plan


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# ULSTER COUNTY, NEW YORK

**Created by:**

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## Executive Summary

Ulster County's updated 2016-2018 Prevention Agenda priorities are the same as submitted in the previous 2014-2017 Community Health Improvement Plan: *Prevent Chronic Disease* and *Promote Mental Health/Prevent Substance Abuse*. Significant and multiple disparities have been identified within both priority areas and are addressed throughout this report.

Emerging trends and areas that Ulster County is watching closely are increases in suicide rates, opioid abuse (prescription drug abuse) rates, adult smoking rates, exposure to secondhand smoke, child poverty rates, food insecurity, child and adult obesity rates, premature death rates, and preventable hospitalizations, both health and behavioral.

At the same time, the Ulster County community is heavily invested in improving access to affordable and locally produced healthy food; enhancing physical activity opportunities; improving access to college level and skilled vocational education; providing safer and affordable housing; and extensive public health messaging campaigns and community engagement activities designed to prevent the onset of chronic diseases.

Data reviewed includes Robert Wood Johnson Foundation's County Health Ranking data, New York State (NYS) Prevention Agenda Dashboard data, StatShots (eBRFSS), the newly released New York State Department of Health (NYSDOH) Sub-County Reports, Community Health Indicator Reports (CHIRS), Ulster County's Biannual Youth Development Survey (substance abuse attitudes and behaviors among youth), Ulster County Medical Examiner's data on death by suicide, as well as a new local community health needs assessment survey that was specifically created and distributed for this update.

This data across the board clearly demonstrates that *Preventing Chronic Disease* must continue to be the first priority in Ulster County's community health improvement efforts.

New York State Vital Statistics Data as of March 2015 indicates that four out of five of the leading causes of morbidity and mortality in Ulster County (heart disease, cancer, chronic lower respiratory disease, and stroke) are chronic disease related conditions. Additionally, among the leading causes of chronic disease conditions, Ulster County exceeds both the Mid-Hudson region and New York State rates. These causational factors include adult and child obesity, tobacco use and exposure to secondhand smoke, access to physical activity opportunities, utilization of preventative screenings, and poor nutrition caused by insufficient access to fresh healthy food, food insecurity and high rates of sugar sweetened beverage consumption.

The second priority is *Promote Mental Health/Prevent Substance Abuse*. This priority builds on Ulster County's strong foundation of community collaboration and collective impact. Working together, Ulster County leverages the availability of robust local data and effective public education and engagement initiatives. These efforts help contribute to preventing and mitigating unacceptably high rates of suicide, as well as illegal and prescription drug abuse.

HealthAlliance of the Hudson Valley, a member of Westchester Medical Center Health Network (HealthAlliance), and Ellenville Regional Hospital are lead partners in our Community Health Assessment and Community Health Improvement Plan process. Through a collaborative planning process, the priorities were selected and each hospital system's respective interventions will be jointly monitored.

In addition to Ulster hospital system partners, key community partners engaged in this update include Ulster County Executive; the Healthy Ulster Council, a broad-based, countywide coalition focused on chronic disease prevention and education; Ulster County Suicide Prevention, Education, Awareness and Knowledge (SPEAK) coalition; Ulster Prevention Council (UPC), a broad-based community substance abuse and prevention coalition; Tobacco Free Action Communities (TFAC) in Ulster, Dutchess and Sullivan; YMCA in Ulster County; the City of Kingston; Kingston Land Trust; the Ulster County Rail Trail Council; Rural Ulster Prevention Company (affordable housing organization); Ulster County Planning Department; Ulster County Department of the Environment; Ulster County Office for the Aging; The Rose Women's Care Service Community Resource Center; Ulster County Veteran's Services Agency; Hudson Valley Farm Fresh Collaborative; Family of Woodstock; Cornell Cooperative Extension Ulster County; Institute for Family Health; Riverview Church; New Central Church; St. Mark's Church; New Progressive Baptist Church; and Live Well Kingston. Specific partner roles in the assessment and implementation process are outlined in the body of this report.

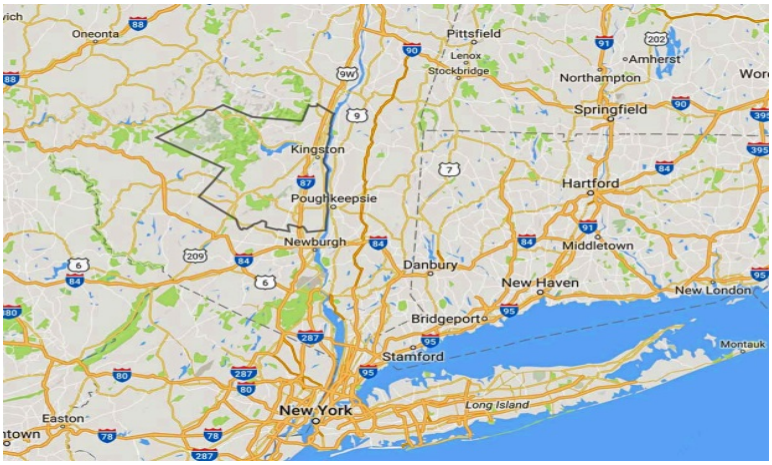
The Ulster County Department of Health and Mental Health (UCDOH-MH) continue to engage the community through collaboration with the Healthy Ulster Council and with active participation in the major community coalitions working to address our key priority and focus areas. Additionally, the 2016 Ulster County Community Health Needs Assessment survey created and implemented for this update achieved a high degree of community response and input into the process.

Outlined in the body of this report are specific evidence-based and existing successful community interventions, strategies, and activities implemented to address the identified priorities and their associated health disparities. The intervention, strategy, and activity selection process was facilitated by a workgroup consisting of members of the UCDOH-MH's Health Education/Community Relations Division, senior representatives of the two major hospital systems, and Ulster County's Evaluative Analyst. The workgroup reviewed all available data sources; the recommended interventions furnished by NYSDOH, the inventory of existing community based interventions maintained by the Healthy Ulster Council, and the promising and best practices currently in place in Ulster County and the nation.

The following criteria were used by the workgroup to evaluate interventions for possible inclusion: 1) Does the intervention address a demonstrated need/disparity per data and trends? 2) Within the allotted timeframe, does the intervention have a realistic chance of implementation and success given available community resources and capacity? 3) How strong and reliable are the process measures associated with the intervention?

The status and progress in all identified areas will be closely monitored and tracked through a strong ongoing collaboration between UCDOH-MH, hospital systems partners, and the three main community coalitions that work within the chosen priority areas: the Healthy Ulster Council (chronic disease prevention), Ulster Prevention Council (substance abuse prevention) and SPEAK (suicide prevention). Specific process measures and tracking mechanisms used to evaluate impact are outlined in the body of the report.

# REPORT




## Description of Community Served

Ulster County (UC) is a community of approximately 181,000 people located in the Hudson Valley region of New York, approximately 90 miles north of New York City. Much of UC can be characterized as suburban and semi-rural, with only one major urban area, the city of Kingston (population 23,700). Based on 2013 US Census data, 80.8% of County residents identified as White; 10.1% identified as Hispanic and 5.1% as Black.

The median household income in UC is $58,592, slightly higher than the median for New York State ($57,683). The NYS poverty rate is 15.6% which is higher than Ulster County's rate of 12.3%. With an unemployment rate of 4.4%, Ulster County has a lower rate than the New York State rate of 4.8%. Main employment sectors include tourism, agriculture, human services, education, and creative services. Ulster County has a high school graduation rate of 81%. Eighty-five percent of residents carry health insurance and 95.3% of children have access to healthcare.

Ulster County is designated as both a Health Professional Shortage Area and a Medically Underserved Area due to the related challenges of the clustering of healthcare professionals within urban and suburban areas, and the difficulty of recruiting new physicians. Leading causes of mortality include diseases of the heart, malignant neoplasms, chronic lower respiratory disease, stroke, and unintended injuries.

## Process Used to Identify Chosen Priority Areas

The community being addressed and served by this plan is all of Ulster County, New York. The process used to identify the chosen priority areas of *Prevent Chronic Disease* and *Promote Mental Health/Prevent Substance Abuse* within UC can be described as follows:

1) A workgroup was established consisting of senior staff of UCDOH-MH's Health Education/Community Relations Division, senior representatives of the HealthAlliance and Ellenville Regional Hospital systems, and Ulster County's Evaluative Analyst to help collate and interpret data.
2) The workgroup met frequently to review the following: a) Ulster County's existing Community Health Improvement Plan to assess progress and lessons learned; b) all available and relevant data and trends from multiple sources; c) a comprehensive inventory of existing community interventions and their status; d) results from the 2016 Ulster County Community Health Needs Assessment Survey; e) recommended evidence-based interventions from NYSDOH; f) best and promising practices established in Ulster County and the nation.
3) The workgroup evaluated recommended interventions, strategies, and actions for inclusion in the Community Health Improvement Plan (CHIP) based on the following criteria: a) how well a proposed intervention, strategy, or action would address identified health disparities and areas where Ulster County was performing below New York State and national averages; b) the realistic chance of successfully implementing a proposed intervention, strategy, or action; c) achieving desired results within the 2016-

18 time-frame, given available community capacity and resources; d) the integrity and reliability of process measures associated with the proposed intervention, strategy, or action.

4) Based on all of the above, the workgroup put together recommended interventions, strategies, and actions for review and discussion by the larger community through the three main community coalitions associated with the recommended priority areas. These were Healthy Ulster Council (chronic disease prevention), Ulster Prevention Council (substance abuse prevention), and SPEAK (suicide prevention).

## Summary of Health/Supporting Data Used to Identify Issues of Concern

Compared to New York State, and with reference to Ulster County's priority areas of choice, *Prevent Chronic Disease* and *Promote Mental Health/Prevent Substance Abuse*, Ulster County is notably performing worse in: premature deaths < age 65 (24.5% UC v 23.7 % NYS); adult obesity (27.6% UC v 24.9% NYS); child and adolescent obesity (19.2% UC v 17.3% NYS); low income population lacking access to supermarkets or large grocery stores (6.01% UC v 4.23% NYS); access to exercise opportunities ( 80.0% UC V 91.0% NYS); adult smoking (21.1% UC v 15.6% NYS) ; poor mental health days (17.1 UC v 11.2 NYS) and age adjusted suicide rates (8.5 per 100K UC v 7.9 per 100K NYS).

# From the 2016 Ulster County Community Health Needs Assessment Survey Results

**What are the three biggest health concerns for the community where you live?**

1. **Drug Abuse- 38.7%**
2. **Mental Health/Depression/Suicide – 35.2%**
3. **Overweight/Obesity – 27.8%**
4. Care for the Elderly – 23.8%
5. Access to Specialty Care – 22.2%

**What are the three biggest health concerns for yourself?**

1. **Nutrition/Eating Habits -27.5%**
3. **Overweight/Obesity – 25.0%**
4. **Access to Specialty Care – 24.3%**
4. Healthy Environment – 22.6%
5. Dental Care-21.5%

**What three things would be most helpful to improve your health concerns?**

1. **Affordable and Healthier Food -34.5%**
2. **Exercise/Weight Loss Programs-32.4%**
3. **Clean Air and Water-19.3%**
4. Job Opportunities/Dental Care-16.4%
5. Safer Places to Walk/Play-14.7%

Highlights taken from the Ulster County Community Health Needs Assessment Survey conducted online and in written form, from July 17, 2016 and concluded on September 15, 2016. Over 600 surveys were completed, representing a broad and diverse spectrum of community residents. Survey results are posted in the *Research and Reports* section of the Ulster County Department of Health and Mental Health website.

# Chronic Disease Prevention Data Review

**Percentage of Adults Obese** (age adjusted) **– 2013-14 eBRFSS**

- Ulster 26.4
- MHR 24.4
- NYS 24.6 (White-22.7/Black 38.1/Hispanic 30.9)

**Adult Obesity – RWJF 2015 County Health Rankings**

- Ulster 28.0
- Top US 25.0
- NYS 24.0

**Percentage Adults 1+ Sugary Beverages Daily - 2013-14 eBRFSS**

- Ulster 30.6
- MHR 21.4
- NYS 24.7

**Percentage of Adults Food Insecure RWJF 2015 County Health Rankings**

- Ulster 25.1
- MHR 22.5
- NYS 22.7

**Percentage of population with low income and low access to a supermarket or large grocery store**

- Ulster 6.01
- MHR 3.61
- NYS 4.23

**Physical Inactivity** (adults 20+ reporting no leisure time activity) **– RWJF 2015 County Health Rankings**

- Ulster 19.0
- Top US 20.0
- NYS 24.0

**Percentage of Adults Obese <$25K Income** (age adjusted) **– 2013-14 eBRFSS**

- Ulster 34.4
- MHR 29.0
- NYS 38.5

**Access to Exercise Opportunities - 2015 RWJF County Health Rankings**

- Ulster 80.0
- Top US 91.0
- NYS 91.0

**Percentage of Adults Engaged in Physical Activity Last 30 Days –2013-14 eBRFSS**

- Ulster 73.5
- MHR 75.6
- NYS 72.9

# Chronic Disease Prevention (Tobacco Use) Data Review

**Percentage of NYS HS Students Aware of Pro-Tobacco Marketing 2000-14 – NY Youth Tobacco Marketing Survey**

- Retail 84.8
- Internet 78.7

**TFAC/Baruch College Survey**

- 40% of those 18-29 have ever smoked
- 17% of UC residents currently smoke
- 22% of UC residents use E-cigarettes
- 78% UC residents say tobacco should not be sold in pharmacies
- 79% UC residents say tobacco should not be sold near schools
- 73% have noticed tobacco products visible behind counters
- 67% favor keeping tobacco products out of view
- 70% are concerned that cigarettes displayed where children can see them will increase youth smoking
- 63% believe tobacco displays will increase youth smoking
- 66% think in-store tobacco advertising will lead teens to smoke
- 65% think in-store tobacco displays will increase youth smoking

**Percentage of Current Smokers Middle and HS Students UC – YDS 2014-15**

- Middle School Use - 1.2
- HS Use - 7.3
- Have Used 7-12 Grades - 20.0
- Tried Between Age 12 and 14 - 47.0
- Tried Before Age 11 - 25.0
- Current Smokers 7-12 Grades - 10.0
  (NYS 7.3 HS/ 1.2 Middle NYS Tobacco Survey)
- Perception of Smoking Not Harmful 7-12 Grades - 14.0 -19.0

# Mental Health/Substance Abuse Prevention Data Review

**Suicide Rates/100K – NYS PA Dashboard**

- UC 8.5
- NYS 7.9
- PA 2018 - 5.9

**Poor Mental Health 14+ Days – NYS PA Dashboard**

- UC 17.1
- NYS 11.2
- PA 2018 - 10.1

**Percentage Adult Smokers <$25K HHI – eBRFSS**

- Ulster 36.3
- MHR 23.4
- NYS 24.2

**UC Suicide Stats – UC Medical Examiner**

- 2015 - 11
- 2016 YTD (Jan-Aug) - 11 (pacing 50% higher than LY)
- Male- 92.3
- Female- 7.7
- < 25 years of age - 23.0
- 26-40 - 38.0
- 41-65 - 31.0
- 66+ - 8.0

**Percentage of Adults Who Are Current Smokers – eBRFSS 2013-14**

- MHR 14.5
- NYS 15.9
- UC 22.2

## 2015 Opioid Overdoses and Rates per 100,000 Population - New York State - County Opioid Quarterly Report - For Counties Outside of New York City

**Data as of: August, 2016**

**Deaths**

**All Opioid:**

- Ulster 5.6
- NYS 6.8

**Heroin:**

- Ulster 4.4
- NYS 3.8

**Overdoses Involving Opioid Pain Relievers:**

- Ulster 2.2
- NYS 3.9

**Outpatient ED Visits**

**All Opioid:**

- Ulster 53.8
- NYS 39.8

**Heroin:**

- Ulster 35.0
- NYS 28.7

**Opioid Overdoses Excluding Heroin:**

- Ulster 18.9
- NYS 11.1

**Hospitalizations**

**All Opioid:**

- Ulster 22.2
- NYS 16.1

**Heroin:**

- Ulster 5.0
- NYS 5.5

**Opioid Overdoses Excluding Heroin:**

- Ulster 17.2
- NYS 10.6

## Prevention Agenda Priorities/Community Engagement Process

Ulster County is reaffirming the same priorities that were selected in the 2014-17 Community Health Assessment and Community Health Improvement Plan, which included: *Prevent Chronic Disease* with a focus on preventing childhood obesity and tobacco use prevention, and *Promote Mental Health/Prevent Substance Abuse* with a focus on preventing suicide and prescription drug abuse. The disparities being addressed, particularly among low socioeconomic populations, include adult and youth obesity, tobacco use, access to affordable and healthy food, access to exercise and physical activity opportunities, premature death, preventable hospitalizations due to recurring chronic disease conditions, substance abuse issues, and recurring incarceration due to substance abuse and other behavioral disorders.

The community was engaged through two primary mechanisms. The first was through ongoing meetings, presentations, and strategy discussions with the Healthy Ulster Council, formerly known as the Ulster County Chronic Disease Prevention Council. This broad-based coalition was formed in 2010 as a result a countywide health summit continues to identify major gaps and opportunities for improving health outcomes. The Council meets six times a year and has been actively engaged in collecting an inventory of the community's preventative health resources and activities. It has worked to identify disparities as well as create synergy among member organizations, and identify funding resources. With the assistance of Ulster County Department of Health staff, the council has monitored key health indicators on an ongoing basis in order to ensure that trend lines continued to point in the direction of improvement.

The second key component was the development and implementation of the 2016 Ulster County Community Health Needs Assessment Survey. This survey was used to confirm and reinforce existing priorities, and to inform the creation of new evidence-based and innovative strategies and interventions. It was created with both English and Spanish language versions and was distributed to members and clients of community coalitions, hospital systems, community clinics, faith based organizations, nonprofit organizations, and the county departments of Aging, Veteran's Services, Social Services and the Ulster County Office of Human Rights. The survey was available in both paper and electronic formats and commenced on July 17, 2016 and concluded on September 15, 2016. Over 600 completed surveys were submitted for analysis.

# Prevention Priority Goals, Objectives, Interventions, Measures

## Priority Area #1: Preventing Chronic Diseases (Action Plan)

### Chronic Disease Prevention Strategy Overview

#### 1. Strengthen Existing Coalitions for Enhanced Effectiveness, Greater Sector and Public Participation, Results and Sustainability

⇒ **Healthy Ulster Council** - continue to work with and strengthen a multi-sector, county-wide chronic disease prevention coalition focused on an integrated and coordinated approach to chronic disease prevention.

⇒ **Live Well Kingston** (outlined in HealthAlliance section) -focused on engagement of all sectors of the City of Kingston community to improve health outcomes through targeted action and collective impact.

#### 2. Strengthen Access to Physical Activity with an Emphasis on Health Disparity Areas and Populations

⇒ **Midtown Linear Park Project** - offering inner-city, low socioeconomic status (SES) residents in the City of Kingston unprecedented access to physical activity, greenspace, and walking access to a large supermarket and farmer's market.

⇒ **Safe Routes to Schools Program** - a comprehensive initiative to include the installation of new sidewalks, crosswalks, and pedestrian signals near four low income neighborhood elementary and middle schools in the City of Kingston.

⇒ **Completion of Ulster County's Rail Trail System** - UC is engaged in developing additional 14 miles of rail trails to add to its existing network of 40 miles. *This $12.8 million dollar investment will improve access throughout the community and result in one of the finest, interconnected bike and pedestrian trail systems in the nation.*

⇒ **Incorporate Bike/Pedestrian Friendly Components into all Ulster County (UC) Road and Bridge Infrastructure, by Policy and Practice**

⇒ **Continue to Promote UC Park and Recreation Resources and Free Access with Innovative and Comprehensive Online Guide (REConnect).**

⇒ **YMCA Starfish Program** - enhancing physical activity and healthy eating through a summer program that serves low income, inner city children.

⇒ **MAC Fit Kids** - physical activity and enhanced nutrition for kids (including scholarships for low income children), and preventative education for families though an Annual Youth Health Expo, within an exceptional afterschool and summer camp program.

⇒ **YMCA Bike Safety and Cycling Promotion Program** - a program dedicated to promoting bike use and safety throughout Ulster County, with an emphasis on low income, inner-city children in Midtown Kingston, the most socioeconomically distressed community in the county, and the area with the greatest health disparities.

⇒ **Walk and Water Campaign** - an ongoing public education and awareness campaign designed to prevent child and adult obesity by promoting daily physical activity and reducing the consumption of sugar sweetened beverages.

## 3. Strengthen Access to Affordable Healthy Food/Improved Nutrition

⇒ **Hudson Valley Farm Fresh Collaborative** - continue to build on the success of linking Ulster County's sizeable agricultural sector to 30+ local food pantries and facilitate expanded and efficient distribution of fresh, healthy, local produce to address food insecurity and poor nutrition among low SES individuals and families throughout the community.

⇒ **Expand Utilization of WIC Nutrition Program/Farm Market Vouchers**

⇒ **Midtown Linear Park Project** - offering inner-city, low SES residents in the City of Kingston unprecedented access to physical activity, greenspace and access by walking to a large supermarket and farmer's market.

## 4. Strengthen and Support Community Tobacco Prevention Programs, Practices, Policies, and Initiatives

⇒ **Strengthen Youth Exposure to Tobacco Marketing/Licensing Law –** amend current Ulster County law that prohibits the issuance of new tobacco retail licenses within 1000 feet of all K-12 schools to cap the number of times that an existing business with

a grandfathered license can be transferred to a new owner, if and when that business is sold. The amendment would also prohibit tobacco couponing and price promotions, and raise the age of purchase of tobacco products from 18 to 21 throughout UC.

⇒ **Promote Adoption of a Local Law to Add E-cigarette Use to the Clean Indoor Air Act Countywide** – adding vaping to the Clean Indoor Air Act in UC protects everyone from exposure to highly addictive nicotine and other harmful chemical substances. It would also help reduce youth exposure to a significant marketing tool that tobacco companies use to recruit new smokers.

⇒ **Promote Smoke Free Multi-Unit Housing Policy** – reduce exposure to secondhand smoke by working with landlords, housing authorities, and the community to educate them on the health and financial advantages of adopting smoke free housing policies and assist in implementing new policy.

⇒ **Promote Adoption of a Local Law to Require Full Disclosure of Smoking Policy in Multi-Unit Housing to All Current and Prospective Tenants**

⇒ **Tobacco Use Prevention and Referral to NYS Smokers' Quitline, Media, and Promotional Campaigns**

⇒ **Assist Mental Health Care Organizations to Establish System-Level Policies and Procedures to Improve Tobacco Dependence Treatment**

## 5. Improve Prevention Education, Management, and Screening

⇒ **Implement and Promote Evidenced Based Chronic Disease Self-Management, Chronic Pain Management, and Chronic Disease Prevention Workshops Throughout the Community**

⇒ **Set a Colorectal Screening Rate Goal of 80% for Ulster County and Work with County Leadership and Community Partners to Reach**

## 6. Strengthening Community Awareness, Outreach and Engagement

⇒ **Continue to Promote and Improve the County Executive's Goal of Making Ulster the Healthiest County in NY** - in 2012, Ulster County was ranked 35th healthiest out of 62 counties in NYS in the Robert Wood Johnson Foundation's County Health Rankings. In 2016, Ulster County had advanced to 16th healthiest. Community buy-in, engagement, and participation has been achieved by continuing to promote this goal in all of the County's messaging and policy areas and across all department policy and program areas.

⇒ **Healthy Ulster Radio** - Healthy Ulster Radio is a weekly radio program produced by the Ulster County Department and Mental Health and presents topics and guests that support a "whole community" approach to preventative health and wellness and creating a vibrant and sustainable community.

⇒ **Healthy Ulster County Network** - the Healthy Ulster County Network is a branding and communications tool that includes a dedicated website and other online and social media pages designed to "connect the dots" between all of the extensive preventative health resources in Ulster County to increase public support for preventative health initiatives and help make the community's preventative health resources readily accessible to all.

## Focus Area 1 – Reduce Obesity in Children and Adults

### Goal #1.1 - Create community environments that promote and support healthy food and beverage choices and physical activity

⇒ *Adequately invest in proven community-based programs that result in increased levels of physical activity and improved nutrition.*

⇒ *Increase retail availability of affordable healthy foods that meet the needs of communities, especially those with limited access to nutritious foods.*

⇒ *Adopt policies and implement practices to reduce overconsumption of sugary drinks.*

## STRATEGY FOCUSED ON PREVENTING CHRONIC DISEASE THROUGH COLLABORATION AND COLLECTIVE IMPACT

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| **INTERVENTION: HEALTHY ULSTER COUNCIL *(ongoing from current CHIP)*** | The Healthy Ulster Council (HUC) is multi-sector, community-wide collaborative body designed to prevent chronic disease by 1) collecting an inventory and supporting all local existing community initiatives; 2) "connecting the dots" by fostering communications, awareness, and potential synergies in and among organizations and individuals working on various aspects of community wellness and prevention; 3) assisting in identifying and responding to barriers to implementation; 4) identifying and tracking new initiatives and best practices on a local, state and national level; 5) seeking out and supporting relevant funding resources and applications where appropriate. |
| **GOALS - OUTCOME(S)** | • Engage community partners and stakeholders in the planning, facilitation, and logistical organization through the use of regularly scheduled bi-monthly meetings.<br>• Mobilize advocates to increase demand for healthy environments, food choices, and improved opportunities for physical activity.<br>• Increase social media presence of the HUC and promote members initiatives and accomplishments through Facebook, Twitter, and LinkedIn. Encourage use of hashtag #healthyulster<br>• Help promote and facilitate the use of the *Healthy Ulster County Network* website: (1) engage and inform the public regarding available preventative health resources; (2) encourage community organizations and partners to contribute relevant content and preventative health related products, services, and events; (3) enhance communications to and from the HUC.<br>• Continue to enhance and update the inventory of chronic disease services as new partners and assets are identified.<br>• Assist with grant applications for HUC-identified projects and initiatives that support collaboration and collective action.<br>• Research evaluation techniques and begin the development of performance measures and a shared evaluation plan. |
| **PARTNERS** | UCDOH-MH, Cornell Cooperative Extension; HealthAlliance; Community members and Community Based Organizations (CBO) |
| **PARTNER ROLES/RESOURCES** | • UCDOH/MH Funding and Staff, Cornell Cooperative Extension - Coordination of Meetings; Community members and CBO- Participate and collaborate in meetings and shared events- In-kind staff time. |
| **BY WHEN** | Ongoing 2016-18 |
| **MEASURES** | Complete six meetings annually, track participation and attendance, track online media reach, track successful grant awards, update services inventory |
| **DISPARITY** | Yes, the Council is focused on identifying disparities, closing gaps and watching trends data, researching and discussing targeted interventions and best practices. |

## INTERVENTION FOCUSED ON IMPROVING COMMUNITY HEALTH AND WELLNESS THROUGH AWARENESS, EDUCATION AND ENGAGEMENT

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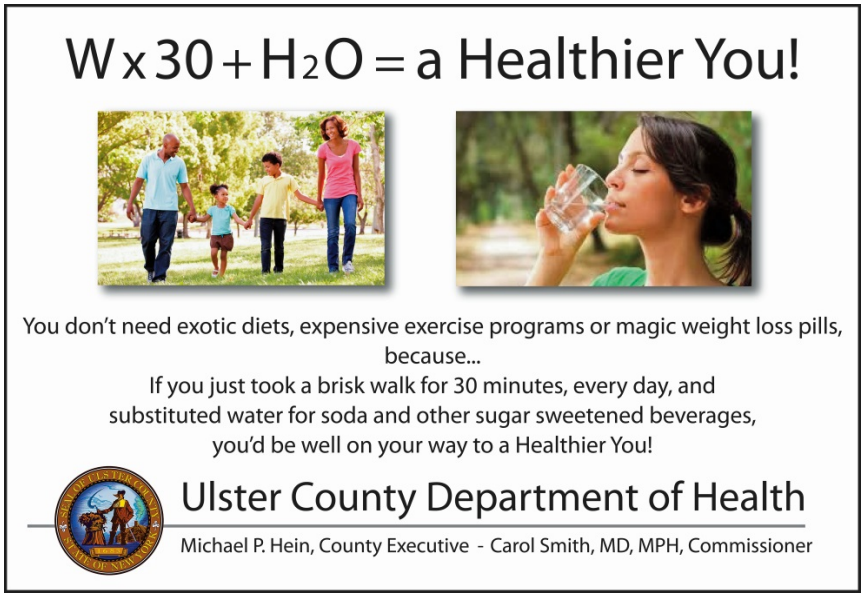
|---|---|
| ***INTERVENTION:*** **HEALTHY ULSTER RADIO** ***(NEW: not in previous CHIP)*** | ***Healthy Ulster Radio*** **is a weekly radio program, produced in-house and hosted by the UCDOH-MH Commissioner of Health and Mental Health and the Director of Community Health Relations. Healthy Ulster Radio is broadcast on WBPM-FM, in Kingston, NY and four other regional AM stations throughout the Mid-Hudson Valley. Healthy Ulster Radio serves as a primary communications tool in helping to engage the community in the collective effort to ensure improved health outcomes for all and to work toward making Ulster the healthiest county in New York. The programs focus on a broad range of preventative health issues, including physical activity; nutrition; access to affordable healthy food; safe and affordable housing; environmental integrity; substance abuse prevention; tobacco prevention; suicide prevention; and additional health related topics. The program takes a "whole community" approach to improving community health, wellness and sustainability.** |
| **GOALS - OUTCOME(S)** | To engage the public and all sectors in creating an environment that helps to promote individual and community wellness, while pursuing the goal of making Ulster the healthiest county in NY. |
| **PARTNERS** | UCDOH-MH, Pamal Broadcasting, HealthAlliance, guests from leading health and prevention related organizations throughout the community, and the public (input on desired content/topics. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH – provides research, logistics, production, content, hosting.<br>• Pamal Broadcasting – airs Healthy Ulster Radio on its FM station (WBPM), in Kingston and three other AM stations that cover the entire Mid-Hudson Valley region.<br>• HealthAlliance – sponsorship funding.<br>• Multiple community partners – providing guests to speak on relevant topics. |
| **BY WHEN** | Ongoing, on a weekly basis throughout 2016-18. |
| **MEASURES** | Number of listeners reached, community organizations engaged, prevention topics covered, public feedback and input. |
| **DISPARITY** | Yes, all of the topics covered include health impacts on low socioeconomic status populations, while guiding them to prevention education and available community resources. |

## INTERVENTION FOCUSED ON PREVENTING OBESITY AND CHRONIC DISEASE BY REDUCING OVERCONSUMPTION OF SUGARY DRINKS

| **INTERVENTION: WALK AND WATER MEDIA CAMPAIGN** ***(NEW: not in previous CHIP)*** | **Continue to work with community partners and use multi-platform media campaigns to promote physical activity and reduce the consumption of sugar sweetened beverages using components of the Sugar Sweetened Beverages Playbook). To this end, UCDOH-MH has created and produced a very effective, ongoing campaign (see example below) titled "Walk and Water" that has been utilized in print and radio applications, as well as complimentary online and social media versions.** |
|---|---|
| **GOALS - OUTCOME(S)** | Per the most recent 2013-14 eBRFSS update, Ulster County's adult consumption of one or more sugary beverages per day stood at 30.61, which is 5.9% higher than the NYS average. The goal is to equal the NYS average of 24.7 by the end of 2018. |
| **PARTNERS** | UCDOH-MH, Healthy Ulster Council, media organizations (print and radio) throughout the community (paid and in-kind), schools, Cornell Cooperative Extension of Ulster County. |
| **PARTNER ROLES/RESOURCES** | • UCDOH and Healthy Ulster Council - create fund and distribute campaign.<br>• All other partners - promote campaign through their communications/media channels and platforms. |
| **BY WHEN** | By the end of 2018. |
| **MEASURES** | Number and frequency of population reached. Available data sources. Survey one or more community focus groups. |
| **DISPARITY** | Yes, consumption of sugar sweetened beverages by low SES populations is far above the average for the community population as a whole. |



## INTERVENTION FOCUSED ON ACCESS TO EXERCISE OPPORTUNITIES AND NUTRITIOUS FOOD

| | |
|---|---|
| **INTERVENTION: ULSTER COUNTY MIDTOWN LINEAR PARK PROJECT** ***(NEW: not in previous CHIP)*** | **The *Ulster County Midtown Linear Park Project* (the "Project") will establish a paved rail trail/ linear park in the City of Kingston and provide residents of Midtown Kingston with the first recreational trail/ park facility in proximity to Midtown neighborhoods. The fully-accessible trail will greatly expand access to outdoor recreation; promote exercise and more active lifestyles, as well as offering safe and improved bicycle and pedestrian access to the City's only major supermarket and to the community farmer's market from one of the lowest-income areas of the City. The Project will also transform a former rail yard into a community pocket park for local children.** |
| **GOALS - OUTCOME(S)** | The Project will construct an approximately 0.8-mile "rail trail" from Midtown Kingston to the Kingston Plaza/ Uptown Kingston, encouraging residents to walk, bike, jog, and skate on an asphalt-paved trail that will be fully accessible for persons with disabilities. In addition to encouraging children and families to be more active, the trail will be a vital non-motorized link to a source of high-quality, reasonable-cost fresh food. The community pocket park will also provide families a safe and enjoyable park space for children to play outdoors. |
| **PARTNERS** | Ulster County (multiple departments), City of Kingston, National Park Service, The Dyson Foundation, Open Space Institute, Parks and Trails NY, NYSDOT, Cornell Cooperative Extension of UC, Hudson River Valley Greenway (HRVG), Ulster County Board of Realtors, Bike Friendly Kingston, Live Well Kingston, Kingston Land Trust, the Bruderhof Community (faith-based organization) and United Health Care. |
| **PARTNER ROLES/RESOURCES** | • Ulster County - all planning, funding, engineering design and construction activities.<br>• The City of Kingston - committed to maintain the trail facility once constructed and will advise as the Project is designed.<br>• The Kingston Police Department - advise on the design to address potential safety issues.<br>• The Bruderhof Community - grant funding pledge for the Project.<br>• The Dyson Foundation- funding support.<br>• The National Park Service, Parks and Trails NY, HRVG, Kingston Land Trust and Open Space Institute- anticipated to provide project support, technical assistance and potential funding.<br>• NYSDOT-funding and engineering support<br>• Cornell Cooperative Extension of UC- promotion and utilization<br>• Ulster County Board of Realtors - project promotion<br>• Bike Friendly Kingston and Live Well Kingston - provide in-kind services, advocacy, community support and awareness, and promote utilization. |
| **BY WHEN** | By the end of 2018. Design and engineering are proposed to begin in early 2017. |
| **MEASURES** | Secure funding commitments from New York State. Complete engineering design phase and resolve right-of-way issues. Prepare final plans and specifications and bid documents for the project. Complete construction and construction inspection. Install signage. Launch event. Promote to community. Transfer operation and maintenance to City of Kingston. Measure demand for this asset and subsequent utilization rates with select community groups. |
| **DISPARITY** | Yes, the Project will benefit thousands of low and moderate income individuals and families who live in nearby neighborhoods. The Project lies within a federally-qualified census tract, which means that at least 50 percent of households have an income less than 60 percent of the Area Median Gross Income (AMGI). According to Census data, 23.6 percent of residents and 30.6 percent of children live below the poverty threshold, and nearly one-half of renter-occupied units in the neighborhood lack access to an automobile. |

## INTERVENTION FOCUSED ON PREVENTING CHILDHOOD OBESITY THROUGH SAFE ROUTES TO SCHOOLS INITIATIVES

| **INTERVENTION: Comprehensive Safe Routes to School Project in the City of Kingston** ***(NEW: not in previous CHIP)*** | **Implementation of a comprehensive "Safe Routes to Schools" initiative in the City of Kingston to include the installation of new sidewalks, crosswalks, and pedestrian signals near four elementary and middle schools (Edson Elementary, George Washington Elementary, JFK Elementary and J. W. Bailey Middle School). Three out of the four schools are located in the Midtown Kingston area, which is one of the most socioeconomically distressed communities in Ulster County.** |
|---|---|
| **GOALS - OUTCOME(S)** | The childhood obesity rate for the Kingston School District is 44% higher than the national state and county averages. This comprehensive, evidenced based "Safe Routes to Schools" project will provide elementary and middle school children in the City of Kingston with an unprecedented level of safe, pedestrian, and bike access to physical activity and alternative transportation opportunities. |
| **PARTNERS** | City of Kingston (Mayor's Office and multiple departments), Kingston Safe Routes to School Advisory Committee, Kingston Consolidated School District, Live Well Kingston, Bike Friendly Kingston, YMCA, Cornell Cooperative Extension of Ulster County, NYSDOT. |
| **PARTNER ROLES/RESOURCES** | • All partners except NYSDOT- support, supervision of project, promotion, community engagement, evaluation.<br>• NYSDOT- funding administration and engineering supervision. |
| **BY WHEN** | By the end of 2018. |
| **MEASURES** | Design phase has been completed. Application submitted and accepted and funding has been allocated. Each step of the build-out/implementation phase will be monitored. Before and after pedestrian counts and accident counts will be evaluated throughout. Walking School Bus and Walk, Bike, and Roll to School Day participation will be measured. |
| **DISPARITY** | Yes, at least 3 of the schools in the project are in Midtown Kingston, a densely populated, low SES community with high rates of obesity, chronic disease, and premature death. Midtown Kingston currently has no outdoor parks or recreation areas available to residents and many parents do not own a vehicle, making safe walking and biking opportunities even more critical. |

## INTERVENTION FOCUSED ON PREVENTING OBESITY AND CHRONIC DISEASE THROUGH ENHANCED ACCESS TO PHYSICAL ACTIVITY

| **INTERVENTION: Bicycle and Pedestrian Friendly Infrastructure** ***(NEW: not in previous CHIP)*** | **Adopt and implement policy to include bike lanes and pedestrian walkways into all possible transportation and recreation infrastructure projects throughout Ulster County**. |
|---|---|
| **GOALS - OUTCOME(S)** | To provide safe and accessible pedestrian access and enhanced physical activity opportunities, to the maximum extent practicable going forward, for all county roadway, bridge, and parks upgrade and development projects. |
| **PARTNERS** | Ulster County Executive's Office, Ulster County Legislature, Ulster County Planning, Ulster County Department of the Environment, Ulster County Department of Public Works, NYSDOT, UCDOH-MH, local municipalities and community development groups throughout the community. |
| **PARTNER ROLES/RSOURCES** | • All partners except NYSDOT - support, supervision of project, promotion, community engagement, evaluation.<br>• NYSDOT - funding administration and engineering supervision. |
| **BY WHEN** | By the end of 2018 and ongoing. |
| **MEASURES** | Number of new and upgraded bridge and park installations. Number of miles of roadway with new and/or improved pedestrian and bike access. Periodic usage surveys on select bike/roadways, parks, and bridges to measure increases in pedestrian and bicycle traffic. |
| **DISPARITY** | Yes, it is a community wide policy and its implementation will benefit all socioeconomic/demographic groups. |

## INTERVENTION FOCUSED ON PREVENTING OBESITY AND CHRONIC DISEASE THROUGH SAFE ACCESS TO PHYSICAL ACTIVITY OPPORTUNITIES/ALTERNATIVE TRANSPORTATION

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|---|---|
| **INTERVENTION: YMCA Bike Safety and Cycling Promotion Program** ***(NEW: not in previous CHIP)*** | **The YMCA has offered bike safety education programs since 2010 at community events such as the Kingston Farmer's Market, Forsyth Nature Center Fall Festival, the YMCA Bike Fest, and the Tour De Kington. Safety programs are offered at schools and parks. These programs build confidence in safety skills that will stay with young participants into adulthood and improve fitness and confidence among all participants. The curriculum varies depending on the length of the program, location, and age groups concerned. Core elements include helmet and bike fit, rules of the road, safe stopping and starting, hand signals, clothing and visibility, and bike maintenance. Whenever feasible, provide on-bike training. Group programs range from six to eight weeks, while YMCA summer camps are five consecutive days.** |
| **GOALS - OUTCOME(S)** | Increase events and participation by at least 15% and steadily reduce the average rate of overweight and obese conditions among participants by the end of 2018. Hundreds of participants will learn to be safer bikers and get exercise. Continue to engage more than 400 youth and 100 adults in bike safety education events yearly. Maintain volunteer engagement. Distribute helmets, high-visibility t-shirts, patch kits, and locks. Continue to repair and give away bikes. |
| **PARTNERS** | YMCA of Ulster, Volunteers, City of Kingston Parks and Rec, Everette Hodge Center, Live Well Kingston, Schools, Kingston Police Department (PD), Kingston Fire Department (FD), United Way, UCDOH-MH. |
| **PARTNER ROLES/RESOURCES** | • YMCA of Ulster - recruiting volunteers and participants, running the program, use of facilities.<br>• Volunteers - time<br>• City of Kingston Parks and Rec-promotion, access to rides<br>• Schools and Everette Hodge Center - promotion and recruitment of youth and program participants<br>• Live Well Kingston - community support and promotion<br>• City of Kingston, Kingston FD, PD - community support and promotion, awareness and interaction with kids and families<br>• United Way of Ulster County - funding<br>• UCDOH-MH - community support and promotion |
| **BY WHEN** | Through the end of 2018. |
| **MEASURES** | Number of events, number of participants and increases in participation. |
| **DISPARITY** | Yes, YMCA of Ulster County program serves all of Ulster County including inner-city children from the Midtown Kingston area, the most socioeconomically distressed community in Ulster County and the area of the greatest health disparities, including child and adult obesity. |

## INTERVENTION FOCUSED ON PREVENTING OBESITY AND CHRONIC DISEASE THROUGH ENHANCED ACCESS TO EXERCISE OPPORTUNITIES

| **INTERVENTION: Completion of Ulster County's Interconnected Rail Trail System** ***(Continued from previous CHIP)*** | **The Ulster County Rail Trail Project is a multi-phase initiative to expand and link the County's network of shared-use "rail trails" to promote physical activity and healthier lifestyles in various parts of the County. Three projects are being advanced as part of this initiative: the Ashokan Rail Trail in the Towns of Olive and Hurley, the Kingston Rail Trail in the Towns of Hurley and Olive, and the Hudson Valley Rail Trail West: Phase 4 in the Town of Lloyd.** |
|---|---|
| **GOALS - OUTCOME(S)** | The County is engaged in developing an additional 14 miles of rail trails to add to its existing network of 40 miles. The expansion and connection projects will improve access to these trails in multiple towns and lay the foundation for a fully connected system of bike and pedestrian trails in the future. The investment in these three projects totals nearly $12.8 million, most of which has been obtained through various federal, State and other grant funding sources. |
| **PARTNERS** | Ulster County (multiple departments), New York State Department of Transportation (NYSDOT), New York State Department of Environmental Conservation (NYSDEC), New York City Department of Environmental Protection (NYCDEP), Open Space Institute, Town of Lloyd, and National Park Service. |
| **PARTNER ROLES/RESOURCES** | • Ulster County -responsible for all planning, funding, engineering design and construction activities<br>• NYSDOT- administering federal transportation funding for the Kingston Rail Trail and Hudson Valley Rail Trail West: Phase 4 projects<br>• Open Space Institute and National Park Service - funding<br>• Town of Lloyd -granting the County a needed property easement for the development of the Hudson Valley Rail Trail West: Phase 4 Project, and the Town will maintain the facility once constructed<br>• NYSDEC and NYCDEP -providing significant funding for the Ashokan Rail Trail |
| **BY WHEN** | All three trail projects are anticipated to go to construction in late 2017 or early 2018 and will be fully completed and open to public use by late 2018 or early 2019 |
| **MEASURES** | Engineering and planning. Right-of-Way acquisition for the two NYSDOT projects. Final plans and specifications. Bidding and contract awards. Construction. Construction Inspection. Ongoing and regular measures of trail utilization rates. |
| **DISPARITY** | Yes, all three projects will be designed to be compliant with the Americans with Disabilities Act (ADA) and will be usable by persons of all ages and abilities. These trail projects are all generally flat and are perfect for younger children, people in wheelchairs, and those with limited mobility, including elderly people who are looking for suitable outdoor recreational activities to stay fit and healthy. |

## INTERVENTION FOCUSED ON PREVENTING OBESITY AND CHRONIC DISEASE THROUGH INCREASED ACCESS TO EXERCISE OPPORTUNITIES

| **INTERVENTION: Promote an Comprehensive Online Guide to all Recreational Resources** ***(Continued from previous CHIP)*** | **Promote free access to all Ulster County Parks and the availability and utilization of REConnect; a comprehensive online/mobile recreational resource guide to UC's recreation resources through paid and earned media, social media campaigns, and targeted presentations to community organizations serving health disparity populations.** |
|---|---|
| **GOALS - OUTCOME(S)** | To reduce obesity in children and adults through the promotion of free access to all county parks and promotion and utilization of REConnect, a comprehensive online and mobile resource guide to all of Ulster County's recreation resources. |
| **PARTNERS** | Ulster County Department of the Environment (UCDOE), UCDOH-MH, Ulster County Parks, Ulster County Area Transit (UCAT) multiple media partners and environmental and community organizations. |
| **PARTNER ROLES/RESOURCES** | • UCDOE/UCDOH-MH/Ulster County Parks - promotion, awareness, paid and earned media, social media campaigns<br>• Ulster County Area Transit (UCAT) - study to better connect public transit routes to park assets<br>• Media partners - public service announcements, promote utilization<br>• Environmental and community organizations- awareness, promote utilization with members and public |
| **BY WHEN** | Ongoing through 2018 and beyond. |
| **MEASURES** | Measure increase in traffic to REConnect web and mobile sites. Measure increase in park attendance. Survey community groups to measure awareness and utilization of free park access and REConnect utilization. |
| **DISPARITY** | Yes, free park access and REConnect will be promoted to health disparity populations through community presentations and multiple communications channels, including the Ulster County public transit system. |

## INTERVENTION FOCUSED ON PREVENTING CHRONIC DISEASE AND ADDRESSING FOOD INSECURITY THROUGH ACCESS TO FRESH AND HEALTHY LOCAL PRODUCE

| **INTERVENTION: Hudson Valley Farm Fresh Collaborative *(NEW: not in previous CHIP)*** | **To continue to develop the highly successful Hudson Valley Farm Fresh Collaborative (HCFFC), a program that has developed a network of local farmers and volunteers to donate and process fresh produce for distribution to food pantries throughout Ulster County. In 2015, HVFFC distributed 32 tons of fresh produce to over 30 food pantries and established 6 regional storage hubs to assist the pantries with their food storage needs.** |
|---|---|
| **GOALS - OUTCOME(S)** | To continue and enhance this highly successful program for the donation, processing, storing and distribution of fresh, healthy local produce to food pantries and meal programs throughout Ulster County. |
| **PARTNERS** | Family of Woodstock, Rondout Valley Growers Association, UlsterCorps, Bruderhof, Community Action, UCDOH-MH, numerous local farmers, food pantries and community volunteers. |
| **PARTNER ROLES/RESOURCES** | • Family of Woodstock -Lead agency, funding and coordination of collaborative<br>• Rondout Valley Growers Association- recruit new farmers to donate produce and promote program<br>• UlsterCorps, Bruderhof - recruit and engage community volunteers<br>• Community Action - funding and transportation resources<br>• UCDOH-MH - active participation on HVFFC board and promoting program<br>• Volunteers, local farmers, food pantries - participating in and promoting program |
| **BY WHEN** | Ongoing through 2018 and beyond. |
| **MEASURES** | Records will be kept on the number of pounds of produce and other donated food and related food items, number of pounds processed and how they are distributed, poundage distributed to each hub, number of programs benefiting from food donated, number of meals distributed by food pantries and feeding programs, number of volunteers and hours donated. |
| **DISPARITY** | Yes, this program specifically addresses food insecurity and access to fresh and healthy local produce for low income individuals and families. |

## Focus Area 1 – Reduce Obesity in Children and Adults

### Goal #1.2 - Prevent childhood obesity through early child-care and schools.

**INTERVENTION FOCUSED ON PREVENTING CHILDHOOD OBESITY THROUGH NUTRITION AND PHYSICAL ACTIVITY IN CHILDCARE SETTINGS**

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|---|---|
| **INTERVENTION: YMCA and Ulster County STARFISH Program** ***(NEW: not in previous CHIP)*** | **YMCA of Kingston and Ulster County's Summer STARFISH program is a 6 week program that serves inner city children entering grades K-5, from low income families and works to prevent and reduce childhood obesity through structured physical activity, including structured cardiovascular activities, swimming, and walking field trips. Healthy eating is emphasized through the provision of healthy lunches and snacks and water instead of sugar sweetened beverages, as well as visits to the YMCA farm to sample and take home fresh produce. Ongoing BMI assessment is a strong component of the program.** |
| **GOALS - OUTCOME(S)** | To reduce overweight and obese conditions among participants by measuring progress over multi-year participation and to increase overall participation by 17% in the short term (1-2 years) and doubling participation over the long term (3-5 year) as a planned, new outdoor recreation complex is designed and constructed. |
| **PARTNERS** | YMCA of Ulster, Family of Woodstock, United Methodist Church Summer Feeding Program, City of Kingston, United Way of Ulster County, Kingston Police Department, Kingston Fire Department, Kingston Library, UCDOH |
| **PARTNER ROLES/RESOURCES** | • YMCA of Ulster - recruiting participants, running the program, use of facilities, interaction with farm resources, BMI assessments<br>• Family of Woodstock and United Methodist Church - healthy food and snacks, funding elements<br>• United Way of Ulster County - funding<br>• City of Kingston, Kingston FD, PD and Library - support, awareness and interaction with kids and families<br>• UCDOH-MH - community support, promotion |
| **BY WHEN** | Increase participation by at least 17% and steadily reduce the average rate of overweight and obese conditions among participants by the end of 2018. |
| **MEASURES** | Participation numbers. BMI assessment data. |
| **DISPARITY** | Yes, YMCA of Kingston and Ulster County's STARFISH program serves inner-city children from the Midtown Kingston area, the most socioeconomically distressed community in Ulster County and the area of the greatest health disparities, including child and adult obesity. |

## INTERVENTION FOCUSED ON PREVENTING CHILDHOOD OBESITY THROUGH NUTRITION AND PHYSICAL ACTIVITY IN CHILDCARE SETINGS

| **INTERVENTION: MAC Fit Kids After School and Summer Program** ***(NEW: not in previous CHIP)*** | **MAC Fit Kids in a non-profit organization that promotes wellness and physical activity among low income children (ages 5-12) though fun-filled, physical activities within its after school and summer programs. MAC Fit Kids follows Ulster County's comprehensive Healthy After School Snack Guidelines and works to educate children and families about the importance of healthy snacking. MAC Fit Kids will continue to work to increase enrollment through interaction with social service agencies, schools, community organizations, paid and earned media, and the production of an Annual Youth Wellness Expo.** |
|---|---|
| **GOALS - OUTCOME(S)** | To prevent and reduce child obesity in the greater Kingston community by increasing the enrollment of youth from low income families by 15%, while continuing to emphasize the value of physical activity, healthy snacking, and the reduction of sugar sweetened beverage consumption. MAC Fit Kids will also offer 10 scholarships per year for its summer camp program to low income families who may not meet strict Department of Social Service guidelines. |
| **PARTNERS** | MAC Fit Kids, UCDOH-MH, City of Kingston School District, Ulster County Department of Social Services (UCDSS), multiple private sector businesses, community organizations. |
| **PARTNER ROLES/RESOURCES** | • MAC Fit Kids - a fully equipped recreation/fitness facility, staff, transportation, promotion<br>• UCDOH-MH - participation on the Mac Fit Board and ongoing promotion and support<br>• City of Kingston School District - promotion and referrals to program<br>• UC DSS - qualification and referral of children from low income qualified families<br>• Private sector businesses and community organizations - Board membership, funding, promotion, in-kind services |
| **BY WHEN** | Increase participation by at least 17% and steadily reduce the average rate of overweight and obese conditions among participants by the end of 2018. |
| **MEASURES** | Measure annual Increase in enrollment figures.<br>Increase awareness and enrollment of DSS low income families.<br>Issuance of scholarships and utilization by low income families.<br>Successful presentation of Annual Youth Wellness Expos, with attendance figures. |
| **DISPARITY** | Yes, the overwhelming majority of MAC Fit Kids youth are from low income qualified families from the greater Kingston, NY community; the same families that have some of the greatest health disparities and highest rates of obesity and chronic disease conditions. |

## <u>Focus Area 2</u> – Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

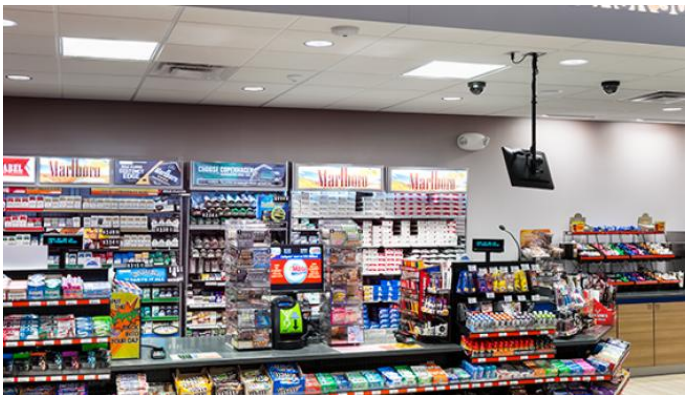
### <u>Goal #2.1</u> - Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status populations.

**INTERVENTION FOCUSED ON PREVENTING INITIATION OF TOBACCO USE BY YOUNG ADULTS BY STRENGTHENING/AMENDING LOCAL LAW POLICY**

| | |
|---|---|
| **INTERVENTION: Strengthen UC Reducing Youth Exposure to Tobacco Marketing/Licensing Law *(Enhancement from previous CHIP)*** | **Advocate and build community and leadership support to amend and strengthen Ulster County's Reducing Youth Exposure to Marketing/Licensing Law to include raising the age to purchase tobacco products in Ulster County from 18 to 21, prohibiting couponing and price promotions, and capping the number of times a retail tobacco license can be transferred from an existing retailer who sells to a new owner, at the same location, when the business is located within a 1000 feet restricted radius/K-12 school zone.** |
| **GOALS - OUTCOME(S)** | It is estimated that 90% of adult smokers began smoking before age 18 and the density and number of tobacco retailers in low SES neighborhoods is higher than the community average. Raising the purchasing age from 18 to 21 and reducing the number of tobacco retailers in school zones will help protect all youth, especially low income youth, and help prevent them from becoming adult smokers. Prohibiting price promotions also eliminates a prime marketing tool that tobacco companies use to target youth and low income persons. |
| **PARTNERS** | Lead Partners: Ulster County Executive, UCDOH-MH, HealthAlliance -Tobacco Free Action Communities (TFAC) Program.<br><br>Reality Check, American Heart Association (AHA), American Cancer Society (ACS), American Lung Association (ALA), Ulster County Legislature, multiple community partners and residents. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH. HealthAlliance - TFAC, AHA, ACS, ALA: research, coordination, public awareness, advocacy, public and leadership education.<br>• Reality Check - advocacy, youth support<br>• Ulster County Executive and Legislature - support and legislative action.<br>• Community organizations and residents - input, advocacy, support for legislative action. |
| **BY WHEN** | Strengthen, amend, and adopt revised local law by the end of 2018. |
| **MEASURES** | Presentations and advocacy campaigns completed, number and diversity of residents engaged in the process, community organizations engaged, number of legislators persuaded to vote favorably, successful adoption of the revised law. |
| **DISPARITY** | Yes, access to tobacco products, exposure to point of sale tobacco marketing and price promotions disproportionately impacts youth and people in low income neighborhoods. |

## INTERVENTION FOCUSED ON PREVENTING INITIATION OF TOBACCO USE BY YOUNG ADULTS AND REFERRALS TO THE NYS QUITLINE FOR EXISTING SMOKERS THROUGH PAID AND EARNED MEDIA, ONLINE MEDIA, AND NATIONAL CAMPAIGN PROMOTION

| **INTERVENTION: Prevent Tobacco Use and Promote Calls to the NYS Quitline through Media Campaigns and Promotions** ***(Continued from previous CHIP)*** | **Work with community partners to create multiple local, paid, and earned media campaigns, and promote national campaigns designed to prevent youth from using tobacco products, including electronic cigarettes. Additionally, promote calls from existing smokers, to the NYS Smokers' Quitline.** |
|---|---|
| **GOALS - OUTCOME(S)** | Prevent initiation of tobacco use by New York youth and adults, especially low socioeconomic status (SES) populations.<br>Promote tobacco use cessation, especially among low SES populations and those with poor mental health |
| **PARTNERS** | Lead Partners - UCDOH-MH, HealthAliiance - Tobacco Free Action Communities (TFAC).<br><br>American Lung Association (ALA), American Heart Association (AHA), American Cancer Society (ACS),Ulster Prevention Council (UPC), numerous media and community partners. |
| **PARTNER ROLES/RESOURCES** | • All Partners: close collaboration on coordination, public awareness and education, paid and earned media, messaging and production of media campaigns for all traditional and new media platforms, along with coordinated state and national campaign promotions. |
| **BY WHEN** | Ongoing through the end of 2018 and beyond. |
| **MEASURES** | Track youth tobacco product use initiation and smoking rates through all data sources, including the local Youth Development Survey (surveys every Middle and HS student in Ulster County, every 2 years). Measure reach and frequency of paid media campaigns and successful placements for earned media. Track referrals, from Ulster County, to the NYS Smokers' Quitline. |
| **DISPARITY** | Yes, paid and earned media campaigns, NYS Smokers' Quitline call campaigns and national campaign promotions will be designed and scheduled to reach the maximum number of low SES populations throughout Ulster County. |



## <u>Goal #2.2</u> - Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

### INTERVENTION FOCUSED ON ASSISTING MENTAL HEALTH CARE ORGANIZATIONS TO ESTABLISH SYSTEM-LEVEL POLICES AND PROCEDURES TO IMPROVE TOBACCO DEPENDENCE TREATMENT

| **INTERVENTION: Assist MH Care Organizations to Establish Policies to Improve Tobacco Dependence Treatment *(NEW: not in previous CHIP)*** | **Advocate and assist with health care and mental health care organization administrators to establish/adopt system-level policies and procedures that improve tobacco dependence treatment as recommended in the Public Health Service (PHS) Guidelines** |
|---|---|
| **GOALS - OUTCOME(S)** | Decrease the smoking prevalence among populations with low SES and serious mental illness (SMI) by working with local health/behavioral health organizations that serve disproportionately affected populations (low SES, low educational attainment, SMI) to expand the reach of evidence-based smoking cessation interventions without direct provision of those services. The focus is on working with higher level administrative decision-makers to ensure that the providers in the health systems they oversee, deliver appropriate and aggressive tobacco dependence treatment to its' members. |
| **PARTNERS** | Center for a Tobacco Free Hudson Valley, (CFTFHV), UCDOH-MH, HealthAlliance -Tobacco Free Action Communities (TFAC), Reality Check, American Heart Association (AHA), American Cancer Society (ACS), American Lung Association (ALA), Ulster County Executive, Ulster County Legislature, community residents. |
| **PARTNER ROLES/RESOURCES** | • Center for a Tobacco Free Hudson Valley - Advocate with Organizational Decision Makers at Healthcare and Mental Healthcare organizations to establish/adopt system-level evidence-based policies and procedures that improve tobacco dependence treatment as recommended in the PHS Guidelines.<br>• UCDOH-MH, HealthAlliance - Tobacco Free Action Communities (TFAC), Reality Check, American Heart Association (AHA), American Cancer Society (ACS), American Lung Association (ALA) - Support and advocacy<br>• Ulster County Executive and Legislature - support and legislative action<br>• Community residents - input, advocacy, support for legislative action |
| **BY WHEN** | By the end of 2018 |
| **MEASURES** | Gain buy-in from decision makers from mental health and healthcare facilities to discuss the importance of establishing tobacco dependence treatment systems. Providing technical assistance (TA) in the form of "successful proof of the 5 A's" with emphasis on improved Assessment (of tobacco dependence) and Assist (to quit smoking). Gain referrals to the NYS Smokers' Quitline by building reminders into electronic medical records (EMR) system. Include the following in presentations: data, PHS Guidelines, sample policies, tobacco dependence treatment education and support. |
| **DISPARITY** | Yes, this is the focus population for this work. |

## <u>Goal #2.3</u> - Eliminate exposure to secondhand smoke

### INTERVENTION FOCUSED ON ELIMINATING EXPOSURE TO SECONDHAND SMOKE BY PROMOTING SMOKE-FREE POLICIES IN MULTI-UNIT HOUSING

| **INTERVENTION: Promote smoke-free policies in multi-unit housing, especially those that house low-SES residents** ***(Enhancement from previous CHIP)*** | **Promote smoke-free policies in multi-unit housing, including apartment complexes, condominiums, and co-ops, especially those that house low-SES residents. (HP 2020; CDC WB; Community Guide). Identify low income housing SES targets to work with to assist with policy change. Disseminate information at community venues and events.** |
|---|---|
| **GOALS - OUTCOME(S)** | Meet with three or more multi-unit property owners, in low-SES communities, to educate them about the benefits of smoke-free housing, with an overall goal of increasing the percentage of adult smokers and youth who live in households where smoking is prohibited by 15%. |
| **PARTNERS** | UCDOH-MH, HealthAlliance-Tobacco Free Action Communities (TFAC), Ulster Prevention Council (UPC), Housing Authority, Housing Managers, Owners and Boards; American Heart Association (AHA), American Cancer Society (ACS), American Lung Association (ALA), Ulster County Executive, Ulster County Legislature, community residents. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH - coordination, public awareness and education, advocacy<br>• HealthAlliance-TFAC, UPC, AHA, ACS, ALA - research, advocacy, public and leadership education<br>• Housing Authority, Housing Managers, Owners and Boards - policy adoption and implementation<br>• Ulster County Executive, Ulster County Legislature - support<br>• Community residents - input, advocacy, support for action |
| **BY WHEN** | By the end of 2018 |
| **MEASURES** | Identify low income housing units. Presentations and advocacy campaigns completed, number and diversity of residents engaged in the process, housing managers, owners and boards engaged, gain earned media pertaining to smoke-free multi-unit housing. |
| **DISPARITY** | Yes, secondhand smoke in rental properties disproportionately impacts low income youth and adults. |

## INTERVENTION FOCUSED ON ELIMINATING EXPOSURE TO SECONDHAND SMOKE BY ADVOCATING FOR A LOCAL LAW TO REQUIRE OWNERS OF MULTI-UNIT DWELLINGS TO DISCLOSE SMOKING POLICIES TO ALL CURRENT AND PROSPECTIVE TENANTS

| **INTERVENTION: Advocating for a Local Law to Require Owners of Multi-Unit Housing to Disclose Smoking Policies *(Enhancement from previous CHIP)*** | **Create a local environment in Ulster County that successfully demands passage of a local law to requiring all landlords and buildings owners to fully disclose their smoking policies to ALL current and prospective tenants.** |
|---|---|
| **GOALS - OUTCOME(S)** | Communicate with and educate elected officials and the community at large about the benefits of fully disclosing smoking policies to community members living in multi-unit dwellings.<br><br>Educate community partners, organizations, and the public about the hazards of secondhand smoke and the preventative health benefits of smoke-free housing policies. Promote broad support for full disclosure on smoking policies to current and prospective tenants, with a particular emphasis on low-SES target populations. |
| **PARTNERS** | UCDOH-MH, HealthAlliance -Tobacco Free Action Communities (TFAC), Ulster Prevention Council (UPC), Housing Authority, Housing Managers, Owners and Boards; American Heart Association (AHA), American Cancer Society (ACS), American Lung Association (ALA), Ulster County Executive, Ulster County Legislature, Municipal Leaders such as Town Supervisors and Boards, community residents. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH - coordination, public awareness, education, and advocacy<br>• HealthAlliance-TFAC, UPC, AHA, ACS, ALA - research, advocacy, public and leadership education<br>• Housing Authority, Housing Managers, Owners and Boards - policy adoption and implementation<br>• Ulster County Executive and Legislature - support and legislative action<br>• Municipal Leaders- support and legislative action<br>• Community residents - input, advocacy, support for action. |
| **BY WHEN** | Through the end of 2018 and beyond if necessary. |
| **MEASURES** | Identify low income housing units, presentations and advocacy campaigns completed, number and diversity of residents engaged in the process, number of owners, building managers and boards engaged, gain earned media pertaining to smoke-free multi-unit housing, introduction of county local law and measure progress of steps (milestones) to adoption. |
| **DISPARITY** | Yes, secondhand smoke in rental properties disproportionately impacts low income youth and adults. |

## INTERVENTION FOCUSED ON PREVENTING INITIATION OF TOBACCO USE AND ELIMINATING EXPOSURE TO SECONHAND NICOTINE AND OTHER CHEMICAL VAPOR FROM THE USE OF ELECTRONIC CIGARETTES

| **INTERVENTION: Advocating for a Local Law to Add Vaping to the Clean Indoor Air Act in Ulster County** ***(NEW: not in previous CHIP)*** | **Advocate and build community and leadership support for a local law to add E-cigarettes (vaping) to the Clear Indoor Act provisions throughout Ulster County**. |
|---|---|
| **GOALS - OUTCOME(S)** | Prevent initiation of tobacco use by youth and young adults, especially low SES populations, and protect all residents from secondhand nicotine infused vapor and other dangerous chemical exposure, by adding vapor produced by electronic cigarette uses to the Clean Indoor Air Act in Ulster County. |
| **PARTNERS** | UCDOH-MH, HealthAlliance -Tobacco Free Action Communities (TFAC), Reality Check, American Heart Association (AHA), American Cancer Society (ACS), American Lung Association (ALA), Ulster County Executive, Ulster County Legislature, numerous community organizations and residents. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH - research, coordination, public awareness and education, advocacy.<br>• HealthAlliance -TFAC, Reality Check, AHA, ACS, ALA- research, advocacy, public and leadership education.<br>• Ulster County Executive and Legislature - support and legislative action.<br>• Community organizations and residents - input, advocacy, support for legislative action. |
| **BY WHEN** | Through the end of 2018. |
| **MEASURES** | Presentations and advocacy campaigns completed, number and diversity of residents engaged in the process, community organizations engaged and supporting the initiative, number of legislators persuaded to vote favorably, track steps/milestones to adoption and implementation of the law. |
| **DISPARITY** | Yes, exposure to nicotine products disproportionately impacts low income youth, while secondhand exposure affects everyone. |

# Priority Area #1: Preventing Chronic Diseases (Action Plan)

## Focus Area 3 – Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings

### Goal #3.1 - Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.

**INTERVENTION FOCUSED ON PREVENTING COLORECTAL CANCER THROUGH A COMMUNITY WIDE INITIATIVE TO INCREASE SCREENING RATES**

| **INTERVENTION: Set an 80% Colorectal Screening Goal for UC and Work with Community Partners to Reach** ***(NEW: not in previous CHIP)*** | **Set an 80% colorectal cancer (CRC) screening goal for Ulster County and work with major employers, including county government, hospital systems, primary care providers, insurers, and other community partners to promote, encourage, and facilitate.** |
|---|---|
| **GOALS - OUTCOME(S)** | To establish a countywide 80% CRC screening goal obtaining commitments and implement the improvement strategy outlined above with at least four major community employers/organizations including county government, one major hospital system or primary care provider, and two private or nonprofit sector organizations. |
| **PARTNERS** | Ulster County Executive, Ulster County Legislature, UCDOH-MH, American Cancer Society, Ulster County Chamber of Commerce, Health Alliance, Ellenville Regional Hospital, Institute for Family Health, CareMount Medical Group, Ulster County Interfaith Council, and multiple community organizations. |
| **PARTNER ROLES/RESOURCES** | • All Partners - committing to reaching an 80% CRC screening goal, promotion, awareness, evaluating data and monitoring, developing and implementing time-off benefits policies for screening, implementing reminder systems. |
| **BY WHEN** | Through the end of 2018. |
| **MEASURES** | Number of organization pledges secured, paid and earned media campaigns, baseline and improvement rate data, reminder systems implemented, time-off policies implemented, barriers identified and addressed. |
| **DISPARITY** | Yes, health disparity populations will be included within the four target community employer/ organizations. |

## Goal #3.3 - Promote culturally relevant chronic disease self-management education.

**INTERVENTION FOCUSED ON PROMOTING CULTURALLY RELEVANT CHRONIC DISEASE SELF-MANAGEMENT EDU**

| **INTERVENTION: Chronic Disease Self-Management Education (CDSME)** ***(NEW: not in previous CHIP)*** | **There will be a minimum of eight Chronic Disease Self-Management Education (CDSME) workshops and one Prevention T-2 or NDPP offerings yearly. At least two of these will be hard to reach populations. The programs will include:**<br>**Chronic Disease Self-Management Program (CDSMP)**<br>**Diabetes Self-Management Program (DSMP)**<br>**Chronic Pain Self-Management Program (CPSMP)**<br>**Prevention T-2 and/or National Diabetes Prevention Program (NDPP)** |
|---|---|
| **GOALS - OUTCOME(S)** | • Implement 8-10 evidence-based chronic disease workshops yearly by the end of 2018.<br>• Objective 3.3.1: By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. (Data Source: BRFSS; annual measure, beginning 2013).<br>• Target hard to reach populations in low income communities as well as organizations serving low SES populations and those experiencing behavioral health and substance abuse issues<br>• Foster collaboration among traditional and non-traditional community partners to improve access to clinical and community preventive services<br>• Expand public-private partnerships to implement community preventive services<br>• Coordinate health-related messaging with local health care systems and public health agencies<br>• Promote awareness of and demand for community preventive services<br>• Highlight community needs and communicate disease burden to engage consumers, communities, and relevant stakeholders<br>• Establish clinical-community linkages that connect patients to self-management education and community resources |
| **PARTNERS** | Lead Agencies: Ulster County Office For the Aging (UCOFA), New York State Office For the Aging (NYSOFA), Institute for Family Health (IFH)<br>Health Care Providers (HCP), Community Based Organizations (CBO), Peer Leaders, African American/Latino Consumer representative, HealthAlliance, Ellenville Regional Hospital (ERH), UCDOH-MH |
| **PARTNER ROLES/RESOURCES** | • UCOFA - CDSME workshop coordination, funding through NYSOFA, Mileage reimbursement for workshop leaders<br>• IFH - CDSME coordination<br>• HCP - groups will do referrals /consumer referrals<br>• CBO - community outreach and possible free site locations<br>• Peer Leaders - Program implementation<br>• African American/Latino Consumer representative - Community Outreach to their population<br>• HealthAlliance - referrals<br>• ERH - identification and referrals<br>• UCDOH-MH - promotion, coordination and tracking<br>• All will work on direct marketing |
| **BY WHEN** | By the end of 2018. |
| **MEASURES** | Assemble a current list of trained peer workshop leaders and master trainers in Ulster County; Train additional program leaders as needed; Maintain licensing agreement with appropriate organization; Establish a county wide quarterly program calendar that includes all organizations implementing workshops. |
| **DISPARITY** | Yes, non-Hispanic Black and Hispanic residents experience higher rates of almost all health indicators than non-Hispanic White residents including premature deaths and preventable hospitalizations. Targets include rural isolated and low income populations with behavioral health disorders. |

# Priority Area #2: Promote Mental Health and Prevent Substance Abuse Action Plan

## Overall Mental Health Promotion/Substance Abuse Prevention Strategy Outline

### 1. Strengthen and Support Community Substance Abuse Prevention Programs, Practices, Research, and Initiatives

⇒ **Ulster Prevention Council** - continue to actively participate, including membership on the Board of Directors, in the all of the activities of Ulster Prevention Council, which is a broad-based community coalition focused on implementing an integrated substance abuse prevention strategy throughout Ulster County.

⇒ **Enhance Unused Prescription Medication Collection System** - continue to aggressively promote, through both paid and earned media campaigns, Ulster County's extensive unused medication collection box system. Work with locally owned pharmacies to install medication collection boxes at their business locations and continue to advocate for a change in NYS law that would require retail chain pharmacies to install medication collection boxes, per Federal and State guidelines.

⇒ **Youth Development Survey -** continue to work with Ulster Prevention Council, schools and other community partners to distribute an anonymous, biennial substance abuse survey to all middle and high school students in Ulster County. To date, UC has collected ten years of data which has proven to be invaluable in creating focused and targeted strategies, interventions, and community awareness initiatives.

⇒ **Family Advocate -** promote utilization of the new UC substance abuse Family Advocate position, designed to help individuals and families navigate their way through addiction by helping to identify and select appropriate treatment and recovery, while helping them understand and overcome obstacles to securing the insurance coverage that they qualify for.

⇒ **Substance Abuse Prevention Community Forums** - continue to conduct community substance abuse/opioid abuse prevention forums throughout UC. These forums have been extremely well attended and have proven to be highly successful in increase public awareness and engagement in the fight against substance abuse and in connecting people to community service providers and resources.

⇒ **Comprehensive Online Substance Abuse Prevention, Treatment and Recovery Resource**- create a comprehensive mobile optimized online guide, to be continuously updated, to all substance abuse prevention, recovery, and treatment resources in Ulster County.

## 2. Strengthen and Support Community Suicide Prevention Programs, Practices, and Initiatives

⇒ **SPEAK Coalition** - continue to work with, participate in and strengthen the Ulster County Suicide Prevention, Education, Awareness, and Knowledge coalition (SPEAK) to reduce suicides in UC by:

- Promoting suicide prevention through awareness and education
- Promotion and utilization of the SPEAK suicide prevention mobile app
- Sponsoring prevention trainings for community organization staff and leadership
- Presenting community wide forums on suicide prevention
- Participating in Ulster County's Annual Human Services Expo
- Educating sportsmen's clubs, gun shop owners, and veterans groups on the importance of gun safety (means restriction) as it relates to suicide prevention

## 3. Strengthen and Support Mental Health Crisis and Criminal Justice/Substance Abuse Diversion Programs, Practices, and Initiatives

⇒ **Expand and Strengthen the Ulster County Mobile Mental Health Team** – expand and promote Ulster County Mobile Mental Health (MMH) Team's hours of operation, utilization, as well as coordination of Emergency Department and inpatient unit discharges with MMH for post discharge follow up.

⇒ **Sequential Intercept Mapping -** work with multi-sector community partners to coordinate a Sequential Intercept Mapping of Ulster County's service and criminal justice system. The mapping will provide a conceptual framework to organize targeted strategies for justice involved individuals with behavioral health, substance abuse, and developmental disabilities in an effort to keep them out of jail and in treatment.

## <u>Focus Area 2</u> – Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

### <u>Goal #2.1</u> - Prevent underage drinking, non-medical use or prescription pain reliever drugs by youth, and excessive alcohol consumption by adults.

**INTERVENTION FOCUSED ON PREVENTING NON-MEDICAL USE OF PRESCRIPTION PAIN RELIEVERS THROUGH AN ENHANCED MEDICATION COLLECTION TAKE BACK SYSTEM**

| | |
|---|---|
| **INTERVENTION: ENHANCING AND STRENGTHENING ULSTER COUNTY'S MEDICATION COLLECTION TAKE BACK SYSTEM** ***(Continued from previous CHIP)*** | **In addition to 19 medication collection boxes located in police agencies throughout Ulster County, UCDOH will work with locally owned pharmacies in key substance abuse "hot spot" communities to help install medication collection box systems in local stores. This would include identifying them, familiarizing them with regulations and guidance resources, helping them to defray startup costs, and promotion via recognition by the County Executive, earned media and listings on appropriate county and community partner web and social media sites.**<br><br>**In addition to the above, Ulster County, through its leadership, agencies, and community partners continue to vigorously advocate for a revision of NYS law that would make it mandatory for retail chain pharmacies to set up unused medication collection box systems in local stores.** |
| **GOALS - OUTCOME(S)** | To have medication collection take back systems successfully installed, along with promotion, in at least 5 locally owned pharmacies in Ulster County, in addition to the 19 currently installed in law enforcement agencies throughout the community. |
| **PARTNERS** | UCDOH-MH, Ulster County Executive, Ulster Prevention Council, Riverkeeper, local pharmacies, law enforcement agencies, local substance abuse coalitions. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH, County Executive, and Ulster Prevention Council - identifying local owner of the pharmacy, education, guidance, staff resources, promotion, funding<br>• Riverkeeper - funding and mobilizing the environmental community to support<br>• Local Pharmacies - participation in the program<br>• Law Enforcement and Local Substance Abuse Coalitions - support, advocacy, community awareness |
| **BY WHEN** | By the end of 2018. |
| **MEASURES** | Local pharmacy owners identified, education and distribution of guidance information provided, number of collection box systems installed, promotion and community awareness campaigns implemented, measure public awareness and utilization. |
| **DISPARITY** | Yes, collection boxes will be located in several low income/health disparity communities where high rates of opioid substance abuse occur. The will lead to an expanded presence in retail pharmacies, and expanded promotion of the program, throughout the community. |

## <u>Goal #2.2</u> - Prevent and reduce occurrence of mental, emotional, and behavioral disorders, including substance abuse among youth and adults

### INTERVENTION FOCUSED ON REDUCING AND PREVENTING SUBSTANCE ABUSE THROUGH COMMUNITY COLLABORATION AND COLLECTIVE IMPACT

| **INTERVENTION: PREVENTING SUBSTANCE ABUSE THROUGH COMMUNITY COLLABORATION AND COLLECTIVE IMPACT** ***(Continued from previous CHIP)*** | **Continued participation in, and support for Ulster Prevention Council (UPC). UPC brings together diverse sectors of the community including, but not limited to, law enforcement, criminal justice, health and mental health, county and local municipal government, youth service organizations, the faith based community non-profits, and higher education to oversee and facilitate ongoing community assessments and an integrated, community wide approach to preventing and mitigating substance abuse.** |
|---|---|
| **GOALS - OUTCOME(S)** | To continually and sustainably reduce substance use and increase perception of harm from substance abuse, on a year-by-year basis, throughout the Ulster County community, with an emphasis on health disparate populations. |
| **PARTNERS** | UCDOH-MH, BOCES (representing all school districts), Ulster County Executive's Office, Ulster County Department of Social Services, Ulster County Probation, Family of Woodstock, Ulster County Legislature, Ulster County Interfaith Council, Tobacco Free Action Communities, SUNY Ulster Community College, United Way of Ulster County, Ulster County Police Chiefs Association, Ulster County District Attorney's Office. |
| **PARTNER ROLES/RESOURCES** | • All County departments, agencies and offices - funding, strategy development and monitoring, support, assessment, promotion, communications and active participation on the governing board<br>• United Way - funding, promotion, and support through active participation on the governing board<br>• All other partners - support, promotion, education, strategy development, communications, awareness, assessment assistance through active participation on the governing board |
| **BY WHEN** | Ongoing through 2018 |
| **MEASURES** | Close monitoring of alcohol and drug use statistical trends from all available data sources and the biennial Ulster County Youth Development Survey (YDS) tracks trends in both use of substances and perception of harm from substance abuse. The next YDS will be administered in early 2017. |
| **DISPARITY** | Yes, Ulster Prevention Council looks closely at and focuses on strategy, initiatives, and activities designed to assist high risk populations of all ages. |

## INTERVENTION FOCUSED ON ASSISTING INDIVIDUALS AND FAMILIES TO IDENTIFY AND SECURE ESSENTIAL SUBSTANCE ABUSE PREVENTION, TREATMENT, AND RECOVERY SERVICES AND RELATED INSURANCE COVERAGE

| **INTERVENTION: ESTABLISH AND PROMOTE A FAMILY ADVOCATE POSITION TO ASSIST PEOPLE ADDRESS SUBSTANCE ABUSE ISSUES** ***(NEW: not in previous CHIP)*** | **Establishment and promotion of a community Family Advocate position designed to help individuals and families identify appropriate substance abuse prevention, treatment, and recovery services while helping them secure the health insurance coverage they are entitled to and/or qualified for.** |
|---|---|
| **GOALS - OUTCOME(S)** | To prevent and reduce substance abuse in the community by helping individuals and families identify and secure the services and insurance benefits they need on a timely basis, with the direct, one-on-one assistance of a knowledgeable professional who can help guide them every step of the way. |
| **PARTNERS** | UCDOH-MH, Ulster County Executive, Ulster County Legislature, Ulster Prevention Council, media, numerous community services providers and community organizations. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH, County Executive, Ulster County Legislature - funding, support, promotion<br>• Ulster Prevention Council - creating and hosting the Advocate position, support, promotion<br>• Media, Community Services Providers, Community Organizations - support, promotion, awareness, referrals |
| **BY WHEN** | Ongoing through 2018. |
| **MEASURES** | Measure postings and awareness activities with community partners, caseload, referrals, and individuals and families successfully assisted. |
| **DISPARITY** | Yes, the Advocate will focus on helping individuals and families in need, with an emphasis on low income and uninsured/underinsured populations. |

## INTERVENTION FOCUSED ON EDUCATING AND ASSISTING INDIVIDUALS, FAMILIES, AND COMMUNITIES TO COPE WITH SIGNIFICANT SUBSTANCE ABUSE CHALLENGES

| **INTERVENTION: COMMUNITY SUBSTANCE ABUSE PREVENTION EDUCATION AND AWARENESS FORUMS** ***(NEW: not in previous CHIP)*** | **To continue to present effective and well received, comprehensive Substance Abuse Prevention/Awareness Forums featuring expert presentations and panelists, comprehensive service providers resources, and testimonials as well as peer-to-peer experiences.** |
|---|---|
| **GOALS - OUTCOME(S)** | To present at least two community abuse forums per year, designed to help families and communities understand substance abuse/addiction challenges and provide them with the information, tools, and resources needed to confront and cope. |
| **PARTNERS** | Individuals and families who have experience addiction, multiple services providers, and community media partners. Ulster County Interagency Substance Abuse Prevention Task Force (UCISATF) consisting of: UCDOH-MH, Ulster County Executive, Ulster BOCES, Ulster Prevention Council, Ulster County District Attorney's Office, Ulster County Police Chief's Association, school districts and prevention coalitions throughout Ulster County. |
| **PARTNER ROLES/RESOURCES** | • ALL - forum content, planning, logistics, scheduling, awareness, promotion and surveying of attendee responses. |
| **BY WHEN** | Ongoing through 2018. |
| **MEASURES** | Number of forums held, attendee surveys, subsequent public input and feedback. |
| **DISPARITY** | Yes, the forums are and will be geographically dispersed to serve hard to reach and low income communities. |

## INTERVENTION FOCUSED ON PROVIDING COMPREHENSIVE AND READY ACCESS TO ALL SUBSTANCE ABUSE PREVENTION, TREATMENT AND RECOVERY RESOURCES IN THE COMMUNITY

| **INTERVENTION: CREATE COMPREHENSIVE, MOBILE OPTIMIZED RESOURCE GUIDE TO ALL SUBSTANCE ABUSE PREVENTION, TREATEMENT AND RECOVERY SERVICES *(NEW: not in previous CHIP)*** | **Create a mobile optimized website as a comprehensive guide to all substance abuse prevention, treatment and recovery services in Ulster County. It will also include features allowing users to instantly communicate with call and text hotlines and other essential services. (Of the 610 respondents to the 2016 UCCHNA 82%, including all demographic/socioeconomic groups reported having smartphones, while 94% reported having internet access at home).** |
|---|---|
| **GOALS - OUTCOME(S)** | For the first time, residents of Ulster County will have instant, "one stop shopping" access to comprehensive substance abuse prevention, treatment and recovery services, which will allow them to identify and get the appropriate information and help they need instantly. |
| **PARTNERS** | UCDOH-MH, Ulster County Executive, Family of Woodstock, all substance abuse service providers, Next Step Digital, Ulster County Information Services, Ulster Prevention Council, community and faith based organizations. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH, County Executive, Ulster County Information Services - funding, creating content and framework, technical assistance, online hosting, promotion<br>• Family of Woodstock - promote utilization<br>• Service Providers - listings, cross promotion on their websites, and publications<br>• Community and faith based organizations: promotion to members and disparity populations<br>• Ulster Prevention Council - support, promotion, and connection to the Family Advocate.<br>• Next Step Digital - programming services |
| **BY WHEN** | By the end of 2017. |
| **MEASURES** | Measure online traffic. Measure awareness of the resource through community surveys. Measure referrals to service providers. |
| **DISPARITY** | Yes, this online/mobile resource guide will be heavily promoted to health disparity populations. |

## ACTIVITY FOCUSED ON PREVENTING YOUTH SUBSTANCE ABUSE AND OTHER BEHAVIORAL PROBLEMS BY COLLECTING AND ANALYZING LOCAL DATA TO IDENTIFY GAPS, DEVELOP AND COORDINATE EFFECTIVE INTERVENTIONS, AND MEASURE OUTCOMES

| | |
|---|---|
| **INTERVENTION: CONTINUE TO SUPPORT AND IMPLEMENT THE ULSTER COUNTY YOUTH DEVELOPMENT SURVEY** ***(Evidence-Based Practice continued from previous CHIP)*** | **Continue to support and implement the Ulster County Youth Development Survey (YDS), a biennial assessment of all Ulster County students in grades 7-12, which provides critical needs assessment data on youth behavioral risk and protective factors around substance abuse and other problem behaviors. YDS data has been collected and analyzed since 2008 and is a critical tool for planning and tracking trends, planning interventions and services, building community support and engagement, and evaluating outcomes.** |
| **GOALS - OUTCOME(S)** | The data collected from the students informs the selection of prevention goals, structuring and delivery of evidence-based interventions, building community support and engagement for prevention services and initiatives, and measuring outcomes.<br><br>Continue to provide multiple community partners YDS data for use in their own needs assessments, strategy development and implementation, and requests for funding. |
| **PARTNERS** | Ulster Prevention Council (UPC), UCDOH-MH, BOCES, all school districts in UC, local community Substance Abuse(SA) coalitions, and multiple community stakeholders. |
| **PARTNER ROLES/RESOURCES** | • BOCES and all school districts in UC - mobilization of students and staff to implement and take the survey and utilization of data for prevention strategy development and measurement.<br>• UCDOH-MH - partners with UPC to provide funding, identify survey tools and to engage an evaluator in analyzing the data.<br>• UPC - staff works with the contracted evaluator to select sample size and methods and to administer the survey in each school district. UPC staff work with each district to plan for the implementation of the survey and are on site for survey administration and collection.<br>• Local SA coalitions and community stakeholders - promote the importance of the survey and utilizing data to rally community support and engagement for Substance Abuse prevention awareness and services. |
| **BY WHEN** | Ongoing through 2018. |
| **MEASURES** | Closely monitor and measure alcohol and drug use statistical trends, perception of harm, levels of community support and engagement, and local and community outcomes. |
| **DISPARITY** | Yes, the YDS identifies disparities across Ulster County and is actively used to identify gaps, develop strategy and measure outcomes. |

## INTERVENTION FOCUSED ON ORGANIZING TARGETED STRATEGIES TO HELP KEEP INDIVIDUALS WITH BEHAVIORAL HEALTH, SUBSTANCE ABUSE, AND DEVELOPMENTAL DISABILITIES OUT OF JAIL AND IN TREATMENT

| **INTERVENTION: DEVELOP A SEQUENTIAL INTERCEPT MAPPING SYSTEM** ***(NEW: not in previous CHIP)*** | **Work with multi-sector community partners to coordinate a Sequential Intercept Mapping (SIM) of Ulster County's behavioral health/human services and criminal justice systems.** |
|---|---|
| **GOALS - OUTCOME(S)** | This mapping will provide a conceptual framework to organize targeted strategies for justice involved individuals with behavioral health, substance abuse, and developmental disabilities in an effort to keep them out of jail and in treatment. |
| **PARTNERS** | UCDOH-MH; PEOPLe, Inc.; Correctional Medical Services (at the County Jail); Westchester Medical Center; Saugerties Police Department; Ulster County Sherriff's Department; Health Alliance Substance Use Services and Psychiatric departments; Ulster County Probation department; The United Methodist Church of Clinton Avenue- Kingston; Ulster Green ARC; Ulster County Court Clerks Association; Family of Woodstock; Mental Health Association; Institute for Family Health; Step One; Ulster County Veterans; Ulster County District Attorney's office; Ulster County ADA's Office; Kingston City Court. |
| **PARTNER ROLES/RESOURCES** | All - participate in SIM workshop and ongoing intercept meetings, contribute information specific to their particular sectors, participate in the development of plans and protocols that can lead to diversion of individuals who are behavioral health and justice involved, and improve access to treatment. |
| **BY WHEN** | Ongoing through the end of 2018. |
| **MEASURES** | Initial SIM workshop identified 5 priority areas:<br>• Housing - identify short term and long term goals to improve access to affordable housing in Ulster County.<br>• Bridger Program - develop a Bridger program that will include Health Homes and care management to assist individuals that are behavioral health and justice involved, access services quickly.<br>• Medicated Assisted Treatment (MATS) - develop a protocol for MATS, specifically vivatrol, for inmates in the county jail that are opiate dependent. This will increase chances of success in remaining abstinent for inmates upon release.<br>• Crisis Restoration Center - research the efficacy of a crisis residential center and/or the possibility of increasing of operation of service system hours to reduce emergency department and police involvement of Behavioral Health Criminal Justice involved individuals.<br>• The development of an ongoing protocol for the training of Law Enforcement, first responders and corrections officers in responding to individuals with behavioral health concerns. |
| **DISPARITY** | Yes, this initiative focuses on individuals experiencing concurrent substance abuse, behavioral health, developmental disabilities, and criminal justice issues. |

## INTERVENTION FOCUSED ON PREVENTING AVOIDABLE PHYSCHIATRIC EMERGENCY ROOM VISITS, HOSPITALIZATIONS, AND RE-HOSPITALIZATIONS

| **INTERVENTION: EXPAND UC MOBILE MENTAL HEALTH TEAM** ***(NEW: not in previous CHIP)*** | **Expand Ulster County Mobile Mental Health (MMH) Team's hours of operation, utilization, and coordination of Emergency Department (ED) and inpatient unit discharges with MMH for post discharge follow up.** |
|---|---|
| **GOALS - OUTCOME(S)** | Reduce avoidable psychiatric emergency department visits, avoidable psychiatric hospitalizations and re-hospitalizations of individuals with behavioral health issues. |
| **PARTNERS** | UCDOH-MH, Ulster County Executive, Access Supports for Living, HealthAlliance, and numerous community partners. |
| **PARTNER ROLES/RESOURCES** | • UCDOH-MH, County Executive - funding, support, promotion, and coordination of service<br>• Access Supports for Living - staffing, training, transportation<br>• HealthAlliance - coordination and support<br>• Community Partners - promotion of service and referrals |
| **BY WHEN** | Ongoing through the end of 2018. |
| **MEASURES** | Number of calls, dispatch of teams, ED visits, hospitalizations and re-hospitalizations of individuals with behavioral health issues. |
| **DISPARITY** | Yes, this initiative focuses on individuals experiencing recurring behavioral health and related substance abuse issues. |

## <u>Goal #2.3</u> - Prevent suicides among youth and adults

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|---|---|
| **INTERVENTION: Suicide Prevention, Education, Awareness, and Knowledge (SPEAK) Coalition** ***(Continued from previous CHIP)*** | Ulster County's Suicide Prevention, Education, Awareness, and Knowledge (SPEAK) Coalition brings together mental health professionals, community leaders and organizations, and concerned citizens to implement a coordinated strategy that includes awareness and education. This is achieved through paid and earned media, online and social media campaigns, promotion and utilization of its SPEAK suicide prevention mobile app, evidenced based trainings, working with gun shop owners and sports associations on reduction of access to lethal means, community prevention forums, and working directly with veteran's groups and other high-risk populations. |
| **GOALS - OUTCOME(S)** | • To present at least one major Community Prevention Forum, per year, through 2018.<br>• To conduct at least two major paid and earned media campaigns, per year, through 2018.<br>• To continue to promote the utilization of the SPEAK Mobile Prevention app.<br>• Conduct ongoing online and social media campaigns designed to reduce stigma, help people recognize the warning signs of suicide, and direct them to the expert help they may need.<br>• To conduct a minimum of two sessions per year, for each of the following evidence-based trainings: ASIST, SafeTalk, Mental Health First Aid, and Youth Mental Health First Aid.<br>• To continue to work with gun shop owners and sports associations, on an ongoing basis, to distribute information and educational materials, including appearing by invitation at their events to promote the value of the reduction of access to lethal means.<br>• Attend at least two veteran organization and/or armed forces/national guard events to educate and inform attendees on how to help recognize and prevent suicide.<br>• To work with as many school districts and community coalitions as possible, by invitation, to present suicide awareness and prevention workshops.<br>• To provide postvention/recovery services, as needed by request, to families and communities that have been impacted by suicide events. |
| **PARTNERS** | UCDOH-MH, Mental Health Association in Ulster County, Inc. (MHA), Family Crisis Hotline/Text line, Mobile Mental Health Team, Ulster County School Superintendent's Association (multiple school districts), Greater New Paltz Community Partnership (and other local community coalitions), Ulster County Sportsmen's Association, National Guard, Ulster County Veteran's Services Agency. |
| **PARTNER ROLES/RESOURCES** | • All SPEAK Coalition partners - participate in SPEAK initiatives by providing time, expertise, education and awareness, varying levels of funding, access to venues and events, in-kind services, and outreach directed to members and the community at large. |
| **BY WHEN** | Various through 2018 |
| **MEASURES** | Number of forums presented with attendance, media campaigns completed (with reach and frequency), online/social media campaigns implemented, evidence-based trainings completed (with attendance), number of gun shop owners engaged and sports/gun events attended, number of veteran's/military events attended, number of school/community workshop presentations, and number of downloads of SPEAK mobile app. |
| **DISPARITY** | Yes, emphasis on prevention directed to high-risk, vulnerable populations. |

## ELLENVILLE REGIONAL HOSPITAL PARTNER SECTION - COLLABORATION

Ellenville Regional Hospital is a 25 bed rural critical access hospital located in Southern Ulster County. Our Mission is to provide exceptional health care services to all people who live in, work in and visit our surrounding communities. This health care is delivered with compassion and respect based on our commitment to improving our community health through excellence, innovation and state-of-the-art technologies.

It is our Vision to:

- Be the Nation's model for Critical Access Hospitals.
- Deliver comprehensive services in collaboration with other community-based health care providers.
- Provide continuity of care to patients and their families through innovative programs and services, and through our affiliation with other health care providers in the region.
- Expand our role in training the next generation of health care providers in the region.

The Hospital offers a wide range of services including inpatient services, rehabilitation, emergency care, physical therapy, orthopedics, gastroenterology, cardiology, cardiac rehab, cardio-stress testing, pulmonary, pain management, ambulatory surgery, laboratory, diabetes education, clinical pharmacy services, medical nutrition therapy, speech language pathology, hospice care, women's health including bone density, mammography, ultrasound, and imaging including CT scan, digital X-Ray, nuclear medicine, and MRI studies.

ERH has won numerous State and Federal quality awards, including four Patient Safety and Clinical Pharmacy Services Collaborative awards from the Health Resources and Services Administration (HRSA) and a Quality and Patient Safety Award from the Northern Metropolitan Hospital Association (NorMet) Patient Safety Institute for reducing the average length of stay in the Emergency Department to less than 100 minutes.

The hospital's newest initiative is gaining state and national attention. The New York State Medicaid Accelerated eXchange (MAX) Project, is a 12- month initiative which places a focus on the Emergency Department (ED) providers and staff on managing care for ED Super Utilizers - patients who present to the ED repeatedly seeking opioid treatment for pain. The parameters of the program include identifying and prioritizing process improvements that will maximize long-term outcomes and clinical efficiency for these patients, and align them with their respective primary care provider and other community resources for their pain management and other healthcare needs.

# Priority Area #2: Promote Mental Health and Prevent Substance Abuse Action Plan

## Focus Area 2 – Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

### Goal #2.2 - Prevent and reduce occurrence of mental, emotional, and behavioral disorders among youth and adults.

| INTERVENTION | **Continue flagging chronic pain super utilizers of the Ellenville Regional Hospital ED so that the pain is better managed with best practices that decrease the use of opioid medications. Underlying substance abuse issues are addressed with the help of a Care Navigator from the Ellenville Family Health Center.** |
|---|---|
| **OUTCOME(S)** | As this project proceeds with the alternative care delivery model for chronic pain patients, visits to the ED by these super utilizers will continue to drop (so far, ED visits by this cohort dropped by 45%) and the administration of opioids to Super Utilizers will continue to drop (the figure thus far is a 70% reduction in opioid administration). In addition, the care navigator will continue to link members of this cohort to needed community services such as housing, primary care, behavioral health providers and home health assistance. |
| **PARTNERS** | Ellenville Regional Hospital (including Administration, Case Management & Hospital-based Providers), Ellenville Family Health Center (including Care Navigator, Administration & Health Center Providers), Community-based Primary Care Providers and local pharmacists. |
| **PARTNER ROLES/RESOURCES** | Ellenville Regional Hospital (including Administration, Case Management & Hospital-based Providers) - Program oversight, Patient referral to Family Health Center, Education of PCP's & Pharmacists; Ellenville Family Health Center (including Care Navigator, Administration & Health Center Providers) – Data collection, Care Navigator referral of patients to community services; Community-based Primary Care Providers and local pharmacists – Program promotion, Adoption of best practices in pain management. |
| **BY WHEN** | By the end of 2018. |
| **MEASURES** | Identify a new super utilizer cohort and continue to incorporate best practices into the model of care for these patients with chronic pain who have been identified as being at risk for opioid abuse. Provide care navigation services on a 24/7 basis. Continue educating providers about this alternative care delivery model for chronic pain patients. |
| **DISPARITY** | Yes, along with observing an overall rise in opioid abuse in Ulster and adjacent counties, Ellenville Regional Hospital has noticed that a small percentage of ED users account for a disproportionate level of ED visits. Utilization of the ED by these patients is driven by chronic pain which has resulted in the administration and/or prescription of opiates. |

Ellenville Regional Hospital collaborates with the Institute for Family Health, a Federally Qualified Health Center (FQHC) to improve blood sugar, lipid and hypertension levels in patients with diabetes and pre-diabetes in an outpatient setting, focusing on improved self-management and adherence, healthy eating and increased physical activity. Adult ERH Emergency Department patients presenting with symptoms of diabetes or pre-diabetes, such as an elevated blood sugar, or hyperglycemia are referred to FQHC's on-site certified diabetes educators and health coaches (with patient's permission) upon discharge. Patients with diabetes that are not patients of the FQHC are invited to participate in the evidence-based Stanford University Diabetes Self-Management Program. Patients of FQHC, or patients who have no primary care provider, with diabetes are offered an appointment with a primary care provider and a diabetes educator. All patients with pre-diabetes are invited to participate in the National Diabetes Prevention Program, a CDC evidence-based workshop. In addition, Emergency Department testing, such as blood work and EKG results, are be sent to FQHC to assist in the continuity of care. For all other patients with long term illness, a referral to the Chronic Disease Self-Management Programs (CDSMP) is offered. In addition, all patients with elevated glucose levels that do not have diabetes are invited to participate in the National Diabetes Prevention Program (NDPP).

The Chronic Disease/Diabetes Self-Management Programs (CDSMP/DSMP) are evidence-based programs developed by the Medical School at Stanford University and have been implemented by The Institute for Family Health at other selected health center sites.

## Priority Area #1: Preventing Chronic Diseases (Action Plan)

**<u>Focus Area 3</u> – Increase access to high quality chronic disease preventive care management in both clinical and community settings.**

**<u>Goal #3.3</u> - Promote culturally relevant chronic disease self-management education.**

| | |
|---|---|
| **INTERVENTION** | **Continued development and implementation of the Ellenville Diabetes Collaborative. This will result in increased participation by the target population in the Diabetes Self-Management Program and/or the Chronic Disease Self-Management Program offered by staff members from the Ellenville Family Health Center (FHC). Eligible individuals with diabetes or pre-diabetes diagnosis or with a long term illness are referred by the Ellenville Regional Hospital Emergency Department to the FHC for consultation and enrollment in one of the two self-management classes.** |
| **GOALS/OUTCOMES** | Pre-diabetes and diabetes patients participating in these chronic disease self-management programs offered through the Diabetes Collaborative will improve their blood sugar, lipid and hypertension levels. They will also improve their healthy eating and increase their physical activity by following these educational programs offered in outpatient and community settings. |
| **PARTNERS** | Ellenville Regional Hospital, Ellenville Family Health Center, local pharmacists, Ellenville First Aid & Rescue Squad, Ellenville, various senior centers and houses of worship and the Ulster County Office for the Aging. |
| **PARTNER ROLES/RESOURCES** | Ellenville Regional Hospital – Patient referrals, program oversight & management; Ellenville Family Health Center – Program implementation, Staff recruitment & training, Data collection; local pharmacists – Program promotion; Ellenville First Aid & Rescue Squad – Patient referral, Program promotion; Senior centers – Program promotion & location for classes; Houses of worship – Program promotion & location for classes and Ulster County Office for the Aging – Program promotion. |
| **BY WHEN** | By the end of 2018. |
| **MEASURES** | Complete hiring FHC staff (diabetes educator and health coaches) including Spanish speaker for Diabetes Collaborative. Arrange schedule of chronic disease and diabetes self-management classes within community settings. Track data on the number of patients who met with a health coach or diabetes educator and who participated in these chronic disease and diabetes self-management programs. |
| **DISPARITY** | Ellenville Regional Hospital is located in an economically depressed area with a high incidence of diabetes among low income residents, along with high rates of cardiovascular disease and obesity in general. |

## Maintaining Engagement/Tracking Progress:

As is the case with the current Community Health Improvement Plan, engagement with community partners is maintained through active participation in, and coordination with, the three major community-wide coalitions that address Ulster County's chosen Prevention Agenda Priority areas. They are the Healthy Ulster Council that coordinates implementation of the community's chronic disease prevention strategy; Ulster Prevention Council that does the same for substance abuse prevention; and the Ulster County Suicide Prevention, Education, Awareness and Knowledge (SPEAK) coalition that coordinates and implements suicide prevention strategy.

All three coalitions meet on an either monthly or quarterly basis. Ulster County Department of Health and Mental Health staff provides guidance, ongoing data and trend updates and actively participates in coalition activities. In addition, staff works with coalition members to discuss and monitor progress, while identifying opportunities for performance improvement and possible mid-course corrections related to the Community Health Improvement Plan and changes in community health conditions and outcomes.

## Dissemination Plans:

The Executive Summary and entire Community Health Improvement Plan will be posted on the Ulster County Department of Health and Mental Health website at http://ulstercountyny.gov/health/research-and-reports and on the Healthy Ulster County Network website at http://healthyulstercounty.net/community-organizationscollaboratives. Links to both sites will be shared at community coalition meetings and will be sent to health and human services listservs that reach community based organizations throughout Ulster County.

# HealthAlliance Hospitals

# 2016-2018

# COMMUNITY SERVICE PLAN

**HealthAlliance Hospital: Broadway Campus**
396 Broadway, Kingston, NY 12401

**HealthAlliance Hospital: Mary's Ave. Campus**
105 Mary's Ave., Kingston, NY 12401

# HealthAlliance Hospital

# 2016-2018 Community Service Plan

**Contact Information:**

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**Mission Statement**

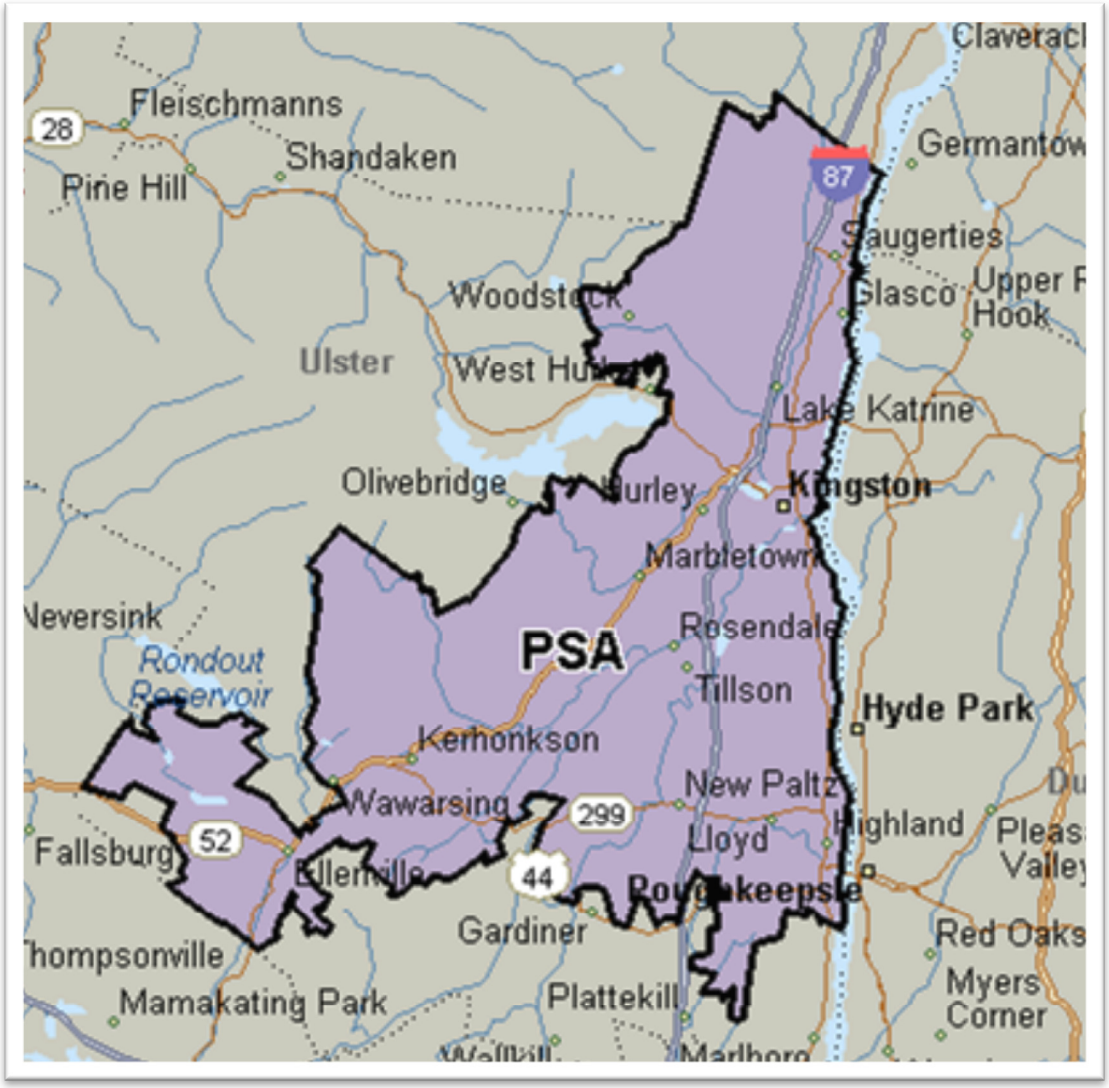
HealthAlliance of the Hudson Valley, a member of Westchester Medical Center Health Network (WMCHealth), operates a 315-hospital-bed health care system comprising HealthAlliance Hospital: Mary's Avenue Campus and HealthAlliance Hospital: Broadway Campus in Kingston, NY, and the Margaretville Hospital in Margaretville, NY. It also operates Mountainside Residential Care Center, an 82-bed nursing home in Margaretville adjacent to Margaretville Hospital. HealthAlliance is guided by the needs of its patients and their families. HealthAlliance delivers the best health care of the highest value in a safe, compassionate environment; invests in innovative technologies and leading-edge therapies to advance health care delivery; and improves the overall health and well-being of the diverse communities it serves.

March 2016 was a pivotal month for HealthAlliance. On March 4, HealthAlliance received from the New York State Department of Health (NYSDOH) and the state Dormitory Authority an $88.8 million Capital Restructuring Financing Program award, the second highest single award in the state, to transform its Mary's Avenue Campus into a single, state-of-the art hospital and to redevelop its Broadway Campus into a "medical village." On March 30, Westchester County Health Care Corp., through its newly created, wholly owned subsidiary WMCHealth Ulster Inc. (WMCHealth–Ulster), became the sole corporate member of HealthAlliance. HealthAlliance remains an active participant in the WMCHealth Performing Provider System (PPS) within the New York State Delivery System Reform Incentive Program (DSRIP). WMCHealth-Ulster oversees operations at HealthAlliance. The change in ownership, along with state funding to transform health care delivery in Ulster County, will have a significant positive impact on operations.

The goal of HealthAlliance is to be an essential provider of health care for the residents of Ulster and Delaware counties and to continue to align with the vision of the WMCHealth Network. This alignment includes clinical integration to enable HealthAlliance to provide superior care in a coordinated manner, while also reducing fragmentation of health care services. HealthAlliance works as an integral member of WMCHealth Network.

**Definition and Brief Description of Community Served**

HealthAlliance defines its primary service area (PSA) by a federal definition that consists of the top 75% of hospital discharges from the lowest number of contiguous zip-codes. Due to the geographical location of acute care hospitals under HealthAlliance, there are two distinct primary service areas that lie within Ulster and Delaware counties, though not encompassing all of each county. Although defined as two service areas, HealthAlliance regards it as a single primary service area for operational community need development.




**Map depicts the Ulster County PSA**

The PSA population in 2016 is 145,441, while the broader population for Ulster County was 180,441 in 2014 and 46,772 for Delaware County in 2013, with populations concentrated in the cities of Kingston, New Paltz and Saugerties. Patients from adjacent counties also visit the hospital or one of our outpatient locations for services that many not be available in their respective communities.

Unlike the population growth in the U.S. of 4.9%, the overall population for the primary service area is expected to decline slightly over the next five years. However, the population of the region is aging rapidly, with a 12% growth rate of pre-Medicare and Medicare populations of seniors (Truven Health, Market Expert). These demographic changes, consistent with national trends, are one of the defining aspects of HealthAlliance's future community health planning.

In 2014, HealthAlliance's PSA market share for inpatient hospital services was 51%, while the market share for inpatient behavioral health (psychiatric and substance abuse services) was 77%. For maternity services, HealthAlliance had a 26% market share, with over 75% of these patients being Medicaid enrollees, given the accessible location within a high-need, lower-income area. Within our region, projections for women of childbearing age and pediatric populations show a decline of 4.5%, or 2,563 people. However, HealthAlliance's share of maternity patients is expected to remain steady as HealthAlliance serves as a safety net provider for lower income, higher risk patients. The stable maternity volume is due to our partnership with the Mid-Hudson Family Practice Residency Program. It is one of the few family practice residency programs in the country whose physicians provide maternity and pediatric care for primary care patients at the nearby Institute for Family Health clinic.

Of HealthAlliance patients, 6.3 % are enrolled in Medicaid and 24.7% have Medicaid Managed Care. An estimated additional 9.2% have no health insurance (census.gov, 2014 SAHIE). In 2014 the median household income for the county is $58,592 and $43,560 for the City of Kingston, while persons below poverty level are 13.7% for the county and 21.5% for the City of Kingston. The region is economically diverse, but adjacent areas in Delaware County have unemployment rates that exceed NYS averages. Consequently, HealthAlliance provides a significant amount of charity care, totaling $1,585,593.00 in 2015.

According to Ulster County HHI-eBRFFS data, the percentage of adult smokers in Ulster County with income below $25,000 is 36.3% compared to 24.2% for NYS, while the rate of lung cancer incidence is 72.5 per 100,000 of the population, which is significantly higher than the state average of 63.3 per 100,000 people. Mental health and substance abuse indicators are also higher than state levels. Ulster County residents report 17.1 days of poor mental health per year, higher than an average of NYS residents who report of 11.2 days. Ulster County has an age adjusted suicide rates of 8.5 per 100,000 people as opposed to 7.9 per 100,000 people for NYS. Diet and exercise are also areas of public health concern. The percentage of obese adults as reported in the 2013-2014 eBRFSS is 26.4% as compared to 24.4% in the Mid-Hudson region and 24.6% in NYS.

**Public Participation**

The 2014-2016 Community Health Needs Assessment, demographic data and trends, NYS Prevention Agenda Dashboard, County Health Rankings, eBRFSS data, a regional Community Needs Assessment (CNA) undertaken in collaboration with WMCHealth, Montefiore Medical Center, HealthAlliance and an Ulster County community health survey was also used to develop the CSP. The survey was available both online and in paper copies that were strategically placed to be accessible to low income, chronically ill and minority communities with the greatest need. Ultimately, more than 600 community surveys were collected and tabulated.

**Assessment and Selection of Public Health Priorities**

This report includes charts outlining the community resources and assets that HealthAlliance is contributing to the 2016-2018 Ulster County Community Service Plan. With regard to DSRIP and Domain 4 Projects please note that HAHV chose to collaborate with the Ulster County Department of Health to promote tobacco use cessation, especially among low SES populations as noted in Focus Area # 2 -Goals #2.1 &2.2 in their CHIP. Each chart that follows begins with a brief explanation of how that resource or department is comprised and includes an update on their work thus far in 2016. These charts include:

1. The HealthAlliance Cancer Committee's:
    a. Weight Management Program
    b. Breast Cancer Screening Program
    c. Colon Cancer Screening Program
2. The HealthAlliance Diabetes Education Center
3. The HealthAlliance Family Birth Place
4. The HealthAlliance Employee Wellness Program
5. The HealthAlliance Partial Hospitalization Program
6. The HealthAlliance People's Place outreach
7. Live Well Kingston

**The Cancer Committee** of the HealthAlliance Hospital's Commission on Cancer (COC) Accredited Cancer Program is comprised of physicians, nurses, social workers and other allied health professionals focused on cancer-related care for hospital patients and community members. HealthAlliance's Cancer Committee is dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education and the monitoring of comprehensive quality care. The committee is responsible for planning, initiating, implementing, evaluating and improving all cancer related activities in our facility.

The Cancer Committee of the HealthAlliance Hospital established a prevention goal for 2016/2017, and for the 2016-2018 Ulster County Community Service Plan, that is aimed at reducing obesity in an effort to decrease the risk of chronic diseases, including certain forms of cancer. HealthAlliance's Oncology Support Program helps to address this by offering ongoing dance and exercise classes, such as yoga, Tai Chi and SmartBells classes to the general population in an effort to increase physical activity in Ulster County, including those with chronic disease. Monthly plant-based diet cooking classes are also offered in an attempt to increase the consumption of whole grains and plant-based foods. These programs and similar will continue through 2018.

In October 2016 the Oncology Support Program also developed the Wellness and Weight Management Series, a free, six-session program that incorporates the services of a dietitian and includes healthy food demonstrations presented at the Reuner Cancer Support House. The goals of the prevention program are to reduce the Body Mass Index (BMI) for participants who are overweight, increase usage of fruits and vegetables and increase physical exercise. As of October 19, 2016, the program met three times and was well attended. A pretest has been administered to help determine outcomes. Three more sessions are scheduled for 2016 and the series will be offered twice annually through 2018.

Additionally, The Cancer Committee has developed a referral form through which health care professionals involved in cancer care can refer patients to the wellness programs available at HealthAlliance Hospital, the Oncology Support Program and in the community.

(Continued)

**Weight Management Program**

**Priority/Focus Area: Prevent chronic disease/Increase access to high quality chronic disease preventive care in both clinical and community settings**

| Goal | Outcome/Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| NYSDOH Goal 3.3: Promote culturally relevant chronic disease self-management education. | Develop a sustainable infrastructure for widely accessible, readily available self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers.<br><br>Weight reduction if overweight.<br><br>Increase the consumption of whole grains and plant-based foods.<br><br>Increase the number of days and the duration of physical exercise.<br><br>Increase knowledge. | Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers.<br><br>Offer a six session Wellness and Weight Management Series that is open to the entire community, monthly plant-based diet cooking classes and weekly exercise classes including yoga and SmartBells. | Conduct pre- and post-tests to determine if participants:<br><br>-Increase their consumption of fruits, vegetables and whole grains<br><br>-Increase their frequency and the duration of moderate to vigorous physical exercise<br><br>-Increase their knowledge of healthy lifestyles<br><br>-Weight loss if overweight | The HealthAlliance Cancer Committee is the lead agency responsible for coordination and evaluation.<br><br>Collaborates with:<br><br>- ShopRite dietitians<br><br>- Health educators<br><br>- The instructors of the exercise classes offered at HealthAlliance<br><br>-Local gyms and YMCA<br><br>-Area physicians | ShopRite dietitian will facilitate the groups through the Oncology Support Program at HealthAlliance.<br><br>Physicians will provide referrals. | Program will take place between October and December of 2016, and may be repeated twice a year through 2018. | Yes. Targets the population with an income of less than $25k per year.<br><br>Low income populations will be targeted at health fairs and at the People's Place. |

**Breast Cancer Screening Program**

Breast Cancer Screenings are regularly offered at the HealthAlliance Fern Feldman Anolick Center for Breast Health, part of the comprehensive breast care program at HealthAlliance Hospital: Mary's Avenue Campus. Our integrated practice brings together a multispecialty cancer treatment team of experts to ensure you get the best care available. The experts include breast health specialists, radiation oncologists, medical oncologists, surgeons, plastic surgeons, pathologists, radiologists and a skilled support staff — all working as a multidisciplinary team to provide whole-person care for women. Our certified Breast Patient Navigator ensures seamless, coordinated care among physicians, diagnostic tests and cancer treatments, while offering education, guidance and supporting the patient and their family. The center is an FDA certified mammography facility, received certification in mammography, stereotactic biopsy and breast ultrasound from the American College of Radiology and is designated as a Breast Imaging Center of Excellence by the American College of Radiology.

The Cancer Committee of HealthAlliance Hospital has identified the need to ensure that low income members of Ulster County have access to breast cancer screenings in order to reduce breast cancer mortality in this population. On three occasions in 2016, the Breast Patient Navigator and the manager of the Center for Breast Health conducted outreach to the low income population that accesses the food pantry at People's Place. This afforded HealthAlliance the opportunity to identify the barriers to breast cancer screening, help members of the community access breast cancer screening, and guide those with positive findings of breast cancer. Further outreach efforts are scheduled for 2016 and more will be coordinated through 2018.

Additionally, the Center for Breast Health will increase access to breast cancer screening for uninsured and underinsured women by opening the center for a special period of time when women enrolled in the Cancer Services Program will be offered free breast cancer screenings. A Spanish translator will be available to provide support to Spanish-speaking women, and child care will be provided.

(Continued)

**Breast Cancer Screening Program**

**Priority/Focus Area: Prevent chronic disease/Increase access to high quality chronic disease preventive care in both clinical and community settings.**

| Goal | Outcome/Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| NYSDOH Goal 3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations. | NYSDOH Objective 3.1.1:<br>By December 31, 2018, 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%<br><br>Increase access to breast cancer screening for uninsured and underinsured women.<br><br>Increase number of women who enroll in the Cancer Services Program. | Women who are uninsured and underinsured will be identified through community outreach efforts and enrolled in the Cancer Services Program.<br><br>The Fern Feldman Anolick Center for Breast Health will open for a special period of time when women enrolled in the Cancer Services Program will be offered free breast cancer screenings. A Spanish translator will be available to provide support to Spanish-speaking women. Child care will be provided. | Women with positive findings on the breast cancer screening will be tracked by the Breast Patient Navigator. | HealthAlliance Cancer Committee is the lead agency.<br><br>Collaborates with:<br><br>- The New York State Cancer Service Program<br><br>- The People's Place provides access to the participating population.<br><br>- The Migrant Education Center provides access to the participating population. | The New York State Cancer Service Program will provide promotional materials and staffing to enroll women who are uninsured or underinsured, and will reimburse cancer screenings for eligible women.<br><br>Migrant Education Center | The Fern Feldman Anolick Center for Breast Health will be open to women eligible for the Cancer Services Program in October 2016, 2017 and 2018. | Yes. Outreach efforts will take place at People's Place, the Migrant Education Center and at other health fairs that target people who may be uninsured or underinsured and do not have access to cancer screenings. |

**Colon Cancer Screening Program**

The HealthAlliance Gastroenterology Department's dedicated and experienced team assists patients at every stage — from admission, through your procedure, recovery and discharge — with expert care. We provide patient focused services and use well-established techniques to perform procedures and testing. Services offered include esophageal dilation, bronchoscopy, upper endoscopy and gastroscopy, endoscopic retrograde cholangiopancreatography and colonoscopy.

The HealthAlliance Cancer Committee has identified the need to increase education about, and the screening rates of colon cancer. HealthAlliance will provide colon cancer screening education through marketing efforts and event outreach, where specialists will connect the uninsured and underinsured with free colon cancer screenings offered through the Cancer Services Program.

**Priority/Focus Area: Increase access to high quality chronic disease preventive care and management in both clinical and community settings**

| Goal | Outcome/ Objective | Intervention/ Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| NYSDOH Goal 3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.<br><br>Increase education about the importance of colon cancer screening and improve access to cancer screenings among the uninsured and underinsured. | NYSDOH 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 five years and a blood stool test in the past three years or a colonoscopy in the past 10 years) by 5% from 68.0% (2010) to 71.4%.<br><br>Increase colon cancer screening among adults age 50 to 75. | Women and men between the ages of 50 and 75 will be educated about the importance and methods of colon cancer screening through hospital-wide marketing and events.<br><br>Outreach efforts will be made to connect the uninsured and underinsured with free colon cancer screenings offered by the Cancer Services Program. | Men and women who are screened through the Cancer Services Program will be identified and guided to ensure access to care. | The HealthAlliance Cancer Committee is the lead agency.<br><br>Collaborates with:<br><br>-American Cancer Society<br><br>-New York State Cancer Services Program.<br><br>- People's Place and the Migrant Education Center provide space to meet with participants. | New York State Cancer Service Program will provide free fecal occult blood testing to the uninsured and underinsured.<br><br>The American Cancer Society's campaign to expand colon cancer screening by 2018 will be utilized to increase awareness. | The campaign to increase awareness of colon cancer screenings will take place in 2018. | Yes. The population with an income less than $25k will be targeted through outreach at sites that serve a lower income population such as People's Place and the Migrant Education Center. |

**The HealthAlliance Diabetes Education Center** in Kingston, NY, is committed to providing individuals with the skills and knowledge to manage diabetes and prevent diabetic complications. The Diabetes Education Center is also a community resource center where we host trainings and educational programs and offer information resources for our community to learn about diabetes. The Diabetes Education Center offers education and training to adults and teens with Type 1, Type 2 or gestational diabetes including weekly classes, a free, monthly support group, pump trainings and continuous glucose monitoring studies. Our Diabetes Educational Program has been recognized since 2003 by the American Diabetes Association for meeting its high-educational standards and for offering quality self-management diabetes education. We remain the only American Diabetes Association accredited education center in Ulster County.

2016 Update:

**Patient Volume:**
The HealthAlliance Diabetes Education Center has served 315 patients so far this year, with 195 new patients. Of these 195:

- 9% inpatient referrals
- 15% self-referred
- 76% physician referred

**Classes:**
The center has held 86 diabetes self-management classes so far in 2016. Of 108 people who attended a class, 36 people completed all five classes, resulting in a 33% completion rate.

**Support Groups and Community Outreach:**
We have held 10 monthly Type 2 diabetes support groups and six Type 1 diabetes support groups. Many area physicians, fitness centers and diabetes company educators have presented at the meetings, including Dexcom, Dr. Ali Hammoud (Cardiology), Mac Fitness, Tandem Diabetes, Keith Bennet Karate, Dr. Geoffrey Lee (Nephrology), Sanofi A1cChampions, Hudson Valley Foot Associates, Dr. Mohsin Cheema (Opthalmology), Dr. Raymond Lippert (Endocrinology), Juvenile Diabetes Research Foundation, Omnipod and the Ulster County Office of the Aging. So far this year 140 people have attended the free events.

Staff from the center also participated in the Ulster Association for Retarded Citizens Health Fair and the O+ Festival.

**Employee Wellness:**
Employee wellness nutrition classes were held at the HealthAlliance Hospital: Mary's Avenue Campus, HealthAlliance Hospital: Broadway Campus, Grant Avenue offices and the HealthAlliance Outpatient Dialysis Center. The 10 week series was attended by 119 employees who completed at least one class.

The above described programs, groups and community outreach will be continued through 2018, with increased marketing and outreach to further promote self-management of diabetes.

(Continued)

**The Diabetes Education Center**

**Priority/Focus Area: Prevent chronic disease/Increase access to high quality chronic disease preventive care and management in both clinical and community settings**

| Goal | Outcome/Objective | Intervention/ Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| NYSDOH Goal 3.3: Promote culturally relevant chronic disease self-management education. | NYSDOH Objective 3.3.1: By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease or diabetes who have taken a course or class to learn how to manage their condition. | Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions linked to the clinical setting.<br><br>Maintain ongoing, evidence-based classes and individual appointments to help individuals with diabetes manage the various aspects of self-management. | Weight, Hgb A1C, lipids, eye exam and patient satisfaction data are collected and reported annually to the American Diabetes Association. | The HealthAlliance Diabetes Education Center is the lead agency.<br><br>Collaborates with:<br><br>- HealthAlliance inpatient diabetes coordinator to ensure transition of care for individuals with diabetes whose A1C values are greater than 8%, are newly diagnosed, changed their treatment (i.e., initiating insulin) or were hospitalized with diabetes complication.<br><br>- Area physicians close the loop and foster collaborative care. | The HealthAlliance Diabetes Education Center has a full-time registered nurse, certified diabetes educator, program coordinator and a part-time registered dietitian. | Ongoing | Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. The disparity we are targeting is the population with income of less than $25k. |

**The Family Birth Place** at HealthAlliance Hospital: Broadway Campus, provides the highest level of care and a range of choices for expectant women in a secure, yet family-friendly environment where the well-being of our mothers and babies is our highest priority. The Family Birth Place offers a Labor, Delivery, Recovery, Postpartum (LDRP) approach to obstetric care, where you can give birth, recover and spend time with your baby all in one homelike room. The Family Birth Place continues to offer prenatal childbirth education and breastfeeding classes in which expectant mothers and their partners are educated about the benefits of breastfeeding. Many clinical staff members are Certified Lactation Counselors. Certification holders demonstrate competence in lactation knowledge, skills and attitudes, and agree to comply with the Academy of Lactation Policy and Practice code of ethics. The Family Birth Place is a Cribs-for-Kids National Certified Gold Safe Sleep Champion and received the 2015 Quality Improvement Award from the New York State Perinatal Quality Collaborative Obstetrical Improvement Project.

The Family Birth Place is in the final stage before designation as a 'Baby-Friendly' hospital. This accreditation recognizes hospitals that successfully implement evidence-based breastfeeding initiatives. The Baby-Friendly Initiative is predicated on the fact that breastfeeding is the normal way for human infants to be nourished. An abundance of scientific evidence points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. With the correct information and the right supports in place, most women who choose to breast-feed are able to achieve their goal. Education of hospital staff in preparation for the 'Baby-Friendly' on-site visit has brought awareness of breastfeeding to other departments such as housekeeping and all medical floors.

The Family Birth Place has met and exceeded the objective of increasing the percentage of infants who are exclusively breastfed during birth hospitalization in New York State hospitals by at least 10% to 48.1%. The 2016 average (to date) of mothers who breastfeed exclusively during hospitalization is 51%.

Additionally, practices such as skin-to-skin contact after birth and rooming-in have also become routine. As soon as a baby is born, he or she will be placed on the mother's chest after being dried. This is called "skin-to-skin care" and HealthAlliance offers it for at least an hour for all babies regardless of the mother's feeding choice, as long as you or your baby don't need special medical attention. Rooming-in can help a baby regulate his or her heart rate, body temperature and sleep cycle because he or she can sense their mother nearby. To encourage rooming-in, the Family Birth Place uses its baby nursery only for babies who need special medical attention or certain procedures.

In working with the community, The Family Birth Place partners with the Breastfeeding Initiative of Ulster County (BIUC), members of which include the Institute for Family Health, the Ulster County Department of Health, the Ulster County Women, Infant and Children (WIC) program, and the Maternal Infant Services Network (MISN). Other community outreach includes sitting on the conference committee for the MISN conference in May, providing a Rock and Rest tent at the Ulster County fair in August and distributing breastfeeding information at the O+ Festival in Kingston in October 2016.

The Family Birth Place aims to increase the number of mothers who ever breastfeed during their hospital stay from 82% to 85% and the number of women who breastfeed exclusively during their hospital stay from 51% to 55% by the end of 2018. This will be accomplished by continuing with skin-to-skin and rooming-in techniques and other practices required for Baby-Friendly designation. The Family Birth Place also plans to increase the number of nurses who are Certified Lactation Counselors from 53% to 75% by end of 2018.

(Continued)

**The Family Birth Place**

**Priority/Focus Area: Prevent chronic diseases/Reduce obesity in children and adults**

| Goal | Outcome/ Objective | Intervention/ Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Per NYSDOH, Expand the role of health care and health service providers and insurers in obesity prevention. | Per NYSDOH, by 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by at least 10% to 48.1%<br><br>Increase number of mothers who ever breastfed during their hospital stay from 82% (end of June 2016) to 85% by the end of 2018.<br><br>Increase numbers of women who breastfed exclusively during their hospital stay from 51% (end of June 2016) to 55% by the end of 2018. | Continue with current best practices, such as immediate skin-to-skin and rooming-in. These are practices that are required for Baby-Friendly designation, which is expected by the end of 2016.<br><br>Increase percentage of full-time and part-time nurses who are Certified Lactation Counselors from 53% to 75% by end of 2018. | Monitor the rate of mothers who ever breastfed and who exclusively breastfed while at HealthAlliance.<br><br>Receive Baby-Friendly designation of the HealthAlliance Hospital: Broadway Campus from Baby-Friendly USA, Inc. | HealthAlliance Family Birth Place is the lead agency.<br><br>Collaborates with:<br><br>-Breastfeeding Initiative of Ulster County<br><br>-Institute for Family Health<br><br>-Ulster County Women, Infants and Children program | In-kind staff time | Increase breastfeeding rates by the end of 2018.<br><br>Baby-Friendly designation by 2016.<br><br>Maintenance of policies and practices is ongoing. | Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. As the safety net hospital we serve the population with income of less than $25k.<br><br>For maternity services, HealthAlliance had a 26% market share, with over 75% of these patients being Medicaid enrollees.<br><br>"Breastfeeding is a natural 'safety net' against the worst effects of poverty. If the child survives the first month of life, the most dangerous period of childhood, then for the next four months or so, exclusive breastfeeding goes a long way toward canceling out the health difference between being born into poverty and being born into affluence…It is almost as if breastfeeding takes the infant out of poverty for those first few months in order to give the child a fairer start in life and compensate for the injustice of the world into which it was born."<br>–James P. Grant, former Executive Director, UNICEF |

**The HealthAlliance Employee Wellness Program** is a new initiative of the HealthAlliance of the Hudson Valley Community Service Plan for the years 2016-2018. The goal is to establish a comprehensive worksite wellness program for employees. HealthAlliance implemented an Employee Wellness Program for all employees, but more specifically for those enrolled in the CDPHP health insurance plan obtained through HealthAlliance. All benefit-eligible employees are encouraged to complete three activities, which include, completing a personal health assessment, completing an annual physical and participating in at least one wellness activity between January 1, 2016 and December 31, 2016. Such wellness activities can include getting an annual flu vaccine, getting an eye exam, partaking in all six sessions of the Wellness and Weight Management Series, and more. Employees who complete all three requirements will receive a $15 wellness credit per pay period towards their CDPHP health insurance premium. In addition, HealthAlliance has started implementing employee-specific nutrition and physical activity classes on campus and has opened the campus to a mobile farm stand during the growing season. Employees who have enabled “Quick Check” on their ID badges can use their badges to purchase this fresh, locally grown produce.

(Continued)

**The HealthAlliance Employee Wellness Program**

**Priority/Focus Area: Prevent chronic disease/Reduce obesity in children and adults**

| Goal | Outcome/ Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| NYSDOH Goal 1.4: Expand the role of public and private employers in obesity prevention. | By December 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and is fully accessible to people with disabilities. | Implement evidence-based wellness programs for all public and private employees, retirees and their dependents through collaborations with unions, health plans and community partnerships that include, but are not limited to, increased opportunities for physical activity; access to and promotion of healthful foods and beverages; and health benefit coverage and/or incentives for obesity prevention and treatment, including breastfeeding support.<br><br>As a role model, HealthAlliance will implement a program that incentivizes employee participation in a personal health assessment, a yearly physical and the adoption of at least one healthy behavior. The program will make health insurance rates favorable for those that participate in wellness activities. This will serve as a template for other community organizations that are interested in creating worksite wellness programs.<br><br>HealthAlliance promotes healthy eating to employees by offering group nutrition classes and private nutrition/weight loss counseling at no charge for employees.<br><br>As the lead agency, HealthAlliance partners with a local gym to bring a variety of movement classes on campus for employees. | Collect a baseline number of employees that participate in a personal health assessment and healthy behavior programs. | HealthAlliance is the lead agency.<br><br>The HealthAlliance Employee Wellness Committee assesses employee interest in programming and makes recommendations to administration.<br><br>CDPHP collaborates by aggregating data on their website. This data is reviewed, evaluated and reported by HealthAlliance.<br><br>Nutrition classes are in-kind from HealthAlliance dietitians.<br><br>Local gyms provide fitness instructors and memberships at a reduced cost. | The HealthAlliance Employee Wellness Committee makes in-kind contributions.<br><br>HealthAlliance has financial input. | Starts December 2016. Will be ongoing. | Yes. Connects with Ulster County adults with incomes under $25k. |

**Partial Hospitalization Programs:** HealthAlliance has two separately operating partial hospitalization programs, one for adults and one for adolescents, at HealthAlliance Hospital: Mary's Avenue Campus. These are medically supervised outpatient programs for persons suffering acute symptoms of psychiatric illness who need intensive daily treatment, but not necessarily hospitalization. The programs provide a multi-disciplinary approach involving a psychiatrist, nurse, social worker and activities therapist, in a less restrictive setting.

HealthAlliance aims to promote the emotional, behavioral and mental well-being in of Ulster County by helping Partial Hospitalization Program participants. This will be done through a comprehensive, personalized treatment and aftercare plan designed especially for each recipient from a multidisciplinary perspective, and takes into account the biopsychosocial needs of that individual. This treatment plan will be developed by coordinating services with community providers.

The main modality of treatment will be daily dialectical behavioral therapy, education and activity groups that teach and reinforce coping skills to program participants. We also offer alternative modalities such as movement therapy and pet therapy. Additionally, the Partial Hospitalization Programs will provide medication management and individual therapy at least twice a week to program participants and family therapy as needed to participants and their families..

(Continued)

**Partial Hospitalization Programs**

**Priority/Focus Area: Promote mental health and prevent substance abuse/Promote mental, emotional and behavioral well-being in communities**

| Goal | Outcome/ Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| To promote mental, emotional and behavioral (MEB) well-being in communities.<br><br>To promote the emotional, behavioral and mental health of Partial Hospitalization Program participants. | NYSDOH Objective 1.1.1: Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.<br><br>To provide mental health services to approximately 200 people each year and facilitate improvement in the ability of the Partial Hospitalization Program participants to regulate emotions, manage behaviors and reduce symptoms of mental illness. | Identify and implement evidence-based practices and environmental strategies that promote MEB health.<br><br>Provide daily dialectical behavioral therapy, education and activity groups that teach and reinforce coping skills to program participants.<br><br>Provide medication management at least twice a week to program participants.<br><br>Provide individual therapy at least twice a week to program participants.<br><br>Provide family therapy as needed to program participants and their families.<br><br>Coordinate services with community providers to develop a comprehensive treatment and aftercare plan. | Pre- and post-patient surveys to indicate changes in patients' emotional, behavioral and mental health as a result of program interventions. The survey results will be processed by staff to obtain data reflecting the overall improvement in mental health for all program participants. | The HealthAlliance Partial Hospitalization Program is the lead agency.<br><br>Collaborates with:<br><br>- Community mental health agencies and area hospitals refer patients and provide aftercare when program participants return to the community.<br><br>- Medical providers provide a comprehensive wellness plan for program participants. | The HealthAlliance Partial Hospitalization Program provides staff and fiscal support for the program. | 2016-2018 with data collected, processed and reported annually. | Yes. All Partial Hospitalization Program participants will have access to the nutritional interventions, strategies and activities provided regardless of their biopsychosocial, economic and cultural considerations. |

**HealthAlliance's People's Place outreach** is a new initiative for HealthAlliance's 2016-2018 Community Service Plan, with the aim of increasing screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, as well as increasing the number of adults with a chronic disease who have taken a course or class to learn how to manage their condition.

The People's Place is a thrift store and food pantry located in Kingston, NY, operating as a 501c3 not-for-profit organization. Founded in 1972, with a mission to feed, clothe and respond to the essential needs of the people in Ulster County with kindness, compassion and the preservation of human dignity. In response to a request from the People's Place executive director in the summer of 2016, HealthAlliance began a pilot program to send staff to the People's Place to provide health screenings and educational services directly in the community.

It is precisely community level collaborations such as this that can help our community hospital to meet the requirements that are outlined in the DSRIP program. The overarching aim of this intervention is to bring health care screenings and education into the underserved community. We began by assessing hospital departments for the type of offerings and staff they could send out into Ulster County and identifying opportunities at the People's Place for a large attendance, such as fresh vegetable distribution on Tuesdays, spring through fall. During the summer of 2016, HealthAlliance sent a variety of health practitioners, including a health coach, to the People's Place on Tuesday mornings to determine what we can offer outside the walls of the hospital and what the population needs. Clinicians in attendance track interest in various offerings which are analyzed and utilized to chart future offerings.

HealthAlliance of the Hudson Valley will continue to outreach and screening efforts at the People's Place through 2018, therefore establishing clinical-community linkages that connect patients to self-management education and community resources.

(Continued)

**HealthAlliance's People's Place outreach**

**Priority/Focus Area: Increased access to high quality preventive care and management in both clinical and community settings**

| Goal | Outcome/ Objective | Intervention/ Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| NYSDOH Goal 3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.<br><br>NYSDOH Goal #3.3: Promote culturally relevant chronic disease self-management education.<br><br>Build partnerships with community agencies that serve disparate communities.<br><br>Promote the use of evidence-based interventions to prevent or manage chronic disease. | NYSDOH Objective 3.3.1: By December 31, 2018, increase by 5% the percentage of adults 18 and over who have tested for high blood sugar within the past three years.<br><br>NYSDOH Objective 3.1.4: By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease or diabetes who have taken a course or class to learn how to manage their condition. | Establish clinical-community linkages that connect patients to self-management education and community resources.<br><br>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. | a. Completed calendar for 2017.<br><br>b. Scheduled events at People's Place.<br><br>c. Collect data on the number of people educated, the number of people screened and the number of interventions completed. | HealthAlliance and People's Place are the co-lead agencies.<br><br>Collaborates with:<br><br>- The Institute for Family Health<br><br>- Local medical practices | HealthAlliance staff<br><br>Site clientele residents<br><br>Able to take referrals | a. April 2017<br><br>b. May 2017<br><br>c. Hold events Spring - Fall in 2017, evaluate and repeat in 2018. | Yes. Connects with Ulster County population with an income less than $25k. People's Place is at the very heart of the disparity population being targeted. |

**Live Well Kingston** is a city-endorsed coalition focused on improving active living and healthy eating opportunities in Kingston, NY. It is fiscally sponsored and coordinated by Cornell Cooperative Extension of Ulster County (CCEUC) in accordance with a Memorandum of Understanding with the City of Kingston. The coalition grew out of a four-year partnership initiative to reverse childhood obesity entitled Healthy Kingston for Kids, and funded by the Robert Wood Johnson Foundation. HealthAlliance of the Hudson Valley was a founding funding partner supporting the Live Well Kingston (LWK) coalition in its infancy and in the development of its focus teams and action plans. In 2014, the LWK coalition finalized its Articles of Collaboration, established a leadership team, and determined and formed its priority focus teams. Each focus team is now developing action plans.

2016 Update:

- The LWK coalition implemented a communications strategy which included new logos and design for website, social media, brochures and other outreach materials to increase the impact of healthy messaging within the community.
- Four focus teams were active in 2015 – Age Well, Eat Well, Heal Well and Travel Well. New leadership was recruited for Play Well.
- Age Well conducted a series of focus groups at different locations to assess barriers to healthy eating and physical activity. This revealed a need for transportation to healthy activities, including farmers' markets and parks, as well as a need for both the availability of internet access and training on how to utilize technology to access resources. Negotiations for Wi-Fi and a computer in the common room of two low income senior residences were successful, and the project is underway. In addition, the Hudson Valley Resource List created by IPRO, was released in August 2016. IPRO's list will be used to develop a list inclusive of Ulster County services and opportunities. Transportation needs are in discussion with mangers of the senior residences as well as with Ulster County Area Transit (UCAT) and the City of Kingston bus system.
- Eat Well held a retreat for focus team members and invited the Mayor of Kingston. They developed a plan to hold 8-10 listening sessions at multiple sites within Kingston to assess barriers to healthy eating. These are set to begin late fall/early winter of 2016-2017.
- Heal Well held a series of "Walk and Talk with a Doc," in local parks and trails and, through the winter months, at the indoor track at the YMCA of Kingston and Ulster County.
- Play Well has two new co-chairs which include the director of the YMCA of Kingston and Ulster County and the owner of Innate Parkour. They are currently recruiting focus team members and will be developing an action plan in early 2017.
- Travel Well, which includes three active transportation groups in Kingston – the Kingston Complete Streets Advisory Council, the Kingston Land Trust: Kingston Greenline Committee and Bike Friendly Kingston – forwarded several active transportation projects in cooperation with the City of Kingston. These included the Kingston Connectivity Project, the Kingston Point Rail Trail and Complete Streets on Cornell, Foxhall, North Street and Broadway. The Kingston Greenline completed construction on the Trolley Trail portion of the Greenline. Funding has been awarded for other sections of the Greenline and design and construction is in progress. In addition, a Safe Routes to School project and the Hudson Landing Promenade and Development Project are underway. Bike Friendly Kingston held several community bike rides, implemented bicycle education and opened a Repair Café. They are currently organizing a bicycle and pedestrian bicycle count on Broadway in collaboration with the Ulster County Transportation Council.
- As a successful health coalition, the structure, function, successes and challenges of LWK were shared in presentations at several conferences including the 2016 New York State Public Health Association, the 2015 American Planning Association of the Greater Metro Area and the 2015 New York DASH-NY Coalition Conference.

**Live Well Kingston**

| NYS Prevention Agenda Focus Area: Reduce Obesity in Children and Adults | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Goal** | **Outcome/Objective** | **Intervention/Strategy** | **Process Measures** | **Partner Role** | **Partner Resources** | **Time Frame** | **Disparity Addressed** |
| Expand the role of health care, health services providers and insurers in obesity prevention. | 1. Live Well Kingston (LWK) will expand the role of the local health care industry's leadership for the local implementation of the NYS Prevention Agenda. | A. Maintain participation from hospital and health care providers on the LWK Leadership Team, and recruit new members from the insurance sector.<br><br>B. Develop the capacity and work plan for the Heal Well Focus Team by incorporating new members from health care, health service providers and insurers. | Hospital and health care providers will participate on LWK Leadership Team.<br><br>Heal Well Focus Team will acquire a new Chair, additional membership and develop a work plan. | LWK Leadership Team: CCEUC, City of Kingston (CoK), SUNY Ulster, Rose Women's Care Center, Institute for Family Health, HealthAlliance, NYSPHA, and UCDOH<br><br>Heal Well Focus Team: Institute for Family Health | | 2017 | Yes. |

| Goal | Outcome/Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 1. LWK will develop, implement and/or support policy, systems and environmental change by supporting and promoting local efforts to improve access to healthy foods throughout the community. Coordinate with gardening/urban agriculture efforts and organizations addressing food insecurity and healthy eating in Kingston. | A. The Eat Well Focus Team will meet 10 times per year to identify areas of possible collaboration on projects to implement policy, system and environmental change (PSE).<br><br>B. The Eat Well Focus Team will implement a series of local food forums to assess barriers to access and consumption of healthy foods.<br><br>C. Information garnered from the food forums will be used to inform decision makers and to develop the 2017-2018 Eat Well Kingston work plan.<br><br>D. Eat Well will promote communications that identify locations where healthy food is available for free or for sale using the LWK website, Facebook and Twitter accounts. | a. 8-10 Eat Well Meetings will occur annually.<br><br>b. 3-5 PSE's will be identified for possible collaboration.<br><br>c. 1-3 PSE's will be implemented as a result of networking with the Eat Well focus team.<br><br>d. Five or more food forums will be implemented within the Kingston School District in 2016-2017 and the results will be incorporated in the 2017-2018 Eat Well work plan.<br><br>e. Free and low cost healthy local food availability will be shared weekly through web and social media during the growing season. | Eat Well Focus Team: CCEUC, HealthAlliance, Institute for Family Health, YMCA Farm Project, Ulster Corps, Pine St. Farm Stand, Seed Song Community Garden, Local Economies Project, Food Bank of the HV, Clean Lunch Company, Gateway Industries, and Local Economies Project<br><br>Other Community Partners: City of Kingston, Food Bank of the Hudson Valley, People's Place, and Family of Woodstock | | a. 2016-2018<br><br>b. 2016-2017<br><br>c. 2017<br><br>d. 2016-2018<br><br>e. 2016-2018 | Yes. |

| Goal | Outcome/Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 2. Food offered at City of Kingston properties and at City of Kingston programs is healthier. | Collaborate with city officials to ensure effective implementation of the recently adopted Healthy Vending Policy which mandates that a certain percentage of food offered on city properties must meet Healthy Meeting Guidelines. | a. City of Kingston property vending machine offerings will be assessed in 2016.<br><br>b. The Eat Well Focus Team will work with city officials to maintain adherence to the guidelines outlined in the policy. | Eat Well Focus Team, CoK Department Heads, CoK Mayor, Food Vending Companies | | 2016-2017 | Yes. |
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 3. City parks, play spaces, recreation facilities and open space will be supported through policy, system and environmental change. | The Play Well Focus Team will provide input and support to the City of Kingston in revising the City of Kingston's Recreation Plan. | An updated City of Kingston Recreation Plan will be completed and adopted. | Play Well Focus Team: YMCA of Kingston, Innate Parkour, and CoK Parks and Recreation | | 2017 | Yes. |
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 4. City residents will have greater access to parks, recreational facilities and programs and will have a greater awareness of both public and private recreational opportunities. | A. The Play Well Focus Team will expand and recruit new members and will include representatives from CoK Parks and Recreation, nonprofits and businesses that provide recreational opportunities. | a. Play Well will meet eight times per year. | Community Partners: Family of Woodstock, CoK Police Department, CoK Building Safety Division, Ulster County (UC) Community Action, UC Probation Department, Friends of Forsyth Park, Kingston Conservation Advisory Council, Junior League of Kingston, and Kingston City School District | | A. 2016-2018 | Yes. |

| Goal | Outcome/Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 4. (continued) | B. Provide support to the CoK Parks Department in securing funds for implementing projects identified in the Recreation Master Plan and Capital Plan.<br><br>C. The Play Well Focus Team will identify parks as well as public and private recreational facilities and programs, and work to promote them through the LWK website, Facebook and Twitter accounts. | b. Focus Team will provide input and support to the CoK Parks and Recreation Department and Board on projects supported by the Recreation Plan.<br><br>c. Promotion of city parks and public and private recreational opportunities will occur via the LWK website and social media. | Community Partners: Family of Woodstock, CoK Police Department, CoK Building Safety Division, Ulster County (UC) Community Action, UC Probation Department, Friends of Forsyth Park, Kingston Conservation Advisory Council, Junior League of Kingston, and Kingston City School District | | B. 2016-2018<br><br>C. 2016-2018 | Yes. |
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 5. Complete Streets practices will be integrated into the day-to-day municipal administration through policy, systems and environmental changes. | A. The Travel Well Focus Team will provide input to CoK officials and the Planning Board regarding transportation and Complete Streets.<br><br>B. The Travel Well Focus Group will work with city officials to develop a comprehensive city sidewalk program that includes new sidewalk standards and codes. | The City of Kingston will incorporate some of the suggestions into planning and projects in order to foster Complete Streets practices by the Travel Well Focus Teams. | Travel Well Focus Team: Bike Friendly Kingston, Kingston Complete Streets Advisory Committee, and Kingston Greenline | | A. 2017<br><br>B. 2016-2017 | Yes. |

| Goal | Outcome/ Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 6. Create better environments for walking and biking by assisting with the organization and implementation of Complete Streets capital improvements. | A. The Travel Well Focus Group will provide support for the implementation of the city's Complete Streets capital projects, the Kingston Connectivity Project, and the Safe Routes to School project.<br><br>B. Identify additional potential Safe Routes to School projects for the next round of federal transportation alternatives funding. | a. New sidewalk standards and codes will be incorporated into planning and projects.<br><br>b. The City of Kingston will incorporate suggested project ideas from the Travel Well Focus Group into new Safe Routes to School projects. | Community Partners: CCEUC, YMCA of Kingston and Ulster County, CoK Economic and Community Development, CoK Parks and Recreation, CoK Engineering, CoK Planning, Bard College, Kingston Land Trust, UC Planning, Kingston City School District, Kingston Tree Commission, Kingston Bluestone Committee, SUNY Ulster Mid-Hudson Health and Safety Institute, and 511 Rideshare | | A.2017-2018<br><br>B. 2016-2018 | Yes |
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 7. Create a culture of walking and biking through educating and encouraging the general public and decision makers. | Increase participation in promotional events for walking and bicycling using existing resources/events (Kingston Walks; Walk, Bike, and Roll to School Day; Bike to Work; Bike Month; O+ Festival, etc.). | Walking and bicycling events will be promoted through the LWK website and social media. | | | 2016-2018 | Yes. |

| Goal | Outcome/ Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 8. Through advocacy, create a better experience and a safe environment for bicyclists of all ages to travel throughout the City of Kingston. | A. Support the implementation of bicycle safety and outreach through social media and the Bike Friendly Kingston website.<br><br>B. Seek funding for a Bicycle and Pedestrian Master Plan. | a. Bicycle safety information, programs and events will be promoted through the LWK website and social media.<br><br>b. Grants will be written to support the development of a Bicycle and Pedestrian Master Plan. | | | A. 2017-2018<br><br>B. 2017-2018 | Yes. |
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 9. Kingston will become a destination for inviting and successful bicycle events. | A. Through promotion and advocacy, support existing bicycle events such as Tour de Kingston, Recovery Ride, YMCA Bike Fest, O+ Festival and Cancer Ride.<br><br>B. Host multiple fun bicycle events including Feast on Two Wheels and Group Rides.<br><br>C. Provide support for and increase membership in Bike Friendly Kingston.<br><br>D. Educate the public on bicycle laws and best practices, and create a positive view of cyclists. | a. Existing bicycle events will thrive and new events will be added.<br><br>b. Bike Friendly Kingston will increase membership and capacity.<br><br>c. An educational campaign supporting cyclists will be implemented. | | | a. 2016-2018<br><br>b. 2016-2018<br><br>c. 2018 | Yes. |

| Goal | Outcome/ Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 10. Residents will have access to a system of trails within the City of Kingston that connect to a larger trail system. | A. Provide support for the Kingston Greenline through the promotion of the Greenline brand.<br><br>B. Complete the Comprehensive Management Plan (CMP) for the Kingston Greenline.<br><br>C. Advance the completion of the connections between the Wallkill Valley Rail Trail, the O&W Rail Trail, the U&D corridor, and the Kingston Greenline.<br><br>D. Advance the completion of the midtown hub of the Kingston Greenline. | a. The Greenline brand will be added to additional signs, pamphlets and websites.<br><br>b. The CMP document for the Kingston Greenline will be in use.<br><br>c. Additional sections of the Greenline Rail Trail will be completed.<br><br>d. Additional sections of the Greenline Rail Trail will be completed. | | | A. 2016-2018<br><br>B.2018<br><br>C. 2017-2018<br><br>D. 2017-2018 | Yes. |
| Create community environments that promote and support healthy food and beverage choices and physical activity. | 11. Senior citizens in Kingston have ample, accessible opportunities for physical activity, healthy eating and social interaction. | A. The Age Well Focus Team will develop and implement a work plan based on the outcomes of a series of focus groups aimed at determining barriers to active living and healthy eating which included transportation, internet access and computer skills.<br><br>B. The Age Well Focus Team will continually assess seniors via focus groups to determine if the strategies to address the identified needs are effective. | a. Seniors living at two low-income housing sites will have access to computers and the internet in the community room of each of the housing sites.<br><br>b. A minimum of two training programs to increase seniors' computer skills will occur.<br><br>c. The City of Kingston Mayor and Common Council will be made aware of identified transportation barriers for seniors to access local healthy food. | | | a. 2017-2018<br><br>b. 2017-2018<br><br>c. 2017-2018 | 11. Yes |

| Goal | Outcome/ Objective | Intervention/Strategy | Process Measures | Partner Role | Partner Resources | Time Frame | Disparity Addressed |
|---|---|---|---|---|---|---|---|
| Prevent childhood obesity through early child care and schools. | The Eat Well Kingston Focus Team will identify projects within school settings to foster healthy eating. | Members of the Eat Well Focus Team will continue to participate on the School Wellness Committee. | Members of the Eat Well Focus Team will continue to foster the implementation of the Summer Meal Program. | CoK Schools, City of Kingston, and Family of Woodstock | | 2016-2018 | Yes. |
| Expand the role of public and private employers in obesity prevention. | Businesses and organizations in Kingston have the information and resources to participate in Worksite Wellness programs. | A. Develop the capacity of a Worksite Wellness Focus Team to include the health department, hospital, health care providers and insurers.<br><br>B. Implement a worksite wellness program within a local institution that can be replicated at other sites within Kingston.<br><br>C. Set up regular competitions between participating organizations to increase participation in worksite wellness programs. | a. A Committee Chairperson and members will be recruited, and a work plan will be drafted.<br><br>b. Local institution will be identified to participate in a worksite wellness program that will be replicated. | Community Partners: UC Department of Health, HealthAlliance, CCEUC, and local health care organizations | | a.2017-2018<br><br>b. 2017-2018 | Yes. |
| Promote culturally relevant chronic disease self-management education. | Kingston residents and visitors will be able to easily find physical activity programs and healthy eating programs that meet their needs. | A. The LWK Communications Committee, along with the Heal Well Focus Team, will work with doctors to refer Kingston patients to the LWK website to find physical activity and healthy eating resources in Kingston.<br><br>B. The Media and Communications Team will continually update the events calendar on the LWK website showcasing LWK member events and activities for healthier lifestyles.<br><br>C. Social media will be used to promote resident, visitor and doctor use of the website. | a. Physicians will provide direct referrals for physical activity and healthy food opportunities.<br><br>b. The LWK website and calendar will be updated weekly with current local events and activities promoting healthier lifestyles.<br><br>c. The number of visits to the LWK website will increase annually. | LWK Communications Committee: CCEUC, HealthAlliance, City of Kingston, and Institute for Family Health | | A. 2016-2018<br><br>B. 2016-2018<br><br>C. 2016-2018 | Yes. |

**APPENDIX A - COMPARISON OF ULSTER COUNTY PERFORMANCE TO REGION, STATE AND PA 2018 OBJECTIVES**

**Ulster County, NY Prevention Agenda 2016-2018**

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|---|---|---|---|---|---|---|
| **Improve Health Status and Reduce Health Disparities** | | | | | | |
| **1-Percentage of premature deaths (before age 65 years)** | 2014 | 24.5 | 21.7 | 22 | 21.8 | X |
| 1.1-Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics | 2012-2014 | 1.86 | 1.91 | 2.1 | 1.87 | X |
| 1.2-Premature deaths: Ratio of Hispanics to White non-Hispanics | 2012-2014 | 1.76 | 2.17 | 2.24 | 1.86 | |
| 2-Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years[b] | 2014 | 117.6 | 100.5 | 106.1 | 122 | |
| 2.1-Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics | 2012-2014 | 1.74 | 2.02 | 1.94 | 1.85 | X |
| 2.2-Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics | 2012-2014 | 0.98 | 1.12 | 1.51 | 1.38 | X |
| **3-Percentage of adults (aged 18-64) with health insurance** | 2014 | 89.2 | | | 100 | |
| **4-Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years** | 2013-2014 | 79.6 | 81.3 | 84.6 | 90.8 | |
| **Promote a Healthy and Safe Environment** | | | | | | |
| 5-Rate of hospitalizations due to falls per 10,000 - Aged 65+ years | 2014 | 197.9 | 176.6 | 188.7 | 204.6 | |
| **6-Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years** | 2014 | 454.3 | 437.4 | 442.7 | 429.1 | X |
| 7-Assault-related hospitalization rate per 10,000 | 2012-2014 | 1.5 | 2.2 | 2.4 | 4.3 | |
| 7.1-Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics | 2012-2014 | 5.39 | 10.89 | 7.68 | 6.69 | |
| 7.2-Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics | 2012-2014 | 2.66 | 1.33 | 2.55 | 2.75 | |
| 7.3-Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes | 2012-2014 | s | 1.68 | 3.24 | 2.92 | |
| 8-Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years | 2014 | 32.7 | 22.1 | 28.2 | 33 | |
| 9-Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge | 2015 | 100 | 72.9 | 56.8 | 32 | |
| **10-Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home** | 2010-2014 | 22 | 30.7 | 22.6 | 49.2 | |

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|---|---|---|---|---|---|---|
| **11-Percentage of population with low-income and low access to a supermarket or large grocery store** | 2010 | 6.01 | 3.61 | 4.23 | 2.24 | |
| 12-Percentage of homes in Healthy Neighborhoods Program that have fewer asthma triggers during the home revisits | 2011-2014 | NA | | 18 | 25 | |
| **13-Percentage of residents served by community water systems with optimally fluoridated water** | 2015 | 3.6 | 48 | 52.6 | 78.5 | |
| **Prevent Chronic Diseases** | | | | | | |
| **14-Percentage of adults who are obese** | 2013-2014 | 27.6 | 23.9 | 27 | 23.2 | |
| **15-Percentage of children and adolescents who are obese** | 2012-2014 | 19.2 | 16.1 | 17.3 | 16.7 | X |
| **16-Percentage of cigarette smoking among adults**[b] | 2013-2014 | 21.1 | 14.1 | 17.3 | 12.3 | |
| **17-Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years**[b] | 2013-2014 | 64.9 | 69.1 | 70 | 80 | |
| 18-Asthma emergency department visit rate per 10,000 population | 2014 | 46.3 | 54.5 | 48.8 | 75.1 | |
| 19-Asthma emergency department visit rate per 10,000 - Aged 0-4 years | 2014 | 80.1 | 106.5 | 117 | 196.5 | |
| **20-Age-adjusted heart attack hospitalization rate per 10,000** | 2014 | 17.5 | 14.9 | 14.7 | 14 | X |
| 21-Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years | 2012-2014 | 2.4 | 2 | 2.9 | 3.06 | |
| 22-Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years | 2012-2014 | 4.7 | 4.5 | 6 | 4.86 | |
| **Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections** | | | | | | |
| **23-Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months** | 2014 | 52.7 | 51.1 | 59.4 | 80 | |
| **24-Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years** | 2014 | 23.5 | 24.8 | 30.3 | 50 | |
| 25-Percentage of adults with flu immunization - Aged 65+ years[b] | 2013-2014 | 73.6 | 76.4 | 77.1 | 70 | |
| 26-Newly diagnosed HIV case rate per 100,000[c] | 2012-2014 | 4.4 | 8.3 | 7.1 | 16.1 | |
| 26.1-Difference in rates (Black and White) of newly diagnosed HIV cases[c] | 2012-2014 | 5.8+ | 23.4 | 22 | 46.8 | |

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|---|---|---|---|---|---|---|
| 26.2-Difference in rates (Hispanic and White) of newly diagnosed HIV cases[c] | 2012-2014 | 7.0+ | 10.7 | 14.4 | 26.6 | |
| 27-Gonorrhea case rate per 100,000 women - Aged 15-44 years | 2014 | 110.7 | 104.5 | 140.1 | 183.4 | |
| 28-Gonorrhea case rate per 100,000 men - Aged 15-44 years | 2014 | 69.1 | 101.8 | 145.3 | 199.5 | |
| 29-Chlamydia case rate per 100,000 women - Aged 15-44 years | 2014 | 1091.5 | 1,113.20 | 1,249.60 | 1,458 | X |
| 30-Primary and secondary syphilis case rate per 100,000 men | 2014 | 2.2* | 5.3 | 7 | 10.1 | |
| 31-Primary and secondary syphilis case rate per 100,000 women | 2014 | 0.0* | 0.2* | 0.3 | 0.4 | |
| **Promote Healthy Women, Infants, and Children** | | | | | | |
| 32-Percentage of preterm births | 2014 | 10.1 | 10.5 | 10.8 | 10.2 | |
| **32.1-Premature births: Ratio of Black non-Hispanics to White non-Hispanics** | 2012-2014 | 2.04 | 1.75 | 1.59 | 1.42 | |
| **32.2-Premature births: Ratio of Hispanics to White non-Hispanics** | 2012-2014 | 1.48 | 1.28 | 1.21 | 1.12 | |
| **32.3-Premature births: Ratio of Medicaid births to non-Medicaid births** | 2012-2014 | 1.16 | 0.9 | 1.12 | 1 | X |
| 33-Percentage of infants exclusively breastfed in the hospital | 2014 | 61.3 | 48.2 | 51.1 | 48.1 | |
| 33.1-Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics | 2012-2014 | 0.73 | 0.61 | 0.53 | 0.57 | X |
| 33.2-Exclusively breastfed: Ratio of Hispanics to White non-Hispanics | 2012-2014 | 0.75 | 0.74 | 0.58 | 0.64 | X |
| 33.3-Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births | 2012-2014 | 0.72 | 0.83 | 0.69 | 0.66 | |
| **34-Maternal mortality rate per 100,000 births** | 2012-2014 | 21.3* | 6.4* | 18 | 21 | |
| **35-Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs** | 2014 | 63.7 | 68.9 | 70.2 | 76.9 | X |

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|---|---|---|---|---|---|---|
| **35.1-Percentage of children aged 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs** | 2014 | 83.8 | 79 | 84.3 | 91.3 | |
| **35.2-Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs** | 2014 | 74.4 | 80.2 | 81.4 | 91.3 | X |
| **35.3-Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs** | 2014 | 55.4 | 60.1 | 62 | 67.1 | |
| **36-Percentage of children (aged under 19 years) with health insurance** | 2014 | 95.9 | | | 100 | |
| **37-Percentage of third-grade children with evidence of untreated tooth decay** | 2009-2011 | 34.2* | | 24 | 21.6 | |
| 37.1-Tooth decay: Ratio of low-income children to non-low income children | 2009-2011 | s | | 2.46 | 2.21 | |
| 38-Adolescent pregnancy rate per 1,000 females - Aged 15-17 years | 2014 | 8.4 | 9.8 | 11.7 | 25.6 | |
| 38.1-Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics | 2012-2014 | 1.95 | 4.77 | 4.13 | 4.9 | |
| 38.2-Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics | 2012-2014 | 1.5 | 4.59 | 3.14 | 4.1 | |
| **39-Percentage of unintended pregnancy among live births** | 2014 | 25.2 | 21.9 | 26.5 | 23.8 | |
| 39.1-Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic | 2014 | 1.63 | 3.01 | 2.14 | 1.9 | |
| 39.2-Unintended pregnancy: Ratio of Hispanics to White non-Hispanics | 2014 | 1.19 | 2.16 | 1.48 | 1.43 | |
| **39.3-Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births** | 2014 | 1.85 | 1.88 | 1.97 | 1.54 | |
| **40-Percentage of women (aged 18-64) with health insurance** | 2014 | 90.7 | | | 100 | |
| 41-Percentage of live births that occur within 24 months of a previous pregnancy | 2014 | 16.8 | 18.5 | 21.1 | 17 | |

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|---|---|---|---|---|---|---|
| **Promote Mental Health and Prevent Substance Abuse** | | | | | | |
| **42-Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month** | 2013-2014 | 17.1 | 10.9 | 11.8 | 10.1 | |
| 43-Age-adjusted percentage of adult binge drinking during the past month | 2013-2014 | 10.4 | 16.1 | 17.4 | 18.4 | |
| **44-Age-adjusted suicide death rate per 100,000** | 2012-2014 | 8.5 | 7.8 | 9.5 | 5.9 | |

NOTES

[a]: The Prevention Agenda 2013-2017 has been extended to 2018 to align and coordinate timelines with other state and federal health care reform initiatives.

[b]: A new target has been set for 2018. Click for more information.

[c]: Indicator baseline data, trend data, and 2018 objective were revised and updated in July 2015. Click for more information.

s: Data do not meet reporting criteria.

* Fewer than 10 events in the numerator, therefore the rate/percentage is unstable.

+ Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio is unstable.