Schuyler County Community Health Improvement Plan

October 2013

Prepared for Schuyler County Public Health
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Executive Summary

What are the health priorities facing Schuyler County?

This was the question facing Schuyler County Public Health Department as they delved into a comprehensive process that involved the local hospital, other local organizations and county residents.

The motto of the Schuyler County Public Health Dept. is, "*Working Hand in Hand with the Community"*. To that end Schuyler County Public Health embarked on an 18 month long process to collect data, solicit opinions, facilitate a process and guide a discussion to determine not only what the most pressing problems facing our residents are, but also what can we effectively and efficiently address. The MAPP (Mobilizing for Action through Planning and Partnership) process was used to accomplish this. The Schuyler County Public Health Dept. was charged with working with local hospitals and other key partner agencies to select two key health priorities and one disparity to address in the community.

In the end, Schuyler County Public Health and the partner agencies decided to tackle two tough areas under the New York State Dept. of Health priority of the prevention of chronic disease:

1. Reduce obesity in children and adults
2. Reduce illness, disability and death related to diabetes

The disparity the partners chose to address was to:

Screen for Diabetes risk 10% of the County's 20 – 49 year old population, as many do not have Primary Care Physician nor Health Insurance coverage. Once screened for their risk of Diabetes, they would be referred to a Primary Care Physician (PCP) and if appropriate a Navigator to be screened for Health Insurance eligibility.

Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State (NYS). Specifically, they account for approximately 70% of all deaths in NYS, and affect the quality of life for millions of other residents, causing major limitations in daily living for about 10% of the population. Costs associated with chronic disease and their major risk factors account for more than 75% of our nation's health care spending[1]. Obesity is a major contributor to chronic disease.

Obesity Prevalence

- The percentage of New York State adults who are overweight or obese increased from 42% in 1997 to 60% in 2008.
- The percentage of obese adults in New York State more than doubled from 10% in 1997 to 25% in 2008.
- Obesity among children and adolescents has tripled over the past three decades. Currently, a third of New York's children are obese or overweight.
- Health care to treat obesity-related illnesses and conditions cost the United States an estimated $150 billion and New York State more than $7.6 billion every year.[2]

In Schuyler County the age adjusted percentage of adults who are obese (BMI 30 or higher) is 33.5% compared to the New York State rate of 23.1%.[3] Public health officials across the state and the nation must take steps to address this rising epidemic.

[1] CDC Chronic diseases: The Power to Prevent, the Call to Control http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm
[2] New York State Dept. of Health Obesity Prevention http://www.health.ny.gov/prevention/obesity/
[3] New York State Dept. of Health New York State Community Health Indicator Reports - Obesity and Related Indicatorshttp://www.health.ny.gov/statistics/chac/indicators/obs.htm

Diabetes is the most rapidly growing chronic disease of our time. It has become an epidemic that affects one out of every 12 adult New Yorkers. Since 1994, the number of people in the state who have diabetes has more than doubled, and it is likely that number will double again by the year 2050. The Centers for Disease Control and Prevention (CDC) has recently predicted that one out of every three children born in the United States will develop diabetes in their lifetime.[4] The diabetes mortality rate in Schuyler County is 32.5 compared to the New York State rate of 16.6.[5]

Failing to win the battle against obesity and diabetes will mean premature death and disability for an increasingly large segment of Schuyler County residents. Without strong action to reverse the obesity epidemic, for the first time in our history children may face a shorter lifespan than their parents. Schuyler County Public Health along with their partners has developed this Community Health Improvement Plan (CHIP) to address these issues.

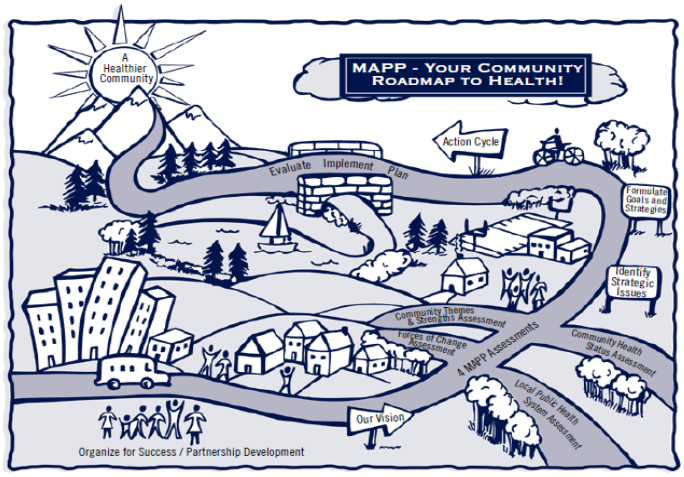
Next steps will center upon accomplishing the activities outlined in the CHIP workplan to accomplish objectives related to our identified priorities. Schuyler County Public Health will continue to meet and work with local hospitals and partners on a regular basis to begin to make progress in addressing the identified priorities to reduce obesity and illness, disability and death related to diabetes in our community.

[4] New York State Dept. of Health Diabetes http://www.health.ny.gov/diseases/conditions/diabetes/
[5] New York State Dept. of Health New York State Community Health Indicator Reports - Obesity and Related Indicatorshttp://www.health.ny.gov/statistics/chac/indicators/obs.htm

Process

Mobilizing for Action through Planning and Partnership

Led by the S2AY Rural Health Network Schuyler County Public Health Department along with local hospitals and community partners utilized the Mobilizing for Action through Planning and Partnership (MAPP) process to determine two priorities and a disparity from the 2013 – 2017 Prevention Agenda. The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is: *"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action".* The MAPP process encompasses several steps.



Organize for Success- Partner Development

The goal of this step is to bring together key partners and familiarize them with the MAPP process and determine key local questions. To accomplish this Schuyler County Public Health Department invited participants from a wide range of the organizations throughout the county. Organizations that participated in the community health assessment process were:

- Schuyler County Public Health Department
- Schuyler Hospital
- Arnot Health
- Guthrie Health
- Diabetes Committee (members are SCPHD, SH, CCE, AOMC, a PCP, and OFA)
- HEAL Committee (members are SCPHD, SH, CCE, OFA, Headstart, and local farmers)
- S2AY Rural Health Network
- Schuyler County Planning Department
- Schuyler County Department of Social Services
- Schuyler ARC
- Schuyler Headstart
- Watkins Glen School District

The Schuyler County Community Health Priority Committee included these organizations that are committed to improving the health of Schuyler County residents. This group has met on a monthly basis in the development of this Community Health Assessment. The members of the Schuyler County Community Health Priority Committee have agreed to meet on a regular basis to ensure that the initiatives outlined in the Community Health Improvement and Community Service Plans are implemented, monitored and evaluated.

Assessments

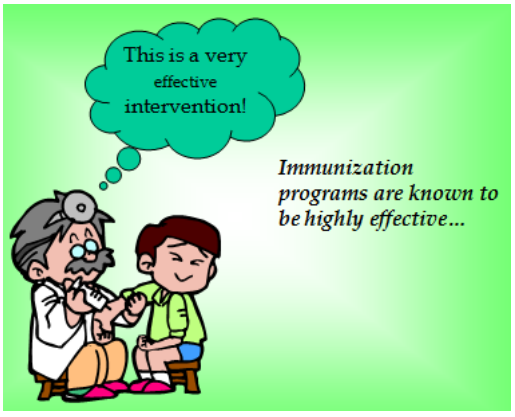
Four assessments inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of four different assessments is a unique feature of the MAPP process. Most planning processes look only at quantitative statistics and anecdotal data. MAPP provides tools to help communities analyze health issues through multiple lenses.

The first assessment examined the Community Health Status Indicators. Two methods were used to examine indicators. The first was to collect relevant statistical data using the NYSDOH Community Health Indicator Reports and a variety of other secondary sources. This was completed by S2AY Rural Health Network staff. The second method was to collect primary data by conducting a comprehensive survey among a random sample of community residents to determine their opinions, health-related behaviors and health needs. A total of 346 completed surveys were returned in Schuyler County. Surveys were conducted electronically through a Survey Monkey link, along with paper copies which were distributed to the public through employers, health, educational and human services agencies and through other community groups. The survey was designed to encompass questions in the five Prevention Agenda areas that the New York State Department of Health (NYSDOH) has identified as high priority issues on a statewide basis.

The second assessment evaluated the effectiveness of the Public Health System and the role of Schuyler County Public Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was also conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. The assessment was completed through the use of a more user-friendly version of the CDC and NACCHO tool, Local Public Health System Assessment (LPHSA). Each of the ten essential public health services was rated by the group by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System.

The third assessment was the Community Themes and Strengths Assessment that was conducted through focus groups which were held throughout the County. This assessment looked at the issues that affect the quality of life among community residents and the assets the County has available to address health needs. These were held in conjunction with the fourth assessment that looked at the “Forces of Change” that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes. The focus groups conducted in Schuyler County included a group of Schuyler Hospital staff members, which included the Medical Staff, Schuyler County Department Heads and Schuyler County public health department staff. These groups helped augment the responses of the public health system assessment and findings of the survey of community residents.

Identification of Strategic Issues



Once these results were tallied, a finalized list of the top issues from all components of the assessment process was compiled. A series of meetings was held with the Schuyler County Community Health Priority Committee to present the data and pick priorities. The Schuyler County Community Health Priority Committee was charged with ranking the priorities based on their knowledge of health needs and available services, along with the data presented, to select two priorities and one disparity. In order to accomplish this, the Hanlon Method was used. This method of ranking focuses most heavily on how effective any interventions might be. The Hanlon Method utilizes the following formula to rank priorities:

(A & 2B) X C

Where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. The effectiveness of the solution is given a lot more weight than the size or seriousness of the problem, with the hope of making wise use of limited resources by targeting solutions that are known to be

effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution) individually using a paper ranking form, the rankings were not heavily influenced by group dynamics. Based upon the ranking through the Hanlon Method, Schuyler County's scores on the top health related issues in the county were:

Issue	Hanlon	Pearl
Diabetes	148.00	5.46
Cardiovascular Disease	142.67	4.85
Obesity	135.62	5.38
Oral Health	105.38	4.23
Lead	102.50	4.85
Cancer	100.31	4.69
Injuries	98.50	3.92
CLRD/COPD	95.08	3.46
ER Visits	87.31	4.46
Breastfeeding	70.00	4.46
Teen Pregnancy	66.25	3.54

Community partners discussed all these issues, but concentrated on the top ranked issues. After reviewing, discussing and considering county assessments, data and previous initiatives the group decided to focus on the top two priorities of:

1. Obesity
2. Diabetes

And the following disparity:

Screen 10% of 20 – 49 year old population, for pre-diabetes and refer to a PCP

Further analysis and statistics can be found in the Schuyler County Public Health Community Health Assessment document.

Obesity and Related Indicators - Schuyler County - 2008-2010

Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	NYS Rate exc NYC	Sig. Dif.	County Ranking Group
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)~	169	31.2	23.4	Yes	26.7	No	4th
% obese (95th percentile or higher) children in WIC (ages 2-4 years)	109	18.3	14.5	Yes	15.2	No	4th
% of children in WIC viewing TV 2 hours or less per day (ages 0-4 years)	576	89.9	78.6	Yes	80.7	Yes	4th
% of WIC mothers breastfeeding at 6 months	42	19.3	39.7	Yes	28.7	Yes	3rd
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2008-2009)	N/A	64.9	59.3	No	60.6	No	3rd
Age-adjusted % of adults obese (BMI 30 or higher) (2008-2009)	N/A	33.5	23.1	Yes	24.3	Yes	4th
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2008-2009)	N/A	79.6	76.3	No	78.9	No	3rd
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	N/A	24.6	27.1	No	27.7	No	3rd
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	N/A	10.3	9.0	No	8.5	No	3rd
Age-adjusted mortality rate per 100,000							
Cardiovascular disease mortality	207	271.6	250.9	No	244.7	No	3rd
Cerebrovascular disease (stroke) mortality	29	39.4	26.7	No	31.9	No	4th
Diabetes mortality	25	32.5	16.6	Yes	14.9	Yes	4th

Formulate Goals and Strategies

During this stage research and evidence-based best practices were considered by the Schuyler County Community Health Priority Committee (SCCHPC) from many different sources including the state's Prevention Agenda 2013 – 2017 material, and national guidance, such as the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020. The Health Impact Pyramid developed by Thomas R. Frieden, MD, MPH was utilized. This is a pyramid approach to describe the impact of different types of public health interventions and provides a framework to improve health. The base of the pyramid indicates interventions with the greatest potential impact and in ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, on-going direct clinical care, and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort.

For each focus area under the selected Prevention Agenda Prevent Chronic Disease priority objectives and goals were identified that included improvement strategies and performance measures with measurable and time-framed targets over the next five years. Strategies proposed are evidence-based or promising practices. They include activities currently underway by partners and new strategies to be implemented.

These strategies are supported and will be implemented in multiple sectors, including at local schools, worksites, businesses, community organizations, and with providers, to make the easy choice also the healthy choice. We will create an environment that is conducive to physical activity and good nutrition through our network of partnerships with these diverse organizations.

Our partnership worked to develop a broad based plan to address our chosen priorities of obesity and diabetes. The Schuyler County Community Health Priority Committee Work Plan places emphasis on three key areas: 1) health promotion activities to encourage healthy living and limit the onset of chronic diseases; 2) early detection opportunities that include screening populations at risk; and 3) successful management strategies for existing diseases and related complications. These strategies recommended by the Health Impact Pyramid are based on the interventions' evidence base, potential to address health inequities, ability to measure success, potential reach, potential for broad partner support and collaboration, and political feasibility. This is based on findings from such organizations as the Institute of Medicine of the National Academies and their report, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation* or the CDC's, *Recommended Community Strategies and Measurements to Prevent Obesity in the United States.*

Obesity is one of the leading causes of preventable deaths leading to other chronic diseases, including diabetes, cancer, heart disease, stroke, arthritis and others. We have included many interventions to encourage increased physical activity and better nutrition thus reducing our obesity rates leading to lower chronic disease rates. These initiatives include pursuing joint use agreements with the local school districts, pushing worksites, clubs, and schools to adopt sugar sweetened beverage policies and asking local restaurants to hi-lite healthier choices on their menus. We will create an up to date resource guide to promote the County's many opportunities for physical activities including the Watkins Glen Gorge, Seneca Lake and the Catherine Valley Trail. We will also direct residents to such things as kayak rentals, farmer's markets, community recreational leagues, and dance classes.

Our identified disparity, to screen for Diabetes risk, 10% in the 20 – 49 year old population, and refer as appropriate to a primary care physician, will provide early detection for this high risk population. Residents needing further treatment will be referred to a local physician for proper follow-up, linked with navigators if needed to become insured, provided education on diabetes prevention and given resources on diabetes management. Five members of the Schuyler County Diabetes Committee recently completed training in the CDC Diabetes Prevention Program. They will schedule classes with those identified in the screenings to reduce their risks.

One exciting aspect of the SCCHPC Work Plan is the unlimited possibilities offered by technological advances. Schuyler Hospital and other local providers are beginning to implement Electronic Health Records (EHR). These EHR's will create a sea of change in how providers manage their patients. When fully functional the benefits of EHRs include improved quality and convenience of patient care, accuracy of diagnoses, health outcomes, and care coordination, increased patient participation in their care and increased practice efficiencies and cost savings. We will utilize this technology to give our residents one more, vital

tool to improve their health outcomes. EHR's will give providers decision support tools and available resources at their finger tips leading to disease management discussions with patients and better chronic disease case management.

Primary care providers will be trained to talk to their patients about their weight, physical activity, diet and tobacco use. Professional training programs in prevention, screening, diagnosis and treatment of overweight, obesity and diabetes will be provided and reach across the spectrum of health care providers. The updated resources mentioned above will be available to providers through a link in the EHR. Through the use of this new technology follow-up calls will be able to be made to check on patient compliance. Additionally, the EHR's will provide the opportunity and documentation necessary to evaluate and measure their use. EHR's provide one more important connection in the network to support residents to fight obesity and diabetes.

As we pursue our SCCHPC Work Plan we will continue to identify emerging best practices to reduce obesity. We will evaluate our own programs and develop data measures to assess their impact. Promising cases for return on investment will be shared with policymakers. Our continued and developing partnerships in the development of this plan have allowed us to strengthen the connection between public health, local hospitals and providers. Specifics are outlined in the work plan below.

Maintenance of Engagement

The Schuyler County Community Health Priority Work Plan designates the organizations that have accepted responsibility for implementing each of the activities outlined in the work plan. Measurements and evaluation techniques are provided for each activity with starting target dates provided. As mentioned above the members of the Schuyler County Community Health Priority Committee have agreed to meet on a regular basis to ensure that the initiatives outlined in this plan are implemented, monitored and evaluated. Progress will also be reported quarterly to the Schuyler County Legislature/ Board of Health, Schuyler County Professional Advisory Committee and the Schuyler Hospital Board. Activities on the work plan will be assessed and modified as needed to address barriers and duplicate successes.
Progress will also be monitored using the "Results Based Score Card", which is an interactive database that assist in monitoring population results and indicators, and the performance of Programs and Services that are part of the County's strategy to improve them. Once trained (planned for October-November 2013) the County's Human Services Departments will use as its Performance Based Budget.

Schuyler County Community Health Priority Committee Workplan

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1**: *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create adult community environments that promote and support healthy food and beverage choices and physical activity**	A1. Physical activity and healthy eating increased at Schuyler Hospital for employees including activities such as annual Biggest Loser contest	Schuyler Hospital	September 2013 Ongoing	Number of pounds lost #Participants Individual's numbers comparisons
		A2. Educate and promote the benefits of limited usage of Sugar Sweetened Beverages	Public Health, Schuyler County Community Health Priority Committee Cornell Cooperative Extension Schools	January 2014	# of signs posted in the community # of worksites/clubs/ school events, that limited sugar sweetened beverages at functions
		A3. Increase community physical activity through the promotion of local hiking trails, Watkins Glen Gorge and other natural resources by updating an online resource guide. Include stroller and handicapped accessible references. Investigate the possibility of using interactive media either using existing apps or creating our own.	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, HEAL Schuyler, Chamber of Commerce, ARC of Schuyler, Schuyler Planning Dept., Regional Economic Development Council	July 2014 - Ongoing	Update community Walking trails, State and National Forest Trail Guides and distributed Create wall art using map of trails to hang in community office buildings Create a QR code taking persons to online guides Guide updated annually and online hits tracked Percentage of people reporting physical activity 3x/wk will increase on the next community health public survey

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Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create adult community environments that promote and support healthy food and beverage choices and physical activity**	A4. Increase and promote adult community physical activity through various community programs such as the Tae Kwan Do, adult free swim, fitness centers, and the Schuyler Steps Out Program. Investigate the possibility of obtaining participants baseline data of one or more programs to measure impact of activity.	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, local businesses and community organizations	February 2014 - Ongoing	Number of participants # miles logged in the Step Out Program Individual's numbers comparisons – pre- and post- measurements, body fat %, weight, glucose levels Percentage of people reporting physical activity 3x/wk will increase on the next community health public survey,
		A5. Continue and expand public service announcements and encourage letters to the editor promoting a healthy lifestyle, appear on weekly local television show, Senior Notebook, highlighting efforts, websites, social media and seminars	Schuyler Hospital, Schuyler County Community Health Priority Committee, HEAL Schuyler, CCE	July 2014 - ongoing	# PSA's provided # PSA's published # appearances made
		A6. Advocate for the inclusion of creating healthy environments with Regional Economic Development Council	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, HEAL Schuyler, Schuyler Planning Dept., Regional Economic Development Council	January 2014 - ongoing	Number of contacts made # of projects including healthy environmental proposal A Member of the Schuyler County Community Health Priority Committee will be appointed to the local SCOPED planning committee

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1**: *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create adult community environments that promote and support healthy food and beverage choices and physical activity**	A7. Continue to develop and expand joint use agreements with schools for use of facilities for healthy activities.	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, HEAL Schuyler, CCE, GST BOCES	January 2014	# of joint use agreements
		A8. Investigate and promote GST BOCES physical activity Adult Education classes including online resource links.	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, HEAL Schuyler, CCE, GST BOCES	January 2014	Online track number of hits to online information Track number of participants
	B. Prevent childhood obesity through early childcare and schools	B1. Create a resource for parents to find activities for their children.	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, local businesses, community organizations, and schools	June 2014	Number of hits to online resource site Number of children participating in activities in community
		B2. Increase and promote youth community physical activity through various community programs such as the Tae Kwan Do, dance, Glen Gators and Chemung Valley Soccer, Little League Baseball programs, 3rd grade cardboard boat regatta, recreational leagues, Youth sports, recess, etc.	Schuyler Hospital, Public Health, Schuyler County Community Health Priority Committee, local businesses and community organizations, schools	February 2014 - Ongoing	Percentage of people reporting physical activity 3x/wk will increase on the next community health public survey,
		B3. Continue sports conditioning program with WG School 7th – 12th	Schuyler Hospital, Schuyler County Community Health Priority Committee, Schools	March 2014	# of participants Track number of injuries

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1**: *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**C. Expand the knowledge base of partners in obesity prevention**	C1. Identify emerging best practices	HEAL Schuyler	December 2013	Best practices identified
		C2. Evaluate obesity prevention initiatives	HEAL Schuyler	December 2013	Initiatives evaluated, data collected and analyzed
		C3. Develop data to strengthen the case for return on investment in obesity reduction programs and share with policymakers	HEAL Schuyler, Public Health, Schuyler County Community Health Priority Committee	January 2014 ongoing	All data tracked and analyzed Reduce adult obesity rate by 2% by 2018
	D. Expand the role of public and private employers in obesity prevention	D1. Increase and promote opportunities for better nutrition through interventions such as links to available resources including the buy local fresh products, farmers markets, community gardens and orchards, teaching garden classes, restaurant initiatives, mobile fresh food truck, public transportation to markets and gardens, farm to school or store or community agencies cafeterias and breastfeeding.	Public Health Schuyler County Community Health Priority Committee Cornell Cooperative Extension Schools	January 2015 ongoing	Establish baseline numbers and monitor utilization of all new initiatives Percentage of people reporting eating 5 or more fruits and vegetable daily will increase in the next community health public survey.
		D2. Educate and promote the benefits of limited usage of Sugar Sweetened Beverages		June 2014	# of worksites that limit sugar sweetened beverages at functions # of worksites that offer free access to tap water, coolers or bottled water

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Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**D. Expand the role of public and private employers in obesity prevention**	D3. Support Finger Lakes Culinary Bounty group	Public Health, Schuyler County Community Health Priority Committee, HEAL Schuyler	January 2014 ongoing	Number of Members in the Finger Lakes Culinary Bounty Group
		D4. Form a Worksite Community Committee with HR directors educating them on the return on investment of worksite wellness program and create a sharing of ideas. • Support the development of new and expansions of existing programs. • Develop list of free resources available to support worksite wellness efforts. Disseminate resources to worksites including hospital via the Community Worksite Committee	Schuyler County Community Worksite Committee, Public Health, Schuyler Hospital, Schuyler County Community Health Priority Committee, HEAL Schuyler	September 2013 Ongoing	Number of Worksites participating in task force Number of new worksite initiatives in the community Number of employees with access to a worksite wellness program in the community Inventory list of available resources, dissemination of list/resources to 20 worksites, # distributed, and # of hits to online resource.
		D5. Promote training to Schuyler County's primary care providers (PCPs) on how to talk with their patients about their weight, physical activity and diet, as appropriate.	Schuyler Hospital, Public Health Schuyler County Community Health Priority Committee Southern Tier's Tobacco Coalition (STAC) Schuyler County Diabetes Committee and HEAL Schuyler	July 2016	30% of PCP's will take training
		D6. Ensure that PCPs can easily link their patients with available community resources simply, through the Schuyler Hospital's EHR or their own practices' EHR			Track usage of EHR resources and referral #'s made to community resources

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 2**: *Reduce illness, disability and death related to diabetes*					
Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce illness, disability and death related to diabetes	**A. Prevention, screening, early detection, treatment, and self-management support**	A1. Work to prevent heart disease and hypertension by assisting Office for the Aging and Schuyler Hospital in reducing sodium content in all meals served including to patients, visitors, staff and the public depending on grant funding.	FLHSA, S2AY Rural Health Network, Public Health, Schuyler Hospital, Schuyler County Community Health Priority Committee, HEAL Schuyler and Schuyler County Diabetes Committee	July 2014	Reduce sodium content in X# of meals by 30% over 3 years, by November 2016
		A2. Provide CDC's Diabetes Prevention Program in the community to all identified Pre-diabetics A3. Educate pre-diabetics using evidence-based curriculum	Public Health, Schuyler County Community Health Priority Committee, Diabetes Committee, Schuyler County Lifestyle Coaches	January 2014	Number of class series offered Number of participants Number of participants meeting their goal of losing 5% of their body weight
		A4. Explore evidence-based curriculums for people with a diabetics diagnosis Provide classes for people with a diabetics diagnosis	Schuyler Hospital, Schuyler County Public Health Schuyler County Community Health Priority Committee Diabetes Committee Southern Tier Diabetes Coalition	July 2016	Number of curriculums available to Diabetic persons Number of people trained to conduct classes Number of classes offered Number of class participants Number of hospital admissions due to diabetes complications will decrease

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 2**: *Reduce illness, disability and death related to diabetes*					
Strategy Area	**Objective**	**Interventions**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Increase access to high quality chronic disease preventive care and management in clinical and community settings	**B. Prevention, screening, early detection, treatment, and self-management support**	B1. Screen 10% of 20-49 years old in Schuyler County for Diabetes risk • Offer finger stick glucose screen to all who score at risk on paper screen • Refer any abnormal finding to a PCP • Refer any without health insurance to a in-person assistor/navigator (Disparity: Increase diabetic screenings by 10% in low-income 20 – 49 year old population, and refer to a PCP)	Diabetes Committee Public Health, Schuyler County Community Health Priority Committee	January 2014	Number of 20-49 year olds screened Number identified at risk Number referred to PCP Number referred to In-person assistor/navigator # referred to Diabetes Prevention Program
	C. Train primary care providers (PCPs) to talk with their patients about their weight. Provide link on EMR to community resources available for patients	C1. Develop list of community resources and upload into Schuyler Hospital's EHR's	Schuyler Hospital, Schuyler County Community Health Priority Committee	July 2016	Inventory list of resources and availability on EHR, track usage
		C2. Promote training to Schuyler County's primary care providers (PCPs) on how to talk with their patients about their weight, physical activity, diet and their tobacco use, as appropriate.	Schuyler Hospital, Schuyler County Community Health Priority Committee Southern Tier's Tobacco Coalition (STAC)	July 2016	PCP's trained
		C3. Ensure that PCPs can easily link their patients with available community resources simply, through the Schuyler Hospital's EHR or their own practices' EHR	Schuyler Hospital, Schuyler County Community Health Priority Committee	July 2016	Track usage of EHR resources and referrals
		C4. Ensure that decision support/reminder tools of EHR s are being used, as well as the community resource list Continue calls by nurses to follow-up with patients on follow-through/compliance	Schuyler Hospital, Schuyler County Community Health Priority Committee	October 2013	Implementation of decision support & reminder tools and referrals to community resources in EHR, documentation of use and documentation of calls via EHR
		C5. Investigate the possibility of monitoring implementation	Schuyler Hospital, Schuyler County Community Health Priority Committee	November 2013	Implementation monitored through EHR