Prevention Agenda 2013-2017

Key Findings from Reviews of CHA-CHIPs and CSPs

April 29, 2014

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Office of Public Health Practice, New York State Department of Health
Outline

• Background

• Findings from the Reports
  Local Health Department (LHD) Community Health Assessment (CHA) – Community Health Improvement Plan (CHIP)
  Hospital Community Service Plans (CSP)

• Snapshots of selected reports identified as “good examples”

• Next steps

• Help with getting hospital CSP liaison contacts

• Call for implementation stories

• May 29th webinar to focus on dashboard and accessing technical support
Prevention Agenda 2013-2017

• Goal is improved health status of New Yorkers and reduction in health disparities through increased emphasis on prevention.

• Call to action to broad range of stakeholders to collaborate at the community level to assess local health status and needs; identify local health priorities; and plan, implement and evaluate strategies for local health improvement.
Prevention Agenda 2013-2017: Steered by Ad Hoc Leadership Group

Six members of Public Health Committee and other leaders from Healthcare, Business, Academia, Community-based & Local Health Departments.
Five Prevention Agenda Priorities

1. Prevent chronic diseases
2. Promote a healthy and safe environment
3. Promote healthy women, infants and children
4. Promote mental health and prevent substance abuse
5. Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated infections
Feedback letters e-mailed to local health departments and hospitals

Local Health Department Community Health Assessment & Community Health Improvement Plan due November 15, 2013; covers years 2014-2017

Hospital Community Service Plans; Due November 15, 2013, covers years 2013-15

Commissioner Shah directs LHDs and Hospitals to work together and include local stakeholders; asked to choose two Prevention Agenda priorities and one that addresses health disparities
• Breadth, role and extent of partner collaboration
• Community Health Assessment
• Meeting Prevention Agenda rationale for selecting two priorities, including one that addresses a health disparity
• Plans for implementation of evidence-based strategies
• Measurable process and outcome objectives and monitoring plan
• Plans for information dissemination and sustaining community engagement.
Priorities Reported by Local Health Departments and Hospitals

Data have been analyzed from 58 LHD CHA-CHIPs and 137 Hospitals CSPs reviews.
New York State Prevention Agenda
Priorities Selected by Counties, 2013

Priority Areas (# Selected by Counties)
- Chronic Disease (n=56)
- Mental Health and Substance Abuse (n=29)
- Women, Infants, Children (n=16)
- Environment (n=9)
- HIV, STD, Vaccines & HAI (n=3)
Percentage of LHDs and Hospitals Selecting Chronic Disease Focus Areas

- **Reduce obesity in children and adults**
  - LHDs: 100% (n=58)
  - Hospitals: 58% (n=79)

- **Reduce illness, disability and death related to tobacco use and secondhand smoke exposure**
  - LHDs: 40% (n=23)
  - Hospitals: 24% (n=33)

- **Increase access to high quality chronic disease preventive care and management in both clinical and community settings**
  - LHDs: 53% (n=31)
  - Hospitals: 65% (n=89)
Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.

Goal #1.2: Prevent childhood obesity through early childcare and schools.

Goal #1.3: Expand the role of health care and health service providers and insurers in obesity prevention.

Goal #1.4: Expand the role of public and private employers in obesity prevention.

Goal #2.1: Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations.

Goal #2.2: Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

Goal #2.3: Eliminate exposure to secondhand smoke.

Goal #3.1: Increase screening rates for cardiovascular diseases; diabetes; and breast, cervical and colorectal cancers, especially among populations experiencing health disparities.

Goal #3.2: Promote evidence-based care.

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### Percentage of LHDs and Hospitals Selecting Chronic Disease Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Percentage of LHDs</th>
<th>Percentage of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal #1.1</td>
<td>67</td>
<td>39</td>
</tr>
<tr>
<td>Goal #1.2</td>
<td>48</td>
<td>23</td>
</tr>
<tr>
<td>Goal #1.3</td>
<td>36</td>
<td>26</td>
</tr>
<tr>
<td>Goal #1.4</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>Goal #2.1</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>Goal #2.2</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Goal #2.3</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>Goal #3.1</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>Goal #3.2</td>
<td>26</td>
<td>22</td>
</tr>
</tbody>
</table>

LHDs  | Hospitals
Percent of LHDs and Hospitals Selecting Chronic Disease Strategies

- Increasing adoption and use of food standards: 45%
- Implementing of Complete Streets policies, plans, and practices: 26%
- Promoting of policies and practices in support of breastfeeding: 22%
- Increasing the availability, accessibility and use of evidence-based interventions in self-care management in clinical and community settings: 47%
- Promoting smoking cessation benefits among Medicaid beneficiaries: 5%
- Promoting smoking cessation among people with mental health disabilities through partnerships with the NYS Office of Mental Health: 3%
- Adopting tobacco-free outdoor policies: 11%
- Promoting NYS Smokers' Quitline: 19%
- Other program or educational approach: 61%
- Other policy (local or organizational) approach: 31%

LHDs and Hospitals: 0% 10% 20% 30% 40% 50% 60% 70% 80%

Percentage
• 11/18 hospitals and 6/9 LHDs, focusing on “injuries, violence and occupational health”.
• 11 hospitals and 5 LHDs goals relate to “reducing fall risk among vulnerable populations.
• 4 hospitals and 4 LHDs goals relate to “design and maintenance of built environment”.
• Strategies: Educational programs for fall prevention, integrate “healthy homes” education into other opportunities such as building inspections.
• 29/39 hospitals and 11/16 LHDs focusing on “maternal and infant health.”
• 22/39 hospitals and 8/16 LHDs goals relate to “Increasing proportion of babies breastfed”.
• Strategies most mentioned are: Breastfeeding education and counseling, Baby-friendly hospitals, link to WIC services for breastfeeding and nutritional supports.
Number of LHDs and Hospitals Selecting Promote Mental Health and Prevent Substance Abuse Focus Areas

- **Focus Area 1: Promote mental, emotional and behavioral (MEB) wellbeing in communities**
  - 11 LHDs
  - 25 Hospitals

- **Focus Area 2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders**
  - 14 LHDs
  - 29 Hospitals

- **Focus Area 3: Strengthen Infrastructure across Systems**
  - 13 LHDs
  - 10 Hospitals

- 29/33 hospitals and 14/29 LHDs focusing on “Substance abuse and MEB disorder prevention”, and slightly less focusing on “mental health promotion”
- Most focused on goals related to “Strengthening infrastructure” and “mental health promotion”
- Strategies most mentioned are: “educational programs”.

15
Number of LHDs and Hospitals Selecting Prevent HIV/STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections Focus Areas

- **Prevent HIV and STDs**: 3 LHDs and 4/11 hospitals focusing on Preventing HIV/STDs.
- **Prevent Vaccine-Preventable Diseases**: Goals related to HIV/STD prevention, Hepatitis C prevention, and decrease burden of pertussis disease.
- **Prevent Healthcare Associated Infections**: Strategies most mentioned are: “educational programs”.

- 6/11 hospitals focusing on Preventing Vaccine-Preventable Diseases and all 3 LHDs and 4/11 hospitals focusing on Preventing HIV/STDs.
**Percentage of Partners Collaborating during Development/Planning**

![Development/Planning Chart](chart-url)

**Percentage of Partners Collaborating during Implementation**

![Implementation Chart](chart-url)
Percentage of LHDs and Hospitals Addressing Disparities

- **Yes:**
  - LHD: 84% (n=49)
  - Hospitals: 85% (n=116)

- **No:**
  - LHD: 12% (n=7)
  - Hospitals: 9% (n=13)

- **Don't Know:**
  - LHD: 3% (n=2)
  - Hospitals: 6% (n=8)
Percentage of LHDs and Hospitals Reports - Selected Elements

- Evidence-based interventions for both priorities: 41% (n=24) for LHDs, 29% (n=40) for Hospitals
- Process and outcome objectives: 41% (n=24) for LHDs, 32% (n=44) for Hospitals
- SMART* Objectives by Organization Type: 66% (n=38) for LHDs, 58% (n=80) for Hospitals
- Plans posted online: 52% (n=30) for LHDs, 74% (n=101) for Hospitals
- Plan for sustaining community engagement: 28% (n=16) for LHDs, 21% (n=29) for Hospitals

*SMART=Specific, Measurable, Attainable, Relevant, Time-bound
Snapshots of selected “good examples”

• Prioritization process and rationale for selecting priorities
• Identifying process and outcome measures, and partner role in implementation
• Using an evidence-based approach
• Sustaining implementation efforts and partner engagement
Thank You for presenting the examples

**Warren County**
Tracy Mills, Glens Fall Hospital

**Niagara County**
Dan Stapleton, Niagara County Public Health

**Oswego County**
Jiancheng Huang, Oswego County Health Department

**New York City**
Arlene Allende, St Barnabas Health, Bronx
Prioritization and Rationale for Priorities
Warren County Health Services and Glens Fall Hospital

Prioritized Significant Health Needs in Warren County

Based on analysis of the available health data, community surveys, input discussions at the regional and local levels, the following have been identified as significant health needs in Warren County that will be of major focus for prioritization:

1. Increase access to high quality chronic disease preventive care and community settings
2. Promote mental, emotional and behavioral health (MEB)

Other Areas of Concern: Although the following areas were not chosen as significant needs, they were identified as areas that still need to be addressed:

3. Promote Healthy and Safe Environment
4. Infant, maternal and reproductive health

Assets and Resources to Address Needs

Priority #1 – Increase access to high quality chronic disease preventive care and community settings

Services are offered to address chronic disease and many of the controllable chronic diseases:

- Nutrition services for assessment, planning and counseling
- Hospital inpatient nutrition counseling for disease and condition

Prioritized Significant Health Needs

As described above, GFH coordinated with Warren, Washington and Saratoga counties to conduct a community health assessment (CHA) in each county. Using the results of the indicator analysis, regional survey and the other county-specific community assessment resources listed previously, each county prioritized the most significant health needs for their residents. Each county’s CHA provides the rationale behind the prioritization of significant health needs. The following table outlines the method for prioritization and the most significant health needs identified in each county.

<table>
<thead>
<tr>
<th>Prioritization Method</th>
<th>Warren County</th>
<th>Washington County</th>
<th>Saratoga County/Saratoga Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dot Method</td>
<td>Dot Method</td>
<td>Weighted Method</td>
<td>Increase access to high quality chronic disease preventive care and management in both clinical and community settings</td>
</tr>
<tr>
<td>Prioritized Health Needs</td>
<td>Increase access to high quality chronic disease preventive care and management in both clinical and community settings</td>
<td>Reduce obesity in children and adults</td>
<td>Improve child health</td>
</tr>
<tr>
<td></td>
<td>Promote mental, emotional and behavioral health (MEB)</td>
<td>Reduce illness, disability and death related to tobacco use and secondhand smoke exposure</td>
<td>Prevent substance abuse and other mental, emotional and behavioral disorders</td>
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<td></td>
<td>Promote mental, emotional and behavioral health (MEB)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Prevent healthcare associated infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STDs</td>
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</table>
Measures and Partner role in implementation
Example: Niagara County Public Health, Kaleida Health – DeGraff Memorial Hospital

Priority Area #2
Promote a Safe and Healthy Environment

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Goal</th>
<th>Objective</th>
<th>Activities/Interventions</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury Prevention</td>
<td>Reduce falls risks among vulnerable populations</td>
<td>By December 2017, reduce the rate of falls-related hospitalizations in the population aged 65+ by 10%. Niagara County rate 216.3 per 10,000. (NYS Indicators for Tracking Public Health)</td>
<td>NCDOH-by 12/31/14 1. Research and review hospital specific data related to falls hospitalizations by 6/14 2. Identify community/hospital resources for reducing falls risks by 6/14 3. Develop a resource listing of falls resources 4. Continue to focus on falls prevention through the Stay Well Program 5. Complete a falls prevention risk assessment on 100% of the participants as part of a health assessment at 8 senior nutrition sites</td>
<td>NCDOH Hospitals  NCDOH Hospitals Community Partners  NCDOH  NCDOH  NCDOH  DeGraff Hospital  NCDOH  Niagara County Office for the Aging</td>
</tr>
</tbody>
</table>

The New York State Department of Health Injury Prevention Program also indicates that males have a higher risk of death due to falls while females have a higher risk of hip fracture. Age increases the risk of falling and the severity of a fall injury, and people who have previously fallen are at an increased risk to fall again.

The good news is many falls and the devastating physical and financial impact resulting from falls are preventable.

Kaleida Health’s Implementation Plan
To address the high number of falls within Niagara County, DeGraff will:
- Increase collaborations with Niagara County hospitals and partner organizations.
- Offer training, resources, and technical assistance to expand the Niagara County Falls Coalition Stay Well On Your Feet/Falls Prevention Outreach Program.
- Broaden outreach and training of falls prevention education to targeted groups.

Kaleida Health’s Milestones
The objective will be benchmarked by the following steps:

By November 2014
1. Reinforce the elements of the Niagara County Falls Coalition Stay Well On Your Feet/Falls Prevention Outreach Program. (March 2014)
2. Expand existing collaboration with Niagara County Department of Health and Niagara County Office of Aging to include other Niagara County hospitals. (March 2014)
3. Share best practices, resources materials and demonstrate the Stay Well On Your Feet/Falls Prevention program to new partners. (April 2014)
4. Continue working with the Health Foundation for Western & Central New York.

6. Collaborate with media sources to identify 3 activities to inform the community about falls prevention.
7. Distributes falls information at resource events, home visits, health clinics and  

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4. Continue working with the Health Foundation for Western & Central New York.
Evidence-based approach

Example: Oswego County Health Department and Oswego Hospital

<table>
<thead>
<tr>
<th>Performance Measures: How We Will Know We Are Making A Difference</th>
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<tbody>
<tr>
<td><strong>Short Term Indicators</strong></td>
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<tr>
<td>By June 30, 2014, increase the number of smoke free units, in</td>
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<tr>
<td>multi-unit housing to 50 units</td>
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<tr>
<td>Source: Tobacco Free Network</td>
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<tr>
<td>Frequency: Annual</td>
</tr>
</tbody>
</table>

| **Long Term Indicators**                                     |
| By December 2016, decrease the number of women that smoke     |
| during pregnancy, with Medicaid as a payer source, from 42%   |
| to 37%                                                       |
| Source: Perinatal Data System                                |
| Frequency: Annual                                            |

| Increase the number of residents that report that they live  |
| in homes where smoking is prohibited from 70.4% to 71%        |
| Source: NYS EERFSS                                           |
| Frequency: Annual                                            |

**Oswego Hospital Goals:**
In its efforts to reduce the incidents of diabetes, heart failure and COPD, Oswego Health will partner with the Oswego County Health Department to offer Chronic Disease Self-Management (CDSM) classes. The health partners will utilize the CDSM program developed by Stanford University’s Patient Education Research Center to achieve this goal.

Oswego Health employees trained in the program will offer at least two CDSM classes each year of the plan. The health system will target those individuals in rural areas and senior citizens, the county’s most fragile groups from a health status standpoint. The anticipated results include: Empowering community members to improve their own health by providing them with education and tools and to also reduce hospital admissions for those enrolled in the program.

To complement the CDSM classes, Oswego Health’s Certified Diabetes Educator will provide diabetes counseling to hospital patients and outpatients. In addition, the Educator will continue to offer two free monthly diabetes support groups.

**OBJECTIVE 1.1 By June 30, 2014 Increase the number of smoke free units in multi-unit housing to 50 units**

**Background**

Source: NYS DOH Prevention Agenda Action Plan, HP 2020

Evidence Base: The Community Guide

Policy Change (Y/N): Yes

Action Plan

Activity: Receive statements of support from landlords that have tobacco policies to use in education of community

Target Date: June 30, 2014

Resources Required: Time, expertise

Lead Person/Organization/Abby Jenkins/Oswego County Tobacco Free Network

Anticipated Product or Results: List of smoke free MHU

Progress Notes:

Activity: Develop list of smoke free MHU rentals to distribute to the public

Target Date: December 31, 2014

Resources Required: Staff time, travel

**Objectives:**
- By December 31, 2017, increase by at least five percent the number of adults with arthritis, asthma, cardiovascular disease or diabetes who have completed a CDSM program.
- By December 31, 2017, increase by at least five percent the number of individuals receiving outpatient diabetic education and attend diabetes support groups.

**Measurements of Effectiveness**
- Staff will routinely track and evaluate the health status of participants.
- Measure the number of active sites providing CDSM programs in Oswego County.
- Measure the number of enrolled adults who have successfully completed the CDSM program, received outpatient diabetic education or attended a support group.

**Modification Strategy**
Hold status meetings with the involved health partners to evaluate progress and achievement of goals.
Sustainability and Engagement
NYC Dept. of Health and Mental Hygiene, and St. Barnabas Hospital, NYC

New York City Department of Health and Mental Hygiene: Community Health Assessment and Community Health Improvement Plan Appendix

1. The DOHMH Partner Portal (launching in 2014) will allow partnering stakeholders to more easily connect both with DOHMH and each other (a need that was identified during the Take Care New York listening sessions held throughout each of the five boroughs in April-May 2013). The Portal provides organizations committed to working on Take Care New York priorities with a mechanism to register for Interventions for Partners (achievable and measurable actions organizations can implement to advance CHIP/TCNY goals). In addition, organizations can utilize the portal to connect with other organizations working on similar priority areas, share resources and request technical assistance. The portal also provides a means to learn about upcoming trainings and events held by both DOHMH and other organizations through a community calendar for registered partners.

A major goal of the portal is to increase partner engagement with both the TCNY agenda and implementation of IFPs. Centralizing resources and streamlining partner communication with both DOHMH and among organizations working on similar priorities will assist partners in implementing measurable interventions that align with TCNY/CHIP programmatic goals.

2. Take Care New York Hospital interventions technical assistance is available to hospitals interested in implementing one or more interventions. The Take Care New York Hospital website, and materials disseminated to hospital CEOs include links to intervention implementation guidance and staff are available to answer questions.

3. Quarterly Take Care New York symposiums will be held on priority areas identified by community partners, to facilitate ongoing stakeholder input on the progress and implementation of the Community Health Improvement Plan (Take Care New York (TCNY)). The symposiums will serve as a forum to share best practices, data and solicit input and feedback on CHIP implementation. The quarterly symposiums will also allow TCNY and agency staff to assist stakeholders, through technical assistance and resource sharing, in implementing their selected Take Care New York Interventions for Partners (IFPs) DOHMH has developed and disseminated. In addition to these quarterly meetings, DOHMH will highlight some of the interventions, DOHMH has developed and disseminated.

IX. ENGAGEMENT WITH LOCAL PARTNERS

St. Barnabas Hospital and the Community Service Program Workgroup are committed to continue to leverage a high level of collaboration and participation in improving the health and well-being of our patient population and community residents. The CSP Workgroup and local partners will maintain an active and ongoing relationship by participating in monthly meetings and in between meetings will communicate by email and phone regarding important project updates, progress and modifications.

Many of the workgroup members have been involved since 2009. All new members receive an orientation to the functions and responsibilities of the Community Service Plan Workgroup and the priorities of the three-year plan. These responsibilities are reviewed annually or as needed. During the regularly scheduled monthly meetings, workgroup members mutually empower one another and renew their commitment to the success of the three-year plan; engage and support all major initiatives; review and evaluate the intervention programs representing the voice of the community.

The CSP Workgroup and community stakeholders are scheduled to kick off the CSP initiatives outlined above in January 2014. The first meeting will address confirmation of the workplan with defined roles and responsibilities to successfully execute the intervention projects. At that time the workgroup will
Summary Observations

• About 31% (n=18) LHD CHA-CHIPs and 24% (n=29) Hospital CSPs are noted as “overall good report” by two reviewers

• Strengths: collaboration and use of formal processes to identify priorities

• Challenges: sustaining collaborative effort, tracking progress and outcomes, incorporating measures/objectives to track progress on disparities
What’s Next: Communication, Dissemination and Technical Assistance Strategies

• Ad Hoc Committee Engagement
• Communication Tools
  • Feedback letters to local health departments and hospitals
  • NYS DOH Website
  • Prevention Agenda brochure
  • Stakeholder fact sheets
• Tracking Indicators and Dashboard
• NYS Health Foundation Local Grants
• Training and Technical Assistance
  • In Person Evidence based Approaches to Preventing Chronic Disease
  • Additional TA on Chronic Disease and Mental Health and Substance Abuse
### Prevent Chronic Diseases

<table>
<thead>
<tr>
<th>Prevention Agenda (PA) Indicator</th>
<th>Data Views</th>
<th>PA 2017 Objective and Most Recent Data</th>
<th>Annual Progress Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - Percentage of adults who are obese</td>
<td><img src="https://www.health.ny.gov/preventionagendadashboard" alt="Chart" /></td>
<td>NYS: 23.6, PA 2017: 23.2</td>
<td>NO SIGNIFICANT CHANGE</td>
</tr>
<tr>
<td>18.1 - Percentage of adults aged 18 years and older with an annual household income less than $25,000 who are obese</td>
<td><img src="https://www.health.ny.gov/preventionagendadashboard" alt="Chart" /></td>
<td>NYS: 27.9, PA 2017: 25.4</td>
<td>NO SIGNIFICANT CHANGE</td>
</tr>
<tr>
<td>25 - Utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care</td>
<td><img src="https://www.health.ny.gov/preventionagendadashboard" alt="Chart" /></td>
<td>NYS: 19.9, PA 2017: 41.0</td>
<td>SIGNIFICANTLY IMPROVED</td>
</tr>
<tr>
<td>26 - Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years</td>
<td><img src="https://www.health.ny.gov/preventionagendadashboard" alt="Chart" /></td>
<td>NYS: 67.3, PA 2017: 71.4</td>
<td>NO SIGNIFICANT CHANGE</td>
</tr>
<tr>
<td>26.1 - Percentage of adults aged 50-75 years with an income less than $25,000 who receive a colorectal cancer screening</td>
<td><img src="https://www.health.ny.gov/preventionagendadashboard" alt="Chart" /></td>
<td>NYS: 61.5, PA 2017: 65.4</td>
<td>NO SIGNIFICANT CHANGE</td>
</tr>
<tr>
<td>27 - Asthma emergency department visit rate per 10,000</td>
<td><img src="https://www.health.ny.gov/preventionagendadashboard" alt="Chart" /></td>
<td>NYS: 88.6, PA 2017: 75.1</td>
<td>SIGNIFICANTLY WORSENED</td>
</tr>
</tbody>
</table>
The New York State Health Foundation selected 17 organizations for grant awards totaling $500,000 to help 28 counties across New York State advance their goals for the Prevention Agenda.

The Awards require a local match to encourage other foundations to invest in Prevention Agenda.
Evidence-Based Approaches
To Preventing Chronic Disease: Action Plans & Implementation

Topic specific training provided to assist with implementing interventions which address the Prevent Chronic Diseases Action Plan

Focus Area 1: **Reduce Obesity in Children and Adults.**


**TOPICS Day 1**
- Implementation of Complete Streets
- Community Wide Systems to Deliver Evidence-Based Interventions to Address Chronic Disease

**TOPICS Day 2**
- Promoting Breastfeeding in Hospitals, Primary Care & Worksites
- Promoting the Adoption and Use of Nutrition Standards
Follow-up Webinars

• Nutrition Standards: http://www.informz.net/ualbany-sph/event.asp?eid=5027

• Implementation of Complete Streets: http://www.informz.net/ualbany-sph/event.asp?eid=5029

• Evidence-Based Interventions to Prevent or Manage Chronic Diseases: http://www.informz.net/ualbany-sph/event.asp?eid=5028

• Promoting Breastfeeding: http://www.informz.net/ualbany-sph/event.asp?eid=5026
Technical Assistance

• The New York State Health Foundation awarded funds to the NY Academy of Medicine to work with NYS DOH to provide technical assistance to local health departments and their partners working on two priorities:
  • Prevent Chronic Diseases
  • Promote Mental Health and Prevent Substance Abuse

• TA will build on needs identified during review of the community health improvement plans.
Staying in Touch/Communicating Your Stories

- Please send contact information from your hospital

- Please send stories about your local community’s efforts to implement your plans

prevention@health.state.ny.us
For More Information:
http://www.hanys.org/community_health/grants/prevention_agenda/

2013-2014 Prevention Agenda Technical Support

Supporting Local Community Health Improvement and Providing Technical Assistance to Communities to Implement New York State's Prevention Agenda

HANYS, in partnership with the New York State Department of Health and other regional collaboratives, has developed this resource center to support local community health improvement, and foster multi-stakeholder coalitions. This collection contains references, information, and tools from regional collaboratives to be shared among stakeholders.

This compilation was established as part of a broader Community Health Partnership, which helps communities implement the New York State Prevention Agenda 2013-2017, a blueprint for state and local communities to improve outcomes and address health disparities. Other components of this partnership included:

- “Statewide Prevention Agenda Technical Support Group” meetings held between April and September 2013, and
- HANYS-led December webinar series

Upcoming Events:

- April 29, 2014 - Local Health Department (CHA-CHIPs) and Hospital Plans (CSPs) Move Toward Making New York the Healthiest State

For more information and to view the program flyer, please visit our Events page!

Questions:

The success and population of this online resource center depends on contributions from our collaboratives. Please feel free to submit any comments, suggestions, or relevant tools and resources to Eileen Clinton at eclinton@hanys.org.
For More Information:

http://www.health.ny.gov

prevention@health.state.ny.us
Acknowledgements

Warren County
Tracy Mills, Glens Fall Hospital  tmills@glensfallshosp.org
Dan Durkee, Warren County Health Services  durkeed@warrencountyny.gov

Niagara County
Dan Stapleton, Niagara County Public Health  dan.stapleton@niagaracounty.com
Melissa Golen, Kaleida Health – DeGraff Memorial Hospital  mgolen@kaleidahealth.org

Oswego County
Jiancheng Huang, Oswego County Health Department  jhuang@oswegocounty.com
Jeff Coakley, Oswego Hospital  jcoakley@oswegohealth.org

New York City
Arlene Allende, St Barnabas Health  aallende@sbhny.org
Linda Adamson, New York City Department of Health and Mental Hygiene  ladamson@health.nyc.gov
May 29 - Webinar to focus on Dashboard and on Technical Support

Make New York the Healthiest State

New York State Prevention Agenda

Thank You