SULLIVAN COUNTY HEALTH IMPROVEMENT PLAN (CHIP)

2019-2021

2019-2021 CHIP Collaborative Partners:

Table of Contents

Executive Summary

Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)

A Community Health Assessment (CHA) identifies key needs and issues of a community through the systematic, comprehensive data collection and analysis. Sullivan County Public Health Services and Catskill Regional Medical Center representatives participated in a year-long regional process that included Hudson Valley county health departments and hospitals with HealtheConnections, to update data and gather community input through community surveys and focus groups to inform the 2019-2024 Community Health Assessment.

A Community Health Improvement Plan (CHIP) is a long-term effort to address public health problems based on a CHA. CHIPs are strategic plans that set priorities and measurable objectives to address the needs of a community. This is a collaborative process between the health department and key, diverse stakeholders in the community including Catskill Regional Medical Center to coordinate efforts, establish priorities, and combine resources to guide evidence based health promotion strategies and interventions.

The 2019-2021 Sullivan County CHIP includes a year-long effort to identify two overarching priority areas chosen for Sullivan County, NY: 1) Prevent Chronic Disease, and 2) Improve Mental Health and Prevent Substance Use.

Progress continues to be made in Sullivan County to improve health outcomes, particularly in these areas:

- A reduction in adult smoking rates from **24.5% in 2013-14 to 18.4% in 2016 (BRFSS).**
- A reduction in teenage pregnancy from **19.6% in 2012 to 16.7% in 2016** (age 15-17 per 1,000).
- The percentage of adults (aged 18-64) with health insurance increased from **82.4% in 2013 to 91.9% in 2016.**
- Premature birth decreased from **12.4 (2013) to 10.2 (2016),** nearly meeting the prevention agenda goal of 10.1. However, health disparities by race continue to exist for Black and Hispanic women, who have higher rates of premature births.

Of note for increased focus are the following concerns:

- The age-adjusted suicide rate (2014-16) in Sullivan County is **15.1 per 100,000**, compared to the NYS rate of **8.0 per 100,000** and the Prevention Agenda goal of 5.9. This speaks to the need for improved mental health and substance use prevention and intervention services and education.
- The percentage of adults who are obese increased from **28.3 (2013-14) to 31.7%** (BRFSS, 2016).
- The percentage of children and adolescents who are obese is **21.6% compared to 17.3%** in NYS excluding NYC (2014-16).
- The percentage of adults who received a colorectal cancer screening based on the most recent guidelines aged 50-75 yrs. was **only 53.7%** compared to the NYS rate of **68.5%** and the Prevention Agenda goal of 80%.
    - Colorectal, lung and breast cancer are the leading types of premature death due to cancers for Sullivan County residents.
- The age-adjusted heart attack hospitalization rate per 10,000 population in Sullivan County is significantly higher than the NYS rate. The hospitalization rate increased **from 14 (2011) to 24.3** (2014) per 10,000 for Sullivan County residents, compared to **14.8** for NYS (excl. NYC) in 2014.

- The percentage of the population with low income and low access to a supermarket or large grocery store improved in Sullivan County from **6.34% (2010) to 4.85% (2015).** However, access to nutritious and affordable food continues to be a significant factor for families and impacts health outcomes.
- More recently, from 2015 to 2019, a few small grocery stores in remote, rural areas of the county have declined to participate in the SNAP (food stamps) and the NYS Division of Nutrition WIC program, which provides access to low income pregnant women, infants and children to nutritious food to improve health outcomes.

Process for Selection of Priority Areas

To assess the needs of Sullivan County residents and identify Prevention Agenda priorities, there was extensive secondary data review and analysis through the CHA Collaborative between HealtheConnections, seven local health departments and seventeen hospitals region wide. Data from that review included but was not limited to: American Community Survey, Behaviors Risk Factor Surveillance System, County Health Rankings & Roadmaps, HRSA Data Warehouse, numerous sources from the New York State Department of Health (NYSDOH) Prevention Agenda Dashboards and Community Health Indicator Reports, New York State Education Department and Hudson Valley Patterns for Progress.

HealtheConnections and Sullivan County Public Health Services conducted the Mid-Hudson Regional Community Health Survey, a randomized telephone survey that collected the residents' perceptions surrounding health and resources in their communities. Focus groups with human service providers that serve underrepresented populations were also held. Representatives from S.A.L.T., the Sullivan County Health Services Advisory Board, and the Sullivan County Rural Health Network participated in reviewing data and providing focus group input in April, May, June and September 2019. The purpose of the focus groups was to collect information on the issues specific to individuals who may be dealing with more complex health issues than the general population. These agencies provide support for persons with low-income, veterans, persons experiencing homelessness, the aging population, and people with a mental health diagnosis or those with a substance use disorder.

An overall review of the data was provided by the Sullivan County Rural Health Network Board members, Drug Prevention Task Force, and Health Equity/Common Ground committees, and the Sullivan County Health Services Advisory Board between June 2019 and November 2019. Approximately 25 partners, including hospitals, health care providers, community-based organizations, community members and academia, were in attendance. The groups provided a review of the most current data in all prevention agenda priority areas, current community priority areas of concern from SALT forums (Sullivan Allies Leading Together), the Sullivan County Office for the Aging and Community Services (mental health unit) assessments, and current leading efforts of Sullivan County Rural Health Network subcommittee efforts to address health disparities. The Sullivan County Rural Health Network (RHN) board and full membership and Health Services Advisory Board (HSAB) participated in an identification process that allowed attendees to vote on the two Prevention Agenda Priorities for the 2019-2021 CHIP. This process included a review of the impacts that the social determinants of health have on health outcomes; and discussions of both assets and barriers in each of the selected priority areas. These meetings occurred during the months of June, September, October, and November 2019. Final RHN and HSAB board approvals of the CHIP document will take place in early December, as well as review and approval by the Board of Catskill Regional Medical Center.

Identified Priority Areas

All of these processes highlighted a common understanding that there continues to be a need for improved coordination of efforts among the many partner organizations who seek to improve health and quality of in Sullivan County, a mostly rural county that differs from its Hudson Valley partner counties in geography, income, and workforce. A long term investment in key evidence-based interventions that are focused on two priority areas are necessary in order to realize sustainable improvement in outcomes.

Prevent Chronic Disease
Improve Mental Health and Prevent Substance Use

Who is involved and how can the broader community be involved?

Leaders from Sullivan County Public Health Services (SCPHS), Catskill Regional Medical Center and its community partners will be responsible for recruiting additional partners and/or community members through the 2019-2021 CHIP cycle. Additionally, SCPHS and Catskill Regional Medical Center has strong partnerships with dozens of organizations serving its residents, including two federally qualified health care centers, private medical providers, SUNY Sullivan, Tuoro Medical College and School of Dentistry, NYU Medical College, PRASAD Children's Dental Health Program, Sullivan County BOCES, community-based organizations, and other not for profit organizations serving a broad variety of community needs including transportation, housing, faith communities, food pantries, and organizations that provide economic stability to low income residents.

SCPHS has established multiple coalitions, including multiple committees through the Sullivan County Rural Health Network, the Maternal, Infant Health Collaborative, and the Sullivan County Visitors Association, in addition to co-leading and participating on a large number of countywide coalitions including the breastfeeding coalition, the oral health committees, and the health equity/common ground committee. These coalition partners will be mobilized to address the health areas of focus and emerging issues for the CHA/CHIP 2019-2021 cycle. When feasible, community forums and surveys will be conducted to engage the broader community at-large. Access to this document as well as the full Community Health Assessment will be provided on the Sullivan County Public Health Services Department website found here: http://sullivanny.us/Departments/Publichealth/Healthrelateddataandreports under "Health Related Data and Reports," and can also be located on the Catskill Regional Medical Center website at https://www.crmcny.org/about-us/community-service-plan. These documents will also be shared with community partner organizations, Rural Health Network members, the Sullivan County Public Health Services Advisory Board, Sullivan County management and leadership, and the Sullivan County Legislature.

Within each of the identified priorities, the need for improvements in health outcomes will be addressed through the concentration of efforts in areas of the county with the highest rates of morbidity and mortality, the most pressing economic needs, and in areas where there are significant health disparities.

Within the priority area of **Prevent Chronic Disease**, the following focus areas, goals and interventions were chosen (*numbers correspond to the New York State Prevention Agenda*):

Prevent Chronic Diseases Action Plan

- Focus Area 1 - **Healthy Eating and Food Security**
- Focus Area 2 - **Physical Activity**
- Focus Area 3 - **Tobacco Prevention**
- Focus Area 4 - **Chronic Disease Preventive Care and Management**

Priority Area: **Prevent Chronic Diseases**	**Focus Area 1: Healthy Eating and Food Security** Overarching Goal: Reduce obesity and the risk of chronic disease
	Goal 1.1 Increase access to healthy and affordable foods and beverages
	Objective 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults)
	Intervention 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results.
	Objective 1.9 Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults)
	Intervention 1.0.5 Increase the availability fruit and vegetable incentive programs Systematic evidence reviews find that financial incentive programs can increase affordability, access, purchases, and consumption of fruits and vegetables.

Priority Area: **Prevent Chronic Diseases**	**Focus Area 2: Physical Activity** Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1 Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.
	Objective 1.7 Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among all adults)
	Intervention 2.1.1 Implement a combination of one or more new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes): Street pattern design and connectivity Pedestrian infrastructure

Priority Area: **Prevent Chronic Diseases**	Bicycle infrastructure Public transit infrastructure and access
	Goal 2.2 Promote school, child care and worksite environments that increase physical activity.
	Objective 2.2 Decrease the percentage of children with obesity (among public school students in NYS exclusive of NYC)
	Intervention 2.2.1 Implement the Centers for Disease Control and Prevention (CDC) Comprehensive School Physical Activity Program in school districts through Local School Wellness Policy Committees aligned with school district educational outcomes; Local School Wellness Policy requirements; School Health Improvement Plans; CDC's Whole School, Whole Community, Whole Child Model; New York State Education Department's Every Student Succeeds Act Plan; School Health Index and Wellness School Assessment Tool (WellSAT) assessments; school staff and teacher professional development and training standards, and with resource or materials support.
	Objective 2.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults)
	Intervention 2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs. Open streets….etc.
	Intervention 2.2.3 Implement a combination of worksite-based physical activity policies, programs, or best practices through multi-component worksite physical activity and/or nutrition programs; environmental supports or prompts to encourage walking and/or taking the stairs; or structured walking-based programs focusing on overall physical activity that include goal-setting, activity monitoring, social support, counseling, and health promotion and information messaging.

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Priority Area: **Prevent Chronic Diseases**	**Focus Area 3: Tobacco Prevention** Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 3.1 Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products by youth and young adults
	Objective 3.1.2 Decrease the prevalence of combustible cigarette use by high school students

Priority Area: **Prevent Chronic Diseases**	*Objective 3.1.3 Decrease the prevalence of vaping product use by high school students*
	Intervention 3.1.2 Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.
	Goal 3.2 Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; and disability.
	Objective 3.2.3 Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among adults with income less than $25,000).
	Intervention 3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quit line.

Priority Area: **Prevent Chronic Diseases**	**Focus Area 4: Preventative Care and Management** Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 4.1 Increase cancer screening rates for breast, cervical and colorectal cancer
	Objective 4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines
	Intervention 4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness and demand.
	Objective 4.1.5 Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines.

	Intervention 4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.

Within the priority area of **Improve Mental Health and Prevent Substance Use Disorders,** the following focus areas and goals were chosen (*numbers corresponding to the New York State Prevention Agenda*):

Promote Well-Being and Prevent Mental Health and Substance Use Disorders Action Plan

- Focus Area 1 - **Well-Being**
- Focus Area 2 - **Mental Health and Substance Use Disorders Prevention**

Priority Area:	Focus Area 1: Well-Being
Improve Mental Health and Prevent Substance Use	**Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan**
	Objective 1.1 Increase the number of programs and initiatives available that integrate social and emotional approaches across the lifespan, and increase participation in these programs for County residents.
	Intervention 1.1.4 Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education.
Priority Area:	**Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages**
Improve Mental Health and Prevent Substance Use	*Objective 1.2.1 Increase the number of programs and initiatives available that integrate social and emotional approaches across the lifespan, and are evidence-based home visiting programs.*
	Intervention 1.2.1 Implement evidence-based Home visiting programs: These programs provide structured visits by trained professionals and paraprofessionals to pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

	Objective 1.2.2 Increase New York State's Community Scores by 7% to 61.3%
	Intervention 1.2.2 Mental Health First Aid is an evidence- based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises (such as suicidal thoughts or behavior, an acute stress reaction, panic attacks or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (such as depressive, anxiety or psychotic disorders, which may occur with substance abuse).

	Focus Area 2. Mental Health and Substance Use Disorders Prevention
Priority Area:	**Goal 2.1 Prevent underage drinking and excessive alcohol consumption by adults**
Improve Mental Health and Prevent Substance Use	*Objective 2.1.1 Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days by 10% from 27.1% in 2017 to 24.4%.*
	Intervention 2.1.1 Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access.
	Intervention 2.1.2 Implement School based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors. Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use.
	Intervention 2.1.6 Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration.

Priority Area: **Improve Mental Health and Prevent Substance Use**	**Focus Area 2. Mental Health and Substance Use Disorders Prevention**
	Goal 2.2 Prevent opioid and other substance misuse and deaths
	Objective 2.2.2 Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.8 per 1,000 population. Baseline: 36.5 per 1,000.
	Intervention 2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine.
	Intervention 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.

Priority Area: **Improve Mental Health and Prevent Substance Use**	**Focus Area 2: Mental Health and Substance Use Disorders Prevention**
	Goal 2.5 Prevent suicides
	Objective 2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.
	Intervention 2.5.5 Promote connectedness, teach coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program.

CHIP Implementation Plan

IMPLEMENTATION PLAN
PRIORITY AREA: Prevent Chronic Diseases
FOCUS AREA 1: Healthy Eating and Food Security
Overarching Goal: Reduce obesity and the risk of chronic diseases **Goal 1.1: Increase access to healthy and affordable foods and beverages** **Objective #1:** By December 31, 2021, decrease the percentage of adults ages 18 years and older who are overweight or obese by 5% from 64.6% to 59.6%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016) **Objective #2:** By December 31, 2021, decrease the percentage of school aged children and adolescents who are overweight or obese by 5% from 37.7% to 32.7%. (Data Source: NYSDOH Student Weight Status Category Reporting System, 2019) **Strategies that address disparity: #1, #2, and #3 (Persons with low socioeconomic status (SES) and concentrated in areas with high racial/ethnic minorities)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Increase the number of institutions with nutrition standards for healthy food and beverage procurement, with emphasis in the Villages of Monticello and Liberty.	Draft polices, engage stakeholders with community-based organizations (CBOs) and worksites to adopt policies	**Staff Time:** *Cornell Cooperative Extension, Sullivan County Government* **Implementation Partners:** *CBOs, Small retailers, Catskill Regional Medical Center (ORMC), Sullivan County Public Health Services & Sullivan 180*	January 2019-December 2021	Number and type of worksites, municipalities, CBOs, and hospitals to develop and adopt policies to implement nutrition standards including cafeterias, snack bars, vending machines, CSAs and corner stores	Increased access and consumption of healthier foods and beverages
(2) Work with school districts to implement multi-component school-based obesity prevention interventions, with emphasis in the Villages	Encourage districts to prohibit advertising and promotion of less nutritious foods and beverages, increase the availability of healthier foods and beverages	**Staff Time:** *Cornell Cooperative Extension (CCE), Eat Smart New York (ESNY)* **Implementation Partners:** *School districts, Catskill Regional Medical Center*	January 2019-December 2021	Number of schools that improve nutrition policies and practices Number schools that adopt and implement comprehensive and strong local	Increased access and consumption of healthier foods and beverages

of Monticello & Liberty.	and provide healthy eating learning opportunities			school wellness policies	
(3) Increase availability of affordable healthy foods especially in communities with limited access through sustaining funded farm markets	Maintain current farm markets in Monticello & Liberty, growing the number of farms who participate and continue growth of mobile market outreach.	**Staff Time**: *CCE*	Ongoing seasonal May-November (2019-2021)	Number of participants and farmers	Increased availability of locally produced items and availability in low income areas directed towards those without transportation
(3 cont.) Increase availability of affordable healthy foods especially in communities with limited access through sustaining locally funded farm markets	Increase participation of farm markets that take SNAP benefits and WIC checks and increase number of SNAP and WIC participants who use their benefits at farm markets	**Staff Time:** *Sullivan County Public Health Services, Women Infants and Children (WIC), Office for the Aging, Department of Social Services,*	Ongoing seasonal May-November (2019-2021)	Dollar amount of Fresh Connect Coupons used at markets EBT transaction dollar amount Dollar amount of senior coupons and veteran coupons issued at markets	Increased percentage of low-income and aging adults with access to fresh fruits and vegetables

IMPLEMENTATION PLAN
PRIORITY AREA: Prevent Chronic Diseases
FOCUS AREA 1: Healthy Eating and Food Security
Overarching goal: Reduce obesity and the risk of chronic diseases **Goal 1.3 Increase Food Security** **Objective #1:** By December 31, 2021, decrease the percentage of adults with perceived food insecurity by 3% from 10.7% to 7.7%. (Source: Feeding America, 2019) **Objective #2:** By December 31, 2021, decrease the percentage of adults who report consuming less than one fruit and less than one vegetable daily by 2% from 28.7% to 26.7%. Source: NYSDOH Expanded Behavioral Risk Factor Surveillance System, 2018

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Screen for food insecurity, facilitate, and actively support referral, with focus in the high-need town of Monticello.	Develop standardized definition and screening questions for food insecurity	**Staff Time:** *Catskill Regional Medical Center, Hudson River Healthcare*	January 2020-March 2020	Developed standardized definition and question to measure food security	Ability to collect hospital and medical provider data in relation to food insecurity.
	Creation of internal policies and practices to consistently screen for food insecurity in both pediatric and adult populations	**Staff Time:** *Catskill Regional Medical Center & Catskill Regional Medical Group* **Support Partners:** *SC PHS, Eat Smart New York, Federation for the Homeless, Crystal Run Healthcare*	January 2020-December 2021	Number of health practices that screen for food insecurity and facilitate referrals to supportive services	Increased awareness among healthcare providers about food insecurity and increased number of food insecure residents connected to resources
	Regular updating of food pantries listings and other local emergency food services.	**Staff Time:** *SC PHS, CCE, Eat-Smart NY, SALT, Sullivan 180* **Support Partners:** *Food bank of the Hudson Valley, Federation for the Homeless, CACHE*	January 2020-June 2020	Number of food pantry lists available to healthcare providers	Increased awareness among healthcare providers about where to refer patients
(2) Increase the availability fruit and vegetable incentive programs	Create an incentive program for the purchasing of fruits and vegetables at local farm markets	**Staff Time:** *CCE* **Support Partners:** *CRMC, CRMG, HRHC* **Advisory Capacity:** *Food bank of the Hudson Valley,*	Seasonal during Farm Markets March 2020-November 2021	Number of coupons distributed by providers Number of coupons redeemed at Farmer's Market	Increased number of residents with access to funds for healthy foods

		Federation for the Homeless, CACHE Wholesome Wave			

IMPLEMENTATION PLAN					
PRIORITY AREA: Prevent Chronic Diseases					
FOCUS AREA 1: Healthy Eating and Food Security					
Overarching goal: Reduce obesity and the risk of chronic disease **Goal 2.1:** Promote school, childcare and worksite environments that support physical activity for people of all ages and abilities. **Objective #1:** By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 2% from 20.7 to 18.7%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016) **Objective #2:** By December 31, 2021, increase the percentage of adults age 18 years and older who participate in leisure-time physical activity by 2% from 72.4%. (Data Source: BRFSS, 2016) **Objective #3:** By December 31, 2021, decrease the percentage of elementary & middle and high school with obesity students by 2% from 20.1% to 18.1% and 24.8% to 22.8% respectively. (Data Source: Student Weight Category Status, 2016-2018) **Strategies that reduce disparities: #1 and #2 (Families with low SES and high rates of obese children)**					
Evidence Based Strategy	**Activities**	**Lead Partners**	**Timeframe**	**Evaluation Measure**	**Outcome: Product/Result**
(1) Encourage school districts to implement Comprehensive School Physical Activity Programs (CSPAP) particularly in the high need Villages of Monticello and Liberty.	Draft policies, engage with school districts and stakeholders during wellness committee meetings to adopt policies Increase the number of schools with comprehensive, strong and supported local school wellness policies by providing childhood obesity education.	**Staff Time:** *Eat Smart New York, CCE, Fallsburg School District, Monticello Central School District and Liberty Central School District* **Support Partners:** *Catskill Regional Medical Center*	January 2019-December 2021	Number of schools implementing CSPAP components	Increased number of students with opportunities for physical activity throughout the school day
(2) Implementation of the obesity prevention guidelines	Work with local gyms, CBOs and school districts to implement the	**Staff Time:** *CRMC, Boys & Girls Club, CCE, Studio Ayo Fitness,*	January 2019-December 2021	Number of students participating in the program	Increased number of students with access to physical activity and education around

utilizing the 5-2-1-0 model with a focus in school districts with high rates of overweight and obese school-aged children	"Warrior Kids" educational program emphasizing at least 1 hour of physical activity a day and allow participants to engage in 30 minutes of additional physical activity one day for four weeks	*PRASAD (Oral Health Education)* **Support Partners:** Monticello Central School District, Liberty Central School District, Town Parks & Rec Departments including camp program directors.		Percentage of program participants reporting intent to be more physically active (1 hour per day)	the importance of daily physical activity
(3) Implement a combination of improved pedestrian, bicycle or transit transportation system components that support safe and accessible physical activity	Promote and assist municipalities with the adoption and implementation of complete streets policies and components with local municipalities	**Staff Time**: CCE, Sullivan County Planning Department, Sullivan County Department of Public Works	January 2019-Decemeber 2021	Number of complete streets policies adopted Percent of residents and roads affected by policies Number of places that implement new or improve existing community planning and transportation interventions	Increased number of adults meeting physical activity guidelines Increase the percentage of adults who walk or bike to get from one place to another

IMPLEMENTATION PLAN					
Priority Area: Prevent Chronic Diseases					
Focus Area 3: Tobacco Prevention **Goal 3.3 Eliminate exposure to secondhand smoke** **Focus Area 3:** Reduce Illness, Disability and Disease Related to Tobacco Use and Secondhand Smoke Exposure					
Goal 3.3.1: Promote tobacco use cessation, especially among populations disproportionally affected by tobacco use including: low SES; frequent mental distress/substance use disorder; and disability **Objective #1:** By December 31, 2021, decrease the prevalence of cigarette smoking by adults ages 18 and older by 3%.					
(1) Use media and health communications to highlight the dangers of tobacco use and reshape social norms	Create a media campaign	**Staff Time:** *SC PHS, Sullivan 180, Alcoholism & Drug Abuse Council (ADAC)* **Support Partners:** *Tobacco Free Action Communities (TFAC),* local community organization, school districts, Catholic Charities of Orange, Ulster and Sullivan Counties	November 2019-December 2020	Number of posters distributed Number of presentations at schools and community events	Increased knowledge among youth regarding the dangers of vaping and combustible tobacco
(2) Promote Medicaid benefits for tobacco cessation services and free cessation classes available in Sullivan County.	Distribution of Medicaid benefits to target populations Host facilitator trainings for Freedom from Smoking Host Freedom from Smoking classes	**Staff Time**: *SC PHS, CRMC* **Support Partner:** *American Lung Association & Tobacco Free Action Communities (TFAC)*	January 2019-December 2021	Number of Freedom from Smoking trainings Number of individuals trained in Freedom from Smoking Number of persons completing Freedom from Smoking program	Increased number of people trained Increased number of adults referred for tobacco cessation Increased number of individuals reducing or quitting smoking

IMPLEMENTATION PLAN

Priority Area: Prevent Chronic Diseases

Focus Area 4: Preventative Care and Management

Goal 1.1: Increase cancer screening rates for breast, cervical and colorectal cancers, especially among disparate populations.

Objective #1: By December 31, 2021, increase the percentage of adults receiving breast cancer (baseline 64%), cervical (baseline 69%), and colorectal cancer (baseline 53.7%) screenings by 2% respectively, based on the most recent screening guidelines.

Data source: NYS Behavioral Risk Factor Surveillance Survey, 2018

Strategies that address disparity: #3 (Persons with low SES and concentrated in areas with high racial/ethnic minorities)

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Remove structural barriers to cancer screening by working with employers to provide employees with paid leave or the option to use flex time for cancer screenings	Sullivan County Worksite Wellness Committee to connect to worksites to establish paid leave policies for screenings	**Staff Time:** *Sullivan 180, CCE, CRMC, SC PHS* **Support Partners:** *Cancer Services of the Hudson Valley, Tobacco Free Action Coalition, SCPHS*	January 2019-December 2021	Number and type of worksites that adopt practices and policies that reduce structural barriers to cancer screening Number of employers with policies for flex time or paid time off for cancer screenings	Increased number of adults able to receive cancer screenings
GOAL 1.2: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and pre-diabetes and obesity. **Objective #1:** By December 31, 2021, decrease the percentage of pre-diabetic adults by 2% from 9.6% to 7.6%. Data source: NYS Behavioral Risk Factor Surveillance Survey, 2016 **Objective #2:** By December 31, 2021, decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups Strategies that address disparity: #3 (Persons with low SES and concentrated in areas with high racial/ethnic minorities)					
(1) Connect pre-diabetic patients to local PreventT2 course taught by a certified lifestyle coach.	Hospital diabetes team to educate local providers about PreventT2.	**Staff Time:** *CRMC,* **Support Partners:** *Sullivan 180, HealtheConnections, Hudson River Healthcare, SCPHS*	January 2019-December 2021	Number of Sullivan County residents who participate in a Prevent T2 course. Baseline -0	Increased number of adults able to prevent diagnosis of diabetes.
(2) Implement The American Lung Association's Asthma-	SCPHS, public health nurses and BOCES via school based nurses	**Staff Time:** *SCPHS* **Support Partners:** *SCPHS, Asthma*	January 2020 - December 2021	Number of Sullivan County school nurses and public health nurses who	Increased number of nurses and schools educated on

Friendly Schools Initiative™ to provide a comprehensive approach to asthma management in schools		*Coalition, SC BOCES*		participate in asthma education courses and train the trainer events. Baseline -0	asthma prevention and management of chronic disease.

IMPLEMENTATION PLAN					
Priority Area: Improve Mental Health and Prevent Substance Use					
Focus Area 1: Promote Well-Being					
Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan. **Objective #1:** By December 31, 2021, reduce the percentage of Sullivan County disconnected youth by 5%, from 16.7% to 11.7%. Source: Measure of America, 2018					
Evidence Based Strategy	**Activities**	**Lead Partners**	**Timeframe**	**Evaluation Measure**	**Outcome: Product/Result**
(1) Parenting education to decrease early education gaps amongst disparate populations in Monticello & Liberty.	Creation of a Basics Sullivan Coalition that is able to support the wide-spread usage of the Boston Basics model for early parenting skills development.	**Staff Time:** *CRMC, Childcare Council, SCPHS* **Support Partners:** *Local libraries, schools, Sullivan County, Head Start and MISN*	January 2019-December 2021	# of organizations on the Coalition. # of Basics host sites. # of Basics participants	Increase of children who are school ready by kindergarten and improved social connectedness of young families in Sullivan.
(2) Increase utilization of home visiting programs and community health workers.	Utilization of a Comprehensive Perinatal Referral Form to connect pregnant and post-partum women with valuable services and programs.	**Staff Time:** SCPHS, CRMC **Support Partners:** *First Way Life Center, MISN, CRMC, Crystal Run, Hudson River Healthcare, SALT*	January 2019-December 2021	# of comprehensive perinatal referral forms completed # of Healthy Families participants, # of referrals to SCPHS maternal child health nursing	Increase in # of Sullivan families receiving structured visits by trained professionals and paraprofessionals, particularly those at risk, providing parents with the skills and resources to raise children who are physically, socially and emotionally healthy.

(3) Increase participation and utilization of evidence based resources to promote well-being.	Provide Mental Health First Aid Programs for local health and human services professionals as well as the general public.	**Staff Time:** CRMC **Support Partners:** HealtheConnections SCPHS, Sullivan 180, NAMI, SALT, SC Youth Bureau	January 2019-December 2021	# of participants in adult Mental Health First Aid programs. # of participants in youth MHFA programs; participant evaluations of all MHFA offerings.	Reduced stigma around mental health disorders and improved community readiness, education and response to mental health issues and crisis.
(4) Provide exposure and education to School Based Mental Health programming in Monticello and Liberty School Districts.	Provide Mental Health First Aid programs for local health and human services professionals as well as the general public.	**Staff Time:** *CRMC* **Support Partners:** *HealtheConnections Sullivan 180, SCPHS, NAMI, SALT, SC Youth Bureau*	January 2019-December 2021	# of Participants in Adult Mental Health First Aid programs. # of participants in Youth Mental Health First Aid programs. Participant evaluations of all Mental Health First Aid offerings.	Increase number of students with coping skills and improved resilience

IMPLEMENTATION PLAN

Priority Area: Improve Mental Health and Prevent Substance Use

Focus Area 2. Mental Health and Substance Use Disorders Prevention

Goal 2.2 Prevent opioid and other substance misuse and deaths

Intervention 2.1.2 Implement School based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors. Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Implement School based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST)	Implement SBPS Life Skills Training in all Sullivan County school districts	SALT, CCE, SCPHS	January 2020 - December 2021	Number of schools who have implemented Life Skills Training (LST)	Increase the number of integrated support and education programs to help teens reduce and ultimately

					eliminate their substance use
Intervention 2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine					
Evidence Based Strategy	**Activities**	**Lead Partners**	**Timeframe**	**Evaluation Measure**	**Outcome: Product/Result**
Buprenorphine is an appropriate treatment for people who are dependent on opioids, such as heroin and prescription drugs. (OASAS, SAMSHA)	Increase the number of local providers certified in buprenorphine treatment.	SCPHS, CRMC, CRHC, GHVHCS, HRHC	January 2020-December 2021	Increased number of providers who can treat opioid substance use disorder (baseline: 8)	Increase in number of providers treating opioid substance use disorder ; increased access to care
Intervention 2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy					
Evidence Based Strategy	**Activities**	**Lead Partners**	**Timeframe**	**Evaluation Measure**	**Outcome: Product/Result**
Trauma informed care as an evidence based practice to improve staff training and ability to reduce substance use and risk factors in populations served	Provide ACES and Trauma Informed Care training to staff of all County health and human services departments	SCPHS, SC Government Depts: Mental Health, Social Services, OFA, Public Health, Youth Bureau	Jan 2020- Dec 2021	Number of policies and/or implementation of policies, baseline: 2	Increase in number of policies and/or implementation of policies

IMPLEMENTATION PLAN					
Priority Area: Improve Mental Health and Prevent Substance Use					
Focus Area 2. Mental Health and Substance Use Disorders Prevention					
Goal 2.2 Prevent opioid and other substance misuse and deaths					
Intervention 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.					
Evidence Based Strategy	**Activities**	**Lead Partners**	**Timeframe**	**Evaluation Measure**	**Outcome: Product/Result**
Train community members, first responders, and public on naloxone use	Expand the number of opioid overdose prevention (naloxone) trainings to general community and	SCPHS, SALT, Catholic Charities	Jan 2020 -Dec 2021	Increase number of individuals in community/county trained in naloxone administration by 20%; baseline 600	20% Increased availability of/access to overdose reversal trainings to prescribers,

	additional first responders				pharmacists and consumers

IMPLEMENTATION PLAN					
Priority Area: Improve Mental Health and Prevent Substance Use					
Focus Area 2. Mental Health and Substance Use Disorders Prevention					
Goal 2.5 Prevent Suicides					
Objective 2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.					
Intervention 2.5.3 Create protective environments: Reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches, reduce excessive alcohol use					
Evidence Based Strategy	**Activities**	**Lead Partners**	**Timeframe**	**Evaluation Measure**	**Outcome: Product/Result**
CALM and Safe Talk training, or similar evidence based interventions to educate public on reducing lethal means among persons at risk of suicide	Provide educational and training events, and social media promotion awareness of evidence based interventions to reduce suicide risk	SCPHS, Youth Bureau, Mental Health, Social Services, CCE, CRMC – RISE (Rape Intervention Services & Education)	Jan 2020 - Dec 2021	Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000. Sullivan Co. Baseline: 15.1 age adjusted rate/100,000 (2014-16) Percent of providers who completed Counseling on Access to Lethal Means (CALM) training	Increased number of family and community members who complete lethal means counseling training

Sullivan County CHIP Participating Partners

2018-19 Health Services Advisory Board / Sullivan County Public Health Services:	
	Affiliation
Bruce E. Ellsweig, MD, Chairperson	Family Practice, Primary Care - Crystal Run Healthcare
Sam Avrett, MPH	Consultant, The Fremont Center
Jennifer Candela, LCSW	HRHCare - Monticello
James Dennis, R. PH, MS	Pharmacist
M. Cecilia Escarra, MD	Executive Director, PRASAD Children's Dental Health Program
Nancy McGraw, LCSW, MBA, MPH	Public Health Director, Sullivan County Public Health Services
Joan Patterson, RN, MSN	Director of Operations – Sullivan County, Crystal Run Healthcare
Patrina Phillip-King, MD	OB/GYN HRHCare- Monticello
Carol Ryan, RN, MPH	President and Director, Health Promotion Strategies
Gladys Walker	Community member, volunteer

Sullivan County Rural Health Network Board Members 2019	
	Affiliation
Colleen Monaghan, MPA Chairperson	Cornell Cooperative Extension of Sullivan County
Martin Colavito	Sullivan Allies Leading Together (S.A.L.T.)
Robert Dufour, Ed. D.	Sullivan County BOCES Superintendent
Lise-Ann Deoul	Director, Office for the Aging
Cecilia Escarra, DDS	PRASAD CDHP
Dan Grady	Hospice of Orange & Sullivan Counties
David Lee, MD MS	NYU School of Medicine, Langone Director of the Health Geographics Research Initiative
Nancy McGraw, LCSW, MBA, MPH	Public Health Director, Sullivan County Public Health Services
Laura Quigley	Center for Workforce Development, Sullivan County
Jay Quaintance	President, SUNY Sullivan
Sandra Rowland, Vice Chair	Sullivan 180
Jonathan Schiller	CEO, Catskill Regional Medical Center
Joseph Todora, MSW, LMSW	Commissioner, Division of Health & Family Services
Robert Wingate	Catskill Area Health Education Center
Bernice Zierler, RPAC	Refuah Health Center

Sullivan County CHIP Participating Partners

2018-19 Sullivan County Rural Health Network Committee Members:		RHN Committees			
Committee members:	Title/Affiliation	Drug Prevention Task Force	Oral Health Committee	Perinatal Drug Task Force	Health Equity / Common Ground Committee
Nancy McGraw, LCSW, MBA, MPH,	Public Health Director, Sullivan County	X	X	X	X
Wendy Brown, RN, MS	Deputy Director, Sullivan County Public Health Services	X	X	X	X
Jill Hubert-Simon, MS	Public Health Educator, SCPHS	X	X	X	X
Catherine Paci, BS, Ed.	Public Health Educator, SCPHS	X	X	X	X
Lise-Anne Deoul	Sullivan County Office for the Aging	X			X
Joseph Todora, MSW, LMSW	Commissioner, Division of Health & Family Services	X			
Melissa Stickle, MSW, CASAC	Director, Community Services	X		X	
Carol Ryan, RN, MPH	Health Promotion Strategies	X	X	X	X
Dean Scher, PhD, LCSW	CEO, Catholic Charities Community Services of Orange and Sullivan	X			
Jeff Skaar	Chief Behavioral Health Officer, Catholic Charities CSOS	X			
Cecilia Escarra, DDS	PRASAD CHDP		X		X
Martin Colavito	S.A.L.T.	X			X
Heidi Reimer	Community Services	X			
Margaret Fonsera	Refuah Health Center		X		
Stephanie Brown	Assistant County Mgr. Sullivan County	X	X		
Jay Manzo	HRHCare	X			
Julie Pisall	Kingfisher Project/WJFF	X			
Rickie Craft	Community member	X			
Albee Bockman	Mobil Medic, Coroner	X			
Kristy Sigelakis	SC Probation	X			
Anna Bernhardt	SC Probation	X			
John Liddle	Deputy County Manager	X			
Brenda Sherman, MSW	Social Worker, SCPHS	X			
Zytona Reynolds	Hudson Valley Community Services	X			

2018-19 Sullivan County Rural Health Network Committee Members:		RHN Committees			
Committee members:	Title/Affiliation	Drug Prevention Task Force	Oral Health Committee	Perinatal Drug Task Force	Health Equity / Common Ground Committee
Maleka Jackson	Maternal Infant Services Network	X		X	
Andrew Oni	Catskill Regional Medical Center	X			X
Amanda Langseder	Community Health Director, CRMC		X	X	X
Jennifer Lansiquot	Community Health Coordinator, CRMC		X	X	
Moreen Lerner	Healthy Bethel Committee				X
Vanessa Sotelo	Action Toward Independence				X
Robert Dufour, Ed.D.	Superintendent, BOCES	X	X		X
Jennifer Tompkins	St. John's Episcopal Food Pantry				X
Diane Scheide	Vicar, Delaware Catskill Episcopal Ministry	X			X
Amy Kolakowski	Catholic Charities, CCCSOS	X			
Sandi Rowland	Executive Director, Sullivan 180	X	X	X	X
Catherine Freda, PHN	Sullivan County Public Health Services	X			
Jennifer Reinhardt	Dynamic Youth Community	X			
Jackie Kellachan	Maternal Infant Services Network (MISN)		X	X	
Jennifer Ocasio	The Alcoholism & Drug Abuse Council of Orange County	X			
Julio Fernandez	National Guard	X			
Kathleen Christie, LCSW	Community member	X			
Laurel Bertram, LCSW	Community member	X			

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