Community Health Improvement Plan 2013–2017

Tompkins County Health Department

CONTENTS

Introduction

THE TOMPKINS County Health Department (TCHD) led the process of engaging the community to determine two 2013–2017 Prevention Agenda priorities for Tompkins County. This process began with informing and educating key stakeholders on the intent and purpose of the Community Health Assessment (CHA), the Community Health Improvement Plan (CHIP) and the Community Service Plan (CSP) in 2012. The Prevention Agenda serves as a catalyst for action for improving health and reducing health disparities in the state and in local communities.

Tompkins County chose *Preventing Chronic Disease* and *Promoting Mental Health and Preventing Substance Abuse* as its two priorities to improve the health of the community. Disparate populations were identified through analysis of socioeconomic data of County zip codes and local data including TCHD and community organization data.

Process

Tompkins County Health Planning Council and Tompkins Health Network

Tompkins County Health Department engaged the Advisory Board of the Health Planning Council (HPC) whose members are also members of the Tompkins Health Network (THN), Tompkins County's rural health network early in the process of the CHA development. HPC and THN are programs of the Tompkins County Human Services Coalition. The Public Health Director and the Director of the Health Promotion Program are board members. The Health Department has a long standing relationship with the HPC. The organizations have collaborated on many community health related projects including the 2010–2013 Prevention Agenda and Community Health Assessment.

Members of the Board include representatives from the Long Term Care/Adult Protective Services at the Department of Social Services, Lifelong (a senior citizens' center), Ithaca Free Clinic, Department of Emergency Response, County Office for the Aging, Kendal Continuing Care and Retirement Care Community, Excellus Health Plan, Inc., Community Health Foundation of Western and Central New York, Ithaca College Gerontology Institute, Hospicare and Palliative Care Services of Tompkins County, Community Health and Home Care, Cayuga Medical Center, Finger Lakes Independent Center, Ithaca City School District, and Tompkins County Health and Mental Health Departments. Monthly board meetings are open to the public and community members and agency and healthcare professionals regularly attend speaker presentations that are part of the monthly meeting program.

Discussion in anticipation of the 2013–2017 began at HPC board in 2012 including a review of accomplishments related to the 2010–2013 Prevention Agenda. At the March

2013 board meeting, TCHD led a discussion of HPC board members to identify community health priorities. Board members were asked to prioritize areas based on their professional knowledge and experience in the community. Mental Health and Substance Abuse emerged as an important and multifaceted concern. The issues affect people across the lifespan, impact the management of chronic diseases, affect emergency management services and emergency department visits. Appropriate services and placement of people with mental health issues are problems that are community responsibilities. Other concerns fell into socioeconomic areas and various other social determinants of health.

Community Survey

TCHD released an online survey in May 2013 to solicit input from various community sectors and the public at large to identify the health challenges in the County. The five-question survey asked respondents to prioritize the five New York State Prevention Priorities for Tompkins County. Responses to open ended questions explained reasons for their first two priority choices. Targeted requests to take the survey were made to County departments, community organizations, Health Planning Council board, educators, health care professionals, Immunization Coalition, Friends of Stewart Park, Cornell Wellness, Chamber of Commerce members, local legislators and the Board of Health. A media release resulted in coverage by the *Ithaca Journal, Tompkins Weekly* and an interview with the Public Health Director on WHCU radio newscast. A notice was sent out twice to the Human Services Coalition listserv (2,500 subscribers).

There were 266 responses to the survey; the greatest response at 35% was from those who identified as a community member. Other sectors were healthcare, business, education, non-profit organizations, government and "other." The results for four of the priorities were equivocal. The prevention of HIV, STD, vaccine preventable diseases and health care infections was not chosen by survey respondents as a focus for community effort.

A review of the open ended responses indicated that concerns tended to focus on prevention of chronic disease and its impact on the largest number of people and cost of chronic diseases. Promoting healthy women, children, and infants revolved around the importance of healthy start and the fact that children are the future. Specific focus areas in this category were similar to prevention of chronic disease — nutrition and healthy lifestyles. Mental Health and Substance Abuse issues — the standout in the five priority areas — centered on inadequate services, funding and access, and the implications that mental health and substance abuse have on the other Prevention Priorities. A presentation on the results of the community survey was made to the Health Planning Council at its monthly board meeting on June 10, 2013. This presentation also served as a progress report and update on the Community Health Assessment.

Based on survey results and the HPC March 11 discussion and interest, Promoting Mental Health and Preventing Substance Abuse stood out as a community priority.

Tompkins County Legislature and Tompkins County Board of Health

On August 27, 2013 TCHD convened Tompkins County Legislators and members of the Board of Health to identify the areas that, in their opinion should be the focus of Tompkins County to improve the health of the community. Twenty four focus areas were drawn from the three remaining Prevention Priorities: Prevention of Chronic Disease, Healthy and Safe Environments, and Healthy Women and Children. The prevention of obesity in children and adults as well as improving the design and maintenance of the built environment were strong favorites among the group.

Progress Report and Priorities Recommendation

PROGRESS of the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) and the Community Service Plan (CSP) was the focus at the October 16, 2013 HPC board meeting. A draft of the CHA was forwarded to the HPC board prior to the meeting. Representatives from Cayuga Medical Center (CMC), the County's only hospital stated that its catchment area included six counties in the region and its CSP included the priorities of all of those counties.

TCHD recommended *Preventing Chronic Disease* and *Promoting Mental Health and Preventing Substance Abuse* as the County's priorities based on the Community Health Assessment and the process undertaken to identify priorities. The Board concurred. Discussion progressed on continuing evidence based programs that already have been implemented through collaboration of community partners. Sustainability of these programs and reducing disparities would be important factors. Next steps include forming work groups particularly with Promoting Mental Health and Preventing Substance Abuse.

Preventing Chronic Disease: Strategy 1

Aim

Address prevention and management capacity for Tompkins County residents diagnosed with Asthma or Chronic Lower Respiratory Diseases (CLRD).

Why

- The asthma hospitalization rate for ages 0–4, 5–14, and 0–17 in Tompkins County are higher than any of the other Top-5 counties,[1] and higher than the upstate median (SPARCS data).
- The self-reported rate of adults who were ever diagnosed with asthma is higher in Tompkins County than in any of the other Top-5 counties, and higher than the upstate median. The rate of adults who currently have asthma is higher than the upstate median (BRFSS data).
- Cayuga Medical Center reports an increasing number of patients with Chronic Obstructive Pulmonary Disease (COPD).
- A county asthma coalition successfully launched a locally developed Asthma Action Plan.
- A newly formed Healthy Lungs Coalition — developed from the asthma coalition to address a range of respiratory illnesses — has launched a series of classes on respiratory issues, which are free and open to the public.

Action

Recommended Step	Brief Description

Eliminate exposure to secondhand smoke and third hand smoke, especially in people's homes
 	
Take actions — evidence based or promising practices — that will assure that renters are not exposed to smoke drifting into their apartment from other units, or to residual smoke from a previous tenant.
 	
Responsible: Tobacco Free Tompkins, Tompkins County
	• Increase percent of adults living in homes in which smoking is prohibited (BRFSS).
	• Increase number of rental properties where smoking is prohibited in all units (no data)
	  o Work with landlords and housing authorities
	• Increase number of renting adults who support no smoking policy throughout their building (Community Tobacco Survey).
	  o May support tenant advocacy for landlords to adopt a new policy; may drive market to favor smoke-free properties.
	• Promote importance of smoke-free living through media and community education
	• Promote cessation of tobacco use and the NYS Smokers' Quitline.

[1] "Top-5 Counties" refers to the top five among New York counties for *Health Outcomes* by the University of Wisconsin County Health Rankings, University of Wisconsin Prevention Health Institute, County Health Rankings and Roadmaps. 2013 Rankings for New York. www.countyhealthrankings.org/new-york. Accessed Aug. 2013. The Top-5 are (in ranking order): Livingston, Rockland, Tompkins, Putnam, and Saratoga. See Tompkins County Community Health Assessment 2013–2017 for more details.

Recommended Step	Brief Description

Health Department	Attention to Disparate Populations
	• Focus on low income housing and low SES tenants:
	  o may be less able to relocate;
	  o have fewer choices in housing selections;
	  o are more likely to use tobacco.
	• Focus on families with young children in areas of high poverty (e.g., Groton, Ithaca city)
	• Focus on ZIP codes with highest rate of children with asthma (e.g., Newfield)

Address in-home risks (Healthy Neighborhood Program strategies)
 	
Increase outreach and home visits to provide the best possible opportunity for household level assessment, education, and corrective action.
 	
Responsible: Environmental Health Division, Tompkins County Health Department
	• Increase the number of persons with asthma who receive assistance with assessing and reducing exposure to environmental risk factors in their home.
	• Increase percentage receiving information about community and self-help resources for asthma management.
	• Increase percentage of persons with asthma who:
	  • receive education about recognizing early signs and symptoms and how to respond.
	  • receive written asthma management plans from their physician.
	  • use daily therapy that also monitors their peak expiratory flow.
	
	Attention to Disparate Populations
	• Focus on families with young children in areas of high poverty (e.g., Groton, Ithaca city).
	• Focus on ZIP codes with highest rate of children with asthma (e.g., Newfield).

Strengthen *Healthy Lungs for Tompkins County* coalition Provide a central resource node for communication of trends and needs seen on the ground at all community and care sectors. *Responsible: Health Promotion Program, Tompkins County Health Department; Cayuga Medical*	• Reassess key stakeholders and coalition partners, and invite them to participate • Establish long term agenda and focus areas • Maintain and update as needed the Tompkins County Asthma Action Plan, and continue promoting its use or use of other NYSDOH and/or physician approved plan • Establish education goals, expectations, and schedule • Develop marketing plan to expand education outreach • Develop communications plan to expand professional outreach and interest • Coordinate Chronic Disease Self Management Program delivery targeting individuals with asthma

Recommended Step	Brief Description
Center	and/ or CLRD • Garner earned media for asthma and CLRD issues, such as press releases that localize national or state health news, announcing educational programs, introducing new *Healthy Lungs* partners, and describing services available to the community
Increase provider referrals to local services *Responsible: Participating organizations listed previously*	• Support for tobacco use cessation • Support for establishing a smoke-free home • Support for eliminating common household risks • Enrollment in CDSMP
Engage Community Partners Broaden outreach beyond *Healthy Lungs* coalition to encourage continual improvement in monitoring and communication. *Responsible: Organizations previously listed as responsible.*	• Potential key partners may include o Health Planning Council o Ithaca City School District o Newfield School District o Ithaca Free Clinic o Greater Ithaca Activities Center (GIAC) o Southside Community Center • Develop an outreach plan that may include a Web presence, brochure, poster for provider offices, personal visits to targeted agencies

Achievement

Improve access to and fulfillment of evidence-based and promising practice interventions that support reduction and management of asthma and of chronic lower respiratory disease.

Objective 2.3.2: By December 31, 2017, increase by 200 the number of low income housing units that are smoke-free as part of a policy covering all housing units within a building or property.
Alternative: By December 31, 2017, among Tompkins County residents who live in a multi-unit dwelling, increase the percent who are in favor of a policy that prohibits smoking everywhere inside their building from 68.5% (2012) to 85.6% (Community Tobacco Survey).

Objective 3.3.2: By December 31, 2017, increase the number of youth with current asthma who have received a written asthma action plan from their school or health care provider (method to be determined).

Short-Term Performance Measures

- Number of low income rental housing units that are leased as smoke-free

- Development and launch of anonymous tracking of asthma-related nurse visits in primary and secondary schools, and receipt/ use of a written asthma action plan.
- Number of low income households assessed for asthma triggers by the Healthy Neighborhood Program
- Total persons in attendance at Healthy Lungs educational programs and activities
- Earned media (e.g., news stories, feature articles) for asthma and CLRD-related issues

Long-Term Performance Measures

- Rate of youth asthma E.D. visits for ZIP code 14867 (SPARCS)
- Rate of hospitalizations for asthma, ages 0–17 years (SPARCS)
- Rate of adults reporting ever-diagnosed asthma (eBRFSS)
- Rate of adults reporting currently have asthma (eBRFSS)
- Rate of adults living in a home in which smoking not permitted (eBRFSS)

Preventing Chronic Disease: Strategy 2

Aim

Increase Availability of, Access to, and Use of Evidence-Based Interventions (EBIs)

Why

- Estimates indicate that there are between 3.7 and 4.2 million (25–30% adult New Yorkers with prediabetes. A diagnosis of prediabetes increases the risk of developing type 2 diabetes without lifestyle interventions to improve health, 15% to 30% of people with prediabetes will develop type 2 diabetes within five years.
    - Tompkins County: The 2008–2009 Behavioral Risk Factor Surveillance System (BRFSS) indicates an age-adjusted adult obesity rate of one in five (20%). For those with only a high school education or less, the rate nears one third (30%). Fifty-five percent of adults self-report that they are either overweight or obese further increasing the prevalence of this risk factor for diabetes and other chronic conditions.

- EBIs promoted by the New York State Department of Health for the prevention and/or management of chronic conditions have significantly helped people develop self-management skills and adopt behaviors to prevent and/or manage their conditions, leading to enhanced well being and improved health outcomes.
    - BRFSS 2008–2009 Tompkins County: 7.4% of adults aged 18 and older who have diabetes
    - BRFSS 2008–2009 Tompkins County: 14.9% of adults aged 18 and older who have current asthma

Action

Recommended Step	Brief Description
Identify community partners engaged in EBI delivery *Responsible:* HSC, TCHD, YMCA	• The Human Services Coalition of Tompkins County (HSC) and the Tompkins County Health Department (TCHD) will offer the Chronic Disease (CDSMP) and Diabetes Self Management Program (DSMP). • HSC, TCHD and the YMCA will offer the Diabetes Prevention Program (DPP). • One more community partner will be recruited to offer the DPP. • HSC and TCHD have MOUs with the Quality and Technical Assistance Center (QTAC) and are registered with the CDC as community providers
Determine populations of focus *Responsible:* HSC, TCHD	• Employers who will offer the DPP, CDSMP and DSMP as a health plan benefit or reimburse employees for completing these programs. • DPP will be offered in rural areas — targeted by zip code — and in a minority community setting
Identify and address gaps to increase the availability and use of EBIs among the populations of focus *Responsible:* HSC	• Train more lifestyle coaches and identify participating organizations to ensure that the DPP program is offered continuously in the County. • Identify funding sources for DPP coach training
Collaborate with delivery partners to promote the benefits of EBIs plus develop implementation strategies for promotion and referral *Responsible:* TCHD	• Identify outreach opportunities in the community to promote the benefits of EBIs including worksites, community organizations, faith communities, community/ neighborhood groups. • Educate community through targeted efforts on definition of the medical term of prediabetes — risks, prevention through lifestyle changes. Promote DPP.
Increase health care provider recommendations/referrals to EBIs *Responsible:* HSC, TCHD	• Explore QTAC online portal that allows for health care provider referral/direct registration • Expand DPP to larger physician practices through outreach efforts including meetings with key office staff, contact with Nurse Practitioners Association
Monitor and evaluate progress to identify new promotion avenues and opportunities for expansion of EBI	• Consultation with QTAC to obtain information and data • Periodic review of data and progress made toward increasing promotion and referral • Frequent contact and meetings between partners to assess progress and develop strategies

Recommended Step	Brief Description
Responsible: HSC, TCHD	• Periodic report to Health Planning Council board (program of HSC) and CHIP steering committee

Achievement

Objective 3.3.1: By December 31, 2017, increase by at least 5% the percentage of adults with asthma, cardiovascular disease, pre-diabetes, diabetes (or other chronic disease) who have taken a course to learn how to manage their condition.

Short-Term Performance Measures

- By 2016, one employer in Tompkins County will offer the DPP as a health plan benefit or reimburse employees (who are diagnosed with prediabetes or are at risk for diabetes) for completing the DPP program
- By 2015, 70% of large physician practices will refer eligible patients to DPP, DSMP, and/or CDSMP
- By 2017, three of the ten DPP classes will be offered in rural areas (targeted by zip code) and/or a minority community setting.

Long-Term Performance Measures

- Percentage of adults who are overweight or obese

Promoting Mental Health and Preventing Substance Abuse: Strategy 1

Aim

Implement Screening, Brief Intervention and Referral to Treatment (**SBIRT**) to provide effective interventions in the Emergency Department to reduce future incidents of high risk use of alcohol and drugs, and assist in facilitating linkage and referral of those in need to appropriate treatment and counseling services.

Why

- Drug-related hospitalizations have increased 67% in Tompkins County over the last 10 years based on the 3-year average age-adjusted rate per 10,000 population (SPARCS).
- Tompkins County's rate of adults who self-report heavy drinking is at the upper end in comparison with the other Top-5 Counties for *Health Outcomes* in the University of Wisconsin County Rankings.
- MEB and Substance Abuse professionals saw a need for this service and conducted a pilot program. The pilot proved promising and warranted another round of implementation.
- Other integration initiatives are in planning stages within our community, including Brief Alcohol Screening for College Students (BASICS) and Behavioral Health Consultant (BHC) programs.
- **SBIRT** is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries. Risky substance use is a health issue and often goes undetected.
- By screening for high risk behavior, healthcare providers can use evidence-based brief interventions focusing on health and other consequences, preventing future problems.

Action

Recommended Step	Brief Description
Collaborate with delivery partners to promote the benefits of SBIRT plus develop implementation strategies for promotion and referral *Responsible: CARS, CMC, CU*	• Cayuga Addiction Recovery Services (CARS) • Emergency Department, Cayuga Medical Center (CMC) • Gannett Health Center, Cornell University (CU) • Hammond Health Center, Ithaca College • Alcohol & Drug Council of Tompkins County • Family & Children's Service of Ithaca • Tompkins County Mental Health Department • The Mental Health Association in Tompkins County
Facilitate SBIRT Training	• NYS OASAS guidelines for SBIRT protocol certification or training provider certification • Boston University School of Public Health, BNI ART

Recommended Step	Brief Description
Secure funding	• Apply for NYS Health Foundation matching grant
Determine populations of focus	• Among those screened by a 16-week CARS pilot program, approximately half were college students. College students will continue to be an important target population, however addressing the needs and circumstances of full time residents is also important Attention to Disparate Populations • Low SES, transient, and/or homeless populations should be accommodated
Increase health care provider referrals to/from SBIRT	• Report updates and progress regularly to o Health & Human Services Committee o Mental Health Subcommittee o Substance Abuse Subcommittee • Establish protocol with CMC-ED and CMC-BSU • Maintain ongoing communication and interaction with key delivery partners • Establish and maintain communications with law enforcement agencies
Monitor and evaluate progress to facilitate expanding networks and secure necessary support.	• Stakeholder engagement • Referrals, connections to services, development of outreach channels

Achievement

Goal 3.1: Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.

Short-Term Performance Measures

- Patients who received Stage 1 screening
- Patients who received Stage 2 Brief Intervention
- Stage 2 patients who left with an action plan
- Patients who received Stage 3 Referral to Treatment
- Stage 3 patients who were confirmed connected to services

Intermediate-Term Performance Measures

- Post SBIRT contacts reporting follow through with Referral or Action Plan
- Post SBIRT contacts reporting reduction in high risk use

Long-Term Performance Measures

- Drug-related hospitalization rates (SPARCS)

Promoting Mental Health and Preventing Substance Abuse: Strategy 2

Aim

Support collaboration among leaders, professionals and community members working in mental, emotional and behavioral well-being (MEB) health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.

Why

- Mental health and substance abuse across the age spectrum is a concern of Tompkins County residents. Lack of services or gaps in services were highlighted as a problem in the community.

Action

- Tompkins County Health Department convened members of the Health Planning Council Board (CHIP) steering committee who were interested in further assessing and addressing the issue on October 28, 2013 to discuss a plan of action. The Tompkins County Department of Social Services, Cayuga Addiction Recovery Services (CARS), and Gannett Health Services at Cornell University attended. The Tompkins County Mental Health Department, Cayuga Medical Center (CMC) and Lakeview Mental Health Services were unable to attend this initial meeting.
- Discussion:
    - Screening, Brief Intervention and Referral to Treatment (SBIRT) – an evidence based program that was piloted at Cayuga Medical Center in collaboration with CARS during the Spring 2013 academic semester. The use of SBIRT services at CMC emergency department allowed for timely and meaningful intervention and strengthened partnerships among CMC, Gannett Health Services, Ithaca College Counseling and Psychological Services (CAPS) and CARS to improve patient access and linkage to necessary community services. Based on the effectiveness of this model the Health Planning Council and the Mental Health work group decided that implementing SBIRT should be a community focus. Funding would be sought to sustain it.
    - College students are part of the Tompkins County community and impact local services. Projects and programs addressing MEB targeted to students are important considerations.
    - Gannett Health Services at Cornell University — Brief Alcohol Screening and Intervention for College Students (BASICS) — the aim is to reduce high risk use of alcohol and other drugs as well as the potentially harmful problems associated with such use. This service is available for students who want to explore their alcohol and drug use. It is designed to assist students in examining their own behaviors in a judgment free environment.

    - Cornell University — pilot project anticipated to begin on or before July 2016. Goal: Cornell seeks to increase the percent of the Cornell student population that accesses mental health services (penetration rate). The strategy is to embed mental health professionals into primary care teams as "Behavioral Health Consultants" (BHC), at ratio of approximately one BHC per 7,000 students (or one BHC per approximately three primary care physicians). The role of the BHC is to provide easy access to service, brief interventions, and where appropriate, facilitated referral to formal mental health services. This model is used with increasing frequency in Federally Qualified Health Centers, and the Military Health Systems.
- Key organizations/representatives in the community were identified who could provide additional necessary information and local data. These representatives will be invited to future meetings.

Achievement

- By June 2014 a MEB work group will be established to assess and address the local infrastructure to strengthen the collaboration among systems to promote mental health and prevent substance abuse.

Tracking Progress and Maintaining Engagement

PROGRESS reports on CHIP initiatives will be included as an agenda item for each monthly HPC board meeting. Reports will be made by those board members involved in or responsible for the initiatives. Updates will also be made at the Community Health and Access Committee, a subcommittee of the HPC board.

The Public Health Director will provide updates to Health and Human Services Committee of the Tompkins County Legislature and to the Board of Health on a routine basis.

Those organizations responsible for and involved in the CHIP initiatives will meet regularly and assess progress and recommend any mid-course corrections based on short and long term measurements outlined in the CHIP.