The Tioga County
Community Health Improvement Plan
(CHIP)

Executive Summary

A Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health problems in a community. The plan is based on the results of our Community Health Assessment and is part of the community improvement process. CHIP's are often used by health, and other governmental and human service agencies, to set priorities and coordinate target resources within a community. The plan should be a collaborative response to address the issues in that community; including but not limited to: strengths, weaknesses, challenges, and opportunities, with an overarching goal to improve the health status of a given community.

After the Community Health Assessment is complete; and all health priorities of a community have been identified; collaboration among professional partners from the local public health system (including, but not limited to: schools, health care agencies, police and fire, non-profit, faith-based, etc) and the community is essential to develop, implement and continually evaluate the CHIP.

Most communities, including ours have been doing the work (developing strategies/programs and services to improve health) of a CHIP for many years; but this is the first year that New York State is formally requiring local Health Departments to have a written Community Health Improvement Plan. Health Departments have been completing assessments for several years. As previously mentioned the CHIP is second to the Community Health Assessment (CHA); therefore it's highly recommended that one read the Tioga County Community Health Assessment 2014-2017 (and/or Executive Summary) prior to reading this CHIP.

The New York State Prevention Agenda is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them. These ideas were turned into a plan that involves a unique mix of organizations including local health departments, health care providers, health plans, community based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses whose activities can influence the health of individuals and communities that will address health disparities. The Prevention Agenda has five overarching goals and is broken into five priority areas, which are further broken into focus areas; followed by goals and objectives. Local communities are charged with identifying these priorities in their communities.

Although the Tioga County Health Department is coordinating the CHIP effort, the Steering Committee that was established and maintained to provide oversight during the CHA process, also provided guidance in the initial development stages of this CHIP and will continue to serve as an advisement council over the next four years. The committee worked meticulously for eleven months developing the CHA, with community health improvement as its end goal.

This final report was compiled by the:

Tioga County Health Department

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Public Health Educators

Vision for a Healthy Community

The main health issues and focus areas that were identified as priorities in Tioga County are:

1. **Priority Area: Prevent chronic diseases**

   Focus Area: Reduce obesity in children and adults

   Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and management in both clinical and community setting

   Focus Area: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure

2. **Priority Area: Promote mental health and prevent substance abuse**

   Focus area: Promote Mental, Emotional and Behavioral Well-Being in Communities

   Focus Area: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

These priority and focus areas will be outlined in this text along with suggested ways for improvement. This makes up the Tioga County Community Health Improvement Plan. At the beginning of the planning process the Steering Committee created a series of statements to help guide their work, thus creating a vision for the future of Tioga County.

Our vision of a healthy community is a Tioga County where …

- Strategic collaboration creates partnerships that empower community members to make informed decisions.

- There is access to and coverage of services that support affordable and appropriate health care that improves community health status.

- People understand their responsibility for personal health and have access to preventive care, disease management services, adequate education and other resources to support their decisions.

- Community members reside, work and recreate in a safe and healthy, natural and built environment. Decisions and policies to maximize environmental safety and health will be data-driven.

- A supportive and easily accessible framework is in place for community members to ensure and value a holistic (mind, body, spirit) lifestyle.

Public Health Partners

CHIP Steering Committee Partners:

Broome/Tioga BOCES
Cornell Cooperative Extension
Franziska Racker Center
Guthrie Healthcare
Mothers and Babies Perinatal Network of SCNY
Our Lady of Lourdes Hospital
Owego Gymnastics
Riverview Manor Nursing Home
Rural Health Network of SCNY
Southern Tier Independence Center
Tioga County Board of Health
Tioga County Council on Alcohol and Addiction
Tioga County Department of Mental Hygiene
Tioga County Department of Public Health
Tioga County Department of Social Services
Tioga County Emergency Management
Tioga County Legislature
Tioga County Office of the Aging
Tioga County Rural Ministry
Tioga County Soil and Water Conservation District
Tioga County Department of Solid Waste
Tioga County Economic Development & Planning
Tioga Downs
Tioga Opportunities
United Health Services (Hospital & Stay HealthyCenter)
United Way of Tioga County
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Jack Salo
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*Special recognition is given to Lisa Bobby for her assistance and guidance with this endeavor.

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Background

The Tioga County Health Department determined the Community Health Assessment (CHA) would be completed internally for the 2014-2017 assessment period as opposed to contracting externally as in previous years. Both Public Health Educators received training in the evidence-based model called MAPP (Mobilizing for Action through Planning and Partnerships) and were charged with carrying out the assessment for Tioga County. In January 2013 the Health Educators convened a Steering Committee of over thirty key stakeholders from several sectors of the community to assist in the planning and development of the CHA.

A Core Support Team was developed from the health department senior staff and some other individuals to assist in providing leadership and clerical support. In addition to the support team, a sub-committee was formed early on to focus on data collection, analysis and the compilation of the final document. After the CHA was finalized, the same Steering Committee was used to develop and implement the Community Health Improvement Plan (CHIP).

Monthly meetings were chaired by the Health Educators and averaged about 18 members per meeting. The typical agenda included review of the current or next phase of the model/assessment that we were working on and often included a Power Point presentation, data sharing, small group breakout sessions, and larger group discussions. The meetings served as a forum to guide the assessment process and for members to provide feedback with various perspectives along the way. The Steering Committee provided oversight in several capacities, such as selecting questions for and disseminating surveys, providing data, choosing priority tools, etc.

It is important to note that the model we used to conduct the CHA does require the process to be community-driven and, while we have acknowledged our many thanks to our Steering Committee and several other individuals for their role in this completed assessment, it never would have been possible without everyone's willingness to come together as a team to improve the health of our community in Tioga County.

NYS Prevention Agenda

The Prevention Agenda 2013 is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disabled, socio-economic and other groups. These ideas were turned into a plan that involves a unique mix of organizations including local health departments, health care providers, community-based organizations, advocacy groups, academia, employers, state agencies, schools, and businesses whose activities can influence the health of individuals and communities and will address health disparities (NYSDOH, 2013).

The Prevention Agenda has five over-arching goals and is broken down into five priority areas:

1. Prevent chronic diseases
2. Promote healthy and safe environments
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

The Prevention Agenda establishes focus areas with goals and objectives for each priority area.

It also defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socio-economic groups and persons with disabilities.

The NYS Prevention Agenda is made up of 58 objectives, 16 focus areas and several goals. In addition, there are suggested plans for interventions that communities can implement if that particular indicator showed a problem area. Interventions will be the center of focus in this Community Health Improvement Plan; however; in order for our community to concentrate on what health needs are most important, we must have a system in place for identifying the top priorities. The system will be covered in public health priority issues.

New York State Department of Health Guidelines

This CHIP will identify at least two priorities from the 2013 NYS Prevention Agenda; which were also identified as priority issues in Tioga County and will be the center of this four year plan. The CHIP will include goals, objectives, improvement strategies, performance measures (both outcome and process), a time line and identification of partners or key agencies/leaders. The end result will be a comprehensive plan of activities and interventions that are evidence-based and promising practices. Collaboration among planning participants, stakeholders, community organizations, Steering Committee members and Hospitals is essential to the success of the CHIP. Local health departments are strongly encouraged to work with their local hospitals to complete their CHA and CHIP. Under the Affordable Care Act, hospitals are required to complete a Hospital Community Service Plan, therefore collaboration is ideal. Although there is no hospital in Tioga County, five hospitals serve residents; with three as primary.

MAPP Model

Mobilizing for Action through Planning and Partnerships (MAPP) is an evidenced-based, community-driven strategic planning process model widely used across the nation for improving community health. Essentially, MAPP is an assessment tool with an ultimate goal for each community to reach optimal community health—a community where residents are healthy, safe, and have a high quality of life. MAPP has six phases and includes four separate assessments that address a variety of issues including community themes and strengths, the local public health system, health status, community resources, community needs and more. The Steering Committee assists the Health Educators in the development and implementation of these assessments and other MAPP phases. Completion of a health assessment is vital in health planning and improvement within a community. Completion of a Community Health Assessment is mandated by the New York State Department of Health and is considered a core function of public health.

Organizing for Success/Partnership Development

The first and second phases of MAPP are Organize for Success and Partnership Development. During these phases the core support team and Steering Committee was formed to prepare and implement the MAPP model. This is one of the most important parts of the planning process; making sure everyone has a voice at the table, and that there is representation from all sectors. Our goal was to represent as many sectors and voices as possible, so that the CHA and CHIP truly could be community-driven. The Tioga County Health Department determined the Community Health Assessment and Improvement Plan would be conducted internally for the 2014-2017 assessment periods, as opposed to contracting externally as in previous years.

Both Public Health Educators received training in the evidence-based model called MAPP (Mobilizing for Action through Planning and Partnerships) and were charged with carrying out the assessment for Tioga County. In January 2013 the Health Educators convened a Steering Committee of over thirty key stakeholders from several sectors of the community to assist in the planning and development of the CHA. (See the list of partners in the beginning of this document for a complete list of Steering Committee Members). A Core Support Team was developed from the health department senior staff and some other key individuals from the community.

The third phase of MAPP involves creating the vision for the County, which the Steering Committee and other Stakeholders will work to uphold during the assessment and improvement processes. The vision was shared at the beginning of this document.

"Alone we can do so little;
together we can do so much"

~Helen Keller

Community Health Champions

The Four Health Assessments

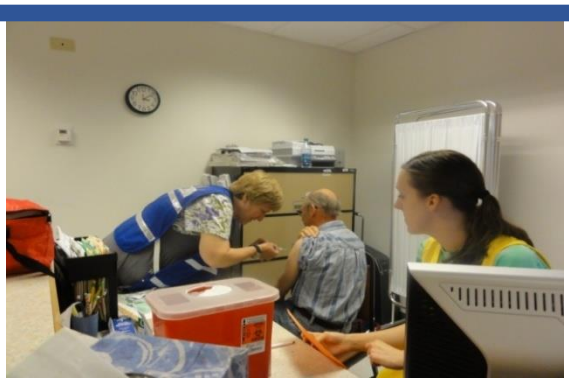
Community Health Status Assessment (CHSA) examines the health status, quality of life and risk factors for disease present in the community. The primary purpose of this assessment is to build a solid foundation for identifying and analyzing health issues and determining where the community stands in relation to peer communities, state and national data.

The data was gathered from several sources; including, but not limited to: New York State Department of Health Community Data Set, County Health Assessment Indicators, the NYS Prevention Agenda, US Census, Behavioral Risk Factor Surveillance Survey (BRFSS), Statewide Planning and Research Committee and Cooperative System (SPARCS) and others.

No physical survey was conducted during this assessment; however Steering Committee members did provide information about their agencies' services and some assisted in providing more specific data that would help in the development of this section. Additionally, key health department supervisors provided information from in-house data sources including annual reports and other publications.

Eleven physical indicators were examined, including demographic and socioeconomic characteristics, death, illness and injury rates, available resources and other factors. An attempt was made to provide the most current data; however it is important to note that in most instances there is at least a two-year (or longer) backlog at the state level. We at the local level and those at the state level feel this is acceptable for the purposes of an "assessment" and will consider it current.

Trend data is provided when available and the primary time periods addressed is 2008-2010; however additional years are provided when possible. For most of this assessment, county rates are compared to Upstate, NY State and *Healthy People 2020* goals and objectives, to gain a better understanding of where Tioga



County is, in comparison to various health indicators.

This assessment was time-consuming and labor-intensive, and was conducted simultaneously during other assessments. This laid a foundation for baseline data that existed previously but, was not in a format for easy viewing. The completed CHSA will allow us to have one resource for statistical information that is accurate, comprehensive and shows current information, trends and comparisons. This information will also be accessible to community.

While there were too many findings of the CHSA to list in this CHIP, the CHA offers a complete detailed synopsis. Here are some key findings that are related directly to the priority health issue of *Prevent chronic disease*:

Top Five Leading Causes of Death in Tioga County 2008-2010

Causes	Tioga County (Per 100,000)	NYS (Per 100,000)
Diseases of the heart *	114.65	153.13
Cancer	171.5	162.5
Alcohol-related motor vehicle injuries	65.7	34.8
Chronic lower respiratory disease (COPD)	37.5	31
Cerebrovascular disease	27.5	26.9

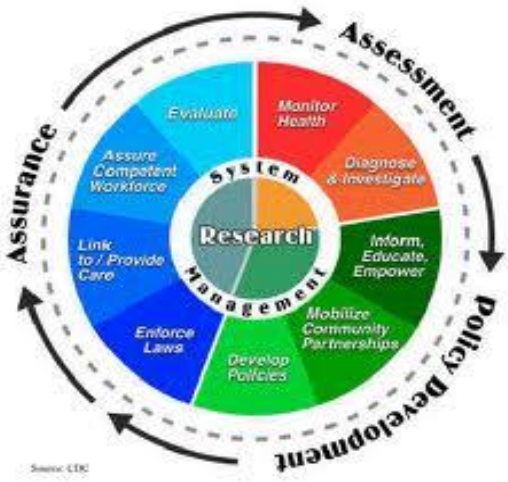
*Diseases of the heart is an avg. rate for four categories of heart related diseases (NYSDOH, 2008-2010).

- In addition to the leading causes of death, Tioga County has eleven mortality indicators that have rates higher than the NYS rate. Four of these eleven indicators fall into the fourth quartile: melanoma of the skin, congestive heart failure pre-transport mortality, alcohol-related motor vehicle injuries and deaths, and infant deaths under one year old with a rate of 3 (per 100,000) in Tioga County, compared to 2.2 in NYS and 2.7 in Upstate. The congestive heart failure pre-transport mortality rate (or deaths that occurred any place other than a hospital, clinic or medical center), for Tioga County was 13.8, 7.2 NYS and 11.4 for Upstate.
- The total crude mortality rate in Tioga County for 2009-2011 was 804.0 (per 100,000), or a total of 1,224 deaths. NYS had a total of 436,892 deaths for a rate of 748.3. In comparison, the 2010 NYS crude mortality rate was 748.3 and the US rate was 799.5, both lower than our county rate.
- The areas that had higher rates of morbidity in Tioga County when compared to NYS were: incidence of elevated lead levels in children, Pertussis incidence, self-inflicted injuries, alcohol-related motor vehicle injuries and deaths, diabetes prevalence, incidence of malignant mesothelioma, high blood pressure, newborn drug related discharges and prevalence of overweight and obese adults.
- Cancer rates for Tioga County (Lung/Bronchus and All Cancers) are higher than the NYS rate and also put the county in the fourth quartile (652.9 Tioga County vs. 545.9 NYS for all cancers).
- There were a total of 948 cancer cases from 2007-2009; therefore, the rate at which cancer occurs in the county is 652.9 (per 100,000). When compared to the NYS crude rate of 536.5, the county number is significantly higher, ranking us in the fourth quartile. Female breast cancer is most prevalent, followed by prostate cancer for males, then lung and bronchus coming in third.
- For the 2007-2009 time period the top five conditions that were responsible for the most hospitalizations in Tioga County were: diabetes (1,590), cardiovascular disease (1,161), diseases of the heart (776), unintentional injury (527) and coronary heart disease (337). These top five conditions account for nearly 49% of the total hospitalizations.
- A fourth quartile ranking is pregnant women in WIC (Supplemental/ Nutritional Federally funded program for Women, Infant and Children) who were pre-pregnancy very overweight. This group totaled 32.6% in Tioga County, while measuring 23.4% at the NYS rate.
- Of Tioga County residents, **62.1 percent of adults are considered overweight or obese,** compared to New York State's rate of 59.3.
- In Tioga County 15.2 percent of children are overweight and 18.1 are obese, making a combined total of 33.4 percent of Tioga County youth who are either overweight or obese.
- Preliminary reports for Tioga County show 66.1 percent of residents self-reported having leisure time physical activity during the past 30 days. New York State had an average of 75.3 reporting having leisure time physical activity.
- Around 48% of Tioga County youth receive a free or reduced-price lunch in 2012; the Food Bank of the Southern Tier distributed 678,551 pounds of food to Tioga County. That works out to be 134 pounds of food for every person who is in poverty.

Local Public Health System Assessment

(LPHSA) is a broad assessment involving the local public health system, defined as all organizations and entities that contribute to public health in the community known as the local public health system (including, but not limited to, health and human service agencies, emergency services, faith-based, philanthropical, police/fire and education, etc.). This assessment answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided/delivered to our community?" The Essential Public Health Services provide the fundamental framework for LPHSA activities and describe the public health activities that should be undertaken in all communities.

The Ten Essential Services of Public Health



For this assessment we used the National Public Health Performance Standards Program (NPHPSP): Local Public Health System, Performance Standards, an evidenced-based model, and developed two separate parts to this assessment. Using the assessment tool we borrowed a modified version of the survey (from Broome County Health Department) and developed an activity where the results would be combined to "grade" our public health system. The results are covered in detail in the CHA.

For the activity portion of this LPHSA, Steering Committee members were asked to identify programs and services that their agency/organization provided within each essential service. The purpose of the activity allowed us to determine what areas were weak and which areas were strong. This group exercise showed that essential services 3, 5 and 7 were provided the most; which related to working directly with the public and serving them in a health capacity. This validated that the partners at the table are truly compassionate about Tioga County residents and improving the health of our community.

Key findings from this assessment that will assist us in implementing our CHIP:

<u>Total Average of all Essential Services:</u>

- **2.58 (Out of 4)**

Results from the LPHSA survey revealed the Local Public Health System "Fully or Almost Fully" does the following (Score is out of 4):

- Collects timely reportable disease information from community health professionals who submit information on disease outbreaks (Scored 3.80).

(LPHSA continued from previous page)

- Designate an Emergency Response Coordinator. There is one at the County level and for the health department. (Scored 3.69).
- Maintains guidelines or protocols to address the handling of laboratory samples, which describe procedure for storing, collecting, labeling, transporting and delivering laboratory samples, and for determining the chain of custody regarding the handling of these samples (Scored 3.58).
- Provide health information to enable individuals and groups, including vulnerable populations and those at increased risk, to make informed decisions about healthy living and lifestyle choices and sponsor educational programs to develop knowledge, skills and behavior needed to improve individual and community health (Scored 3.20)
- Develop collaborative networks for health promotion activities that facilitate healthy living in healthy communities (Scored 3.50)
- Establish community partnerships to assure a comprehensive approach to improving health in the community (Scored 3.25).
- Coordination with the state public health system (Scored 3.25).

These areas that may not have scored as well as we would have liked, but are still important. It is important to note that prior to this CHIP, there was no formal Improvement Plan in Tioga County, and therefore some of the "grades" in these areas may be lower. Additional findings include:

- Contribute to the development and/or modification of public health policy by facilitating community improvement in the process and by engaging in activities that inform the process (Scored 2.73)
- Establish a community health improvement process which includes broad-based participation and uses information from the community health assessment as well as perceptions of community residents (Scored 2.47).
- Develop strategies to achieve community health improvement objectives and identify accountable entities to achieve each strategy (Score 2.56).
- Have access to a current compilation of federal, state and local laws, regulations and ordinances that protect the public's health (3.36).
- Assure equitable access to personal health services for all community residents (Score 2.53).
- Define personal health service needs for the general population. This includes defining specific preventative, curative and rehabilitative health service needs for the catchment areas within its jurisdiction (Score 2.31).
- Assure the linkage of individuals to personal health services, including populations who may encounter barriers to care (Score 2.40).
- Identify and address gaps in the public and personal health workforce, using information from the assessment (Score 1.73).
- Identify gaps in the provision of population-based health services (Score 2.38).

- Use information from the evaluation process to refine existing community health programs, to establish new ones, and to redirect resources as needed to accomplish LPHSA goals (Score 2.08).
- Encourage proactive interaction between the academic/research and practice communities, including field training experiences and continuing education opportunities (Score 2.00).

Community Strengths and Themes Assessment

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(CSTA) answers the three questions: "What is important to our community?", "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" This portion of the MAPP model is vital to our community as it helps us understand the community's issues, concerns and perceptions about quality of life. We were able to identify what the health priorities are and build a map of community assets. This assessment is the foundation to include the community's input for mobilizing various groups and movements during our improvement (Community Health Improvement Plan) efforts.

For this assessment a survey was created using examples from a combination of several local health department's previous CSTA (or in some cases what they used as their entire CHA). A comprehensive survey was developed covering all areas that we determined were important and/or relevant. The Steering Committee approved the final survey which was launched electronically through Survey Monkey. There were a total of 22 main questions, although most of them had sub-questions which were based on a rating system. Questions asked respondents about their perceptions on the strengths and health issues in Tioga County, quality of life factors, environmental issues, health services and their own demographic information. The survey collection was open for three months and was managed by the CHA Coordinators. A total of 354 surveys were collected. Despite falling short of our original goal of 800, we felt comfortable with this amount after our learning at the fall regional CHA/CHIP consultation meeting that two counties with populations' double and quadruple our size had collected less surveys in their assessments. Complete findings from the CSTA are available in the CHA; however, the key findings are listed below:

Respondents felt (question is in grey shaded box and responses in table by percentage answered):

Most important HEALTH RELATED ISSUE	
Mental Health (depression, anxiety, stress etc)	57.8%
Alcohol and drug Abuse	56.9%
Aging	51.3%
Obesity	48.4%
Clean and healthy environment	32.3%

Top 5 behaviors that have greatest impact on health of Tioga County	
Alcohol Abuse	72.2%
Drug Abuse	68%
Poor eating habits	62.9%
Lack of exercise	62.0%
Smoking/tobacco use	57.5%

The Four Health Assessments

Greatest STRENGTHS of the Community	
Local 24-hour police, fire and rescue services	58.3%
Low crime/violence	47.9%
Walk-able, bike-able community	44.2%
Access to parks and recreation	43.9%
Safe food supply (won't make you sick)	41.4%

Have you been diagnosed by a doctor with any of following conditions:	
I have not been diagnosed with any of these	53.3%
Obesity	20.7%
Depression	17.9%
Diabetes	11.8%
Asthma	11.5%
Heart Disease	6.9%

How important are these issues in our community?		
Preventing child abuse	Very important/High priority	89.2%
Promoting healthy mothers and babies	Very important/High priority	73.7%
Preventing substance abuse	Very important/High priority	70.8%
Promoting healthy lifestyles	Very important/High priority	70.0%
Preventing chronic disease	Very important/High priority	65.4%

Rate the health services in Tioga County		
Specialty Care	Less than sufficient	59%
Primary Care	Sufficient	58.5%
Care for infants and Children	Sufficient	50.3%
Dental Care	Sufficient	48.3%
Mental health/counseling	Less than sufficient	43.0%

Forces of Change Assessment (FOCA) identifies forces that are currently affecting or may affect the community or local public health system. This assessment answers the following questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" This assessment results in a comprehensive, focused list that identifies key forces (trends, factors or events) and describes their impact. Examining forces are important because they affect, either directly or indirectly, the health and quality of life in the community and the effectiveness of the local public health system.

This assessment must be saved for last because it encompasses all of the other assessments and can assist in identifying potential threats and opportunities for public health interventions. It also provides insight for gaps in programs and services. Furthermore, this assessment will help pave the way for identifying priority areas and implementing our CHIP.

Forces are broad and all-encompassing trends, events and factors. Trends are patterns over time, factors are discrete elements and events are one-time occurrences. When beginning this process the steering committee made sure to include social, economic, political, technological, environmental, scientific, legal and ethical categories. Steering Committee members used a brainstorming session to create lists of forces in Tioga County. Once the smaller lists were created the groups reconvened to narrow the list down to a more concrete list to identify threats and opportunities of these forces. **The top six Forces of Change in our community are:**

1. Potential for gas development
2. Underemployment/Working poor
3. Natural Disasters
4. Affordable Care Act
5. Aging population
6. Housing in Tioga County

Once we had this substantial list we were able to go through and label the threats and opportunities that affect each force. This process brought a rich discussion to the group. The members of the steering committee were from different sectors in the local public health system and had varying responses and professional opinions as to the threats and opportunities. In the end the Steering Committee had a substantial chart of what they felt were the forces of change.

The Forces of Change Assessment will be used when writing the Community Health Improvement Plan (CHIP). Whether positive or negative, these are forces that affect our local public health system in many ways and if not considered, could affect the remainder of the MAPP process. Some of these forces remain out of our control and may not impact our community for years to come. Some may remain unknown, such as natural disasters like Tropical Storm Lee or the potential of gas development. Still others we are dealing with today, such as the aging population and the housing stock for Tioga County. Identification of these forces will be useful in making sure we choose interventions that will have the largest impact on the community's health and quality of life as well as closing gaps in programs and services that may exist in Tioga County.

Public Health Priority Issues (MAPP: Stage 5)

As previously stated, the ultimate goal of a Community Health Improvement Plan is to improve the health status of a community and reduce health disparities with an emphasis on prevention. Collaboration with community stakeholders is essential to the success of a CHIP, but the interventions in the plan will be the center of focus. The goals and objectives are important because they will assist in the development of the plan; In order for our community to concentrate on what health needs are the most important, we must have a system in place for identifying the top priorities.

The Health Educators/CHA Facilitators conducted an activity with three key groups; the Steering Committee, Tioga County Healthy Communities Partnership (TCHCP) and health department senior staff (HDSS) to present/review information on the NYS Prevention Agenda (priority and focus areas). At the July meeting the Steering Committee were shown data gathered from the Community Health Status Assessment from that point. Participants were instructed to "rank" priority and focus areas (based on the NYS Prevention Agenda) based on what they thought were the top issues in the community, but also considering the data provided to them and their personal knowledge of those health indicators associated with that priority and focus area in our community.

At each meeting, individuals were given a worksheet and asked to rank the priority areas in order, with number one as most important and five least important number. Priority areas as identified above (Prevent Chronic Diseases, Promote Healthy and Safe Environments, Promote Healthy Women, Infants and Children, Promote Mental Health and Prevent Substance Abuse, Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Health Care Associated Infections). In addition to ranking the Priority areas, participants from each group were asked to rank the Focus Areas in order one through sixteen. The Steering Committee had four smaller groups, while the partnership had two and senior staff only one. During each meeting, the larger group discussions (reporting of the smaller groups to the larger) allowed the members the opportunity to discuss important issues and to sort out disputes; however, it was clear that trying to reach a consensus through this method as one large group proved more challenging. After group discussions, and reaching a majority consensus of "ranking," the health department was able to assist in combining scores and assigning numerical values to determine a weighted average for both the priority and focus areas.

Although it may seem confusing, when using the 'weighted method' the lower the numerical value represents the higher rating. In other words, the Focus Area which is determined to be the highest (or number 1) in importance would have the lowest numerical rating.

In addition to the "Group" ranking, we also compiled the average score of the individual responses (without consideration for which survey group they came from). Determining these two scores separately allowed for the significance of the three distinct groups as well as the value of individual members. Once these two scores were compiled, we then averaged the two scores to come up with a final and overall ranking of the Focus Areas. For this assessment we chose to direct our efforts on the first five focus areas which happen to fall under the two priority areas that were identified.

Public Health Priority Issues (MAPP: Stage 5)

Top Priority Areas:

Priority Issues in Tioga County 2014-2017

1. *Prevent Chronic Diseases*
2. *Promote mental health and prevent substance abuse*

Top Focus Areas (In order ranked):

- *Focus Area: Reduce Obesity in Children and Adults*
- *Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and management in both clinical and community setting*
- *Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and management in both clinical and community setting*
- *Focus area: Promote Mental, Emotional and Behavioral Well-Being in Communities*
- *Focus Area: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders*

Note: Chronic Disease was clearly the first priority area chosen by all three groups and came out first mathematically when using the weighted average calculations. The weighted calculations indicated "Promotion of Healthy Women, Infants and Children" came in second, followed by "Promote Mental Health and Prevent Substance Abuse" as the third choice. Health status data and results from our Community Strengths/Themes Assessment indicated mental health and substance abuse was more of a need and should be chosen as a priority health issue for this assessment period and be part of our improvement plan. This doesn't mean that promotion of Healthy Women, Infants and Children should be put aside. The health department along with collaborative partners, should take responsibility to see that important health issues among this indicator be examined and any interventions implemented.

Chronic Disease Information

Chronic Diseases (CD) are among the leading causes of death in the nation and New York plus have a serious impact on quality of life. The most common are: heart disease, stroke, cancer, diabetes, and arthritis. Seven out of 10 deaths among Americans each year are from chronic diseases. While (CD) can cause several conditions that are usually long in duration or slow in progression, obesity is a significant risk factor. In fact, in NYS nearly 25% of adults are obese and 35.6 % overweight. Among children age two to four in the WIC program (in NY) living in low-income families 31.5% are overweight. The second leading cause of preventable death in the US is attributed to obesity and being overweight. Health status data for Tioga County and from our community survey indicate that the epidemic has reached the local level. We need to address the issue by developing and implementing public health interventions through policy, environmental and system changes (NYSDOH, 2013).

Mental Health Information

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood to adolescence through adulthood. Mental and emotional well-being is essential to overall health. According to the New York State Department of Health, at any given time, almost

one in five young people nationally are affected by mental, emotional and behavioral (MEB) disorders, including conduct disorders, depression and substance abuse. One out of five Americans have experienced a mental health issue; however, only 38% of adults with diagnosable mental health problems and less than 20% of children and adolescents receive needed treatment. Although there is a mental health clinic in Tioga County, data clearly indicates the need for additional services. Community members also voice strong support for additional programs and services (USDOH 2013). Prevention of mental, emotional, and behavioral disorders focus on addressing known risk factors such as exposure to trauma that can affect the chances that children, youth, and young adults will develop mental health problems. Promoting the social-emotional well-being of children and youth leads to higher overall productivity and people who contribute to society, better educational outcomes, stronger increased lifespan and improved quality of life.

The following pages are our priority areas, goals and objectives to improving health in Tioga County (MAPP Phase-Action Cycle).

PRIORITY AREA – PREVENTING CHRONIC DISEASES

FOCUS AREA:	**Reduce Obesity** in Children and Adults
GOAL:	Reduce the percentage of children and adults in Tioga County who are obese
OBJECTIVE 1:	By December 31, 2017, reduce the percentage of children in Tioga County who are obese by 5% among WIC children ages 2-4 years
OBJECTIVE 2:	By December 31, 2017, increase by 10%, the number of children, ages 3-17 years who receive a BMI screening in Primary Care
OBJECTIVE 3:	By December 31, 2017, 100% of licensed day care providers in Tioga County will be offered a bi-monthly newsletter “Small Steps … to a Healthier You” prepared by the Eat Smart New York program
OBJECTIVE 4:	Create community environments that promote and support healthy food and beverage choices and physical activity
OBJECTIVE 5:	Increase breastfeeding
OBJECTIVE 6:	By December 31, 2017, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees that has a focus on chronic disease prevention
IMPROVEMENT STRATEGY DESCRIPTION:	1. Health care systems and providers will: a. Encourage primary care providers’ participation in the screening, prevention and treatment measures for obesity as part of a comprehensive approach for the prevention of childhood overweight and obesity b. Adopt breastfeeding-friendly policies for primary care, pediatric and obstetrical practices, as appropriate 2. Collaborative partners in Tioga County will create social marketing messages to

FOCUS AREA:	**Reduce Obesity** in Children and Adults
	promote breastfeeding education as the norm
EVIDENCE-BASE (cite source):	http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf http://www.cdc.gov/nccdphp/dnpao/ http://www.thecommunityguide.org/index.html http://www.health.ny.gov/prevention/obesity/preventing_childhood_obesity.htm http://www.ama-assn.org/ama1/pub/upload/mm/433/ped_obesity_recs.pdf http://www.uspreventiveservicestaskforce.org/uspstf/uspschobes.htm http://www.aap.org/obesity/index.html http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html http://www.health.ny.gov/prevention/nutrition/wic/breastfeeding/
PERFORMANCE MEASURE(S) (source):	1. NYS hospitals will participate in the NYSDOH "Great Beginnings" breast feeding initiative 2. Develop policies that encourage community-wide adoption of breastfeeding policies 3. Number of children with BMI screen in primary care (EQARR, local healthcare system data) 4. Number of small to medium worksites with wellness programs
MAJOR ACTIVITIES	1. On-going communication with providers to assess status of pediatric and adult BMI screening 2. Collaborate with Tioga County Health Department to train health care providers regarding childhood obesity identification, assessment and treatment protocol as prescribed by the U.S. Preventive Services Taskforce 3. Collaborative Partners will strive to identify women appropriate for referral to WIC and /or other resources related to breast feeding 4. Collaborative Partners will support enhancement of consumer awareness of appropriate choices and programs around diet and physical activities 5. By 2017 Healthcare systems serving Tioga County residents will move towards a baby friendly hospital encouraging breastfeeding
PROCESS/OUTCOME MEASURES	1. # or % of primary care providers conducting BMI screening 2. # and/or % of children screened for obesity 3. % of children at risk for overweight: defined as having an age- and gender-specific BMI at ≥85th to 95th percentile 4. 100% of NYS hospitals serving Tioga County residents will participate in the NYS "Beginnings NY, The Future Starts with Breastfeeding" program and achieve the *Healthy People 2020* goals by 2017 5. At least one hospital, by 2015, will begin the "Baby Friendly Hospital Initiative" application process, with the target to be designated a "Baby Friendly Hospital" by 2017; Hospital(s) achieving this will provide support and encouragement to other hospitals serving Tioga County residents 6. Collaborative Partners will implement associate wellness initiatives supportive of the Tioga County CHIP to decrease the amount of sugary drink consumption and increase participation in leisure time physical activity. Initiatives may result in metrics which include:

FOCUS AREA:	**Reduce Obesity** in Children and Adults
	a) Establish baseline employee health wellness objective b) Establishment of walkable routes; promotion of Tioga walking trails c) Number of organizations/ associates engaging in walking as exercise d) Number of organizations/ associates reporting healthy life style behaviors

PRIORITY AREA: PREVENTING CHRONIC DISEASES

FOCUS AREA :	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Setting.
GOAL:	Increase screening rates for chronic disease
OBJECTIVE #1:	By December 31, 2017, increase the percentage of women aged 50-74 years with an income of <$25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), by 5%
OBJECTIVE #2:	By December 31, 2017, increase the percentage of men aged 50-74 years who receive prostate cancer screening, based on the most recent clinical guidelines, by 5%
OBJECTIVE #3:	Increase screening rates for cardiovascular disease, especially among disparate populations
OBJECTIVE #4:	By December 31, 2017, increase the percentage of adults ages 18-85 years with hypertension who have controlled their blood pressure (below 140/90): • By 7% for residents who have a primary care provider
OBJECTIVE #5	By December 31, 2017, reduce the mortality rate for disease of the heart by 10% for residents of all ages
EVIDENCE-BASED (cite source):	NYS Information for Action # 2013-8 The Community Guide Cardiovascular Disease Prevention and Control: Clinical Decision-Support Systems (CDSS) The Community Guide Cardiovascular Disease Prevention: Team-Based Care to Improve Blood Pressure Control http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm http://www.health.ny.gov/statistics/chac/chai/chai_49.htm
IMPROVEMENT STRATEGY DESCRIPTION	1. Continued Implementation of evidenced-based chronic disease screening services 2. Develop a network of partners who will provide venues to increase access to chronic disease screening services, education and outreach 3. Identify processes to refer residents to primary care and specialty providers 4. Work with collaborative partners to remove transportation barriers to access 5. Provide education on the importance of early detection and screening guidelines
PERFORMANCE MEASURE(S)	1. Increase the % of residents receiving screening mammography by 5% over baseline established in year 1

FOCUS AREA :	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Setting.
(source):	2. Increase the % of residents receiving prostate screening services by 5% over baseline established in year 1 3. Increase residents aged 18-85 years with hypertension who have controlled their blood pressure (below 140/90), by 7%
MAJOR ACTIVITIES	1. Collaborative partners will work with primary care providers and health systems to increase screening rates, outreach and education. Foster collaboration in the community to identify underserved groups and implement programs to improve access to preventive services 2. Ensure consumer access to and coverage for preventive services, and enhance reimbursement and incentive models 3. Work with Cancer Services Program and Encore Plus to expand the number of clients served in Tioga County 4. Use social media to promote screening for chronic disease in smaller communities using satellite locations such as the Mission in Motion van or a local pharmacy
PROCESS/OUTCOME MEASURES	1. Development of measurement-based outcomes 2. Work collaboratively with the Tioga County Health Department Community Health Steering Committee to provide data on: a. % of providers adhering to screening guidelines b. Percentage of patients screened for hypertension c. Number of patients screened of breast cancer d. Number of patients screened for prostate cancer e. Number of patients with annual cholesterol screening f. Number of patients needing chronic disease education

PRIORITY AREA: PREVENTING CHRONIC DISEASES

FOCUS AREA :	Reduce Illness, Disability and Death Related to Tobacco Use and Reduce Secondhand Smoke Exposure
GOAL:	Decrease the rate of tobacco use and secondhand smoke exposure by Tioga County residents
OBJECTIVE #1:	By December 31, 2017, decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students by 10%
OBJECTIVE #2:	By December 31, 2017, decrease the prevalence of cigarette smoking by adults aged 18-24 years by 17%, from 21.6% (2011) to 5%
OBJECTIVE #3:	By December 31, 2017, two out of six municipalities will restrict tobacco marketing (including banning store displays, limiting the density of tobacco vendors and their proximity to schools)
OBJECTIVE #4:	By December 31, 2017, increase the number of local businesses that adopt a smoke-free policy
OBJECTIVE #5:	By December 31, 2017, increase the number of Tioga County residents who seek smoking cessation benefits (through Tioga County Health Dept., TCCASA and or New York State Smokers' Quitline) by 5%
EVIDENCE-BASE (cite	http://ccetioga.org/reality-check/

FOCUS AREA :	Reduce Illness, Disability and Death Related to Tobacco Use and Reduce Secondhand Smoke Exposure
source):	http://ccetioga.org/tobacco-free-tioga-program/ http://www.tccasa.org/ http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=28 http://www.hazelden.org/web/public/teenintervene.page http://www.nysmokefree.com/
IMPROVEMENT STRATEGY DESCRIPTION	1. Collaborative partners in Tioga County will continue ongoing programs for youth to educate on the importance of not using tobacco 2. Collaborative partners will work to reduce the number of public places that do not allow tobacco use 3. Use social media to educate young adults on the negative impact of tobacco use 4. Advocate for policies that reduce the impact of tobacco marketing 5. Promote the New York State Smokers' Quitline and TCCASA's free nicotine replacement program 6. Adopt smoke-free policies 7. Educate community leaders and policy makers on the problems of youth smoking
PERFORMANCE MEASURE(S) (source):	1. Number of youth groups and initiatives in Tioga County support this goal 2. Number of partners who participate in social media campaign 3. Number of evidence-based programs being used and their effectiveness 4. Number of town and village board meetings attended 5. Number of smoke-free policies signed 6. Number of Public Service Announcements released
MAJOR ACTIVITIES	1. Collaborative partners will continue to lead youth groups and initiatives that are in support of achieving this goal 2. Collaborative partners will use a social marketing campaign to educate youth and young adults on the dangers of tobacco use 3. Collaborative partners will continue evidence-based programming on substance abuse prevention including tobacco education 4. Collaborative partners will attend town and village board meetings to educate policy makers on the impact point of sale marketing has on youth smoking 5. Advertise the New York State Smokers' Quitline and cessation services at TCCASA 6. Mobilize advocates to create a demand for smoke free policies in Tioga County 7. Highlight dangers of tobacco through public service announcements

PRIORITY AREA – PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA:	**Promote Mental Health and Prevent Substance Abuse** (focus areas 1 & 2 combined to maximize improvement efforts in our community)
GOAL:	Increase the mental health status and prevent substance abuse among Tioga County residents
OBJECTIVE 1:	Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults

FOCUS AREA:	**Promote Mental Health and Prevent Substance Abuse** (focus areas 1 & 2 combined to maximize improvement efforts in our community)
OBJECTIVE 2:	By December 31, 2017, 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 5%
OBJECTIVE 3:	By December 31, 2017, reduce the percentage of youth ages 12-17 years reporting the use of non-medical use of prescription pain relievers by 5%
OBJECTIVE 4:	By December 31, 2017, reduce the percentage of adult New Yorkers reporting 14 or more days with poor mental health in the last month by 10%
OBJECTIVE 5:	By December 31, 2017, reduce the age-adjusted suicide mortality rate by 10%
OBJECTIVE 6:	Work with collaborative partners to integrate behavioral health into the primary care setting
IMPROVEMENT STRATEGY DESCRIPTION:	1. Collaborative partners in Tioga County will work to continue to incorporate mental health strategies such as evidence-based programming and character education into their programming 2. Educate employees about risk factors and warning signs of Mental, Emotional and Behavioral (MEB) disorders and ways to access support services 3. Collaborative partners in Tioga County will work to develop and support social marketing campaigns that counter social norm misconceptions about alcohol use; reduce stigma of MEB disorders; inform public about risk factors associated with substance abuse and other MEB disorders 4. Collaborative care for the management of anxiety and depressive disorders as a multicomponent healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists
EVIDENCE-BASE (cite source):	http://www.oasas.ny.gov/ http://www.omh.ny.gov/ http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/goals_objectives.htm#2rationale http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=28 http://www.tiogacountyny.com/departments/mental-hygiene-administration.html http://www.tccasa.org/ The Community Guide Improving Mental Health and Addressing Mental Illness
PERFORMANCE MEASURE(S) (source):	1. Evidence-based programming will continue to be implemented in three of the six school districts 2. Tioga County collaborative partners will use evidence-based practices that prevent MEB disorders 3. Health care facilities will report on screening for depression 4. Integrate social work/ behavioral health into the primary care setting 5. Explore feasibility of implementing tele-psychiatry in Tioga County
MAJOR ACTIVITIES	1. Continued support and expansion of the Tioga County Suicide Coalition 2. Implement and conduct active screening for depression in clinical settings 3. Evaluate the feasibility of increasing access to services for rural

FOCUS AREA:	Promote Mental Health and Prevent Substance Abuse (focus areas 1 & 2 combined to maximize improvement efforts in our community)
	communities through tele-health 4. Establish clinical-community linkages that connect patients to mental health community resources 5. Advocate for addressing common protective factors such as poverty and exposure to violence 6. Work collaboratively with schools to implement evidence-based programming
PROCESS/OUTCOME MEASURES	1. Number of evidence-based policies and programs that have been implemented in Tioga County 2. Percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days 3. Percentage of youth ages 12-17 years reporting the use of non-medical prescription pain relievers 4. Percentage of adult New Yorkers reporting 14 or more days with poor mental health 5. Reduce the suicide mortality rate by 5% 6. Implement and report on screening for depression in the primary care setting 7. Recruit psychiatrist (tele-psychiatry)

Continuing the Process

The Tioga County Health Department is responsible for monitoring the health status of our county's population. By gathering and continuously reviewing health statistics and seeking community input we are able to evaluate the overall health of our community. It is our vision to be the public health leader to ensure that the needs of our community are met through an integrated and coordinated network of resources that empower people to make healthier choices. Our Mission is to protect and promote the health and well-being of our community through advocacy, education, enforcement, prevention and partnerships.

Throughout this planning and improvement process we forged great partnerships with key stakeholders from several sectors representing our local public health system. Collaboration with these partners, including those on our Steering Committee, is vital to the success of our improvement plan. We are fortunate to have so many endowed and dedicated professionals in our midst. The level of participation and enthusiasm elicited by the participants helped fuel the process and will remain a constant reminder that the job can be done and be done well. It is also important to mention that this CHIP would not be possible without the participation and support of the community. It was the invariable feedback and commitment to this project that carried it through. "Thank you" is hardly enough to everyone that contributed their efforts whether it was taking a survey or providing hours of editing.

We now have a clear understanding of what it takes to improve the overall health of the county and we have a written formal plan to hold us accountable. This Community Health Improvement Plan was developed using an evidence-based strategic planning tool, recognized and approved by health departments and in communities across the United States. There is work to be done and it may prove to be challenging at times, yet the goals and suggested interventions are not insurmountable.

This is just the beginning…the CHIP is a living document, a starting point, a direction and we, the health department will lead the way, with our collaborative partners supporting our efforts. As with all things, sometimes directions need to be changed and if we get lost along the way, we can ask for help, but the end goal will always remain in plain view "Creating a healthier tomorrow, today" (for Tioga County).

Susquehanna River, Owego NY