

ORANGE COUNTY COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN EXECUTIVE SUMMARY 2019-2021

Our shared vision and health promotion
strategic plan to address the most
pressing health issues of our residents



What is a Community Health Assessment and Community Health Improvement Plan?

A Community Health Assessment (CHA) identifies key needs and issues of a community through systematic, comprehensive data collection and analysisⁱ. A Community Health Improvement Plan (CHIP) is the long-term systematic 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 the area hospitals to coordinate efforts, establish priorities, and combine resources to guide health promotion strategies.

How did we choose our priorities?

To assess the needs of Orange County residents and select Prevention Agenda priorities, there was extensive secondary data review and analysis through the CHA Collaborative between HealthConnections, 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, United for ALICE, National Environmental Public Health Tracking Network, Map the Meal Gap, New York State Education Department and County Business Patterns.

In addition, the Collaborative 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. 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, the LGBTQ community, and people with a mental health diagnosis or those with a substance use disorder.

Summary review of the data was provided at the Orange County Health Summit that took place on June 4, 2019. Over 100 partners, including hospitals, health care providers, community-based organizations, community members and academia, were in attendance. The summit completed a number of tasks including: 1) a review of the most current data in all prevention agenda areas; 2) results from a region-wide data-driven prioritization analysis known as the Hanlon Methodⁱⁱ; 3) current community mobilization efforts to determine barriers to accessing health care in the City of Newburgh; 4) a selection process that allowed attendees to vote on the two Prevention Agenda Priorities for the 2019-2021 CHIP; 5) a review of the impacts that the social determinants of health have on health outcomes; and 6) discussion of both assets and barriers each of the selected priority areas.

Conference participants signed up to contribute to the ongoing strategic planning and implementation efforts for the 2019-2021 CHIP cycle. Each focus area chosen has a corresponding workgroup co-led by Orange County Department of Health (OCDOH) and area hospital staff to ensure the strategies laid out in the strategic plan are being executed. These workgroups will report out at the larger yearly Orange County Health Summit to share the ongoing efforts of the CHIP to the community-at-large. To become involved, contact information for focus group leaders is provided on page 32 of the Full CHIP.

What priorities were chosen?

The two overarching priority areas chosen were **Prevent Chronic Disease** and **Prevent Communicable Disease**. Within each of the priorities' strategic plan, the reduction of health disparities will be addressed through the concentration of efforts in areas of the largest economic needs and in areas with minority majorities.

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

Focus Area 1: Healthy Eating and Food Security

Goal 1.1 Increase access to healthy and affordable foods and beverages

Goal 1.3 Increase food security

Focus Area 2: Physical Activity

Goal 2.1 Improving community environments that support active transportation and recreational physical activity for people of all ages and abilities

Goal 2.2 Promote school, child-care and worksite environments that support physical activity for people of all ages and abilities

Focus Area 3: Tobacco Prevention

Goal 3.1 Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products by youth and young adults

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

Focus Area 4: Preventative Care and Management

Goal 4.1 Increase cancer screening rates for breast, cervical and colorectal cancer

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

Focus Area 2: Human Immunodeficiency Virus (HIV)

Goal 2.1. Decrease HIV morbidity (new HIV diagnoses)

Goal 2.2 Increase HIV viral suppression

Focus Area 3: Sexually Transmitted Infections (STIs)

Goal 3.1 Reduce the annual rate of growth for STIs

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

Focus group leaders from OCDOH, Bon Secours Community Hospital, Montefiore St Luke's Cornwall Hospital, Orange Regional Medical Center, and St. Anthony Community Hospital will be responsible for recruiting any additional partners and/or community members through the 2019-2021 CHIP cycle. Additionally, OCDOH and the participating hospitals have strong community partnerships with hundreds of organizations serving its residents, including federally qualified health care centers, private medical providers, local two-year and four-year colleges, a medical school, community-based organizations, and other organizations serving a broad variety of community needs including transportation, housing and economic stability. OCDOH has established multiple coalitions, including Healthy Orange, the Maternal and Infant Community Health Collaborative, Orange County Health Disparities Initiative Planning Committee, Orange County Chamber Health and Wellness Committee, and the Orange County Cancer Screening Collaborative, in addition to co-leading and participating on a large number of countywide coalitions, such as Changing the Orange County Addiction Treatment Ecosystem, WELCOME Orange, and the Resilience Project. 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, the full Community Health Assessment is provided on the County Health Department website found here: www.orangecountygov.com/health under "Data and Reports/Community Health Assessments". The documents were also shared with all the Orange County Health Summit registrants and attendees.

What strategies are being implemented to address the priority areas?

Every strategy chosen is an evidence-based or a highly evaluated promising practice, such as the development of a farmer's market, to maximize both effectiveness and the resources available.

CHIP Focus Area	Evidenced Based Strategies
Healthy Eating and Food Security	<ul style="list-style-type: none"> • Increase the number of institutions with nutrition standards for healthy food and beverage procurement* • Work with school districts to implement multi-component school-based obesity prevention interventions * • Increase the availability of affordable healthy foods especially in communities with limited access through sustaining OCDOH funded farm markets* • Screen for food insecurity, facilitate, and actively support referral* • Increase the availability of fruit and vegetable incentive programs*
Physical Activity	<ul style="list-style-type: none"> • Implement a combination of improved pedestrian, bicycle or transit transportation system components that support safe and accessible physical activity* • Promote the adoption of complete streets policies • Encourage school districts to implement Comprehensive School Physical Activity Programs (CSPAP)* • Implement obesity prevention guidelines utilizing the 5-2-1-0 model with a focus in school districts with high rates of overweight and obese school-aged children*
Tobacco Prevention	<ul style="list-style-type: none"> • Use media and health communications to highlight the dangers of tobacco use and reshape social norms • Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts by encouraging use of available cessation benefits such as Medicaid benefits when applicable and free smoking cessation classes * • Promote Medicaid benefits for tobacco cessation and available free cessation classes to Orange County residents especially those with incomes <\$25,000 per year and adults living with a disability *
Preventative Care and Management	<ul style="list-style-type: none"> • 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 • Use small media and health communications to build public awareness and demand for breast, cervical and colorectal cancer screenings • Link patients with primary care and ensure access to health insurance to reduce barriers to cancer screening*
Human Immunodeficiency Virus (HIV)	<ul style="list-style-type: none"> • Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high risk person to keep them HIV negative • Link and retain persons diagnosed with HIV in care to maximize viral suppression
Sexually Transmitted Infections (STIs)	<ul style="list-style-type: none"> • Increase STI testing and treatment • Distribute condoms and provide education around the importance of condoms to prevent STIs • Promote expedited partner therapy (EPT)

**Strategies that address disparities: person with low socioeconomic status (SES) and concentrated in areas with minority majorities*

How is progress and improvement being tracked?

Progress and improvement data are tracked quarterly and collected by focus area workgroup leaders for each of the strategies and documented in an excel database. Both short-term process indicators and long-term outcome indicators are collected through primary data analysis, anecdotal comments from partners and the community and through review of secondary data sources including NYSDOH. Data measures collected will guide any mid-course corrections needed. Data updates are completed quarterly, placed directly on the CHIP document and uploaded to the Orange County Department of Health Website found [here](#). Full descriptions of process measures, partners, timelines and outcome objects can be found in the full Orange County Community Health Improvement Plan 2019-2021 document on the website listed above.

ⁱ<https://www.cdc.gov/publichealthgateway/cha/index.html#targetText=A%20community%20health%20assessment%2C%20also.comprehensive%20data%20collection%20and%20analysis>.

ⁱⁱ<https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf>