ORANGE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN 2019-2021

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

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What is a Community Health Improvement Plan?

A Community Health Improvement Plan (CHIP) is the long–term systematic effort to address public health problems based on a community-wide health assessment[1]. 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 will we use the CHIP?

This document has been created in conjunction with Bon Secours Hospital, Montefiore St. Luke's Hospital, Orange Regional Medical Center and St. Anthony Community Hospital with the support of almost 100 other community organizations. This 2019-2021 plan will guide efforts for the next three years as we strive to improve population-level health issues collaboratively. This document will be continually reviewed and revised to incorporate new opportunities and reflect any challenges or changes throughout the next three years. Access to this document and subsequent updates will be available on the Orange County Department of Health (OCDOH) website here: www.orangecountygov.com/health under "Data and Reports → Community Health Assessments".

How did we choose our priorities?

The New York State Public Health and Health Planning Council's Ad Hoc Committee to Lead the Prevention Agenda created the Prevention Agenda Health Improvement Plan for 2019-2024. The Prevention Agenda establishes priority areas, goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities[2]. The five Prevention Agenda priority areas include:

- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants and children
- Promote well-being and prevent mental substance use disorders
- Prevent communicable diseases

As part of the required update to the CHIP, the New York State Department of Health (NYSDOH) requires all health departments and hospitals to choose two priority areas and address at least one health disparity in their communities. For the first time, OCDOH created a combined CHIP with Bon Secours Hospital, Montefiore St. Luke's Hospital, Orange Regional Medical Center and St. Anthony Community Hospital. Priority areas were selected through a collaborative process during 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. A complete list of conference attendees can be found page 31.

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[1] Adapted from Public Health Accreditation Board (PHAB) Acronyms and Glossary of Terms, Version 1.0 (PDF: 512KB / 38 pages) http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf

[2] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm

Participants at the conference were provided with the OCDOH Community Health Assessment Data Review Guide, which reviews 140 of the most current data indicators available, stratified by the NYSDOH Prevention Agenda Areas for Orange County and New York State. Data from the Mid-Hudson Region Community Health Survey, a randomized telephone survey that collected the residents' perceptions surrounding health and resources in their communities were provided at the conference along with results from the Mid-Hudson Region Community Health Survey, which collected data from human service providers on underrepresented populations in the Mid- Hudson Region Community Survey, including persons with low-income, veterans, persons experiencing homelessness, the aging population, LGBTQ community, and people with a mental health diagnosis or those with a substance use disorder. The conference completed a number of tasks including: 1) a review of the most current data in all prevention agenda areas; 2) Current community mobilization efforts to determine barriers to accessing health care in the City of Newburgh; 3) a selection process that allowed attendees to vote on the two Prevention Agenda Priorities for the 2019-2021 CHIP; 4) a review of the impacts that the social determinants of health have on health outcomes; and lastly 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 will have a corresponding workgroup co-led by OCDOH and area hospital staff to ensure the strategies laid out in the strategic plan below 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.

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 high racial and ethnic minorities.

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

How can the community-at-large and other organizations be involved?

Focus group leaders 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, 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. Additionally, community members can contact the OCDOH Epidemiologist at 845-291-2330 to become involved.

How is progress and improvement being tracked?

Progress, improvement and data are tracked quarterly and collected through 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 below in the strategic planning charts.

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASES
FOCUS AREA 1: Healthy Eating and Food Security
OVERARCHING GOAL: Reduce obesity and the risk of chronic diseases **GOAL 1.1: Increase access to healthy and affordable foods and beverages** **OBJECTIVE #1:** By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 5% from 29.7% to 28.2%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016) **OBJECTIVE #2:** By December 31, 2021, decrease the percentage of children with obesity among elementary, middle and high school students in public school by 5% from 19.7% to 18.7%. (Data Source: Student Weight Category Status, 2016-2018) **OBJECTIVE #3:** By December 31, 2021, decrease the percentage of adults who consume less than one fruit and vegetable per day by 5% from 23.6% to 22.4%. (Data Source: BRFSS, 2016) **STRATIGIES THAT ADDRESS DISPARITY: #1, #2, and #3 (Persons with low socioeconomic status (SES) and concentrated in areas with high racial/ethnic minorities)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Increase the number of institutions with nutrition standards for healthy food and beverage procurement, with emphasis in the cities of Middletown, Newburgh and Port Jervis	Draft polices, engage stakeholders with community-based organizations (CBOs) and worksites to adopt policies	**Staff Time:** *Orange County Department of Health (OCDOH), Orange County Planning Department (OCPD)* **Implementation Partners:** *CBOs, Small retailers, Montefiore St. Luke's Cornwall Hospital, Orange Regional Medical Center (ORMC)*	January 2019-December 2021	Number and type of worksites, municipalities, CBOs, and hospitals to develop and adopt policies to implement nutrition standards including cafeterias, snack bars, vending machines, CSAs and bodegas	Increased access and consumption of healthier foods and beverages

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(2) Work with school districts to implement multi-component school-based obesity prevention interventions, with emphasis in the cities of Middletown, Newburgh and Port Jervis	Encourage districts to prohibit advertising and promotion of less nutritious foods and beverages, increase the availability of healthier foods and beverages and provide healthy eating learning opportunities	**Staff Time:** *OCDOH, Cornell Cooperative Extension (CCE), Eat Smart New York (ESNY)* **Implementation Partners:** *School districts including Newburgh Enlarged City School District, Port Jervis City School District, Enlarged City School District of Middletown*	January 2019-December 2021	Number of schools that improve nutrition policies and practices Number schools that adopt and implement comprehensive and strong local school wellness policies	Increased access and consumption of healthier foods and beverages
(3) Increase availability of affordable healthy foods especially in communities with limited access through sustaining OCDOH funded farm markets	Maintain current farm markets in Newburgh and Port Jervis through the continuation of contracts with farm market managers and growing the number of farmers who participate	**Staff Time**: *OCDOH, Port Jervis and Newburgh Farm Market managers, House of Refuge, Office for Aging, Veteran's Affairs, CCE* **Sponsorship and Space**: *First Baptist Church Newburgh, House of Refuge, City of Port Jervis, City of Newburgh, Foundry 42*	Ongoing seasonal May-November (2019-2021)	Number of participants and farmers	Increased availability of locally produced items and availability in low income areas directed towards those without transportation

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(3 cont.) Increase availability of affordable healthy foods especially in communities with limited access through sustaining OCDOH funded farm markets	Increase participation of farm markets that accept SNAP benefits and WIC checks and increase number of SNAP and WIC participants who use their benefits at farm markets	**Staff Time:** *OCDOH, CCE, Port Jervis and Newburgh Farm Market managers* **Provide clients**: *Office for the Aging, Department of Social Services, Women Infants and Children (WIC)*	Ongoing seasonal May-November (2019-2021)	Dollar amount of Fresh Connect Coupons used at markets EBT transaction dollar amount Dollar amount of senior coupons and veteran coupons issued at markets	Increased percentage of low-income and aging adults with access to fresh fruits and vegetables

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASES
FOCUS AREA 1: Healthy Eating and Food Security
OVERARCHING GOAL: Reduce obesity and the risk of chronic diseases **GOAL 1.3: Increase food security** **OBJECTIVE #1:** By December 31, 2021, increase the percentage of adults with perceived food security by 5% from 75.6% to 79.4%. (Date Source: BRFSS, 2016) **STRATIGIES THAT ADDRESS DISPARITY: #1 and #2 (Persons with low SES and low food security)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Screen for food insecurity, facilitate, and actively support referral, with focus in the high-need areas of the cities of Middletown and Newburgh	Develop standardized definition and screening questions for food insecurity	**Staff Time:** *ORMC, St. Anthony Community Hospital (SACH), Montefiore St. Luke's Cornwall Hospital, Cornerstone* **Advisory Capacity:** *Cornerstone*	January 2020-March 2020	Developed standardized definition and question to measure food security	Ability to compare data across all hospitals
	Creation of internal policies and/or practices to consistently screen for food insecurity in both pediatric and adult populations	**Staff Time:** *ORMC, SACH, Montefiore St. Luke's Cornwall Hospital, OCDOH* **Support Partners:** *OCDOH, CCE* **Advisory Capacity:** *Wholesome Wave*	January 2020-December 2021	Number of health practices that screen for food insecurity and facilitate referrals to supportive services Number of referrals	Increased awareness among healthcare providers about food insecurity and increased number of food insecure residents connected to resources

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1 cont.) Screen for food insecurity, facilitate, and actively support referral, with focus in the high-need areas of the cities of Middletown and Newburgh	Creation or updating of food pantries registries and other local emergency food services report for provider referrals	**Staff Time:** *OCDOH, CCE, Eat-Smart NY* **Support Partners:** *Food bank of the Hudson Valley*	January 2020-June 2020	Number of food pantry lists available to healthcare providers	Increased awareness among healthcare providers about where to refer patients
	Create polices and processes for active connection to WIC and/or SNAP	**Staff Time:** OCDOH, *SACH, Monetfiore St. Luke's Cornwall Hospital, ORMC* **Advisory Partners:** *Cornerstone, WIC programs, Orange County Office for the Aging*	April 2020-Decemeber 2021	Number of facilities adopting policies and/or procedures to support active connection to SNAP and/or WIC	Increased access to funds for healthy foods for both pediatric and senior populations
(2) Increase the availability of fruit and vegetable incentive programs	Create an incentive program for the purchasing of fruits and vegetables at local farm markets	**Staff Time:** *OCDOH, Cornerstone, Port Jervis and Newburgh Farm Market managers* **Support Partners:** *OCDOH, House of Refuge, Foundry 42* **Advisory Capacity:** *Wholesome Wave*	Seasonal during Farm Markets March 2020-November 2021	Number of coupons distributed by Cornerstone Number of coupons redeemed at Farmer's Market Number of programs that adopt policies and practices to increase consumption of fruits and vegetables	Increased number of residents with access to funds for healthy foods

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASE
FOCUS AREA 2: Physical Activity
OVERARCHING GOAL: Reduce obesity and the risk of chronic disease **GOAL 2.1:** Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities **OBJECTIVE #1:** By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 5% from 29.7% to 28.2%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016) **OBJECTIVE #2:** By December 31, 2021, increase the percentage of adults age 18 years and older who participate in leisure-time physical activity by 5% from 70.7% to 74.2%. (Data Source: BRFSS, 2016) **STRATEGY THAT ADDRESSES DISPARITY: #1 (Persons with low SES and concentrated in areas with high racial/ethnic minorities)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Implement a combination of improved pedestrian, bicycle or transit transportation system components that support safe and accessible physical activity	Promote and assist municipalities with the adoption and implementation of complete streets policies and components with local municipalities	**Staff Time**: *OCDOH, Orange County Planning Department, Orange County Department of Public Works, Orange County Complete Streets Committee* **Advisory Capacity:** *Tri-State Transportation Council, Orange County Citizens Foundation, Orange County Office for the Aging*	January 2019-Decemeber 2021	Number of complete streets policies adopted Percent of residents and roads affected by policies Number of places that implement new or improve existing community planning and transportation interventions	Increased number of adults meeting physical activity guidelines Increase the percentage of adults who walk or bike to get from one place to another

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASE
FOCUS AREA 2: Physical Activity
OVERARCHING GOAL: Reduce obesity and the risk of chronic disease **GOAL 2.2:** Promote school, childcare and worksite environments that support physical activity for people of all ages and abilities. **OBJECTIVE #1:** By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 5% from 29.7% to 28.2%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016) **OBJECTIVE #2:** By December 31, 2021, increase the percentage of adults age 18 years and older who participate in leisure-time physical activity by 5% from 70.7% to 74.2%. (Data Source: BRFSS, 2016) **OBJECTIVE #3:** By December 31, 2021, decrease the percentage of children with obesity among elementary, middle and high school students in the cities of Middletown, Newburgh and Port Jervis by 5% from 23.8% to 22.6%, 25.3% to 24%, and 23.7% to 22.5%, respectively. (Data Source: Student Weight Category Status, 2016-2018) **STRATIGIES THAT ADDRESS DISPARITY: #1 and #2 (Families with low SES and high rates of obese children)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Encourage school districts to implement Comprehensive School Physical Activity Programs (CSPAP) particularly in the high need cities of Middletown, Newburgh and Port Jervis	Draft policies, engage with school districts and stakeholders during wellness committee meetings to adopt policies Increase the number of schools with comprehensive and strong local school wellness policies	**Staff Time:** *OCDOH, Newburgh Enlarged City School District, Port Jervis City School District, Eat Smart New York, CCE, Enlarged City School District of Middletown* **Provide clients and space:** *Newburgh Enlarged City School District, Port Jervis City School District, Enlarged City School District of Middletown*	January 2016-December 2021	Number of schools implementing CSPAP components	Increased number of students with opportunities for physical activity throughout the school day

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(2) Implementation of the 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	Work with local gyms, CBOs and school districts to implement the “Warrior Kids” educational program emphasizing at least 1 hour of physical activity a day and allow participants to engage in 30 minutes of physical activity each day for four weeks	**Staff Time:** *ORMC, Boys & Girls Club, CCE, Studio Ayo Fitness* **Provide space and clients:** *Orange County school districts (to be determined), Boys & Girls Club* **Support Partners:** *OCDOH*	January 2020- December 2021	Number of students participating in the program Percentage of program participants reporting intent to be more physically active (1 hour per day)	Increased number of students with access to physical activity and education around the importance of daily physical activity

PERFORMANCE MEASURES			
Short Term Process Indicators for Goals 1.1 and 1.3	**Baseline**	**Source**	**Frequency**
By December 2020, increase the number of worksites, bodegas, CBOs or hospitals that will implement nutrition standards, policies or practice (systems) changes by 10 from 48 to 58.	48 worksites (January 2016-June 2019)	Healthy Orange	Quarterly
By December 2020, increase the number of schools that improve nutrition wellness policies and/or practices from 4 schools to 5 schools.	4 school districts (2019)	Healthy Orange	Quarterly
By December 2020, increase the number of comprehensive school wellness policies from 4 districts to 5 districts.	4 school districts (2019)	Healthy Orange	Quarterly
By December 2020, increase the number of participants utilizing the farmers markets in Newburgh and Port Jervis by 10% from 3,400 to approximately 3,740 participants.	1,685 Newburgh participants (2018) 1,715 Port Jervis participants (2018)	Healthy Orange	Seasonally
By July 2020, increase the number of farmers/vendors participating by 2 in the City of Newburgh's established farm market.	Average 4 farmers (2018)	Healthy Orange	Seasonally
By December 2020, increase the dollar amount of fresh connect coupons used at both the Port Jervis and Newburgh markets by 20% from $616 to $739.	$616 Combined (2018) ($492- Newburgh $124- Port Jervis)	Healthy Orange	Seasonally
By December 2020, increase the EBT transaction dollar amount at both the Port Jervis and Newburgh markets by 20% from $600 to $720.	$600 Combined (2018) ($425-Newburgh $175- Port Jervis)	Healthy Orange	Seasonally
By December 2020, increase the dollar amount of veteran coupons distributed at the Port Jervis and Newburgh markets by 10% from $1000 to $1100.	$1000 Combined (2018) ($600 Newburgh $400 Port Jervis)	Healthy Orange	Seasonally
By December 2020, increase the dollar amount of senior coupons distributed at the Port Jervis market by 20% from $600 to $720 and keep the same amount distributed at the Newburgh market of $24,000.	$600 Port Jervis (2018) $24,000 Newburgh (2018)	Healthy Orange	Seasonally
By June 2020, determine a baseline of large Orange County healthcare providers and practices that screen for food insecurity.	To be determined 2020	CHIP evaluation database	One-time
By December 2020, increase the number of health care practices that screen for food insecurity by at least 3.	To be determined 2020	CHIP evaluation database	Quarterly

PERFORMANCE MEASURES			
Short Term Process Indicators for Goals 1.1 and 1.3 (cont.)	**Baseline**	**Source**	**Frequency**
By December 2020, increase the number of referrals made for food insecure residents and families from practices adopting new screening policies and protocols.	Zero	CHIP evaluation database	Quarterly
By June 2020, increase the number of updated location-based food pantry lists available to healthcare providers from one to at least three.	One (2019)	CHIP evaluation database	Monthly
By December 2020, increase the number of health care practices/facilities that adopt policies and/or procedures to support active connection to SNAP and/or WIC to at least 2 facilities.	To be determined 2020	CHIP evaluation database	Quarterly

PERFORMANCE MEASURES			
Short Term Process Indicators for Goals 2.1 and 2.2	**Baseline**	**Source**	**Frequency**
By December 2020, increase the number of school districts that will implement the CSPAP guidelines by one from three districts.	Three school districts (2019)	CHIP evaluation database	Annually
By December 2020, increase the number of children participating in the "Warrior Kids" program by 13.3% from 1,500 to 1,700, with at least 85% of students reporting intent to make a behavior change.	1500 students (2019)	CHIP evaluation database	Quarterly
By December 2020, increase the number of health care practices/facilities that adopt policies and/or procedures to support active connection to SNAP and/or WIC to at least 2 facilities.	To be determined 2020	CHIP evaluation database	Quarterly

PERFORMANCE MEASURES				
Long Term Outcome Indicators for Goals: 1.1, 1.3, 2.1 and 2.2	**Baseline**	**NYSDOH Prevention Agenda Goal**	**Source**	**Frequency**
By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 5% from 29.7% to 28.2%.	Obese: 29.7% (2016)	Obese: 24.2% by 2024	New York State Behavioral Risk Factor Surveillance Survey (BRFSS)	Every 4 years
By December 31, 2021, decrease the percentage of children with obesity among elementary, middle and high school students in public school by 5% from 19.7% to 18.7%.	Obese: 19.7% (2016-2018)	Obese: 16.4% by 2024	NYS Student Weight Category Status Reporting System	Every 2years
By December 31, 2021, decrease the percentage of adults who consume less than one fruit and vegetable per day by 5% from 23.6% to 22.4%.	23.6% (2016)	29.6% by 2024	BRFSS	Every 4 years
By December 31, 2021, increase the percentage of adults with perceived food security by 5% from 75.6% to 79.4%.	75.6% (2016)	80.2% by 2024	BRFSS	Every 4 years
By December 2021, increase the number of municipalities with complete streets policies by 100% from 4 policies to 8 policies.	Four policies (2019)	Increase number of policies	Orange County Complete Streets Committee	Quarterly
By December 2021, increase the number of places that implement new or improve existing community planning and transportation interventions by at least 3.	Zero (2019) Will begin measuring in 2020	Not available	Orange County Complete Streets Committee	Quarterly
By December 31, 2021, increase the percentage of adults age 18 years and older who participate in leisure-time physical activity by 5% from 70.7% to 74.2%.	70.7% (2016)	77.4% by 2024	BRFSS	Every 4 years
By December 31, 2021, decrease the percentage of children with obesity among elementary, middle and high school students in the cities of Middletown, Newburgh and Port Jervis by 5% from 23.8% to 22.6%, 25.3% to 24%, and 23.7% to 22.5%, respectively.	Middletown: 23.8% Newburgh: 25.3% Port Jervis: 23.7% (2016-2018)	Obese: 16.4% by 2024	NYS Student Weight Category Status Reporting System	Every 2 years

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASES
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 **OBJECTIVE #1:** By December 31, 2021, decrease the prevalence of lifetime vaping product use by high school students by 20% from 25% to 22.5%. (Data source: Orange County Youth Survey, 2016) **OBJECTIVE #2:** By December 31, 2021, decrease the current tobacco use by high school students by 20% from 6.3% to 5.0%. (Data source: Orange County Youth Survey, 2016)

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Use media and health communications to highlight the dangers of tobacco use and reshape social norms	Create a media campaign including posters and advertisements through the County	**Staff Time:** *OCDOH, BSCH* **Support Partners:** *ADAC, Local community organizations, School districts, Catholic Charities of Orange, Ulster and Sullivan Counites*	November 2019- December 2020	Number of posters distributed Number of presentations at schools and community events	Increased knowledge among youth regarding the dangers of vaping and combustible tobacco

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASE
FOCUS AREA 3: Tobacco Prevention
GOAL 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; and disability **OBJECTIVE #1:** By December 31, 2021, decrease the prevalence of cigarette smoking by adults ages 18 and older by 10% from 13.2% to 11.9%. (Baseline Data: BRFSS, 2016) **OBJECTIVE #2:** By December 31, 2021, decrease the prevalence of cigarette smoking among adults with income less than $25,000 by 10% from 26.2% to 23.6%. (Baseline Data: BRFSS, 2016) **OBJECTIVE #3:** By December 31, 2021, decrease the prevalence of cigarette smoking among adults who are living with any disability by 10% from 25.2% to 22.7%. (Baseline Data: BRFSS, 2016) **STRATIGIES THAT ADDRESS DISPARITY: #1 and #2 (Adults with low SES, adults living with a disability)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts by encouraging use of available cessation benefits including local Freedom from Smoking classes and Medicaid benefits (when applicable)	Partner with NYSDOH tobacco-control partners to educate providers on Medicaid benefits for cessation	**Staff Time**: *OCDOH, ORMC, Center for Tobacco Free Hudson Valley, BSCH* **Provide Clients**: *ORMC and BSCH*	January 2019-December 2021	Number of practices/ providers given education	Increase knowledge among health care providers about the availability of cessation benefits for their patients in Orange County

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(2) Promote Medicaid benefits for tobacco cessation services and free cessation classes available in Orange County particularly among target populations in Middletown and Port Jervis	Distribution of Medicaid benefits to target populations Host facilitator trainings for Freedom from Smoking Host Freedom from Smoking classes	**Staff Time**: *OCDOH, ORMC, BSCH* **Support Partner:** *HealtheConnections* **Advisory Capacity:** *Access: Supports for Living, Independent Living, Office for the Aging*	January 2019-December 2021	Number of Freedom from Smoking trainings Number of individuals trained in Freedom from Smoking Number of persons completing Freedom from Smoking program	Increased number of people trained Increased number of adults referred for tobacco cessation Increased number of individuals reducing or quitting smoking

PERFORMANCE MEASURES			
Short Term Process Indicators for Goals 3.1 and 3.2	**Baseline**	**Source**	**Frequency**
By June 2020, distribute at least 200 posters throughout the County.	Zero	CHIP evaluation database	Quarterly
By December 2020, conduct at least 10 presentations to schools and/or community events about the dangers of vaping/tobacco use.	Eleven (2019)	CHIP evaluation database	Quarterly
By December 2020, conduct at least 4 trainings to health care providers on Medicaid benefits for cessation.	Zero	CHIP evaluation database	Quarterly
By December 2020, offering at least 2 Freedom from Smoking Train-the-Trainer.	One (2018)	CHIP evaluation database	Quarterly
By December 2020, train at least 16 individuals in Freedom from Smoking.	14 trainers (2019)	CHIP evaluation database	Quarterly
By December 2020, enroll at least 80 individuals in Freedom from Smoking classes.	To be determined (2019)	CHIP evaluation database	Quarterly

PERFORMANCE MEASURES				
Long Term Outcome Indicators for Goals 3.1 and 3.2	**Baseline**	**NYSDOH P.A. Goal**	**Source**	**Frequency**
By December 31, 2021, decrease the prevalence of lifetime vaping product use by high school students by 20% from 25% to 22.5%.	25% (2016-2017)	15.6% by 2024	Orange County Youth Survey	Every 2 years
By December 31, 2021, decrease the current tobacco use by high school students by 20% from 6.3% to 5.0%.	6.3% (2016-2017)		Orange County Youth Survey	Every 2 years
By December 31, 2021, decrease the prevalence of cigarette smoking by adults ages 18 and older by 10% from 13.2% to 11.9%.	13.2% (2016)	11% by 2024	New York State Behavioral Risk Factor Surveillance Survey (BRFSS)	Every 4 years
By December 31, 2021, decrease the prevalence of cigarette smoking among adults with income less than $25,000 by 10% from 26.2% to 23.6%.	26.2% (2016)	15.3% by 2024	BRFSS	Every 4 years
By December 31, 2021, decrease the prevalence of cigarette smoking among adults who are living with any disability by 10% from 25.2% to 22.7%.	25.2% (2016)	20.1% by 2024	BRFSS	Every 4 years

PREVENT CHRONIC DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT CHRONIC DISEASE
FOCUS AREA 4: Preventative Care and Management
GOAL 1.1: Increase cancer screening rates for breast, cervical and colorectal cancers, especially among disparate populations in the cities of Newburgh, Middletown and Port Jervis. **OBJECTIVE #1:** By December 31, 2021, increase the percentage of adults receiving breast cancer, cervical, and colorectal cancer screenings based on the most recent screening guidelines by 5%. (Baselines: 74.5% Breast Cancer Screening; 85.7% Cervical Cancer Screening and 71% Colorectal Cancer Screening, 2016) Data source: NYS Behavioral Risk Factor Surveillance Survey, 2016 **STRATIGIES THAT ADDRESS DISPARITY: #3 (Persons with low SES and concentrated in areas with high racial/ethnic minorities)**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Remove structural barriers to cancer screening by working with employers to provide employees with paid leave or the option to use flex time for cancer screenings	Work with the Chamber of Commerce's Health Means Business Committee to connect to worksites to establish paid leave policies for screenings Recruit worksites with current policies in development to host one-time on-site screening events	**Staff Time:** *OCDOH, Chamber of Commerce Health Means Business Committee, Orange County Cancer Services*	January 2019-December 2021	Number and type of worksites that adopt practices and policies that reduce structural barriers to cancer screening Number of employers with policies for flex time or paid time off for cancer screenings	Increased number of adults able to receive cancer screenings

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(2) Use small media and health communications to build public awareness and demand	Develop one consistent branded message across all entities to increase cancer screenings during awareness months for breast, cervical and colorectal cancers (October, January and March respectively)	**Staff Time:** *OCDOH, Orange County Cancer Services, Montefiore St. Luke's Cornwall Hospital, BSCH, ORMC, Hudson River Healthcare (HRHC), Cornerstone, SACH, Planned Parenthood of the Hudson Valley*	June 2019-December 2019	Number and type of locations where posters were distributed Number of calls received about screening due to campaign	Change in knowledge and awareness for need of cancer screening
	Work with SUNY Orange Graphic Design Department for poster designs for public health awareness campaign and messaging for breast, colorectal cancer and cervical cancers	**Staff Time:** *SUNY Orange graphic arts students, OCDOH, Orange County Cancer Services, Montefiore St. Luke's Cornwall Hospital, BSCH, ORMC, HRHC, Cornerstone, SACH*	August 2019-December 2021	Number of designs submitted for consideration for breast, colorectal and cervical cancers	One consistent branded message about the importance of breast, cervical and colorectal cancer screenings being utilized by as many Orange County healthcare organizations as possible
	Evaluate how patients have found cancer screenings through surveys (i.e. newspaper, mailings, flyers, word of mouth, social media or other)	**Staff Time:** *Cornerstone, Montefiore St. Luke's Cornwall Hospital, ORMC, BSCH, SACH*	June 1, 2019-December 2019	Number of surveys distributed Percentages of how patients found cancer screenings by type	Increased knowledge of how patients are finding cancer screening services

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(3) Link patients with primary care and ensure access to health insurance to reduce barrier to screening	Survey patients from other facility-sponsored events to establish a baseline of patients who have health insurance and whether they have a primary care provider (PCP)	**Staff Time:** *Cornerstone, Montefiore St. Luke's Cornwall Hospital, ORMC, BSCH, SACH*	April 23rd 2019-December 31st 2019	Number of survey participants Percentage of patients with a PCP Percentage of patients with health insurance	Established baseline for both PCP and health insurance status sample
	Utilize in-house urgent care facilities to make referrals to primary care	**Staff Time:** *Cornerstone, Montefiore St. Luke's Cornwall Hospital, ORMC, BSCH*	July 1, 2019-December 2021	Number of referrals Number/percentage of patients referred to primary care appointments	Increased number of patients enrolled in primary care
	Primary care provider outreach to the community	**Staff Time:** *Cornerstone, Montefiore St. Luke's Cornwall Hospital, ORMC, BSCH, SACH*	April 2019-December 2021	Number and type of events from providers Number of attendees at each event	Increased trust among the public/patients with the medical community to get recommended procedures including cancer screening

PERFORMANCE MEASURES			
Short Term Process Indicators for Goal 4.1	**Baseline**	**Source**	**Frequency**
By October 2019, create the infrastructure for a shared calendar for the collaborative to share events for Breast Cancer, Colorectal Cancer and Cervical Cancer Awareness Months.	Not available	Not available	One-time
By October 2019, create a registry of Orange County CSP providers.	Not available	Orange County Cancer Services	Annually
By December 2019, determine a baseline of Chamber of Commerce members with policies that allow for paid time off or flex time to complete cancer screenings.	Not applicable	Orange County Chamber of Commerce Health Means Business Survey	One-time
By December 2019, determine a proxy baseline of residents with a primary care provider and health insurance.	Baseline to be determined by January 2020	CHIP Evaluation Database	One-time
By June 2020, create a registry of Orange County navigators for non-profit organizations to refer clients.	Not available	CHIP Evaluation Database	Updated quarterly
By December 2020, increase the number of Chamber of Commerce membership worksites with cancer screening policies.	Baseline to be determined by January 2020	CHIP Evaluation Database	Quarterly
By December 2020, increase the number of primary care provider outreach events collectively by 5%.	Baseline to be determined by January 2020	CHIP Evaluation Database	Quarterly

PERFORMANCE MEASURES				
Long Term Outcome Indicators for Goal 4.1	**Baseline**	**NYSDOH P.A. Goal**	**Source**	**Frequency**
By December 2021, increase the percentage of women ages 50-74 receiving breast cancer screening by 5% from 74.5% (2016) to 78.2%.	74.5% (2016)	79.7% by 2024 HP2020: 81.1%	New York State Behavioral Risk Factor Surveillance Survey	Every 4 years
By December 2021, increase the percentage of adults aged 50-75 receiving colorectal screening by 5% from 71% (2016) to 74.6%.	71% (2016)	80% by 2024 HP2020: 70.5%	New York State Behavioral Risk Factor Surveillance Survey	Every 4 years
By December 2018, increase the percentage of women ages 21-65 receiving cervical cancer screening by 5% from 85.7% (2016) to 90%.	85.7% (2016)	*Not available* HP2020: 93%	New York State Behavioral Risk Factor Surveillance Survey	Every 4 years

PREVENT COMMUNICABLE DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT COMMUNICABLE DISEASES
FOCUS AREA 2: Human Immunodeficiency Virus (HIV)
GOAL 2.1: Decrease HIV morbidity (new HIV diagnoses) **OBJECTIVE #1:** By December 31, 2021, reduce the newly diagnosed HIV case rate by 10% from 5.5 per 100,000 to 5.0 per 100,000 population in Orange County. (Baseline data 5.5 per 100,000, 2014-2016) (Data source: NYSDOH HIV Surveillance Data available through the NYSDOH Community Health Indicator Reports (CHIRS), 2014-2016)

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high risk persons to keep them HIV negative	Create referral mechanism in local emergency department and primary care settings for high-risk patients to be enrolled in PrEP	**Staff Time**: *OCDOH, Cornerstone Family Healthcare, ORMC, Montefiore St. Luke's Hospital* **Advisory Capacity**: *New York State Department of Health Division of HIV/STD/HCV Prevention*	January 2020-December 2021	Number of referrals from local hospitals to Cornerstone PrEP program Number of patients prescribed PrEP by race/ethnicity, sexual orientation, gender and age	Increased number of high-risk patients on PrEP and reduced number of newly diagnosed HIV cases

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(2) Link and retain persons diagnosed with HIV in care to maximize virus suppression	Promote the message that individuals with undetectable viral load will not sexually transmit HIV through public health detailing visits and distribution of educational materials of "Undetectable = Untransmissable"	**Staff Time**: *OCDOH* **Collaborating Agencies:** *ORMC, Montefiore St. Luke's Hospital* **Advisory Capacity**: *New York State Department of Health Division of HIV/STD/HCV Prevention*	January 2020- December 2021	Number of public health detailing visits Number of educational materials distributed	Increased number of HIV- positive persons with viral suppression
	Continue Data to Care (DTC) activities using HIV surveillance data to identify previously known HIV- positive individuals who appear to be out of care to re-engage these individuals back in medical care	**Staff Time**: *OCDOH* **Collaborating Agencies:** *Orange County Healthcare Providers treating HIV positive persons* **Advisory Capacity**: *New York State Department of Health Division of HIV/STD/HCV Prevention*	January 2019- December 2021	Percentage of HIV-positive individuals in DTC activities re-engaged in care	Increased number of HIV- positive persons with viral suppression

PERFORMANCE MEASURES			
Short Term Process Indicators for Goal 2.1 and 2.2	**Baseline**	**Source**	**Frequency**
By December 2020, increase the number of high-risk persons prescribed PrEP.	To be determined	Cornerstone Family Health Center Database	Quarterly
By June 2020, increase the number of public health detailing visits completed to provider offices.	Zero	CHIP evaluation database	Monthly
By December 2020, increase the percentage of HIV-positive individuals re-engaged in care to by 25% from 47.4% to 59.3%.	2018	Orange County HIV MIS	Quarterly

PERFORMANCE MEASURES				
Long Term Outcome Indicators for 2.1. and 2.2.	**Baseline**	**Source**	**NYSDOH P.A. Goal**	**Frequency**
By December 2021, reduce the newly diagnosed HIV case rate by 10% from 5.5 per 100,000 to 5.0 per 100,000 population in Orange County.	5.5 per 100,000 (2014-2016)	NYSDOH HIV Surveillance	5.2 per 100,000 population by 2024	Annually or as often as available

PREVENT COMMUNICABLE DISEASES: STRATEGIC PLAN
PRIORITY AREA: PREVENT COMMUNICABLE DISEASES
FOCUS AREA 3: Sexually Transmitted Infections (STIs)
GOAL 3.1: Reduce the annual rate of growth for STIs **OBJECTIVE #1:** By December 31, 2021, reduce the annual rate of growth of chlamydia by 50% from 2.17% to 1.09%. (Baseline Data: 2016-2018 average 3-year percent change) **OBJECTIVE #2:** By December 31, 2021**,** reduce the annual growth rate for gonorrhea by 50% from 4.0 to 2.0% (Baseline Data: 2016-2018 average 3-year percent change) **OBJECTIVE #3:** By December 31, 2021**,** reduce the annual growth rate for early syphilis by 50% from 20% to 10% (Baseline Data: 2016-2018 average 3-year percent change) (Data source: NYSDOH Communicable Disease Electronic Surveillance System (CDESS), 2016-2018)

Evidenced Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(1) Increase STI testing and treatment	Convene with local hospitals to provide the most recent Orange County STI data and CDC guidelines for STI screening and treatment	**Staff Time**: *OCDOH, ORMC, BSCH, SACH, Montefiore St. Luke's Cornwall Hospital, Orange County primary care and specialty providers*	August 2019-Decemeber 2021	Number of patients tested for chlamydia, gonorrhea, and syphilis Number of patients positive for chlamydia, gonorrhea, and/or syphilis Number of patients diagnosed with chlamydia, gonorrhea, and/or syphilis Number of in-person education sessions at hospitals Number of public health detailing visits to primary care and specialty completed	Increased number of patients tested and treated appropriately for STIs
	Provide in-person education to local hospital emergency departments, hospital urgent cares and outpatient providers associated with local hospitals about the recommended guidelines on screening and treatment for STIs				
	Public health detailing visits with primary care and specialty providers to provide the most recent Orange County STI data and CDC guidelines for STI screening and treatment				

Evidenced Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
(2) Distribution of condoms and education around the importance of condoms to prevent sexually transmitted infections (STI)	Utilize the NYS Condom program to distribute condoms to non-traditional organizations such as local social meet-up locations and adult video and bookstores	**Staff Time:** *OCDOH, Planned Parenthood of the Hudson Valley, Hudson Valley Community Services, local 'social meetup' locations, Orange County adult video and bookstores*	January 2020-December 2021	Number of condoms distributed	Increased availability of condoms at no cost to at-risk populations
(3) Promote expedited partner therapy (EPT)	Promote the use of EPT among health care providers through public health detailing visits	**Staff Time:** *OCDOH* **Collaborating Agencies:** *ORMC* **Advisory Capacity**: *NYSDOH Division of HIV/STD/HCV Prevention*	September 2019-December 2021	Number of public health detailing visits completed Number of providers who offer EPT Number of EPT prescriptions distributed	Increased number of partners treated for chlamydia and reduction of the transmission of chlamydia

PERFORMANCE MEASURES			
Short Term Process Indicators for Goal 3.1	**Baseline**	**Source**	**Frequency**
By October 2019, meet with each hospital to develop a plan to measure data and set up educational meetings with clinicians.	Zero	CHIP evaluation database	One-time
By March 2020, complete at least 10 public health detailing visits to primary care providers in Orange County.	Zero	CHIP evaluation database	Quarterly
By June 2020, complete at least one educational training to each participating hospital system.	Zero	CHIP evaluation database	Quarterly
By December 2020, complete at least 25 public health detailing visits to specialty and primary care providers in Orange County.	Zero	CHIP evaluation database	Quarterly
By December 2020, increase the percentage of STI tests done in each participating hospital system by 10%.	To be determined by January 2020	Hospital-specific data reports	Quarterly
By December 2020, increase the percentage of persons appropriately treated for STIs by 25%.	To be determined by January 2020	CDESS reports and hospital-specific reports	Quarterly
By December 2020, increase the number of condoms distributed into the community through new outreach places.	Zero	CHIP evaluation database	Quarterly
By December 2020, increase the number of providers prescribing EPT in Orange County from zero to five.	Zero	CHIP evaluation database	Quarterly

PERFORMANCE MEASURES				
Long Term Outcome Indicators for Goal 3.1	**Source**	**Baseline**	**NYSDOH P.A. Goal**	**Frequency**
By December 31, 2021, reduce the annual rate of growth of chlamydia by 50% from 2.17% to 1.09%.	CDESS	2.17% (2016-2018) Annual 3-year percent change	1% by 2024	Annually
By December 31, 2021, reduce the annual growth rate for gonorrhea by 50% from 4.0 to 2.0%.	CDESS	4.0% (2016-2018) Annual 3-year percent change	4% by 2024	Annually
By December 31, 2021, reduce the annual growth rate for early syphilis by 50% from 20% to 10%.	CDESS	20% (2016-2018) Annual 3-year percent change	10% by 2024	Annually

Orange County Health Summit Participating Organizations
June 4, 2019

Arms Acres
Access: Supports for Living
Alcohol and Drug Abuse Council of Orange County
American Heart Association
American Lung Association
Action Towards Independence Inc.
Bon Secours Community Hospital
Catholic Charities of Orange, Sullivan and Ulster Counties
Chester Union Free School District
City of Middletown
Community advocates
Cornell Cooperative Extension
Cornerstone Family Healthcare
Crystal Run Village Inc.
Eat Smart New York
Enlarged Middletown City School District
Greater Hudson Valley Health System-Orange Regional Medical Center
Habitat for Humanity of Greater Newburgh
HealtheConnections
Honor Emergency Housing Group
Horizon Family Medical Group
Hudson River Healthcare
Hudson Valley Community Services
Independent Living
Keller Army Community Hospital
Liberty Management
Maternal Infant Services Network
Mental Health Association of Orange County
Montefiore St. Luke's Cornwall Hospital
NAMI, Orange County NY
Newburgh Seventh Day Adventist Church
New York State Senator Meztger's Office
Office for Persons with Developmental Disabilities
Orange County Office of Community Development
Orange County Department of Mental Health
Orange County Department of Planning
Orange County Department of Social Services
Orange County Office for the Aging
Orange County Youth Bureau
Orange-Ulster BOCES
Planned Parenthood of the Hudson Valley
RECAP
Rehabilitation Support Services
Rockland County Department of Health
Safe Homes Orange County
St. Anthony Community Hospital
SUNY Orange
Touro College of Osteopathic Medicine
Tri County Community Partnership