



Rockland County Community Health Improvement Plan

2019 - 2021



Data compiled and reviewed in a collaboration between the Rockland County Department of Health, Good Samaritan Hospital, and Montefiore Nyack Hospital

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And the selection of health priorities was conducted through a collaborative process with the **Rockland County Public Health Priorities (PHP) Steering Committee**, which included representatives from:

AARP	Legal Services of the Hudson Valley
American Lung Association	Lexington Center for Recovery
ARC of Rockland	Lower Hudson Valley Perinatal Network
Bikur Cholim	Maternal-Infant Services Network
Good Samaritan Hospital	Meals on Wheels
BRIDGES	Mental Health Assoc. of Rockland
CANDLE	Montefiore Nyack Hospital
Catholic Charities	NAMI Rockland
Center for Safety and Change	People to People
Community Collaboratives of Western Ramapo, Spring Valley, Haverstraw & Nyack	PFLAG Rockland
Dominican College	Planned Parenthood Hudson Peconic
Epilepsy Society of Southern New York	POW'R Against Tobacco
Fidelis Care	Refuah Health Center
Friends of Recovery	Rehabilitation Support Services, Inc.
HACSO Community Center	Rockland Alliance for Health
Helen Hayes Hospital	Rockland County Dept of Mental Health
Hudson River Healthcare	Rockland County Dept of Social Services
Hudson Valley Perinatal Network	Rockland County Office For the Aging
Immigration Coalition of Rockland	Rockland County School Nurses Assoc.
Independent Living, Inc.	Rockland Pride Center
Jawonio, Inc	United Hospice of Rockland
Konbit Neg Lakay	United Way of Rockland
	VCS, Inc.
	WMC Health, PPS

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INTRODUCTION

The purpose of this Community Health Improvement Plan (CHIP) is to outline a course of action that addresses the underlying factors influencing health conditions of among Rockland County residents. Using the current New York State Department of Health (NYSDOH) Prevention Agenda 2019-2024 as a guide, the two most significant health concerns for the county were identified through a collaborative data assessment and review process that began in 2017. This CHIP is the culmination of that process and was developed through the joint efforts of the Rockland County Department of Health (RCDOH), Good Samaritan Hospital (GSH) and Montefiore Nyack Hospital (MNH), in collaboration with the more than 50 varied community partner organizations who comprise the Rockland County Public Health Priorities (PHP) Steering Committee (acknowledged on the previous page). It is the hope of this collective workgroup that the utilization of evidence-based approaches with predetermined goals, improvement strategies, and measurable objectives will improve overall health and reduce health disparities. The chosen priority areas for this three-year CHIP cycle (2019 – 2021) are: **Preventing Chronic Diseases**; and **Promoting Well-Being and Preventing Mental and Substance Use Disorders**. The specific goals and objectives to be addresses within these two topic areas are outlined on pages 6-7.

This CHIP document is intended to serve as the underlying framework for the collaborative efforts being conducted in Rockland County and is expected to be re-evaluated and revised regularly over the three-year improvement cycle. Annual Community Health Forum events are planned where essential feedback from partners can be garnered on the issues being addressed, the data points being collected, and to assist in evaluating progress towards the designated goals. It is anticipated that any decisions to make midstream adjustments to the chosen priority goals and measures will occur following these events. The working version of this document, and the Community Health Assessment (CHA) that was utilized to inform this planning process, can be found on the Rockland County Department of Health website at: (www.rocklandgov.com/departments/health/statistics-and-data/) for ease of public access.

EXECUTIVE SUMMARY

Every three years, the New York State Department of Health requires Local Health Departments to submit Community Health Improvement Plans (CHIP) and hospitals to submit Community Service Plans (CSP) which require a thorough Community Health Assessment (CHA) to be completed. In addition, the IRS requires all non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and to adopt an implementation strategy to meet the identified community health needs. These assessments and subsequent action plans are meant to meet several requirements outlined by both the Affordable Care Act (ACA) and New York State public health law. The overarching purpose of these documents is to identify and address unmet health needs in local communities.

In recent years, the New York State Department of Health has encouraged local hospitals and health departments to collaborate in the creation of joint CHIP/ CSP documents in order to better serve the populations served. To that end, beginning in 2017, the seven Local Health Departments and community hospitals in the Mid-Hudson Region, (including Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties), along with HealtheConnections (the Regional Health Information Organization covering the Hudson Valley of New York) created the Local Health Department Prevention Agenda Collaborative with the purpose of creating the first Regional Community Health Assessment for the Mid-Hudson Region. The assessment incorporated information from a diverse set of secondary sources (CDC, US Census Bureau, NYSDOH, County Health Rankings), and was further supplemented with primary data collection in the form of a resident level health opinion survey and community service provider focus group sessions held in each county.

The agencies involved in the CHA process contributed both funding and staff members to join the Collaborative in a contract with Siena College Research Institute (SCRI) who developed and implemented the resident level health assessment survey. The survey conducted by SCRI was a random digit dial community health survey designed to supplement the Regional Community Health Assessment. In order to gauge the perception of residents surrounding health and resources in their communities, responses from 812 residents of Rockland County (5,372 in total for the region) were collected. To further enhance the data collected, members of the Collaborative held 12 focus groups with service providers to understand the needs of specific communities and populations, and the barriers they face to achieving optimal health.

Implementation of the 2019-2021 Community Health Improvement Plan in Rockland County requires a coordinated effort from all Public Health Priority (PHP) member organizations, especially from the lead agencies of Good Samaritan Hospital, Montefiore Nyack Hospital and the Rockland County Department of Health. It was evident from the survey results that enhanced collaboration is required to reduce the disparities observed along racial and ethnic lines for the incidence and prevalence of various conditions like heart disease, stroke, diabetes, and mental health. The themes identified as having the greatest influence on health disparity in Rockland were housing, transportation, and nutrition. It is extremely difficult to address these broad social determinants individually, so developing stronger referrals among participating organizations and enhancing partnerships that allow residents to overcome these barriers is a priority of this plan.

Moving forward the PHP Committee will hold quarterly meetings in order to discuss any emerging opportunities or challenges identified. The RCDOH also intends to arrange annual Public Health Summits over the course of the CHIP cycle, and to provide progress reports towards meeting the specific objectives with feedback from stakeholders and the public. It is expected that during these meetings, input from participants will be obtained through open forum, Q&A, and survey format. The collected feedback will be used as a guide to determine if modification of interventions is necessary and to ultimately aid in making any midcourse adjustments deemed necessary. The process measures listed in the workplan will be tracked continuously and shall be the basis of impact evaluation. By engaging the community in this way, it is hoped that a broader set of organizations will become involved, and an expansion of interagency collaborations made possible.

The plan recommends several strategies to improve health and well-being across the lifespan for all Rockland County residents. All agencies involved will of course maintain their commitment to improving health outcomes related to goals in all 5 of the NYS Prevention Agenda priority areas, but the expressed mission at this time is to concentrate on health objectives related to Preventing Chronic Diseases and Promoting Well-Being and Preventing Mental and Substance Use Disorders. These areas were chosen collectively in a data assessment review session held with the Public Health Priorities Committee. The evidence-based interventions to be implemented in these areas are outlined in the attached workplan grids. This 'living document' is a plan for community members, designed to be implemented by health agencies, community organizations, collaborative partners, and residents across the county. Working together we envision a safe, healthy community in which to live, work and play where everyone has

equal opportunity for a healthy productive life as we aspire to make Rockland the healthiest county possible.

IMPROVEMENT PLAN - 2019-2021

Rockland County is located approximately 30 miles north of Manhattan on the western side of the Hudson River. The county is the smallest by area and third most dense in the state, outside of New York City, at only 115,000 total acres which includes more than 35,000 acres of preserved open space parkland.

Due to its proximity to New York City, Rockland has continued to experience a steady population growth over the past several years within all incorporated towns and 19 villages. The most recent population estimates from the 2018 indicates that Rockland County grew by 14,001 people (4.3%) between 2010 and 2017, up to 325,027. The statewide growth rate over the same period was 2.2%. Between 2010 and 2017, all five Rockland County towns increased in number, led by the Town of Ramapo (6.2%), followed by Clarkstown (3.6%), Stony Point (2.9%), Haverstraw (2.4%), and Orangetown (2.3%). It is home to an ever-expanding diverse population, comprised of 70.9% Caucasian, 12.5% Black or African American, 17.3% Hispanic or Latino, and 6.1% Asian residents. Consistent with what has been seen at both the state and national level, there continues to be increases in the proportion of older county residents, ages 55-85, with the largest growth being 13% in the 64-74 age group. The recent population estimates indicate steady increase in the proportion of residents speaking languages other than English, with the estimated percentage of Spanish speakers up 15.9% since 2010. In 2019 the County Health Rankings designated Rockland County as #1 for health outcomes in New York State. With respect to health factors (health behaviors, clinical care, socioeconomic factors, physical environment) Rockland County ranked at #6 in the state. Lack of physical activity and the percentage of children living in poverty were indicators that showed room for improvement.

HEALTH IMPROVEMENT PLANNING PROCESS

Beginning in late 2017, a 7-County partnership was launched to create one Mid-Hudson Regional Community Health Assessment (CHA) which was organized by the Epidemiologists and Public Health Educators from each of the Local Health Departments involved and facilitated by representatives from

HealthConnections Population Health Improvement Program (PHIP). With input and funding from the cooperating local hospitals this cooperative developed the Regional Community Health Assessment Survey for the purposes of collecting primary data from residents that is comparable across the region and could inform future health improvement decisions within each county. This survey was designed to include questions that collect information around several initiatives and priorities put forward by the New York State Department of Health and the NYS Prevention Agenda 2019 -2024.

Survey data collection, analysis, and charting were provided by a team from Siena College Research Institute (SCRI). SCRI administered a randomized telephone survey which took place between April and September of 2018, utilizing both landline and mobile phone numbers to reach respondents. Results were then weighted by gender, age, race, and region according to the U.S. Census 2010.

The Regional Community Health Assessment Survey ultimately collected responses from a random sample of over 5,000 Hudson Valley residents, with 812 of those being from Rockland. It was determined that certain populations could have been missed through this survey technique and unaccounted for in the survey findings. Some of these under-represented populations include those who are low-income, veterans, seniors, people experiencing homelessness, LGBTQ members, and people with a mental health diagnosis. In order to ensure that the needs of these special populations were met, focus groups were conducted with the community providers that serve these populations by offering mental health support, vocational programs, nutritional and educational programs, and family and community support. Before these focus groups took place, a Stakeholder Interview Form was sent out to these providers in order to supply additional insight around local factors influencing community health. This survey covered several topics, including the populations the providers serve; the issues that affect health in the communities they serve; barriers to people achieving better health; and interventions that are used to address social determinants of health. Throughout the seven counties in the Mid-Hudson Region, 285 surveys were completed by service providers, 66 of which from service providers in Rockland. The answers to the survey varied throughout each county, and these differences were expanded upon in the focus group sessions.

The culmination of this process was the Rockland County Community Health Forum held in June of 2019, where 60 local health/human services providers assisted in the selection of the county's CHIP/CSP Focus Areas. In conjunction with the data from the stakeholder Interview forms and the focus groups mentioned above, other primary and secondary data culled from local, state, and federal partners were presented to the Public Health Priorities (PHP) Committee members. The Rockland County Director of

Epidemiology delivered population health statistics from: the US Census Bureau, NYSDOH (disease rates, eBRFSS responses, Hospital Discharge data), DSRIP Regional Assessment data, the NYSDOH Prevention Agenda Dashboard, the HealthConnections Community Dashboard, and the County Health Rankings website. Using the NYSDOH 5 Prevention Agenda Focus Areas as a guide, the group was then asked to consider this synopsis of Rockland County's health and come to a consensus on the which health issues were most pressing and could be influenced by implementing collaborative interventions. Consideration was also given to what evidence-based programs could be put into place that will align and bolster, or serve to reduce gaps within, the initiatives each organization is already operating throughout the region.

PRIORITIES SELECTED FOR 2019-2021

As mentioned previously, the two Prevention Agenda priority areas chosen through the local selection process in 2019 were **Prevent Chronic Disease** and **Promote Well-Being and Prevent Mental and Substance Use Disorders**. The activities planned under each of these main areas also include an emphasis on the reduction of health disparities associated with transportation, housing and nutrition by supporting interventions in the communities with the greatest documented health inequities.

Under the priority area of **Prevent Chronic Disease**, the following focus areas and goals were designated for inclusion in the workplan (*numbering corresponds 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

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

Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity

Focus Area 4: Preventative Care and Management

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

Under the priority area of **Promote Well-Being and Prevent Mental and Substance Use Disorders**, the following focus areas were designated for inclusion in the workplan (*numbering corresponds to the New York State Prevention Agenda*):

Focus Area 2: Prevent Mental and Substance User Disorders

Goal 2.2. Prevent opioid overdose deaths

Goal 2.5 Prevent suicides

Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population

CHOSEN PRIORITY FOR 2019-2021: PREVENTING CHRONIC DISEASE

Caring for healthy people is an important component of health care. Educating all residents about health and promoting health-seeking behaviors can assist in postponing or preventing illness and disease. In addition, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and costs. Even when preventive care is ideally implemented, it cannot entirely avert the need for acute care. Delivering optimal treatments for acute illness can help promote quicker recovery and reduce the long-term consequences of illness.

Chronic diseases by nature cannot simply be remedied in a singular episode but must be carefully monitored over time. Management of chronic illness often involves promotion and maintenance of lifestyle changes and regular contact with a provider to monitor the status of disease progression. For patients, effective self- management of chronic diseases can mean the difference between normal, healthy living and frequent medical problems or disability. However, for many individuals, appropriate preventive services, timely treatment of acute illness and injury, and meticulous management of chronic disease can positively affect mortality, morbidity, and quality of life.

The leading causes of death for Rockland residents continue to be heart disease and cancer. Leading a healthy lifestyle (avoiding tobacco use, being physically active, and eating well) greatly reduces a person's risk for developing chronic disease. Access to high-quality and affordable prevention measures (including screening and appropriate follow-up) are essential steps in saving lives, reducing disability and lowering costs for medical care. The collaborative authors of this CHIP (Rockland County Department of Health, Montefiore Nyack Hospital, and Good Samaritan Hospital) fully understand this concept and plan to maintain and enhance their outreach and educational services internally and externally with the local Federally Qualified Health Centers (Hudson River Healthcare and Refuah Healthcare Center). The development and initiation of enhanced disease prevention and maintenance courses like the National Diabetes Prevention Program (NDPP), Diabetes Self-Management Program (DSMP), and Chronic Disease Self-Management Program (CDSMP), are scheduled to be given at more locations, times, and in multiple languages in the coming years. These and other concerted efforts are planned to continue throughout this implementation cycle utilizing staff, funds and other resources provided from each of the county, the local hospitals, the FQHC's, and grant opportunities.

A wide array of educational services and interventions spanning the life spectrum are in place from childcare center nutritional and school physical activity programs, to farmer's market and CSA initiatives, and to senior citizen physical activity and disease education programs. Using the current health statistics as a guide, the collaborative partners aim to curb troubling trends in several important indicators. The current data indicates that approximately 20.7% of the adults in Rockland County are classified as obese. Although this percentage is slightly below the NY Prevention Agenda goal of 23.2% and below the national target of 30.5%, there exists an increased percentage of adults who are classified as being overweight or obese (55.6%) than what is occurring at the regional and the state levels. The number of school-aged children and adolescents with overweight or obesity in Rockland County is double than the goal of Healthy People 2020 at 33.9% vs 15.7%. The largest high school disparities in the Region exists in Rockland County between non-Hispanic White (94%) and Hispanic (78%) students. The partners included in this plan have committed themselves to preventing and addressing the impact of chronic illnesses by attacking the issues at several levels along the life path, from direct patient care interventions to the development and adoption of broader public health policies in schools, workplaces and elsewhere.

CHOSEN PRIORITY FOR 2019-2021: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

In Rockland County there is an independent Department of Mental Health (RCDOMH) which spearheads the coordination of programs aimed at increasing the well-being and behavioral health of Rockland residents across the spectrum. The Department of Health works in collaboration with the RCDOMH to aid and assist their efforts as much as possible. For decades there had been a large Mental Health Department with an in-patient unit and a crisis center which could accept at risk residents for emergency care. During a budget crisis in 2014, the county chose to shutter those facilities and drastically reduce staff. Without these safety nets in place there was a clear loss in appropriate services accessible county-wide. During the health assessment in 2018 the available data reflected the downstream impact of that loss and identified an essential need for more comprehensive services and improved access to, and community understanding of, those services. For example, the 3-year average suicide mortality rate per 100,000 among Rockland teens aged 15 – 19 in 2016 was shown to be 4.1, which is a considerable increase over the rate of 2.8 that the county maintained since 2013. Rockland providers have been tasked with doing more with less, and to that end the PHP organizations have decided to take action as a group to reduce the existing gaps. Building connectedness among families and communities through the integration of enhanced mental and emotional well-being support systems is an important part of this campaign. The prevention efforts to reduce stigma around and to enhance the general understanding of mental health disorders are outlined in the attached workplan grids. Items to be conducted include the expansion of educational opportunities like Mental Health First Aid and Safe Talk training to be offered by providers county-wide and increased presence of the Suicide Prevention Coalition of Rockland at community-based events. The Coalition which formed in 2016 has been gaining ground and is dedicated to its mission of developing and implementing prevention measures, postvention programs, and enhancing public awareness of behavioral health needs and community-wide resources.

Another major concern identified through the assessment process was the need to fully ascertain the impact that substance abuse, mainly opioids, is having on Rockland residents. Over the past few years this issue has come to the forefront across New York State and elsewhere, yet the data to quantify the true scope of the epidemic have been somewhat limited. Organizations working to reduce substance abuse have expressed their difficulty in gathering and sharing the information they collect in a standardized format that can be used to inform prevention and response efforts. Several long-standing measures do exist that clearly support the cause for concern such as drug overdose deaths involving any

drug, where in Rockland that rate has risen steadily from 8.0 per 100,000 in 2014 to 16.2 per 100,000 in 2016. The issues contributing to substance abuse cross many sectors and a wide range of collaborative efforts between mental health providers, emergency services, law enforcement, public health, and social services are being planned for this CHIP cycle. Grant funding is being sought to secure funding for the creation of a unified Opioid Task Force in the county that can increase collaboration through pooled resources, referral systems, and data sharing. In conjunction there will be continued expansion of educational efforts to provide residents the tools they need reduce overdose incidence, like expansion of Naloxone administration training and kits, drug take back events and locations, and peer to peer recovery and counseling opportunities.

ADDITIONAL AREAS OF CONCERN FOR 2019-2021

As stated earlier, the CHIP process is devoted to identifying and taking measurable action around 2 New York State Prevention Agenda priority areas. This is of course not the full extent of community health improvement work planned for this period. Other areas of concern identified during the 2018 planning phase that fall under the remaining 3 state prevention agenda areas will be addressed as well. The main difference being that these additional interventions will not be officially tracked and reported out upon along the workplan that is associated with this version of the CHIP. Given below are brief descriptions of the local health issues identified and the intended actions planned for the three remaining prevention agenda priority areas.

PROMOTING HEALTHY WOMEN, INFANTS AND CHILDREN

Enhancing the health of the youngest generation, ultimately increases the overall chances that a population will attain its healthiest state. This important goal can only be reached by focusing strategic interventions at all levels of the lifepath associated with childbearing; from preconception and interconception health, to healthy pregnancies and births, to ultimately ensuring the well-being and healthy opportunities throughout childhood. This NYSDOH prevention agenda focus area had been included as one of the 2 main concerns in Rockland during the previous CHIP cycle and was tracked according to an official workplan. Many of the interventions developed through that process will remain in operation or be expanded further over the next three years. A major concern that continues to be a focus moving forward is reducing the health disparity that has been observed among babies born to

African American and Hispanic mothers with regards to low birthweight and preterm birth. Rockland has the highest birth rate in the Mid-Hudson region at 260.6 per 1,000, and both Montefiore Nyack Hospital and Good Samaritan Hospital are dedicated to minimizing these existing racial ethnic inequities. Community outreach and education that has been conducted by community-based organizations (LHVPN, HACSO) for many years will continue with to occur in the communities most affected, mainly Spring Valley and Haverstraw. Additionally, Montefiore Nyack Hospital has expressed a commitment to this particular prevention agenda area with new interventions aimed at increasing the percentage of infants being exclusively breastfed. They are dedicating resources to improve education and support systems that promote breastfeeding among pregnant women and post-partum mothers, as well as establishing policies to increase early skin-to-skin contact birthing practices inhouse.

PROMOTING A HEALTHY AND SAFE ENVIRONMENT

Ensuring that natural and built environments throughout Rockland are safe is an important factor in promoting and preserve health. To that end there are both public health enforcement and private sector and community cooperative initiatives in place that are committed to monitoring conditions and responding to emerging concerns. The environmental conditions that were identified to be of most concern in the coming years were improved water quality oversight, reduction of lead hazards causing elevated blood lead levels, and prevention of conditions that contribute to Legionella. Increased need for improvement efforts in these areas stems from recent changes to state regulation like the lowering of the blood lead action level from 10 to 5 mg/L. This seemingly small change has significantly increased the incidence and follow up required by environmental workers and medical providers. In that regard plans are in place to enhance the existing RCDOH programs with better education and technological infrastructure to more effectively meet the increased need. It is hoped that through the development and usage of more efficient database and technology resources to monitor compliance and conduct enforcement activities that some of these emerging concerns can be alleviated.

PREVENT COMMUNICABLE DISEASES

The PHP collaborative partners in Rockland also expressed significant concern for several of the goals within this prevention topic area. In the forefront was the steadily increasing trend in the incidence of Sexually Transmitted Infections that has been observed locally, regionally and nationally. The available

2016 incidence rates of Chlamydia (907.5), Syphilis and Gonorrhea (51.0) per 100,000 women continue to show upward trends among Rockland residents. It has been evident from disease reporting data that the infections are impacting a much younger age range of the population than seen in decades prior. While the measured burden falls below the NYSDOH and Healthy People 2020 targets, the community-based organizations in Rockland are determined to effect change on these diseases. Plans are in place to increase access to care among the high school aged population and to further outreach efforts that raise awareness of the growing disease burden among Rockland teens. Similarly, there are plans to widen access to PrEP (Pre-Exposure Prophylaxis) services for residents who are at risk of contracting HIV. This initiative is also in-line with Governor Cuomo's 'Ending the AIDS Epidemic in New York State' plan which was announced in 2014.

EVALUATION

The following grids outline the designated goals, objectives, and process measures for 2019-2021 and is meant to act as the framework for tracking progress towards improvement in the two chosen priority areas. In addition to reviewing these goals at the standard quarterly PHP meetings, annual public health summit meetings are planned for 2020 and 2021 to do the same. Progress in attaining the predetermined goals will be discussed at these events which will be organized by the RCDOH. This type of community engagement is a recent addition to the RCDOH CHIP process and is anticipated to enhance effectiveness of the partnerships in place. The purpose of these health forums is to open the channels of communication between all stakeholders involved and garner productive feedback and advice. It is expected that during these meetings input from participants will be obtained through data exchange, open discussion and survey format. The assembled group will be asked to recommend guidance concerning the appropriateness of the interventions in place. Collected responses will then be used as a barometer to gauge if fine tuning of interventions should occur or midcourse adjustments be made. Meeting dates and times will be made available to the public through social media, the Rockland County website, and through traditional press releases. Similarly, this full Community Health Improvement Plan will be made available on the Rockland County main page, and the Rockland County Department of Health website in early 2020. <http://rocklandgov.com/departments/health/>

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 children with obesity among elementary, middle and high school students in public school by 5% from 16.5% to 15.7%. (Data Source: Student Weight Category Status, 2016-2018)*

Objective 2: *By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 5% from 20.7% to 19.7%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016)*

Objective 3: *By December 31, 2021, decrease the percentage of adults who consume less than one fruit and vegetable per day by 5% from 25.5% to 24.2%. (Data Source: BRFSS, 2016)*

Disparity Addressed: Creating Healthy Schools and Communities (CHSC) work is being performed in East Ramapo School District; FMNP program is aimed to assist WIC participants and Seniors.

Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
<p>1 Multi-component school-based obesity prevention interventions including the New Norms for Healthy Schools and Communities, Alliance for a Healthier Generation, and the CDC Parent Engagement: Strategies for Involving Parents in School Health.</p>	<p>Complete the CHSC deliverables for the East Ramapo School District, as per the grant</p> <p>Collaborate with additional school districts and parent-teacher organizations to support policy, and environmental changes that target nutrition before, during or after school by providing healthy eating learning opportunities.</p>	<p>RCDOH (CHSC), Montefiore Nyack Hospital (MNH) school nutrition outreach program to advise</p> <p>East Ramapo School District, Creating Healthier Schools and Communities (CHSC) Wellness Committees to implement</p>	<p>January 2019-December 2021</p>	<p># of ERCSD schools that implement at least two actions to comply with Smart Snacks in School Standards for competitive foods/beverages</p> <p>#of schools that participate in the programs and employ improved nutrition standards</p> <p># of strategies implemented to increase Smart Snacks compliance of competitive foods and beverages</p>	<p>The 14 ERCSD schools will implement at least two actions to comply with Smart Snacks in School Standards for competitive foods/beverages (this includes a la cart, vending, school stores, snack or food carts, food-based fundraising).</p> <p>Increased number of school districts and individual schools that revise school nutrition policies and strategies to comply with the Smart</p>

	Supporting and co-leading efforts to create school meal policies that ensure that school breakfast and/or lunches meet specific nutrition requirements. based on the premises of Alliance for Healthier Generation.			<p># of schools that have no violations in the Smart Snacks Standards for fundraising.</p> <p># of educational activities offered to students, staff and/or parents</p> <p># of nutrition education workshops provided in public schools: prior year / current year</p> <p># of children participating in taste tests and/or educational workshops that want to switch to lower calorie drinks and water / total number of children participating in taste tests and/or educational workshops</p>	Snacks in School standards
2 Rockland Worksite Wellness, Healthy Meeting Guidelines, Food Pantry enhancement programs to deliver healthy options and client choice	Provide education and support to worksites to improve access and availability of healthier food options	RCDOH, MNH, Businesses & CBOs (where programming is being developed) to facilitate	January 2019 – October 2021	<p># of sites that have signed Healthy Meeting Guidelines</p> <p># of sites with improved vending machine purchasing policies</p> <p># of employees affected by the updates</p>	Increased percentage of worksites that are committed to providing healthier options for employees and the clients served at their locations
3 Promotion and support of the Farmers Market Nutrition Program (FMNP) to improve uptake of fresh fruits and vegetables in areas of the county where access to	Provision of Farmers' Market Nutrition Program (FMNP) checks to women, infants and children through the Women,	RCDOH WIC Clinic, Farmer's Market vendors, municipalities where the markets	January 2019 – December 2021	# of Farmer's Markets in Rockland supported by the RCDOH, and the number which accept FMNP / SNAP / EBT.	Increased distribution and higher redemption rate of FMNP benefits at the farmers markets in Rockland among WIC participants and seniors.

supermarkets is limited; especially among seniors, and families below poverty level.	Infants and Children Program (WIC) and to seniors through the Commodity Supplemental Food Program (CSFP) for the purchase of locally grown, fresh fruits and vegetables.	are held, Grocery stores		Percentage of Farmer's Market Nutrition Program benefits utilized by WIC clients and Seniors.	
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Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 2: Physical Activity					
<p>Overarching Goal: Reduce obesity and the risk of chronic diseases</p> <p>Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.</p> <p>Objective 1: <i>By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 5% from 20.7% to 19.7%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016)</i></p> <p>Objective 2: <i>By December 31, 2021 increase the percentage of adults age 18 years and older who participate in leisure-time physical activity by 5 % from 73.2% to 76.9%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016)</i></p> <p>DISPARITIES ADDRESSED: The higher population density communities, which happen to be the most diverse in the county, are targeted. According to BRFSS the rate of obesity among adults considered low-income is 36.6%, which is 77% greater than what is seen among all adults surveyed</p>					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
1 Implementation of the Complete Streets model to enable safe transportation access for all residents, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities	<p>Complete Streets Inter-Departmental outreach to municipalities that have not passed resolutions or ordinances for their jurisdiction</p> <p>Policy level changes and environmental changes are sought</p>	<p>Rockland County Inter Departmental Workgroup (IWG) comprised of Health, Transportation, Local Government boards</p> <p>All IWG members to provide staff; Municipalities to provide funds for appropriate equipment during new projects</p>	January 2019 – December 2021	<p># of new municipalities that adopt Complete Streets Policies.</p> <p># of roadway projects begun around schools and hospitals, that will follow Complete Streets practices.</p> <p># of communities that develop and/or implement a community or transportation plan that promotes walking</p>	Increased number of municipalities adopting Complete Streets policies for future land use and development

Prevent Chronic Diseases Strategic Plan

Priority Area: Prevent Chronic Diseases

Focus Area 2: Physical Activity

Overarching Goal: Reduce obesity and the risk of chronic diseases

Goal 2.2: Promote school, childcare and worksite environments that increase physical activity.

Objective 1: *By December 31, 2021, decrease the percentage of children with obesity among elementary, middle and high school students in public school by 5% from 16.5% to 15.7%. (Data Source: Student Weight Category Status, 2016-2018)*

Objective 2: *By December 31, 2021, decrease the percentage of adults who consume less than one fruit and vegetable per day by 5% from 25.5% to 24.2%. (Data Source: BRFSS, 2016)*

DISPARITIES ADDRESSED: Programs are focused on the

Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
1 Comprehensive School Physical Activity Program (CSPAP)	Implement the CDC Comprehensive School Physical Activity Program (CSPAP) in school districts through Local School Wellness Policy Committees aligned with school district educational outcomes Adoption of Local School Wellness Policy requirements; School Health Improvement Plans; CDC's Whole School, Whole Community, Whole Child Model; New York State Education Department's Every	RCDOH, MNH to advise, School Districts to facilitate Staff time for outreach and education; grant funding to be used for school enhancements	January 2019 – October 2021	# of new schools reached by enhanced outreach of RCDOH and MNH # of teachers (K-6) that participate in the Active Learning certificate course provided by Fizika Group, LLC. # of physical education teachers (K-12) that participate in professional development to enhance their skills in leading fitness programming for students Percentage of schools where Playground game stencils are painted on the school playgrounds	Contact made to all school districts in Rockland County. A minimum of 200 teachers in the ten K-6 grade schools combined will participate Up to 25 physical education teachers K-12 will participate in professional development Playground game stencils will be painted at 12 elementary schools

	<p>Student Succeeds Act Plan; School Health Index and Wellness School Assessment Tool (WellSAT) assessments; school staff and teacher professional development and training standards, and with resource or materials support.</p>			<p># of Districts, and individual schools, that adopt Comprehensive School Wellness Policies</p> <p># of school staff trained in the physical and nutritional curriculum</p>	
<p>2 Worksite Wellness programming, which includes Lose to Win Programs (LTW), Put-It-Out Rockland, Tai-Chi, Walking Groups and technical assistance in developing those policies and practices that support healthy behaviors at worksites and in the local hospitals.</p>	<p>Deployment of Worksite physical activity programs designed to improve health behaviors and results (Lose to Win, Tai-Chi, Walking Groups). The interactive courses, conducted by registered dietitians and public health outreach, aim to teach participants how to lose weight safely, make healthy food choices, add physical activity to their daily routine and overcome obstacles they may face in achieving a healthy weight</p>	<p>RCDOH, MNH to educate</p> <p>Local businesses and Community Organizations to facilitate</p>	<p>January 2019 – December 2021</p>	<p># of employers and locations that establish a Wellness policy that includes physical activity components, or improve upon an already existing plan</p> <p># of activity sessions held for each opportunity offered at worksites: current year / previous year</p> <p># of participants enrolled and the percentage engaged until course completion</p>	<p>Larger percentage of local worksites that adopt Wellness policies, to influence behaviors of employees and clients served</p> <p>Increased number of physical fitness courses available</p>

Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 4: Chronic Disease Preventative Care and Management					
<p>Goal 4.1: Increase cancer screening rates for breast, cervical and colorectal cancers, especially among disparate populations.</p> <p>Objective 1: <i>By December 31, 2021, increase the percentage of adults receiving breast, cervical and colorectal cancer screenings based on the most recent screening guidelines for breast cancer by 5% from 72% to 75.6%; for cervical cancer by 5% from 79.1% to 83% and for colorectal cancer by 5% from 66.8% to 70.1%. (Baseline: BRFSS, 2016)</i></p> <p>DISPARITIES ADDRESSED: Strategies are concentrated in areas with persons with low socioeconomic status and with minority majorities.</p>					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
<p>1 Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session) in a church, home, senior center or other setting (Source: The Community Guide)</p>	<p>Conduct community education sessions about need for cancer screenings at local libraries, senior centers, and community events</p>	<p>GSH as lead agency; Bon Secours Medical Group (BSMG) Breast Navigator, Bon Secours Charity Health System (BSCHS) Community Engagement</p>	<p>March 2020-December 2021</p>	<p># of individuals reached through one-on-one or group education that were referred to health providers for cancer screenings</p> <p>Change in awareness of the importance of cancer screenings as a preventative measure</p>	<p>Change in awareness of need for cancer screenings as part of preventative care</p> <p>Compliance with screening guidelines among individuals that were reached through one-on-one or group education Increase in the percentage of adults receiving cancer screenings</p>
<p>2 Use small media and health communications to build public awareness and demand (Source: The Community Guide)</p>	<p>Develop consistent message across all entities to increase cancer screenings, esp. during awareness months for breast, cervical and colorectal cancers</p>	<p>Good Samaritan Hospital (GSH) Radiology, BSCHS Community Engagement, BSMG providers</p>	<p>January 2020-December 2020</p>	<p># and type of locations where posters were distributed</p> <p># of calls received about screening due to campaign</p>	<p>Change in knowledge and awareness of need for cancer screenings</p>

	Evaluate how patients have found cancer screenings through surveys (i.e. newspaper, mailings, flyers, word of mouth, social media or other)	BSMG Breast Navigator, GSH Breast Navigator, BSCHS Community Engagement	December 2019-December 2020	# of community members surveyed at community events Percentages of how patients found cancer screenings by media type	Increased knowledge of how patients are learning about cancer screening services Ability to target areas and markets for greater impact and community awareness
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Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 4: Chronic Disease Preventative Care and Management					
<p>Goal 4.4: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity</p> <p>Objective 4.4.1: <i>By December 31, 2021 increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition by 5% from 5.6% to 5.9%. (Data Source: NYS Behavioral Risk Factor Surveillance Survey (BRFSS), 2016)</i></p> <p>DISPARITIES ADDRESSED: Strategies are concentrated in areas with persons with low socioeconomic status and with minority majorities.</p>					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
<p>1 Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.</p>	<p>Delivery of the Chronic Disease Self-Management Program (CDSMP), the Diabetes Self-Management Program (DSMP),</p>	<p>Montefiore Nyack Hospital (MNH) , RCDOH,</p>	<p>January 2019-December 2021</p>	<p># of CDSMP/DSMP classes held</p> <p># of patients completing CDSMP/DSMP courses, and annual participation rates associated with those classes</p>	<p>Increase the number of courses offered in the county</p>
<p>2 Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for <i>preventing</i> type 2 diabetes, especially among disparate populations</p>	<p>Delivery of the master trainer course for NDPP</p>	<p>RCDOH Center for Community Health</p>	<p>January 2019-December 2021</p>	<p># of staff or volunteers trained to facilitate the NDPP program to priority and high-risk populations</p> <p># of NDPP classes held</p>	<p>Increase the number of courses being offered in the county</p> <p>Provide greater opportunity for residents to receive training from peers in languages and settings they prefer</p>

	<p>Delivery of the NDPP for participants in English, and in languages other-than-English (Spanish, Creole, etc.)</p> <p>Strengthening of referral system to between local providers to NDPP services offered</p>	<p>MNH, RCDOH as lead agencies</p> <p>CBO's and medical providers to refer</p>	<p>January 2019-December 2021</p>	<p># or participants completing a course in a language other than English (Spanish, Creole, Yiddish, etc.)</p> <p># of referrals from RCDOH clinics to 'Mamas Maravillosas!' Program at Nyack Hospital</p> <p># of mothers that have been enrolled and completed the training.</p> <p># of referrals from RCDOH clinics to 'Mamas Maravillosas!' Program at Nyack Hospital</p> <p># of mothers that have been enrolled and completed the training</p>	
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Promote Well-Being and Prevent Mental and Substance Use Disorders Strategic Plan					
Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders Strategic Plan					
Focus Area 2: Mental and Substance Use Disorders Prevention					
Goal 2.2: Prevent opioid and other substance misuse and deaths					
Objective 2.2.1: By December 31, 2021 reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population (Data Source: CDC WONDER)					
DISPARITIES ADDRESSED: None					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine (Source: Larochelle, M.R. et al (2018) Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study; FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications	Develop internal policies/procedures for initiation of Buprenorphine administration in Emergency Department (ED)	GSH as lead	August 2019- January 2020	Policy implemented and ED staff education completed	Buprenorphine treatment begun in GSH ED (with patient consent and as medically indicated)
	Contracts in place with Peer Services for warm hand off for continued care	GSH, ADAC, Lexington Center for Recovery	August 2019- March 2020	# of patients referred to Peer Services	Increased referrals to peer services; increased number of patients receiving appropriate care
2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and	Develop internal policies/procedures for distribution of Naloxone kits in ED	GSH as lead Rockland County Department of	August 2019- March 2020	Percent of staff who completed naloxone administration training	Increased access to naloxone kits in community

consumers (Source: Oregon Health and Science University: Best Practices in Naloxone Treatment Programs for Opioid Overdose)		Health, RCDOMH as participants		# of kits distributed	
3 Establish a unified Opioid Task Force for the county that brings together providers, public health, and public safety and aligns the goals of each sector to address the growing issue of drug misuse and overdose	Identify gaps in current services Assess the true impact of opioids through use of Paramedic info and ODMAP	RCDOH as lead GSH, MNH, RC Sheriff, HIDTA, RC Medical Examiner to participate RCDOH to secure grant funding	October 2019 – December 2021	Official development and proof of implementation of a written course of action for task force goals and objectives # of agencies engaged # of meetings held	Creation of an active Task Force that can both describe the current impact of substance abuse and overdoses Evidence of cross-agency interventions to minimize overdose occurrence and death.

Promote Well-Being and Prevent Mental and Substance Use Disorders Strategic Plan

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders Strategic Plan

Focus Area 2: Mental and Substance Use Disorders Prevention

Goal 2.5: Prevent suicides

Objective 2.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 5.3 per 100,000. (Data Source: Data Vital Statistics, 2016)

Objective 1.2.2: Increase New York State's Community Scores by 7% to 61.3%

DISPARITIES ADDRESSED: None

Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
1 <i>Mental Health First Aid / Safe Talk</i> public education programs that teaches how to respond to individuals who are experiencing one or more acute mental health crises (such as suicidal thoughts or behavior, an acute stress reaction, panic attacks or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (such as depressive, anxiety or psychotic disorders, which may occur with substance abuse).	Providers to offer Mental Health First Aid and Smart Talk educational sessions county wide	RCDOMH, MHA, OASAS Rockland Outpatient Provider Sub Workgroup members to implement	October 2019 – December 2021	# of staff trained to deliver the MHFA/ST trainings # of agencies providing the educational sessions # of individuals who enroll and complete the courses	Increased understanding among health workers around best practices to care for individuals who may be in crisis
2 Enhanced Suicide Prevention Coalition efforts to raise awareness and identify areas for action in the county.	Collaborate with multisector partners to provide support, education and referrals to prevention services in the county. Creation and delivery of community events	RCDOMH as lead MNH, GSH, RCDOH, DSS, MHA, RCADD, BHRT, CBO's to participate	January 2019 – December 2021	# of projects delivered # of community events the coalition participates in annually # of participants at each event held	Increased access to care through better community knowledge of services available. Decreased stigma around mental health

	to reduce stigma and increase awareness will be held.				
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Promote Well-Being and Prevent Mental and Substance Use Disorders Strategic Plan

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders Strategic Plan

Focus Area 2: Mental and Substance Use Disorders Prevention

Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population

Objective 2.6.1: *Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4% (Data Source: National Survey on Drug Use and Health (NSDUH), 2015-2016)*

DISPARITIES ADDRESSED: Strategies are concentrated in areas with persons with low socioeconomic status and with minority majorities. Is also being conducted to assist patients seeking mental health care, and as a result addresses a disparate population for this condition

Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/Result
1 - Integrated and concurrent treatment for mental illness and nicotine addiction.	<p>Provider groups participating in the existing MH Workgroup and Outpatient Treatment Provider subcommittees will provide treatment to reduce tobacco usage.</p> <p>Policies and procedures to enhance and track progress will be drafted and implemented at each participating agency.</p>	RCDOMH, RCDOH, MHA Rockland, Jawonio, Rockland Psychiatric Center, NAMI, OASAS	January 2020 – December 2021	<p># of provider groups participating in education on the dangers of tobacco use</p> <p># of eligible individuals served by providers</p> <p># of those individuals who have reduced tobacco use</p> <p># of individuals who have become free of tobacco use after set target time frames</p>	<p>Evidence of a written plan that has components of individual, health systems, community and policy level interventions</p> <p>Evidence of implementation and evaluation of the plan</p>

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