The Annual CHIP Report documents progress made in 2018 on the implementation of the 2016-2018 CHIP. The purpose of the report is to determine if our combined efforts have had a positive effect on the health of our community; if our process measures have been met; if there are strategies that should be set aside or added; and if partners are able to continue their work.

Mary Griffiths, PHN
mgriffiths@yatescounty.org
Introduction

In 2016, a community-wide health assessment was completed. Based on those findings, a Community Health Improvement Plan (CHIP) was developed by members of the Choose Health Yates Coalition, partner, and members of the community. Periodically, updates have been made based on:

- Addition of new partners and stakeholders;
- Emerging issues; and
- Loss of some programs due to loss of funding and/or partners.

The disparity addressed throughout the CHIP (low socioeconomic status) remains unchanged.

2016-2018 CHIP Priority and Focus Areas

- **Priority Area 1: Prevent Chronic Diseases**
  - **Focus Area 1:** Reduce Obesity in Children and Adults
  - **Focus Area 3:** Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings

- **Priority Area 4: Promote Mental Health and Prevent Substance Abuse**
  - **Focus Area 1:** Promote mental, Emotional and Behavioral Well-Being

Timing

A new Community Health Assessment is being completed in 2019. Though our current CHIP is dated 2016-2018, we will continue to use it throughout 2019 and make any adjustments as needed. A new CHIP (2019-2021) will be developed during the summer and fall of 2019. After receiving approval from the NYSDOH, our new CHIP will be implemented in 2020.

Purpose of the 2018 Annual CHIP Report

The purpose of this report is to determine if our combined efforts toward defined goals and objectives have been effective and continue to be feasible.

- Has our work had a positive effect on the health and/or safety of our community?
- Did we meet our process measures?
- Do we need to revise, replace or remove any strategies?
- Do we need to add or develop new interventions due to emerging issues?
- Can partners continue their work?
How to Review the Report

This document is divided into our 2 Priority Areas (Prevent Chronic Disease; and Promote Mental Health and Prevent Substance Abuse), Focus Areas and Goals, Interventions & Strategies, Partners and Their Roles.

Process Measures are noted for each goal. Whenever possible, new data related to the NYS Prevention Agenda’s Overarching Objectives has been provided. It is important for the reader to review progress on Process Measures, as well. These are highlighted in yellow. Areas in which progress was not seen are highlighted in gray. Areas highlighted in red are questions that will need to be answered. Blue highlights reflect discussions regarding continued feasibility or changing priorities.

Thank you for your partnership throughout 2018 and for making Yates County a healthier, safer place in which to live, work and play.

Yates County Public Health and Finger Lakes Health (Soldiers & Sailors Hospital)
PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 1: REDUCE OBESITY IN CHILDREN AND ADULTS

GOAL 1.4: EXPAND THE ROLE OF PUBLIC AND PRIVATE EMPLOYERS IN OBESITY PREVENTION.

Overarching Objective 1.4.2

By 12/31/18 increase the percentage of employers with supports for breastfeeding at the worksite by 10%.

Baseline to be determined.

(Data Source: NYSDOH Healthy Heart Program Worksite Survey) unable to locate this data.

(Also, see: Focus Area – Maternal and Infant Health)

Do the suggested interventions address a disparity? Yes (lower socioeconomic status [SES] female employees at county located worksites)

Results: There weren’t any new Breastfeeding Friendly Worksites added in 2018.

Interventions, Strategies and Activities

1. Use the Business Case for Breastfeeding to encourage employers to implement breastfeeding-friendly policies.

Partners & Roles/Resources

- Finger Lakes Health (FLH) to provide Business Case for Breastfeeding and CLC referrals materials to practices who see new mothers – 0.01 FTE to support efforts
- Yates County Public Health (YCPH) to actively participate in the Finger Lakes breastfeeding Partnership (FLBP) – Full time Maternal Child Health/CLC Nurse devoting approximately 0.25 FTE to Breastfeeding initiatives.
- YCPH will identify worksites employing women of lower SES - Full time Maternal Child Health/CLC Nurse devoting approximately 0.25 FTE to Breastfeeding initiatives.
- YCPH will outreach to a minimum of 2 worksites per year and will offer training, resource materials & assistance to facilitate the implementation of policies - Full time Maternal Child Health/CLC Nurse devoting approximately 0.25 FTE to Breastfeeding initiatives.
- YCPH will maintain 1 staff with current Certified Lactation Counselor (CLC) status who can provide technical expertise to employers and their workforce - Full time Maternal Child Health/CLC Nurse devoting approximately 0.25 FTE to Breastfeeding initiatives.
FLBP, Regional Worksite Wellness and S2AY Rural Health Network (RHN) to support efforts of YCPH & FLH – Breastfeeding goals continues through the S2AY Network in agreement with Common Ground Health & the LIFT grant.

Process Measures

- Number of employers that have implemented lactation support programs
  - **Number to date**: 4 (Yates County, Rainbow Junction, Child & Family Resources, WIC).
  - **Number in 2018**: No new employers added
- Number and demographics of women reached by policies and practices to support breastfeeding.
  - This measures was not met

Strengths & Challenges, Feasibility

**Strengths:**

- Public Health continues to be a member of the **Finger Lakes Breastfeeding Partnership**. Regionally, throughout 2018, the partnership made great strides in their work plan and goals. Their Facebook page posts reached over 15,000 people with over 800 likes. They continue to educate and promote employers and other local business organizations to create environments supportive of lactating mothers using model practices. Also through the partnership, 74 health care practices were educated about the importance of being breastfeeding friendly and 4 practices became certified breastfeeding friendly practices. Partnership members also outreach to both home and center based daycares. In 2018 13 center based and 46 home daycares became breastfeeding certified in the region.

**Challenges:**

- Resignation of MCH nurse in 2018. Focus has been on recruitment & training of new MCH nurse and CLC training (completed in 9/18).

**Feasibility: Discussion at CHY meeting 4/18/19**

- Is this Intervention still attainable and effective?
  - There was discussion among members that some employers (i.e. Soldiers & Sailors Hospital) that comply with the federal guidelines as part of Joint Commission Accreditation. This may also be the case for the school districts. This may reflect that there are more employers that are supportive of breastfeeding than it appears (school districts, ARC etc.)
- Do we need to make any changes for 2019? Changing Priorities?
  - Regional Worksite Wellness Coalition working on toolkit for employers to become Breastfeeding Friendly.
  - Include Breastfeeding “Supportive” employers in addition to Breastfeeding Friendly.

Data from CHIRS – Yates County has worsened – now just above Prevention Agenda goal
New York State Community Health Indicator Reports (CHIRS)

Yates County - Percentage of WIC infants breastfeeding at least 6 months

Data from CHIRS – data suppressed from 2011-2016.
FOCUS AREA 3: INCREASE ACCESS TO HIGH QUALITY CHRONIC DISEASE PREVENTIVE CARE AND MANAGEMENT IN BOTH CLINICAL AND COMMUNITY SETTINGS

Goal 3.2: PROMOTE EVIDENCE-BASED CARE TO MANAGE CHRONIC DISEASES.

Overarching Objective 3.2.4

By 12/31/18 increase the percentage of health plan members, ages 18 – 85 years, with hypertension who have controlled their blood pressure (below 140/90) - (Data Source: NYS QARR) (PA Tracking Indicator; Health Disparities Indicator)

Do the suggested interventions address a disparity? Yes Lower SES patients receiving primary care through the Federally Qualified health Center (FQHC) – ended June ’18.

Results

Data shows a slight increase to 55.2% (’16) from 54.7% (’15), but approx. 4% decrease from 2014 data.
Data shows a decrease in Medicaid Managed Care members from 64.3% (‘15) to 61.8% (‘16)

Data shows a decrease from 59.1% (‘14) to 55% (‘15) to 54.4% (‘16) among African Americans
Interventions, Strategies and Activities

- Promote the use of evidence-based interventions (EBI’s) to prevent or manage chronic diseases, including the use of decision support tools/reminder systems in EMR’s.
- Encourage provider practice participation in the regional blood pressure registry.
- Promote participation of the FQHC’s in the Health Systems Learning Collaborative (HSLC) efforts (ended June ’18).
- Offer technical assistance & quality improvement training to providers
- Participate in the Self-Monitoring Blood Pressure Program (SMBP) in collaboration with ASTHO (Association of State and Territorial Health Officials), YMCA of Greater Rochester, Penn Yan Community Health and the Yates Community Center (added 1/18).
- Promote participation in a BP Loaner Program for area provider offices by providing forms and BP cuffs to implement in their offices (added 11/18).
Partners & Roles/Resources

- FLH provider offices to provide data to the registry & “My Reminder Campaign” materials to patients, as needed – 0.02 FTE.
- YCPH to actively participate in the HSLC and offer training/assistance with quality improvement/practice change to FQHC’s and provider practices – Full time Chronic Disease Nurse and full time Health Educator, each devoting approximately 0.25 FTE to chronic disease initiatives.
- Common Ground Health (formerly Finger Lakes Health Systems Agency – FLHSA) - administer the Hypertension Registry Program including technical assistance – in-kind support.
- Finger Lakes Community Health (FLCH)/Penn Yan Community Health ((PYCH) – will provide data 2x/yr. to the HTN Registry & will continue to participate in the HSLC.
- CHY Coalition and S2AY RHN will promote & support the program – S2AY RHN $2,475 (2 years) Funding & support continues through the LIFT grant & S2AY Network
- ASTHO (Association of State and Territorial Health Officials (added 1/18) – Provided oversight and funding for the SMBP
- YMCA of Greater Rochester – Provided oversight, form development, information for the nutrition seminars for SMBP
- Penn Yan Community Health – participated in the SMBP by attending meetings via phone & in person, staff trained as Healthy Heart Ambassador.
- Yates Community Center – provided meeting place for weekly SMBP “office hours”
- YCPH – participated in the SMBP through promotion & advertisement, staff trained as Healthy Heart Ambassadors, attended meeting via phone & in person.
- YCPH – outreach to area providers about initiating a BP Loaner Program (added 11/18) – YCPH staff will supply needed forms, BP cuffs (funding through ASTHO) and orientation to the program, as well as follow-up to monitor its success or obstacles.

Process Measures

- Number of primary care practices that submit patient numbers to the regional registry.
  - 5 (Keuka Health Care, Pre-Emption Family Medicine, Dundee Medical Center, Valley View, Penn Yan Community Health.
- Number of patients enrolled in the Hypertension Registry (new measure).
  - 4543 patients enrolled.
- % of patients enrolled in the registry whose BP is less than 140/90 for 18-59 year olds or those with diabetes; or less than 150/90 if 60 years old or older.
  - 82%
- Number of follow-up contacts made with participating providers following biannual practice level registry reports.
  o 1 – 12/18 - Regional Hypertension Committee developed a follow up letter to the provider practices that participate in the Hypertension Registry offering assistance (accurate BP training, adopting/revising BP measurement policy, Healthy Eating and Active Living with Eat Smart NY and BP Loaner Program.
  o Sent to 5 providers
- % of patients in the participating FQHC diagnosed with HTN that are controlled.
  o HSLC ended in June ’18. This information was requested from Michelle Tropper – information not available
- % of patients in the participating FQHC diagnoses with HTN that have been screened for pre-diabetes and diabetes.
  o HSLC ended in June ’18. This information was requested from Michelle Tropper – information not available
- Number of people enrolled in the SMBP and completed.
  o 6 total enrolled – most applicants did not complete the requirements of the program (meet w/ Healthy Heart Ambassador twice a month over a 4 month enrollment period and attend
- % of Yates County Provider offices that were contacted regarding the BP Loaner Program (added 11/18)
  o 100% - all Yates County Provider offices (minus PYCH as they had already implemented a BP Loaner Program)
- % of Yates County Provider offices that are participating in the BP Loaner Program (added 11/18)
  o 66% - 4 provider offices (Keuka Health Care, Pre-Emption Family Health, Medical Associates of the Finger Lakes and Valley View Family Medicine.
- % of patients that demonstrated an improvement in BP control through use of the BP Loaner Program (will be evaluated in Spring ’19 via survey with participating practices).

Strengths:
- The Hypertension Registry allows us to look at several years of data to identify trends.
- Collaboration between area agencies has been helpful in assisting with SMBP.
- Left-over funding from ASTHO has allowed YCPH to initiate the BP Loaner Program

Challenges:
- Difficulty in keeping participants motivated. Do incentives work?
Feasibility: Discussion at CHY meeting 4/18/19

- Are our interventions still attainable?
  - Discussed need for improved insurance data
  - Medical Associates of the Finger Lakes – EMR doesn’t work with the registry. Kathi will check if they now have that capacity.

- Do we need to make any changes for 2019? Changing Priorities?
  - Discussed need to remove EHR’s and focus on self-referrals as that is where the majority of referrals come from. Will focus on promotion of offered programs.
**PRIORITY AREA: PREVENT CHRONIC DISEASE**

**FOCUS AREA 3:** INCREASE ACCESS TO HIGH QUALITY CHRONIC DISEASE PREVENTIVE CARE AND MANAGEMENT IN BOTH CLINICAL AND COMMUNITY SETTING

**GOAL 3.3** PROMOTE CULTURALLY RELEVANT CHRONIC DISEASE SELF-MANAGEMENT EDUCATION.

**Overarching Objective 3.3.1**

By 12/31/18 increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.

(Data Source: BRFSS; annual measure, beginning 2013)

*Do the suggested interventions address a disparity?* Yes – Clients of Workforce Development Job Club are un or under employed individuals with a higher percentage being lower SES and male.

*Result – Data Source BRFSS (Behavioral Risk Factor Surveillance System) – this demonstrates an increase from 2013-14 to 2016*

| Percentage of adults who have taken a class to learn how to manage their chronic disease or condition. |
|----------------------------------|--------------------------------------------------|
| Year                             | 2013-14                                          | 2016                                          |
| Yates County                     | 7.2% (age-adjusted)                              | 9.7% (age-adjusted)                          |

**Interventions, Strategies and Activities**

1. Promote the use of evidence-based interventions to prevent or manage chronic diseases, including the use of decision support tools/reminder systems in EHR’s.

**Partners & Roles/Resources**

- Finger Lakes Health to provide care managers in physician practices with information to facilitate referral into Chronic Disease Self-Management programs (CDSMP) – 0.01 FTE
• YCPH will promote and offer the National Diabetes Prevention Program (NDPP) – (added 1/18) - NDPP offered 1/18 in collaboration with FLH dietician, grant funding through Greater Rochester Health Foundation and Yates Community Center (YCC)- Full time Chronic Disease Nurse and Full Time Health Educator, each devoting approximately 0.25 FTE to chronic disease initiatives.
  o YCPH – secured funding through GRHF to offer free 6 month gym memberships and athletic shoes and supplies; advertised and promoted the program; enrolled participants; attended core and post-core sessions to assist in weigh-ins and distribution of materials; coordinated with YCC to secure location and assist participants in obtaining gym membership/athletic shoes; and surveyed participants regarding the effectiveness of the program.
  o FLH – provided registered dietician as facilitator for core and post-core sessions and DPT as guest speaker; provided hand-outs/materials.
  o Yates Community Center (YCC) – provided space for core and post-core sessions. Assisted participants in obtaining their 6-month gym memberships.
  o Greater Rochester Health Foundation – provided $7135 in funding for gym memberships, athletic shoes, cost of dietician and materials.

• YCPH will explore opportunities with Workforce Development Office to offer NDPP or CDSMP to their clients - Full time Chronic Disease Nurse and Full Time Health Educator, each devoting approximately 0.25 FTE to chronic disease initiatives – completed 2017

• YCPH will promote & assist with referral to CDSMP. LHD will encourage provider practice use of EHR’s support tools - Full time Chronic Disease Nurse and Full Time Health Educator, each devoting approximately 0.25 FTE to chronic disease initiatives.
  o YCPH developed a provider referral form for the Diabetes Prevention Program, Self-Monitoring Blood Pressure Program, and CDSMP classes – this did not result in any physician referrals.

• Pro-Action Office for the Aging & PYCH - will provide CDSMP classes and other EBI’s

• FLH – Get Up and Get Going (added 10/18) – The hospital PT teaches the class & provides rehab space and equipment to start the 4 week, 8 session program. It teaches participants how to begin an exercise program, how to use exercise equipment & how to exercise without specialized equipment.
  o Yates Community Endowment grant through the Rochester Area Community Foundation – offers the program free in Yates County and can include a 3 month membership to the Yates Community Center.
  o Yates Community Center (YCC) – FLH therapy staff will work with YCC staff to make a safe transition between programs.
Process Measures

- Number of participants at EBI’s offered by partners.
  - In 2018, **OFA** offered Bone Builders, Eat Better Move More, CDSMP, Matter of Balance, Tai Chi, Walk with Ease – **201 participants & 4377 units** (a unit of service is when a participant comes to class).
  - In 2018, **FLH** offered **Get Up and Get Going** – classes are small (5) to allow individual attention. First class offered in October met the required number of participants and 5 subsequent classes are full.
  - In 2018, **YCPH** in collaboration with **FLH, YCC & funding through the Greater Rochester Health Foundation**, offered the first Diabetes Prevention Program in Yates County – 47 individuals showed interest, 27 were enrolled and **23 were engaged**. 19 gym memberships were issued and 2 vouchers (worth $70) were issued for athletic shoes. **Average attendance was 80% and average weight loss was 10.2 pounds with a total of 222 pounds lost for the group.**
  - In 2018, **YCPH** in collaboration with **ASTHO, FLCH, YMCA of Greater Rochester & YCC**, offered the **Self-Monitoring Blood-Pressure Program (SMBP)** – 6 Yates County residents enrolled in the program.

- Number of providers that use EHR’s to trigger
  - In 2018, 0 referrals were initiated by use of EHR’s

- Number of referrals to EBI’s made by providers
  - In 2018, 0 referrals were initiated by providers

- Percent of adults with one or more chronic diseases who have attended a self-management program.
  - 2016 - 9.7% (according to BRFSS data 2016). Up from 7.2% (2013-14 data)

Strengths

- OFA provides several self-management classes and has good attendance and feedback.
- Able to secure grant funding for programs (Get Up and Get Going – Yates Community Endowment & Diabetes Prevention Program (Greater Rochester Health Foundation).
- Collaboration between area agencies have been helpful in assisting with self-management classes (YCC, YMCA, PYCH)
Challenges

- Physicians/providers are not making referrals. This may be due, in part, to lack of funding to make changes to their EMR’s.
- Cardiac Prehab will no longer be offered as Dr. Gomez has relocated out of the area.
- Finger Lakes Health offers DPP, but these are usually offered in Ontario and Seneca Counties.

Feasibility – Discussed at CHY meeting on 4/18/19

- Are our interventions still attainable?
  - Interventions are still attainable but question how to keep participants motivated. Even with incentives (i.e. gym memberships), participation decreases as time goes on.
- Do we need to make any changes for 2019? Changing Priorities?
  - Reach out to U of R regarding “Promote Health, Prevent Cancer” – this is an 8 week evidence “informed” program. Look at possibly holding classes in Dundee as this is an underserved area.
  - Remove measures related to the Health Systems Learning Collaborative (HSLC) as that ended in June ’18.
  - Explore evidence-informed programs in addition to evidence-based.
  - Focus on and promote self-referrals, rather than EHR triggers.
  - Dr. Strouse has discussed starting a smoking cessation class, possibly at the Village Drug location. He prefers a larger group setting. Yates County Public Health Educator will be making contact with him to see if this can get started.
PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA 1: PROMOTE MENTAL, EMOTIONAL AND BEHAVIOURAL WELL-BEING

GOAL 1.1: PROMOTE MENTAL, EMOTIONAL AND BEHAVIOURAL WELL-BEING IN COMMUNITIES.

Overarching Objective 1.1.1

Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth & adults.

DATA

Data from NYS Prevention Agenda Dashboard

Yates County - Age-adjusted suicide death rate per 100,000 population

<table>
<thead>
<tr>
<th>Year</th>
<th>Age-adjusted rate</th>
<th>PA 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-2010</td>
<td>9.6*</td>
<td>9.9</td>
</tr>
<tr>
<td>2009-2011</td>
<td>13.9</td>
<td>9.9</td>
</tr>
<tr>
<td>2010-2012</td>
<td>11.1</td>
<td>9.9</td>
</tr>
<tr>
<td>2011-2013</td>
<td>0.2*</td>
<td>5.9</td>
</tr>
<tr>
<td>2012-2014</td>
<td>8.9</td>
<td>5.9</td>
</tr>
<tr>
<td>2013-2015</td>
<td>10.3</td>
<td>5.9</td>
</tr>
<tr>
<td>2014-2016</td>
<td>13.1</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Data Source: Vital Records data as of May 2018
### Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

<table>
<thead>
<tr>
<th>Year</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>3.8</td>
</tr>
<tr>
<td>2018</td>
<td>3.8</td>
</tr>
<tr>
<td>2017</td>
<td>3.9</td>
</tr>
<tr>
<td>2016</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Data from BRFSS

### Frequent Mental Distress (14 or more days/month)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>12% (2016 data)</td>
</tr>
<tr>
<td>2018</td>
<td>12% (2016 data)</td>
</tr>
<tr>
<td>2017</td>
<td>12% (2015 data)</td>
</tr>
</tbody>
</table>

Data from BRFSS

### Mental Health Providers

<table>
<thead>
<tr>
<th>Year</th>
<th>Providers</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>27</td>
<td>920:1</td>
</tr>
<tr>
<td>2018</td>
<td>25</td>
<td>1000:1</td>
</tr>
<tr>
<td>2017</td>
<td>23</td>
<td>1090:1</td>
</tr>
<tr>
<td>2016</td>
<td>21</td>
<td>1200:1</td>
</tr>
</tbody>
</table>

Data from CMS, Nat’l Provider

### Excessive Drinking - % of adults reporting binge or heavy drinking

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>19% (2016 data)</td>
</tr>
<tr>
<td>2018</td>
<td>19% (2016 data)</td>
</tr>
<tr>
<td>2017</td>
<td>18% (2015 data)</td>
</tr>
<tr>
<td>2016</td>
<td>18% (2014 data)</td>
</tr>
</tbody>
</table>

Data from BRFSS
Partners & Roles/Resources

- FLH to support trainings through promotion to employees and participation in Yates Substance Abuse and Suicide Prevention Coalitions – 0.01 FTE
- YCPH to actively participate in the Yates Substance Abuse Coalition (YSAC) and the Yates County Suicide Coalition. YCPH will encourage county workforce attendance and will promote training opportunities for members of the public & professionals via website, social media and media releases – Director of PH (DPH) serves on the YSAC. Steering Committee and the Suicide Coalition, each meeting monthly. The Public Health Educator serves on YSAC and the Community Education Subcommittee, each meeting monthly.
- Community Services – provides training at no cost to attendees.
Process Measures

- Number of Mental Health First Aid & Youth First Aid Trainings offered
  - Youth Mental Health First Aid Trainings – 2 with 30 attendees
  - Mental Health First Aid Trainings – 0 in 2018
- Number of QPR Gatekeeper trainings offered (replaced by Talk Saves Lives as funding no longer available for QPR Gatekeeper training)
  - 2 trainings have been done in 2018

Strengths & Challenges, Feasibility

Strengths:

- The Yates Substance Abuse Coalition continues to meet monthly.
- Community Services & the Suicide Coalition of Yates County have been active throughout 2018 offering the following:
  - June 3rd – Taste of Penn Yan
  - June 8th – Talk Saves Lives
  - August 14th – Ice Cream Social & Walk kick-off
  - September 30th – Out of Darkness Walk
  - October 17th – Talk Saves Lives
  - November 17th – International Survivors of Suicide Loss Day
  - November 28th – YMHFA

Challenges:

- Schools reporting increased challenges with behavioral/mental health issues in children.
- FLH currently doesn’t have anyone participating in YSAC or the Suicide Coalition of Yates County.
- Requested discontinuation of inpatient mental health services at Soldiers and Sailors Hospital – hospital was seeing more outpatient services and less inpatient as well as patients outside our service area.

Feasibility – Discussed at CHY meeting on 4/18/19

- Are our interventions still attainable?
  - Is actual participation on YSAC or the Suicide Coalition absolutely necessary as there may be other meetings that the hospital participates in that are as effective. FLH will make the decision of where best to fit in.
  - Invite Sarah Thompson (Suicide Coalition) to CHY meetings.
- Do we need to make any changes for 2019? Changing Priorities?
  - **Crisis Intervention Team (CIT)** – The Yates Crisis Intervention Training project will move forward in 2019. A work group will be made up of law enforcement, jail, probation, mental health providers, emergency dispatch, substance abuse providers, social services, hospital emergency department leadership, 911, EMS and dispatch, emergency housing, crisis services, and community representatives. The goal is to find ways to reduce unnecessary Emergency Department admissions, increase the utilization of the crisis team and decrease the number of individuals with treatment needs in our jail. We also hope to better coordinate our local services.
  - The New York State Office of Mental Health in response to concerns about services to children in our community, is providing assistance and guidance to do “Systems of Care” planning in Yates County. This approach identifies the needs of children and youth and their families and determines a systems plan for better access to services and supports. A kick off meeting is scheduled for April 5th and will include leadership from all children’s providers, including the hospital, Finger Lakes Community Health, schools, providers, community supports, housing, families, clergy, local advocates etc.
PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA 2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

GOAL 2.1: PREVENT UNDERAGE DRINKING, NON-MEDICAL USE OF PRESCRIPTION PAIN RELIEVERS BY YOUTH, & EXCESSIVE ALCOHOL CONSUMPTION BY ADULTS

Overarching Objective 2.1.1

Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one for the past 30 days to no more than 34.6%

Reduce the percentage of youth indicating substance use of the Yates County youth survey

Data from 2016 Youth Survey

2016 Youth Survey Percentage of Youth in Grades 9-12 reporting use of alcohol in past 30 days

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th Graders</td>
<td>8.30%</td>
</tr>
<tr>
<td>10th Graders</td>
<td>18.40%</td>
</tr>
<tr>
<td>12th Graders</td>
<td>19.10%</td>
</tr>
</tbody>
</table>

2016 Youth Survey Data - Proportion of 12th Grade Students Who Used in Past 30 Days

<table>
<thead>
<tr>
<th>Substance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>19.10%</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>10.90%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>21.80%</td>
</tr>
<tr>
<td>Other Drug</td>
<td>9.10%</td>
</tr>
<tr>
<td>Heroin</td>
<td>1.80%</td>
</tr>
</tbody>
</table>

The Youth Survey is done every 3 years, therefore no new data is available.
Interventions, Strategies and Activities

1. Too Good for Drugs program offered in Dundee & Penn Yan School Districts for the 2017-2018 school year.
2. Red Ribbon Week offered in Dundee and Penn Yan School Districts
3. Hidden in Plain Sight

Partners & Roles/Resources

- FLH to support through creating awareness of programs to employees and providers; representation on YSAC, and Narcan trainings for employees – 0.01 FTE
- YCPH to participate in review/analysis of Youth Survey data, support awareness campaigns, serve on YSAC and operate Opioid Overdose Prevention (OOP) Program – Director serves on the YSAC Steering Committee and the Suicide Coalition monthly; Public Health Educator serves on YSAC and the Community Education Subcommittee; each meeting monthly; Deputy Director conducts Narcan training events.
- Community Services – administers and pays for the youth survey (every 3 years)
- Council on Alcoholism & Addictions of the Finger Lakes – conducts the programs (Too Good for Drugs, Hidden in Plain Sight; Red Ribbon Week)
- YSAC – covers the cost of student materials

Process Measures

- Number of program sessions offered
  - Too Good for Drugs (TGFD) – continues in the Dundee School District – 10 wk. session concluded in Dec. ‘18 with 187 students participating. TGFD was also presented to the Middle School Age Girls Club with 5 students participating and the Rainbow Junction Day Care After-School Program with 18 participants.
  - Red Ribbon Week (added Oct ‘18) – offered in both Penn Yan and Dundee Central School districts.
    - Penn Yan – (K-5) – 558 students
    - Penn Yan – (6-8) – 343 students
    - Penn Yan – (9-12) – 541 students
    - Dundee – (K-12) – 726 students
    TOTAL = 2168 STUDENTS
  - Hidden in Plain Sight (added 2018) – 4 trainings were done in Yates County with 78 participants.
• Number of “Dear Parent” letters sent (added 2018)
  o Dundee Central School – 40 letters
  o Penn Yan Central School – 105 letters
• Number of Narcan trainings in 2018
  o YCPH conducted 5 Narcan trainings in 2018 with 30 participants trained
  o FLH Employee Health Director has been trained as a trainer for Narcan. This is offered to interested employees and their families.

Strengths

• The LHD has continued participation in YSAC with 2 staff members attending the meetings.
• Strong commitment continues on the part of partner agencies and the county legislature to address the issue of substance abuse.

Challenges

• “TGFD” - Not all school districts in Yates County are able to accommodate the program due to other academic program. The in-school educator is working with the school superintendent to offer other educational training.
• “Hidden in Plain Sight” – Participant # is limited for each session, so additional sessions are being planned t/o the county for adults.
• “Dear Parent” letter – change in DA office leadership. Will need to monitor for 2018-19 school year.
• Large volume of coalitions limits participation in YSAC, Suicide Coalition.

Feasibility – Discussed at CHY meeting 4/18/19

• Are our interventions still attainable?
  ➢ Do we have the correct stakeholders?
• Do we need to make any changes for 2019? Changing Priorities?
  ➢ Probable legalization of marijuana in NYS in the future and how this will impact the population (i.e. pregnant women, youth etc.)
  ➢ Increased use of e-cigs/Juuls among adolescents and teens. Schools reporting this as a big problem. Include TACFL in this.