St. Lawrence County - Canton Potsdam - CSP
2018 Update

Completed by: Deborah Chase-Lauther
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions/ Strategies/Activities	Family of Measures	2018 Progress to Date	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s)	Strengths	Challenges? How will they be addressed?
Prevent Chronic Diseases	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	Improve health and outcomes of those with Chronic Diseases.	1) Provide home-based interventions for target pop., 2) Improve self-mgmt of CD, 3) reduce readmit rates and ED visits	Transportation barriers Chronic disease management Elderly population	Health Coach Program: Partnered with SUNY Potsdam, Clarkson U, and St. Lawrence U, for 2 semester training sessions for students pursuing HC. 1st semester consists of lectures, 2nd semester students are matched with most frequently readmitted transitional care patients, and those who make repeated trips to the ED and are failing to manage their chronic condition.	Readmission rates and ED visits within 6 month timeframe. Stanford University Certified training program	Stanford Master Trainer accreditation obtained (two certified in SLC) for Leader Training for the Stanford University Based Chronic Disease Self-Management and Work Place Chronic Disease Self-Management. Students: 35 in spring (12% increase from 2018), 46 in fall (130% increase from 2017), working with 24 community members.	College	Students in pre-health studies	Students gain practical experience with chronic disease patients.	Student transportation costs to clients' homes, offset by paid mileage. Transportation for clients to access resources, offset by increased public transit routes. Student retention from 1st to 2nd semester, offset by success of program and word-of-mouth. Meeting demand of increasing referrals offset by program growth.Willingness of clients to allow strangers into their homes offset by relationship-building.
Prevent Chronic Diseases	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	Improve health and outcomes of those with Chronic Diseases.	Promote Mutual Accountability™	Chronic Disease population Medicaid Patients	Implement Chronic Disease Self-Management workshop over the course of 6 weeks. Living Healthy Workshops	Quality and Technical Assistance Center of New York (QTAC-NY) COMPASS survey data. Stanford University Certified program.	6 workshops completed, 66 chronic disease participants. 7 new leaders trained, 2 certified as Master Trainers, Stanford U certification. Outcomes: 01-06 2018 saw 61% decrease in participants' ED visits, and 30 day readmit was 0. 100% success in adopting healthy behavior trends and medication compliance system usage. July-Sept, 2018: 67% decrease in ED visits.	College			
Prevent Chronic Diseases	Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure	Reduce tobacco use among target population.	Promote Mutual Accountability™	Generational, geographic	Awarding of 2017-2018 grant from AHI for COPD prevention and treatment projects, including Dynamic Dialogues and Mutual Accountability training video.		Dynamic DialoguesTM and Mutual Accountablility training video produced for instruction in 2019.	Hospital	Time and locales	Evidenced-base Dynamic Dialogues TM and Mutual Accountability	Dynamic Dialogues is time-intensive for patients, but one-on-one w/provider is seen as beneficial.
Prevent Chronic Diseases	Employee health	Reduction in employee smoking rates	Measured reduction in smoking rates	Generational	Canton-Potsdam Hospital encourages employees to attend tobacco cessation information sessions and cessation appointments on hospital time.	Smoking rates for CPH employees	Free confidential appts (paid time) with a provider. Nicotine replacements provided at n/c to employee. To date, 22 employees expressed interest; 15 (68%) have been seen by provider; of this number, 5 (33%) report cessation, 2 report quitting w/o program.	Providers	Provides time coach and counsel	One-on-one coaching; time allotment and economic costs offset by hospital.	CDC reports tobacco addiction as rivaling opioid for tenacity of addiction. Reduction of spaces designated for smoking, expansion of smoke-free hospital permimeters, as well as education. 7 of 22 participants who have not been seen will be followed up.
Prevent Chronic Diseases	Pulmonary, COPD	Improve quality of life for COPD, Pulmonary pts	Provide assessments/treatment	Geographic, transportation	Pulmonary Independence Program - in conjuction with Respiratory Navigator, provide assessments for inpatients and outpatients. Treatment options for post d/c, or in home services as well as rehab institutions.	Based on ED visit: ED 48 & 72 hour returns; ED d/c to Obs/admit/home; and 30 day readmits.	Since 2/18, 140+ patients seen by Resp Navigator; 20 patients transitioned to short-term facilities for pulm rehab, 36 for in home resp therapy services.	Senior Center	provides environment for short-term rehab care	Direct intervention for patients	Lack of short-term beds at Maplewood and Riverledge assisted living homes. In talks with United Helpers to address the problem.
Prevent Chronic Diseases	Pulmonary Rehabilitation	Broader availability of pulmon/rehab services for Medicaid patients	Expansion of pulmonary rehab services to Medicaid patients in SLC.	Geographic, facilities	Institutional Review Board grant submitted for Pulmonary Rehab services for Medicaid patients.		15K received from AHI for pulmonary rehab services for Medicaid patients, ensuring 15 non-insurance covered patients rehab services 18 visits for 18 weeks in 2019.	Advocates	Provision of funding	Direct intervention for patients	Time commitment of 18 wks, travel logistics for Medicaid patients. Each case will be assessed.

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Prevent Chronic Disease	Reduce Obesity in Children and Adults	Reduce childhood and family obesity in SLC	Identify potential barriers to engagement in a healthy lifestyle, provide support and encouragement to children and families.	Geographic and economic	Nutrition and Wellness Outreach Program: Healthy Buddy Program. SUNY Potsdam and SLU interns are matched with families identified by PCP as having a child who is overweight or obese. Students will conduct home-based family education and intervention under the supervision of the Nutritionist. Each intern w/5 families, including 1 hour x7 weeks visits.	Robert Wood Johnson Foundation 2017 (SLC K-12 students are 24% obese, compared to 18% elsewhere in state.	To date, ten interns have served 22 families. CPH has partnered with Cornell Coop Extension for cooking classes w/participating families, no measurable data available at present.	College	Interns and cooking classes	one-on-one coaching	Funding; grants being submitted
Prevent Chronic Disease	Reduce childhood obesity; disposition to pre-diabetes	Increase awareness of healthy eating habits, local produce, and basic kitchen competency in simple meal prep	Measurably increase awareness of local foods and healthy food choices	Generational, economic	Pilot program Kids in the Kitchen, 22 local middle schools students participated in 2 day training in local produce prep and healthy eating.	Broad demographic of students, training completed with pre-post informational survey	Program completed with 21 of 22 participants agreeing to be healthy food ambassadors in their communities	Business	Provides onsite instruction and use of facilities.	During hiatus year of North Country Junior Iron Chef (CPH is Platinum Sponsor again in 2019), this program keeps momentum of healthy cooking and eating in school age children.	CPH assumed all costs for 2018 program. 2019 will offset costs through sponsorship opps for local partners.
Prevent Chronic Disease	Reduce childhood obesity; disposition to pre-diabetes	Education of nutritional choices and food prep geared to 12-13 year olds.	Increase awareness of pediatric services available.	Generational, economic	Special children's events for 12yrs and under, with emphasis on health issues and fostering healthy interactions with pediatricians.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2691736/ underscores importance of humanizing face of healthcare for ped patients	Two events per year in 2018, w/ 2 additional planned for 2019. Each event introduces new pediatricians to community. Attendance of parents w/ children 116.	Business	North Country Children's Museum provides locale, with access to science-based exhibits at no cost to attendees.	Children meet pediatricians in friendly, fostering environment	Dispersed population in a large county is an issue; parents w/o transportation. Addressed on a case by case basis.
Prevent Chronic Diseases	Chronic disease prevention and management	Better health outcomes for community through educational programming	Develop community health ambassadors to increase awareness of CDM and prevention.	Geography, demographics	Community panels and forums geared to CDP education, Wise Community, Wise Choices, Partnering in Your Care, Ask the Physician Panels, health fairs	Post-event evaluations	2018: 3000+ individual interactions with community	Community-based organizations	Locales for large events	Strong attendance, quality programs	Broaden community participation through additional marketing and programs. Additional costs to be offset through inhouse catering and hosting as opposed to local hotels and restaurants.
Prevent Chronic Diseases	Pre- Diabetic/Diabetic	Lower county rates of diabetes, pre-diabetes	Offer ongoing programs run concurrently to help manage and prevent diabetes	Geography, generational	St. Lawrence Health Initiative in collab with partner CPH offered 4 Diabetes Self-Management Programs, 2 Diabetes Prevention Programs	https://www.cdc.gov/diabetes/prevention/index.html	Self-Management Programs : 7 males, 30 females w/ 2 males, 23 females completed. Prevention Program: 3 males, 16 females, w/all meeting goals of 5% weight loss and 150 min wkly mod activity.	Community-based organizations	Provided training	Intensity and duration of programs allow for validated results.	Time commitment of 2 months and 1 year for programs; day and evening hours for classes.
Prevent Chronic Diseases	Employee health	Mirror better health to community as Health care providers; improve employee health	Through incentive programs, reduce CDs by measurable amounts.	Generational	Discounts on Fitbits, Welcoa On the Move activity challenges, vending machine inventories, subsdized local produce programs, nutritional videos (internally and FB), internal nutritional presentations, Walk With a Doc national program. Wellness employee health insurance incentive.	NY State Healthy Vending Guidelines, hospital insurance incentives	600 employee purchases of Fitbits, 130 employees participated in challenges (approx 10% of workforce), 50% of vending machines meet NY guidelines.	Health Insurance Plans	Structures lower premiums/assists with high deductible plans for those participating in biometrics program	Employees rewarded with incentives for healthy habits	Apathy addressed through new programs, education and awareness, as well as new incentives.
Prevent Chronic Diseases	Early breast cancer detection	Improve 5 year survival rates through early detection.	Reduce Stage 3,4 breast cancer diagnoses by detection in stages 1,2 with outcome of 90% passing 5 year marker.	Economic, generational	Promotion of Yearly Breast Cancer Screens. 2018 Screens to date: 4191.	Current and previous year baselines.	Annual Breast Cancer Screenings (3 years) 2016 - 4122 screens (Stage 0-1 50% minimal cancer 0%); 2017 - 4177 screens (Stage 0-1 66.67%, and minimal cancer 16.67%); 2018 - 4191 screens (Stage 0-1 68.75% and minimal cancer 12.5%) Outcome: Since 2016, annual screenings have increased, as well as early detection rates.	Federally qualified health care center	Site of screen and interpretation of results	3-D mammography widely accepted by insurances as gold standard. Automated Breast Volume Scanner (ABVS) ultrasound recommended if required following 3-D mammography.	Reinforcement of need for screenings; education.
Chronic Disease Prevention	Clinical Trials	Establishment of clinical trials that aid in the management of Chronic Disease	Participation in clinical trials.	Those germaine to clinical studies	Participation in 7 clinical trials, including CD Psoriatic Arthritis, Ankylosing Spondilitis, Lupus, RA, Non-Rad Axial Spondyloarthritis, Heart Failure, Paroxysmal Supraventricular Tachycardia (PSVT)	As determined by studies.	17 community members participated	Business	Drug trials by pharmas	Ensures our community is represented in potentially ground-breaking drug trials. Ensure access to qualified participants.	Stringent participant qualifications and participant's adherence to protocols, addressed through awareness and education.

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Promote Mental Health and Prevent Substance Abuse	Promote mental, emotional and behavioral (MEB) well-being in communities	Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	Measurable reduction in SLC smoking rates.	Geographic barriers that limit educational opportunities, generational behaviors/attitudes	Dr. Seifer will deliver tobacco education and prevention programming for all school aged children in St. Lawrence County	Self-declared and statistical youth Smoking rates in St. Lawrence County.	Dr. Seifer has met with regional superintendants to develop curriculum.	K-12 School	Curriculum development & allocation of time and space to implement program.	Physician-Educator interaction for best outcome curriculum	Creation of time/space in existing curriculum.
Promote Mental Health and Prevent Substance Abuse	Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.	Support efforts to integrate MEB disorder screening and treatment into primary care.	Reduce ED admits for mental trauma, as well as SLC suicide rates	Geographic Barriers and Transportation	Develop cadre of mental health staff, opioid awareness program, Narcan program expansion. PHQ9 risk evaluations part of PC visit.	Number of SLC residents who report poor mental health and the number of SLC residents who report having medical care for mental health issues.	2 new hires: Psychiatric NP, and Psychologist and Substance Use Service Line Manager	Hospital	Inpatient mental trauma intervention.	Increasing cadre of MEB providers and strengthening community ties with other resources.	Dearth of MEB providers. Ongoing recruitment will address this, as do grass-roots help lines and community education of awareness of MEB issues. Education of Primary Care Providers on routine implementation of PHQ9 risk assessment as part of basic patient care.
Promote Mental Health and Prevent Substance Abuse	Better outcomes for long-term recovery sustainability	Through partnership with Seaway Valley Prevention Council, increase coordination and referrals providing continuum of care and ongoing recovery services.	Reduce ED admits for opioid overdose and relapse.	Geographic and economic	Peer Recovery Coach: Peer Recovery Coaches will be available to opiate overdose survivors after they have been stabilized in the ED. Peer Coaches have been trained using an evidence-based intervention program.	Seaway Valley Prevention Council evidenced-base program. Number of returns to the ED for opiate overdose.	5 Peer Recovery Coaches currently being trained. Behavioral Health Director now partnered with St. Josephs, and member of Community Services Subcommittee.	Community-based organizations	Provision of evidenced-based program curriculum	Peer coaching is evidenced-based proven to enhance and sustain recovery.	Lack of qualified candidates, able to undertake rigorous training and time commitments. Travel logistics will be addressed with enhanced public bus routes.
Promote Mental Health and Prevent Substance Abuse	Reduction of high SLC suicide rates	Educate and de-stigmatize suicide to engage discussion.	Provide community with educational forums, 800 telephone interventions, and access to counseling.	Geographic and economic	QPR (Question, Persuade, Refer) training for community. Risk evals PHQ9 conducted through PCP visits, as guidelined by Nat'l Institute of Mental Health. Suicide Awareness Coalition involvement.	https://www.tandfonline.com/doi/abs/10.1080/17522430902913450 Post-event evaluations.	QPR Gatekeeper Training provided to 17 community members. SLC Suicide rates 2017: 12, 2018: 5 (to date) Two QPR training sessions planned for 2019.	Community-based organizations	As nationally-recognized training, QPR Gatekeeping Training is available on demand to all community groups and facilities.	Creates dialogue and awareness of suicidal tendancies/signs, and how to obtain help.	Mechanisms to adequately and accurately assess suicides as cause of death; PHQ9 assessments not conducted consistently, addressed through education
Promote Mental Health and Prevent Substance Abuse	Mental Health and Depression	Promote overall mental health of SLC	Provide forums for education and awareness of MH issues such as depression and grief management.	Geographic and economic	Community forums and panels on mental health issues. Medical Minute radio segments promoting issues of mental health, Grief Management Training by Hospice and Palliative Care of SLV.	Post-event evaluations	Evaluations indicate a greater awareness of symptoms of depression and resources to cope.	Community-based organizations	Hospice and Palliative Care of St. Lawrence Valley; REACHOUT: Crisis line, preventsuicideny.org	Immediate, confidential assistance for those in mental trauma.	Lack of awareness of existing services addressed through education and creation of a data base of county resources.
Promote Mental Health and Prevent Substance Abuse	Mental Health and substance abuse	Reduce readmits, facilitate recovery.	Facilitate recovery; reduce incidents of relapse.	Geographic and economic	Inpatient detox and outpatient counseling available through SLHS at Gouverneur Hospital. O/P service moved to Potsdam, new groups: Seeking Safety, Medicated Assisted Recovery, DBT (Dialectical Behavior Therapy), Connections, Wellness in Recovery. Now servicing North Country Freedom Homes Halfway House. Medicated Assisted Therapy set to resume when provider is replaced (left in 2018).	Person-centered approach https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/substance-use-disorders-treatment.pdf	To date, 350 individuals seen, 6310 units of service, 01/18-11/30/18, All staff trained in SBIRT, Narcan, implementing trauma approaches, safety precautions (cameras, CPI training) Person-centered approach resulting in harm reduction rather than abstinence only, Addition of a prevention counselor through SLU, new hires 1 CASAC, 1 LMHC, 1 patient rep, 1 intake coordinator.	Federally qualified health care center	Training and certification	Person-centered approach proves best outcomes.	Lack of MAT (medication assisted treatment) providers - PA's trained but need a supervising provider, actively recruiting. Transportation: SLC working to increase bus routes and improve Medicaid and non-Med transport options.
Promote Mental Health and Prevent Substance Abuse	Reduce substance abuse	Reduce availability of unused medications.			Hospital-wide drug take-back program.	Pilot Project - no formal method of measurement.	All hospital registrations sites have envelopes provided; public aware of program.	Advocates	Provision of envelopes	Public is educated on safe drug disposal with tools available.	Resistance to disposing of unused medications, addressed through education and tools to assist disposal.