NEW YORK STATE OF OPPORTUNITY. Department of Health

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Governor

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Commissioner

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Executive Deputy Commissioner

November, 2015

Dear Hospital Chief Executive Officers and Local Health Department Commissioners and Directors:

I am writing to update you on New York State's progress in meeting its *Prevention Agenda* goals, and to transmit guidance for the next cycle of collaborative community health planning.

As of April 2015, the *Prevention Agenda* dashboard showed that 16 of the Agenda's 96 outcome objectives had been met, including the state goal for preventable hospitalizations among adults. In addition to the outcomes that have been met, progress is evident for an additional 22 indicators. There are some areas, such as reducing obesity among adults and reducing pre-term births, where progress is slow.

As you know, the *Prevention Agenda 2013-2018* is New York State's health improvement plan; a vision for New York to become the nation's healthiest state by addressing five health priorities: Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; and Prevent HIV, Sexually-Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections. The *Prevention Agenda* has been the framework for state and local action to improve the health of New Yorkers. It has served as the basis for local community health improvement planning and action by local health departments and hospitals starting since 2013, and has been incorporated into state health care reform initiatives, including the Delivery System Reform Incentive Program (DSRIP) and the State Health Innovation Plan. In December 2014, all of the state's local health departments and almost 100 percent of hospitals reported implementing interventions to address *Prevention Agenda* goals.

To achieve our ambitious goals, the continued active participation of the public health and health care communities is essential. I am asking each local health department (LHD) and hospital or hospital system to work together in 2016 to address identified community health priorities tied to the *Prevention Agenda*. Because many hospitals recently completed a community health needs assessment as part of the DSRIP process, the Department is not asking for a new comprehensive health assessment this cycle. To complete the 2016-18 assessment and planning cycle, each LHD and hospital should:

- collaborate with community partners to review community health data from recently completed health assessments, including updated data on the priority health issues;
- identify two *Prevention Agenda* priorities and one health disparity in the community based on the data;
- develop and submit an implementation plan that describes the evidence based interventions being implemented and the process measures being used to track progress toward these priorities; and

- demonstrate evidence of collaboration among LHDs, hospitals and community organizations in selecting new or confirming existing priorities and addressing them.

Local health departments and hospitals are encouraged to submit one plan per county that describes the efforts of all participants, or each organization within a county can submit an individual plan. The attached guidance spells out the required information. The completed plan will meet the state's requirements for an LHD community health assessment and community health improvement plan and a hospital community service plan. The plans are due on December 30, 2016.

I am also asking each hospital involved in DSRIP to work with its partners to ensure that their *Prevention Agenda* goals and implementation efforts are aligned with DSRIP efforts. Specifically, the projects selected in DSRIP Domain 4 should be tied to countywide efforts to achieve overall *Prevention Agenda* goals. A hospital's *Prevention Agenda* efforts should also be reflected in the community benefit programs, where applicable, described in its Internal Revenue Service Form 990 Schedule H. With the state's increased focus on prevention, and as more New Yorkers become insured through the New York State of Health, the Health Plan Marketplace, we are expecting that hospitals will increase their investments in the Community Benefit categories of Community Health Improvement and Community Building, whose definitions include the kinds of activities needed to improve the health of communities. The Department's goal is for each hospital to increasingly align its investments in evidence-based interventions related to the *Prevention Agenda*.

Local health departments and hospitals can utilize the resources of their regional Population Health Improvement Programs (PHIPs) to assist in the completion of these plans. PHIPs can provide data analysis, convene community stakeholders and/or contribute to the writing of LHD and/or hospital reports. More specific plans for technical assistance on completing the plan will be available in late 2015.

Thank you for your commitment to improve the health of New Yorkers. If you have any questions, please contact Sylvia Pirani, Director, Office of Public Health Practice at sylvia.pirani@health.ny.gov, phone number 518-473-4223.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Enclosure

Template
New York State 2016 Community Health Assessment and Improvement Plan and Community Service Plan

Cover Page

1. Identify county/counties) or service area covered in this assessment and plan
2. Participating Local Health Department(s) (LHDs) and contact information
3. Participating Hospital/Hospital System(s) and contact information
4. Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals

Executive Summary

(Maximum four double-spaced pages. This report should be posted on your public website(s) and shared with community partners.)

Include succinct statements that answer the following questions:

1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners including the local health department and hospitals for the 2016-2018 period?
2. What has changed, if anything, with regard to the priorities you selected since 2013 including any emerging issues identified or being watched?
3. What data did you review to identify and confirm existing priorities or select new ones?
4. Which partners are you working with and what are their roles in the assessment and implementation processes?
5. How are you engaging the broad community in these efforts?
6. What specific evidence-based interventions/strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected?
7. How are progress and improvement being tracked to evaluate impact? What process measures are being used?

Report

1. Provide a short description of the community being served and how the service area has been defined. This could be one county or several counties or parts of several counties. If this is a regional assessment and plan, the plan must describe each county's health issues and identify the process each county used to identify its priorities and how it will contribute to addressing them.

2. Provide a short summary of health and other data that was reviewed to identify health issues of concern in the community. This could include the Prevention Agenda Dashboard, County Health Rankings and/or other sources of data on demographics and health issues facing the community and the underlying conditions that contribute to their health.

3. Identify the two Prevention Agenda priorities and the health disparity being addressed with community partners including LHDs and hospitals and provide a description of the community engagement process that was used to select or confirm existing priorities.

4. For each of at least two Prevention Agenda priorities, identify the goal(s) and objectives, the interventions/strategies/activities you are or will implement, and process measures with measurable and time-framed targets that will be used to track progress over the three-year period. Interventions should be evidence-based or promising practices. They can include activities currently underway and/or new strategies to be implemented. Process measures must be selected to track progress in implementing the strategies.

For each health priority that is or will be addressed:

a) Describe the actions the hospital intends to take to address the health issue and the anticipated impact of these actions
b) Identify resources the hospital will commit to address the health need
c) Describe the actions the LHD intends to take to address the health need and the anticipated impact of these actions
d) Identify resources the LHD will commit to address the health need
e) Describe the roles of other participants, stakeholders, other local governmental agencies, or other community based organizations including business, academia, etc. in addressing the priority
f) State whether the action(s) will address a health disparity and if so, how.

To provide this information, use a work plan chart like the one below. *The roles and contributions of LHDs and hospitals must be explicitly identified, either on one chart or separate charts for each organization.*

Priority/Focus Area:

Goal	*Outcome Objectives*	*Interventions/ Strategies/ Activities*	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Will action address disparity*

For some examples of CHIP work plans that include most of these components, see Appendix 1.

5. Briefly describe the process that will be used to maintain engagement with local partners over the next three years, and the process that will be used to track progress and make mid-course corrections.

6. Briefly describe plans for the dissemination of the executive summary to the public and how it will be made widely available to the public including providing the website where it can be located.

Appendix 1: Examples of Community Health Improvement Plan Work Plans

Seton Health/St. Mary's Hospital Community Service Plan, see p. 11
http://209.23.127.116/www-setonhealth-org/img/document_files/2013CommunityServicePlanSetonHealth.pdf

Our Lady of Lourdes Memorial Hospital, Inc., see p. 2
https://www.lourdes.com/media/202913/chip20132015.pdf

CVPH Medical Center, see p. 12
http://www.cvph.org/data/files/CVPH%20Community%20Services%20Plan%202013_rev2014.pdf

Delaware County Public Health, see p. 81
http://delawarecountypublichealth.com/wp-content/uploads/2014/12/DelawareCountyCHA-CHIP2013-2017.pdf

Warren County Public Health, see p. 5
http://www.warrencountyny.gov/healthservices/docs/2013hip.pdf

Dutchess County Department of Health, see pp. 23
http://www.co.dutchess.ny.us/CountyGov/Departments/Health/Publications/DutchessCounty_CHIP_2013_2017.pdf

Appendix 2 –Resources

- 2013 Community Service Plans
- 2013 LHD Community Health Assessments and Community Health Improvement Plans
- Prevention Agenda Dashboard
- CHNAs completed for DSRIP by PPSs. These used DSRIP Performance Chartbooks

The Prevention Agenda 2013-2017 lists priority-specific evidence-based interventions:

- Prevent Chronic Disease
- Promote Healthy Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, STDs Vaccine-Preventable Diseases and Healthcare-Associated Infections

The County Health Rankings Roadmap describes the community health improvement cycle and provides *Effective Policies and Programs for Implementation*.

The CDC Community Health Improvement Navigator provides hospitals, public health agencies, and other community organizations with evidence-based interventions for implementation.