WMC Health | HealthAlliance
Westchester Medical Center Health Network

Community Health Needs Assessment

2016 Update

2016–2018 Implementation Plan

HealthAlliance Hospitals

Broadway Campus • Mary's Ave Campus

Ulster County

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I. Executive Summary

Background and Process

In accordance with the Affordable Care Act (ACA) of 2010 and the New York State (NYS) Health Improvement Plan's Prevention Agenda Requirements, HealthAlliance of the Hudson Valley (HealthAlliance), a member of the Westchester Medical Center Health Network (WMCHealth), participated with other area hospitals, public and government agencies, community partners and the Ulster County Department of Health and Mental Health (UCDOHMH) to conduct a community health assessment and develop a local community health improvement plan. A work group consisting of UCDOHMH and local area hospitals met regularly beginning in May 2016 to identify and prioritize community health needs. The 2016-2018 Community Health Needs Assessment (CHNA) and Community Health Improvement Plan is an update to the previously created 2014-2016 CHNA and Community Health Improvement Plan. As such, the 2014-2016 plans served as a foundation for creating the 2016-2018 plans.

Partners met on a monthly to bimonthly basis to analyze data sets and community strengths. The community participated in the process to prioritize improving the health of Ulster County by means of a community health survey.

HealthAlliance's continuing progress and monitoring of goals identified in this assessment will be managed by an internal Community Benefits Committee (CBC). This committee met on April 26, 2016, for an update by the UCDOHMH on the NYS Prevention Agenda and the progress made since 2013 when the last Community Service Plan was written, and to strategize the 2016-2018 interventions. The CBC will engage internal and external resources to develop and implement evidence based strategies across the service areas to directly address identified health needs that HealthAlliance will pursue. Current and new outreach strategies will be modified, if needed, and developed during the current term of the 2016-2018 Community Health Needs Assessment (CHNA).

This document highlights findings from the 2016 CHNA, outlines the process by which the public health priorities were chosen, and describes the goals, objectives and action plans for the selected NYS Prevention Agenda priority focus areas.

Health Needs Identified

The 16 health needs identified in the 2013 CHNA continue to be relevant in 2016. The health needs include cancer, heart disease, tobacco use, obesity and mental health, among others. According to the 2014 publication "One Region, One Community Needs Assessment", an eight county community needs assessment of the Hudson Valley region undertaken in collaboration with: Westchester Medical Center, Montefiore Medical Center, Refuah Health Center and HealthAlliance of the Hudson Valley as part of DSRIP to extensively assess regional needs, ranked the top health issues in the community (out of 17) as cancer, obesity, mental health, diabetes and heart disease. These include the same health needs identified by the community in the 2016 Ulster County Community Health Survey (drug abuse, mental health and obesity). These identified areas will be addressed in HealthAlliance's 2016-2018 Implementation Strategy, after which the next community health needs assessment will be performed.

Prioritized Health Needs

The identified health needs were prioritized based upon the CHNA results that identified the size and severity of the problem and the availability of community resources to address the problem. Predetermined health

indicator focus areas were examined as they relate to current data from the NYS Prevention Agenda Dashboard, Robert Wood Johnson County Health Rankings, Delivery System Reform Incentive Payment (DSRIP) Community Needs Assessment, expanded Behavioral Risk Factor Surveillance System and other data sets. Preliminary findings allowed the group to understand the progress that has or has not been made since the 2013 CHA; understand which data sources would be most useful; determine additional community partners and organizations to further include in the process and select a disparity that all the interventions will seek to address. The disparity selected is the population with an income of less than $25,000 per year. Many of the health needs that HealthAlliance selected align with the two NYS Prevention Agenda categories of Prevent Chronic Disease/Promote Mental Health and Prevent Substance Abuse.

Implementation Plan

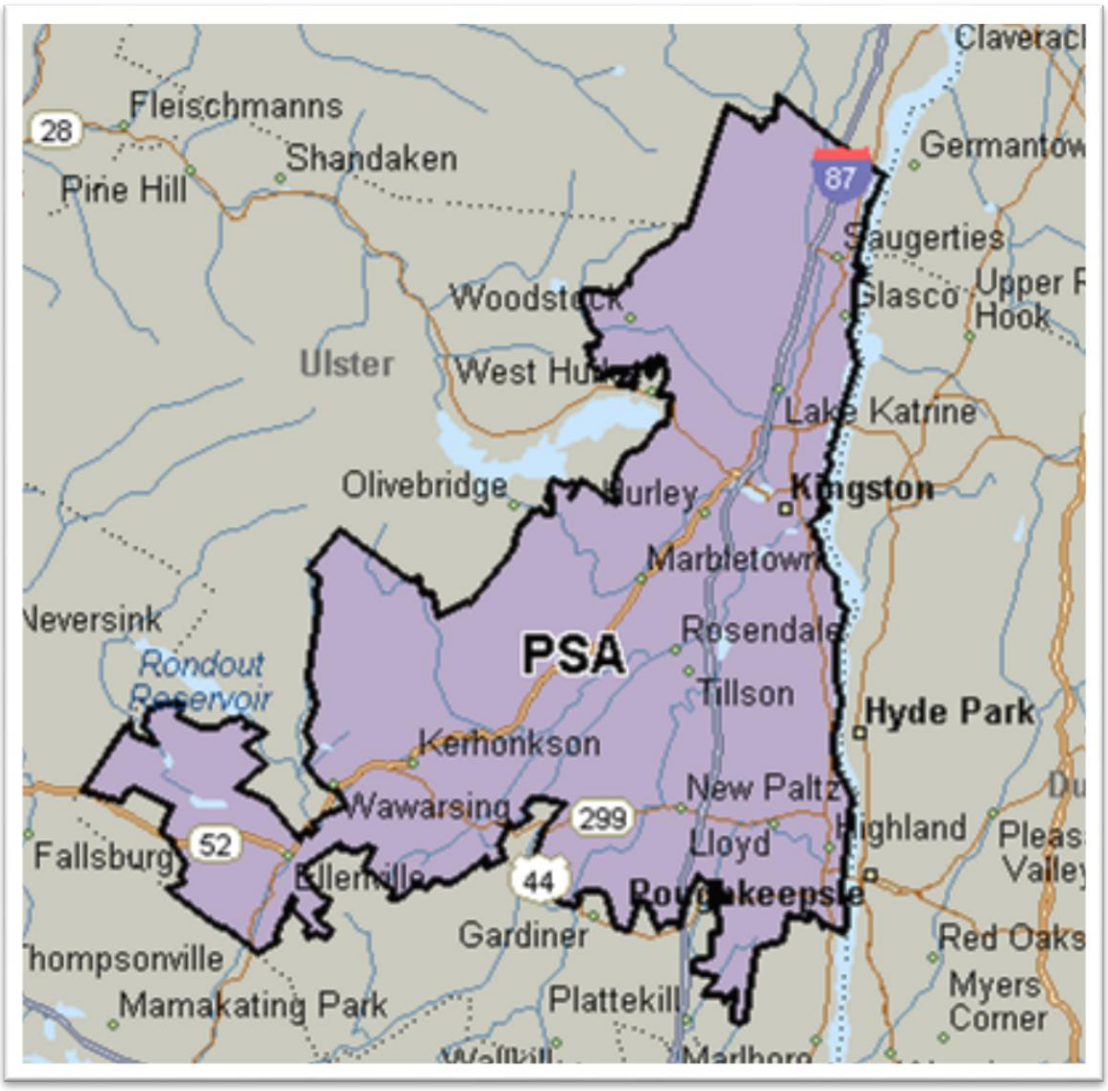
HealthAlliance developed an implementation plan to address the community needs identified in the CHNA, while paying particular attention to aligning with the goals and objectives set forth by the NYS Prevention Agenda and DSRIP initiative. As a requirement of the NYS Prevention Agenda, the two categories (identified above) must be collaboratively selected between UCDOHMH and HealthAlliance.

II. Community Description

HealthAlliance of the Hudson Valley, a member of the Westchester Medical Center Health Network (WMCHealth), operates a 315-hospital-bed health care system comprising HealthAlliance Hospital: Mary's Avenue Campus and HealthAlliance Hospital: Broadway Campus in Kingston, NY, and the Margaretville Hospital in Margaretville, NY. It also operates Mountainside Residential Care Center, an 82-bed nursing home in Margaretville adjacent to Margaretville Hospital. HealthAlliance is guided by the needs of its patients and their families. HealthAlliance delivers the best health care of the highest value in a safe, compassionate environment; invests in innovative technologies and leading-edge therapies to advance health care delivery; and improves the overall health and well-being of the diverse communities it serves.

March 2016 was a pivotal month for HealthAlliance. On March 4, HealthAlliance received from the New York State Department of Health (NYSDOH) and the state Dormitory Authority an $88.8 million Capital Restructuring Financing Program award, the second highest single award in the state, to transform its Mary's Avenue Campus into a single, state-of-the art hospital and to redevelop its Broadway Campus into a "medical village." On March 30, Westchester County Health Care Corp., through its newly created, wholly owned subsidiary WMCHealth Ulster Inc. (WMCHealth–Ulster), became the sole corporate member of HealthAlliance. HealthAlliance remains an active participant in the WMCHealth Performing Provider System (PPS) within the New York State Delivery System Reform Incentive Program (DSRIP). WMCHealth-Ulster oversees operations at HealthAlliance. The change in ownership, along with state funding to transform health care delivery in Ulster County, will have a significant positive impact on operations.

HealthAlliance defines its primary service area (PSA) by a federal definition that consists of the top 75% of hospital discharges from the lowest number of contiguous zip-codes. Due to the geographical location of acute care hospitals under HealthAlliance, there are two distinct primary service areas that lie within Ulster and Delaware counties, though not encompassing all of each county. Although defined as two service areas, HealthAlliance regards it as a single primary service area for operational community need development.



Map depicts the Ulster County PSA

The PSA population in 2016 is 145,441, while the broader population for Ulster County was 180,441 in 2014 and 46,772 for Delaware County in 2013, with populations concentrated in the cities of Kingston, New Paltz and Saugerties. Patients from adjacent counties also visit the hospital or one of our outpatient locations for services that many not be available in their respective communities.

Unlike the population growth in the U.S. of 4.9%, the overall population for the primary service area is expected to decline slightly over the next five years. However, the population of the region is aging rapidly, with a 12% growth rate of pre-Medicare and Medicare populations of seniors (Truven Health, Market Expert). These demographic changes, consistent with national trends, are one of the defining aspects of HealthAlliance's future community health planning.

In 2014, HealthAlliance's PSA market share for inpatient hospital services was 51%, while the market share for inpatient behavioral health (psychiatric and substance abuse services) was 77%. For maternity services, HealthAlliance had a 26% market share, with over 75% of these patients being Medicaid enrollees, given the accessible location within a high-need, lower-income area. Within our region, projections for women of

childbearing age and pediatric populations show a decline of 4.5%, or 2,563 people. However, HealthAlliance's share of maternity patients is expected to remain steady as HealthAlliance serves as a safety net provider for lower income, higher risk patients. The stable maternity volume is due to our partnership with the Mid-Hudson Family Practice Residency Program. It is one of the few family practice residency programs in the country whose physicians provide maternity and pediatric care for primary care patients at the nearby Institute for Family Health clinic.

Of HealthAlliance patients, 6.3 % are enrolled in Medicaid and 24.7% have Medicaid Managed Care. An estimated additional 9.2% have no health insurance (census.gov, 2014 SAHIE). In 2014 the median household income for the county is $58,592 and $43,560 for the City of Kingston, while persons below poverty level are 13.7% for the county and 21.5% for the City of Kingston. The region is economically diverse, but adjacent areas in Delaware County have unemployment rates that exceed NYS averages. Consequently, HealthAlliance provides a significant amount of charity care, totaling $1,585,593.00 in 2015.

According to Ulster County HHI-eBRFFS data, the percentage of adult smokers in Ulster County with income below $25,000 is 36.3% compared to 24.2% for NYS, while the rate of lung cancer incidence is 72.5 per 100,000 of the population, which is significantly higher than the state average of 63.3 per 100,000 people. Mental health and substance abuse indicators are also higher than state levels. Ulster County residents report 17.1 days of poor mental health per year, higher than an average of NYS residents who report of 11.2 days. Ulster County has an age adjusted suicide rates of 8.5 per 100,000 people as opposed to 7.9 per 100,000 people for NYS. Diet and exercise are also areas of public health concern. The percentage of obese adults as reported in the 2013-2014 eBRFSS is 26.4% as compared to 24.4% in the Mid-Hudson region and 24.6% in NYS.

III. Community Needs Assessment

A. Partners

Beginning May 2016, the HealthAlliance community health coordinator met with the staff of the UCDOHMH and commenced the Community Health Needs Planning Initiative. Additional health care leaders were invited to participate in the initiative, including Ellenville Regional Hospital. Meetings were held May 17, May 31, June 14, June 28, July 26, August 9, September 27, October 25 and November 22. The community participated in the process to prioritize improving the health of the county by means of a community health survey that was drafted and distributed as a result of these meetings. It was provided to the community online and in paper format with a collection box at community agencies strategically located for populations with the greatest need. Ultimately, more than 600 community surveys were collected and tabulated.

B. Methodology and Process

The previous CHNA, demographic data and trends, NYS Prevention Agenda Dashboard, County Health Rankings, eBRFSS data, a regional Community Needs Assessment (CNA) undertaken in collaboration with WMCHealth, Montefiore Medical Center, HealthAlliance and an Ulster County community health survey completed by over 600 residents of Ulster County, were used to develop the CHNA. The survey was available both online and in paper copies that were strategically placed to be accessible to low income, chronically ill and minority communities with the greatest need.

IV. Identified Community Health Needs

After reviewing various sources of quantitative and qualitative data, health needs were identified as those that pose risks to our community's wellbeing.

A. Health Needs

Adult Obesity	Asthma Hospitalizations (Child)	Breast Cancer Deaths	Cardiovascular Disease
Childhood Obesity	Colorectal Cancer	Coronary Heart Disease Deaths	Exclusive Breastfeeding
Fall Hospitalizations 65+	Lung Cancer Deaths	Motor Vehicle Crash Deaths	Poor Mental Health (Adults)
Suicide Deaths	Tobacco Use Among Adults	Tobacco Use Among Children	Unplanned Pregnancy

Although there are 16 identified health needs, most can be categorized more broadly within two NYS Prevention Agenda priorities. The NYS priority of Prevent Chronic Disease links with heart disease, obesity, tobacco use and cancer. Prevent Drug Abuse/Prevent Substance Abuse is the other priority that directly links with poor mental health and suicide deaths in the community.

B. Process for Prioritizing

A review of the data collected during 2014 by a regional CNA confirmed that the priorities identified in 2013 continue to be of concern to our community today. Out of 17 health issues, community respondents ranked cancer, obesity, mental health, diabetes and heart disease as the top ranked concerns. The 2016 Ulster County Community Health Survey confirmed that respondents ranked drug abuse, mental health/depression and overweight and obesity as the top three health concerns for their communities. The process used to identify the chosen priority areas of Chronic Disease Prevention and Mental Health Promotion/Substance Abuse Prevention can be described as follows:

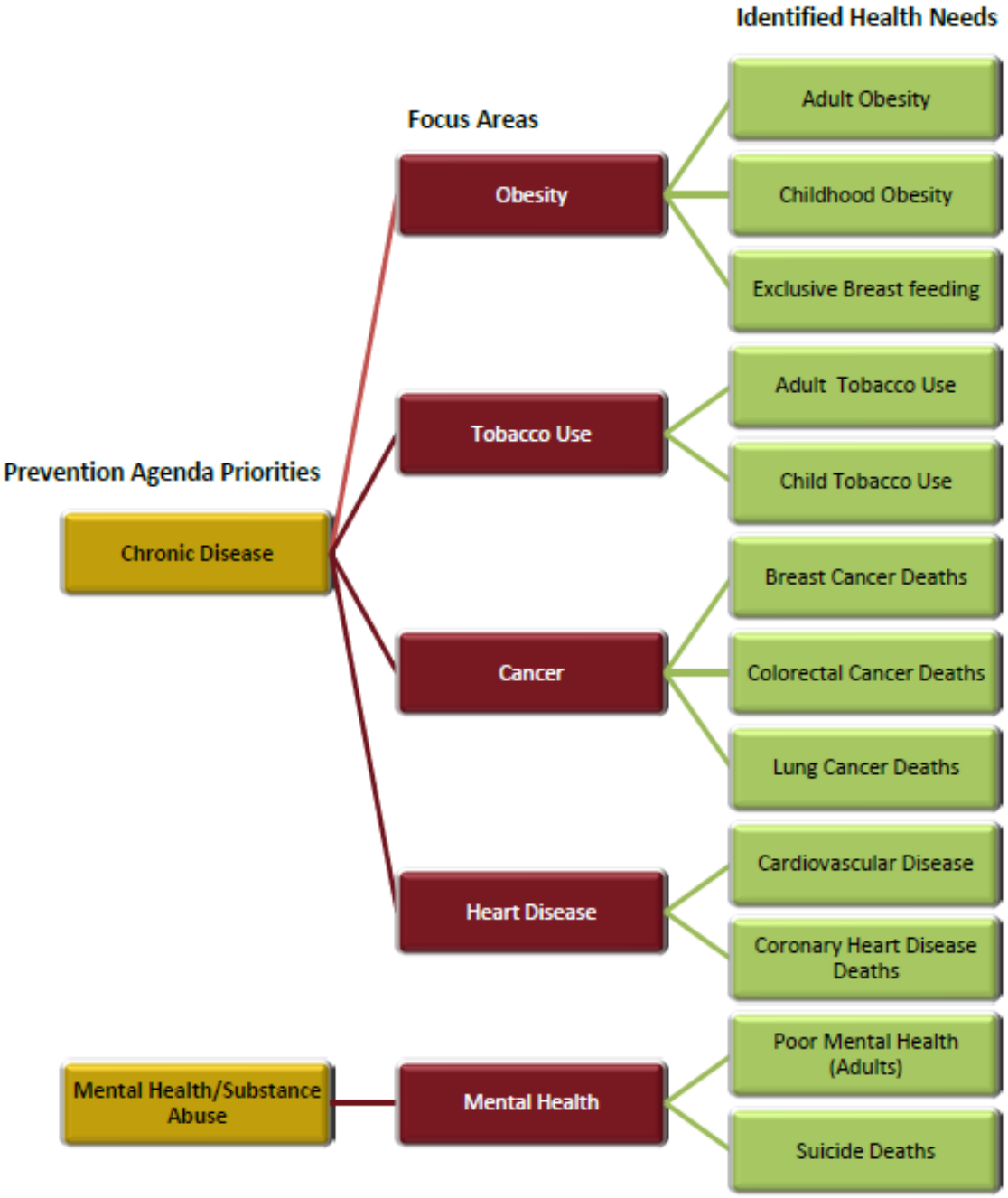
1. A workgroup was established consisting of senior staff from the Ulster County Department of Health and Mental Health's Community Relations/Health Education Division, senior representatives from HealthAlliance/WMCHealth and Ellenville Regional Hospital systems and data analysists to help collate and interpret data.
2. The workgroup reviewed Ulster County's existing Community Health Improvement Plan to assess progress and lessons learned; all available and relevant data and trends from multiple sources; a comprehensive inventory of existing community interventions and their status; created and distributed an online and written CHNA survey in both English and Spanish; reviewed and analyzed responses from the CHNA; reviewed recommended evidence-based interventions from NYSDOH; and reviewed best and promising practices established in Ulster County and the nation.
3. The workgroup crafted recommended interventions/strategies and actions (ISA) based on the following criteria: a) how well the ISA addressed identified health disparities and areas where Ulster County was performing below New York state and national averages, b) the realistic chance of successfully implementing an ISA and achieving desired results, given pre-existing performance (if applicable),

timeline and available community resources and capacity, and c) the strength and reliability of process measures associated with the proposed ISA.

4. Based on all of the above, the workgroup put together recommended interventions, strategies and actions for review and discussion by the larger community through the three main community coalitions associated with the recommended priority areas. These were Healthy Ulster Council (chronic disease prevention), Ulster Prevention Council (substance abuse prevention) and SPEAK (suicide prevention).

V. Implementation Strategy

In accordance with the NYS Prevention Agenda mandate, HealthAlliance will align with UCDOHMH to focus on two priority areas, Prevent Chronic Disease and Promote Mental Health/Prevent Substance Abuse. These priorities consist of focus areas that impact 12 of the 16 health needs identified in the CHA and will be addressed by HealthAlliance.



A. Health Needs Addressed by HealthAlliance - Community Resources and Implementation Plan

The Cancer Committee of the HealthAlliance Hospital's Commission on Cancer (COC) Accredited Cancer Program is comprised of physicians, nurses, social workers and other allied health professionals focused on cancer-related care for hospital patients and community members. HealthAlliance's Cancer Committee is dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education and the monitoring of comprehensive quality care. The committee is responsible for planning, initiating, implementing, evaluating and improving all cancer related activities in our facility.

The Cancer Committee of the HealthAlliance Hospital established a prevention goal for 2016/2017, and for the 2016-2018 Ulster County Community Service Plan, that is aimed at reducing obesity in an effort to decrease the risk of chronic diseases, including certain forms of cancer. HealthAlliance's Oncology Support Program helps to address this by offering ongoing dance and exercise classes, such as yoga, Tai Chi and SmartBells classes to the general population in an effort to increase physical activity in Ulster County, including those with chronic disease. Monthly plant-based diet cooking classes are also offered in an attempt to increase the consumption of whole grains and plant-based foods. These programs and similar will continue through 2018.

In October 2016 the Oncology Support Program also developed the Wellness and Weight Management Series, a free, six-session program that incorporates the services of a dietitian and includes healthy food demonstrations presented at the Reuner Cancer Support House. The goals of the prevention program are to reduce the Body Mass Index (BMI) for participants who are overweight, increase usage of fruits and vegetables and increase physical exercise. As of October 19, 2016, the program met three times and was well attended. A pretest has been administered to help determine outcomes. Three more sessions are scheduled for 2016 and the series will be offered twice annually through 2018.

Additionally, The Cancer Committee has developed a referral form through which health care professionals involved in cancer care can refer patients to the wellness programs available at HealthAlliance Hospital, the Oncology Support Program and in the community.

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Weight Management Program

Priority/Focus Area: Prevent chronic disease/Increase access to high quality chronic disease preventive care in both clinical and community settings

Goal	Outcome/Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
NYSDOH Goal 3.3: Promote culturally relevant chronic disease self-management education.	Develop a sustainable infrastructure for widely accessible, readily available self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers. Weight reduction if overweight. Increase the consumption of whole grains and plant-based foods. Increase the number of days and the duration of physical exercise. Increase knowledge.	Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers. Offer a six session Wellness and Weight Management Series that is open to the entire community, monthly plant-based diet cooking classes and weekly exercise classes including yoga and SmartBells.	Conduct pre- and post-tests to determine if participants: -Increase their consumption of fruits, vegetables and whole grains -Increase their frequency and the duration of moderate to vigorous physical exercise -Increase their knowledge of healthy lifestyles -Weight loss if overweight	The HealthAlliance Cancer Committee is the lead agency responsible for coordination and evaluation. Collaborates with: - ShopRite dietitians - Health educators - The instructors of the exercise classes offered at HealthAlliance -Local gyms and YMCA -Area physicians	ShopRite dietitian will facilitate the groups through the Oncology Support Program at HealthAlliance. Physicians will provide referrals.	Program will take place between October and December of 2016, and may be repeated twice a year through 2018.	Yes. Targets the population with an income of less than $25k per year. Low income populations will be targeted at health fairs and at the People's Place.

Breast Cancer Screening Program

Breast Cancer Screenings are regularly offered at the HealthAlliance Fern Feldman Anolick Center for Breast Health, part of the comprehensive breast care program at HealthAlliance Hospital: Mary's Avenue Campus. Our integrated practice brings together a multispecialty cancer treatment team of experts to ensure you get the best care available. The experts include breast health specialists, radiation oncologists, medical oncologists, surgeons, plastic surgeons, pathologists, radiologists and a skilled support staff — all working as a multidisciplinary team to provide whole-person care for women. Our certified Breast Patient Navigator ensures seamless, coordinated care among physicians, diagnostic tests and cancer treatments, while offering education, guidance and supporting the patient and their family. The center is an FDA certified mammography facility, received certification in mammography, stereotactic biopsy and breast ultrasound from the American College of Radiology and is designated as a Breast Imaging Center of Excellence by the American College of Radiology.

The Cancer Committee of HealthAlliance Hospital has identified the need to ensure that low income members of Ulster County have access to breast cancer screenings in order to reduce breast cancer mortality in this population. On three occasions in 2016, the Breast Patient Navigator and the manager of the Center for Breast Health conducted outreach to the low income population that accesses the food pantry at People's Place. This afforded HealthAlliance the opportunity to identify the barriers to breast cancer screening, help members of the community access breast cancer screening, and guide those with positive findings of breast cancer. Further outreach efforts are scheduled for 2016 and more will be coordinated through 2018.

Additionally, the Center for Breast Health will increase access to breast cancer screening for uninsured and underinsured women by opening the center for a special period of time when women enrolled in the Cancer Services Program will be offered free breast cancer screenings. A Spanish translator will be available to provide support to Spanish-speaking women, and child care will be provided.

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Breast Cancer Screening Program

Priority/Focus Area: Prevent chronic disease/Increase access to high quality chronic disease preventive care in both clinical and community settings.

Goal	Outcome/Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
NYSDOH Goal 3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	NYSDOH Objective 3.1.1: By December 31, 2018, increase the percentage of women aged 50-74 years with an income of < $25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), by 5% from 76.7% (2010) to 80.5% Increase access to breast cancer screening for uninsured and underinsured women. Increase number of women who enroll in the Cancer Services Program.	Women who are uninsured and underinsured will be identified through community outreach efforts and enrolled in the Cancer Services Program. The Fern Feldman Anolick Center for Breast Health will open for a special period of time when women enrolled in the Cancer Services Program will be offered free breast cancer screenings. A Spanish translator will be available to provide support to Spanish-speaking women. Child care will be provided.	Women with positive findings on the breast cancer screening will be tracked by the Breast Patient Navigator.	HealthAlliance Cancer Committee is the lead agency. Collaborates with: - The New York State Cancer Service Program - The People's Place provides access to the participating population. - The Migrant Education Center provides access to the participating population.	The New York State Cancer Service Program will provide promotional materials and staffing to enroll women who are uninsured or underinsured, and will reimburse cancer screenings for eligible women. Migrant Education Center	The Fern Feldman Anolick Center for Breast Health will be open to women eligible for the Cancer Services Program in October 2016, 2017 and 2018.	Yes. Outreach efforts will take place at People's Place, the Migrant Education Center and at other health fairs that target people who may be uninsured or underinsured and do not have access to cancer screenings.

Colon Cancer Screening Program

The HealthAlliance Gastroenterology Department's dedicated and experienced team assists patients at every stage — from admission, through your procedure, recovery and discharge — with expert care. We provide patient focused services and use well-established techniques to perform procedures and testing. Services offered include esophageal dilation, bronchoscopy, upper endoscopy and gastroscopy, endoscopic retrograde cholangiopancreatography and colonoscopy.

The HealthAlliance Cancer Committee has identified the need to increase education about, and the screening rates of colon cancer. HealthAlliance will provide colon cancer screening education through marketing efforts and event outreach, where specialists will connect the uninsured and underinsured with free colon cancer screenings offered through the Cancer Services Program.

Priority/Focus Area: Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Goal	Outcome/ Objective	Intervention/ Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
NYSDOH Goal 3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations. Increase education about the importance of colon cancer screening and improve access to cancer screenings among the uninsured and underinsured.	NYSDOH Objective 3.1.3: By December 31, 2018, increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or a sigmoidoscopy in the past five years and a blood stool test in the past three years or a colonoscopy in the past 10 years) by 5% from 68.0% (2010) to 71.4%. Increase colon cancer screening among adults age 50 to 75.	Women and men between the ages of 50 and 75 will be educated about the importance and methods of colon cancer screening through hospital-wide marketing and events. Outreach efforts will be made to connect the uninsured and underinsured with free colon cancer screenings offered by the Cancer Services Program.	Men and women who are screened through the Cancer Services Program will be identified and guided to ensure access to care.	The HealthAlliance Cancer Committee is the lead agency. Collaborates with: -American Cancer Society -New York State Cancer Services Program. - People's Place and the Migrant Education Center provide space to meet with participants.	New York State Cancer Service Program will provide free fecal occult blood testing to the uninsured and underinsured. The American Cancer Society's campaign to expand colon cancer screening by 2018 will be utilized to increase awareness.	The campaign to increase awareness of colon cancer screenings will take place in 2018.	Yes. The population with an income less than $25k will be targeted through outreach at sites that serve a lower income population such as People's Place and the Migrant Education Center.

The HealthAlliance Diabetes Education Center in Kingston, NY, is committed to providing individuals with the skills and knowledge to manage diabetes and prevent diabetic complications. The Diabetes Education Center is also a community resource center where we host trainings and educational programs and offer information resources for our community to learn about diabetes. The Diabetes Education Center offers education and training to adults and teens with Type 1, Type 2 or gestational diabetes including weekly classes, a free, monthly support group, pump trainings and continuous glucose monitoring studies. Our Diabetes Educational Program has been recognized since 2003 by the American Diabetes Association for meeting its high-educational standards and for offering quality self-management diabetes education. We remain the only American Diabetes Association accredited education center in Ulster County.

2016 Update:

Patient Volume:
The HealthAlliance Diabetes Education Center has served 315 patients so far this year, with 195 new patients. Of these 195:

- 9% inpatient referrals
- 15% self-referred
- 76% physician referred

Classes:
The center has held 86 diabetes self-management classes so far in 2016. Of 108 people who attended a class, 36 people completed all five classes, resulting in a 33% completion rate.

Support Groups and Community Outreach:
We have held 10 monthly Type 2 diabetes support groups and six Type 1 diabetes support groups. Many area physicians, fitness centers and diabetes company educators have presented at the meetings, including Dexcom, Dr. Ali Hammoud (Cardiology), Mac Fitness, Tandem Diabetes, Keith Bennet Karate, Dr. Geoffrey Lee (Nephrology), Sanofi A1cChampions, Hudson Valley Foot Associates, Dr. Mohsin Cheema (Opthalmology), Dr. Raymond Lippert (Endocrinology), Juvenile Diabetes Research Foundation, Omnipod and the Ulster County Office of the Aging. So far this year 140 people have attended the free events.

Staff from the center also participated in the Ulster Association for Retarded Citizens Health Fair and the O+ Festival.

Employee Wellness:
Employee wellness nutrition classes were held at the HealthAlliance Hospital: Mary's Avenue Campus, HealthAlliance Hospital: Broadway Campus, Grant Avenue offices and the HealthAlliance Outpatient Dialysis Center. The 10 week series was attended by 119 employees who completed at least one class.

The above described programs, groups and community outreach will be continued through 2018, with increased marketing and outreach to further promote self-management of diabetes.

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The Diabetes Education Center

Priority/Focus Area: Prevent chronic disease/Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Goal	Outcome/Objective	Intervention/ Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
NYSDOH Goal 3.3: Promote culturally relevant chronic disease self-management education.	NYSDOH Objective 3.3.1: By December 31, 2018, 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.	Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions linked to the clinical setting. Maintain ongoing, evidence-based classes and individual appointments to help individuals with diabetes manage the various aspects of self-management.	Weight, Hgb A1C, lipids, eye exam and patient satisfaction data are collected and reported annually to the American Diabetes Association.	The HealthAlliance Diabetes Education Center is the lead agency. Collaborates with: - HealthAlliance inpatient diabetes coordinator to ensure transition of care for individuals with diabetes whose A1C values are greater than 8%, are newly diagnosed, changed their treatment (i.e., initiating insulin) or were hospitalized with diabetes complication. - Area physicians close the loop and foster collaborative care.	The HealthAlliance Diabetes Education Center has a full-time registered nurse, certified diabetes educator, program coordinator and a part-time registered dietitian.	Ongoing	Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. The disparity we are targeting is the population with income of less than $25k.

The Family Birth Place at HealthAlliance Hospital: Broadway Campus provides the highest level of care and a range of choices for expectant women in a secure, yet family-friendly environment where the well-being of our mothers and babies is our highest priority. The Family Birth Place offers a Labor, Delivery, Recovery, Postpartum (LDRP) approach to obstetric care, where you can give birth, recover and spend time with your baby all in one homelike room. The Family Birth Place continues to offer prenatal childbirth education and breastfeeding classes in which expectant mothers and their partners are educated about the benefits of breastfeeding. Many clinical staff members are Certified Lactation Counselors. Certification holders demonstrate competence in lactation knowledge, skills and attitudes, and agree to comply with the Academy of Lactation Policy and Practice code of ethics. The Family Birth Place is a Cribs-for-Kids National Certified Gold Safe Sleep Champion and received the 2015 Quality Improvement Award from the New York State Perinatal Quality Collaborative Obstetrical Improvement Project.

The Family Birth Place is in the final stage before designation as a 'Baby-Friendly' hospital. This accreditation recognizes hospitals that successfully implement evidence-based breastfeeding initiatives. The Baby-Friendly Initiative is predicated on the fact that breastfeeding is the normal way for human infants to be nourished. An abundance of scientific evidence points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. With the correct information and the right supports in place, most women who choose to breast-feed are able to achieve their goal. Education of hospital staff in preparation for the 'Baby-Friendly' on-site visit has brought awareness of breastfeeding to other departments such as housekeeping and all medical floors.

The Family Birth Place has met and exceeded the objective of increasing the percentage of infants who are exclusively breastfed during birth hospitalization in New York State hospitals by at least 10% to 48.1%; The 2016 average (to date) of mothers who breastfeed exclusively during hospitalization is 51%.

Additionally, practices such as skin-to-skin contact after birth and rooming-in have also become routine. As soon as a baby is born, he or she will be placed on the mother's chest after being dried. This is called "skin-to-skin care" and HealthAlliance offers it for at least an hour for all babies regardless of the mother's feeding choice, as long as you or your baby don't need special medical attention. Rooming-in can help a baby regulate his or her heart rate, body temperature and sleep cycle because he or she can sense their mother nearby. To encourage rooming-in, the Family Birth Place uses its baby nursery only for babies who need special medical attention or certain procedures.

In working with the community, The Family Birth Place partners with the Breastfeeding Initiative of Ulster County (BIUC), members of which include the Institute for Family Health, the Ulster County Department of Health, the Ulster County Women, Infant and Children (WIC) program, and the Maternal Infant Services Network (MISN). Other community outreach includes sitting on the conference committee for the MISN conference in May, providing a Rock and Rest tent at the Ulster County fair in August and distributing breastfeeding information at the O+ Festival in Kingston in October 2016.

The Family Birth Place aims to increase the number of mothers who ever breastfeed during their hospital stay from 82% to 85% and the number of women who breastfeed exclusively during their hospital stay from 51% to 55% by the end of 2018. This will be accomplished by continuing with skin-to-skin and rooming-in techniques and other practices required for Baby-Friendly designation. The Family Birth Place also plans to increase the number of nurses who are Certified Lactation Counselors from 53% to 75% by end of 2018.

(Continued)

The Family Birth Place

Priority/Focus Area: Prevent chronic diseases/Reduce obesity in children and adults

Goal	Outcome/ Objective	Intervention/ Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Per NYSDOH, Expand the role of health care and health service providers and insurers in obesity prevention.	Per NYSDOH, by 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by at least 10% to 48.1% Increase number of mothers who ever breastfed during their hospital stay from 82% (end of June 2016) to 85% by the end of 2018. Increase numbers of women who breastfed exclusively during their hospital stay from 51% (end of June 2016) to 55% by the end of 2018.	Continue with current best practices, such as immediate skin-to-skin and rooming-in. These are practices that are required for Baby-Friendly designation, which is expected by the end of 2016. Increase percentage of full-time and part-time nurses who are Certified Lactation Counselors from 53% to 75% by end of 2018.	Monitor the rate of mothers who ever breastfed and who exclusively breastfed while at HealthAlliance. Receive Baby-Friendly designation of the HealthAlliance Hospital: Broadway Campus from Baby-Friendly USA, Inc.	HealthAlliance Family Birth Place is the lead agency. Collaborates with: -Breastfeeding Initiative of Ulster County -Institute for Family Health -Ulster County Women, Infants and Children program	In-kind staff time	Increase breastfeeding rates by the end of 2018. Baby-Friendly designation by 2016. Maintenance of policies and practices is ongoing.	Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. As the safety net hospital we serve the population with income of less than $25k. For maternity services, HealthAlliance had a 26% market share, with over 75% of these patients being Medicaid enrollees. "Breastfeeding is a natural 'safety net' against the worst effects of poverty. If the child survives the first month of life, the most dangerous period of childhood, then for the next four months or so, exclusive breastfeeding goes a long way toward canceling out the health difference between being born into poverty and being born into affluence…It is almost as if breastfeeding takes the infant out of poverty for those first few months in order to give the child a fairer start in life and compensate for the injustice of the world into which it was born." –James P. Grant, former Executive Director, UNICEF

The HealthAlliance Employee Wellness Program is a new initiative of the HealthAlliance of the Hudson Valley Community Service Plan for the years 2016-2018. The goal is to establish a comprehensive worksite wellness program for employees. HealthAlliance implemented an Employee Wellness Program for all employees, but more specifically for those enrolled in the CDPHP health insurance plan obtained through HealthAlliance. All benefit-eligible employees are encouraged to complete three activities, which include, completing a personal health assessment, completing an annual physical and participating in at least one wellness activity between January 1, 2016 and December 31, 2016. Such wellness activities can include getting an annual flu vaccine, getting an eye exam, partaking in all six sessions of the Wellness and Weight Management Series, and more. Employees who complete all three requirements will receive a $15 wellness credit per pay period towards their CDPHP health insurance premium. In addition, HealthAlliance has started implementing employee-specific nutrition and physical activity classes on campus and has opened the campus to a mobile farm stand during the growing season. Employees who have enabled “Quick Check” on their ID badges can use their badges to purchase this fresh, locally grown produce.

(Continued)

The HealthAlliance Employee Wellness Program

Priority/Focus Area: Prevent chronic disease/Reduce obesity in children and adults

Goal	Outcome/ Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
NYSDOH Goal 1.4: Expand the role of public and private employers in obesity prevention.	By December 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and is fully accessible to people with disabilities.	Implement evidence-based wellness programs for all public and private employees, retirees and their dependents through collaborations with unions, health plans and community partnerships that include, but are not limited to, increased opportunities for physical activity; access to and promotion of healthful foods and beverages; and health benefit coverage and/or incentives for obesity prevention and treatment, including breastfeeding support. As a role model, HealthAlliance will implement a program that incentivizes employee participation in a personal health assessment, a yearly physical and the adoption of at least one healthy behavior. The program will make health insurance rates favorable for those that participate in wellness activities. This will serve as a template for other community organizations that are interested in creating worksite wellness programs. HealthAlliance promotes healthy eating to employees by offering group nutrition classes and private nutrition/weight loss counseling at no charge for employees. As the lead agency, HealthAlliance partners with a local gym to bring a variety of movement classes on campus for employees.	Collect a baseline number of employees that participate in a personal health assessment and healthy behavior programs.	HealthAlliance is the lead agency. The HealthAlliance Employee Wellness Committee assesses employee interest in programming and makes recommendations to administration. CDPHP collaborates by aggregating data on their website. This data is reviewed, evaluated and reported by HealthAlliance. Nutrition classes are in-kind from HealthAlliance dietitians. Local gyms provide fitness instructors and memberships at a reduced cost.	The HealthAlliance Employee Wellness Committee makes in-kind contributions. HealthAlliance has financial input.	Starts December 2016. Will be ongoing.	Yes. Connects with Ulster County adults with incomes under $25k.

Partial Hospitalization Programs: HealthAlliance has two separately operating partial hospitalization programs, one for adults and one for adolescents, at HealthAlliance Hospital: Mary's Avenue Campus. These are medically supervised outpatient programs for persons suffering acute symptoms of psychiatric illness who need intensive daily treatment, but not necessarily hospitalization. The programs provide a multi-disciplinary approach involving a psychiatrist, nurse, social worker and activities therapist, in a less restrictive setting.

HealthAlliance aims to promote the emotional, behavioral and mental well-being in of Ulster County by helping Partial Hospitalization Program participants. This will be done through a comprehensive, personalized treatment and aftercare plan designed especially for each recipient from a multidisciplinary perspective, and takes into account the biopsychosocial needs of that individual. This treatment plan will be developed by coordinating services with community providers.

The main modality of treatment will be daily dialectical behavioral therapy, education and activity groups that teach and reinforce coping skills to program participants. We also offer alternative modalities such as movement therapy and pet therapy. Additionally, the Partial Hospitalization Programs will provide medication management and individual therapy at least twice a week to program participants and family therapy as needed to participants and their families.

(Continued)

Partial Hospitalization Programs

Priority/Focus Area: Promote mental health and prevent substance abuse/Promote mental, emotional and behavioral well-being in communities

Goal	Outcome/ Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
To promote mental, emotional and behavioral (MEB) well-being in communities. To promote the emotional, behavioral and mental health of Partial Hospitalization Program participants.	NYSDOH Objective 1.1.1: Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults. To provide mental health services to approximately 200 people each year and facilitate improvement in the ability of the Partial Hospitalization Program participants to regulate emotions, manage behaviors and reduce symptoms of mental illness.	Identify and implement evidence-based practices and environmental strategies that promote MEB health. Provide daily dialectical behavioral therapy, education and activity groups that teach and reinforce coping skills to program participants. Provide medication management at least twice a week to program participants. Provide individual therapy at least twice a week to program participants. Provide family therapy as needed to program participants and their families. Coordinate services with community providers to develop a comprehensive treatment and aftercare plan.	Pre- and post-patient surveys to indicate changes in patients' emotional, behavioral and mental health as a result of program interventions. The survey results will be processed by staff to obtain data reflecting the overall improvement in mental health for all program participants.	The HealthAlliance Partial Hospitalization Program is the lead agency. Collaborates with: - Community mental health agencies and area hospitals refer patients and provide aftercare when program participants return to the community. - Medical providers provide a comprehensive wellness plan for program participants.	The HealthAlliance Partial Hospitalization Program provides staff and fiscal support for the program.	2016-2018 with data collected, processed and reported annually.	Yes. All Partial Hospitalization Program participants will have access to the nutritional interventions, strategies and activities provided regardless of their biopsychosocial, economic and cultural considerations.

HealthAlliance's People's Place outreach is a new initiative for HealthAlliance's 2016-2018 Community Service Plan, with the aim of increasing screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, as well as increasing the number of adults with a chronic disease who have taken a course or class to learn how to manage their condition.

The People's Place is a thrift store and food pantry located in Kingston, NY, operating as a 501c3 not-for-profit organization. Founded in 1972, with a mission to feed, clothe and respond to the essential needs of the people in Ulster County with kindness, compassion and the preservation of human dignity. In response to a request from the People's Place executive director in the summer of 2016, HealthAlliance began a pilot program to send staff to the People's Place to provide health screenings and educational services directly in the community.

It is precisely community level collaborations such as this that can help our community hospital to meet the requirements that are outlined in the DSRIP program. The overarching aim of this intervention is to bring health care screenings and education into the underserved community. We began by assessing hospital departments for the type of offerings and staff they could send out into Ulster County and identifying opportunities at the People's Place for a large attendance, such as fresh vegetable distribution on Tuesdays, spring through fall. During the summer of 2016, HealthAlliance sent a variety of health practitioners, including a health coach, to the People's Place on Tuesday mornings to determine what we can offer outside the walls of the hospital and what the population needs. Clinicians in attendance track interest in various offerings which are analyzed and utilized to chart future offerings.

HealthAlliance of the Hudson Valley will continue to outreach and screening efforts at the People's Place through 2018, therefore establishing clinical-community linkages that connect patients to self-management education and community resources.

(Continued)

HealthAlliance's People's Place outreach

Priority/Focus Area: Increased access to high quality preventive care and management in both clinical and community settings

Goal	Outcome/ Objective	Intervention/ Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
NYSDOH Goal 3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations. NYSDOH Goal #3.3: Promote culturally relevant chronic disease self-management education. Build partnerships with community agencies that serve disparate communities. Promote the use of evidence-based interventions to prevent or manage chronic disease.	NYSDOH Objective 3.3.1: By December 31, 2018, increase by 5% the percentage of adults 18 and over who have tested for high blood sugar within the past three years. NYSDOH Objective 3.1.4: By December 31, 2018, 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.	Establish clinical-community linkages that connect patients to self-management education and community resources. Foster collaboration among community-based organizations, the education and faith-based sectors, independent living centers, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive services.	a. Completed calendar for 2017. b. Scheduled events at People's Place. c. Collect data on the number of people educated, the number of people screened and the number of interventions completed.	HealthAlliance and People's Place are the co-lead agencies. Collaborates with: - The Institute for Family Health - Local medical practices	HealthAlliance staff Site clientele residents Able to take referrals	a. April 2017 b. May 2017 c. Hold events Spring - Fall in 2017, evaluate and repeat in 2018.	Yes. Connects with Ulster County population with an income less than $25k. People's Place is at the very heart of the disparity population being targeted.

Live Well Kingston is a city-endorsed coalition focused on improving active living and healthy eating opportunities in Kingston, NY. It is fiscally sponsored and coordinated by Cornell Cooperative Extension of Ulster County (CCEUC) in accordance with a Memorandum of Understanding with the City of Kingston. The coalition grew out of a four-year partnership initiative to reverse childhood obesity entitled Healthy Kingston for Kids, and funded by the Robert Wood Johnson Foundation. HealthAlliance of the Hudson Valley was a founding funding partner supporting the Live Well Kingston (LWK) coalition in its infancy and in the development of its focus teams and action plans. In 2014, the LWK coalition finalized its Articles of Collaboration, established a leadership team, and determined and formed its priority focus teams. Each focus team is now developing action plans.

2016 Update:

- The LWK coalition implemented a communications strategy which included new logos and design for website, social media, brochures and other outreach materials to increase the impact of healthy messaging within the community.
- Four focus teams were active in 2015 – Age Well, Eat Well, Heal Well and Travel Well. New leadership was recruited for Play Well.
- Age Well conducted a series of focus groups at different locations to assess barriers to healthy eating and physical activity. This revealed a need for transportation to healthy activities, including farmers' markets and parks, as well as a need for both the availability of internet access and training on how to utilize technology to access resources. Negotiations for Wi-Fi and a computer in the common room of two low income senior residences were successful, and the project is underway. In addition, the Hudson Valley Resource List created by IPRO, was released in August 2016. IPRO's list will be used to develop a list inclusive of Ulster County services and opportunities. Transportation needs are in discussion with mangers of the senior residences as well as with Ulster County Area Transit (UCAT) and the City of Kingston bus system.
- Eat Well held a retreat for focus team members and invited the Mayor of Kingston. They developed a plan to hold 8-10 listening sessions at multiple sites within Kingston to assess barriers to healthy eating. These are set to begin late fall/early winter of 2016-2017.
- Heal Well held a series of "Walk and Talk with a Doc," in local parks and trails and, through the winter months, at the indoor track at the YMCA of Kingston and Ulster County.
- Play Well has two new co-chairs which include the director of the YMCA of Kingston and Ulster County and the owner of Innate Parkour. They are currently recruiting focus team members and will be developing an action plan in early 2017.
- Travel Well, which includes three active transportation groups in Kingston – the Kingston Complete Streets Advisory Council, the Kingston Land Trust: Kingston Greenline Committee and Bike Friendly Kingston – forwarded several active transportation projects in cooperation with the City of Kingston. These included the Kingston Connectivity Project, the Kingston Point Rail Trail and Complete Streets on Cornell, Foxhall, North Street and Broadway. The Kingston Greenline completed construction on the Trolley Trail portion of the Greenline. Funding has been awarded for other sections of the Greenline and design and construction is in progress. In addition, a Safe Routes to School project and the Hudson Landing Promenade and Development Project are underway. Bike Friendly Kingston held several community bike rides, implemented bicycle education and opened a Repair Café. They are currently organizing a bicycle and pedestrian bicycle count on Broadway in collaboration with the Ulster County Transportation Council.
- As a successful health coalition, the structure, function, successes and challenges of LWK were shared in presentations at several conferences including the 2016 New York State Public Health Association, the 2015 American Planning Association of the Greater Metro Area and the 2015 New York DASH-NY Coalition Conference.

(Continued)

Live Well Kingston

NYS Prevention Agenda Focus Area: Reduce Obesity in Children and Adults							
Goal	**Outcome/Objective**	**Intervention/Strategy**	**Process Measures**	**Partner Role**	**Partner Resources**	**Time Frame**	**Disparity Addressed**
Expand the role of health care, health services providers and insurers in obesity prevention.	1. Live Well Kingston (LWK) will expand the role of the local health care industry's leadership for the local implementation of the NYS Prevention Agenda.	A. Maintain participation from hospital and health care providers on the LWK Leadership Team, and recruit new members from the insurance sector. B. Develop the capacity and work plan for the Heal Well Focus Team by incorporating new members from health care, health service providers and insurers.	Hospital and health care providers will participate on LWK Leadership Team. Heal Well Focus Team will acquire a new Chair, additional membership and develop a work plan.	LWK Leadership Team: CCEUC, City of Kingston (CoK), SUNY Ulster, Rose Women's Care Center, Institute for Family Health, HealthAlliance, NYSPHA, and UCDOH Heal Well Focus Team: Institute for Family Health		2017	Yes.

Goal	Outcome/Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Create community environments that promote and support healthy food and beverage choices and physical activity.	1. LWK will develop, implement and/or support policy, systems and environmental change by supporting and promoting local efforts to improve access to healthy foods throughout the community. Coordinate with gardening/urban agriculture efforts and organizations addressing food insecurity and healthy eating in Kingston.	A. The Eat Well Focus Team will meet 10 times per year to identify areas of possible collaboration on projects to implement policy, system and environmental change (PSE). B. The Eat Well Focus Team will implement a series of local food forums to assess barriers to access and consumption of healthy foods. C. Information garnered from the food forums will be used to inform decision makers and to develop the 2017-2018 Eat Well Kingston work plan. D. Eat Well will promote communications that identify locations where healthy food is available for free or for sale using the LWK website, Facebook and Twitter accounts.	a. 8-10 Eat Well Meetings will occur annually. b. 3-5 PSE's will be identified for possible collaboration. c. 1-3 PSE's will be implemented as a result of networking with the Eat Well focus team. d. Five or more food forums will be implemented within the Kingston School District in 2016-2017 and the results will be incorporated in the 2017-2018 Eat Well work plan. e. Free and low cost healthy local food availability will be shared weekly through web and social media during the growing season.	Eat Well Focus Team: CCEUC, HealthAlliance, Institute for Family Health, YMCA Farm Project, Ulster Corps, Pine St. Farm Stand, Seed Song Community Garden, Local Economies Project, Food Bank of the HV, Clean Lunch Company, Gateway Industries, and Local Economies Project Other Community Partners: City of Kingston, Food Bank of the Hudson Valley, People's Place, and Family of Woodstock		a. 2016-2018 b. 2016-2017 c. 2017 d. 2016-2018 e. 2016-2018	Yes.

Goal	Outcome/Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Create community environments that promote and support healthy food and beverage choices and physical activity.	2. Food offered at City of Kingston properties and at City of Kingston programs is healthier.	Collaborate with city officials to ensure effective implementation of the recently adopted Healthy Vending Policy which mandates that a certain percentage of food offered on city properties must meet Healthy Meeting Guidelines.	a. City of Kingston property vending machine offerings will be assessed in 2016. b. The Eat Well Focus Team will work with city officials to maintain adherence to the guidelines outlined in the policy.	Eat Well Focus Team, CoK Department Heads, CoK Mayor, Food Vending Companies		2016-2017	Yes.
Create community environments that promote and support healthy food and beverage choices and physical activity.	3. City parks, play spaces, recreation facilities and open space will be supported through policy, system and environmental change.	The Play Well Focus Team will provide input and support to the City of Kingston in revising the City of Kingston's Recreation Plan.	An updated City of Kingston Recreation Plan will be completed and adopted.	Play Well Focus Team: YMCA of Kingston, Innate Parkour, and CoK Parks and Recreation		2017	Yes.
Create community environments that promote and support healthy food and beverage choices and physical activity.	4. City residents will have greater access to parks, recreational facilities and programs and will have a greater awareness of both public and private recreational opportunities.	A. The Play Well Focus Team will expand and recruit new members and will include representatives from CoK Parks and Recreation, nonprofits and businesses that provide recreational opportunities.	a. Play Well will meet eight times per year.	Community Partners: Family of Woodstock, CoK Police Department, CoK Building Safety Division, Ulster County (UC) Community Action, UC Probation Department, Friends of Forsyth Park, Kingston Conservation Advisory Council, Junior League of Kingston, and Kingston City School District		A. 2016-2018	Yes.

Goal	Outcome/Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Create community environments that promote and support healthy food and beverage choices and physical activity.	4. (continued)	B. Provide support to the CoK Parks Department in securing funds for implementing projects identified in the Recreation Master Plan and Capital Plan. C. The Play Well Focus Team will identify parks as well as public and private recreational facilities and programs, and work to promote them through the LWK website, Facebook and Twitter accounts.	b. Focus Team will provide input and support to the CoK Parks and Recreation Department and Board on projects supported by the Recreation Plan. c. Promotion of city parks and public and private recreational opportunities will occur via the LWK website and social media.	Community Partners: Family of Woodstock, CoK Police Department, CoK Building Safety Division, Ulster County (UC) Community Action, UC Probation Department, Friends of Forsyth Park, Kingston Conservation Advisory Council, Junior League of Kingston, and Kingston City School District		B. 2016-2018 C. 2016-2018	Yes.
Create community environments that promote and support healthy food and beverage choices and physical activity.	5. Complete Streets practices will be integrated into the day-to-day municipal administration through policy, systems and environmental changes.	A. The Travel Well Focus Team will provide input to CoK officials and the Planning Board regarding transportation and Complete Streets. B. The Travel Well Focus Group will work with city officials to develop a comprehensive city sidewalk program that includes new sidewalk standards and codes.	The City of Kingston will incorporate some of the suggestions into planning and projects in order to foster Complete Streets practices by the Travel Well Focus Teams.	Travel Well Focus Team: Bike Friendly Kingston, Kingston Complete Streets Advisory Committee, and Kingston Greenline		A. 2017 B. 2016-2017	Yes.

Goal	Outcome/ Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Create community environments that promote and support healthy food and beverage choices and physical activity.	6. Create better environments for walking and biking by assisting with the organization and implementation of Complete Streets capital improvements.	A. The Travel Well Focus Group will provide support for the implementation of the city's Complete Streets capital projects, the Kingston Connectivity Project, and the Safe Routes to School project. B. Identify additional potential Safe Routes to School projects for the next round of federal transportation alternatives funding.	a. New sidewalk standards and codes will be incorporated into planning and projects. b. The City of Kingston will incorporate suggested project ideas from the Travel Well Focus Group into new Safe Routes to School projects.	Community Partners: CCEUC, YMCA of Kingston and Ulster County, CoK Economic and Community Development, CoK Parks and Recreation, CoK Engineering, CoK Planning, Bard College, Kingston Land Trust, UC Planning, Kingston City School District, Kingston Tree Commission, Kingston Bluestone Committee, SUNY Ulster Mid-Hudson Health and Safety Institute, and 511 Rideshare		A.2017-2018 B. 2016-2018	Yes
Create community environments that promote and support healthy food and beverage choices and physical activity.	7. Create a culture of walking and biking through educating and encouraging the general public and decision makers.	Increase participation in promotional events for walking and bicycling using existing resources/events (Kingston Walks; Walk, Bike, and Roll to School Day; Bike to Work; Bike Month; O+ Festival, etc.).	Walking and bicycling events will be promoted through the LWK website and social media.			2016-2018	Yes.

Goal	Outcome/ Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Create community environments that promote and support healthy food and beverage choices and physical activity.	8. Through advocacy, create a better experience and a safe environment for bicyclists of all ages to travel throughout the City of Kingston.	A. Support the implementation of bicycle safety and outreach through social media and the Bike Friendly Kingston website. B. Seek funding for a Bicycle and Pedestrian Master Plan.	a. Bicycle safety information, programs and events will be promoted through the LWK website and social media. b. Grants will be written to support the development of a Bicycle and Pedestrian Master Plan.			A. 2017-2018 B. 2017-2018	Yes.
Create community environments that promote and support healthy food and beverage choices and physical activity.	9. Kingston will become a destination for inviting and successful bicycle events.	A. Through promotion and advocacy, support existing bicycle events such as Tour de Kingston, Recovery Ride, YMCA Bike Fest, O+ Festival and Cancer Ride. B. Host multiple fun bicycle events including Feast on Two Wheels and Group Rides. C. Provide support for and increase membership in Bike Friendly Kingston. D. Educate the public on bicycle laws and best practices, and create a positive view of cyclists.	a. Existing bicycle events will thrive and new events will be added. b. Bike Friendly Kingston will increase membership and capacity. c. An educational campaign supporting cyclists will be implemented.			a. 2016-2018 b. 2016-2018 c. 2018	Yes.

Goal	Outcome/ Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Create community environments that promote and support healthy food and beverage choices and physical activity.	10. Residents will have access to a system of trails within the City of Kingston that connect to a larger trail system.	A. Provide support for the Kingston Greenline through the promotion of the Greenline brand. B. Complete the Comprehensive Management Plan (CMP) for the Kingston Greenline. C. Advance the completion of the connections between the Wallkill Valley Rail Trail, the O&W Rail Trail, the U&D corridor, and the Kingston Greenline. D. Advance the completion of the midtown hub of the Kingston Greenline.	a. The Greenline brand will be added to additional signs, pamphlets and websites. b. The CMP document for the Kingston Greenline will be in use. c. Additional sections of the Greenline Rail Trail will be completed. d. Additional sections of the Greenline Rail Trail will be completed.			A. 2016-2018 B.2018 C. 2017-2018 D. 2017-2018	Yes.
Create community environments that promote and support healthy food and beverage choices and physical activity.	11. Senior citizens in Kingston have ample, accessible opportunities for physical activity, healthy eating and social interaction.	A. The Age Well Focus Team will develop and implement a work plan based on the outcomes of a series of focus groups aimed at determining barriers to active living and healthy eating which included transportation, internet access and computer skills. B. The Age Well Focus Team will continually assess seniors via focus groups to determine if the strategies to address the identified needs are effective.	a. Seniors living at two low-income housing sites will have access to computers and the internet in the community room of each of the housing sites. b. A minimum of two training programs to increase seniors' computer skills will occur. c. The City of Kingston Mayor and Common Council will be made aware of identified transportation barriers for seniors to access local healthy food.			a. 2017-2018 b. 2017-2018 c. 2017-2018	11. Yes

Goal	Outcome/ Objective	Intervention/Strategy	Process Measures	Partner Role	Partner Resources	Time Frame	Disparity Addressed
Prevent childhood obesity through early child care and schools.	The Eat Well Kingston Focus Team will identify projects within school settings to foster healthy eating.	Members of the Eat Well Focus Team will continue to participate on the School Wellness Committee.	Members of the Eat Well Focus Team will continue to foster the implementation of the Summer Meal Program.	CoK Schools, City of Kingston, and Family of Woodstock		2016-2018	Yes.
Expand the role of public and private employers in obesity prevention.	Businesses and organizations in Kingston have the information and resources to participate in Worksite Wellness programs.	A. Develop the capacity of a Worksite Wellness Focus Team to include the health department, hospital, health care providers and insurers. B. Implement a worksite wellness program within a local institution that can be replicated at other sites within Kingston. C. Set up regular competitions between participating organizations to increase participation in worksite wellness programs.	a. A Committee Chairperson and members will be recruited, and a work plan will be drafted. b. Local institution will be identified to participate in a worksite wellness program that will be replicated.	Community Partners: UC Department of Health, HealthAlliance, CCEUC, and local health care organizations		a.2017-2018 b. 2017-2018	Yes.
Promote culturally relevant chronic disease self-management education.	Kingston residents and visitors will be able to easily find physical activity programs and healthy eating programs that meet their needs.	A. The LWK Communications Committee, along with the Heal Well Focus Team, will work with doctors to refer Kingston patients to the LWK website to find physical activity and healthy eating resources in Kingston. B. The Media and Communications Team will continually update the events calendar on the LWK website showcasing LWK member events and activities for healthier lifestyles. C. Social media will be used to promote resident, visitor and doctor use of the website.	a. Physicians will provide direct referrals for physical activity and healthy food opportunities. b. The LWK website and calendar will be updated weekly with current local events and activities promoting healthier lifestyles. c. The number of visits to the LWK website will increase annually.	LWK Communications Committee: CCEUC, HealthAlliance, City of Kingston, and Institute for Family Health		A. 2016-2018 B. 2016-2018 C. 2016-2018	Yes.

B. Health Needs Not Addressed by HealthAlliance

Of the health needs identified by Ulster County, HealthAlliance is focusing on the priorities outlined above. Pediatric asthma hospitalizations, unplanned pregnancy, motor vehicle crash deaths and fall hospitalizations were among the prioritized health needs HealthAlliance chose not to focus on. HealthAlliance does not possess the infrastructure and resource's to aid in prevention and continuous measurement of these health needs, nor does it align with NYS Prevention Agenda Priorities. We recognize that we cannot pursue all of the identified health needs and that decisions are based upon internal and external assets to sustain programs that would make a meaningful impact.

VI. Board Approval

HealthAlliance of the Hudson Valley, Chairman of the Board of Directors

Approved by: _____

Date:_____