Steuben County Community Health Improvement Plan
2022 - 2024

Priority: **Prevent Chronic Diseases**
Goal 1.2: **Increase skills and knowledge to support healthy food and beverage choices**

Focus Area 1: **Healthy Eating and food security**
Objective 1.2: **Decrease the percentage of children with obesity**

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Steuben County Public Health	1.0.4 Multi-component school-based obesity prevention interventions. Public Health will focus on outreach and collaboration with school district decision makers from the districts with the highest rates of obesity to inform and educate on evidence based interventions, policies and environmental changes that impact healthy student weights and address district/community specific risk factors	# school districts reached out to # policy recommendations shared with district decision makers % schools who adopted new policies	Public Health will focus on the following: 1. Outreach to the Guthrie Clinic and Calvin U. Smith Elementary / Corning-Painted Post School District to determine feasibility of reviving program in CPP and extending to other districts 2. Outreach to school district administrator(s) to share current health need (obesity) of student population, why it's important and identify ways to seek input from the school community on contributing causes and potential solutions 3. Coordinate with members of the school district/community to: • Better understand the reasons or causes of disparities within the district • Identify potential policies to alleviate causes 4. Assist in planning and implementation of selected policy(s) around childhood healthy lifestyles in identified school(s) 5. Support pre and post surveys, data collection and review of progress
Corning Hospital	1.0.4 Multi-component school-based obesity prevention interventions. Corning Hospital will continue offering age-appropriate health curriculum to children in the surrounding area schools through collaborative curriculum development and events.	# participants in each program or initiative # teachers incorporating healthy eating curriculum # community events	Corning Hospital will continue offering age-appropriate health curriculum to children in the surrounding area schools through collaborative curriculum development and events. Assess ability to expand program to schools experiencing disparities in obesity rates. Examples: Healthy Kids Day, Childhood Healthy Lifestyle Program, Wellness Fairs A kick off meeting will be held to re-establish team and goals after break during COVID.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Corning Hospital	1.0.6 Screen for food insecurity, facilitate and actively support referral. *Disparity: Low SES*	% of patients screened for social determinants of health SDOH % of patients who indicate financial strain or food insecurity	Corning Hospital will screen all patients annually for food insecurity, facilitate and actively support referrals to community-based resources to address patient needs. Corning Hospital will meet quarterly with community partners to improve referral pathways and will evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance. *Smart Steuben partner roles & resources:* Utilize Community Health Workers from Care Compass Network Social Impact Pilot to facilitate increased screening and referrals
	Corning Hospital will promote community exercise programs for children by offering families referrals from pediatric providers	# referrals to community based physical activity programs	Corning Hospital will meet quarterly with community partners to improve referral pathways and will evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance. *Smart Steuben partner roles & resources:* Girls on the Run, Youth Running Club- SOAR, YMCA
Steuben Rural Health Network at The Institute for Human Services, Inc.	SRHN will implement Girls on the Run of the Southern Tier (3rd-5th grade) evidence-based program	# of participants # of trained coaches # of sites % open rate for family newsletter % of participants in GOTR who show an increase in physical activity through participating in GOTR (attendance tracking) % participants who complete a 5K	The Steuben Rural Health Network (SRHN) will coordinate and implement Girl on the Run at a number of sites, including at school sites in Steuben. Registration for the program will open in the beginning of January 2023. *Smart Steuben partner roles & resources:* Examples: CBO's provide nutrition education/resources to provide to the families for the newsletter; school districts will "host" a site. During the 5K Celebration at the end of the season; local organizations that implement nutrition education/resources would be invited to table
	SRHN will implement Cope 2 Thrive (cognitive behavior based therapy) program 15 session teen curriculum (pilot stages)	# of participants % of participants that indicate increased knowledge of nutrition education or skills to be more physically active	The Steuben Rural Health Network (SRHN) will implement an evidence-based program with at least one school district in Steuben County.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
SNAP-Ed New York – Southern Finger Lakes Region and Cornell Cooperative Extension	1.0.4 Multi-component school-based obesity prevention interventions through implementation of Coordinated Approach to Child Health (CATCH) program, an EBI *Disparity: Low SES*	# schools trained in CATCH % of trained schools that implement CATCH # students impacted in CATCH schools % participating schools reporting a change in moderate - to - vigorous activity students are engaged in during the school day as documented by CATCH Champion Surveys	SNAP-Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) will have trained 7 area schools in CATCH with 2,255 students impacted. Partner schools receiving 50% or more free or reduced lunch indicating decreased opportunities for healthy food access outside of school as compared to those of middle/high- SES status. SNAP-Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) work with local elementary and middle schools to implement the Coordinated Approach To Child Health (CATCH) program. Quality nutrition and physical activity is provided in 7 area schools serving 2,255 students. Utilizing the Whole School, Whole Community, Whole Child (WSCC) framework, CATCH is integrated school wide (classroom, PE, brain breaks, cafeteria).
	1.0.5 Increase the availability of fruit and vegetable incentive programs. *Disparity: Low SES*	# of participants Monetary sum of vouchers distributed % of vouchers redeemed	SNAP -Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) will partner with 1 Steuben County FQHC, Finger Lakes Community Health (FLCH) to deliver the Fruit and Vegetable Prescription Program (FVRx). Patients of FLCH are eligible to participate in a 6-week nutrition education series and receive $20 in fruit and vegetable vouchers each week to spend at local produce vendors, totaling $120.The goal will be for the FVRx voucher redemption rate to be greater than 60% in Steuben County. Identify patients of FQHC or identified as having experienced food insecurity in last 12 months indicating decreased access to healthy eating and exercise opportunities as compared to those who are food secure and/or use private insurance.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Arnot Health	Arnot Health primary care offices will make referrals to appropriate community resources for nutritional and/or exercise programs for pediatric patients.	% of patients eligible for the resource list with a BMI percentile 95% or greater (definition of childhood obesity)	Arnot Health will create and distribute a list of community resources available to their primary care providers in Steuben County. *Smart Steuben partner roles & resources:* Utilize community partners and LHD to create list of community resources available to help decrease childhood obesity. Tri-County Family Medicine has an extensive Community Resource List used by care managers to support providers for patients identified with community needs.
	1.0.6 Screen for food insecurity, facilitate and actively support referral.	% of patients screened for social determinants of health, including food insecurity, housing, language and literacy issues % of patients who screen positive for food insecurity	In spring 2022, Arnot Health created and implemented a policy to screen all primary care patients once yearly or as clinically indicated for social determinants of health, including food insecurity, housing, language and literacy. They will facilitate and actively support referrals to community-based resources to address patient needs.
Oak Orchard	Perform BMI assessment on all patients 3-17 years old and provide counseling for nutrition and physical activity. Educate patients and families of Oak Orchard Health utilizing educational boards and Bright Future hand outs.	% of compliance with Oak Orchard Quality Measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents % of 3-17 year old that have completed well child visit	Oak Orchard will continue to provide BMI assessments and provide counseling on nutrition and physical activity in Hornell for ages 3-17yrs (current compliance is 75%) Goal of 80% compliance. Oak Orchard will use Bright Future Handouts at well child visits to educate patients. Will have 75% completed well child visits. *Smart Steuben partner roles & resources:* Early Head Start / Head Start can support BMI assessments with enrolled children.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
ProAction	1.0.2 Quality nutrition and physical activity in early learning and child care settings.	# children participated in I am Learning I am Moving # Families served through I am Learning I am Moving % of children with healthy BMI # Child Care providers received I Am Learning I Am Moving training and monitoring # Families assessed for nutritional risks % families provided with resources based on nutritional risks	ProAction will: Provide education to families Implement I am Learning I am Moving in classrooms and homes. Provide training to home based child care providers on health and nutrition following CACFP guidelines and menus Provide Technical assistance and nutritional activities to Child Care Providers.
St. James Hospital	1.0.4 Multi-component school-based obesity prevention interventions. St. James Hospital will partner with Hornell School District & Hornell Area YMCA along with Concern for Youth to support knowledge of healthy food choices and activities.	# of children enrolled in classes # of free or low cost activities for children % children demonstrating an increase in knowledge of healthy food choices and activities	St. James Hospital will work with Partners listed to identify ways to decrease costs for activities and increase education about healthy for choices for kids. Discuss with Hornell School District items offered in vending machines & at meal times. St. James Hospital will have worked with our community partners (YMCA, Hornell School District, GST BOCES & Concern for Youth) to identify program opportunities. Identify curriculums to use in school districts to educated students on healthy eating. Increase number of free or low cost sport/activity programs for children in the Hornell area.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Tri-County Family Medicine	Perform BMI assessment on all patients 3-17 years old and provide counseling for nutrition and physical activity. Educate patients and families of Tri-County Family Medicine utilizing educational boards and Bright Future hand outs	% of provider compliance with TCFM Quality Measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents % of 3-17 year old that have completed well child visit % patients who show decrease or improvement in BMI	Tri-County Family Medicine (TCFM) completes BMI assessments for ages 3-17, provides counseling on nutrition and physical activity. Current compliance for Wayland and Cohocton Centers is 66%. Goal to increase to 75%. TCFM utilizes Bright Futures handouts for ages 3-17. Utilizes poster boards to educate children and parents on sugar intake in various products. TCFM completes well child visits. TCFM compliance for 3-21 years is 75% with a goal of 80%
	1.0.6 Screen for food insecurity, facilitate and actively support referral.	% of patients who indicate food insecurities based on PraPare screening tool % of patients that are referred to community resources for food security based on PES tracking	TCFM is currently using the PraPare Tool to screen all care-managed patients. TCFM will increase screening to all patients during CHIP Planning years

Priority: **Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area 2: **Prevent Mental and Substance Use Disorders**
Goal 2.2: **Prevent opioid overdose deaths**
Objective 2.2.4: **Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population**

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Steuben County Public Health	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# Narcan trainings provided by PH # participants trained by PH % participants that feel confident administering narcan after training # of training inquiries referred to the Opioid Committee # Narcan kits provided by mail / request	1. Public Health will provide at least 2 Narcan trainings per year in Steuben County and will refer those seeking training to the Opioid Committee 2. Knowledge of the proper use of Narcan and access to it will increase 3. A program to mail Narcan by request to county residents and service providers will be implemented.
Steuben Prevention Coalition Opioid Committee	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# Narcan trainings provided by Opioid Committee	The Opioid Committee will have trained at least 100 residents of Steuben County by December 2023.
Steuben County Alcohol and Substance Abuse Services (SCASAS)	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# Clients trained in proper naloxone use # Naloxone kits distributed	SCASAS will offer naloxone training and kits to all admitted clients prior to discharge.
Corning Hospital	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	% of Corning Hospital staff who complete naloxone administration training # Naloxone kits distributed % patients seen in the ED for an opioid related visit who receive Naloxone	Corning Hospital will register as NYS Opioid Overdose Prevention program to distribute Naloxone from the emergency department to patients at risk of overdose

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Corning Hospital	2.2.4 Build support systems for opioid users or those at risk of an overdose	# ED, inpatient, and primary care patients referred to CASA-Trinity # patients connected with substance use disorder services within 30 days	Corning Hospital (CH) will continue its collaboration with CASA-Trinity to provide education to Guthrie Social Workers, Crisis Workers and Care Coordinators on local resources and other drug and alcohol topics as identified. CH will explore NY Matters and other closed loop referral systems to increase patient access to medication assisted treatment and other supported services for substance use disorder *Smart Steuben partner roles & resources:* CH will meet quarterly with CASA-Trinity to improve referral process
	2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days Corning Hospital will continue to promote safe drug disposal units and community events.	# pounds of medication disposed of quarterly	MedSafe drug disposal units are installed for community use in two Guthrie locations in Steuben County: • Guthrie Medical Group Centerway site at 130 Centerway, Corning in the 1st floor lobby area • Corning Hospital, 1 Guthrie Dr, Corning in the Corning Hospital Outpatient Pharmacy
The Institute for Human Services, Inc.	2.2.4 Build support systems for opioid users or those at risk of an overdose	# contacts referred to mental health / substance abuse services in Steuben County	2-1-1 HELPLINE (2-1-1 Teen Helpline) will refer at least 65 contacts per quarter to the appropriate mental health/substance abuse counseling services in Steuben County
Arnot Health	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	# of providers licensed to prescribe suboxone in Steuben County # readmissions to IDMH ED for opioid overdose	Arnot will work to increase the number of providers waivered to prescribe MAT in Steuben County and will implement a program at Ira Davenport Medical Hospital ED for mid-level providers to prescribe initial dose of suboxone and assist with outpatient treatment set-up.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Arnot Health	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# staff who completed naloxone administration training #naloxone kits distributed	Arnot Will work with Steuben County Substance Abuse Advisory Council for naloxone training opportunities for ED staff. Arnot has a program in place at their Addiction Recovery Unit in Elmira: patients discharged AMA from ARU receive Naloxone spray and education on use. Working on getting the same process in ED.
	2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	# Pounds of medication disposed of yearly	Arnot Health will continue to maintain prescription drug collection kiosk at Ira Davenport Memorial Hospital located within the IDMH ED waiting/reception area.
	Utilize CAGE-AID questionnaire to screen patients for alcohol or substance abuse.	% patients screened with CAGE-AID	Arnot Health will screen all primary care patients 18+ with CAGE-AID substance abuse screening.
Oak Orchard	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# of Naloxone trained staff upon hire and routinely # of Naloxone trainings provided for staff % of patients prescribed opioids chronically who also have a Naloxone order	Oak Orchard will increase the availability of access to Naloxone trainings to staff. Will have 50% of staff trained on Naloxone administration. 50% of patients who are prescribed chronic opioids will have a Naloxone order.
St. James Hospital	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# hospital staff trained to conduct Narcan trainings and provide Narcan to others # of participants trained to administer Narcan # of Narcan kits distributed % of individuals presenting to the ED with overdoses	St. James is to register as a NYS Opioid Overdose Prevention program to distribute Naloxone from the emergency department to patients at risk of overdose. They will increase the number of hospital staff trained to provide Narcan to members of the community (patients and non-patients) and increase the number of providers with X-waivers.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Steuben Prevention Services (Catholic Charities)	Provide substance misuse and abuse prevention across Steuben County school districts, incorporating EBIs.	# students educated about substance use, misuse & prevention % students indicated an increase in knowledge about substance use, life skills and/or prevention factors #students counseled who are at risk for substance abuse % students showing an increase in protective factors after counseling	Steuben Prevention Services will continue to provide substance use prevention in Hammondsport, Addison, Avoca, Corning, Haverling, Prattsburgh, Wayland-Cohocton, and Campbell-Savona school districts, incorporating EBIs, custom designed education, and substance use policies that include the use of brief screenings and interventions for youth. They also will provide prevention counseling services in Hammondsport and Haverling for students whose families have a history of substance use and for students that are at risk for substance use problems.
Tri-County Family Medicine	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# staff who completed naloxone administration training #naloxone kits distributed	Tri-County Family Medicine (TCFM) has joined the NYS state program to offer Narcan and is training staff on its use and prescribing to patients with high dose opioids.
	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	# of TCFM providers licensed to prescribe suboxone in Steuben County # suboxone scripts written	TCFM has 16 out of 21 provider who prescribe suboxone in the setting of primary care for patients who are stable in their recovery

Priority: **Promote Well-Being and Prevent Mental and Substance Use Disorders**
Focus Area 2: **Prevent Mental and Substance Use Disorders**
Goal 2.4: **Reduce the prevalence of major depressive disorders**
Objective 2.4.1: **Reduce the past year prevalence of major depressive episode among adults age 18 and older**

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Corning Hospital	2.4.1 Strengthen economic supports and household financial security by screening for financial strain and housing needs in primary care settings and referring patients to community-based organizations to address identified needs. *Disparity: Low SES*	% patients screened for social determinants of health % patients who indicate need for financial/housing assistance # referrals to community resources for financial strain or housing needs	Corning Hospital will meet quarterly with community partners to improve referral pathways and will evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance. *Community Resources:* Arbor Housing and Development, The Institute for Human Services, Inc. Catholic Charities
	2.4.2 Strengthening resources for families and caregivers	% adults screened with PHQ-2 # patients seen by psychologist	Corning Hospital will review and adjust workflows to utilize additional psychology support. Corning Hospital will Increase access to mental health providers by hiring a psychologist to support Corning service area and will increase depression screening in primary care and refer to treatment when indicated.
Steuben Rural Health Network at The Institute for Human Services, Inc.	2.4.2 Strengthening resources for families and caregivers	# of participants completed training	The Steuben Rural Health Network, in partnership with ProAction, will host 1 Youth Mental Health First Aid training and 1 Adult Mental Health First Aid Training.
Arnot Health	Arnot Health primary care completes depression screening and follow up plan for patients age 12 and older, once yearly or as clinically indicated	% Positive Depression screening with follow up ages 18+ and 12-18	Arnot Health will continue to implement and work on meeting composite goal of 75%.
	Refer patients presenting to IDMH ED with depressive symptoms to outpatient sites	# referrals made	Arnot Health will track number against baseline.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
Oak Orchard	Identify depression utilizing PHQ9 screening tools and intervening with positive screening	% of patients aged 18 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool % of patients aged 18 years and older with positive screening with a follow-up plan documented on the date of the visit	Oak Orchard will screen patients aged 12 years and older for depression and provide a follow up plan for those who screen positive. Hornell is at 47%; goal is to have 60% compliance.
	2.4.2 Strengthening resources for families and caregivers Increase the number of closed referrals for patients who have been referred to mental health counseling	% of patients with closed referrals who were referred to internal/external mental health services	Oak Orchard will have 50% closed referrals (established care with provider they were referred to)
	Increase the number of patients who have been diagnosed with depression who have achieved remission 10-14 months after positive screening	% of patients aged 18 years and older with depression who reached remission 10-14 months after positive screening.	Oak Orchard will put processes and procedures in place to increase the number of patients who have been diagnosed with depression who have achieved remission 10-14 months after positive screening Hornell is 5%; goal is to have 20% compliance
ProAction	2.4.2 Strengthening resources for families and caregivers Increase awareness, knowledge and skills of providers serving children, youth and families related to social-emotional development, adverse childhood experiences (ACES), and trauma-informed care.	# ACES trained participant by sector (ProAction) # ACES master trainers # ACES trainings provided # Mental Health Adult and Youth training sessions.	ProAction to provide 10 screenings of Resilience: The Biology of Stress and the Science of Hope followed by ACES information on brain development to more than 400 providers. Hold Resilience Symposium for providers with national level speakers on ACES science. Provide community training on adult and youth mental health first aide.

Partner Organization	Intervention	Performance Measures	Goals to complete by December 2023
ProAction	2.4.2 Strengthening resources for families and caregivers	# children served % of growth in social emotional development # of parents receiving parenting education % parents gaining new knowledge about expected social and emotional wellbeing and developmental milestones % parents gaining parenting skills # staff trained in evidence based models	ProAction Resilient Children and Families (RCF) Programs include 12 Head Start / Early Head Start sites, 3 Family Resource Centers, and multiple RCF Home Visitors. All utilize the Pyramid Model, Conscious Disciple, Parents as Teachers, Your Journey Together, Flip It, Strengthening Families and the Dial Assessment to work with children and their families on social and emotional development, resulting in 400 children's growth in social and emotional milestones, and 150 parents increasing their knowledge of social and emotional wellbeing milestones, developmental milestones and increased parenting skills.
Tri-County Family Medicine	Identify depression utilizing PHQ9 screening tools and intervening with positive screening	% of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool % with positive screening with a follow-up plan documented on the date of the visit	TCFM screens patients 12 and older for depression. Currently screening rate is at 53% for Wayland and Cohocton with a goal to increase to 60%.