Chemung County 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP)

County Name:	**Chemung County**
Participating local health department and contact information:	**Chemung County Department of Public Health** Peter Buzzetti Director of Public Health pbuzzetti@chemungcountyny.gov 607-737-2028
Participating Hospital/Hospital System(s) and contact information:	**Arnot Health** Ashley Gleason AGleason@arnothealth.org 607-737-7727
Name of entity completing assessment on behalf of participating counties/hospitals:	**Common Ground Health** Catie Kunecki Catie.Kunecki@commongroundhealth.org 585-224-3157

Public Health
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Chemung County Health Dept.

ArnotHealth

Common Ground Health

Chemung County Executive Summary

The Chemung County Health Department, in partnership with Arnot Health, has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

County	Priority Areas & Disparity
Chemung County	**Prevent Chronic Disease** 1. Healthy eating and food security 2. Physical activity 3. Tobacco prevention **Disparity: reduce tobacco use among pregnant women**

Selection of the 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP) priority and disparity areas was a joint process which began in the summer of 2018 with assistance from the S2AY Rural Health Network and Common Ground Health. A variety of partners were engaged throughout the process including the public health departments and hospital staff, Community Based Organizations (CBOs), school district representatives, the S2AY Rural Health Network, Common Ground Health, and more. The community at large was engaged throughout the assessment period via a regional health survey in 2018 (*My Health Story 2018*) and focus groups. Partners' role in the assessment were to help inform and select the 2019-2021 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings.

On April 9, 2019, the health department engaged key stakeholders in a prioritization meeting facilitated by the S2AY Rural Health Network. Key partners

and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail, news media and newsletters were utilized to help stimulate participation. Common Ground Health provided group members copies of county specific pre-read documents in advance of the meetings. The documents included information on current priority areas and progress made to date, as well as a mix of updated quantitative, qualitative, primary and secondary data on each of the five priority areas outlined in the New York State Prevention Agenda. Data were collected from a variety of different sources including, but not limited, to the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports and primary data collected from the *My Health Story 2018* Survey. A copy of the pre-read document, prioritization meeting materials and meeting attendees are available upon request.

Using the above referenced data and group discussions, participants utilized Hanlon and PEARL methods[2] to rank a list of group identified and pre-populated priorities. To address the previously mentioned priorities and disparities, the health department facilitated a CHIP planning meeting where partners discussed opportunities to leverage existing work. Existing work efforts were then compared to intervention options (primarily selected from the New York State Prevention Agenda Refresh Chart) and were informally voted on and selected.

[2] Hanlon and Pearl are methods which rate items based on size and seriousness of the problem as well as effectiveness of interventions.

Regionally[3], Chemung County aligns with nearby counties on several interventions including the following:

Focus Area	Intervention* & # of Counties Selected
Tobacco prevention	**3.1.2** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties) **3.2.3** Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence based quitting, increasing awareness of available cessation benefits (especially Medicaid) and removing barriers to treatment (selected by three counties) **3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Healthy eating and food security	**1.0.3** Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties)
*Interventions shown are those where three or more counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix A.	

Tobacco prevention was a widely selected focus area by several regional counties (five out of eight counties). Many counties, including Chemung, have selected goals which revolve around prevention of initiation of tobacco use as well as tobacco cessation efforts. Leveraging region-wide all of the previously mentioned interventions will aid in reaching as many persons as possible throughout the region. The complete list of Chemung County's selected interventions, process measures and partner roles in implementation processes can be found in the county's Community Health Improvement Plan grid (Appendix A).

The CHIP's designated overseeing body, Health Priorities Partnership (HP2), meets on a bi-monthly basis. The group has historically reviewed and updated the

[3] The region includes eight of the nine Finger Lakes counties: Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties.

Community Health Improvement Plan and will continue to fulfill that role. During meetings, group members will identify any mid-course actions that need to be taken and modify the implementation plan accordingly. Progress will be tracked during meetings via partner report outs and will be recorded in meeting minutes and a CHIP progress chart. Partners and the community will continue to be engaged and apprised of progress via website postings, email notification, presentations, and social media postings.

Planning and Prioritization Process

Eight County Region

The MAPP (Mobilizing for Action through Planning and Partnerships) process was used by all eight health departments to develop their health assessments and improvement plans. This process includes four community assessments. The first assessment began in the summer of 2018 when local health departments partnered with Common Ground Health to conduct a nine county regional health survey (*My Health Story 2018*).[11] This survey served as the vehicle for gathering primary qualitative and quantitative data from Finger Lakes region residents on health issues in each county. Health departments, hospitals, and other local partners were instrumental in distributing the survey to community members including disparate populations.

The second assessment was of the local public health system completed by stakeholders in each respective county. The survey sought to determine how well the public health system works together to address the ten essential services and provides an effective work-flow that promotes, supports and maintains the health of the community. Results from the survey are available in county specific prioritization pre-read documents (available upon request) and, overall, were very positive.

For additional community engagement and feedback, and the third and fourth assessments (forces of change and community themes and strengths), health departments conducted focus groups with lesser represented survey populations between the months of November and February.[12] Results from the focus groups and a list of attendees are available upon request.

After conducting each of the four assessments above with assistance from the S2AY Rural Health Network, local health departments invited key stakeholders and focus group attendees to participate in a prioritization meeting to help inform and select the 2019-2021 priority and focus areas. Participants utilized the Hanlon (PEARL) method to rank a list of group identified and/or pre-populated health department identified priorities. The method rates items based on size and seriousness of the problem as well as effectiveness of interventions. The result of each group scoring led to the selection of the priority areas and disparities and are summarized in greater detail in the county-specific chapters to follow.

As demonstrated in the health data section, each county's residents face their own unique and challenging issues when it comes to their community, yet

[11] Common Ground Health services nine counties in the Finger Lakes region. For the purposes of this Community Health Assessment, Monroe County was excluded from data analysis.
[12] The majority of survey respondents were middle aged white women. Common Ground Health staff performed weighting calibration to align with each county's actual demographics, though, results may be biased.

commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

***Age**: Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.*

***Poverty**: Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.*

***Education**: Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that adults aged 25 without a high school diploma can expect to die nine years sooner than college graduates. Persons who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.*

***Housing**: Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).*

Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Chemung County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

Chemung County

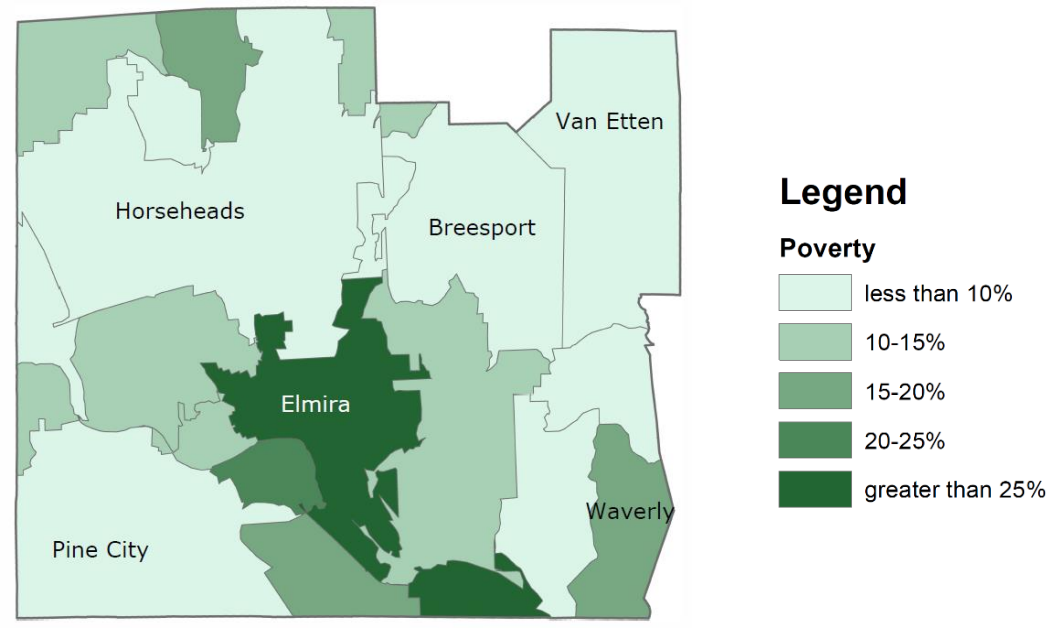
Demographic and Socioeconomic Health Indicators

Chemung County is home to one city, eleven towns and five villages and is located in the southeastern border of the Finger Lakes region. It borders the New York/Pennsylvania state line and has an estimated 86,883 residents. The majority of its residents (88%) are White Non-Hispanic and the population is heavily centered in the City of Elmira. It is estimated that 16% of the population are women of childbearing age, and 25% of the 18+ population are living with a disability[13].

2017 estimates reveal 30% of the 65+ population (N=4,492) are living alone. This rate is down 9 percent from 2012 when 33% of the 65+ population (N=4,562) was living alone.

In Chemung County, 16% of residents are living below the federal poverty level, and another 19% live near it. The distribution of poverty in the county is shown below in Map 6. Interestingly, the two ZIP codes which make up the City of Elmira are polar opposites when it comes to income- one half of the City is very poor, while the other half is rather wealthy.

Map 6: Poverty rates by ZIP code

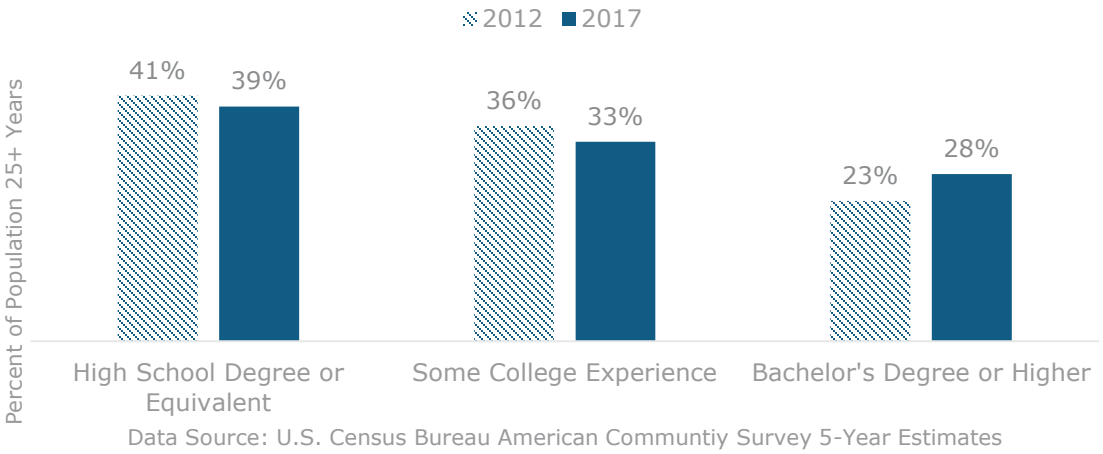


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year estimates

[13] Disability in this context is defined as impairment to body structure or mental functioning, activity limitation such as difficulty hearing, moving or problem-solving, and participation restrictions in daily activities such as working, engaging in social/recreational activities or obtaining healthcare or preventative services.

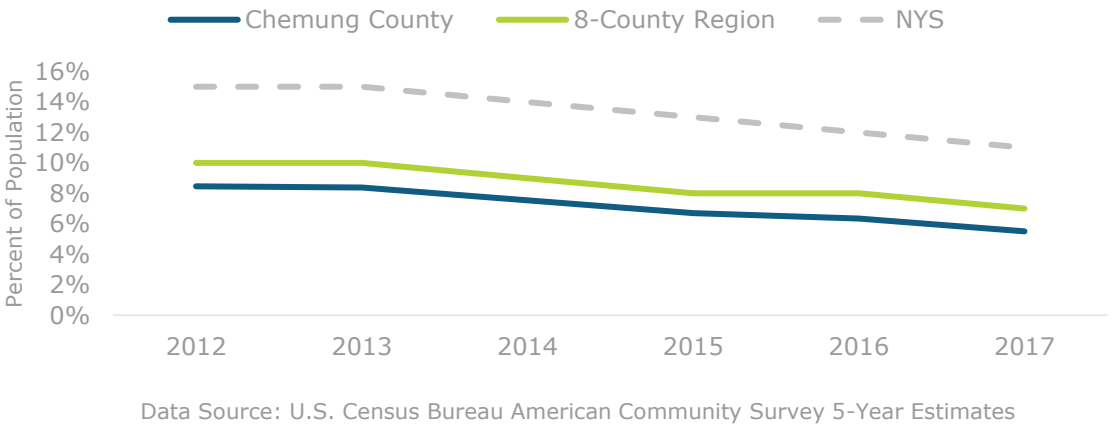
Over the past 5 years, there has been a shift in educational attainment where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 17).

Figure 17: Educational attainment for Chemung County by year



Data below show the trend in uninsured rates over the past 5 years compared to the eight county region and NYS which has decreased 35% since 2012 for Chemung County (Figure 18).

Figure 18: Percent of population that is uninsured



Finally, 32% of Chemung County residents rent vs. own their home. In addition, 11% of occupied housing units have no vehicles available. Another 34% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 44% of residents are paying more than 35% or more of their household income in rent costs. [14]

[14] Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Main Health Challenges

On April 9, 2019, stakeholders and community members were invited to attend a priority setting meeting. At this meeting, participants reviewed the MAPP process, as well as relevant qualitative, quantitative, primary and secondary data. Data were reviewed from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports and primary data collected from the My Health Story 2018 Survey. Lively group discussions took place regarding the potential priority areas. The meeting was very well attended with multiple agencies represented. Ultimately, using the Hanlon/PEARL method, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

Prevent Chronic Disease

1. Healthy eating and food security
2. Physical activity
3. Tobacco prevention

Disparity: reduce tobacco use among pregnant women

In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the prioritization meeting). Weight and mental/emotional health issues rose to the top for each of the four categories (Figure 19). Exercise, education and diet/nutrition were concerns for children in the county. Tobacco appeared to be a concern for adults in the county. Chronic conditions such as cancer and heart conditions were also highlighted as respondents' top fears for themselves and for others. All of these findings help support the decision to move forward with the above mentioned priority areas.

Figure 19: Chemung County summary of health-related concerns for self, loved ones and county to prioritize

Biggest fear - for self	Biggest fear - for others
Weight (14.1%)	Weight (9.3%)
Cost (8.9%)	Cancer (7.1%)
Mental / emotional health issues (8.6%)	Mental / emotional health issues (6.7%)
Cancer (7.0%)	Heart conditions (6.3%)
Aging (6.8%)	Cost (6.0%)

County priority - for adults	County priority - for children
Substance abuse (21.9%)	Diet / nutrition (19.0%)
Weight (21.2%)	Weight (17.7%)
Mental / emotional health issues (17.4%)	Education (16.5%)
Cost (14.3%)	Mental / emotional health issues (13.8%)
Tobacco (12.1%)	Exercise (13.4%)

Source: *My Health Story* survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Top 5 issues shown for each question. Data shown are the percent of participants with responses in each category.

Behavioral Risk Factors

Approximately one in three adults in Chemung County are obese. The disease affects an estimated 20,000 adults and 625 children, and a higher percentage of the low income population (45%) and those living with a disability (49%).[15] Long-term health complications associated with obesity include increased risk for development of diabetes and hypertension and premature mortality due to related conditions.[16] Respondents to the *My Health Story 2018* survey revealed 15% of Chemung County residents reported poor or fair general health and one in five reported poor or fair physical health.

Two contributing factors to poor health are poor diet and lack of physical activity. Data retrieved from the 2016 Behavioral Risk Factor Surveillance System estimates that only two out of five residents reported eating fruits and three out of five reported eating vegetables on a regular basis. Approximately one in three reported daily sugary drink consumption. *My Health Story 2018* respondents were asked the biggest challenges or barriers keeping them from eating healthier. The biggest barrier to eating healthier, particularly for low income populations, is that healthy food is too expensive. Other issues which rose to the top were not enough time and lack of knowledge of how to shop for and prepare the food.

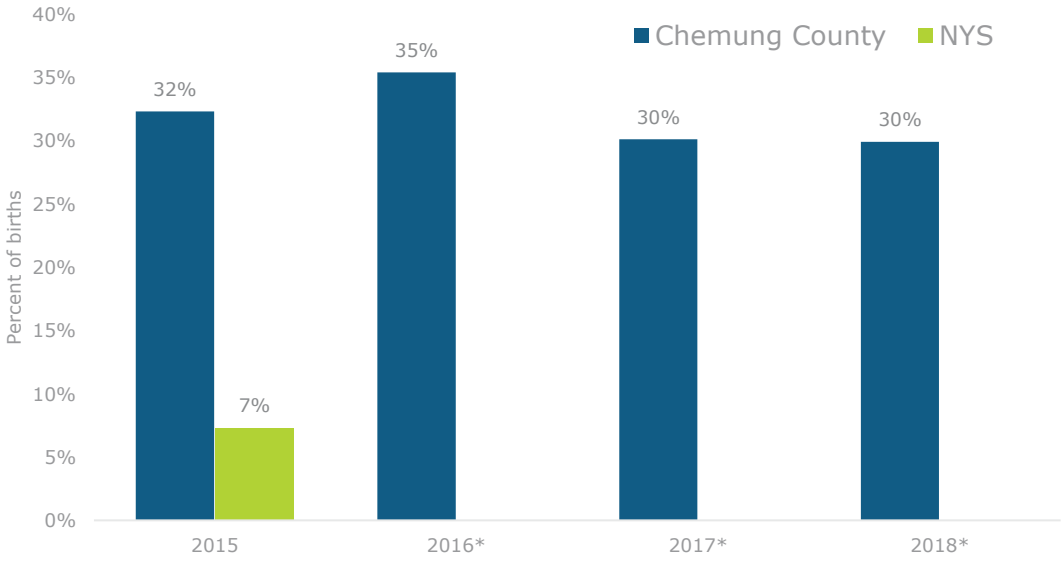
[15] Source: Behavioral Risk Factor Surveillance System 2016 and Student Weight Categorizing Reporting System 2016-2018. Note: low income data are unreliable due to large standard error.
[16] Source: Behavioral Risk Factor Surveillance System 2016 and Student Weight Categorizing Reporting System 2016-2018

In Chemung County, 77% of residents engaged in physical activity in the past month. According to *My Health Story 2018* data, the main reason for not engaging in more physical activity are lack of time and feeling too tired to exercise. Of note, the low income population reported that their biggest barrier to being physically active is that they cannot afford a gym membership.

Further evidence to support the priority area decisions are the rates of tobacco use in Chemung County. Rates of tobacco use among adults in the county are the highest in the eight-county region (26% of adults) and are particularly high among the low-income population (38%[17]). Reported use of e-cigarettes is also highest in Chemung County where 5% of adults report using e-cigarettes. It is important to note that e-cigarette use is frequently seen more often in youth and data are relatively new. In actuality, rates of use are likely much higher than 5%.[18]

Of particular concern in Chemung County are the rates of reported tobacco use among pregnant women. Almost one in three pregnant women have reported smoking during pregnancy (Figure 20). Smoking during pregnancy poses significant risks to the baby's health in the womb as exposure to smoke increases rates of premature birth, low birth weight, birth defects, and infant death. Rates of reported tobacco use are substantially higher than New York State and significantly higher than the Healthy People 2020 objective of less than 1.4%.

Figure 20: Percent of births with reported tobacco use during pregnancy



Data Source: NYS SPDS Data Child Abuse.
*preliminary data. Note NYS data are not available past 2015 at the time of this report.

[17] Data are unreliable due to large standard error. Source: Behavioral Risk Factor Surveillance System 2013-2014.
[18] Source: Behavioral Risk Factor Surveillance System 2016.

Policy and Environmental Factors

Current policies in the county help to defer smoking in public places. The Southern Tier Tobacco Awareness Coalition (STTAC) has done tremendous work in tobacco free outdoor policies. Over 50 agencies located in the county have documented tobacco free outdoor policies dating back to 2005. Part of the agency's success may be due to resident support for tobacco free outdoor policies. According to the agency's 2017 Community Tobacco Survey of Adult Residents of Chemung, Schuyler and Steuben Counties, 80% of Chemung County residents favor policies prohibiting smoking cigarettes in entrances of public buildings and workplaces. The majority of respondents also reported favoring policies prohibiting smoking in public parks or outdoor recreational areas (49%), at outdoor public community events (55%), in apartment buildings (49%), on workplace grounds (55%), and in cars with children (82%). Of note, 54% favor policies prohibiting use of electronic cigarettes inside all public places. Significantly, 72% of respondents indicated they would support raising the tobacco purchasing age to 21, a law that was recently signed by Governor Cuomo.

In January 2017, the Empire State Poverty Reduction Initiative released a report on Elmira, New York – "The Community Resources and Opportunities are Aligned. It's a new day in Elmira, New York." Within the report, residents stated their concerns with walkability in the City of Elmira. While many residents reported they do not feel safe walking in certain areas of the City, the total number of crimes in the area has decreased, which is positive and may help to improve perceived neighborhood safety. To further assist in ensuring a safe and welcoming built environment, the local zoning board is working to help implement the 2016 Comprehensive Plan recommendations. One of those recommendations is to "revise its zoning ordinance to implement the community's vision and encourage healthy urban growth." The new vision will encourage "walkable urbanism over suburban-style more vehicle-centric development." Greater opportunity for physical activity will occur when the plans are put into place.

Unique Characteristics Contributing to Health Status

The county has experienced nursing and other staff shortages over the past several years. Staff note they are currently in short supply and state it is difficult to attract new employees for a variety of different reasons. Most notably, all local healthcare providers are fighting for the same staff and some agencies are unable to compete with external wages. As part of the ten essential public health services, it is necessary to ensure a competent public and personal healthcare workforce. The inability for healthcare agencies to remain fully staffed negatively impacts the community by inadvertently creating decreased access to services.

Another unique challenge Chemung County faces is the decline in brick and mortar stores. The area was once a booming shopping area with a variety of entry-level,

managerial, and executive job opportunities, though the rise in online shopping has dramatically decreased the need for shopping plazas and malls. Brick and mortar stores which have now closed leave large empty and unused space- each one a missed opportunity for job creation and economic gain for the area. It is important for entry-level positions to be sustained to help those entering the workforce learn generic job skills training and, eventually, obtain greater responsibilities in new positions.

Community Assets and Resources to be Mobilized

During focus groups completed in late 2018 and early 2019, community members identified several assets and resources in Chemung County. For example, focus group attendees identified local farmers' markets, supplemental food programs (i.e. backpack programs, Meals on Wheels, etc.), school based programing (Guess Club and SADD), Special Olympics, and Planned Parenthood as community strengths and resources. A comprehensive list of identified strengths and resources can be found in focus group summaries and are available upon request.

Through implementation of the Community Health Improvement Plan, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles can be found in the Chemung County Community Health Improvement Plan document. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

Community Health Improvement Plan/Community Service Plan

As previously discussed in the executive summary, the MAPP process was utilized to help create the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to prioritization and Health Planning Partnership (HP2) group members which included updated data measures for each of the five priority areas outlined in the Prevention Agenda (please see executive summary for more information on pre-read documents). A variety of partners were engaged in each county's specific process including:

Chemung County Prioritization Agencies		
Chemung County Public Health	S2AY Rural Health Network	Common Ground Health
Able 2	Anglican Health Ministries	Mothers and Babies Perinatal Network
WIC	EOP	FSCC
Man2Man	Guthrie Hospital	EPC
CIDS	AIM	CCP

Chemung County Prioritization Agencies (continued)		
Elmira Central School District	Chemung County Mental Health	Finger Lakes Eat Smart NY/CDD
Creating Healthy Schools and Communities	CASA-Trinity	Arnot Health
Foodbank of the Southern Tier	Chemung County Office of Aging	Chemung County Youth Bureau

The community at large was engaged throughout the assessment period via a regional health survey and focus groups. Community members were also invited to attend the prioritization meeting to help inform and select the 2019-2021 priority areas. Preliminary findings of the assessment were shared with partners at Health Priority Partnership meetings and were shared at coalition meetings that the health department sits on. The public were invited to attend Health Priority Partnership meetings via Facebook.

Specific interventions to address the priority areas were selected at HP2 meetings and were a group effort. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Chemung County Community Health Improvement Plan (Appendix A). Interventions selected are evidence based. Special focus will be placed on reducing tobacco use among pregnant women.

The Community Health Improvement Plan progress and implementation will be overseen by HP2, a group that meets bi-monthly and brings together diverse partners to improve the health of its residents. Progress and relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

This Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) was created in partnership between the Chemung County Health Department and Arnot Health. It will be disseminated to the public in the following ways:

- Through a media release summarizing the results and offering the opportunity for the public to attend Health Priority Partnership meetings.
- It will be made publicly available on the Chemung County Health Department, Arnot Health, and S2AY Rural Health Network websites.

- Chemung County Health Department and Arnot Health will share the link for the CHA on their social media accounts.
- It will be presented to and reviewed by the Chemung County Board of Health and the governing board of Arnot Health.

The websites that will have the Chemung County Community Health Assessment 2018 – 2021 posted are:

Chemung County Public Health: http://www.chemungcountyhealth.org/

Arnot Health: https://www.arnothealth.org/

S2AY Rural Health Network: http://www.s2aynetwork.org/community-health-assessments.html

Common Ground Health: www.CommonGroundHealth.org

<table>
<tr><td colspan="2">Priority Area: Prevent Chronic Disease</td><td colspan="2">Focus Area: Healthy Eating And Food Security</td></tr>
<tr><td colspan="2">Goal: 1.2 Increase Skills And Knowledge To Support Healthy Food And Beverage Choices</td><td colspan="2">Disparity: Low Income</td></tr>
<tr><td colspan="4">Objective: 1.1 Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC])</td></tr>
<tr><td colspan="2">Implementation Partner: Local Health Dept.</td><td colspan="2">Partner Role(s) and Resources: CCHD/WIC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.</td></tr>
<tr><td colspan="4">Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings</td></tr>
<tr><td colspan="2" rowspan="3">Family of Measures: WIC provides nutrition education at every appointment. Secondary nutrition education contact also made. Education provided at annual breastfeeding and community baby shower events. Refers to Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Nutrition and breastfeeding assessments conducted. Education on reducing sugar sweetened beverages included.</td><td colspan="2">Projected (or completed) Year 1 Intervention:
Obesity NYS 10.1 Chemung 9.7
High Maternal Weight Gain NYS 35.0% Chemung 41.8%</td></tr>
<tr><td colspan="2">Projected Year 2: Obesity NYS 10.1 Chemung 9.7, High Maternal Weight Gain NYS 35.0% Chemung 41.8%, and Fruits/Veggies NYS 82.8 Chemung 78.5%</td></tr>
<tr><td colspan="2">Projected Year 3: Obesity NYS 10.1 Chemung 9.7, High Maternal Weight Gain NYS 35.0% Chemung 41.8%, and Fruits/Veggies NYS 82.8 Chemung 78.5%</td></tr>
<tr><td colspan="4">Objective 1.2 Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])</td></tr>
<tr><td colspan="2">Implementation Partner: Headstart</td><td colspan="2">Partner Role(s) and Resources: EOP Headstart responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.</td></tr>
<tr><td colspan="4">Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings</td></tr>
<tr><td colspan="2">Family of Measures: Economic Opportunity Program (EOP) Birth to Five School Readiness supports five locations as well as a Home Based Program. They utilize the I am Moving, I am Learning (IMIL) Program. The goals of IMIL are:
1) Increase Physical Activity in the Classroom
2) Improve the Quality of Nutrition Provided
3) Improve Staff Wellness
4) Improve Family Engagement
Nutrition education is provided daily to the children, quarterly in a newsletter to families, and monthly to families at meetings at their site.
The Eat Well Play Hard curriculum will be added to three sites in October and two others in the spring of 2020. It includes these initiatives:
1) Make nutrition and movement lessons part of a child’s daily routine</td><td colspan="2">Projected (or completed) Year 1 Intervention:
Five Head Start sites and a home based program serving 204 center based Head Start children, 27 center based Early Head Start children, 50 Early Head Start home based children and 12 pregnant mothers in the home based program for a total of 293 students and their families. 40-60 minutes of active indoor or outdoor play, as well as several 15 minute sessions of movement throughout the day such as circle time dance & songs, and Zumba Kids Jr. for 30 minutes 1-2 times per week provided. In year one children’s BMI was reduced by 3% and the number of children in the obese category was decreased by 2%. Children participated in a “Food Experience” monthly learning about and cooking a healthy food. Child and Adult Care Food Program (CACFP) guidelines followed. In addition, we have done away with all canned foods and the children only receive fresh vegetables and as much local organic produce as possible. We do serve fresh-frozen, but we try not to. In addition, children are taught how to self-serve in specialty portioned cups and scoops. They learn what a serving is, and what it should look like. The children eat whole grains, vegetables, fruits, protein, and dairy at each meal. Allergies are always accommodated. Families receive a quarterly newsletter with fresh healthy recipes on a budget. They are invited to education events surrounding nutrition & health. We recently hosted Dr. Zama with Arnot Health who discussed Heart Health. Our Health Educator also attends monthly meetings with the parents and delivers health information that is current and addresses issues they may have (for example changes with immunizations).</td></tr>
</table>

2) Provide nutrition and physical activity education to families 3) Offer fruits, vegetables, and low-fat dairy more often 4) Create or enhance nutrition and physical activity policies 5) Make family-style dining an everyday practice 6) Provides education workshops/trainings for families	**Projected Year 2:** We would like to increase the physical activity to 1.5 hours per day and increase Zumba Kids Jr. to 2 times per week as well as explore other options such as children's YOGA and Mindfulness
	Projected Year 3: We would like to increase the physical activity to 1.5 hours per day and increase Zumba Kids Jr. to 3 times per week as well as explore other options such as children's YOGA and Mindfulness
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** Comprehensive Interdisciplinary Developmental Services (CIDS) responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings	
Family of Measures: Comprehensive Interdisciplinary Developmental Services (CIDS) encourages healthy eating and breastfeeding during home visits.	**Projected (or completed) Year 1 Intervention:** # of home visits
	Projected Year 2: # of home visits
	Projected Year 3: # of home visits
Implementation Partner: Local Health Dept., Hospital, Community Based Organizations	**Partner Role(s) and Resources:** CCHD, Arnot Health, and HP2 members responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings	
Family of Measures: Chemung County Health Department (CCHD), Arnot Health, and community partners provide education at free summer meal sites.	**Projected (or completed) Year 1 Intervention:** CCHD tabled at 7 meal sites. Arnot Health was at 7 locations serving 107 children.
	Projected Year 2: # of sites # reached
	Projected Year 3: # of sites # reached
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** SRHN responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.4 Multi-component school-based obesity prevention interventions	
Family of Measures: Steuben Rural Health Network; Girls on the Run of the Southern Tier: • 80% of participants in Girls on the Run of the Southern Tier will show an increase of physical activity outside of participating in the program during the weekday and weekend. • 80% of participants in Girls on the Run of the Southern Tier will show a decrease in screen time after participating in the program (These measured	**Projected (or completed) Year 1 Intervention:** 80% of participants will show an increase of physical activity outside of the program. 80% of participants will show a decrease in screen time after participating in the program (completion of pre and post survey asking 2 questions on physical activity) 90% of participants will complete a 5K Open rate of 35 % for the nutrition fact email
	Projected Year 2: 85% of participants will show an increase of physical activity outside of participating in the program during the weekday and weekend. 85% of participants will show a decrease in screen time after participating in the program, 90% of participants will complete a 5K, and open rate of 40 % for the nutrition fact email.

by completion of pre and post survey asking 2 questions on physical activity) • 90% of participants will complete a 5K Open rate for "Nutrition tips and tricks" sent weekly to families via email and posted on social media.	**Projected Year 3:** 90% of participants will show an increase of physical activity outside of participating in the program during the weekday and weekend. 90% of participants will show a decrease in screen time after participating in the program 90% of participants will complete a 5K, and open rate of 45% for the nutrition fact email
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** FLESNY responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.4 Multi-component school-based obesity prevention interventions	
Family of Measures: Finger Lakes Eat Smart NY (FLESNY) 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 seven area schools serving 2,851 students. The Elmira City School District (ECSD) adopted CATCH in their wellness policy for all elementary schools, CATCH is used school wide (classroom, PE, brain breaks, MBE minutes, cafeteria).	**Projected (or completed) Year 1 Intervention:** 7 schools trained in CATCH with 2,851 students impacted. ECSD adopted CATCH in their wellness policy for all elementary schools, CATCH is used school wide (classroom, PE, brain breaks, MBE minutes, cafeteria)
	Projected Year 2: 8 schools trained in CATCH 3,157 students impacted in CATCH schools
	Projected Year 3: 8 schools trained in CATCH 3,157 students impacted in CATCH schools
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources: CHSC** responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.4 Multi-component school-based obesity prevention interventions	
Family of Measures: Creating Healthy Schools and Communities (CHSC) works with Elmira School District staff and partners to build capacity for assessing, developing and implementing Local Wellness Policy (LWP) aligned with USDA Healthy, Hunger-Free Kids Act	**Projected (or completed) Year 1 Intervention:** Providing ongoing support to assist with implementation of 2017 updated LWP, impacting the 6,000+ students. Support provided for using the 2017 School Health Index, self-assessment planning tool as a the school level to guide: Daily recess for elementary students, Access to physical activity facilities outside of school day, Prohibit using physical activity as punishment and taking away physical activity as punishment, Using food as reward or punishment, Access to drinking water, All foods/beverage sold and served during the school day meet USDA's Smart Snacks in Schools nutrition standards, implicitly addresses SSB
	Projected Year 2: Ongoing support to assist with assessing and enhancing 2017 LWP in 2020. As well as ongoing support to assist with implementation of 2017 LWP and 2020 updated LWP, impacting the 6,000+ students
	Projected Year 3:
Objective 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults)	
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources: CHSC** responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results.	

Family of Measures: Creating Healthy Schools and Communities (CHSC) # of engaged worksites # of engaged small retailers # of policies adopted Education provided and distributed	**Projected (or completed) Year 1 Intervention:** Arnot Health: new Community Supported Agriculture program. CIDS: new Healthy Vending Machine. EOP: new Healthy Vending, Wellness Newsletter, & Employee Wellness Activities. Perry & Carrol: new Healthy Snack options being offered to employees. Riverside Elementary: Smoothie blenders purchased for staff break rooms; indoor walking path floor decals with motivational posters. Parley Coburn: Yoga materials to offer classes for staff. Able2: Community Garden and Produce Cart, distribution of educational materials to all work sites. 3 small retail locations adding fresh fruit stand to their stores. 2 small retailers signing up to accept Fruit & Vegetable Prescription Program vouchers which will increase access to healthy options in low income neighborhoods. CHSC signage outside location advertising that Fruit is now being sold here.
	Projected Year 2: # of engaged worksites, # of engaged small retailers, # of policies adopted, Education provided and distributed
	Projected Year 3:
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** CCHD and partners responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results.	
Family of Measures: Creating Healthy Schools and Communities (CHSC) - EOP, CCHD, Arnot Health, and other partners participate in the CHSC program.	**Projected (or completed) Year 1 Intervention:** EOP recently put in a "healthy vending" machine that offers more healthy choices, and promotes health. They have instituted a Wellness Program for staff educating and encouraging them to make healthier choices. They provide healthy snacks at meetings and gatherings. CCHD provides monthly wellness tips and provides activities to encourage physical activity. Arnot Health started a Community Supported Agriculture program and holds a weekly farmers market. Many others listed above.
	Projected Year 2: Continue to provide education and opportunities. Increase education to families and employees. Implement Healthy food Policies.
	Projected Year 3:

Priority Area: Prevent Chronic Disease	**Focus Area:** Physical Activity
Goal: 2.2 Promote school, child care and worksite environments that increase physical activity	
Objective: 1.1 Decrease the percentage of children with obesity (among WIC children ages 2-4 years)	
Implementation Partner: Local Health Dept.	**Partner Role(s) and Resources:** CCHD/WIC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.2 Promote school, child care and worksite environments that increase physical activity	
Family of Measures: WIC - Increase the percentage of TV and Screen Time to less than 2 Hours daily (currently 83%)	**Projected (or completed) Year 1 Intervention:** 1 earned media activity, 3 social media posts, 2 community outreach disseminating information on reducing screen time

	Projected Year 2: 1 earned media activity, 3 social media posts, 2 community outreach disseminating information on reducing screen time
	Projected Year 3: 1 earned media activity, 3 social media posts, 2 community outreach disseminating information on reducing screen time
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** EOP responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.2 Promote school, child care and worksite environments that increase physical activity	
Family of Measures: Economic Opportunity Program (EOP) - Head Start provides structured physical activity opportunities every day. In the Family Support Services program the monthly events offered occasionally offer opportunities for physical activity which may include swimming, walking in a park or at the YMCA, going to the Zoo, bowling, etc.	**Projected (or completed) Year 1 Intervention:** EOP provides 40-60 minutes per day of structured indoor-outdoor play, as well as 30 minutes of Zumba Kids Jr. and movement/dance breaks throughout the day of 15 minutes or so.
	Projected Year 2: Continue to provide
	Projected Year 3: Continue to provide
Goal 2.1 Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	
Objective: 1.15 Increase the percentage of adults age 18 and over who walk or bike to get from one place to another (among all adults)	
Implementation Partner: Community Based Partner	**Partner Role(s) and Resources:** CHSC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.1.1 Implement a combination of one or more new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes)	
Family of Measures: Creating Health Schools and Communities (CHSC) and Chemung County Planning - # Complete Streets policies adopted	**Projected (or completed) Year 1 Intervention:** Town of Elmira: Complete Streets Traffic Calming Signage. Town of Southport: Complete Street Implementation Project to increase community physical fitness -- fit stations. Walking College - planning a Complete Streets implementation project to increase community physical fitness and boost economic development.
	Projected Year 2: # Complete Streets policies adopted
	Projected Year 3: # Complete Streets policies adopted
Objective: 1.7 Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among all adults))	
Implementation Partner: Local Health Dept., Hospital, Community Based Organizations	**Partner Role(s) and Resources:** CCHD, Arnot Health, and HP2 members responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities, new or upgraded park or facility amenities or universal design features; supervised activities or programs combined with onsite marketing, community outreach, and safety education.	
Family of Measures: Chemung County Health Department (CCHD), Arnot Health, and community partners: #	**Projected (or completed) Year 1 Intervention:** 278 people at final event for Gold Shoe. 65 screenings done by Arnot Health. 95% visited one or more parks for the first time, 84% said

participating in Gold Shoe# participating in Park Prize Pursuit # social media posts # reached thru newsletter	they felt healthier, and 82 participated in scheduled walks. CCHD newsletter goes out to 593 people.
	Projected Year 2: # participating in Gold Shoe# participating in Park Prize Pursuit # social media posts # reached thru newsletter
	Projected Year 3: # participating in Gold Shoe# participating in Park Prize Pursuit # social media posts # reached thru newsletter

Priority Area: Prevent Chronic Disease	**Focus Area:** Tobacco Prevention
Goal: Prevent initiation of tobacco use	
Objective: 3.1.1: Decrease the prevalence of any tobacco use by high school students.	
Implementation Partner: Local Health Dept.	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.	
Family of Measures: Southern Tier Tobacco Awareness Coalition (STTAC) - # of media outreaches (radio, TV, newspapers), # of paid ads in Chemung County, # of educational presentations provided to youth focused organizations, # of Reality Check activities in Chemung County	**Projected (or completed) Year 1 Intervention:** YTD - 57 earned media outreaches (March - Kick Butts Day, May - World No Tobacco Day, November - Great American Smokeout) 4 –paid ads completed - April -Newspaper?, May - Radio, June – Tobacco-free pharmacies, June – Reality Check recruitment 3 – presentations to youth focused organizations completed 3 – Reality Check activities in Chemung County
	Projected Year 2: 6 – earned media outreaches, 1 - paid ad, 5-presentations to youth focused organizations completed, 3 -Reality Check activities in Chemung County
	Projected Year 3: 6 – earned media outreaches, 1 - paid ad, 5-presentations to youth focused organizations completed, 3 -Reality Check activities in Chemung County
Objective: 3.1.6 Increase the number of municipalities that adopt retail environment policies, including those that restrict the density of tobacco retailers, keep the price of tobacco products high, and prohibit the sale of flavored tobacco products areas. **Disparity:** Low income, minorities, rural	
Implementation Partner: Local Health Dept.	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.1.3: Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas.	
Family of Measures: Southern Tier Tobacco Awareness Coalition - # of community events hosted or attended in Chemung County, # of stakeholders educated # of retail observations completed, # of community members mobilized to write or spread about tobacco marketing	**Projected (or completed) Year 1 Intervention:** 5 - community events hosted or attended (March – Kick Butts Day and Neighborhood Conversations , April – Earth Day and Neighborhood Conversations, May – World No Tobacco Day), 19 - stakeholders were educated - (Feb – Legislative Education Day (2), March – Neighborhood Conversations (1), May – World No Tobacco Day (15)) 2 - retail observations completed , (June – Dollar General, AA Mart)

	4 - community members wrote or spoke about tobacco marketing
	Projected Year 2: 5 - community events hosted or attended, 3 - stakeholders were educated, 2 - retail observations completed , 5 - community members wrote or spoke about tobacco marketing
	Projected Year 3: 5 - community events hosted or attended, 3 - stakeholders were educated, 2 - retail observations completed , 5 - community members wrote or spoke about tobacco marketing
Goal: 3.2 Promote tobacco use cessation	
Objective: 3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%	
Implementation Partner: Hospital	**Partner Role(s) and Resources:** Arnot responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.	
Family of Measures: Arnot Health –Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure). # of referrals to NYS Quitline, and # of prescriptions to address tobacco dependency.	**Projected (or completed) Year 1 Intervention:** Currently all PCP show a rate of 91% compliance of screening for tobacco use. Jan. – July 2019 3,842 unique patients (19,000 scripts) receiving prescription and non-prescription medications (Nicotrol, Nicorette, Nicoderm, RA Gum, Chantix, Buproprion, etc.). Approximately 1,211 referrals to NYS Quitline during this time.
	Projected Year 2: Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure). # of referrals to NYS Quitline and # of prescriptions to address tobacco dependency.
	Projected Year 3: Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure). # of referrals to NYS Quitline and # of prescriptions to address tobacco dependency.
Objective: 3.2.3: Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among adults with income less than $25,000) **Disparity:** Pregnant mothers	
Implementation Partner: Community Based Organizations	**Partner Role(s) and Resources:** Mothers & Babies, CCHD, CIDS, STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline. (among all adults focusing on pregnant moms)	
Family of Measures: Mothers & Babies Perinatal Network, CCHD, CIDS, and community partners - # of referrals to Quit	**Projected (or completed) Year 1 Intervention:** Increase referrals to Quit Kit smoking program by 10%, 2 tobacco free outdoor policies by 6/30/20, and increase # referrals to NYS Quitline.

Kit Program's phone based, smoking cessation program for pregnant and parenting women & family members or anyone caring for young children based on American Lung Association materials. URMC Center for Community Health & Prevention Stop Smoking program available for others, in addition to the NYS Quitline. # of social media posts, outreach, etc. promoting these programs. STTAC – concentrate on policies for those serving pregnant moms.	**Projected Year 2:** Increase referrals to Quit Kit smoking program by 10%, 2 tobacco free outdoor policies by 6/30/20, and increase # referrals to NYS Quitline.
	Projected Year 3: Increase referrals to Quit Kit smoking program by 10% and increase # referrals to NYS Quitline.
Goal: Goal 3.3 Eliminate exposure to secondhand smoke	
Objective: 3.3.1: Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes. **Disparity:** Low income	
Implementation Partner: Local Health Department	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.3.1: Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents.	
Family of Measures: STTAC - # of earned media outreaches# venues/events information disseminated# stakeholders educated# new units covered by policies	**Projected (or completed) Year 1 Intervention:** 3 earned media outreaches (February - Legislative Education Day, June - grant renewal, July - HUD anniversary), # venues /events stakeholders educated (February - St. Joseph's and St. Patrick's, April & June - Libertad), and 107 new units covered by smoke free policies - (St. Joseph's, St. Patrick's, and Skip Mills)
	Projected Year 2: 3 earned media outreaches # venues/events information disseminated, 1 stakeholder educated, and 15 new units covered by policies.
	Projected Year 3: 3 earned media outreaches # venues/events information disseminated, 1 stakeholder educated, and 15 new units covered by policies.
Objective: Decrease the percentage of residents (non-smokers) exposed to secondhand smoke in the community.	
Implementation Partner: Local Health Department	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.3.2: Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces.	
Family of Measures: STTAC - # of earned media outreaches, # venues/events information disseminated, # stakeholders educated, and # tobacco free major employer or municipal policies adopted.	**Projected (or completed) Year 1 Intervention:** 8 earned media outreaches, # venues/events information disseminated, 6 stakeholders educated, and 3 tobacco free policies adopted.
	Projected Year 2: 6 earned media outreaches, # venues/events information disseminated, 3 stakeholders educated, and 2 tobacco free major employer or municipal policies adopted.
	Projected Year 3: 6 earned media outreaches, # venues/events information disseminated, 3 stakeholders educated, and 2 tobacco free major employer or municipal policies adopted.