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

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Introduction

The Prevention Agenda is New York State's blueprint to help improve the health and well-being of its residents and promote health equity through state and local action. Every three years, New York State requests that local health departments and their local hospital systems work together to create a joint community health assessment and improvement plan using the Prevention Agenda guidelines. Local entities must choose two areas of focus for community improvement efforts during the plan period. Local entities can choose from five priority areas:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Diseases

During each new cycle, public health and hospital systems turn to key partners and community informants to help determine what the course of action ought to be to improve the population's health. For this particular cycle, eight local health departments and hospitals opted to leverage a local regional health planning agency (Common Ground Health) to conduct a community health assessment for the eight county region.

The following report summarizes Common Ground Health's assessment of local demographics and health data relating to the above priority areas for the eight county region. The report also contains a section devoted to discussion of Steuben County's local health challenges, assets and resources and selected interventions to improve community health. A copy of the complete Regional Community Health Assessment (which includes a chapter on each of the eight counties) can be found on the websites of the S2AY Rural Health Network and Common Ground Health.

www.S2AYnetwork.org

www.CommonGroundHealth.org

Key Findings

Eight County Region

The total population in the region[1] has increased since 1990. Over the next ten years, however, Cornell University's Program on Applied Demographics projects a decrease in the overall population with an increase in the aging (65+) population. The most recent American Community Survey reports that 92% of the region's residents are white non-Hispanic. However, the community is becoming more diverse. Since 1990, there has been a 63% regional growth in the Hispanic population and a 32% regional growth in the African American population. In addition, there is anecdotal evidence to suggest a growing number of Amish and Mennonite settlements within the region due to the affordability of land. In fact, it is estimated that nearly 20% of Yates County's population is Amish or Mennonite.

There are several implications that both the growing diverse and aging populations will have an impact on health. Healthcare providers must be equipped to care for patients with more co-morbid conditions than ever (aging population) as well as remaining culturally competent and relatable to diverse patients (growing number of Hispanics, African Americans, Amish and Mennonites). Ensuring a competent workforce is one of public health's ten essential services, which is why it is important to consider the population shift while health planning.

As identified through several avenues of local research, lack of transportation is one of the top barriers in each of the regional counties. Access to a vehicle and/or public transportation is not a privilege that all residents have. For those living on the outskirts of the populous cities and towns, access to transportation is essentially nonexistent unless they have their own vehicle or nearby neighbors, family and friends who have vehicles. This is particularly concerning for the aging population due to their need to attend more medical appointments than the average person, which could necessitate greater transportation planning in rural communities.

In addition, when looking at food insecurity data for the Community Health Assessment, data revealed that a portion of each county's population (average of 5%) are low income and have low access to a supermarket or grocery store. According to *My Health Story 2018* survey data, a supermarket or grocery store is where the majority of residents access their fresh fruits and vegetables (75%). Ensuring access to healthy and affordable food is essential to practicing a healthy lifestyle.

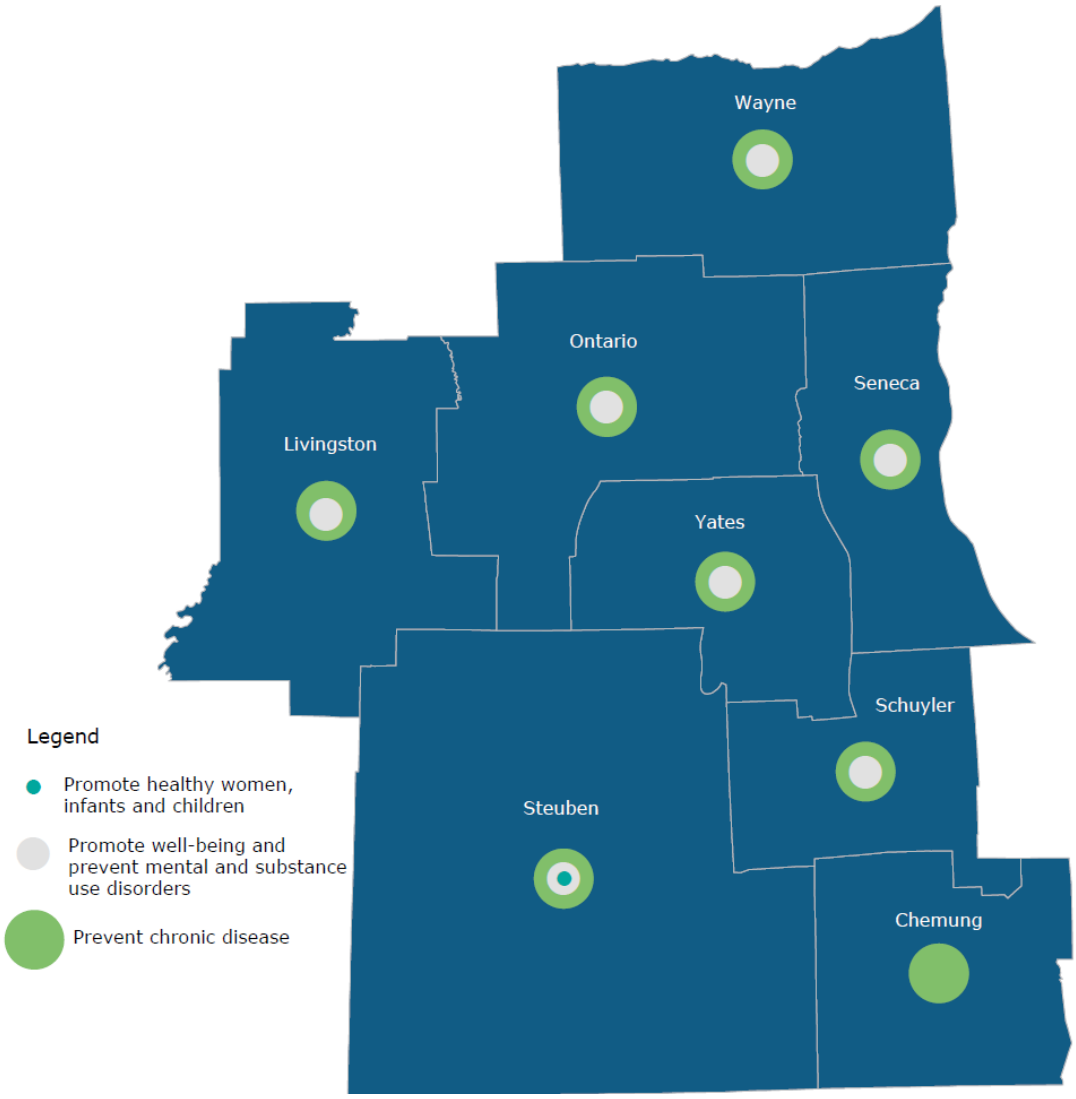
[1] Region includes Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

Regional Priority Alignment

It is not surprising that each of the eight counties have selected Prevent Chronic Diseases as one of their priority areas to focus on through 2021. It has been an opportunity for improvement for the past several assessment periods and remains one of the top priorities for each department. The most commonly selected focus areas within Prevent Chronic Diseases are (1) chronic disease preventative care management (six out of eight counties), (2) tobacco prevention (four out of eight counties) and (3) healthy eating and food security (four out of eight counties).

Promote Well-Being and Prevent Mental and Substance Use Disorders was the second most popular priority area with seven out of eight counties selecting this area. The particular focus area the majority of counties have selected revolves around prevention (seven out of eight counties).

Map 1: Selected Priority Areas



Interventions

To address the top focus areas, counties have selected the following interventions:

Focus Area	Intervention* & # of Counties Selected
Chronic disease preventative care and management	**4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting) (selected by three counties) **4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)
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)
Prevent mental and substance use disorders	**2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties) **2.2.4** Build support systems to care for opioid users at risk of an overdose (selected by three counties) **2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties) **2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five 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.	

Several of the above interventions include communication and small-media. As several counties have selected the same interventions, this poses an opportunity to create unified regional messaging. Residents do not remain within their counties' borders, so this concept will create an opportunity for Finger Lakes residents, regardless of where they live, work and play, to receive consistent messaging on health related topics. In addition, local health departments have the opportunity to work together and leverage each other's resources when creating and disseminating these communications and educational materials.

Regional Assets and Resources to be Mobilized

The Finger Lakes region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies which promote and facilitate collaboration: the S2AY Rural Health Network and Common Ground Health.

The S2AY Rural Health Network is a partnership of seven local health departments including Chemung, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties. The network's mission is to be a leader in improving health outcomes for rural communities and has a vision of their rural communities being among the healthiest in the nation. Common Ground Health covers the same geographic area as the network, with the addition of Livingston and Monroe Counties. The agency brings together leaders from health care, business, education and other sectors to find common ground on health challenges.

Both of these agencies together help support the work of the Community Health Improvement Plan process and continually strive towards highlighting alignment, leveraging shared resources, and creating opportunities for shared learning. With facilitation and coordination by each agency, local leaders are able to meet regularly to discuss health challenges and issues as a team and devise plans towards improving health of all Finger Lakes residents (via S2AY's Public Health Directors/Board Development Committee and Common Ground Health's quarterly Regional Leadership meeting). Regular discussions regarding challenges in health outcomes and resources take place at both of these meetings.

In addition to the resources available at both S2AY and Common Ground Health, there are regional workgroups and local nonprofit organizations. The S2AY Rural Health Network has helped in leading four regional workgroups designed to address health needs of residents. The workgroups include:

1. **Farm to Table**
    - *A regional workgroup that addresses increased access to healthy foods and collaborates with schools, food pantries, farmers, and local communities to get locally grown, fresh produce and raised products to them.*
2. **Healthy Living**
    - *A regional workgroup which enhances skills in our communities through collaboration among partners to prevent and control chronic health conditions through the delivery of evidence-based and evidence-informed interventions.*
3. **Worksite Wellness**
    - *A regional workgroup to help improve worksite wellness at area businesses and organizations for employers and their employees.*

4. **Finger Lakes Breastfeeding Partnership**
    - *A regional coalition that focuses on supporting breastfeeding mothers and increasing the number of women who breastfeed in the Finger Lakes region.*

Local nonprofit organizations are additional assets and resources that Finger Lakes region leaders may mobilize when implementing their community health improvement plans. There are several organizations in addition to those already mentioned which cover several counties in their work efforts. For example, the Tobacco Action Coalition of the Finger Lakes (TACFL) and the Southern Tier Tobacco Awareness Coalition (STTAC) may be leveraged in support of tobacco prevention efforts. In relation to healthy eating and food security, local Cornell Cooperative Extension agencies and worksite wellness coordinators (such as at hospitals, school districts, etc.) are potential agencies and departments which may support initiatives outlined in the improvement plans.

In addition to the above referenced regional partners, each county has built and sustained relationships with countless partner organizations that help to support initiatives within their specific county. Within each community health improvement plan, the roles of each agency are identified in relation to the selected priority areas, focus areas and interventions.

Steuben County Executive Summary

Steuben County Public Health, in partnership with Arnot Health and Ira Davenport Memorial Hospital, Guthrie Corning Hospital, and St. James Hospital, has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

County	Priority Areas & Disparity
Steuben County	**Prevent Chronic Disease** 1. Tobacco prevention **Promote Healthy Women, Infants and Children** 2. Child and adolescent health **Promote Well-Being and Prevent Mental and Substance Use Disorders** 3. Prevent mental and substance use disorders **Disparity: low socioeconomic status and 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 department and hospitals, representatives from local Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), the county legislature, county government employees, school district representatives, Office for the Aging, 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' roles 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 May 7, 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 priorities. To address the previously mentioned priorities and disparities, the health department facilitated a CHIP planning meeting where partners discussed opportunities to leverage existing

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

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.

Regionally[3], Steuben 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)
Prevent mental and substance use disorders	**2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties) **2.2.4** Build support systems to care for opioid users at risk of an overdose (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where Steuben County and at least two 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 Steuben, have selected goals which revolve around prevention of initiation of tobacco use as well as tobacco cessation efforts. Leveraging all of the previously mentioned interventions region-wide will aid in reaching as many persons as possible throughout the region. In addition, widespread goal alignment exists among promotion of well-being and prevention of mental and substance use disorders. Several counties, including Steuben, have selected goals that revolve around prevention of suicides. The

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

complete list of Steuben 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, Smart Steuben, meets on a monthly basis. The group has historically reviewed and updated the 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, newsletter articles, and social media postings.

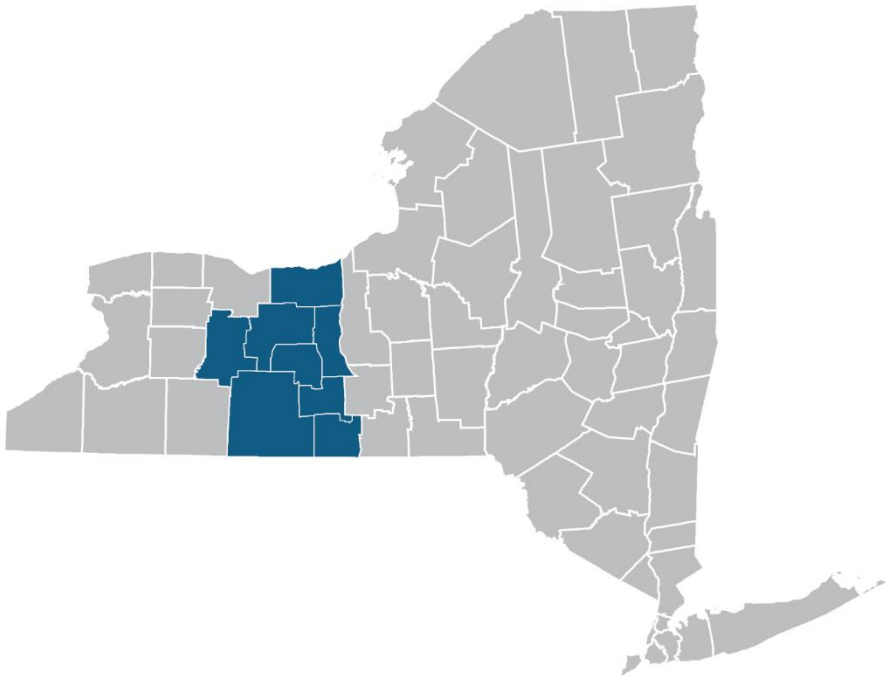
Community Health Assessment

Eight County Region

Total Population

Located in the Western half of New York State between Lake Ontario and the New York/Pennsylvania border, the Finger Lakes region is home to renowned waterfront, hiking trails, thousands of acres of farmland, quaint and lively towns and villages, and active small cities (Map 2). Such a picturesque region brings in thousands of tourists each year. Despite all of its assets, residents experience health related issues and illness just like any other community in New York State. The following assessment will take a closer look at the health of Finger Lakes region residents and selected interventions to improve the health of its residents.

Map 2: The eight-county Finger Lakes region



The total population of the eight county region has increased by approximately 11,000 residents since 1990, with an estimated 528,000 total residents. Projections from Cornell University's Program on Applied Demographics expect a decrease in overall population (13,000 residents) over the next ten years, though there is an expected increase in the aging (65+) population. Implications of the growing aging population ought to be considered when health planning in the region.

According to the most recent American Community Survey data, 92% of the region's residents are white non-Hispanic. Since 1990, there has been a 63% regional growth in the Hispanic population (6,000 to 17,000 residents), and a 32% regional growth in the African American population (13,000 to 19,000 residents).

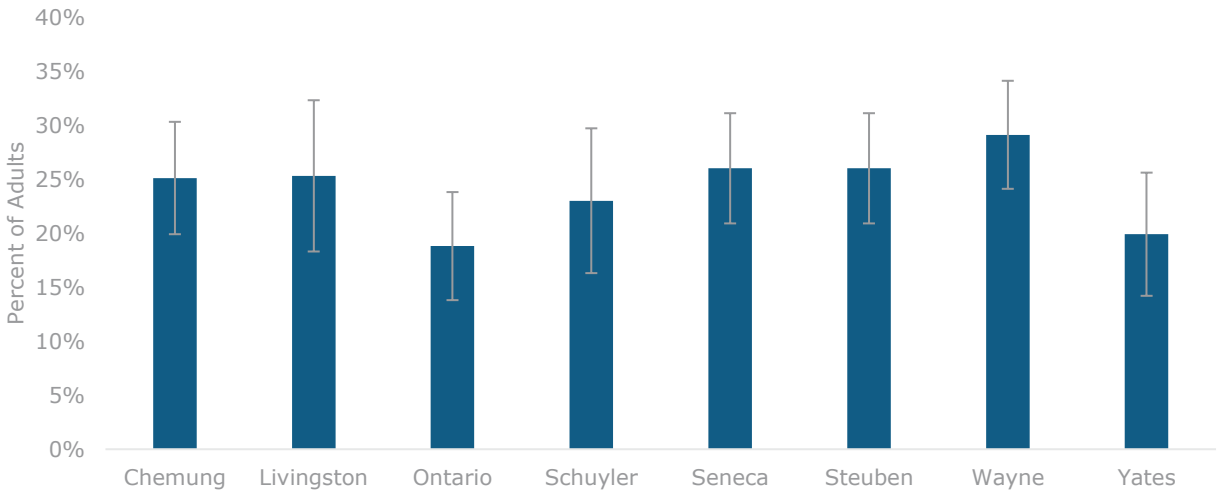
Disability

Those living with any form of disability (physical, activity or daily functioning impairments) are at greater risk for the development of chronic conditions including

obesity, heart disease, and diabetes. Creating a built environment that helps eliminate structural barriers and building a culture of inclusion helps to reduce disparities in health outcomes for the disabled. Doing so requires support from a variety of change initiatives such as policy, system and environmental changes.

In the eight county region, an average of 24% of adult residents are living with a disability. The rates range from 19% in Ontario County to 29% in Wayne County (Figure 1).

Figure 1: Percent of adults living with a disability



Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016.

Household Language

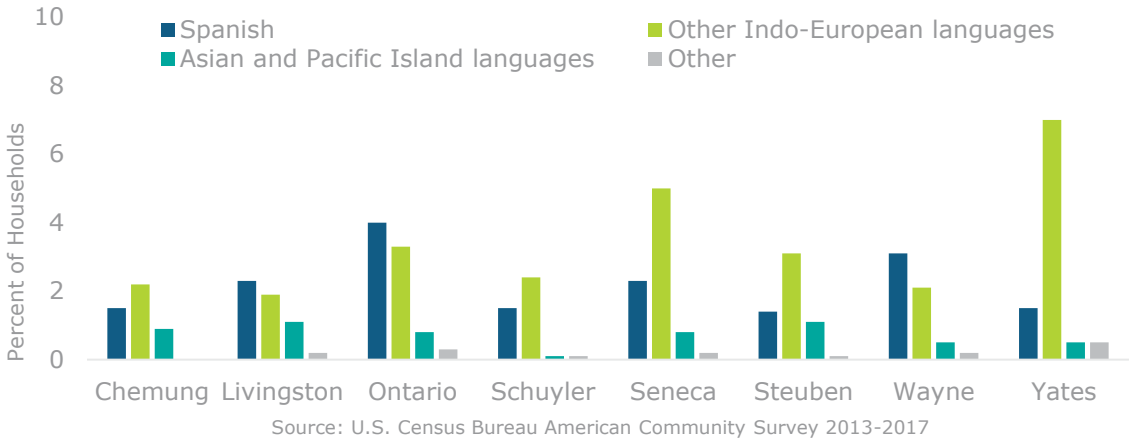
Providers of all types (medical, social service, etc.) should be aware of language and cultural differences when working with patients/clients. Being respectful of a person's cultural practices is important to building a trusting and positive relationship. A system where healthcare providers are culturally competent can help improve patient health outcomes and quality of care. In addition, it can help to eliminate racial and ethnic disparities in outcomes.[4]

The majority of residents in the eight county region speak English. A small percentage speak limited English (<1.5% of total population per county). Other popular languages spoken in the home include Spanish, Asian and Pacific Island

[4] Source: Health Policy Institute at Georgetown University, "Cultural Competence in Health Care: Is it important for people with chronic conditions?"

languages, and other Indo-European languages. Figure 2 shows the percent of each county's residents who speak a language other than English.

Figure 2: Percent of households speaking a language other than English



Special Populations

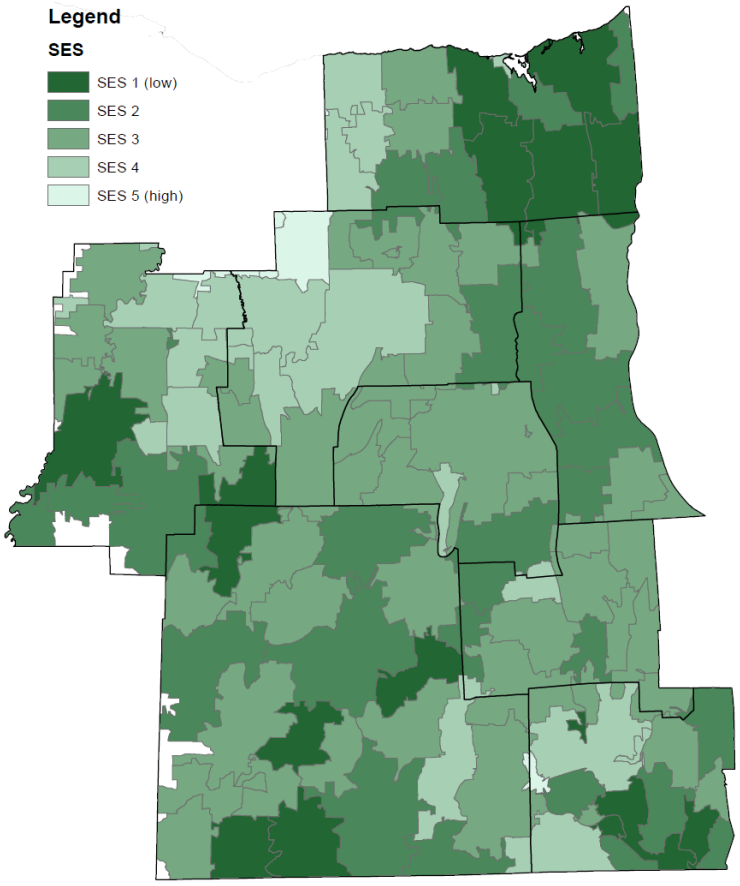
Finding accurate and up-to-date data on Amish and Mennonite populations is a challenge. These populations often do not respond to surveys such as those conducted by the U.S. Census Bureau. Local churches, however, collect information on their members and may share this information with public health officials. The Groffdale Conference Mennonites (Old Order Mennonites), for instance, releases an annual map of its congregation. Groffdale Conference Mennonite families span the area between Canandaigua and Seneca Lakes (Yates County), and from Geneva (Ontario County) all the way down to Reading, NY (Schuyler County). The church reports a total of 697 Groffdale Conference Mennonite households throughout Yates, Ontario, Schuyler and Steuben Counties; the majority of whom reside in Yates County.[5] It is important to note, however, that these data do not include the Crystal Valley Mennonite and Horning Order groups- two additional congregations which are found in the region.

Cultural practices of Amish and Mennonites must be considered when reviewing data and planning health initiatives. It is customary in Amish and Mennonite cultures to practice natural and homeopathic medicine as opposed to traditional American medical care (family planning, preventative care visits, dental screenings, vaccinations, etc.). Late entrance into prenatal care and home births are common practices. Children attend school through eighth grade and learn farming and other trades throughout childhood and adolescence, creating potential for unintentional and farm-related injuries. Bikes and buggies (horse drawn) are common forms of transportation and, combined with speeding traffic on rural roads, can create the potential for road accidents. Health decision making is often based on the attitudes,

[5] Source: Groffdale Conference Mennonites in the Finger Lakes Area of New York State, March 2019 Map

beliefs and practices of church leadership. These factors along with the anticipated growth in these populations create unique challenges for Public Health practitioners.

Map 3: Socioeconomic status in the eight-county Finger Lakes region



Socioeconomic Status

Socioeconomic status[6] affects several areas of a person's life, including their health status. Data have revealed that low-income families are less likely to receive timely preventative services or have an established regular healthcare provider than families with higher incomes. Map 3 reveals the socioeconomic status of the Finger Lakes region based on ZIP code. Note that almost half of Wayne County was found to be in the two lowest socioeconomic statuses in the region, yet pockets of poverty exist throughout the eight counties.

One of the factors influencing socioeconomic status is income, largely driven by employment status. Having a job may afford a person the ability to maintain safe and adequate housing, purchase healthy foods, remain up to date on health visits, and more. The type of position a person holds plays a significant role in the individual's ability to become self-sufficient and is closely related to educational attainment. Higher paid jobs are directly correlated to greater self-sufficiency. The 2017 American Community Survey estimates 28% of regional residents have received a Bachelor's degree or higher, which has increased since 2012 (26%).

Unemployment

Unemployment in the Finger Lakes region has declined since 2012, as shown in the table below (Table 1). The percent of the population who are not in the labor force, however, has increased. It is important to note the percent not in the labor force

[6] The Common Ground Health estimation of socioeconomic status is developed from U.S. Census and American Community Survey data by ZIP Code. It is based on the average income, average level of education, occupation composition, average value of housing stock, age of the housing stock, a measure of population crowding, percentage of renter-occupied housing, percent of persons paying more the 35% of their income on housing, and percent of children living in single parent households.

includes those over the age of 65. With a growing number of elderly in the region, it is not surprising that this rate has increased since 2012.

Table 1: Percent of 16+ by labor force and employment status

	2012		2017	
	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force
Chemung	7	41	5	43
Livingston	6	39	5	43
Ontario	7	34	5	36
Schuyler	6	41	7	41
Seneca	6	44	5	43
Steuben	9	40	7	41
Wayne	8	34	6	37
Yates	6	38	6	40
8 County Region	**7**	**38**	**6**	**40**
NYS	9	35	7	37

Source: US Census Bureau American Community Survey 5-Year Estimates

Unemployed persons under age 65 do not have access to employer-based subsidized health insurance, and are therefore more likely to be uninsured. Health insurance helps individuals access the care that they need. Like the low socioeconomic status population, the uninsured are less likely to receive or seek preventative care such as health screenings, are less likely to have an established regular healthcare provider and are more likely to use the emergency room for services that could have been rendered in a primary care provider setting. Since the implementation of the Affordable Care Act, the rate of uninsured individuals has decreased 3% over the past six years to 5% of residents. This is a step in the right direction, but health insurance attainment is not the only barrier to health care. Underinsured individuals, or those who have high deductibles that affect their ability to access healthcare, is a real concern. Transportation, lack of provider availability (including difficulty scheduling with providers) and cost (i.e. cost of care, time away from work, and childcare) were repeatedly identified as barriers and top concerns in *My Health Story 2018* survey discussions and are areas that could see improvement.

Health Assessment

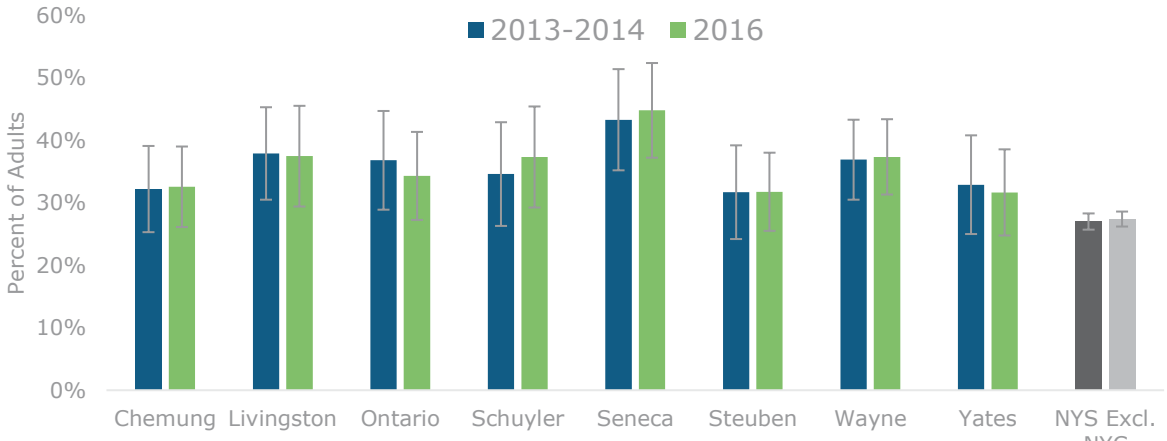
Eight County Region

At priority setting meetings, participants reviewed and discussed data from a variety of sources and five different topic areas recommended by the NYS Prevention Agenda. A summary of regional health challenges by topic area are below.

Prevent Chronic Diseases

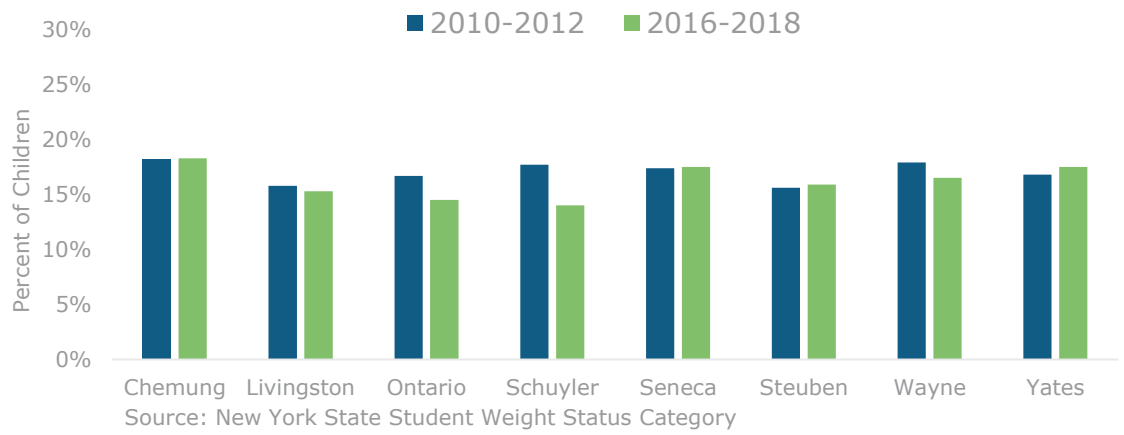
Preventing chronic disease has been a long standing priority area in the eight county region. Efforts have largely been focused on reducing illness, disability and death related to hypertension, tobacco use and secondhand smoke, and reducing obesity in children and adults. Rates of obesity in the eight county region have not changed significantly in recent years. Affecting both adults (Figure 3) and children (Figure 4), obesity-related long-term health complications may lead to development of diabetes, hypertension, and premature mortality due to related conditions. Regionally, respondents to the *My Health Story 2018* survey indicated that better diet, nutrition and physical activity habits would help them manage their weight better.

Figure 3: Percent of adults 18+ who are obese



Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

Figure 4: Percent of children who are obese



Obesity disproportionately affects specific populations. Both the low-income population and those living with a disability have higher rates of obesity than the general population, as shown in Table 2 below.

Table 2: Obesity rates among low income and those living with a disability

	Obesity	Obesity among low-income population	Obesity among those living with a disability
Chemung	33%	45%	49%
Livingston	38%	39%	48%
Ontario	34%	41%	51%
Schuyler	37%	54%	46%
Seneca	45%	46%	46%
Steuben	32%	37%	36%
Wayne	37%	42%	45%
Yates	32%	29%	48%
8 County Region	**35%**	**41%**	**45%**
NYS	27%	33%	40%
Source: Behavioral Risk Factor Surveillance System, 2016			

In addition, there are some stark differences in rates of obesity by sex. Data appears to demonstrate that more males are reported obese than females (Table 3).

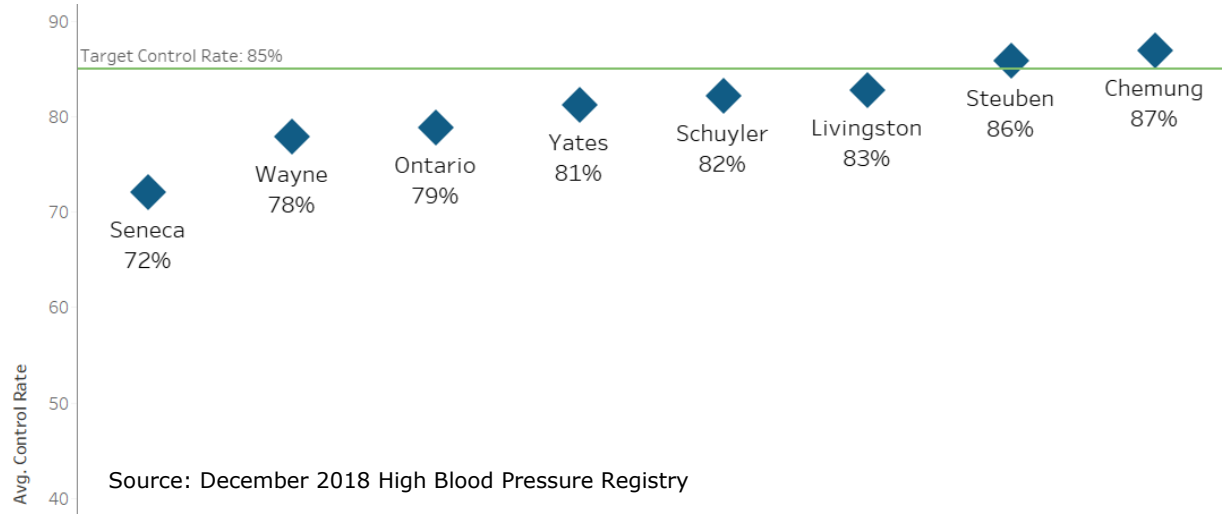
Table 3: Obesity rates by sex

	Obesity- Males	Obesity- Females
Chemung	34%	30%
Livingston	31%	40%
Ontario	40%	36%
Schuyler	24%	42%
Seneca	56%	35%
Steuben	33%	31%
Wayne	43%	31%
Yates	31%	30%
8 County Region	**37%**	**34%**

Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

An estimated 36% of adults in the region have been diagnosed with hypertension. However, it is important to note the hypertension control rate for residents. According to the December 2018 High Blood Pressure Registry[7], 79% of hypertensive patients in the region are in control of their blood pressure. Rates of blood pressure control in the eight county region range from 72-87%, with an overall target of 85% control (Figure 5). Maintaining greater control of blood pressure can lead to lower risk of heart attack, stroke and death. Among those who reported they were not managing their high blood pressure well in the *My Health Story 2018* survey, respondents indicated that prescriptions and better diet and nutrition would help them manage their disease better.

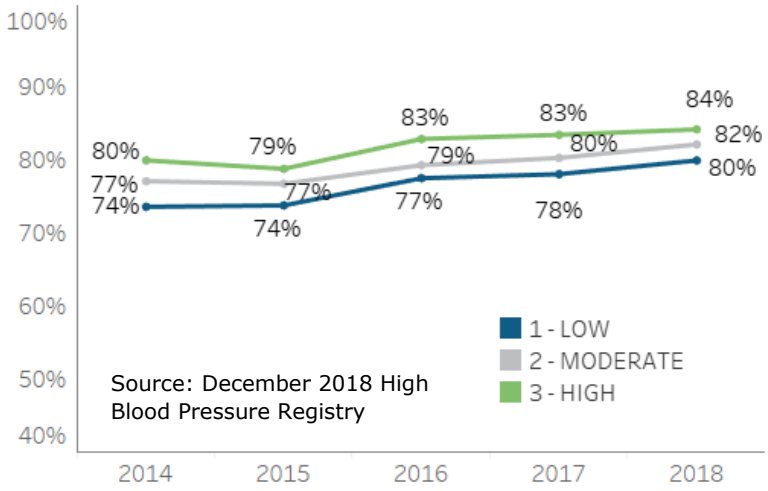
Figure 5: Percent of patients with blood pressure controlled, December 2018 high blood pressure registry



Source: December 2018 High Blood Pressure Registry

[7] The High Blood Pressure Registry is a biannual effort led by Common Ground Health, which collects data on hypertensive patients from healthcare providers in the nine county Finger Lakes region.

Figure 6: Regional control rate by socioeconomic status over time



There is a four percent difference in hypertension control rate by socioeconomic status in the eight county region (Figure 6). Reducing the disparity requires engaging patients in taking control of their blood pressure through various methods including blood pressure medication adherence, being physically active and eating healthy. Low income patients are less able to afford medications and healthy foods and may live in circumstances that limit their ability to exercise regularly. Working with providers to prescribe generic medications covered by insurance, mitigating lack of access to healthy foods, and addressing the built environment are important interventions to consider when looking to reduce disparities.

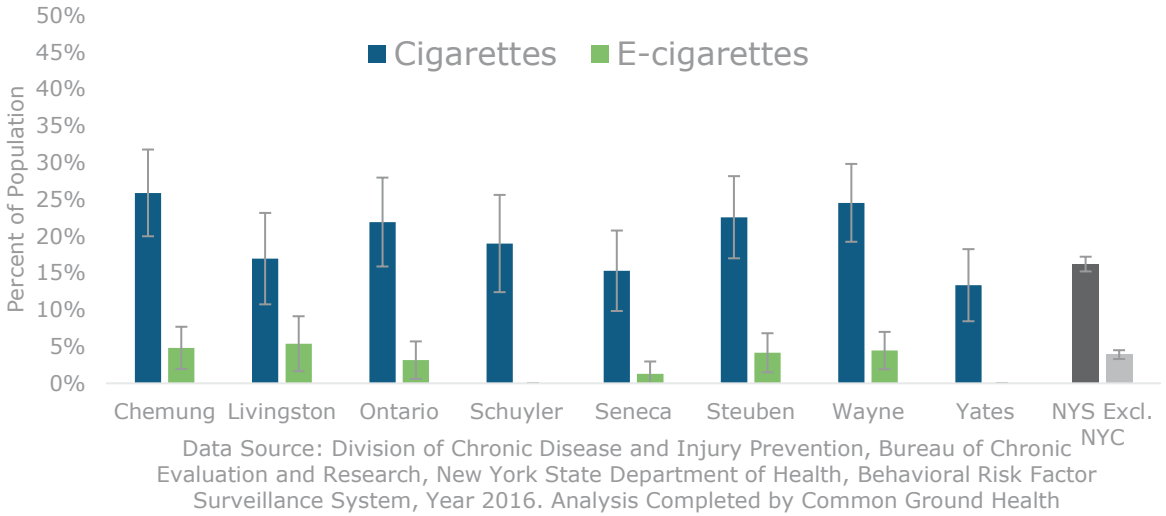
Those diagnosed with hypertension and/or obesity are at greater risk for other diseases such as chronic kidney and cardiovascular (heart) diseases. In fact, heart disease is one of the top two leading causes of death in the eight county region (additional data can be found later in report). Cardiovascular disease (CVD), similar to its contributing factors (obesity, hypertension and smoking), impacts different populations at varying levels. Data have revealed that those living with a disability are at greater risk for development of cardiovascular disease (Table 4) and may be a population where health intervention ought to be focused.

Table 4: Cardiovascular disease by demographic

	CVD	CVD- those living with a disability
Chemung	13%	24%
Livingston	9%	20%
Ontario	8%	16%
Schuyler	9%	27%
Seneca	13%	28%
Steuben	15%	37%
Wayne	10%	21%
Yates	8%	24%
8 County Region	**11%**	**25%**
NYS	9%	21%
Source: Behavioral Risk Factor Surveillance System, 2016		

Tobacco use increases the risk of cardiovascular disease. An emerging issue identified in the region is the use of e-cigarettes and other nicotine delivery systems, especially among younger adults. Nicotine is addictive – regardless of the form in which it is consumed - and has deleterious effects on developing fetuses and underdeveloped brains in children and adolescents. Unregulated child-friendly flavorings and colorings found in vaping and other devices damage the oral mucosa and airway. There is much still unknown about the full health effects of electronic cigarettes. A recent NY State DOH Health Alert (August 15, 2019) of severe pulmonary disease among ten NY State residents related to vaping highlights the need for public health professionals to address this issue in the coming years. While data at this time are sparse, the popularity of these devices has grown substantially. It is likely use is actually much higher than the estimates shown in Figure 7.

Figure 7: Percent of adults (18+) who smoke every day or some days



Smoking rates vary by demographic. For instance, the low-income population has higher rates of smoking than the general population, as shown in Table 5 below. Additionally, those living with a disability are also estimated to have higher rates than the general population.

Table 5: Smoking rates by demographic

	Current smoker	Current smoker- low income	Current smoker- those living with a disability
Chemung	26%	37%	34%
Livingston	17%	20%	20%
Ontario	22%	45%	29%
Schuyler	19%	32%	32%
Seneca	15%	33%	20%
Steuben	23%	31%	29%
Wayne	25%	32%	30%
Yates	13%	30%	27%
8 County Region	**26%**	**33%**	**28%**
NYS	16%	25%	23%

Source: Behavioral Risk Factor Surveillance System, 2016

There are also differences in rates of smoking by sex (Table 6). Some counties, such as Chemung, Seneca and Livingston Counties, see a fairly big difference in smoking rates by sex. In Chemung and Seneca counties, males are upwards of 8% more likely to report smoking than females. In Livingston, the reverse is seen with females 8% more likely to report smoking than males. Targeting public health interventions towards males and the above mentioned disparate populations may help to reduce disparities.

Table 6: Smoking rates by sex

	Current smoker- Males	Current smoker- Females
Chemung	32%	22%
Livingston	11%	19%
Ontario	22%	21%
Schuyler	18%	21%
Seneca	19%	11%
Steuben	24%	25%
Wayne	27%	21%
Yates	13%	14%
8 County Region	**21%**	**23%**

Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

Healthy eating habits are important when it comes to decreasing the burden of obesity in children and adults. According to *My Health Story 2018* survey data, 9% of the region's respondents reported the nearest grocery store is 20+ minutes

away, where vehicles are needed to access them. Of note, the majority of residents (75%) indicated they usually get their fruits and vegetables from a supermarket or grocery store or local grocery store (47%). A substantial amount utilize local farm stands (39%), farmers markets (29%), or grow their own in their garden (22%), with estimates higher in Schuyler, Seneca, Wayne and Yates Counties.

My Health Story 2018 respondents were also asked the biggest challenges or barriers keeping them from eating healthier. Table 7 reveals barriers reported by residents. The biggest barrier to eating healthier, particularly for those with low income, 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.

Table 7: Barriers to eating healthy

	8 County Region				
	under $25K	**$25-50K**	**$50-75K**	**$75K+**	**Overall**
Buying healthy food is too expensive	57%	50%	43%	24%	42%
I don't enjoy the taste of healthy food	3%	6%	11%	8%	7%
I don't have any place nearby to buy healthy food	4%	5%	2%	3%	3%
I don't have the supplies and equipment I'd need to cook healthy food	8%	4%	3%	1%	4%
I don't have the time to shop for, and prepare, healthy food	15%	18%	22%	22%	19%
I don't have the transportation to go shopping for healthy food	11%	1%	0%	0%	3%
I don't know how to cook and prepare healthy meals that taste good	16%	15%	14%	9%	13%
The others in my household don't eat healthy, and we eat together	14%	13%	14%	13%	13%
I really don't have any barriers keeping me from eating healthy food	22%	33%	37%	48%	36%
I don't want or need to eat healthier than I already do	5%	6%	10%	11%	8%

Source: My Health Story *survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.*

In the eight county region, 74% of residents reported engaging in physical activity in the past month (2016 BRFSS). According to *My Health Story 2018* data, the main reason for not engaging in more physical activity is lack of time and feeling too tired to exercise (Table 8). Of note, the low income population reported inability to afford a gym membership as the biggest barrier to being physically active.

Table 8: Barriers to being physically active

	8 County Region				
	under $25K	**$25-50K**	**$50-75K**	**$75K+**	**Overall**
I always seem to be too tired to exercise	29%	31%	33%	26%	29%
I can't afford a gym membership or other fitness opportunities	46%	31%	22%	10%	26%
I can't exercise because of a physical limitation or disability	25%	13%	12%	7%	14%
I don't have a safe place nearby to get more exercise	9%	6%	5%	3%	6%
I don't have anyone to exercise with, and don't like to exercise alone	21%	19%	17%	11%	16%
I don't have the time to get more exercise	17%	38%	46%	54%	40%
I don't have transportation to get places where I could get more exercise	11%	2%	1%	0%	3%
My life is too complicated to worry about exercise	6%	10%	9%	7%	8%
I really don't have any barriers keeping me from being physically active	16%	27%	20%	30%	24%
I don't want or need to be more active than I already am	8%	8%	10%	8%	8%

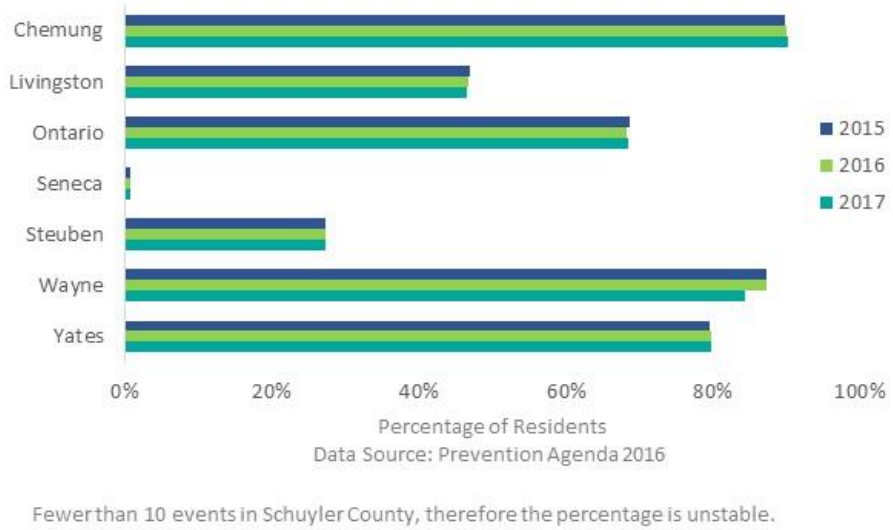
Source: My Health Story *survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.*

Promote a Healthy and Safe Environment

Healthy and safe environments relate to all dimensions of the physical environment(s) in which we live, work and play that impact health and safety. This includes the air we breathe, the water we drink and utilize for recreational use, interpersonal violence, incidence of injury and more.

Water quality is one way to examine healthy environments and is measured by the percentage of residents served by community water systems with optimally fluoridated water. Fluoridation benefits both children and adults by rebuilding weakened tooth enamel and helping to prevent tooth decay. There are varying levels of optimal water by county as shown in Figure 8. Several counties in the region exceed 50% of residents served by optimally fluoridated water. Progress could be made in Steuben and Seneca Counties.

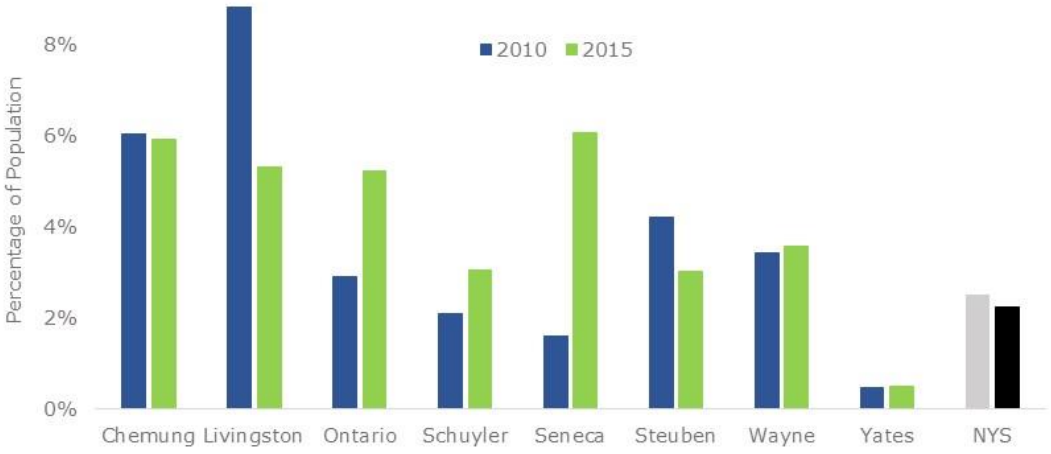
Figure 8: Percent of residents served by community water systems with optimally fluoridated water



Fewer than 10 events in Schuyler County, therefore the percentage is unstable.

As previously discussed, access to a supermarket or grocery store is important for accessing healthy foods. In the eight county region, 9% of *My Health Story 2018* respondents indicated the nearest grocery or supermarket store was 20+ minutes away. Access to a vehicle may be particularly challenging for the low income population. Figure 9 shows the percent of residents who are low income and have low access to a grocery store.[8] NYS rates are much lower than several counties in the region with the exception of Yates County. Rates of low income and residents with low access have increased since 2010 in Ontario, Schuyler and Seneca Counties.

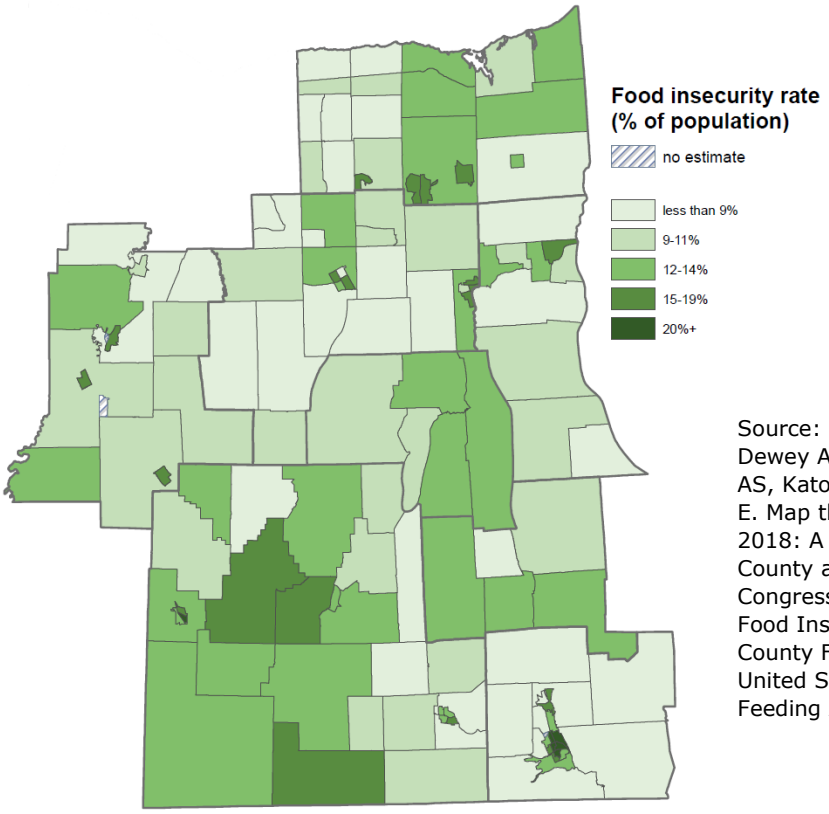
Figure 9: Percent of population that is low income and has low access to a supermarket or large grocery store



[8] Source: NYS Prevention Agenda Dashboard

Over 22% of the regional population reported experiencing food insecurity in the past 12 months. Of note, 14% of *My Health Story 2018* respondents reported they are always stressed about having enough money to afford healthy food. Map 4 shows the food insecurity rates by census tract in the eight county region. Higher rates of food insecurity are found in previously identified low income areas such as Geneva, Mount Morris and Elmira. In addition, Steuben County has the highest reported food insecurity rate with insecurity noted in communities throughout the county.

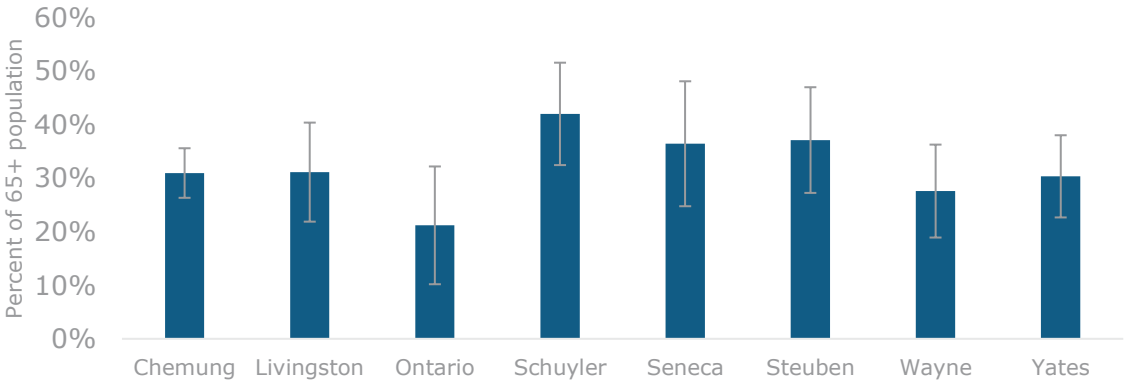
Map 4: Food insecurity rate by census tract



Source: Gunderson C. Dewey A, Crumbaugh AS, Kato M & Englehard E. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States, 2016. Feeding American 2018.

Falls in the 65+ population are another indicator of environmental health and safety. In the eight county region, an average of 30% of residents aged 65+ have fallen in the past year, though the rate varies by county (Figure 10). The results of falls in the elderly can be devastating. These may include death, decreased life expectancy, chronic pain, loss of mobility and resultant loss of independence. Several counties in the region have partnered with their Office for the Aging to offer evidence-based classes on fall prevention.

Figure 10: Reported falls in 65+ population



Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, NYSDOH, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

Promote Healthy Women, Infants and Children

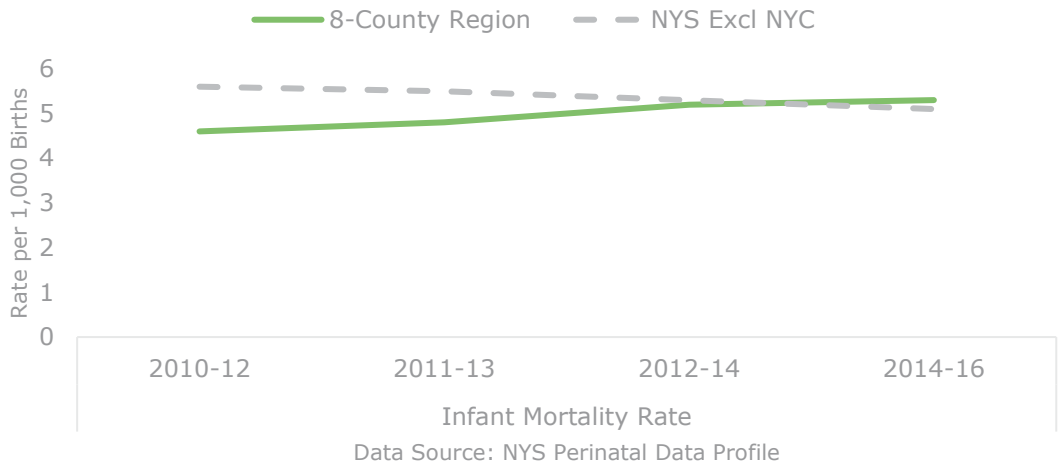
New York State collects several pieces of information on births including the number of premature and low birth weight babies. A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier a baby is born in pregnancy, the more likely it is that the baby will need to spend time in the neonatal intensive care unit (NICU). Long-term health complications associated with premature birth include intellectual and developmental delays, problems with communicating, getting along with others, and even taking care of him or herself. Neurological disorders, behavioral problems, and asthma may also occur.[9]

Premature birth is the primary cause of low birth weight. A child born at a low birth weight may suffer a range of health complications at birth. Some of the common issues for a low birth weight newborn include low oxygen levels, breathing complications due to immature lungs, difficulty feeding and gaining weight, neurological and gastrointestinal problems, infection, and more.[10] In the eight county region, rates of premature birth (9.5%) and low birth weight (6.8%) have remained below the NYS excluding NYC average (10.6% and 7.6%).

The rate of infant mortality (deaths that occurred less than 1 year after birth) has increased slightly over the past several years (Figure 11). Causes of infant mortality may be related to prematurity and related conditions, infections, obstetric conditions, sudden unexpected infant death and external causes such as unsafe sleep practices.

[9] March of Dimes, Premature Babies and Long-Term Health Effects of Premature Birth, www.marchofdimes.org.
[10] Stanford Children's Health, Low Birthweight

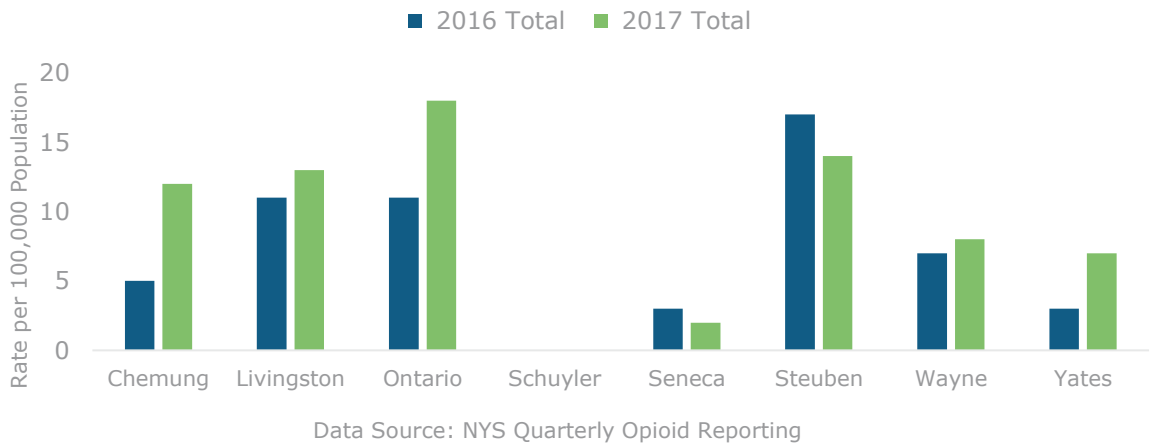
Figure 11: Rate of Infant Mortality



Promote Well-Being and Prevent Mental and Substance Use Disorders

Data from New York State Opioid Reporting indicate a 23% increase in overdose deaths from 2016 (N=57) to 2017 (N= 74) (Figure 12). Notably, Seneca and Steuben Counties were the only counties that saw a decrease in deaths from 2016. The largest increases in deaths were in Chemung and Ontario Counties. No data are available for Schuyler County.

Figure 12: All opioid overdose death rates per 100,000 population



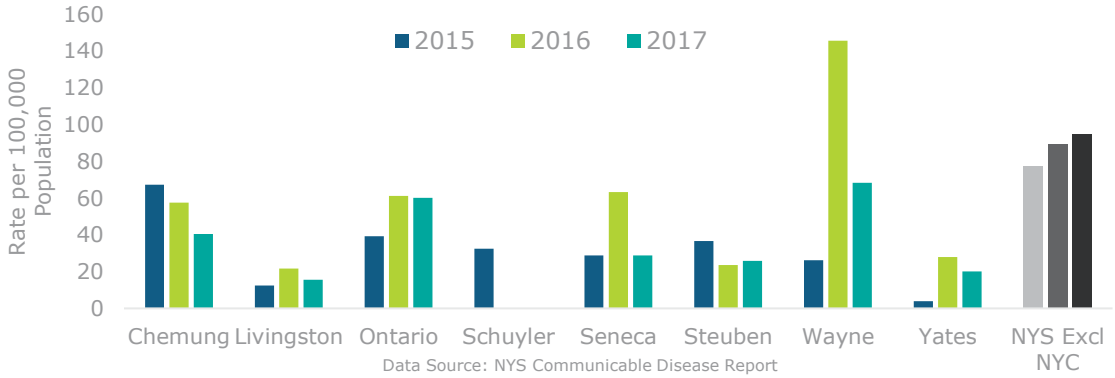
According to survey data from *My Health Story 2018*, half of the respondents indicated they have dealt with anxiety, fear, depression or sadness (Figure 13). For those who have dealt with mental or emotional health issues, 75% of survey respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family.

Figure 13: Percent of adults who have personally dealt with each of the following mental or emotional health issues

Prevent Communicable Diseases

Sexually transmitted diseases are a prominent issue in New York State, including all eight counties in the region. Historical data are available on the incidence of chlamydia and gonorrhea. In comparison to NYS excluding NYC, all eight counties have lower rates of chlamydia in recent years. Typically, rates of gonorrhea in the region are lower than NYS excluding NYC. However, rates spiked in 2016 for several counties in the region including Ontario, Seneca and Wayne which could be due to an outbreak or increased testing and diagnosis. (Figure 14).

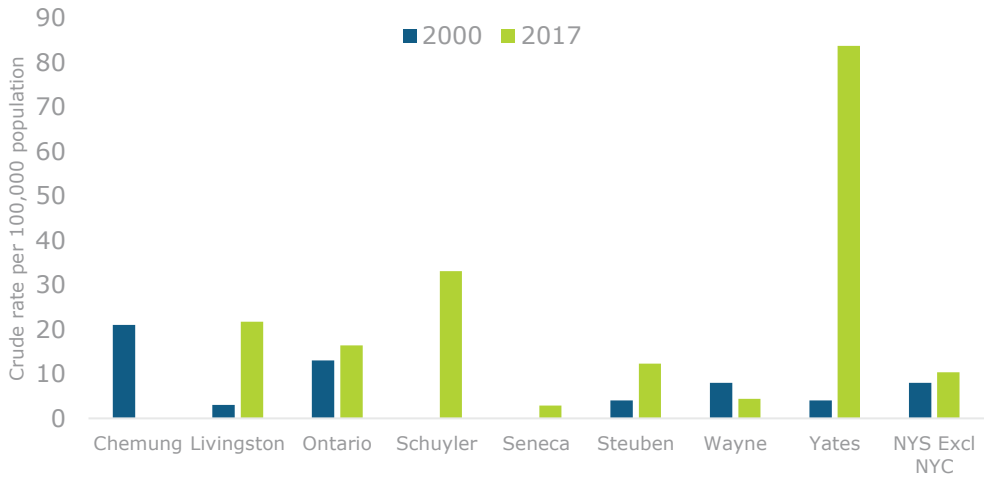
Figure 14: Rate of gonorrhea per 100,000



Vaccine preventable diseases are on the rise in the region. An average of 10 patients were diagnosed with vaccine preventable diseases in 2017 in the region with a range by county from 0 to 21 patients. In 2000, the average was 6 patients with a range of 0 to 18 by county. With the increased number of those who choose not to vaccinate, it is important now more than ever to increase education and awareness of the benefits of vaccinating children. Herd immunity occurs when the

majority of the population is immune to infection or disease. It helps to reduce risk of disease for those who are unable to be vaccinated due to age, health conditions or other factors. The rise in the number of those who choose not to vaccinate negatively impacts the effectiveness of herd immunity. The majority of vaccine preventable diseases in the region are cases of pertussis (Figure 15).

Figure 15: Rate of vaccine preventable diseases

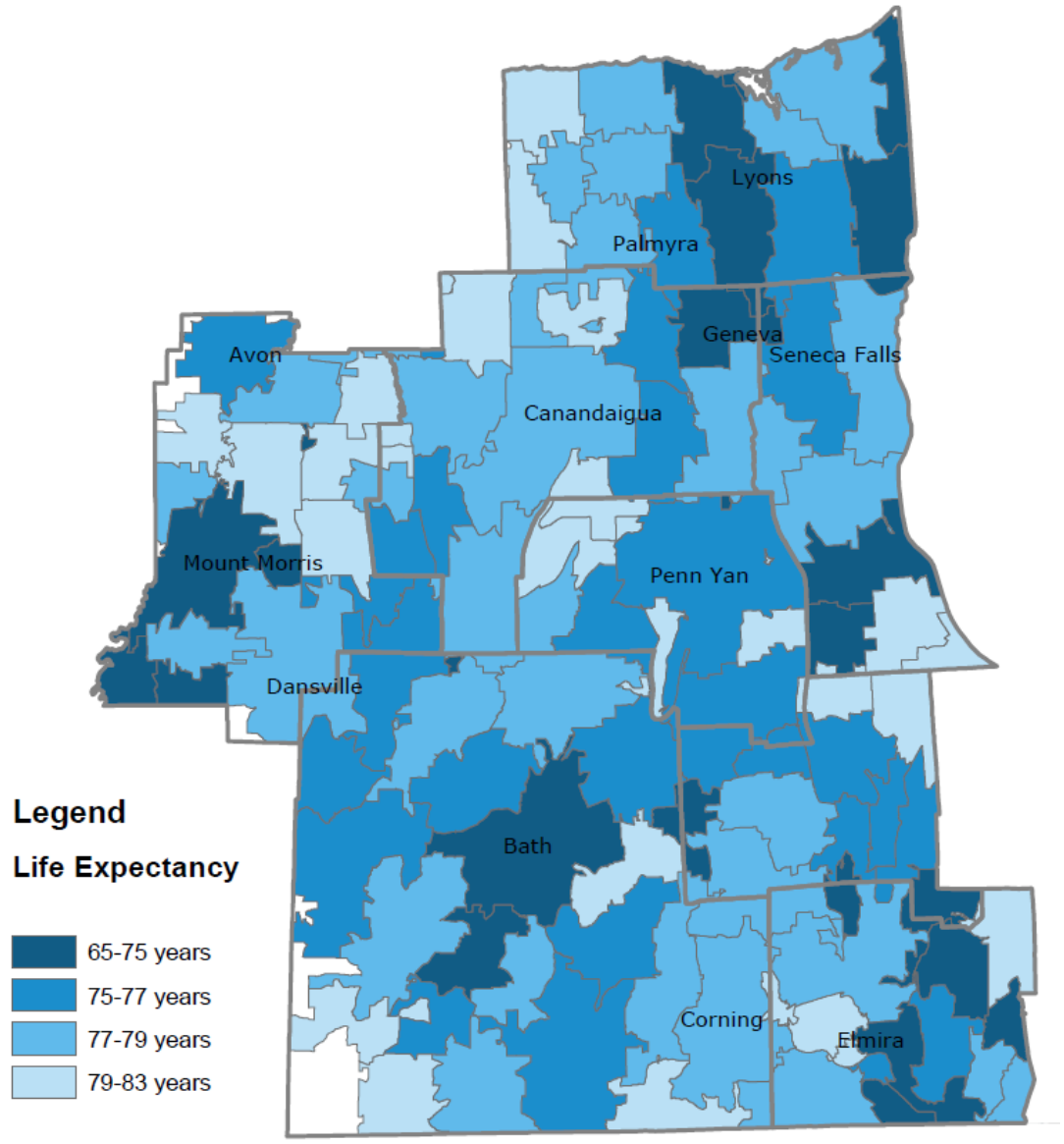


Source: NYS Communicable Disease Reporting, 2000 and 2017

Mortality

Each of the behavioral, environmental and socioeconomic factors previously discussed have a collective impact on one major health outcome: life expectancy. Community members who engage in risky health behaviors, are socioeconomically disadvantaged, and live in environments that negatively impact health have a greater risk of dying sooner than someone on the opposite spectrum. Within our region, we find pockets of lower life expectancy (under 75 years) in communities such Lyons, Geneva, Mount Morris, Bath and portions of Elmira (Map 5). Of note, a death which occurs before age 75 is considered premature. Therefore, communities with life expectancies under 75 years (highlighted in dark blue below) are considered as communities experiencing health inequities.

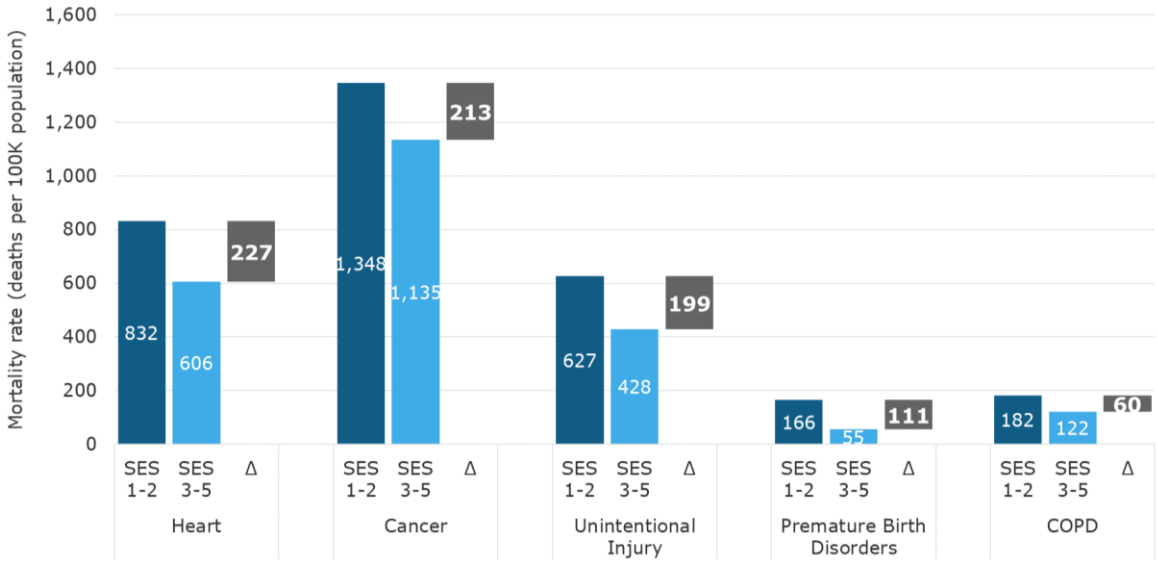
Map 5: Life expectancy by ZIP code



Source: NYSDOH Vital Statistics 2012-2014. Calculations performed by Common Ground Health.

The largest force behind health inequity relates to socioeconomic difference. Premature mortality is one measure that can be used to identify health inequities. Communities with low life expectancy also tend to be communities with higher rates of poverty. Disparities in premature mortality are the greatest in the top two causes of death – heart disease and cancer – and may be attributed back to risk factors (such as smoking, obesity, etc.) which are more commonly found in a low income population (Figure 16).

Figure 16: Rates of premature mortality disparities for eight county region



Source: NYSDOH Vital Statistics 2010-2015. Calculations performed by Common Ground Health.

In general, males have a lower life expectancy than females. This is partly attributed to biological differences, but perhaps more so to behavioral tendencies differences in the two sexes. For instance, males may be more likely to drink excessively, smoke cigarettes, not follow-up with preventative care, etc. Many of these factors may play a role in development of heart disease and cancer later in life. According to New York State Department of Health Vital Statistics, males tend to have higher rates of death due to heart disease and cancer compared to their female counterparts (Table 9).

Table 9: Heart Disease and Cancer mortality by sex

	Heart Disease		Cancer	
	Male	**Female**	**Male**	**Female**
Chemung	221.9	162.4	185.2	145.9
Livingston	155.9	106.6	210.9	140.6
Ontario	217.9	93.5	213.7	156.6
Schuyler	268.5	104.9	216.4	214.8
Seneca	231.1	103.8	182.2	185.8
Steuben	188.7	165.1	187.1	138.2
Wayne	174.2	133.9	189	179.5
Yates	216.1	104.3	181.2	124.0

Source: NYSDOH Vital Statistics, 2016. Rates are per 100,000 population

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 by 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 Steuben 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.

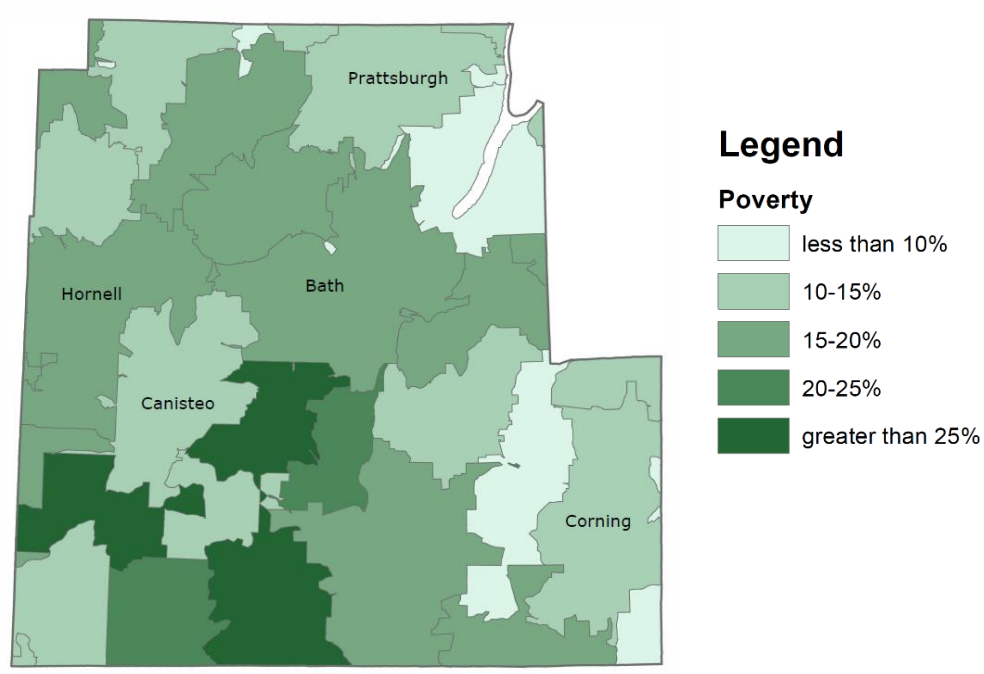
Steuben County

Demographic and Socioeconomic Health Indicators

Steuben County is home to popular tourist attractions including the Corning Museum of Glass and portions of Keuka Lake. It is located west of Chemung County and borders the New York/Pennsylvania state lines. A total of 97,539 people live in the county, the majority of which (95%) are White Non-Hispanic. Women of childbearing age make up 15% of the population, and 26% of the 18+ population live with a disability.[13] 2017 estimates reveal 26% of the 65+ population (N=4,623) is living alone. This rate is down 13 percent from 2012 estimates when 30% of the 65+ population (N=4,675) was living alone.

Of note is the rate of poverty in the county. Residents living below the federal poverty level make up 14.5% of the population and another 22% live near it. The distribution of poverty in the county is shown below in Map 6.

Map 6: Poverty rates by ZIP code

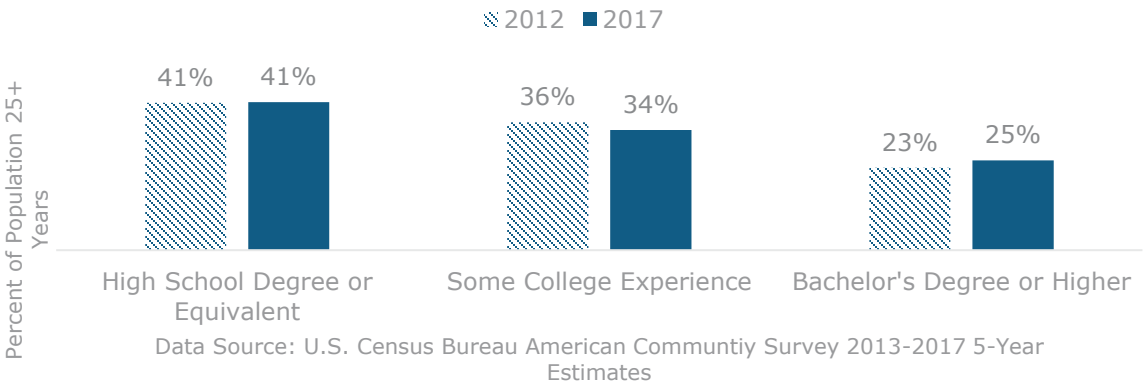


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year estimates

[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.

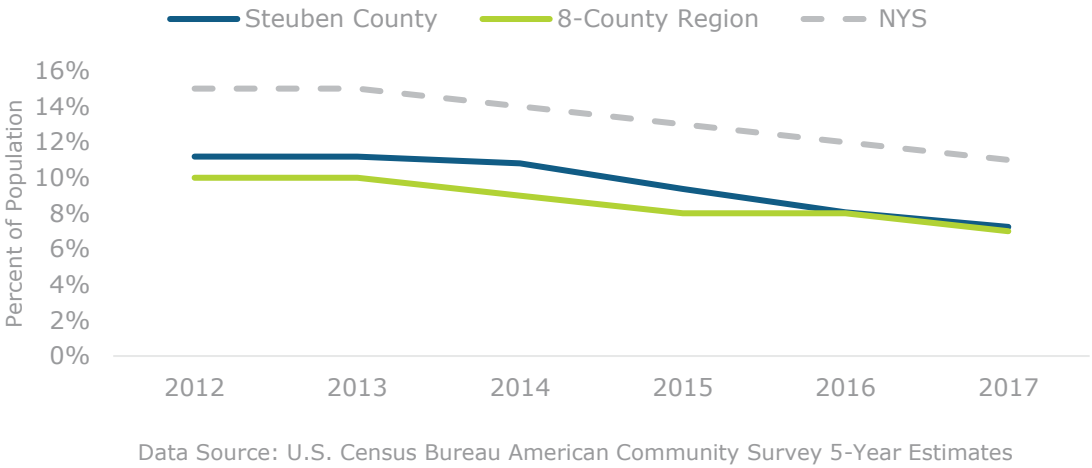
Over the past 5 years, there has been a slight shift in educational attainment where there are now more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 17). Of note, there has been no change in high school degree or equivalent attainment.

Figure 17: Educational attainment for Steuben County by year



Data below show the trend in uninsured rates over the past 5 years for Steuben County compared to the eight county region and NYS. There has been a 38 percent decrease since 2012 for Steuben County (Figure 18).

Figure 18: Percent of population that is uninsured



Finally, 28% of Steuben County residents rent vs. own their home. In addition, 9% of occupied housing units have no vehicles available. Another 35% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 35% of residents are spending 35% or more of their household income on rent costs.[14]

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

Main Health Challenges

On May 7, 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 occurred regarding the potential priority areas. The meeting was well attended with nearly 60 individuals. 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 Diseases

1. Tobacco prevention

Promote Healthy Women, Infants and Children

2. Child and adolescent health

Promote Mental Well-Being and Prevent Substance Use Disorders

3. Mental and substance use disorders prevention

Disparity: low socioeconomic status and pregnant women

My Health Story 2018 respondents were asked questions related to their top concerns for the health of themselves, loved ones, adults and children in the community. Their responses were reviewed at the priority setting meeting (Figure 19). Weight and mental/emotional health issues rose to the top for each of the four categories. Of note, substance use and obesity indicators including exercise, diet and nutrition were concerns for children in the county. Aging and cost of care were also highlighted as respondents' top fears for themselves and for others.

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

Biggest fear - for self	Biggest fear - for others
Weight (12.6%)	Cost (9.5%)
Mental / emotional health issues (9.2%)	Weight (8.8%)
Exercise (9.2%)	Mental / emotional health issues (8.1%)
Aging (9.0%)	Cancer (7.0%)
Cost (7.8%)	Aging (6.6%)

County priority - for adults	County priority - for children
Substance abuse (23.6%)	Diet / nutrition (25.2%)
Weight (20.3%)	Mental / emotional health issues (20.5%)
Mental / emotional health issues (18.6%)	Weight (18.5%)
Cost (11.0%)	Substance abuse (15.5%)
Aging (9.7%)	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

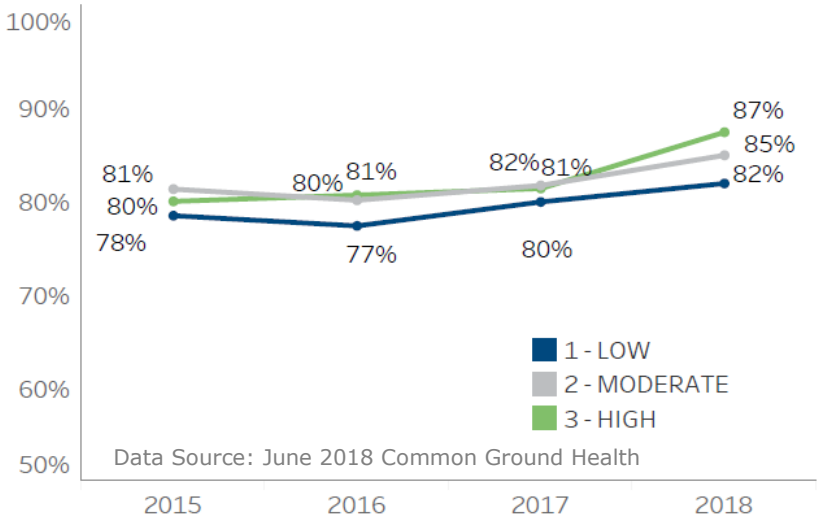
Rates of tobacco use in Steuben County (23%) are similar to the average in the eight-county region (22%). E-cigarette use has recently emerged as an issue across many counties and New York State. Data at this time are sparse, though anecdotal evidence suggests an inverse relationship between cigarette and e-cigarette smoking. Many persons have switched from cigarette to e-cigarette usage under the impression that e-cigarettes are "safer," and others are now using both cigarettes and e-cigarettes, consuming more nicotine than before. This perception that vaping is harmless is erroneous. Nicotine is addictive and has an impairing effect on the development of childhood and adolescent brains. Chemical flavorings and colorings, as yet unregulated, may damage the oral mucosa and airway. In addition, usage of both items increases the likelihood for development of lung cancer, hypertension, risk of strokes and heart attacks, and premature mortality. The prevalence of smoking is more commonly seen in vulnerable populations. Estimates of usage among those whose income is less than $25,000 annually (33%) and those living with a disability (28%) are higher than general population estimates (23%).[15]

As mentioned, persons who smoke are at greater likelihood of developing chronic conditions such as hypertension. In Steuben County, it is estimated that 32%[16] of

[15] Source: Behavioral Risk Factor Surveillance System, 2016. Data on low-income are unreliable due to large standard error: standard error between 19.3% and 43.3%.
[16] Source: Behavioral Risk Factor Surveillance System 2016.

adults have been diagnosed with hypertension, 84%[17] of whom are in control of their blood pressure. However, this varies by income level (Figure 20). Reducing the disparity by income requires engaging patients to take control of their blood pressure through various methods: blood pressure medication adherence, promotion of physical activity, healthy eating, and more. Low-income patients are often less likely to be able to afford medications, and it is therefore important to work with providers to prescribe generic medications that are less expensive and accepted by insurance companies. In addition, encouraging and assisting patients in quitting smoking (if applicable) could help to improve control.

Figure 20: Steuben County hypertension control rate by socioeconomic status over time



Social-emotional health is an important developmental skill that is learned in early childhood. It encompasses a child's ability to control his or her own feelings and behaviors, build positive relationships, and understand feelings of others. The World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Therefore, ensuring good health of Steuben County's community warrants its leaders to include mental health as an issue. It was noted in Steuben County's priority setting meeting that access to mental health providers and supports for very young children and adults is limited, and there are barriers to accessing timely care and follow up.

Rates of adults reporting poor mental health days in the past month have improved in the county, though they still impact a large portion of the county. Estimates reveal that 18% of adult residents have been told they have a depressive disorder.[18] According to survey data from *My Health Story 2018*, half of the respondents (50%) indicated they have dealt with depression or sadness, however.

[17] Source: Common Ground Health High Blood Pressure Registry, June 2018.
[18] Source: 2016 Behavioral Risk Factor Surveillance System

Many others also reported they have personally dealt with anxiety or fear (43%) and trouble sleeping (36%).

Substance use, particularly use of opioids, has increased in the past several years. Deaths due to opioids in the county have decreased 21% from 2016 to 2017, though this does not mean the issue has been resolved. Documented Naloxone administrations have increased from 69 in 2016 to 88 in 2017, which does not include undocumented administrations by family, friends or bystanders. In addition, clients admitted to OASAS-certified chemical dependence treatment programs have increased in Steuben County from 2016 (N=418) to 2017 (N=477). The increased support from these programs is likely helpful in contributing to the lower number of deaths related to opioids noted in 2017.[19]

Policy and Environmental Factors

Smart Steuben and its partners have worked the past several years to improve health of Steuben County residents through policy and environmental changes. In 2017, all county parks went tobacco and nicotine free. Public Health and partners supported local agencies and housing units which went smoke free by offering smoking cessation classes to help residents quit.

Both Corning Hospital and Arnot Health have worked within their cafeterias to include menu labeling on hospital food items. The gentle reminder to patrons may help to encourage healthier eating habits. In addition, Corning Hospital rearranged cafeteria items to keep healthier food items in reachable areas to encourage purchasing and consumption of the items.

Finally, the Creating Healthy Schools and Communities grant is working towards Complete Streets in several locations, though none have been put in effect at this time. It was noted that sidewalks are broken and uneven in locations throughout the county, including Bath, the current county seat. This makes walking outside in communities difficult and sometimes even dangerous. Implementing Complete Streets in Steuben County would be beneficial in increasing opportunities for walkable communities for people of all ages and abilities.

Other Unique Characteristics Contributing to Health Status

With state legislation exploring the option of legalizing recreational marijuana, several local municipalities have moved towards or have passed resolutions opposed to legalizing marijuana in New York State. Local human service agencies are concerned about the negative impact that legalizing recreational marijuana could pose. They have joined together under the Steuben Prevention Coalition and its Marijuana Task Force to identify steps to educate the community and stakeholders about the hazards and prepare for anticipated changes in legislation.

[19] Source: NYS Quarterly Opioid Reporting

The Steuben Prevention Coalition also holds a youth summit each year to engage student leaders in discussions around drugs and alcohol and how to reduce youth use.

Corning-Painted Post School District has implemented programming to educate students on various health topics during the school day and then expands that same education to parents and the community in the evening throughout the school year. Topics have included teen mental health, teen suicide, and vaping among others. The former principal of Columbine even came to speak at one forum.

Youth Drug Court recently started in Hornell, and a new office for youth counseling will be opening on the Ira Davenport campus in the fall.

Transportation poses a problem in Steuben County, which is larger than the state of Rhode Island. Limited public transportation or odd bus scheduling makes it difficult for residents without access to a personal vehicle to traverse the county. Head Start and Early Head Start families noted that the distance between resources and lack of transportation prevents families from getting to doctors' offices on a regular basis for routine exams. Additionally, there is a very limited number (2) of dental offices accepting Medicaid patients or pediatric Medicaid patients. For any extensive dental treatment, families get referred to offices in or near Buffalo, Binghamton, or Rochester, posing further problems for those with already limited transportation options. Luckily, it was noted in the priority setting meeting that many schools have dental assistants make onsite preventative oral health visits for students covered by Medicaid.

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 Steuben County. For example, focus group attendees identified local agencies and support groups in the community, including mental health services/clinics, Planned Parenthood, Meals on Wheels, schools and after school programming, libraries, food pantries and YMCAs as community strengths and resources. In addition, attendees identified the county's clean environment as a strength. 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, Smart Steuben will work to leverage identified resources and pre-existing agencies and services. The Steuben County CHIP document has a full description of interventions and partner roles. 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 Smart Steuben and prioritization 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 Steuben County's process including:

Steuben County Prioritization Agencies		
Steuben County Public Health	S2AY Rural Health Network	Common Ground Health
Canisteo Valley Family Practice	Southern Tier Library System	Steuben County Mental Health
Steuben Rural Health Network at the Institute for Human Services, Inc.	Cornell Cooperative Extension of Steuben / Finger Lakes Eat Smart NY	Retired and Senior Volunteer Program (RSVP)
UR St. James Hospital	Guthrie Corning Hospital	County Legislature
Arc of Steuben	Bath School District	Office for the Aging
Steuben Prevention Coalition	Steuben County Youth Bureau	Finger Lakes Community Health
Healthy Families Steuben	Genesee Valley BOCES	ProAction
Southern Tier Tobacco Awareness Coalition	UR Center for Community Health and Prevention	Pregnancy Resource Center of the Valleys
211	Steuben County DSS	Arnot Health
Food Bank of the Southern Tier	Hornell Area Concern for Youth	URMC Primary Care Hornell
Steuben County Alcoholism & Substance Abuse Services (SCASAS)	City of Corning Health Board	Steuben Council on Addictions
Oak Orchard Health	Family Service Society	County Administration
Prattsburgh CSD	WIC	Guthrie Home Care

Throughout the assessment period, the community at large was engaged 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 the public via social and traditional media, on Public Health's website, by newsletter, and in Public Health's monthly report.

Specific interventions to address the priority areas were selected at Smart Steuben 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 Steuben County Community Health Improvement Plan (Appendix A). Interventions selected are evidence based and strive to achieve health equity by focusing on creating greater access for the low-income population.

Smart Steuben, a group of diverse partners who meet monthly to improve the health of Steuben residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be posted to Steuben County Public Health's website (www.steubencony.org/publichealth) and social media pages:

- Facebook: www.facebook.com/SCNYPublicHealth and www.facebook.com/smartsteuben
- Instagram: @steubenpublichealth
- Twitter: @steubencohealth

Additionally, a press release will be submitted to traditional media sources sharing where to find the published documents. Public Health's bimonthly newsletter *Wellness Matters* will also provide a link to the completed CHA and CHIP. This newsletter is distributed to healthcare providers, libraries, food pantries, schools, county departments and legislators, municipalities, and local service agencies and partners. It is also shared on the website and social media pages, reaching well over 1,000 individuals.

Attachment A

Steuben County Community Health Improvement Plan
2019 - 2021

12/3/19

Color Coded Partners: Arnot Health, Center for Community Health and Prevention, Center for Tobacco Free Finger Lakes, Corning Hospital, Finger Lakes Community Health, Oak Orchard Health, Pregnancy Resource Center of the Valley, ProAction, St. James Hospital, Steuben County Alcohol and Substance Abuse Services/Mental Health, Steuben County Public Health, Steuben Rural Health Network, STTAC					
Priority: Prevent Chronic Diseases					
Focus Area 3: Tobacco Prevention					
Goal 3.1: Prevent initiation of tobacco use			**Objective 3.1.1:** Decrease the prevalence of any tobacco use by high school students		
Disparities: Pregnant women, low SES, mental and substance use disorders, those with disabilities					
Interventions	**Family of Measures**	**Projected (or completed) Year 1 Intervention ('19)**	**Projected Year 2 ('20)**	**Projected Year 3 ('21)**	**Partner Roles & Resources**
3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.	STTAC: # of Reality Check activities in Steuben County # of Reality Check social media activities (posts and paid media ads) # of education presentations provided to youth-focused organizations, such as school districts Public Health / Smart Steuben partners: # of media outreaches (radio, TV, newspaper, etc.) completed by Smart Steuben partners related to tobacco # of social media or other communications provided by Smart Steuben team members related to tobacco	STTAC Completed as of 7/12/19: 23 - Reality Check activities in Steuben County 95 posts and 1 paid media ad - Reality Check social media activities (posts and paid media ads) 2 - education presentations provided to youth-focused organizations, such as school districts 57 - media outreaches (radio, TV, newspaper, etc.) Public Health (PH), Oak Orchard Health (OOH), and Finger Lakes Community Health (FLCH) to provide messaging related to the dangers of	STTAC to complete: 30 - Reality Check activities in Steuben County 125 posts and 1 paid media ad - Reality Check social media activities (posts and paid media ads) 5 - education presentations provided to youth-focused organizations, such as school districts 75 - media outreaches (radio, TV, newspaper, etc.) PH to provide at least 12 monthly social media messages related to the dangers of tobacco FLCH and Oak Orchard	STTAC to complete: 30 - Reality Check activities in Steuben County 125 posts and 1 paid media ad - Reality Check social media activities (posts and paid media ads) 5 - education presentations provided to youth-focused organizations, such as school districts 75 - media outreaches (radio, TV, newspaper, etc.) PH to provide at least 12 monthly social media messages related to the dangers of tobacco FLCH and Oak Orchard Health to provide social media messages related to the dangers of tobacco.	STTAC oversees the Reality Check program, a youth advocacy program to reduce the impact of tobacco. STTAC will continue to provide and track education and outreach regarding the dangers of tobacco, effective tobacco control policies, and reshaping social norms. 1 FTE PH, FLCH and Oak Orchard Health will provide education and outreach through social and traditional media outlets and other opportunities as they arise.

		tobacco.	Health to provide social media messages related to the dangers of tobacco.		
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%.		
Disparities: Pregnant women, low SES, mental and substance use disorders, those with disabilities					
Interventions	**Family of Measures**	**Projected (or completed) Year 1 Intervention ('19)**	**Projected Year 2 ('20)**	**Projected Year 3 ('21)**	**Partner Roles & Resources**
3.2.1: Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures, and workflows to facilitate the delivery of tobacco dependence treatment, consistent with	Public Health: # people trained in Baby & Me Tobacco Free program delivery # of individuals enrolled in program % of individuals who successfully quit by time of delivery % remaining quit for 1st year of baby's life	PH to identify partner healthcare organizations to provide the Baby & Me Tobacco Free program through PH funds.	PH to pay for training for Baby & Me TF and program costs. Start implementation through partner organization(s).	PH to continue funding Baby & Me through partners and collecting data.	PH to provide funding to train and implement Baby and Me Tobacco Free Program and to help with data collection needs.
	Corning Hospital: #of individuals who receive tobacco cessation resources and quit within one year. % those assisted who successfully quit	Corning Hospital (CH) will be continuing its commitment to smoking cessation discussions with each admission. CH to partner with Guthrie Medical Group (GMG) to evaluate and determine the feasibility of implementing the Baby and Me Tobacco Free Program for OB/GYN patients.	CH continued commitment to smoking cessation discussions with each admission. CH/GMG principal training to be completed for Baby and Me Tobacco Free Program. Facilitators will be identified, trained and workflows developed.	Full implementation and monitoring of the Baby and Me Tobacco Free program through CH/GMG.	CH/GMG staff to conduct Baby and Me Tobacco Free Program and provide cessation assistance. Provide education and support materials required for patient education.

the Public Health Service Clinical Practice Guidelines, Community Health Centers and behavioral health providers.	St. James Hospital: % of inpatient admissions tobacco cessation is offered to	St James Hospital (SJH) is in the process of hiring patient care partners who could offer education on cessation for inpatient/urgent care and ER.	Continue to offer tobacco cessation education to inpatients and prepare to expand to outpatient.	Expand to outpatient cessation assistance SJH	St James Hospital and St. James Primary Care assess patients for tobacco use and provide tobacco cessation education and also refer patients to NY Quits if patient is agreeable. Treatment options are discussed and offered to patients. 2 FTE
	Center for Community Health and Prevention: # smokers assisted in quitting % of smokers attending 3 or more counseling sessions who identify as having quit smoking	CCHP is publicizing their Tobacco Dependence Counseling and is expanding to 15 counties.	Continue to offer counseling and support to 15 county area for those interested in quitting.	Continue to offer counseling and support to 15 county area for those interested in quitting.	Center for Community Health and Prevention to offer free tobacco cessation telephone guidance and track Steuben outreach. 1.5 FTE
	Arnot Health: % 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 tobacco user	Arnot Health primary and specialty care providers screen all patients for tobacco use. All patients who are identified as a tobacco user receive cessation intervention.	Arnot Health primary and specialty care providers screen all patients for tobacco use. All patients who are identified as a tobacco user receive cessation intervention.	Arnot Health primary and specialty care providers screen all patients for tobacco use. All patients who are identified as a tobacco user receive cessation intervention.	Arnot Health primary and specialty care providers screen all patients for tobacco use. All patients who are identified as a tobacco user receive cessation intervention.
	Oak Orchard Health: # of patients screened for tobacco use # of patients who receive tobacco cessation interventions	All patients are screened for tobacco use. All patients screening positive for tobacco use will be offered tobacco cessation assistance.	All patients are screened for tobacco use. All patients screening positive for tobacco use will be offered tobacco cessation assistance.	All patients are screened for tobacco use. All patients screening positive for tobacco use will be offered tobacco cessation assistance.	OOH has an established protocol to screen for tobacco use in all patients 12+ at every visit. The system recently received tobacco/ nicotine cessation training from a NYSDOH

					sponsored program run by URMC and Roswell Park Cancer Institute. OOH utilizes the Fax to Quit program.
	Steuben County Alcohol and Substance Abuse Services/Mental Health: # of clients assessed for tobacco use	Steuben County Alcohol and Substance Abuse Services (SCASAS) refers clients to group or individual cessation sessions. Every client is assessed for tobacco use. Admitted clients go through Healthy Living group which includes tobacco education.	SCASAS refers clients to group or individual cessation sessions. Every client is assessed for tobacco use. Admitted clients go through Healthy Living group which includes tobacco education.	SCASAS refers clients to group or individual cessation sessions. Every client is assessed for tobacco use. Admitted clients go through Healthy Living group which includes tobacco education.	SCASAS and Mental Health assess for tobacco dependence in all clients. SCASAS treats and counsels those with tobacco dependence alongside their other addictions.
	Center for Tobacco Free Finger Lakes (CTFFL): # of medical and behavioral health care organizations and provider groups approached # of above to establish policies, procedures and workflows to facilitate tobacco cessation info	CTFFL will offer its services to the following FQHCs in Steuben County at least twice per year: Finger Lakes Community Health and Oak Orchard Health.	CTFFL will offer its services to the following FQHCs in Steuben County at least twice per year: Finger Lakes Community Health and Oak Orchard Health.	CTFFL will offer its services to the following FQHCs in Steuben County at least twice per year: Finger Lakes Community Health and Oak Orchard Health.	Center for Tobacco Free Finger Lakes (CTFFL) is a program that provides free tobacco-cessation training and technical assistance to health care systems and to health care professionals.

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 and other substance misuse and deaths			**Objective 2.2.1:** Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population		
Interventions	**Family of Measures**	**Projected (or completed) Year 1 Intervention ('19)**	**Projected Year 2 ('20)**	**Projected Year 3 ('21)**	**Partner Roles & Resources**
2.2.2: Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.	Public Health: # Narcan trainings provided # people trained to administer Narcan % of those trained indicating an increase in knowledge	4 Narcan trainings provided by PH, reaching at least 20 people. 100% of those trained indicate an increase in knowledge after training.	4 Narcan trainings provided by PH, reaching at least 20 people. 100% of those trained indicate an increase in knowledge after training.	4 Narcan trainings provided by PH, reaching at least 20 people. 100% of those trained indicate an increase in knowledge after training.	PH to provide Narcan trainings in the community.
	Oak Orchard Health: # of trainings provided # of employees in the Hornell office who are trained in Narcan administration	Oak Orchard Health has Narcan in emergency kits in all medical sites. OOH is a recognized Narcan training provider. All sites are in the process of being trained to administer Narcan. Hornell office currently has 1 employee trained.	All medical staff will be trained to administer Narcan in OOH Hornell office	All staff in Hornell office will be trained to administer Narcan.	Oak Orchard Health RN Care Managers were trained to recognize opioid overdose and to administer Narcan by CASA 2 years ago.
2.2.4: Build support systems to care for opioid users or at risk of an overdose.	St. James Hospital: # controlled drugs dispensed during open pharmacy hours monthly # times providers enter data into NYSPMP # patients seen in ED by PAO who are referred to CASA	St James Hospital is linking ED providers with I-STOP/ Prescription Monitoring Program (PMP). SJH is providing education regarding CASA and info to providers.	All ED providers expected to be linked with I-STOP this year. SJH Enforcing providers accessing I-STOP and continuing partnership with CASA.	SJH Enforcing providers accessing I-STOP and continuing partnership with CASA.	SJH is working with CASA Trinity to identify patients with substance abuse concerns whether new or chronic. SJH reaches out to CASA's case worker who comes directly on-site at the hospital to get them linked with their program (either inpatient or outpatient). If the

					patient is in withdrawal at the time of arrival to SJH, they are admitted and provided care to safely get through the acute detox/withdrawal phase. They are linked with CASA from the time they arrive. 2 beds guaranteed to CASA for detox. Also provide education and training to ED providers for opiate prescribing.
	Public Health: # of ODMAP inputs % of ODMAP inputs followed up on	ODMAP program adopted in Steuben County and partner agencies identified and roles delineated	PH to continue as an ODMAP administrator. PH may run daily reports related to ODs and connect with peer specialists.	PH to continue as an ODMAP administrator. PH may run daily reports related to ODs and connect with peer specialists.	PH and Steuben County departments will work together to bring ODMAP to the county to address overdoses and try to prevent future ODs.
	Steuben Rural Health Network: # CPSMP classes offered % participants completing CPSMP	Steuben Rural Health Network (SRHN) through their Living Healthy of the Southern Tier program will provide 1 Chronic Pain Self-Management (CPSMP) Workshop with a completion rate of 75%.	SRHN will provide 1 CPSMP Workshop with a completion rate of 75%.	SRHN will provide 1 CPSMP Workshop with a completion rate of 75%.	SRHN to provide support and/or CPSMP workshops (FTE)
	Corning Hospital: # cans filled and returned to the processing facility for MedSafe drug disposal (50 lbs each) # of patients that allow social work to initiate resource	CH will utilize MedSafe Drug Disposal units at their annual Opioid Take Back Day. CH plans to address the appropriate prescribing practices of opiates.	Implement discharge planning process changes to include contact information for substance abuse resources. Address the appropriate prescribing practices of	Evaluation of data and opportunity for growth and continue.	CH staff to implement education and training components of prescribing appropriately.

	contact # of providers receiving education on opiate prescribing		opiates. Work with CASA/Trinity for education support for patients.		
	Steuben County Alcohol and Substance Abuse Services/Mental Health: # assessed for opioid use % accepting treatment	Mental Health assesses for opioid use and offers treatment, counseling and referrals. SCASAS treats opioid use through individual counseling and group education and therapy.	Mental Health assesses for opioid use and offers treatment, counseling and referrals. SCASAS treats opioid use through individual counseling and group education and therapy. In addition, peer services are expected to be offered.	Mental Health assesses for opioid use and offers treatment, counseling and referrals. SCASAS treats opioid use through individual counseling and group education and therapy. Peer services are expected to be continued.	Mental Health assesses for opioid use and offers treatment, counseling and referrals. SCASAS treats opioid use through individual counseling and group education and therapy.
Goal 2.5: Prevent suicides			**Objective 2.5.2:** Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.		
Interventions	**Family of Measures**	**Projected (or completed) Year 1 Intervention ('19)**	**Projected Year 2 ('20)**	**Projected Year 3 ('21)**	**Partner Roles & Resources**
2.5.4: Identify and support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicide.	Oak Orchard Health: # providers receiving training related to suicide prevention # of behavior health referrals made from the office (including in-house BH and outside referrals)	Oak Orchard completed suicide prevention training "Suicide Safer Care" and this training was skyped out to all locations. Behavioral Health department and psychiatrist have been implemented in office.	Implement / continue to review policy for depression screening. All patients are screened for depression. Continue to implement "warm hand off" with in-house behavioral health providers and offer this service or future appointment or outside referral to any patient screening positive for depression.	Implement / continue to review policy for depression screening. All patients are screened for depression. Continue to implement "warm hand off" with in-house behavioral health providers and offer this service or future appointment or outside referral to any patient screening positive for depression.	Oak Orchard Health has an established protocol to screen for depression using PHQ-2, reflex to PHQ-9 in all patients 12+. Pediatric providers are asking at well visits age 12-17 and nurses are asking all patients 18+ at any visit. Patients with depression/anxiety are automatically given the GAD-7 or PHQ-9 (depending on diagnosis) at follow up visits. Their collaborative care model

					with Behavior Health is available at most locations for a warm hand off if needed.
	Pregnancy Resource Center of the Valley: # clients disclosing struggles with substance use/abuse # clients disclosing or expressing suicidal ideation # staff/volunteers trained to assess for suicide risk # staff trained to assess for substance use/abuse risks # of referrals for substance abuse services # of referrals for MH support services	5 PRCV staff/volunteers will be trained in best practice suicide risk assessment and 5 staff/volunteers will be trained in best practice assessment for substance use/abuse.	10 additional PRCV staff/volunteers will be trained in best practice suicide risk assessment. 10 additional staff/volunteers will be trained in best practice assessment for substance use/abuse.	10 additional PRCV staff/volunteers will be trained in best practice suicide risk assessment. 10 additional staff/volunteers will be trained in best practice assessment for substance use/abuse.	PRCV uses standardized assessments to identify the additional need for substance abuse or mental health services for pregnant and parenting families across Steuben County.
	St. James Hospital: # patients seen by PAO	SJH's Psychiatric Assessment Officer (PAO) is located in the Emergency Department. The PAO connects mental health patients and substance abuse patients with community resources. The PAO works with a telepsych psychiatrist to identify the need for inpatient treatment as well. This helps to keep patients within their own community and not have	PAO to continue to see patients and assess need for psychiatric inpatient of telepsych. SJH exploring opportunity to fund an additional PAO in medical office building (MOB).	PAO to continue to see patients and assess need for psychiatric inpatient of telepsych. If financing available begin expansion of PAO services to MOB	PAO housed in ED, able to see patients in ER and on inpatient unit. St James contracted with URMC for telepsych.

		to travel outside the community unless the need for further services is available.			
	Corning Hospital: # telepsych patients served at CH # patients receiving PHQ-9 tool % receiving mental health consult # attending stakeholder meetings	CH and GMG to use PHQ-9 to determine if a mental health consult is justified in all areas of care.	CH to expand telemedicine services to include telepsych in ED. CH will hold quarterly community stakeholder meeting (SPAM) to determine if needs of patients are being met.	Evaluation of data and opportunity for growth will occur. Other services will be continued.	CH staff to conduct education and training on PHQ9 and hold stakeholder meetings. IT resources and staff related to telepsych.
	Steuben County Mental Health: # attending Youth Mental Health First Aid training # participating in AFSP Presentations # health fairs attended / people reached at health fairs	MH's Steuben County Suicide Prevention Coalition has 8 trained individuals who can provide the American Foundation for Suicide Prevention's (AFSP) Talk Saves Lives presentation. 2 individuals are trained in Suicide Safety for Teachers and staff to provide to school districts. 2 individuals are trained in Lifelines Postvention to provide workshops and consultation to school districts. The coalition is co-sponsoring a Youth Mental Health First Aid training in Hornell 9/10/19 and providing AFSP's "It's	Hold 2 community based prevention / awareness events, 2 school-based prevention / awareness events, and 1 survivor based event.	Hold 2 community based prevention / awareness events, 2 school-based prevention / awareness events, and 1 survivor based event.	Mental Health has a Suicide Prevention Coalition that focuses on education and training in the community to reduce suicide rates.

		Real" to Corning Community College's residential students 9/21/19. Also providing AFSP's Talk Saves Lives presentation at the Bath VA on 9/13/19 and working with local police departments to lower rates of those who are mentally ill from entering the legal system when appropriate.			
	Steuben Rural Health Network / IHS: # 211 callers referred to appropriate Mental Health/Substance Abuse Counseling Services in Steuben County	2-1-1 will refer at least 50 callers per quarter to the appropriate Mental Health/Substance Abuse Counseling Services in Steuben County (reporting will be based on age)	2-1-1 will refer at least 50 callers per quarter to the appropriate Mental Health/Substance Abuse Counseling Services in Steuben County (reporting will be based on age)	2-1-1 will refer at least 50 callers per quarter to the appropriate Mental Health/Substance Abuse Counseling Services in Steuben County (reporting will be based on age)	SRHN/IHS: referrals
	Arnot Health: % of BSU patients followed up by PCP within 7 days from discharge # utilizing telepsych services	Arnot Health to establish a baseline for PCP follow up from Behavioral Science Unit (BSU).	Increase % of follow up by PCP by 10% from baseline.	Increase % of follow up by PCP by 10% from previous year.	Because Ira does not have a BSU, any patients requiring this service may be referred to Arnot. Patients would remain in the BSU until they are ready to be discharged. The DSRIP goal is that all BSU discharged patients be contacted by their PCP within 7 days. Ira utilizes telepsych for adult patient consults with Arnot Health Psychiatrists.

Priority: Promote Healthy Women, Infants and Children					
Focus Area 3: Child and Adolescent Health					
Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships			**Objective 3.1.2:** Increase the percentage of children and adolescents, age 3-17 years, with a mental/behavioral health condition who received treatment or counseling by 10% to 49.8%.		
Disparities: Low SES, women					
Interventions	**Family of Measures**	**Projected (or completed) Year 1 Intervention ('19)**	**Projected Year 2 ('20)**	**Projected Year 3 ('21)**	**Partner Roles & Resources**
3.1.1: 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.	ProAction: # ACES trained participant by sector # ACES master trainers # ACES trainings provided	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.	ProAction staff to attend ACE Interface Master training (train the trainer). Train trainers throughout Steuben County to educate providers, health care, education, law enforcement, and community at large on ACEs. Hold 2nd Annual Resilience Symposium for providers on topics related to ACES and TIC. Continue to host Resilience screenings.	ProAction to continue to train and educate providers on ACES. Train more ACES trainers. Begin Healthy Communities work regionally. Hold 3rd Annual Symposium on Resilience for providers on ACES and TIC related topics.	ProAction: Facilitate film screenings, ACES Interface Master Trainer, Train the Trainer, Resilience Symposiums, Resilience film screening, Healing Communities work.
	Public Health: # of PH staff trained in ACES % of PH staff indicating an increased knowledge of ACES	PH Staff to receive ACES training.	PH staff begin to implement ACES work in their interactions with youth, families, providers, etc.	PH staff to continue using ACES principles In their work.	Public Health staff will be trained in ACES and will use their understanding of ACES to enhance the interactions they have with the public. 15 FTE
	Corning Hospital: # CH staff trained in trauma informed care	CH to investigate and develop an education plan for patient-facing staff in	Guthrie Corning Hospital patient-facing staff in ED, LDRP, Social Work and	Completion of and/or ongoing education for CH staff.	CH: Education Staff to conduct training and any materials required

	% of staff reporting increased knowledge	regard to Trauma Informed Care.	Case Management to complete Trauma Informed Care Training.		
	Steuben Rural Health Network: # GOTR coaches trained % indicating increased knowledge in the topic area % participants indicating coaches made them feel good	SRHN: Girls on the Run (GOTR) of the Southern Tier Coaches will complete 1 training around social-emotional development, ACES, and/or trauma informed care during the season/school year. 80% of participants complete an end of the season survey assessing the climate of their practices and coach autonomy support. 80% of participants indicate that "the coaches made us feel good when we improve; the coaches encourage us to give our best effort; the coaches tell us that trying our best is the most important thing."	GOTR Coaches will complete 1 training around social-emotional development, ACES, and/or trauma informed care during the season/school year. 80% of participants complete an end of the season survey assessing the climate of their practices and coach autonomy support. 80% of participants indicate that "the coaches made us feel good when we improve; the coaches encourage us to give our best effort; the coaches tell us that trying our best is the most important thing."	GOTR Coaches will complete 1 training around social-emotional development, ACES, and/or trauma informed care during the season/school year. 80% of participants complete an end of the season survey assessing the climate of their practices and coach autonomy support. 80% of participants indicate that "the coaches made us feel good when we improve; the coaches encourage us to give our best effort; the coaches tell us that trying our best is the most important thing."	Steuben Rural Health Network will provide Girls on the Run of the Southern Tier coaches training and materials, along with the 10 week program in 6 sites across Steuben County.
	Pregnancy Resource Center of the Valley: # staff/volunteers trained in ACES # staff/volunteers trained in Youth Mental Health First Aid % client evaluations reflecting car received as trauma	25% of PRCV staff/volunteers will be trained in ACES. 4 staff/volunteers will be certified in Youth Mental Health First Aid. PRCV will continue using existing evaluation forms and will	60% of staff/volunteers will be trained in ACES. 2-6 additional staff/volunteers will be certified in Youth Mental Health First Aid. Begin using the updated evaluation and intake and	85% of staff/volunteers will be trained in ACES. 3-6 additional staff/volunteers will be certified in Youth Mental Health First Aid. Begin using the updated evaluation and intake and assessment forms.	PRCV will provide mentors and support through the Real Essentials curriculum. PRCV will provide community support groups facilitated through a network of trained volunteers and

	informed # or % intakes and assessments reflecting trauma informed language	implement updates in 2020.	assessment forms. Update through 2020 as needed.		donors. Sites will be identified through our ministry partners across identified Steuben county communities.
Disparities: Low SES, pregnant and parenting teens, dual diagnosed pregnant/parenting mothers					
3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.	ProAction: #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.	ProAction Resilient Children and Families 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.	ProAction Resilient Children and Families 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.	ProAction: Resilient Children and Families Programs and staff will deliver social and emotional learning using the Pyramid Model Framework, Conscious Discipline, Flip It, Your Journey Together, Dial Assessment, Parents as Teachers, and Strengthening Families.

	Steuben Rural Health Network: # schools piloting Cope to Thrive program # instructors completing and passing training for Cope to Thrive program # participants completing Cope to Thrive % participants showing improvement in understanding and managing stress, increasing healthy behaviors, reducing negative thoughts and emotions, building problem solving skills or improving communication skills # sites hosting Girls on the Run of the Southern Tier program in Steuben County # girls signed up for GOTRST in Steuben sites % average attendance across sites in Steuben % of participants completing 5K % of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices	SRHN: *Cope to Thrive* 2 schools will implement the 7 session program in Steuben. 4 instructors will complete a 2.5 hour training and pass with a score of 80% or higher. At least 15 participants will complete the program. Students will show improvements through pre and post survey in the following areas: understanding and managing stress, increasing healthy behaviors, reducing negative thoughts and emotions, building problem solving skills, and improving communication skills by 80%. *GOTR* 3 sites will implement the GOTRST program (heart and sole or GOTR) in Steuben County with 70% attendance rate. 80% of participants will complete a 5K. Pre and Post survey will show that 75% of participants increased	SRHN: *Cope to Thrive* 1 class of 15 students will pilot the COPE Teen Online Program. Students will show improvements through pre and post survey in the following areas: understanding and managing stress, increasing healthy behaviors, reducing negative thoughts and emotions, building problem solving skills, and improving communication skills by 80%. *GOTR* 3 sites will implement the GOTRST program (heart and sole or GOTR) in Steuben County with 80% attendance rate. 85% of participants will complete a 5K. Pre and Post survey will show that 80% of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices.	*SRHN GOTR:* 4 sites will implement the GOTRST program (heart and sole or GOTR) in Steuben County with 85% attendance rate. 90% of participants will complete a 5K. Pre and Post survey will show that 82% of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices.	SRHN: Providing programming and planning for Cope 2 Thrive and Girls on the Run (GOTR and Heart and Sole) SRHN's Role: FTE's, cost of curriculum/training

		their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices.			
	Pregnancy Resource Center of the Valley: # of Real Essentials participants identified by gender # of Real Essentials participants identified by zip code # of Real Essentials participants identified by DOB % showing an increase in knowledge from participating in Real Essentials # of Childbirth Education participants identified by gender # of Childbirth Education participants identified by zip code # of Childbirth Education participants identified by DOB % showing an increase in knowledge from participating in Childbirth Education # staff trained in Real Essentials # staff trained to be Birth and Beyond Educators (BABE)	PRCV: Report data outcomes for 2018-2019 school year on Real Essentials with community participants. Schedule and implement 3 Childbirth Education classes to take place in Steuben County. 1 staff certified and 3 additional staff trained in childbirth education by 12/31/19. 5 staff/volunteers certified with the Academy of Certified Birth Educators (ACBE) in 2019. Continue offering services in existing Steuben County venues and increase community awareness and involvement.	PRCV: Continue gathering and reporting data for each established Real Essentials site. Increase Childbirth Education class opportunities by 50%. 1-3 additional staff trained/certified in childbirth education by 12/31/20. Maintain staff/CE in childbirth education. Maintain and increase existing sites in Steuben County for childbirth education. Maintain or increase community awareness and involvement.	PRCV: Continue gathering and reporting data for each established Real Essentials site. Increase Childbirth Education class opportunities by 50% from 2020. 1-3 additional staff trained/certified in childbirth education by 12/31/21. Increase trained staff/volunteers by 1-2 in childbirth education program. Maintain and increase existing sites in Steuben County for childbirth education. Maintain or increase community awareness and involvement.	PRCV oversees implementation of the Real Essentials curriculum in multiple community and center based locations across Steuben County. PRCV connects multiple partners to provide safe community space for service provision. PRCV is able to partner with other organizations to fill in gaps based on funder requirements. PRCV provides trained/certified medical and educational staff, certified Birth and Beyond Educators, and a variety of support groups.