Priority: Prevent Substance Abuse Goal: Prevent Non-medical Prescription Opioid Use and Overdose **Outcome Objectives:** Reduce drug-related hospitalization rate per 10,000 currently 29.5 (2011-2013), Newborn drug-related diagnosis rate per 10,000 newborn discharges, and Fatal opioid overdose rates for adults. Develop system wide approach to substance abuse issues					
Interventions/ Strategies/ Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Evidence-based (EB) Reference**
Develop system wide approach to substance abuse issues **1. Prescriber education and behavior:** Provide prescriber education on pain management. Continuing medical education sessions on pain management, Promotion of I-STOP. Use of SBIRT. **2. Pain patient services and drug safety:** Policy change: mandatory use of narcotic patient-prescriber agreements. Have or refer to support groups for pain patients, ED care navigator for patients with chronic pain or substance abuse disorders. **3. Supply reduction and diversion control:** Assess hospital and primary care opioid dispensing policies and consider modifications (e.g., limits on amount dispensed at once, required check of I-STOP for hospital ED admissions)**.** Promote unused medication take-back events by sheriff/police departments, with support from DEA & SBI. Explore expanding fixed medicine disposal sites at law-enforcement, primary care, and other offices. **4. Community organization and activation:** Hold and/or promote town hall like meetings**.** Build community-based leadership and County coalition. Assemble resource toolkit. **5. Drug treatment and demand reduction:** Operate and/or refer to drug detox program**.** Investigate expansion of capacity to provide services. **6. Harm reduction:** Administer naloxone prescriptions**.** Provide drug user and those in their support system education on overdose prevention and response. **7. Community-based prevention education**: Provide education at sites such as schools, community and faith based organizations from evidence-based curriculums such as Too Good for Drugs and Violence, Life Skills, Second Step, Teen Intervene, and Prime for Life.	1. # of staff trainings held and # attending	In-services and continuing education offered Participate in Arnot Opioid Task Force	Trinity of Chemung County.*/ Drug Free Community Coalition	Ongoing – tracked annually School classes tracked by school year	Interventions to prevent substance abuse are taken directly from Overdose Prevention: Project Lazarus. Trinity of Chemung County utilizes many EB programs. Interactions with patients include: Motivational Interviewing, Cognitive Behavioral Therapy, DBT-(Dialectical Behavior Therapy), Matrix Model, Seeking Safety, Patrick Carnes, Gorsky Relapse Prevention, Medication Assisted Therapy (MAT), and the Life Skills Program. For prevention efforts Trinity offers these EB programs: Alcohol Literacy Challenge, Too Good for Drugs and Violence, Life Skills, Second Step, Teen Intervene, and Prime for Life.
	2. # of support groups held # attending support groups	Provide medical and outpatient substance abuse treatment through Trinity services Track and report on program			
	4. # of community forums held # in attendance at community forums # substance coalition meetings held # attending coalition meetings	Organize community forums like town hall events Engage community partners Run county substance abuse coalition			
	5. # of patients utilizing drug treatment programs	Provide medical and outpatient substance abuse treatment Provide Medication Assisted Therapy (MAT) that will be used in combination with individual/group counseling Provide comprehensive evaluations Assess need for additional services Track and report on program			
	6. # of trainings held # participating in Naloxone trainings #'s educated on overdose prevention and response	Conduct Naloxone trainings			
	7. # of classes held for substance abuse prevention # of students educated on substance abuse prevention Results of pre and post tests	Provide education in local schools and other sites Conduct evaluations of classes Track and report on programs			

Priority: Prevent Substance Abuse Goal: Prevent Non-medical Prescription Opioid Use and Overdose **Outcome Objectives:** Reduce drug-related hospitalization rate per 10,000 currently 29.5 (2011-2013), Newborn drug-related diagnosis rate per 10,000 newborn discharges, and Fatal opioid overdose rates for adults. Develop system wide approach to substance abuse issues

Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Evidence-based (EB) Reference
Develop system wide approach to substance abuse issues **1. Prescriber education and behavior:** Provide prescriber education on pain management. Continuing medical education sessions on pain management, Promotion of I-STOP. Use of SBIRT. **2. Pain patient services and drug safety:** Policy change: mandatory use of narcotic patient-prescriber agreements. Have or refer to support groups for pain patients, ED care navigator for patients with chronic pain or substance abuse disorders. **3. Supply reduction and diversion control:** Assess hospital and primary care opioid dispensing policies and consider modifications (e.g., limits on amount dispensed at once, required check of I-STOP for hospital ED admissions)**.** Promote unused medication take-back events by sheriff/police departments, with support from DEA & SBI. Explore expanding fixed medicine disposal sites at law-enforcement, primary care, and other offices. **4. Community organization and activation:** Hold and/or promote town hall like meetings**.** Build community-based leadership and County coalition. Assemble resource toolkit. **5. Drug treatment and demand reduction:** Operate and/or refer to drug detox program**.** Investigate expansion of capacity to provide services. **6. Harm reduction:** Administer naloxone prescriptions**.** Provide drug user and those in their support system education on overdose prevention and response. **7. Community-based prevention education**: Provide education at sites such as schools, community and faith based organizations from evidence-based curriculums such as Too Good for Drugs and Violence, Life Skills, Second Step, Teen Intervene, and Prime for Life.	1. # of staff trainings held and # attending # SBIRT screenings conducted # of referrals to treatment	In-services and continuing education offered I-STOP and SBIRT education provided Referrals to treatment made Continue Opioid Task Force	Arnot Health and Arnot Medical Services (AMS)*	Ongoing – tracked annually	Interventions to prevent substance abuse are taken directly from Overdose Prevention: Project Lazarus. Arnot Health utilizes Screening, Brief Intervention, and Referral to Treatment (SBIRT) which is an EB practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Arnot Health also uses Narcotics Anonymous a Dept. of Mental Health & Addiction Services recognized EB 12-step facilitation practice.
	2. # of narcotic patient prescriber agreements # of referrals to support groups # patients utilizing care navigator	Narcotic patient prescriber agreements developed Narcotic patient prescriber agreements administered Care navigators in ED provide appropriate assessments and referrals			
	3. Opioid Dispensing Policy developed	Assess current opioid dispensing policies Modify policy as appropriate			
	5. # of patients utilizing drug treatment programs	Provide medical substance abuse treatment Operate Addiction Rehabilitation Unit Assess need for additional services Track and report on program			
	7. #'s educated on overdose prevention and response	Provide/refer to New Dawn Inpatient Addiction Rehabilitation Hold support group meetings for New Dawn graduates			

Priority: Prevent Substance Abuse Goal: Prevent Non-medical Prescription Opioid Use and Overdose **Outcome Objectives:** Reduce drug-related hospitalization rate per 10,000 currently 29.5 (2011-2013), Newborn drug-related diagnosis rate per 10,000 newborn discharges, and Fatal opioid overdose rates for adults. Develop system wide approach to substance abuse issues

Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Evidence-based (EB) Reference
Develop system wide approach to substance abuse issues **1. Prescriber education and behavior:** Provide prescriber education on pain management. Continuing medical education sessions on pain management, Promotion of I-STOP. Use of SBIRT. **2. Pain patient services and drug safety:** Policy change: mandatory use of narcotic patient-prescriber agreements. Have or refer to support groups for pain patients, ED care navigator for patients with chronic pain or substance abuse disorders. **3. Supply reduction and diversion control:** Assess hospital and primary care opioid dispensing policies and consider modifications (e.g., limits on amount dispensed at once, required check of I-STOP for hospital ED admissions)**.** Promote unused medication take-back events by sheriff/police departments, with support from DEA & SBI. Explore expanding fixed medicine disposal sites at law-enforcement, primary care, and other offices. **4. Community organization and activation:** Hold and/or promote town hall like meetings**.** Build community-based leadership and County coalition. Assemble resource toolkit. **5. Drug treatment and demand reduction:** Operate and/or refer to drug detox program**.** Investigate expansion of capacity to provide services. **6. Harm reduction:** Administer naloxone prescriptions**.** Provide drug user and those in their support system education on overdose prevention and response. **7. Community-based prevention education**: Provide education at sites such as schools, community and faith based organizations from evidence-based curriculums such as Too Good for Drugs and Violence, Life Skills, Second Step, Teen Intervene, and Prime for Life.	5. # of screenings for substance abuse issues # of referrals to drug treatment programs	Screen for substance abuse issues Refer to substance abuse treatment programs	Mothers and Babies Perinatal Network, CIDS, WIC*	Ongoing – tracked annually	CIDS uses the Nurse Family Partnership and Healthy Families programs, both evidence-based. Mothers & Babies uses the following evidence-based screening tools: Edinburgh Perinatal Depression Scale, CAGE & will be using SBIRT shortly.
	3. # of take back events held # of sites for medicine disposal # pounds of medication disposed	Develop list of medication drop off sites Promote take back events online and through local media	Health Priorities Partnership (HP2), Chemung County Health Department (CCHD)*, Trinity of Chemung County/Drug Free Community Coalition	Ongoing – tracked annually	Interventions to prevent substance abuse are taken directly from Overdose Prevention: Project Lazarus.
	4. # community forums participating in # substance coalition meetings attended	Participate in and promote community forums Attend substance coalition meetings Work on resource toolkit			
	6. # of posts, press releases, newsletter articles, etc. done to promote substance abuse prevention	Conduct educational campaigns to raise public awareness, to change attitudes, beliefs, and norms towards substance abuse			
	*Resources for all partners may include staff time, meeting space, printing, media, utilities, supplies and materials. The Chemung County Departments of Social Services and Mental Hygiene have an agreement with CASA of Livingston County (DBA Trinity of Chemung) to provide substance abuse services in the County. Trinity of Chemung received $443,655 in State and Federal Aid along with $6,506 local dollars in 2016.				

Prevent Chronic Disease – Hypertension Goal Prevent chronic disease by reducing illness, disability, and death related to hypertension, tobacco use and second hand smoke, and obesity in adults and children **Outcome Objectives** Increase the percentage of residents with hypertension who have adequately controlled their blood pressure					
Interventions/ Strategies/ Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Evidence-based Reference**
Participate and/or encourage participation in FLHSA registry.	# providers in hypertension registry # enrolled in hypertension registry Control rates for hypertension	Enroll in and promote enrollment in BP registry	Arnot Health Guthrie FLHSA*	Ongoing – tracked annually	https://www.health.ny.gov/prevention/prevention_agenda/chronic_disease/heart_disease.htm http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/section2b.html#hbp http://millionhearts.hhs.gov/abouthds/blood_pressure.html PAM is a DSRIP recommended evidence-based tool to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
Conduct media campaigns to raise awareness of hypertension. Increase awareness and control of hypertension such as self-monitoring of blood pressure and compliance with medication directions.	# of earned media, social media, and website postings	Issue press releases, letters to the editor, etc. Post items supporting efforts to social media and websites	Health Priorities Partnership, CCHD*		
Conduct blood pressure screenings. Continued sodium reduction in hospital meals.	# blood pressure screenings # identified as hypertensive # of recipes analyzed for sodium content	Conduct blood pressure screenings Refer hypertensive patients to a provider Continued monitoring of sodium in meals	Arnot Health*		
Conduct Patient Activation Measure (PAM) surveys to assess knowledge, confidence, and ability to engage in their own health care and make referrals as appropriate.	# PAM surveys completed	Administer PAM surveys	Arnot Health and HP2*		
*For all partners resources may include staff time, meeting space, printing, media, utilities, supplies and materials.					

Prevent Chronic Disease – Hypertension Goal Prevent chronic disease by reducing illness, disability, and death related to hypertension, tobacco use and second hand smoke, and obesity in adults and children **Outcome Objectives** Prevent initiation of tobacco use by youth and reduce percentage of tobacco use, specifically cigarette smoking, among adults - currently 24.8%**Disparity -** Reduce the percentage of lower income individuals who use tobacco.					
Interventions/ Strategies/ Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Evidence-based Reference**
Reduce the impact of retail tobacco product marketing on youth. Increase the number of local laws, regulations and voluntary policies that prohibit tobacco use in outdoor areas. Increase the percent of adult smokers and youth who live in households where smoking is prohibited.	# tobacco laws adopted # tobacco policies adopted # government/organizational leaders educated # of earned media # tobacco related events participated in # individuals/organizations mobilized to assist with tobacco efforts	Educate and encourage adoption of local laws & policies Lead local tobacco coalition Participate in and promote tobacco related events Issue press releases, LTEs, etc. and post items supporting efforts to social media and websites Recruit youth to assist with efforts	STTAC/CCHD*	Ongoing – tracked annually by grant year	https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/focus_area_2.htm#sector http://www.cdc.gov/tobacco/stateandcommunity/best_practices/ http://www.thecommunityguide.org/uses/policy_development.html https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/docs/eliminating_exposure_to_secondhand_smoke.pdf https://www.nysmokefree.com/
	# tobacco policies adopted # tobacco coalition meetings attended # of letters, social media, and website postings # individuals/organizations mobilized	Adopt a policy Participate in local coalition Write letters to the editor, post items supporting efforts to social media and websites Assist in recruiting youth	Health Priorities Partnership, CCHD*	Ongoing – tracked annually	

Prevent Chronic Disease – Hypertension Goal Prevent chronic disease by reducing illness, disability, and death related to hypertension, tobacco use and second hand smoke, and obesity in adults and children **Outcome Objectives** Prevent initiation of tobacco use by youth and reduce percentage of tobacco use, specifically cigarette smoking, among adults - currently 24.8%**Disparity -** Reduce the percentage of lower income individuals who use tobacco.					
Interventions/ Strategies/ Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Evidence-based Reference**
Promote smoking cessation through NYS Quitline and programs such as ALA Freedom From Smoking.	# of referrals to NYS Quitline	Promote and refer to NYS Quitline	Arnot Health, CIDS, WIC, HP2*	Ongoing – tracked annually	Per above and Mothers & Babies refers to the American Lung Association's Freedom From Smoking program which includes a comprehensive variety of evidence-based cessation techniques.
Promote smoking cessation through NYS Quitline and programs such as ALA Freedom From Smoking.	# of referrals to Freedom From Smoking	Promote and refer to NYS Quitline Utilize Freedom From Smoking	Mothers & Babies Perinatal Network*	Ongoing – tracked annually	
For all partners resources may include staff time, meeting space, printing, media, utilities, supplies and materials. Additionally, the Chemung County Health Department houses the Southern Tier Tobacco Awareness Coalition (STTAC) which was awarded a five-year grant at annual funding of $ 325,000 to engage community stakeholders and youth to change policies and norms about tobacco and tobacco use in 2014. This grant builds on previous grant-funded tobacco control work by our organization, to better support Chemung, Schuyler, and Steuben County tobacco control efforts and provide more comprehensive programming across the state. As part of this grant, all counties of New York State will have access to the resources of a community engagement program and the youth action efforts known as Reality Check. The grant was awarded by the NYSDOH, Bureau of Tobacco Control.					

Prevent Chronic Disease – Hypertension Goal Prevent chronic disease by reducing illness, disability, and death related to hypertension, tobacco use and second hand smoke, and obesity in adults and children **Outcome Objectives** Prevent obesity trend from rising and aim to reduce the percentage of adults (29.8) and children (18.4) who are obese					
Interventions/ Strategies/ Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Evidence-based Reference**
Promote Breastfeeding – through activities such as participating in coalitions like the Twin Tiers Breastfeeding Network or Finger Lakes Breastfeeding Coalition, assisting/ promoting annual Breastfeeding Open House and Breastfeeding Friendly Awards, establishing /promoting Baby Bistros, conducting breastfeeding media campaigns, and establishing/ promoting lactation rooms.	# participating in coalition # attending TTBN Open House # of BF Friendly awards # attending Baby Bistros # of earned media, social media, and website postings encouraging breastfeeding # lactation rooms # infants fed breast milk only at hospital discharge % of WIC mothers breastfeeding at least 6 months	Participate in local coalition Attend & promote BF Open House & awards Post items supporting efforts to social media and websites Designate/ promote lactation room	TTBN, WIC, Arnot, HP2, CCHD*	Ongoing – tracked annually	https://www.cdc.gov/breastfeeding/resources/guide.htm https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/docs/breastfeeding_fact_sheet.pdf
	# infants fed breast milk only at hospital discharge % of WIC mothers breastfeeding at least 6 months	Encourage and provide resources to clients	CIDS, WIC*	Ongoing – tracked annually	Nurse Family Partnership Program and Healthy Families

Prevent Chronic Disease – Hypertension Goal Prevent chronic disease by reducing illness, disability, and death related to hypertension, tobacco use and second hand smoke, and obesity in adults and children **Outcome Objectives** Prevent obesity trend from rising and aim to reduce the percentage of adults (29.8) and children (18.4) who are obese					
Interventions/ Strategies/ Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Evidence-based Reference**
Promote physical activity & better nutrition - through activities such as participating in local coalitions, holding/ promoting Chronic Disease Self-Management classes, participating/ promoting programs such as Gold Shoe/Step It Up, and conducting physical activity & better nutrition media campaigns.	# participating in coalition # participating in CDSMP classes # participants in Gold Shoe/Step It Up # of earned media, social media, and website postings	Participate in local coalition Promote/ hold CDSMP classes Promote/ participate in PA/BN programs Post items supporting efforts to social media and websites Establish/adopt worksite wellness policies	CHCS, BacPac, Arnot, HP2, CCHD*	Ongoing – tracked annually	http://www.cdc.gov/obesity/downloads/pa_2011_web.pdf https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/focus_area_1.htm#sector
	# participants CDSMP	Train facilitators and hold CDSMP classes	Arnot & Steuben Rural Health Network The cost for 2 classes and a peer leader training are estimated to be $12,775	Ongoing – tracked annually	http://www.health.ny.gov/diseases/conditions/arthritis/programs.htm
Promote physical activity & better nutrition - Enroll schools, worksites, and small retailers in Creating Healthy Schools and Communities initiatives to promote physical activity & better nutrition.	# schools, businesses and retailers participating in CHSC # policies and changes adopted # engaged in coalition	Recruit local businesses Engage small retailers Lead local coalition	Creating Healthy Schools and Communities, HP2*	Ongoing – tracked annually	https://www.health.ny.gov/prevention/obesity/prevention_activities/chsc/
*For all partners Resources may include staff time, meeting space, printing, media, utilities, supplies and materials. Additionally, Arnot Health partners with the Genesee, Livingston, Steuben, Wyoming BOCES on the Creating Healthy Schools and Communities (CHSC) program. This is a five-year (2015-2020), public health initiative of the New York State Department of Health (NYSDOH) with the goal of reducing major risk factors of obesity, diabetes, and other chronic diseases in 85 high-need school districts and associated communities. Parts of Chemung County in the City of Elmira are covered by this $250,000 grant. Additionally, Arnot Health will dedicate 0.5 FTE for implementation of the CHIP.					