Steuben County Community Health Improvement Plan

October 2013

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Executive Summary

What are the health priorities facing Steuben County?

This was the question facing well over 1,000 people in a comprehensive process that involved health care organizations, hospitals, business and community leaders, academia, government agencies, non-profit organizations and county residents. Key partner agencies (Steuben County Public Health, St. James Mercy Hospital, Ira Davenport Hospital, Corning Hospital, and other community partners), engaged in a process facilitated by the S2AY Rural Health Network over a 22 month period to collect data, solicit opinions, facilitate the process and guide a discussion to determine not only what are the most pressing problems facing our residents, but also what can we effectively and efficiently address.

The mission of the Steuben County Public Health Dept. is, "*To foster, expand, and improve organized efforts to better the health of all residents of Steuben County through health promotion and illness prevention*".

To that end Steuben County Public Health and their partners utilized the Mobilizing for Action through Planning and Partnership (MAPP) process to select two key health priorities and one disparity to address in the community.

In the end, Steuben County Public Health and the partner agencies decided to tackle two tough areas under the New York State Dept. of Health priority of the prevention of chronic disease:

1. Reduce obesity in children and adults
2. Reduce heart disease and hypertension

The disparity the partners chose to address was to:

Promote tobacco cessation, especially among low SES populations and those with mental health illness

Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State (NYS). Specifically, they account for approximately 70% of all deaths in NYS, and affect the quality of life for millions of other residents, causing major limitations in daily living for about 10% of the population. Costs associated with chronic disease and their major risk factors account for more than 75% of our nation's health care spending[1]. Obesity is a major contributor to chronic disease.

Obesity Prevalence

- The percentage of New York State adults who are overweight or obese increased from 42% in 1997 to 60% in 2008.
- The percentage of obese adults in New York State more than doubled from 10% in 1997 to 25% in 2008.
- Obesity among children and adolescents has tripled over the past three decades. Currently, a third of New York's children are obese or overweight.
- Health care to treat obesity-related illnesses and conditions cost the United States an estimated $150 billion and New York State more than $7.6 billion every year.[2]

According to the data available when the CHA was completed (2008-09 EBRFSS data), Steuben County has a high rate of age-adjusted percentage of adults who are obese or overweight (BMI 25 or above) compared to New York State. 65.9% of Steuben County residents are obese or overweight versus the New York State average of 59.3%.

[1] CDC Chronic diseases: The Power to Prevent, the Call to Control
http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm
[2] New York State Dept. of Health Obesity Prevention http://www.health.ny.gov/prevention/obesity/

In Steuben County the age adjusted percentage of adults who are obese (BMI 30 or higher) is 27.6% compared to the New York State rate of 23.1%.[3] According to our survey, the average BMI of respondents was 30.4. Public health officials across the state and the nation must take steps to address this rising epidemic. Heart disease, and hypertension in particular as a major contributor to heart disease (and cerebrovascular disease) must also be prioritized.

Cardiovascular Disease (CVD) is the leading cause of death in the United States and in New York State. NYS has the second highest mortality rate in the U.S. from cardiovascular disease. CVD was responsible for 31% of deaths in NYS in 2010 and accounted for a substantial proportion of the estimated $50 billion in direct medical costs spent on chronic disease in the state. For every person who dies from a heart attack, 18 people survive. For every person who dies from a stroke, seven people survive. Many of these survivors are disabled and cannot lead productive lives. Stroke is a leading cause of premature, permanent disability among working-age adults in the United States. Stroke alone accounts for the disability of more than a million Americans. The economic impact of CVD and stroke on the health system will grow as the population ages.[4]

Hypertension and tobacco use are two major contributing factors to cardiovascular diseases. The age adjusted cardiovascular disease mortality rate in Steuben County is 249.5 compared to the upstate New York rate of 244.7.[5] The age adjusted percentage of adults who smoke cigarettes in Steuben County is 22.1% compared to the upstate NY rate of 18.9%. Failing to win the battle against obesity and heart disease will mean premature death and disability for an increasingly large segment of Steuben County residents. Without strong action to reverse the obesity epidemic, for the first time in our history children may face a shorter lifespan than their parents. Steuben County Public Health along with their partners has developed the Steuben Health Priorities Team Work Plan to address these issues.

Next steps will center upon accomplishing the activities outlined in the Steuben Health Priorities Team Work Plan to accomplish objectives related to our identified priorities. Steuben County Public Health will continue to meet and work with local hospitals and partners on a regular basis to begin to make progress in addressing the identified priorities to reduce obesity, heart disease and hypertension in our community.

[3] New York State Dept. of Health New York State Community Health Indicator Reports - Obesity and Related Indicatorshttp://www.health.ny.gov/statistics/chac/indicators/obs.htm

[4] New York State Dept. of Health Cardiovascular Disease https://www.health.ny.gov/diseases/cardiovascular/heart_disease/

[5] New York State Dept. of Health New York State Community Health Indicator Reports http://www.health.ny.gov/statistics/chac/indicators/

Background and Process

Mobilizing for Action through Planning and Partnership

Led by the S2AY Rural Health Network, Steuben County Public Health Department along with local hospitals and community partners utilized the Mobilizing for Action through Planning and Partnership (MAPP) process to determine two priorities and a disparity from the 2013 – 2017 Prevention Agenda. The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is: *"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action".* The MAPP process encompasses several steps.

Organize for Success- Partner Development

The goal of this step is to bring together key partners and familiarize them with the MAPP process and determine key local questions. To accomplish this Steuben County Public Health Department invited participants from a wide range of the organizations throughout the county. Organizations that participated in the community health assessment process were:

- Steuben County Public Health Department
- St. James Mercy Hospital
- Ira Davenport Memorial Hospital
- Corning Hospital
- Arnot Health
- Guthrie Health
- Steuben Rural Health Network
- Health Ministry of the Southern Tier
- S2AY Rural Health Network
- Cancer Services Program of Steuben County

The Steuben Health Priorities Team includes these organizations that are committed to improving the health of Steuben County residents. This group has met on a monthly basis in the development of the Steuben Health Priorities Team Work Plan. The members of the Steuben Health Priorities Team have agreed to meet on a regular basis to ensure that the initiatives outlined in the Steuben Health Priorities Team Work Plan are implemented, monitored and evaluated.

Assessments

Four assessments inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of four different assessments is a unique feature of the MAPP process. Most planning processes look only at quantitative statistics and anecdotal data. MAPP provides tools to help communities analyze health issues through multiple lenses.

The first assessment examined the Community Health Status Indicators. Two methods were used to examine indicators. The first was to collect relevant statistical data using the NYSDOH Community Health Indicator Reports and a variety of other secondary sources. This was completed by S2AY Rural Health Network staff. The second method was to collect primary data by conducting a comprehensive survey among a random sample of community residents to determine their opinions, health-related behaviors and health needs. A total of 747 completed surveys were returned in Steuben County. Surveys were conducted electronically through a Survey Monkey link, along with paper copies which were distributed to the public through employers, health, educational and human services agencies and

other community groups. St. James Mercy Hospital posted a link to the survey on their public website, on their employee intranet and emailed employees, boards and providers the link. A public press release was issued. The survey was designed to encompass questions in the five Prevention Agenda areas that the New York State Department of Health (NYSDOH) has identified as high priority issues on a statewide basis.

The second assessment evaluated the effectiveness of the Public Health System and the role of Steuben County Public Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was also conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. The assessment was completed through the use of a more user-friendly version of the CDC and NACCHO tool, Local Public Health System Assessment (LPHSA). Each of the ten essential public health services was rated by the group by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System.

The third assessment was the Community Themes and Strengths Assessment that was conducted through focus groups which were held throughout the County. This assessment looked at the issues that affect the quality of life among community residents and the assets the County has available to address health needs. These were held in conjunction with the fourth assessment that looked at the "Forces of Change" that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes. The focus groups conducted in Steuben County included students of a GED classes in Corning and Hornell, members of the Greenwood Fire Dept. and students of an English as a second language class. These groups helped augment the responses of the public health system assessment and findings of the survey of community residents.

Identification of Strategic Issues

Once these results were tallied, a finalized list of the top issues from all components of the assessment process was compiled. A series of meetings was held with the Steuben Health Priorities Team to present the data and pick priorities. The Steuben Health Priorities Team was charged with ranking the priorities based on their knowledge of health needs and available services, along with the data presented, to select two priorities and one disparity. In order to accomplish this, the Hanlon Method was used. This method of ranking focuses most heavily on how effective any interventions might be. The Hanlon Method utilizes the following formula to rank priorities:

(A & 2B) X C

Where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. The effectiveness of the solution is given a lot more weight than the size or seriousness of the problem, with the hope of making wise use of limited resources by targeting solutions that are known to be effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores.

It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution) individually using a paper ranking form, the rankings were not heavily influenced by group dynamics. Based upon the ranking through the Hanlon Method, Steuben County's scores on the top health related issues in the county were:

Issue	Hanlon	Pearl
Obesity	180.86	6.07
Smoking/Tobacco	152.07	6.64
Cancer	151.57	4.86
Heart Disease	139.21	5.50
Depression/other mental illness	130.50	4.79
Cerebrovascular Disease	122.00	4.43
Substance Abuse	108.57	4.64
Diabetes	108.07	6.29
Births to teens	103.21	5.14
CLRD/COPD	102.38	5.54
Problems with Teeth or Gums	84.57	5.29
Unintentional Injuries	79.86	5.43
Behavioral Problems in Children	79.14	4.07

Community partners discussed all these issues, but concentrated on the top ranked issues. After reviewing, discussing and considering county assessments, data and previous initiatives the group decided to focus on the top two priorities of:

1. Reduce obesity in children and adults
2. Reduce Heart disease and hypertension

And the following disparity:

Promote tobacco cessation, especially among low SES populations and those with mental health illness

Formulate Goals and Strategies

During this stage research and evidence-based best practices were considered by the Steuben Health Priorities Team from many different sources including the state's Prevention Agenda 2013 – 2017 material, and national guidance, such as the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020. The Health Impact Pyramid developed by Thomas R. Frieden, MD, MPH was utilized. This is a pyramid approach to describe the impact of different types of public health interventions and provides a framework to improve health. The base of the pyramid indicates interventions with the greatest potential impact and in ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, on-going direct clinical care, and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort.

For each focus area under the selected Prevention Agenda Prevent Chronic Disease priority objectives and goals were identified that included improvement strategies and performance measures with measurable and time-framed targets over the next five years. Strategies proposed are evidence-based or promising practices. They include activities currently underway by partners and new strategies to be implemented.

These strategies are supported and will be implemented in multiple sectors, including at local schools, worksites, businesses, community organizations, and with providers, to make the easy choice also the healthy choice. We will create an environment that is conducive to physical activity and good nutrition through our network of partnerships with these diverse organizations.

Over a period of several months, our partnership worked to develop a broad based plan to address our chosen priorities of obesity, heart disease, hypertension, and tobacco cessation. The Steuben Health Priorities Team Work Plan places emphasis on three key areas: 1) health promotion activities to encourage healthy living and limit the onset of chronic diseases; 2) early detection opportunities that include screening populations at risk; and 3) successful management strategies for existing diseases and related complications. These strategies recommended by the Health Impact Pyramid are based on the interventions' evidence base, potential to address health inequities, ability to measure success, potential reach, potential for broad partner support and collaboration, and political feasibility. This is based on findings from such organizations as the Institute of Medicine of the National Academies and their report,

Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation or the CDC's, *Recommended Community Strategies and Measurements to Prevent Obesity in the United States.*

Obesity is one of the leading causes of preventable deaths leading to other chronic diseases, including diabetes, cancer, heart disease, stroke, arthritis and others. We have included many interventions to encourage increased physical activity and better nutrition thus reducing our obesity rates leading to lower chronic disease rates. These initiatives include pursuing joint use agreements with the local school districts, promoting breast feeding policies to worksites, and urging members of the Regional Economic Development Council to consider health in their projects. We will create an up to date resource guide to promote the County's many opportunities for physical activities including local farmer's markets, parks and hiking trails.

As mentioned above cardiovascular Disease (CVD) is the leading cause of death in New York State. Hypertension and tobacco use are two major contributing factors to cardiovascular diseases. The age adjusted cardiovascular disease mortality rate in Steuben County is 249.5 compared to the upstate New York rate of 244.7.[6] The age adjusted percentage of adults who smoke cigarettes in Steuben County is 22.1% compared to the upstate NY rate of 18.9%. Failing to win the battle against obesity and heart disease will mean premature death and disability for an increasingly large segment of Steuben County residents. Without strong action to reverse the obesity epidemic, for the first time in our history children may face a shorter lifespan than their parents. Steuben County Public Health along with their partners has developed the Steuben Health Priorities Team Work Plan to address these issues.

The CHIP Chart that follows outlines the workplan to address both heart disease and obesity in Steuben County.

One exciting aspect of the Steuben Health Priorities Team Work Plan is the unlimited possibilities offered by technological advances. Area hospitals and other local providers are beginning to implement Electronic Health Records (EHR). These EHR's will create a sea of change in how providers manage their patients. When fully functional the benefits of EHRs include improved quality and convenience of patient care, accuracy of diagnoses, health outcomes, and care coordination, increased patient participation in their care and increased practice efficiencies and cost savings. We will utilize this technology to give our residents one more, vital tool to improve their health outcomes. EHR's will give providers decision support tools and available resources at their finger tips leading to disease management discussions with patients and better chronic disease case management.

Primary care providers will be trained to talk to their patients about their weight, physical activity, blood pressure, diet and tobacco use. Professional training programs in prevention, screening, diagnosis and treatment of overweight, obesity and diabetes will be provided and reach across the spectrum of health care providers. The updated resources mentioned above will be available to providers through a link in the EHR. Through the use of this new technology follow-up calls will be able to be made to check on patient compliance. Additionally, the EHR's will provide the opportunity and documentation necessary to evaluate and measure their use. EHR's provide one more important connection in the network to support residents to fight obesity, heart disease and hypertension.

As we implement our Community Health Improvement Plan we will continue to identify emerging best practices to address our priorities. We will evaluate our own programs and develop data measures to assess their impact. Promising cases for return on investment will be shared with policymakers. Our continued and developing partnerships in the development of this plan have allowed us to strengthen the connection between public health, local hospitals and providers. Specifics are outlined in the work plan below.

[6] New York State Dept. of Health New York State Community Health Indicator Reports
http://www.health.ny.gov/statistics/chac/indicators/

Maintenance of Engagement

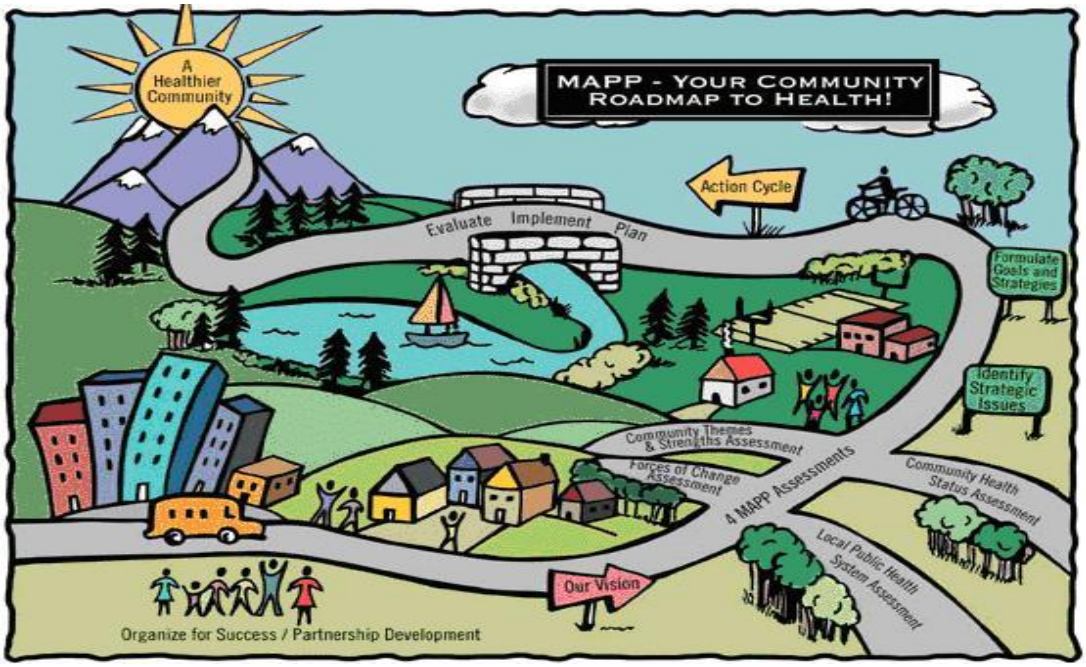
The Steuben Health Priorities Team Work Plan designates the organizations that have accepted responsibility for implementing each of the activities outlined in the work plan. Measurements and evaluation techniques are provided for each activity with starting target dates provided. As mentioned above the members of the Steuben Health Priorities Team have agreed to meet on a regular basis to ensure that the initiatives outlined in this plan are implemented, monitored and evaluated. Progress will also be reported quarterly to the Steuben County Legislature through the Health and Education Committee. Hospital partners will provide updates annually to their Community Service Plans to their respective Hospital Boards. Activities on the work plan will be assessed and modified as needed to address barriers and duplicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives.

Community Health Improvement Plan

The Steuben Health Priorities Team spent several meetings developing and refining the attached CHIP Chart, the overall workplan for community health improvement. While many objectives will only focus on program-related measures, we have made sure to include three measures that will specifically lead to improved health outcomes and help to achieve our goals of reducing heart disease, hypertension and obesity in a very measurable way. These include:

- Increase in women exclusively breastfeeding and breastfeeding at 6 months
- Increase of WIC mothers breastfeeding at 6 months
- Reduce sodium content in meals by 30% over 3 years by November 2016

We fully expect that our continued efforts will lead to a healthier Steuben County.



Steuben Health Priorities Team Work Plan

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create community environments that promote and support healthy food and beverage choices and physical activity**	A1. Support and encourage programs such as 10k walk/run through Ira Davenport, Walk with the Doc through Guthrie, Pop Can Fun Run through Corning Hospital, Girls on the Run, Strong Kids Safe Kids, the Wine Glass Marathon, Hornell CSD Pace grant and the Fit and Fun Program through Hornell YMCA.	Steuben Health Priorities Team (SHPT), Public Health (PH), Local Hospitals	November 2013 - ongoing	# of participants, # of activities
		A2. To increase community physical activity, investigate and contact applicable parties to compile resources and create a central guide to promote local hiking trails and the area's natural resources. Investigate creating and annually updating an online resource guide as well as the cost of printed copies. Provide link to guide on partner websites and social media outlets.	SHPT Possible Partners: Steuben County Conference and Visitors Bureau, Chemung County "River Friends", Traffic Safety Board, 211	January 2014 - ongoing	Schedule created to update guide, guide created, QR code created, online hits, # of partners posting link
		A3. Advocate for the inclusion of creating healthy environments with Regional Economic Development Council - including the Rails to Trails program.	SHPT, County Rotaries	January 2014 - ongoing	# of contacts made # of projects including healthy environments proposed
		A4. Work with local media to reach community members - highlighting our initiatives. Efforts will include social media, radio shows/service announcements and striving to develop a relationship with WETM and other local television shows to explore the possibility of creating a yearly campaign.	WETM - local TV stations, local radio stations, PH, SHPT	April 2014 - ongoing	# PSA's/messages provided to various media outlets, # appearances made/social media posts ("likes", etc.)

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create community environments that promote and support healthy food and beverage choices and physical activity**	A5. Investigate and continue to develop and expand joint use agreements with county schools. Create a list of current joint use agreements and resources open to the community.	13 Steuben County School Districts, PH, SHPT	January 2014 – ongoing	# of joint use agreements, list of resources available to community members (parks, basketball courts, etc.), provide information online and track hits
		A6. Work with Corning-Painted Post Schools to attempt to expand the implementation of the PE 4 Life program including additional training of staff, equipment purchases and group advocacy with the school board.	Corning Hospital, Superintendant of schools	April 2014 - ongoing	# of staff trained, funding secured, equipment purchased
		A7. Work together to increase breastfeeding in Steuben County. Increase access to breastfeeding information and encourage continued breastfeeding after leaving the hospital. Inform and assist worksites with breastfeeding policies. Encourage health care professionals to heavily promote the benefits of breastfeeding, including triggers in EHR (if possible when in place), and encourage referrals to community resources. Engage and support WIC to heavily promote and support breastfeeding among their clients. Encourage breastfeeding rally sponsored by WIC and continue one on one support to mothers through public health.	Local Hospitals WIC, PH	January 2014 - ongoing	EMR/EHR documentation of education in applicable facilities, % of women exclusively breastfeeding and breastfeeding at 6 months, % increase of WIC mothers breastfeeding at 6 months

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**B. Expand the knowledge base of partners in obesity prevention**	B1. Identify emerging best practices.	SHPT, Local Hospitals	April 2014 - ongoing	Best practices identified And posted online
		B2. Evaluate obesity prevention initiatives.	SHPT, Local Hospitals	September 2014 - ongoing	Initiatives evaluated, data collected and analyzed
		B3. Investigate database development to strengthen the case for resource allocation and obesity reduction programs to share with policymakers.	Local Hospitals, SHPT	January 2015 - ongoing	All data tracked and analyzed, results shared
	C. Expand the role of public and private employers in obesity prevention	C1. Provide and promote opportunities for physical activity and links to available resources including the new hiking guide, local gyms and farmers markets to public and private employers.	SHPT, local hospitals, PH, Steuben Rural Health Network	September 2014 - ongoing	Opportunities provided and promoted, online resources provided, # hits tracked
		C2. Promote, support and conduct Know Your Numbers Campaign headed by Corning Hospital and public health.	Corning Hospital, SHPT	May 2014 - ongoing	Launch of program, # of participants
	D. Increase access to high quality chronic disease preventive care and management in clinical and community settings	D1. Educate health care professionals to talk with their patients about their weight, nutrition, and physical activity (such as Guthrie's bariatrician). Develop a resource guide for providers regionally.	Guthrie, Local Hospitals, SHPT	September 2014 - ongoing	# educated, # resources disseminated

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce Heart disease and hypertension					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce illness, disability and death related to heart disease and hyper-tension	**A. Prevention, screening, early detection, treatment, and self-management support.**	A1. Work to prevent heart disease and hypertension by assisting Office for the Aging, local hospitals and long term care facilities in reducing sodium content in all meals served to patients, visitors, staff and the public.	Local Hospitals, Office for the Aging, ProAction, PH	October 2013 - ongoing	Establish a baseline. Reduce sodium content in meals by 30% over 3 years, by November 2016
		A2. Investigate possibility of expanding heart disease support group in Hornell. Promote support groups of all local hospitals.	Guthrie, St. James	September 2014 - ongoing	Creation of support group, # participating
	B. Reduce exposure to secondhand smoke	B1. Invest in efforts to create smoke-free environments throughout the community, encouraging Steuben County government to lead by example.	PH, STTAC	January 2016	Steuben County government policy developed and implemented, # of smoke free policies implemented
		B2. Highlight dangers of tobacco through public service announcements and promote media campaigns with hard hitting cessation messages and the importance of tobacco free outdoors.	SHPT, Local Hospitals, Health Ministry of the Southern Tier, PH, STTAC, Tobacco Cessation Center	May 2014 - ongoing	# PSA's provided, # campaigns held

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce Heart disease and hypertension					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce illness, disability and death related to heart disease and hyper-tension	**C. Promote tobacco cessation, especially among low SES populations and those with mental health illness (disparity)**	C1. Promote cessation counseling to community residents targeting people with disabilities, mental health and substance abuse problems. Promote NYS Smokers' Quitline. Provide tobacco cessation education to clients of organizations such as home care, ARC, ProAction, Cancer Services Partnership, HMST and hospital patients. Work to promote cessation messages by sending out quitline cards, showing cessation videos at DSS, and conducting site assessments at outpatient adolescent psychiatric facilities in Wayland/Alfred that include tobacco use.	211, Local Hospitals, PH, SHPT, Health Ministry, Steuben RHN, STTAC, CSP, Tobacco Cessation Center	September 2014 - ongoing	# NYS Smokers Quitline calls, #agencies/organizations participating in tobacco cessation education to clients
	D. Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations	D1. Participate in local and national activities and/or events that educate the public on the impact of retail tobacco marketing on youth (Point of Sale -POS) such as the Great American Smoke Out, Kick Butts Day, World No Tobacco Day, Strong Kids Safe Kids and the Adolescent Health and Wellness conference.	Local Hospitals, PH, Steuben RHN, STTAC, Tobacco Cessation Center, Local Schools	January 2014 - ongoing	# activities held and/or events attended

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce Heart disease and hypertension					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce illness, disability and death related to heart disease and hyper-tension	**E. Train primary care providers (PCPs) to talk with their patients about their weight and tobacco use. Provide link on EMR to community resources available for patients**	E1. Create a list of community resources specific to diagnosis and investigate the possibility of uploading into EHR's.	211, Local Hospitals, Health Ministry of the Southern Tier	September 2015 - ongoing	Inventory list of resources and availability on EHR, track usage
		E2. Provide resources and literature to educate health care professionals to talk with their patients about their weight (including physical activity and diet) and their tobacco use, as appropriate. Encourage discussions that include dividing goals into manageable milestones and that health care professionals can easily link their patients with available community resources. Investigate the use of EHR as a tool for health care providers to link patients with appropriate community resources.	Local hospitals, Health Ministry of the Southern Tier	September 2015 - ongoing	# educated, # resources disseminated, track usage of EHR resources where applicable
		E3. When and if available, encourage the use of decision support/reminder tools of EHRs, as well as the community resource list. When and if available, continue calls by nurses to follow-up with patients on follow-through/compliance. Monitor implementation	Local Hospitals, PH, Health Ministry of the Southern Tier, SHPT	January 2015 - ongoing	Implementation of decision support and reminder tools and referrals to community resources in EHR where applicable, documentation of use and documentation of calls via EHR where applicable

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce Heart disease and hypertension					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce illness, disability and death related to heart disease and hyper-tension	**F. Develop infrastructure for widely accessible, readily available chronic disease self-management (CDSMP) and diabetes prevention programs**	F1. Provide CDSMP programs and continue to recruit peer trainers	Steuben Rural Health Network, Public Health Southern Tier Diabetes Coalition	January 2014 - ongoing	# of classes # trained
		F2. Offer Diabetes Prevention programs as need is expressed in the county			# participants
		F3. Sustain links to Emory University's Diabetes Training and Technical Assistance Center, and the NYS Diabetes Prevention Program and QTAC			Links sustained
	G. Promote CDSMP and Diabetes Prevention programs to health-care providers	G1. Conduct campaign that includes activities such as PSAs, articles, letters to the editor, postings on social media, mailings to health-care providers, meetings with practice managers	Steuben Rural Health Network, Public Health Southern Tier Diabetes Coalition Hospitals	January 2014 - ongoing	# of articles, letters, mailings and meetings
		G2. Provide business model to hospitals/health care providers on the improved health outcomes with CDMSP and Diabetes Prevention programming			Business model provided
	H. Maximize organizational capacity to provide CDMSP and Diabetes Prevention Programs	H1. Explore reimbursement strategies under the new Affordable Care Act and the selected Steuben County insurance vendors for CDMSP and Diabetes Prevention programs	SRHN Public Health	January 2014 - ongoing	Strategies explored and findings communicated to SHPT