Chemung County Community Health Improvement Plan 2013 - 2017

October 2013

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Executive Summary

What are the health priorities facing Chemung County?

This was the question facing Chemung County Health Department 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 (Chemung County Health Dept., Arnot Health, Guthrie Health and other community partners), engaged in a course of action facilitated by a consultant over a 12 month period to collect data, solicit opinions, facilitate a 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 Chemung County Health Dept. is to:

- *Promote and respond to our community's health needs,*
- *Demonstrate teamwork through open communication, support, respect and accountability and*
- *Provide efficient, courteous, professional service fairly and consistently.*

To that end Chemung County Health Dept. 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.

This resulted in Chemung County Health Dept. and the partner agencies deciding to tackle two tough areas under the New York State Dept. of Health priority of "prevention of chronic disease":

1. Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%
2. Reduce percentage of tobacco use, specifically cigarette smoking, among adults by 3% from 30.8% to 29.9%.

The disparity the partners chose to address was to:

- Reduce the percentage of lower income individuals who smoke including those with mental health and substance abuse issues.

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 62% 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 and smoking are major contributors 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]

[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/

According to the data available when the CHA was completed (2008-09 EBRFSS data), Chemung County had the fifth highest age-adjusted percentage of adults who are obese or overweight (BMI 25 or above) in New York State: 69.7% of Chemung County residents are obese or overweight vs. the New York State average of 59.3%. According to our survey, the average BMI of respondents was 29.9 (Overweight = BMI of 25-29.9; Obese = BMI > 30). Public health officials across the state and the nation must take steps to address this rising epidemic.

Additionally, the Chemung County percentage of adults who smoke is the **highest** in the state at 30.8% compared to the New York State average of 17%. It is the primary contributor to a host of chronic diseases. As noted in the NY State Chronic Disease Action Plan:

> Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS) and in the United States. Cigarette use, alone, results in an estimated 440,000 deaths each year in the United States, and 25,000 deaths in NYS. There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer, including lung and oral; heart disease; stroke; chronic lower respiratory disease and other lung diseases.
>
> The economic costs of tobacco use in NYS are staggering. Smoking-attributable health care costs are $8.2 billion annually, including $3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in $6 billion in lost productivity. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.
>
> Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health.[3]

Failing to win the battle against obesity and tobacco use will mean premature death and disability for an increasingly large segment of Chemung 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. Chemung County Health Dept. along with their partners has developed the Community Health Improvement Plan (CHIP) to address these issues (see pg. 13).

Next steps will center upon accomplishing the activities outlined in the CHIP workplan to accomplish objectives related to our identified priorities. They include activities currently underway by partners and new strategies to be implemented. The Chemung County Health Department and their partners, the Health Priorities Partnership or HP[2], will continue to meet and work with on a regular basis to begin to make progress in addressing the identified priorities to reduce obesity and tobacco use in our community.

[3] NYSDOH Focus Area 2 http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/focus_area_2.htm#content

Background and Process

Mobilizing for Action through Planning and Partnership

The Chemung County Health Department engaged a consulting firm (Human Service Development of Corning) to work with Arnot Health along with the other partners, listed below, to utilize 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 Chemung County Health Department and Arnot Health invited participants from a wide range of the organizations throughout the county. Organizations that participated in the community health assessment process were:

- Chemung County Health Department
- Arnot Health
- Guthrie Health
- EMSTAR
- Creating Healthy Places
- Health On Demand
- Family Services
- Chemung ARC
- YWCA
- Elmira City Council
- Chemung County DSS
- Cornell Cooperative Extension
- Eat Smart NY
- Chemung County Dept. of Aging
- Elmira College
- Chemung County Mental Health
- Health Ministries of the Southern Tier
- WIC
- Comprehensive Interdisciplinary Developmental Services, Inc (CIDS)
- Cancer Services Program of Chemung & Schuyler
- Arnot Tobacco Cessation Center
- Southern Tier Tobacco Awareness Community Partnership (STTAC)
- Southern Tier Pediatrics
- Chemung County Medical Reserve Corps.
- Community Mental Health Program at Family Services
- Chemung County School Readiness Project
- Economic Opportunity Program
- Chemung County Poverty Reduction Coalition
- Community members

The Chemung County Health Priority Partnership (HP^2) included these organizations that are committed to improving the health of Chemung County residents. This group has met on a monthly basis since last fall to work on the development of the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Community Service Plan (CSP). The members of the Health Priority Partnership agreed to continue to meet at least bimonthly to ensure that the initiatives outlined in the Community Health Improvement and Community Service Plans are implemented, monitored and evaluated.

The Chemung County Health Dept. works diligently to search out potential collaborative partners throughout its service area in efforts to enhance needed healthcare services to those most vulnerable residents. Due to the rural nature of much of Chemung County, the high percentage of low-income residents and the limited resources available in the community, we understand the need to create meaningful partnerships to best serve the community at large. We have formed collaborative relationships with the above organizations and community agencies, and work together as a team to address the many and varied health issues in the community.

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 the Consultant's staff. In order to complete the work in a timely fashion and allow time for the Committee to review all data, identify priorities, establish and refine goals and objectives and prepare the CHA, CHIP and CSP, data that was available in the fall of 2012 and early winter of 2013 was used. The second method of getting data on community health status 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 564 completed surveys were returned in Chemung County (0.63% of the population). 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 through other community groups. Links to the survey were posted on the Chemung Valley Rural Health Network website, hospital and Health Department websites and in signature lines of partners' communications. Press releases were issued, flyers and postcards distributed, and partners promoted the completion of the surveys at community presentations and health fairs. Additionally a commercial was produced by CVRHN and aired on TV for 4 weeks. We also held group sessions to help people who may have limited ability to self-complete the survey such as persons with low educational attainment, disability or low literacy levels. 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. A summary of survey results can be found in our Community Health Assessment.

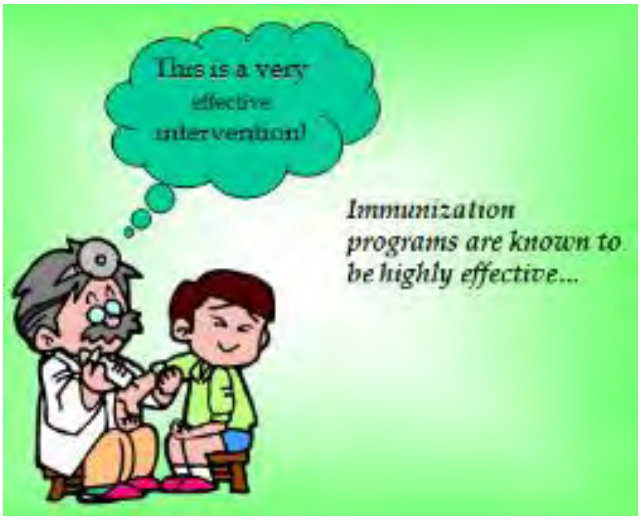
The second assessment evaluated the effectiveness of the Public Health System and the role of Chemung County Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was also conducted via an electronic 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. A summary of those results can also be found in our Community Health Assessment.

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 Chemung County included Horseheads Head Start parents, Workforce Development Center GED students, Booth School Head Start parents and Broad St. Head Start parents (all four representing low income populations), Chemung Valley Rural Health Network board members, and Economic Opportunity Program First Choice members(low-income, ethnically diverse). These groups helped augment the responses of the public health system assessment and findings of the survey of community residents, and also helped to ensure that opinions of the low-income and minority groups in the community were captured.

Identification of Strategic Issues

Chemung County Health Dept., Arnot Health and their partners considered many factors in assessing the health status of their residents to determine two priorities and a disparity to focus on. The Consultants reviewed all statistical data from the survey and the New York State Dept. of Health, along with Frieden's Pyramid and the other documents from the NYSDOH website on the Prevention agenda including goals, indicators and data. Additionally, partners throughout the community were asked to provide any data, surveys or reports they had recently conducted to provide a broad and comprehensive picture of the health of our residents.
http://www.health.ny.gov/prevention/prevention_agenda/2013-2017.

Choosing Priorities



Once all these statistics and the results of these assessments 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 Health Priorities Partners listed above to present the data and pick priorities. The Health Priorities Partnership 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. As a multiplier, 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, Chemung County's scores on the top health related issues in the county were:

Issue	Hanlon	Pearl
Cerebrovascular Disease (stroke)	**163.00**	**5.27**
Mental Health	**146.44**	**5.53**
Cancer - specifically lung, bronchus & ovarian	**146.06**	**5.19**
Obesity	**145.75**	**6.00**
Smoking	**143.67**	**6.06**
Substance Abuse	121.75	**5.88**
CLRD/COPD	121.75	**5.47**
Oral Health	109.13	4.81
Injuries	96.25	4.64
Teen Pregnancy	92.56	4.88
Behavioral problems in young children	85.81	4.13
STD's - gonorrhea	81.44	4.33

Chronic diseases such as heart disease, diabetes, stroke and some cancers are the most common and costly of all health problems, they are also the most preventable. Growing evidence indicates that a comprehensive approach to prevention can save tremendous costs, can save lives and can enhance the quality of life. There are four common modifiable behaviors that contribute to chronic illness, disability and premature death related to chronic disease. These are tobacco use, insufficient physical activity, poor eating habits and excessive alcohol use.
http://www.cdc.gov/chronic diseases/resources/publications/aag/chronic.htm

Community partners then narrowed their focus to discuss the top ranked issues (bolded above). In general, the discussion included the facts that CLRD/COPD, lung and bronchus cancer, and cerebrovascular disease would all be positively impacted to a certain extent if the top priorities to be addressed were obesity and tobacco use. Additionally, if the disparity chosen was to specifically target tobacco use among mental health patients, substance abusers and the low-income populations, we would be working to a certain extent to improve the health of two other priority populations identified above. So finally, after all of the above discussion and data review, the group decided to focus on the top two priorities of:

- Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%
- Reduce percentage of tobacco use, specifically cigarette smoking, among adults by 3% from 30.8% to 29.9%.

The disparity the partners chose to address was to:

- Reduce the percentage of lower income individuals who smoke including those with mental health and substance abuse issues.

Formulate Goals and Strategies

During this stage research and evidence-based best practices were considered by the Health Priorities Partnership 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 extensively 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 several month process, our partnership worked to develop a broad based plan to address our chosen priorities of reducing obesity and tobacco use. The Health Priorities Partnership 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.* *http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx* *and* *http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf*

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 many suggested activities from the State's "Prevent Chronic Disease Plan" such as creating community environments to support physical activity and improved nutrition and breastfeeding, and involving the clinical community in solutions.

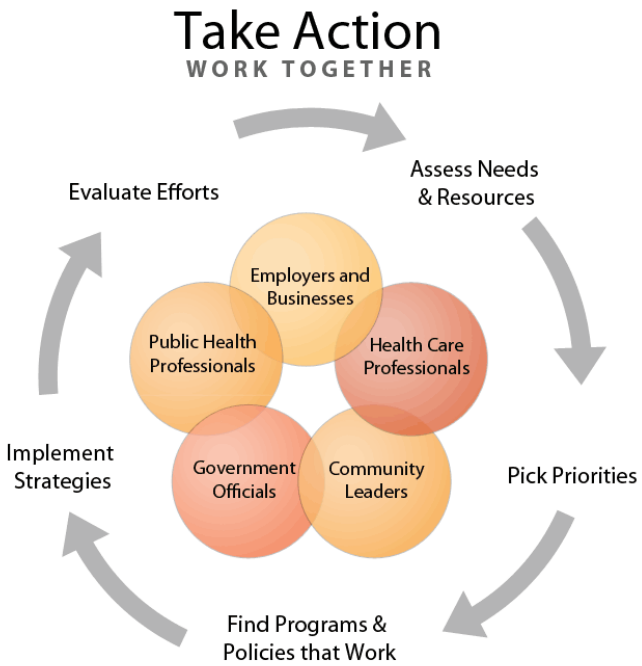
The CHIP Chart that follows in a few pages outlines the workplan to address both tobacco use and obesity in Chemung County.

One exciting aspect of the CHIP Chart is the unlimited possibilities offered by technological advances. Arnot Health and other local providers are beginning to implement Electronic Health Records (EHR). These EHR's will create a sea 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, 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, important 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, diet and tobacco use. Utilizing residents, we will conduct Continuing Medical & Nursing Education programs or Grand Rounds for health care professionals on these topics. 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. We will encourage referrals to the Diabetes Prevention Program (DPP) and Chronic Disease Self Management Program (CDSMP) and facilitate patient engagement though reminder calls and care coordination. 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 in their fight to reduce obesity and tobacco use.

As we pursue our CHIP we will continue to identify emerging best practices to reduce obesity and tobacco use. 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 CHIP Chart below.

Maintenance of Engagement



The Health Priority Partnership CHIP Chart designates the organizations that have accepted responsibility for implementing 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 Health Priorities Partnership have agreed to meet on a bi-monthly basis with the understanding that meetings may need to be held more frequently, and will maintain ongoing communication via emails and conference calls. This will help ensure that the initiatives outlined in this plan are implemented, monitored and evaluated. Progress will also be reported quarterly to the Board of Health, Chemung County Professional Advisory Committee and the Arnot Health Board. Activities on the work plan will be assessed and modified as needed to address barriers, to make mid-course corrections where needed and to duplicate successes. We will continue to monitor county, regional and state indicators and county health rankings to assess the CHIP's impact on the health of the community.

Community Health Improvement Plan

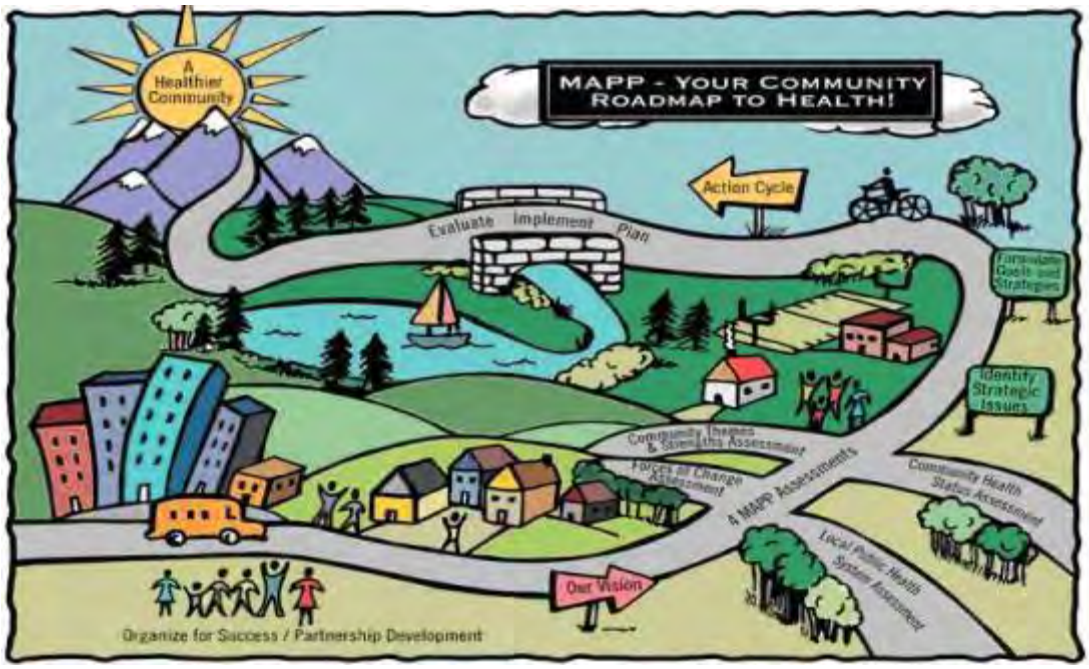
The Chemung County Health Priority Partnership spent several meetings developing and refining the attached CHIP Chart, the overall workplan for community health improvement. While many objectives will only focus on program-related measures, we have made sure to include measures that will specifically lead to improved health outcomes and help to achieve our goals of reducing smoking and reducing obesity in a very measurable way. As noted above we have included in our priorities themselves specific reductions in obesity and tobacco use:

1. Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%
2. Reduce percentage of tobacco use, specifically cigarette smoking, among adults by 3% from 30.8% to 29.9%.

In addition we have included the following breastfeeding goal:

- By December 2016, the number of WIC mothers breastfeeding at six months will increase by 5% from15.3% to 16%.

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



Community Health Improvement Plan

HP^2 is made up of Chemung County organizations committed to improving the health of Chemung County residents. Members include: Chemung County Health Department, Arnot Health, Guthrie Health, EMSTAR, Creating Healthy Places, Health On Demand, Comprehensive Interdisciplinary Developmental Services, Inc (CIDS), Family Services, Chemung ARC, Health Ministries of the Southern Tier, YWCA Chemung County DSS, Cornell Cooperative Extension, Eat Smart NY, Chemung County Dept. of Aging, Elmira College, Chemung County Mental Health, WIC, Cancer Services Program of Chemung & Schuyler counties, Arnot Tobacco Cessation Center, Southern Tier Tobacco Awareness Community Partnership (STTAC), Southern Tier Pediatrics, Chemung County Medical Reserve Corps., Community Mental Health Program at Family Services, Chemung County School Readiness Project, Economic Opportunity Program, Elmira City Council, Chemung County Poverty Reduction Coalition and community members.

Prevention Agenda Priority: Prevent Chronic Disease **Focus Area: Reduce Obesity in Children and Adults**					
Objective: Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%. (According to NYS 08-09 BRFSS, Chemung County (30.1%) currently exceeds the NYS average of 23.2%)					
Focus Area	**Goal**	**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.**	A.1 Create a breast feeding friendly environment in Chemung County: • Promote breastfeeding to WIC mothers. • Evaluate existing breastfeeding environment in Chemung County • Review hospital breastfeeding data and policies • Promotion of breastfeeding friendly environments in hospitals and businesses • Provide education re: breastfeeding such as through CIDS, Breastfeeding series (6 weeks) by Eat Smart NY offered to pregnant and breastfeeding moms. • Investigate the possibility of utilizing EHR/EMR's for actions such as adding breastfeeding resources or tracking documentation of breastfeeding education.	Health Priorities Partnership, WIC peer counselors, certified lactation consultants, WIC staff, hospital staff, Eat smart NY, CIDS, Possible Partners: Twin Tiers Breastfeeding Network, Ch. Valley LaLeche League, Chambr of Commerce	October 2014 - ongoing	By December 2016, the number of WIC mothers breastfeeding at six months will increase by 5% from15.3% to 16%. Education provided % of women exclusively breastfeeding in the hospital. # Businesses educated on breastfeeding supportive environment
		A.2 Utilizing residents, conduct Continuing Medical & Nursing Education programs or Grand Rounds for health care professionals, such as programs on healthy nutrition, physical activity, obesity and diabetes prevention & community resources.	HP2, Arnot Health, Guthrie Health Professional nursing organizations	October 2014 - ongoing	CME /Grand Rounds programs held, # of participants, # of CME's & CEU's earned.

Prevention Agenda Priority: Prevent Chronic Disease Focus Area: Reduce Obesity in Children and Adults					
Objective: Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%. (According to NYS 08-09 BRFSS, Chemung County (30.1%) currently exceeds the NYS average of 23.2%)					
Focus Area	**Goal**	**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.**	A.3 Provide and promote resource links on partner websites and social media that include supports for breastfeeding, increased opportunities for physical activity and healthy nutrition such as reducing fat, sodium and Sugar Sweetened Beverages (SSB,) and increasing fruit and vegetable consumption. Generate Community resource list of services to address overweight & obesity. • Promote ongoing resources, programs and active transportation initiatives such as Step It Up, FFIST, the Gold Shoe program, Get Active Elmira, bike racks on buses (CTRAN), Southern Tier Bicycle League bike racks & bike share program, bike to work days, Matter of Balance.	Health Priorities Partnership, CIDS, CCE, CHP	December 2014 - ongoing	# of partner websites with links to resources and programs on physical activity and healthy nutrition. Resource list developed
		A.4 Utilize earned media to promote Physical Activity and Healthy Foods and Beverages through public service announcements, local print, radio and television media, social media, news interviews and newsletters highlighting efforts. • Engage community leaders, stakeholders, businesses, agency heads, and elected officials to encourage them to establish environmental and policy changes and to promote physical activity (such as Complete Streets) and consumption of healthy foods and beverages.	Health Priorities Partnership, Eat Smart NY	July 2014 - ongoing	# of PSA's provided by partnering agencies. # of local print, radio & TV ads, interviews, letters to the editor, newsletters. # and level of leaders engaged
		A.5 Plan and implement initiatives and evidence based programs that promote physical activity and/ or healthy nutrition such as Eating Right is Basic, and Jumping Into Foods and Fitness. • Assess, plan and implement other evidence promising programs such as: Step It Up, FFIST, Gold Shoe, Bicycle Sharing Sheds and Strong Kids/Safe Kids. • Continue to apply for seasonal opportunities to increase utilization of Farmer's Markets	Health Priorities Partnership, Eat Smart NY	December 2014 - ongoing	# of programs, # of participants. # of participants with improved health outcomes.

Prevention Agenda Priority: Prevent Chronic Disease Focus Area: Reduce Obesity in Children and Adults					
Objective: Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%. (According to NYS 08-09 BRFSS, Chemung County (30.1%) currently exceeds the NYS average of 23.2%)					
Focus Area	**Goal**	**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.**	A.6 Partner with County & City officials to develop and implement a plan to rehabilitate, improve and promote parks, playgrounds and trails in underserved areas to offer safe, and accessible opportunities for physical activity for persons of all ages and abilities.	Health Priorities Partnership, Creating Healthy Places, DOT	November 2013 & Ongoing	Completion of improvement of at least 1 park
		A.7 Increase physical activity by improving street scale urban design for small geographic areas such as safe street crossings, use of traffic calming approaches, tactile ramps (Complete Streets).	Health Priorities Partnership, Creating Healthy Places	January 2014 & Ongoing	
		A.8 Establish or enhance community gardens & promote use t to encourage consumption of fruits and vegetables.	Creating Healthy Places, civic& faith based orgs.	March 2014 & ongoing	At least 2 gardens established/enhanced
		A.9 Conduct research to support evidence-based approaches to reducing obesity through research foundation partnership with Cornell University. Collect and analyze data on evidence based programs such as Diabetes Prevention Program and CDSMP.	Guthrie Health Arnot Health Health Priorities Partnership	January 2014 ongoing	Research conducted and findings published.
		A.10 Investigate joint use agreements with county schools. Create a list of current joint use agreements and resources open to the community.	Health Priorities Partnership, 4 County School districts Parent Partners	January 2014 - ongoing	# joint use agreements, list of resources available to community members (playgrounds, fitness equipment, etc.), provide info online.
		A.11 Investigate data on obesity prevention programs to strengthen the case on return on investment in obesity reduction programs and share findings with policy makers and businesses including Chamber of Commerce and Leadership Chemung.	Health Priorities Partnership	January 2015 Ongoing	Data analyzed and findings shared.

Prevention Agenda Priority: Prevent Chronic Disease Focus Area: Reduce Obesity in Children and Adults					
Objective: Prevent obesity trend from rising and aim to reduce the percentage of adults who are obese by 1% - from 30.1% to 29.8%. (According to NYS 08-09 BRFSS, Chemung County (30.1%) currently exceeds the NYS average of 23.2%)					
Focus Area	**Goal**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce Obesity in Children and Adults	**B. Expand the role of health care and health service providers and insurers in obesity prevention.**	B.1 Educate and provide resources to health care professionals as a way to talk with their patients about their weight, nutrition, physical activity and disease prevention & management. Investigate use of "prescription pads" for health care providers to include need / resources for physical activity and healthy nutrition including Chronic Disease Self Management and Diabetes Prevention Program.	Health Priorities Partnership, Arnot Health, Guthrie Health, Health On Demand	June 2014 ongoing	# health professionals educated # resources disseminated
		B.2 Once EMR/EHR system is completed and operational, investigate the possibility of providing obesity prevention and community resources to persons who are overweight, obese and / or at risk for diabetes. Encourage referrals to Diabetes Prevention Program (DPP) and Chronic Disease Self Management Program (CDSMP). Facilitate patient engagement though reminder calls and care coordination.	Arnot Health, Guthrie Health Human Services Committee	December 2014 - ongoing	Monitor and evaluate usage.
		B.3 Educate providers and the public on Medicare coverage for obesity counseling to patients with a BMI over 30 and for preventative health screenings.	Health Priorities Partnership	January 2014 - ongoing	Methods used to disseminate information
		B.4 Encourage public to investigate their health promotion coverage under their insurance policy	Health Priorities Partnership	June 2014 – ongoing	Methods used to educate public
		B.5 Recruit new members and sustain HP2 Partnership through ongoing communication and at least bimonthly meetings.	Health Priorities Partnership New partners	January 2014- ongoing	# new partners recruited Minutes of meetings

Prevention Agenda Priority: Prevent Chronic Disease Focus Area: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure. Disparity: Reduce percentage of lower income individuals who smoke including those with mental health and substance abuse issues.					
Objective: Reduce percentage of tobacco use, specifically cigarette smoking, among adults by 3% from 30.8% to 29.9%. (According to NYS 08-09 BRFSS, Chemung County (30.8%) currently exceeds the NYS average of 17%)					
Focus Area	**Goal**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce illness, disability and death related to tobacco use and second hand smoke exposure	**C. Reduce exposure to secondhand smoke.**	C.1 Avocacy: • Invest in efforts to create smoke-free environments throughout the community, encouraging Chemung County government to lead by example. • Provide support to community partners to adopt tobacco-free outdoor policies	Health Priorities Partnership STTAC	January 2015 - ongoing	By October 2014, four tobacco free outdoor policies will be adopted. Links to policies will be posted.
		C.2 Highlight dangers of tobacco through • Public service announcements and earned media • Promote media campaigns with hard-hitting cessation messages and the importance of tobacco free outdoors.	Health Priorities Partnership, STTAC, Arnot Cessation Center	July 2014 ongoing -	# PSA's provided, # campaigns held
		C.3 Investigate the possibility of providing landlords throughout the county & local municipalities with guidelines on how to make their properties smoke free	Health Priorities Partnership STTAC City of Elmira	October 2014 ongoing	# landlords receiving guidelines. #smoke free properties.

Prevention Agenda Priority: Prevent Chronic Disease Focus Area: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure. Disparity: Reduce percentage of lower income individuals who smoke including those with mental health and substance abuse issues.					
Objective: Reduce percentage of tobacco use, specifically cigarette smoking, among adults by 3% from 30.8% to 29.9%. (According to NYS 08-09 BRFSS, Chemung County (30.8%) currently exceeds the NYS average of 17%)					
Focus Area	**Goal**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce illness, disability and death related to tobacco use and second hand smoke exposure	**D. Promote tobacco cessation, especially among low SES populations and/or those with mental health illness.**	D.1 Promote cessation counseling to community residents targeting people with disabilities, mental health and substance abuse problems. • Promote NYS Smokers' Quitline. • Provide tobacco cessation information / education to clients of organizations such as home care, CIDS, hospital patients, Health Ministry of the Southern Tier, Cancer Services Program, etc. • Advocate with organizational decision makers of health care facilities and programs that provide services for people of lower SES, and/or mental health to adopt system changes that identify, refer, and treat tobacco users according to the U.S. Department of Health and Human Services Public Guidelines for Treating Tobacco Use and Dependence. • Provide community education, discrete events, earned media and other ways of disseminating information to the public and health care providers • Develop community resource list of services for tobacco cessation • CIDS will continue to work with parents re: going outside the home to smoke to decrease exposure to secondhand smoke. Work with Homecare agencies to encourage caregivers of clients to smoke outside the home.	Health Priorities Partnership, Arnot Tobacco Cessation Center, Cancer Services Program Health Ministries of the Southern Tier, CIDS	July 2014 ongoing	# NYS Smokers Quitline calls. #agencies/organizations participating in tobacco cessation education to clients. Resource list developed

Prevention Agenda Priority: Prevent Chronic Disease Focus Area: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure Disparity: Reduce percentage of lower income individuals who smoke including those with mental health and substance abuse issues.					
Objective: Reduce percentage of cigarette smoking among adults.					
Focus Area	**Goal**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	**E. Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations.**	E.1 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.	Health Priorities Partnership, STTAC	July 2014 ongoing	# activities held and/or events attended.
	F. Encourage providers to talk with their patients about tobacco cessation.	F.1 Once EMR/EHR system is completed and operational, investigate the possibility of providing community resources for tobacco cessation.	Arnot Health, Guthrie Health, Arnot Tobacco Cessation Center	December 2014 – ongoing	Monitor and evaluate usage.
		F.2 Communicate with and Influence decision makers and advocate for change in their organizations' policies, programs, or practices by offering education, training and technical assistance with adopting system-level changes that foster comprehensive tobacco dependence treatment.	Arnot Health, Guthrie Health, Arnot Tobacco Cessation Center	December 2014 - ongoing	Monitor and evaluate usage.

Prevention Agenda Focus Area: Prevent Chronic Disease Objectives: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure Disparity: Reduce smoking rates in lower income individuals including those with mental health and substance abuse issues					
Decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students					
Focus Area	**Goal**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	G. Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations	G.1 Utilize local media to promote education on youth smoking and the impact of tobacco marketing.	Chemung County Health Dept., STTAC	July 2014 - ongoing	# media contacts made, # stories published
		G.2 Educate community leaders and policymakers on the problems of youth smoking and the impact of tobacco marketing on youth smoking.	Health Priorities Partnership Chemung County Health Dept., Arnot Health, Guthrie Health, STTAC	July 2014 - ongoing	# educated
		G.3 Conduct a Youth POS and TFO survey in local schools and/or youth centers/organizations.	Health Priorities Partnership Chemung County Health Dept., STTAC	July 2014 - ongoing	# schools/youth organizations surveyed, # surveys collected
		G.4 Educate and engage a youth focused organization to attend and speak during a legislature/board of health/council meeting, write letters to editor, educate their network and/or educate community members	Health Priorities Partnership Chemung County Health Dept., STTAC	July 2014 - ongoing	Organization engaged, meeting attended or letter written