St. James Mercy Hospital
Community Service Plan
2013 – 2015

January 2015
Progress as of 12/31/14

St James Mercy Hospital

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Executive Summary

Hospitals in New York State are required by the Department of Health to create and publicly distribute an annual "Community Service Plan," which identifies and describes progress toward collaboratively meeting health priorities in their service areas. The progress of these activities must be reported annually for three years through updates of the Community Service Plan to the Department of Health and publicly. 2013 marks the first year of the three-year cycle.

In 2012, St. James Mercy Hospital (SJMH) collaborated with community health agencies in an eighteen-month Community Health Assessment to identify and prioritize health care needs in Steuben County (comprising a significant portion of SJMH's primary service area) for the next three years. This comprehensive process, based on the NYS 2013 – 2017 "Prevention Agenda" initiative, was coordinated by Steuben County Public Health and included the three county hospitals (St. James Mercy Hospital, Corning Hospital, Ira Davenport Memorial Hospital), area health organizations, and local residents.

The process of collecting data, soliciting opinions, facilitating a process, and guiding a discussion helped determine not only what the most pressing problems facing county residents are, but also what can be effectively and efficiently addressed. In the end, SJMH, Steuben County Public Health and the partner agencies identified two challenging areas under the New York State Department 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:

Promote tobacco cessation, especially among low SES (socioeconomic status) 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 NYS 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.
- Healthcare to treat obesity-related illnesses and conditions cost the United States an estimated $150 billion and NYS more than $7.6 billion every year.[2]

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] Public health officials across the state and the nation must take steps to address this rising epidemic. Without strong action to reverse the obesity epidemic, children may be facing a shorter lifespan than their parents.

Heart Disease Prevalence

Cardiovascular Disease (CVD) is the leading cause of death in the United States and in NYS. In New York State, CVD killed almost 59,000 residents in 2007. 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

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

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 effectively address obesity and heart disease will mean premature death and disability for an increasingly large segment of Steuben County residents.

SJMH and Steuben County Public Health along with their partners have developed a Community Health Assessment and Improvement Plan (specific to Public Health) and Community Service Plan (specific to SJMH) to address these issues.

SJMH's three-year plan of action (aka Community Service Plan) to address the priorities includes the following programs, in addition to supporting community health initiatives and activities led by Steuben County Health Priorities Team:

Reduce Adult Obesity

a. Breastfeeding Education

SJMH participates in the Healthy People 2020 maternal/infant health initiative to promote breastfeeding as the most complete form of nutrition for most infants and a healthy approach to maternal weight control. SJMH staff will promote national "Baby Friendly Hospital" standards, focused on educating parents in the importance of breastfeeding and decreasing the use of pacifiers and formula. This initiative is in collaboration with local health organizations including WIC (Women, Infants and Children), Public Health Nursing, Lamaze educators, and the MOMS (Medicaid, Obstetrical and Maternal Services) program.

Reduce Heart Disease

a. Chronic Heart Failure (CHF) Reduction Program

SJMH is expanding its patient education resources to 1) reduce cardiac readmissions, complications and emergency room visits, and 2) improve overall rehabilitative outcomes through the establishment of post-discharge monitoring of CHF patients, development of an in-house patient education center, and enhanced outpatient referral services to help patients better manage their cardiac disease and prevent unnecessary admissions.

b. Heart Disease Support Group

SJMH will create a community-based Heart Disease Support Group to supplement ongoing education and behavior modification efforts initiated during hospitalization, ultimately to achieve long-term maintenance of changed behavior and better health.

Reduce Tobacco Use With Low Income/Mental Health Populations

a. Tobacco Use Assessment with Adolescent Outpatients

SJMH is initiating a program to address adolescent tobacco use with low-income patients as part of a new outpatient behavioral health outreach initiative, integrating evidence-based tobacco use screening, cessation assistance, referral to services, and tracking of patients' success to reduce or eliminate tobacco use among adolescents.

The specific three-year plans with measurements for these four programs are detailed in full in the body of the Community Service Plan, and will be updated annually and communicated publicly. In addition, the Steuben County Health Priorities Team 2013 – 2015 Work Plan is attached (appendix A). SJMH and its partners will continue to meet regularly and work collaboratively to address the identified healthcare priorities.

[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/

St. James Mercy Hospital Community Service Plan

Mission Statement

Faithful to our sponsor, the Sisters of Mercy, St. James Mercy Hospital, a member of CHE (Catholic Health East) Trinity Health, is a community of persons committed to being a transforming, healing presence within the rural communities we serve, particularly addressing the needs of the poor, underserved and disadvantaged.

Definition of the Community Served

Located in the rural Southern Tier of New York State in Steuben County, SJMH is the sole community provider within its service area. The primary service area for SJMH is the 15-mile radius extending from Hornell (zip code 14843), and includes the towns of Wayland to the northeast and Troupsburg to the southeast (just outside of the 15-mile radius). The secondary service area is the 30-mile radius extending from Hornell.

The population for Steuben County remains relatively flat, increasing 0.3% from 2000 to 2010 to 98,990 and is projected to remain flat through 2014 (*2010 Census*). The population aged 65 and over comprises 16% of the county compared to 13% for New York State population (*2010 Census*). Steuben is one of the most economically challenged counties in NYS with unemployment of 8.2% (*August 2013, NYS Dept. of Labor*).

Public Participation Process

Led by the S²AY Rural Health Network, SJMH and Steuben County Public Health Department along with local 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).

In early 2012, key Steuben County partners were brought together to become familiar with the MAPP process and determine pertinent local questions. Steuben County Public Health Department invited participants from a wide range of the organizations – aka "Steuben County Health Priorities Team", comprised of entities that are committed to improving the health of county residents:

- Steuben County Public Health Department
- St. James Mercy 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

During the process this group met on a bi-monthly basis to collaboratively critique and assist in promoting and executing the community health needs assessment, which led to the development of the Steuben Health Priorities Team Work Plan. The Team continued to meet bi-monthly through 2013 to ensure that the initiatives outlined in the Work Plan are able to be implemented, monitored and evaluated.

Assessment and Selection of Public Health Priorities

Four assessments inform the entire MAPP process using both qualitative and quantitative methods. The first assessment examined the Community Health Status Indicators through two methods: collecting relevant statistical data using the New York State Department of Health (NYSDOH) Community Health Indicator Reports and a variety of other secondary sources (completed by S²AY Rural Health Network staff), and collecting 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 through other community groups. The survey encompassed questions in the five Prevention Agenda areas that the 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 (Centers for Disease Control) and NACCHO (National Association of County and City Health Officials). 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 third assessment was the Community Themes and Strengths Assessment that was conducted through focus groups held throughout the County, and looked at the issues that affect the quality of life among community residents and the assets Steuben County has available to address health needs. The focus groups 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.

Once 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 select priorities. The 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. This was accomplished using the Hanlon Method, which focuses most heavily on how effective any interventions might be, utilizing 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.

Emphasis is placed on effectiveness of the solution, 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 Team participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. While the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since Team 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 health concerns, but concentrated on the top ranked issues. After reviewing, discussing and considering county assessments, data, and previous initiatives the Team decided to focus on the top two priorities of:

1. **Reduce obesity in children and adults**
2. **Reduce heart disease and hypertension**
3.

And the following disparity:

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

Prevalence of the Problems in Steuben County

- 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.
- Healthcare to treat obesity-related illnesses and conditions costs the United States an estimated $150 billion and NYS more than $7.6 billion every year.[6]

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%.[7] Public health officials agree this is a rising epidemic.

Cardiovascular Disease (CVD) is the leading cause of death in the United States and in the state. In NYS, CVD killed almost 59,000 residents in 2007. For every person who dies from a heart attack, 18 people survive. For every person who dies from a stroke, seven survive. Many 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.[8] 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.[9] 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 effectively address obesity and heart disease will mean premature death and disability for an increasingly large segment of Steuben County residents.

Identified 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 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 was utilized. This approach describes the impact of different types of public health interventions and provides a framework to improve health.

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 three years. Strategies proposed are evidence-based or promising practices. They include activities currently underway by partners and new strategies to be implemented collaboratively. Members of the Steuben Health Priorities Team have agreed to meet on a regular bi-monthly basis to ensure that the initiatives are implemented, monitored and evaluated. Progress will also be reported annually to NYSDOH and SJMH Board of Directors, with modifications made as needed to address barriers and duplicate successes.

[6] New York State Dept. of Health Obesity Prevention http://www.health.ny.gov/prevention/obesity/
[7] New York State Dept. of Health New York State Community Health Indicator Reports - Obesity and Related Indicators http://www.health.ny.gov/statistics/chac/indicators/obs.htm
[8] New York State Dept. of Health Cardiovascular Disease https://www.health.ny.gov/diseases/cardiovascular/heart_disease/
[9] New York State Dept. of Health New York State Community Health Indicator Reports http://www.health.ny.gov/statistics/chac/indicators/

St. James Mercy Hospital's Three-Year Plan

As a result of the collaborative community health needs assessment coordinated by Public Health, SJMH will implement the following three-year action plan. Also attached for reference is the Steuben Health Priorities Team Work Plan that Public Health is submitting, to further illustrate the collaborative efforts to work towards goals and track progress.

Note: SJMH currently does not have an electronic medical record (EMR) system in place for expedient and accurate data collection and tracking. Through an affiliation with a larger health system, SJMH can add this capability in the future and/or utilize the data mining capabilities of its collaborative partners for data tracking. Therefore, most of SJMH's program tracking (i.e. health outcomes) will be tracked manually and on a smaller scale.

Reduce Obesity in Children and Adults

St. James Mercy Hospital currently participates in various efforts to address obesity. For example, SJMH staff coordinate an annual pediatrics health fair in collaboration with the Kiwanis Club "Kids' 1/4 Miler". This event promotes childhood fitness and nutrition, and attracts 300 attendees and 15 community groups. Several local organizations are developing childhood fitness and obesity reduction programs, and SJMH is evaluating if and how it can provide support and/or referrals to these programs. SJMH is also exploring sponsorship of a national non-profit initiative to introduce lifetime fitness education to underserved county school districts. The funding of this initiative may involve collaboration with other community organizations.

In regards to adult obesity, SJMH is spearheading the following collaborative program:

b. Breastfeeding Education

SJMH actively participates in Healthy People 2020, an initiative from the Department of Health & Human Services utilizing science-based, 10-year objectives to improve the health of all Americans. Specifically, SJMH participates in the maternal/infant health objective through promotion of breastfeeding as the most complete form of nutrition for most infants and a healthy approach to maternal weight control. Healthy People 2020 is targeting a breastfeeding rate of 80% at post-delivery.

Even as a small rural facility, SJMH has been a strong proponent of breastfeeding for the last fifteen years and is currently at 70% post-delivery. Staff will promote national "Baby Friendly hospital" standards, focused on educating parents in the importance of breastfeeding and decreasing the use of pacifiers and formula. SJMH is strengthening its position as a Baby Friendly Hospital by collaborating with local organizations:

- **WIC** (Women, Infants and Children) clinic through ProAction of Steuben and Yates counties, which promotes the health of women, infants and children through the provision of nutritious foods, nutrition education, healthcare referrals and other services: SJMH fills out the WIC qualification forms for new mothers, and assists in addressing concerns relative to WIC services.
- **Public Health Nursing**: SJMH assists in assessing breastfeeding, and provides support and education to supplement Public Health's program.
- **Lamaze**: SJMH is providing resources to instruct pregnant women on breastfeeding during childbirth classes.
- **MOMS** (Medicaid, Obstetrical and Maternal Services) program: Located at SJMH, the MOMS program provides comprehensive prenatal education and resources, including instruction with an on-site International Board Certified Lactation Consultant/IBCLC.

The three-year plan is designed as follows:

2013 objective: Reduce participation in commercial promotion of formula, pacifiers and related products. Screen maternity patients for ongoing breastfeeding education needs. Build a database and mechanism to track post-discharge breastfeeding outcomes.

2014 objective: International Board Certified Lactation Consultants/IBCLC offer public presentations at community health fairs and community education days on breastfeeding and community resources. Provide educational materials to area clinicians and women's health patients and develop public service announcements around breastfeeding. Continue offering monthly breastfeeding education at childbirth classes with an ultimate goal of initiating a breast feeding support group in 2014.

Update 2014: *Through November 2014, 212 live births occurred at SJMH with 151 mothers continuing to breastfeed prior to discharge from the hospital, or 71% at post-delivery.*

2015 objective: Modify promotion efforts as necessary and expand to additional sites as determined.

Outcomes/Measurement: Achieve 80% breastfeeding rate at post-delivery (prior to discharge).

Reduce Heart Disease

c. Chronic Heart Failure (CHF) Reduction Program

SJMH is committed to giving patients with a diagnosis of chronic heart failure (CHF) the tools they need to manage their health and improve quality of life. Through its Chronic Heart Failure Reduction Program, SJMH works closely with clinicians, dietitians, patients and families to monitor symptoms, activity, diet and medications. Key to success of the program is patient education that is evidenced-based, current and user-friendly. SJMH is expanding its patient education resources to reduce cardiac readmissions, complications and emergency room visits, and improve overall rehabilitative outcomes.

The three-year plan is designed as follows:

2013 objective: Develop inpatient education criteria to enhance the rehabilitative process of chronic heart failure (CHF) patients post-discharge.

Update 2013: *A Chronic Heart Failure education booklet was developed to educate inpatients admitted with a diagnosis of CHF.*

2014 objective: Provide inpatient education for those admitted with CHF to help patients and their families better manage their disease process post-discharge and prevent avoidable readmissions.

Update 2014: *SJMH launched access to the Patient Channel®, a 24-hour network that provides free, in-room education on CHF and chronic disease topics. This educational tool is regularly utilized with patients admitted with CHF and provided free of charge post-discharge for ongoing disease management.*

2015 objective: Establish CHF criteria classification and staging criteria for SJMH's inpatient population on admission and stage each patient on as part of the care plan. Nursing staff will educate patients with CHF related to their stage and more directly speak to management related to that stage. Admission with a diagnosis of CHF will trigger a referral for outpatient cardiac rehabilitation.

Measurement: Create the infrastructure to reduce the incidence of stage II chronic heart failure patients advancing to stage III acute admissions. Tracking and measurement will be driven by the overall use of the education programs and heart failure admissions. When chronic heart failure criteria are established, SJMH will begin to track categories of patients admitted, leading to monitoring of admissions based on stage/severity. Ultimate goal is to reduce admitting stage III patients by 20%.

Outcomes/Measurement:	2013 acute care admissions for CHF	3.3%
	2014 YTD acute care admissions for CHF	2.8%

d. Heart Disease Support Group

Community-based heart support groups provide education, information and encouragement to cardiac patients and their families for coping with the physical and emotional stresses of cardiovascular disease. SJMH will create a community-based Heart Disease Support Group to supplement ongoing education and behavior modification efforts initiated during hospitalization, ultimately to achieve long-term maintenance of changed behavior and better health.

The three-year plan is designed as follows:

2013 objective: Begin developing criteria for establishing a local Heart Disease Support Group, with focus on outpatients in their early post-discharge or long-term maintenance period.

Update 2013: *25 patients enrolled in the SJMH cardiac rehabilitation program were offered enhanced heart disease education to help them recognize potential symptoms and avoid unavoidable admissions.*

2014 objective: Develop a local Heart Disease Support Group that is accessible to patients, families and community members to facilitate improve maintenance of their disease.

Update 2014: *In November 2014 SJMH launched a Hornell-based Chronic Heart Failure (CHF) Support Group to assist patients and caregivers in managing the physical and emotional aspects of chronic heart failure. The group will meet monthly and the program will be marketed to local healthcare providers.*

2015 objective: Implement the marketing strategy to drive referrals and elicit clinicians' participation in the program (as speakers, etc.). Expand geographic outreach to establish a similar group in the Bath area.

Outcomes/Measurement: Reduce the rate of cardiac-related complications and hospitalizations by 50% among support group participants who have experienced a cardiac event.

Reduce Tobacco Use With Low Income/Mental Health Populations

b. Tobacco Use Assessment with Adolescent Outpatients

Child health care clinicians are in a unique and important position to address parental and adolescent smoking. SJMH is initiating a program to address adolescent tobacco use with low-income patients as part of a new outpatient behavioral health outreach initiative. The strategies will integrate evidence-based tobacco use screening, cessation assistance and referral to services. A tobacco use assessment will be included as part of the psychiatric screening in three SJMH outpatient offices. Adolescent patients who use tobacco will be offered consultation, primary treatment (i.e. medications) and family counseling.

SJMH's three-year plan is designed as follows:

2013 objective: Develop the program goals, assessment tool, tracking tool and infrastructure with anticipated rollout in calendar year 2014.

Update 2013: *The program was outlined for implementation in 2014 and a measurement tool was developed.*

2014 objective: Engage SJMH adolescent psychiatrist to identify tobacco users among low-income patients (ages 11 – 17), by documenting smoking status during mental health consultations at three clinical offices. Gather data about tobacco use, assess patients' interest in quitting smoking and acceptance of cessation assistance, and provide educational materials and information on free or low-cost cessation services and products. Recommend pharmacotherapy, as appropriate, for relief of

withdrawal symptoms and to aid cessation. Provide documentation in patient charts for manual tracking of the program.

Update 2014: *In December 2013, SJMH's inpatient psychiatric units were closed and the psychiatrists were released from employment. Thus, there were no providers available to implement the program.*

2015: The initial plan was to track and document success of patients' smoking cessation efforts during follow up visits with primary care providers, and train pediatrics clinicians to conduct smoking assessment and counseling. With the termination of the staff psychiatrists the program will not be implemented by SJMH.

Measurement: SJMH will track the number of adolescent psychiatric patients in three outpatient clinics assessed positive for tobacco use; number who receive smoking cessation information and assistance information; and number who actually stop using tobacco within one year of clinical interaction. Caveat: The ability to maintain information on patients over a three-year period will be wholly dependent upon continued use of SJMH's adolescent psychiatrist or a primary provider in the Hospital system. In addition, once patients reach the age of 18 SJMH will be unable to follow them. Creating a position of smoking cessation coordinator would greatly enhance program results, but SJMH currently cannot fund this position without State or other assistance. Program has been terminated due to lack of providers.

Dissemination of the Plan to the Public

SJMH will disseminate its Community Service Plan (CSP) and annual updates in a variety of ways including the employee intranet, public website (www.stjamesmercy.org) and e-mail. Notices of availability will be placed with the local media. Copies of the CSP will be made available to the Health Association of NYS (HANYS), appropriate CHE (Catholic Health East) Trinity Health administration, and SJMH administration and management. SJMH staff and physicians will be notified that the CSP is posted on the employee intranet. The CSP will also be made accessible to local community leaders and organizations such as the mayor of Hornell, mayor of North Hornell, Hornell Chamber of Commerce, Hornell Partners for Growth, St. James Mercy Hospital Board of Directors, St. James Mercy Foundation Board of Directors, St. James Mercy Properties Board of Directors, Catholic Charities, Steuben Rural Health Network, and Steuben County Health Priorities Team. Portions of the plan will be used for business development activities and presentations. SJMH will track and evaluate progress of its plan of action on an annual basis, make mid-course corrections and additions as appropriate, and submit/post updates to interested parties as noted above.

Process to Maintain Engagement with Local Partners

SJMH will continue to actively participate as a member of Steuben County Health Priorities Team, comprised of key partners from a wide range of health/social service organizations throughout the county:

- Steuben County Public Health Department
- St. James Mercy 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

This group will continue to meet regularly to ensure that the initiatives outlined in the Steuben Health Priorities Team Work Plan are implemented, monitored and evaluated, and to provide support to Team members for internal initiatives. SJMH will also maintain close working relationships with the community partners outlined in its individual Community Service Plan to ensure effective utilization of resources and track progress toward addressing county health priorities.

For more information on this report contact:

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2013 – 2015 Steuben Health Priorities Team Work Plan (of which SJMH is an active member)

Updated 12/2/14

Participants: Steuben County Public Health, S2AY Rural Health Network, Health Systems for Tobacco Free Finger Lakes, Corning Hospital, St. James Mercy Hospital, Guthrie Healthcare, Arnot Health, Southern Tier Tobacco Awareness Coalition, Steuben County Cancer Services Program, Cornell Cooperative Extension, ProAction of Steuben and Yates, Steuben County Legislature, Steuben Rural Health Network

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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, Strong Kids Safe Kids, Girls on the Run, 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	Provide baseline #'s Provide promo info Report participation	Arnot	12/9/14	2013 Davenport & Taylor run had 138 participants. 2014 event took place September 20th. Wineglass Marathon: More than 6,000 people registered. Arnot Health's rehab services dept. attended and performed free "Functional Movement Screenings." Approx. 200 screenings were performed.
				Provide baseline #'s Provide promo info Report participation	Guthrie	12/9/14	Approx. seven "Walks with the Doc" last year, average participation 20+ per. One event in conjunction with Walk a Mile Suicide Prevention Walk. Presented Lyme Disease with 20-30 attending. Pop Can Fun Run estimated about 250 participants.
				Provide baseline #'s Provide promo info Report participation	SJMH	Recurring 1/1/15	SJMH hosted its annual pediatrics fair / kids ¼ miler event on 5/17/14 for ages 2–12. Total number served was approximately 800.
				Provide baseline #'s Provide promo info Report participation	SCPH	12/9/14	September 2013: 328 children and their families attended September 13, 2014 is next event See promotional materials attached to email to post and promote SCPH also received funds through Tyrtle Beach to pay for registrations for youth for

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							events such as these. Please disseminate promotional materials. Noted since SKSK is FREE, can the hospitals participate. Noted SRHN is a vendor and noted someone from Ira would be there. The SKSK committee is looking for funds for a Rock Climbing wall. Reminded the group of the funding available for youth runs / walks from Tyrtle Beach through Public Health. Strong Kids Safe Kids: Sept 13, 2014: 350 kids + their families. SCPH fitted 98 kids ages 2 -12 with bike helmets.
				Provide baseline #'s Provide promo info Report participation	SRHN	8/15/14 Recurring 11/15/14	400 runners, 100 volunteers, and 800 spectators on 6/8. Approx. $4,000 in sponsorships. 150 participants are expected this fall with 2 teams from Hornell Intermediate and one from Bradford. 5K event will be held on the first Sunday in November.
				Provide baseline #'s Provide promo info Report participation	Hornell CSD Pace	10/1/14	Carol M. White Pep grant is ending, but believed a 21st Century grant is in place. PACE grant ended in Hornell. Still have a 21st Century grant in 5 school districts: Bradford, Campbell-Savona, Canisteo-Greenwood, Hornell, and Addison. Grant incorporates physical activity with study and extra-curricular activities**.** 21st Century Grant in 2013: 538 total participants registered. 338 attended 90 hours or more.
				Provide baseline #'s Provide promo info Report participation	Hornell YMCA	10/1/14	Fit & Fun is part of the Pace grant and YMCA is the contact. Question arose if Girls on the Run was taking the place of Fit and Fun. Will contact YMCA to find out about Fit and Fun status and participation #s.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	Resources provided Online resource guide created Partners post link Track hits	SCPH	9/3/14	The S2AY GRHF proposal was not funded, but it will be resubmitted in September. Seneca County has a moving motion map. There has been a Bike and Hike Committee created in the County, but has not met since March. Several sites up and running with most of the information and links: http://www.fingerlakes.org/things-to-do/outdoor-fun/hike-and-bike and http://www.corningfingerlakes.com/trip-ideas/hiking-and-biking . Contacted Corning Finger Lakes site administrator to see if we could promote their site and suggestions additions as we find them; in process of scheduling a meeting. Corning Finger Lakes is very receptive to working with us and has good ideas, including refurbishing bikes to give out, possibly applying for Tyrtle Beach funds to purchase used bikes for children, creating meet up groups to do outdoor activities. Electronic formats for any known trails that were not on the website were requested. SCPH will attend another meeting with Corning Finger Lakes and partners to discuss possible ventures, as well as Hike and Bike Committee. S2AY Rural Health Network resubmitted the grant proposal to the GRHF for mapping software. It was accepted; awaiting final approval to announce it as official.
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	Write LOS's?	HMST	Recurring 2/10/15	SCPH spoke with Health Ministry Southern Tier who was not familiar with the initiative; work has not progressed. No one was familiar with how the activity came to be in the plan. The issue was tabled until next meeting. Confirming process for creating Rails to Trails

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							like was done with the Lackawanna Rail Trail.
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.)	Report media efforts quarterly	Arnot	12/9/14	Updates forthcoming
				Report media efforts quarterly	Guthrie	12/9/14	Media report provided by Corning Hospital.
				Report media efforts quarterly	SJMH	12/9/14	SJMH implemented a digital marketing program in Aug. that includes social media networks, which will be used to drive awareness and participation in county-wide health initiatives among multiple organizations. Information was added to the media spreadsheet for September's meeting.
				Report media efforts quarterly	SCPH	12/9/14	SCPH is active on Facebook and Twitter and has done interviews with WENY (May on Wellness Fair and August on immunizations), and radio interviews in May for World No Tobacco Day. Press releases were sent to media contacts regarding scholarships available for run/walk events.
				Report media efforts quarterly	SRHN	12/9/14	Updates forthcoming
				Report media efforts quarterly	Others	12/9/14	Updates forthcoming
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,	Sample MOU List of school superintendents Letter developed and	S2AY SCPH	10/7/14 1/15/15	Group discussed hesitancy some have in signing MOU's – recommended letters instead. S2AYsent SCPH template letter for schools regarding joint use agreements. SCPH will review and revise as needed to make an

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
			basketball courts, etc.), provide information online and track hits	sent Responses tallied	S2AY	 2/1/15	informational letter rather than an MOU.
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, Superintendent of schools	April 2014 - ongoing	# of staff trained, funding secured, equipment purchased	Provide baseline #'s Seek other funding? Provide promo info Report participation	Guthrie	8/15/14 Recurring 12/9/14	Meeting is scheduled with the superintendent in Sept. to discuss direction. Continual problem with lack of PE teachers. Corning - Painted Post school district may apply for pep grant in March.
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	Report current BF status Become BF friendly Add BF to EMR's Track usage	Arnot	12/9/14	Arnot reported 3 were attending the CLC training and they are still working on EMRs. Several staff are trained and a BF committee meets monthly.
				Report current BF status Become BF friendly Add BF to EMR's Track usage	Guthrie	12/9/14	Corning Hospital is in transition and actively recruiting next leader for Labor and Delivery. Spoke w/ L&D, have 8 out of the 10 requirements met for becoming BF Friendly. Goal in the next 2 years to have all healthcare staff trained in regards to BF practices; currently 7 out of 11 nurses are certified. Identified local BF group that meets at the Southeast Steuben County Library in Corning the 1st Thursday and the 3rd Thursday. Anyone is welcome to attend. They also have a closed group on Facebook where mothers can get support. S2AY Network received a grant and is applying for a second round of grant funding for Baby Cafes where new moms or supporters can meet and receive information or guidance about BF as needed. The Baby Cafes require the presence of CLCs and an

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							IBCLC to at least be on call. There are no La Leche Leagues in Steuben County, but there is one that meets monthly in Horseheads. http://lllofnylocal.weebly.com/chemung-county.html
				Report current BF status Become BF friendly Add BF to EMR's Track usage	SJMH	12/9/14	SJMH reported they have 2 CLCs on staff and close to 70% BF on discharge. EMR's are currently on hold until future plans are determined. SJMH is actively involved in the NYS Baby Friendly initiative, and to-date 83% compliant with obtaining consents for supplements when a baby is breastfed.
				Provide baseline data Provide promo info Report participation	WIC	12/9/14	WIC reported awarding six local businesses for being BF friendly and are launching a pilot project to increase BF. Working with ProAction and Public Health to get daycares certified.
				Report current BF status Provide promo info Report participation	SCPH	12/9/14	(Regional BF Coalition) SCPH said 2 people from Public Health were attending the S2AY BF training. Regional BF group is working on BF friendly daycares and centers. 32 attendees were CLC trained under the S2AY grant and an additional 9 were trained outside of the grant funding. Yates and Ontario are planning on opening Baby Cafes, which are spaces manned by professionals (IBCLC, CLC, peer counselors, etc.) to aid in any BF support and direct new mothers or advocates to resources. Pregnant women, breastfeeding and formula feeding mothers are all welcome. Nurses from SCPH attended the CLC training. They have been going out on baby visits and helping mothers with breastfeeding concerns. Another avenue to explore is Breastfeeding Friendly Practices. Need to identify recognized

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults A. Create community environments that promote and support healthy food and beverage choices and physical activity							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							BF champions in provider offices. Suggestions made to contact Finger Lakes Breastfeeding Partnership. Thoughts were to start with pediatrics, OB/GYNs, and family practitioners. Need to confirm if there are identifiable champions in Guthrie OB and family practices. It was believed there were no CLCs in offices in Steuben currently. Contacted all family practices in Hornell, but did not get a response. Plans to follow up.
				Report current BF status Identify BF opportunities & develop strategies to implement	Committee	1/1/15	Suggested looking at other states such as North Carolina which has good statistics.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults B. Expand the knowledge base of partners in obesity prevention							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
B1. Identify emerging best practices.	SHPT, Local Hospitals	April 2014 - ongoing	Best practices identified And posted online				Guthrie is working on a project with Cornell University -- a collaborative research jointly funded by the NCI and Donald Guthrie Foundation. Have presented two presentations and had over 13 abstracts accepted at national meetings including SIVB and Obesity Week. Guthrie is working with Cornell University's bio-medical engineering dept. to look at changes in individuals after dramatic weight loss and trends. Looking for biomarkers that

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults B. Expand the knowledge base of partners in obesity prevention							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							can be tracked long term. NCI = National Cancer Institute; SIVB = Society of In Vitro Biology.
B2. Evaluate obesity prevention initiatives.	SHPT, Local Hospitals	September 2014 - ongoing	Initiatives evaluated, data collected and analyzed				Discuss with committee
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				Discuss with committee

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults C. Expand the role of public and private employers in obesity prevention							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	Obtain funding to develop local motion map	S2AY	Ongoing	Funding applied for through GRHF 2014 Opportunity grant. Was not funded and will reapply. SCPH said Schuyler was doing this through their planning dept. Working with Corning Finger Lakes may provide a portion of this. Steuben County Planning Dept. offered to create a large map of trails if provided information, but would need funding for printing and graphic design to make it user friendly.
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	Provide baseline #'s Provide promo info Report participation	Guthrie	9/15/14 Recurring 10/1/14	April 17-26 at Corning East and West High Schools, Salvation Army, Corning Community College, YMCA, and Wegmans. 245 participants were tested for body fat %, BMI, cholesterol and blood pressure. More females (58%) participated than males (42%). 53% of participants were under age

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults C. Expand the role of public and private employers in obesity prevention							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							40. 54% of females had a body fat % of 30 and over, whereas 65% of males had a body fat % below 25. The majority of participants had cholesterol under 200 and a BMI under 25 – 29.9. HealthWorks held a one day screening in August and tested 20 people. There was much success with the large screening in the spring, especially with the C-PP 10th grade health classes, with plans to do it again. Investigating possibility of going into other county high schools. CCC also provided a great venue. Corning Inc. will be doing a biometric screening and having employees complete an online Health Risk Assessment at the end of September or early October. Biometric screening was done last week in September for Steuben County employees.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in children and adults D. Increase access to high quality chronic disease preventive care and management in clinical and community settings							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	Report education provided annually	Arnot	10/1/14	Lake Erie Osteopathic School of Medicine is affiliated with Arnot and is launching a "Healthy Kitchen" out of Tulane University that pairs residents with chefs who teach healthy recipes and nutritional value. Residents will teach 3rd year medical students and the students go into community kitchens to teach. There will be a few in Steuben County. A press conference was held Sept 15. 5 guest chefs are affiliated with the project: EOP, Wegmans, Hilltop, Culinary Arts at BOCES, and Classic Café owner.
				Report education provided annually	Guthrie	10/1/14	A standard nutrition curriculum has been developed by Guthrie Bariatric Center. As of April 2014, 2 community classes have been held in Sayre, taught by a registered dietician (RD, LDN), registered nurse (RN, MSE) and fitness specialist (ACSM-HFS). Total participants was 49 for the first class and 47 for the second (96 total). Health Eating Basic Nutrition Form was distributed at conclusion of each class and individuals scored greater than 85% on all effect measures. Everyone completed each of the four sections. Guthrie's Director Medical Bariatrics met with lead doctors in March and discussed their needs and input re: patient needs within each specialty. As of April 2014, preliminary info was gathered on validated survey tools used within healthcare systems to assess providers' basic understanding of obesity management. The method used to investigate included a literature search. To date, no validated survey tool has been identified within the literature.

				Report education provided annually	SJMH	10/1/14	SJMH offers free quarterly blood pressure screenings and kidney health education sessions at the Hornell Wegmans store, serving approximately 200 individuals per year. On 5/31/14, SJMH sponsored a community-wide blood screening event, serving 244 individuals. SJMH will work with its registered dietitian on developing chronic disease and/or obesity education resources for community providers.
				Report education provided annually	HMST	10/1/14	Updates forthcoming
				Resource guide developed and distributed	Committee	12/30/15	

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension A. Prevention, screening, early detection, treatment, and self-management support							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	SCPH provide qtrly updates	SCPH	8/15/14	Reported the NYSDOH grant to reduce sodium by 30% over three years in hospitals and senior meals. There is an upcoming event to kick off the expansion of the program to other counties on September 16, 10 am – 2 pm at the Harbor Hotel in Watkins. All interested are welcome to attend. Corning Hospital is offering new healthy options, about 5 new recipes. A hypertension project is taking place through Finger Lakes Health Systems Agency with physicians in multiple counties. Guthrie has Epic and may be able to send out results to FLHSA. Part of the rationale is that monitoring equals more cognizant. FLHSA would like to link up with Guthrie, Arnot, and St. James on this project.
A2. Investigate possibility of expanding	Guthrie, St.	September	Creation of	Provide current status	Arnot	8/5/14	Arnot reported they had a stroke group and

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension A. Prevention, screening, early detection, treatment, and self-management support							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
heart disease support group in Hornell. Promote support groups of all local hospitals.	James	2014 - ongoing	support group, # participating	Provide promo info Report participation		Recurring 10/1/14	would find out if they had a Heart Disease group.
				Provide current status Provide promo info Report participation	Guthrie	8/5/14 Recurring 10/1/14	Guthrie is working on identifying resources to expand this support group. The Diabetes Education Support Group through Guthrie might touch on some topics.
				Provide current status Provide promo info Report participation	SJMH	8/5/14 Recurring 10/1/14	SJMH reported their new vision for healthcare is focused on ambulatory services with a tertiary partner, and anticipates cardiac rehab support services will be included in the new model. Specific services are yet to be determined.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension B. Reduce exposure to secondhand smoke							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	Discuss with CM Discuss with health advisory board Draft resolution	SCPH	12/30/14	ProAction had been smoke-free for one year. For government buildings a designated area / hut will be needed to pass a resolution. Chemung County Health Department has a tobacco free policy, but will build a butt hut similar to the looks of a bus stop to offset unsightliness of smokers and butts on the sidewalks. Meeting with Buildings and Grounds to get the ball rolling. Polled people regarding their objection to the last vote. The consensus was to designate an area and not build a hut. It will be about 100 feet from front entrance. Will be getting signage from STTAC. Thanks to STTAC, SCPH drafted a tobacco / smoke-free policy. It went to the Health and

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension B. Reduce exposure to secondhand smoke							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							Ed Committee and was upheld. Will go into effect October 22. Articles have run in the Star Gazette and Evening Tribune regarding the new tobacco free policy. County security will play a role in making sure people abide by the policy. Hornell Housing Authority has 158 units going smoke-free. Smokers who have leases that are not up yet are grandfathered in until lease renewal. Changeover will be complete within a year. There is one designated smoking area on the grounds of each location beginning October 1. Knowing this was coming has prompted people to quit smoking even before the policy was in place.
				Provide support as needed to SCPH	STTAC		Smoke-free / tobacco free policies in Steuben County: The Udder Place: July 15, 2012 Corning and Hornell Salvation Armies: October 15, 2012 Friends of Addison Youth Center: January 10, 2013 Family Life Ministries: February 28, 2013 ProAction: July 1, 2013 Hornell Smoke Free Bus Stops: November 2013 Catholic Charities of Steuben (7 sites): July 2014
B2. Highlight dangers of tobacco through public service announcements and promote media campaigns with hard hitting cessation messages and the importance of tobacco free	SHPT, Local Hospitals, Health Ministry of the Southern	May 2014 - ongoing	# PSA's provided, # campaigns held	Report any media efforts quarterly Provide committee members with material	STTAC	12/9/14	Reports forthcoming

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension B. Reduce exposure to secondhand smoke							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
outdoors.	Tier, PH, STTAC, Health Systems for a Tobacco Free Finger Lakes			Report any media efforts quarterly	Committee	12/9/14	Reports forthcoming

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension C. Promote tobacco cessation, especially among low SES populations and those with mental health illness (disparity)							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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, HSTFFL	September 2014 – ongoing	# NYS Smokers Quitline calls, #agencies/organizations participating in tobacco cessation education to clients	Report any media efforts quarterly Provide committee members with material	Health Systems Change for a Tobacco Free Finger Lakes	10/15/14	University of Rochester received the grant and most support would be electronic. Arnot is giving out Quitline cards at every event, has a monthly cessation support group, and info on the website. SJMH counsels patients and inpatients get cessation tools. Guthrie reported participants in their LCSP receive smoking cessation counseling and resources (to date over 300 individuals are enrolled). Smoking cessation counseling provided by the NYS Smokers' Quitline or Guthrie trained Respiratory Therapists who certified. In coming months the program will expand to all patients and education for primary care providers at Guthrie. The majority of people who utilized the Quitline were between 25 – 44 years old, smoked ½ a pack to 1 ½ packs of cigarettes. There were more females than males. The Health Systems Change grant needs to be driven system wide to be sustainable. Includes a train-the- trainer model.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension C. Promote tobacco cessation, especially among low SES populations and those with mental health illness (disparity)							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
							Champions are provided with materials and training. They implement refer to quit or opt to quit for policy level change. Opt to quit is different in that every patient who smokes is automatically referred, but can opt out. Utilizes 5A model in treating tobacco dependence. Striving for providers to spend 1 to 3 minutes discussing tobacco cessation as it has an impact. Discussion around lung cancer screening. Typically patients are seen by a pulmonologist; positive / negative results and diagnosis / treatment go from there based on an algorithm. Covered by BCBS and Aetna, but not Medicare. Guthrie's program covers the cost of high-risk groups if uninsured. Steuben County has worked with Quitline to send referrals electronically. The program was initiated on the Great American Smokeout, November 20, 2014. SCPH also completed the Freedom from Smoking facilitator training and plans to start offering cessation classes in the new year.
				Report any media efforts quarterly	Committee	8/15/14	Updates forthcoming

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension D. Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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, HSTFFL, Local Schools	January 2014 - ongoing	# activities held and/or events attended	Per STTAC workplan – report efforts qtrly Request committee help as needed	STTAC	12/9/14	STTAC said current efforts are around getting pharmacies to stop selling tobacco, following the national CVS example. 2014: Kick Butts Day in March was held at the First Arena. World No Tobacco Day was media push with radio and TV interviews, and social media highly utilized. For the Great American Smokeout, Reality Check (RC) youth will do cigarette butt pickups in hazmat suits.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension 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							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	Report current EHR status	Arnot	12/9/14	Arnot has EHR, with connectivity to other facilities and providers in development. Health on Demand scans anything they receive in and can send to doc offices. Medicaid may cover some services. Guthrie bariatrician is booked through February. PCPs are receiving training to discuss this with patients.
				Provide resources	Guthrie	12/9/14	Currently working to identify resources to meet this goal.
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	Local hospitals, Health Ministry of the Southern Tier	September 2015 - ongoing	# educated, # resources disseminated, track usage of EHR resources where applicable	Put links in EHR's Track usage	SJMH	12/9/14	SJMH is in affiliation discussions with tertiary partner UR Medicine, and likely will implement their EMR system upon completion of a formal partnership. In 2014 SJMH received a grant from the Rural Healthcare Access program (NYSDOH) to upgrade Meditech servers, including ambulatory care software modules, to facilitate working with a tertiary partner.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension 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							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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.							
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		HMST	8/5/14	Updates forthcoming
				Help develop resources	Committee		

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension F. Develop infrastructure for widely accessible, readily available chronic disease self-management (CDSMP) and diabetes prevention programs							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	Schedule classes Provide promo info Report #'s	SRHN		SRHN reported all current classes are in Chemung County. Funding provided by United Way that limits number of classes in each county. Will hold 5 classes in Steuben County by next July.
F2. Offer Diabetes Prevention programs as need is expressed in the			# participants	Schedule classes Provide promo info	SRHN		One DPP class is currently being held at IHS. SCPH being trained.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension F. Develop infrastructure for widely accessible, readily available chronic disease self-management (CDSMP) and diabetes prevention programs							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
county				Report #'s			Corning Y is holding a class beginning at the end of September for a fee; Corning Inc. employees are free. SCPH has completed training and are in the planning stages of creating a DPP class for County employees. SCPH spoke with Hornell YMCA who is supportive of SCPH offering DPP classes there. Ophthalmologists may be a good source of referrals. S2AY is in discussion with the Allegany / Steuben Rural Health Network to have more lifestyle coaches trained. Southern Tier Diabetes Coalition held its Diabetes Fair October 25 at Arnot Mall. Over 30 vendors attended. Approximately 120 participants completed a risk assessment. More were at the fair but did not complete an assessment. HemoCue was purchased to do blood glucose screenings, and approx. 50 screenings were completed. SCPH plans to offer a DPP class for County employees beginning in the new year.
F3. Sustain links to Emory University's Diabetes Training and Technical Assistance Center, and the NYS Diabetes Prevention Program and QTAC			Links sustained	QTAC relationship established DPP trainings held Classes held Promo info provided #'s reported	S2AY RHN	9/30/14	Regional CDSMP group convened, first class of NDPP trained, 2nd class scheduled

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension G. Promote CDSMP and Diabetes Prevention programs to health-care providers							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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	QTAC relationship established DPP trainings held Classes held Promo info provided #'s reported	S2AY RHN	9/30/14	Regional CDSMP group convened, first class of NDPP trained, 2nd class scheduled Most counties have staff trained in the program. Yates is planning on running a class for employees starting in September. Wayne is starting a class in October. Schuyler's class is running with 8 participants. Classes for other counties have been pushed back to the new year most likely.
G2. Provide business model to hospitals/health care providers on the improved health outcomes with CDMSP and Diabetes Prevention programming			Business model provided	QTAC relationship established DPP trainings held Classes held Promo info provided #'s reported	S2AY RHN	9/30/14	Regional CDSMP group convened, first class of NDPP trained, 2nd class scheduled

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce illness, disability and death related to heart disease and hypertension H. Maximize organizational capacity to provide CDMSP and Diabetes Prevention Programs							
Activities	**Partners**	**Time frame**	**Measurement /Evaluation**	**Action Steps**	**Owner**	**Target Date**	**Status/ Progress**
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		S2AY RHN	12/30/14	Being pursued as part of NYSHF DPP grant with Viridian. S2AY said this was part of the NYSHF grant and was still being pursued. Attempting to get classes for all that are certified reimbursed thru insurance, hopefully in early 2015.