Steuben County									
2023 Workplan									
Planning Report Liaisor	Lorelei Wagner								
E-mail:	lwagner@steubencountyny.gov								
	Focus Area (select one from drop	Goal Focus Area (select one from drop						Implementation Partner (Please select one partner from the	
Priority	down list)	down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed	dropdown list per row)	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices			1.0.4 Multi-component school-based obesity prevention interventions. Public Health will focus on outreach and collaboration with school district decision makers from the districts with the highest rates of obesity to inform and educate on evidence based interventions, policies and environmental changes that impact healthy student weights and address district/community specific risk factors.	% schools who adopted new policies	Public Health will focus on the following: 1. Outreach to the Guthrie Clinic and Calvin U. Smith Elementary / Corning-Painted Post School District to determine feasibility of reviving program in CPP and extending to other districts 2. Outreach to school district administrator(s) to share current health need (obesity) of student population, why it's important and identify ways to seek input from the school community on contributing causes and potential solutions 3. Coordinate with members of the school district/community to: "Better understand the reasons or causes of disparities within the district "dientify potential policies to alleviate causes 4. Assist in planning and implementation of selected policy(s) around childhood healthy lifestyles in identified school(s) 5. Support pre and post surveys, data collection and review of progress	Local health department	LHD will promote obesity interventions policie and programs and advise and assist new schoo on implementation of any childhood healthy lifestyles program. Other Smart Steuben partn will work on interventions to complement and enhance offerings.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	of children with obesity	Low SES	1.0.6 Screen for food insecurity, facilitate and actively support referral.	% of patients screened for social determinants of health SDOH % of patients who indicate financial strain or food insecurity	Corning Hospital will screen all patients annually for food insecurity, facilitate and actively support referrals to community-based resources to address patient needs. Corning Hospital will meet quarterly with community partners to improve referral pathways and will evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance.	Hospital	Utilize Community Health Workers from Care Compass Network Social Impact Pilot to facilita increased screening and referrals
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices			1.0.4 Multi-component school-based obesity prevention interventions. Corning Hospital will continue offering age- appropriate health curriculum to children in the surrounding area schools through collaborative curriculum development and events.	# participants in each program or initiative # teachers incorporating healthy eating curriculum # community events	Corning Hospital will continue offering age-appropriate health curriculum to children in the surrounding area schools through collaborative curriculum development and events. Assess ability to expand program to schools experiencing disparities in obesity rates A kick off meeting will be held to re-establish team and goals after break during COVID.		Ex. Healthy Kids Day, Childhood Healthy Lifesty Program, Wellness Fairs
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices		Low SES	Corning Hospital will promote community exercise programs for children by offering families referrals from pediatric providers	# referrals to community based physical activity programs	Corning Hospital will meet quarterly with community partners to improve referral pathways and will evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance.	Hospital	Community resources: Girls on the Run, Youth Running Club- SOAR, YMCA
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Coal 1.2 Increase skills and knowledge to support healthy food and beverage choices			SRHW will implement Girls on the Run of the Southern Tier (3rd-5th grade) evidence-based program	# of participants # of trained coaches # of sites % open rate for family newsletter % of participants in Girls on the Run who Show an increase in physical activity through participating in GOTR (attendance tracking) % participants who complete a 5K	The Steuben Rural Health Network (SRINI) will coordinate and implement Girl on the Run at a number of sites, including at school sites in Steuben. Registration for the program will open in the beginning of January 2023.	Community-based organizations	EX: CBV's provide nutrition education/resource to provide to the families for the newsletter; school districts will "host" a site. During the SK Celebration at the end of the season; local organizations that implement nutrition education/resources would be invited to table
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices				# of participants % of participants that indicate increased knowledge of nutrition education or skills to be more physically active	The Steuben Rural Health Network (SRHN) will implement an evidence-based program with at least one school district in Steuben County.	Community-based organizations	SRHN will partner with at least one school dist to pilot the evidence-based program
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices		Low SES	1.0.4 Multi-component school-based obesity prevention interventions through implementation of Coordinated Approach to Child Health (CATCH) program, an EBI	# schools trained in CATCH % of trained schools that implement CATCH # students impacted in CATCH schools % participating schools reporting a change in moderate - to - vigorous activity students are engaged in during the school day as documented by CATCH Champion Surveys	SNAP-Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) will have trained 7 area schools in CATCH with 2,255 students impacted. Partner schools receiving 50% or more free or reduced lunch indicating decreased opportunities for healthy food access outside of school as compared to those of middle/high- SES status. SNAP-Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) work with local elementary and middle schools to implement the Coordinated Approach To Child Health (CATCH) program. Quality nutrition and physical activity is provided in 7 area schools serving 2,255 students. Utilizing the Whole School, Whole Community, Whole Child (WSCC) framework, CATCH is integrated school wide (classroom, PE, brain breaks, cafeteria).	Community-based organizations	SNAP-Ed New York - Southern Finger Lakes Reg will provide needed staff and resources to mee measures with assistance from Steuben CHIP partners as needed.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	Objective 1.2 Decrease the percentage of children with obesity	Low SES	1.0.5 Increase the availability of fruit and vegetable incentive programs.	# of participants Monetary sum of vouchers distributed % of vouchers redeemed	SNAP-Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) will partner with 1 FQHC to deliver FVRx to Steuben County FVRx voucher redemption rate of greater than 60% in Steuben County SNAP-Ed New York - Southern Finger Lakes Region and Cornell Cooperative Extension (CCE) will partner with 1 Steuben County FQHC, Finger Lakes Community Health (FLCH) to deliver the Fruit and Vegetable Prescription Program (FVRx). Patients of FLCH are eligible to participate in a 6-week nutrition education series and receive 520 in fruit and vegetable vouchers each week to spend at local produce vendors, totaling 5120. Identify patients of FQHC or identified as having experienced food insecurity in last 12 months indicating decreased access to healthy eating and exercise opportunities as compared to those who are food secure and/or use private insurance.	Community-based organizations	SNAP-Ed New York - Southern Finger Lakes Reg will provide needed staff and resources to mee measures with assistance from Steuben CHIP partners as needed.

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Prevent Chronic Diseases	Focus Area 1: Healthy eating and	Goal 1.2 Increase skills and knowledge	Objective 1.2 Decrease the percentage		Arnot Health primary care offices will make	% of patients eligible for the resource list with a BMI	Arnot Health will create and distribute a list of community resources available to their		Utilize community partners and LHD to create list
	food security	to support healthy food and beverage choices	or children with obesity		reterrais to appropriate community resources for nutritional and/or exercise programs for pediatric patients.	percentile 95% or greater (definition of childhood obesity)	primary care providers in Steuben County.		of community resources available to help decrease childhood obesity. Tri-County Family Medicine has an extensive Community Resource List used by care managers to support providers for patients identified with community needs.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices			actively support referral.	% of patients screened for social determinants of health, including food insecurity, housing, language and literacy issues % of patients who screen positive for food insecurity	In spring 2022, Arrot Health created and implemented a policy to screen all primary care patients once yearly or as clinically indicated for social determinants of health, including food insecurity, housing, language and iteracy. They will facilitate and actively support referrals to community-based resources to address patient needs.	Hospital	
Prevent Chronic Diseases	Focus Area 1: Healthy eating and	Goal 1.2 Increase skills and knowledge			Perform BMI assessment on all patients 3-17	% of compliance with Oak Orchard Quality Measures for	Oak Orchard will continue to provide BMI assessments and provide counseling on	Federally qualified health care center	Early Head Start / Head Start can support BMI
	food security	to support healthy food and beverage choices	of children with obesity			Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents % of 3-17 year old that have completed well child visit	nutrition and physical activity in Hornell for ages 3-17yrs (current compliance is 75%) Goal of 80% compliance. Oak Orchard will use Bright Future Handouts at well child visits to educate patients Will have 75% completed well child visits		assessments with enrolled children.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and	Goal 1.2 Increase skills and knowledge			1.0.2 Quality nutrition and physical activity in	# children participated in I am Learning I am Moving	ProAction will:	Community-based organizations	I am Moving I am Learning resources and
	food security	to support healthy food and beverage choices	of children with obesity			# Families served through I am Learning I am Moving % of children with healthy BMI # Child Care providers received I Am Learning I Am Moving training and monitoring # Families assessed for nutritional risks % families provided with resources based on nutritional risks	Provide education to families Implement I am Learning I am Moving in classrooms and homes. Provide training to home based child care providers on health and nutrition following CACFP guidelines and menus Provide Technical assistance and nutritional activities to Child Care Providers.		activities. Pre and Post Assessment of individual student BMI. CACFP guidelines WIC STRONG Nutrition Education Program
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices			prevention interventions.	# of children enrolled in classes # of free or tow cost activities for children % children demonstrating an increase in knowledge of healthy food choices and activities	St. James Hospital will work with Partners listed to identify ways to decrease costs for activities and increase education about healthy for choices for vide. Discuss with Hornell School District items offered in vending machines & at meal times. St. James Hospital will have worked with our community partners (YMCA, Hornell School District, GST BOCES & Concern for Youth) to identify program opportunities. Identify curriculums to use in school districts to educated students on healthy eating. Increase number of free or low cost sport/activity programs for children in the Hornell area.		Hornell Area YMCA, Hornell School District, GST BOCES, Concern for Youth & Area Pediatricians
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	Objective 1.2 Decrease the percentage of children with obesity		Perform BMI assessment on all patients 3-17 years old and provide counseling for nutrition and physical activity. Educate patients and families of Tri-County Family Medicine utilizing educational boards and Bright Future hand outs	% of provider compliance with TCFM Quality Measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents % of 3-17 year old that have completed well child visit % patients who show decrease or improvement in BMI	Tri-Courty Family Medicine (TCFM) completes BMI assessments for ages 3-17, provides counseling on nutrition and physical activity. Current compliance for Wayland and Cohocton Centers is 66%. Goal to increase to 75%. TCFM utilizes Bright Futures handouts for ages 3-17. Utilizes poster boards to educate children and parents on sugar intake in various products. TCFM completes well child visits. TCFM compliance for 3-21 years is 75% with a goal of 80%	Federally qualified health care center	
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices			actively support referral.	% of patients who indicate food insecurities based on PraPare screening tool % of patients that are referred to community resources for food security based on PES tracking	TCFM is currently using the PraPare Tool to screen all care-managed patients. TCFM will increase screening to all patients during CHIP Planning years	Federally qualified health care center	
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