H 2. Broome County Community Health Improvement Plan- Local Partner CHIP Interventions

Broome County Community Health Improvement Plan

Local Partner CHIP Interventions

Please use the checkboxes (☐) in the following tables to indicate which of the following Prevention Agenda priority areas, focus areas, goals, objectives and interventions **your organization** is working on. Please provide your contact information, so we may contact you about your responses, if necessary.

Name:		**Organization:**	
Phone:		**Email:**	

Table 1. Healthy Eating and Food Security

Priority Area	☐ Prevent Chronic Diseases	
Focus Area	☐ Healthy Eating and Food Security	
Goals	☐ **Goal 1.1** Increase access to healthy and affordable foods and beverages ☐ **Goal 1.2** Increase skills and knowledge to support healthy food and beverage choices ☐ **Goal 1.3** Increase food security	
Objectives & Interventions ****(NYSDOH has not aligned*	☐ **Objective 1.1** Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC])	☐ **Intervention 1.0.1** Adopt policies and implement practices to reduce (over)consumption of sugary drinks ☐ **Intervention 1.0.2** Quality nutrition (and physical activity) in early learning and child care settings

*objectives and interventions with specific goals for this focus area)****	☐ **Objective 1.2** Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC]) ☐ **Objective 1.3** Decrease the percentage of children with obesity (among public school students in NYC) ☐ **Objective 1.4** Decrease the percentage of adults ages 18 years and older with obesity (among all adults) ☐ **Objective 1.5** Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) ☐ **Objective 1.6** Decrease the percentage of all adults ages 18 years and older with obesity (among adults living with a disability) ☐ **Objective 1.7** Decrease the percentage of adults who consume one or more sugary drinks per day (among all adults) ☐ **Objective 1.8** Decrease the percentage of adults who consume one or more sugary drinks per day (with an annual household income of <$25,000) ☐ **Objective 1.9** Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults) ☐ **Objective 1.10** Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among adults who are non-Hispanic black) ☐ **Objective 1.11** Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among adults who are Hispanic) ☐ **Objective 1.12** Increase the percentage of adults who buy fresh fruits and vegetables in their neighborhood (among adults who are non-Hispanic black)	☐ **Intervention 1.0.3** Worksite nutrition and physical activity programs designed to improve health behaviors and results ☐ **Intervention 1.0.4** Multi-component school-based obesity prevention interventions ☐ **Intervention 1.0.5** Increase the availability fruit and vegetable incentive programs ☐ **Intervention 1.0.6** Screen for food insecurity, facilitate and actively support referral

	☐ **Objective 1.13** Increase the percentage of adults with perceived food security (among all adults) ☐ **Objective 1.14** Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000)	

Table 2. Chronic Disease Preventive Care and Management

Priority Area	☐ Prevent Chronic Diseases	
Focus Area	☐ Chronic Disease Preventive Care and Management	
☐ **Goal 4.1** Increase Cancer Screening Rates	☐ **Objective 4.1.1** Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines ☐ **Objective 4.1.2** Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening based on the most recent guidelines ☐ **Objective 4.1.3** Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) ☐ **Objective 4.1.4** Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (adults with an annual household income less than $25,000) ☐ **Objective 4.1.5** Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines	☐ **Intervention 4.1.1** Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts). ☐ **Intervention 4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting). ☐ **Intervention 4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand. ☐ **Intervention 4.1.4** Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance (Provider Assessment and Feedback). ☐ **Intervention 4.1.5** Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient

		navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings. ☐ **Intervention 4.1.6** Ensure continued access to health insurance to reduce economic barriers to screening.
☐ **Goal 4.2** Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	☐ **Objective 4.2.1** Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% ☐ **Objective 4.2.2** Increase the percentage of low-income (<$25,000) adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% ☐ **Objective 4.2.3** Increase the percentage of children and adolescents ages 3 -17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5%	☐ **Intervention 4.2.1** Promote strategies that improve the detection of undiagnosed hypertension in health systems. ☐ **Intervention 4.2.2** Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.
☐ **Goal 4.3** Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	☐ **Objective 4.3.1** Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%) ☐ **Objective 4.3.2** Decrease the percentage of adult Black Medicaid members with diabetes whose most recent HbA1c level indicated poor control (>9%) ☐ **Objective 4.3.3** Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbA1c level indicated poor control (>9%) ☐ **Objective 4.3.4** Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year	☐ **Intervention 4.1.1** Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts). ☐ **Intervention 4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting). ☐ **Intervention 4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand. ☐ **Intervention 4.1.4** Work with clinical providers to assess how many of their patients receive screening services and provide them

	☐ **Objective 4.3.5** Increase the percentage of adult Black Medicaid members who had hypertension whose blood pressure was adequately controlled during the measurement year ☐ **Objective 4.3.6** Increase the percentage of adult Medicaid members 18-44 who had hypertension whose blood pressure was adequately controlled during the measurement year ☐ **Objective 4.3.7** Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups ☐ **Objective 4.3.8** Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups ☐ **Objective 4.3.9** Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year ☐ **Objective 4.3.10** Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year ☐ **Objective 4.3.11** Increase the percentage of adults with HTN who are currently taking medicine to manage their high blood pressure ☐ **Objective 4.3.12** Increase the percentage of adults with arthritis who have been told by their doctor or health professional to be physically active/exercise to help with arthritis or joint symptoms by 5%	feedback on their performance (Provider Assessment and Feedback). ☐ **Intervention 4.1.5** Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings. ☐ **Intervention 4.1.6** Ensure continued access to health insurance to reduce economic barriers to screening.
☐ **Goal 4.4** In the community setting, improve self-management skills for	☐ **Objective 4.4.1** Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition	☐ **Intervention 4.4.1** Expand access to home-based multi-trigger, multicomponent visits by licensed professionals or qualified lay health workers to provide targeted, intensive asthma self-management education and to reduce home asthma triggers for individuals whose asthma is not well-controlled with NAEPP

individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	☐ **Objective 4.4.2** Increase the percentage of children (0-17) and adults (18+) with asthma who were ever given an asthma action plan by a doctor or health professional by 10% in both groups	Guidelines' medical management and asthma self-management education (ASME). ☐ **Intervention 4.4.2** Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone. ☐ **Intervention 4.4.3** Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.

Table 3. Mental and Substance Use Disorders Prevention

Priority Area	☐ Promote Well-Being and Prevent Mental and Substance Use Disorders	
Focus Area	☐ Mental and Substance Use Disorders Prevention	
☐ **Goal 2.1** Prevent underage drinking and excessive alcohol consumption by adults	☐ **Objective** 2.1.1 Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days by 10% from 27.1% in 2017 to 24.4% ☐ **Objective 2.1.2** Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% to no more than 16.7% ☐ **Objective 2.1.3** Reduce the age-adjusted percentage of adult (age 55+ and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% from 21.7% in 2017 to 19.5%	☐ **Intervention 2.1.1** Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access ☐ **Intervention 2.1.2** Implement School based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors. Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-

		behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use. ☐ **Intervention 2.1.3** Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and cross-system collaboration ☐ **Intervention 2.1.4** Implement routine screening and brief behavioral counseling in primary care settings to reduce unhealthy alcohol use for adults 18 years or older, including pregnant women ☐ **Intervention 2.1.5** Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) Electronic screening and brief interventions (e-SBI) using electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI ☐ **Intervention 2.1.6** Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration
☐ **Goal 2.2** Prevent opioid and other substance misuse and deaths	☐ **Objective 2.2.1** Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population ☐ **Objective 2.2.2** Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population. Baseline: 35.9 per 1,000 ☐ **Objective 2.2.3** Reduce the opioid analgesics prescription for pain, age-adjusted rate by 5% to 343 per 1,000 population ☐ **Objective 2.2.4** Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.2 per 100,000 population	☐ **Intervention 2.2.1** Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine ☐ **Intervention 2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers ☐ **Intervention 2.2.3** Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations ☐ **Intervention 2.2.4** Build support systems to care for opioid users or at risk of an overdose ☐ **Intervention 2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days

		☐ **Intervention 2.2.6** Integrate trauma informed approaches in training staff and implementing program and policy
☐ **Goal 2.3** Prevent and address adverse childhood experiences (ACES)	☐ **Objective 2.3.1** Reduce the percentage of adults experiencing two or more adverse childhood experiences (ACEs) by 5% to no more than 12.9% ☐ **Objective 2.3.2** Reduce indicated reports of abuse/maltreatment rate per 1,000 children and youth ages 0-17 years by 9% to 10 per 1,000 children and youth ages 0-17 years ☐ **Objective 2.3.3** Increase communities reached by opportunities to build resilience by at least 10 percent	☐ **Intervention 2.3.1** Integrate principles of trauma-informed approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation ☐ **Intervention 2.3.2** Address Adverse Childhood Experiences and other types of trauma in the primary care setting ☐ **Intervention 2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration ☐ **Intervention 2.3.4** Implement evidence-based Home visiting programs: These programs provide structured visits by trained professionals and paraprofessionals to pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.
☐ **Goal 2.4** Reduce the prevalence of major depressive disorders	☐ **Objective 2.4.1:** Reduce the past year prevalence of major depressive episode among adults aged 18 or older by 5% to no more than 6.2%. - Tracking Indicator ☐ **Objective** 2.4.2 Reduce the past-year prevalence of major depressive episodes among adolescents aged 12-17 years by 10% to no more than 10.4%	☐ **Intervention 2.4.1** Strengthen economic supports: strengthen household financial security; policies that stabilize housing ☐ **Intervention 2.4.2** Strengthening resources for families and caregivers ☐ **Intervention 2.4.3** Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn's Coping with Depression course, Gregory Clarke's Cognitive-Behavioral Prevention Intervention ☐ **Intervention 2.4.4** Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC_CBT): This is a short-term (16-20 sessions), strength-based therapy program for children ages 3-17 and their parents (or caregivers) in families where parents

		engage in a continuum of coercive parenting strategies. These families can include those who have been substantiated for physical abuse, those who have had multiple unsubstantiated referrals, and those who fear they may lose control with their child.
☐ **Goal 2.5** Prevent suicides	☐ **Objective 2.5.1** Reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past year by 10% to no more than 9.1%. ☐ **Objective 2.5.2** Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.	☐ **Intervention 2.5.1** Strengthen economic supports: strengthen household financial security; policies that stabilize housing ☐ **Intervention 2.5.2** Strengthen access and delivery of suicide care - Zero Suicide: Zero Suicide is a commitment to comprehensive suicide safer care in health & behavioral health care systems. ☐ **Intervention 2.5.3** Create protective environments: Reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches, reduce excessive alcohol use ☐ **Intervention 2.5.4** Identify and support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides ☐ **Intervention 2.5.5** Promote connectedness, each coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program
☐ **Goal 2.6** Reduce the mortality gap between those living with serious mental illness and the general population	☐ **Objective 2.6.1** Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%	☐ **Intervention 2.6.1** Implement a multilevel intervention model that focused at the individual, health systems, community and policy-levels ☐ **Intervention 2.6.2** Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes. Smokers who receive mental health treatment have higher quit rates than those who do not. For example, people with schizophrenia showed better quit rates with the medication bupropion, compared with placebo, and showed no worsening of psychiatric symptoms. A combination of the medication varenicline and behavioral support has shown promise for helping people with bipolar and major depressive disorders quit, with no worsening of

		psychiatric symptoms. A clinical trial found that a combination of varenicline and cognitive behavioral therapy (CBT) was more effective than CBT alone for helping people with serious mental illness stop smoking for a prolonged period—after 1 year of treatment and at 6 months after treatment ended. ☐ **Intervention 2.6.3** Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers.