DECEMBER 2025

# STEUBEN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

2025 - 2030

In collaboration with

Public Health
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Steuben County NY

ArnotHealth
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SMART STEUBEN
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# COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) OVERVIEW

The 2025–2030 Steuben County Community Health Improvement Plan (CHIP) was developed using data and community input gathered through the Community Health Assessment (CHA). Throughout 2024–2025, Steuben County Public Health and partners engaged residents and stakeholders through surveys, focus groups, and data review to identify the most pressing health needs in the county.

Based on this assessment, three priority areas were selected for the 2025 - 2030 CHIP: **Housing Stability and Affordability**, **Poverty**, and **Primary Prevention, Substance Misuse, and Overdose Prevention**. These priorities reflect the issues identified by the community and supported by local data trends, particularly those affecting Steuben County's rural population. They also align with the New York State Prevention Agenda[1]. The development of CHIP interventions was guided by several criteria:

- Strength of evidence supporting the intervention
- Ability to reach populations most affected by identified issues
- Organizational capacity and community readiness
- Alignment with ongoing work and available resources
- Potential for meaningful, sustainable impact

The CHIP highlights new or enhanced initiatives that participating organizations have committed to implementing. Interventions were chosen based on evidence-informed practices, feasibility within current capacity, and potential for measurable, countywide impact. Many strategies intentionally focus on reducing health disparities identified in the CHA, including:

- Individuals with low socioeconomic status
- Rural residents with limited access to services
- Older adults
- Individuals experiencing housing instability or homelessness
- Individuals with disabilities
- Individuals with mental health or substance use disorders

Implementation of the CHIP is a shared effort among Steuben County Public Health, healthcare providers, and community organizations. Each entity contributes through leadership, program delivery, staff time, data support, or aligned activities. Several initiatives are supported through state and federal grants, while others are integrated into routine operations.

The 2025–2030 CHIP represents a coordinated roadmap for improving health outcomes in Steuben County. Through collaboration, evidence-based action, and a commitment to equity, the county and its partners aim to make measurable progress in addressing the structural and social determinants of health that most significantly affect the well-being of residents.

[1] Prevention Agenda 2025-2030: New York State's Health Improvement Plan. Ny.gov. Published 2025. https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/

# SMART STEUBEN CHIP WORKGROUP

SMART Steuben is a group made of Public Health, local hospital systems, and other health-related organizations in Steuben County working to improve health. The group meets quarterly to improve the health of Steuben residents and will oversee the CHIP progress and implementation. Attendees at these meetings regularly review progress and relevant data on each measure. Group members identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

| **Members** |
| --- |
| Arnot Health - Ira Davenport Memorial Hospital |
| Common Ground Health |
| Cornell Cooperative Extention - SNAP-Ed |
| Corning Hospital |
| Fingerlakes Community Health |
| Food Bank of the Southern Tier |
| Institute for Human Services (IHS) |
| NAMI Steuben |
| Oak Orchard Health Center |
| Pivital Public Health Partnership |

| **Members (cont.)** |
| --- |
| ProAction of Steuben & Yates |
| Steuben County Alcoholism and Substance Abuse Services (SCASAS) |
| Southern Tier Tobacco Awareness Coalition (STTAC) |
| St. James Hospital |
| Steuben County Community Services |
| Steuben County Mental Health Services |
| Steuben County Opioid Comittee |
| Steuben County Public Health |

# Steuben County Community Health Improvement Plan
# 2025 - 2030

Priority: **Housing Stability and Affordability**

Goal: **Foster reliable and equitable access to safe, affordable, and secure housing options.**

Objective: **4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| St. James Hospital | Develop a structured tracking system to monitor housing support efforts, follow patient progress, and coordinate placement attempts for individuals experiencing homelessness who are admitted to the hospital. | # of patients presenting as unhoused during hospital admission.<br><br>% of unhoused patients referred to housing support services.<br><br>% of referred patients who successfully obtain temporary or permanent housing.<br><br>% of housing referrals that are unsuccessful, with documented reasons for barriers. |
| STTAC | Implement a local policy initiative that encourages or requires landlords to conduct environmental contaminant testing for current tenants and prior to new tenant occupancy. | # of landlords participating in the incentive program.<br><br># of contaminant tests completed before leasing.<br><br># of educational materials or training sessions provided to landlords and tenants.<br><br>Volume of incentives distributed (e.g., grants, fee waivers). |

Priority: **Housing Stability and Affordability**

Goal: **Foster reliable and equitable access to safe, affordable, and secure housing options.**

Objective: **4.1 Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Steuben County Public Health | Develop and implement targeted social media campaigns to promote assistance programs such as HEAP, Emergency HEAP, Weatherization Assistance, Section 8, rental assistance programs, faith-based supports, and utility hardship programs. | # of social media posts published<br><br># of total impressions generated<br><br># of link clicks to program information or applications<br><br># of shares or engagements (e.g., comments, saves) |
| Arnot Health - Ira Davenport Memorial Hospital | Host community events that connect residents with resources addressing social needs such as housing assistance, financial counseling, food security, utility support, and other stabilization services. | # of events held<br><br># of people in attendance<br><br># of housing resources distributed<br><br>% of patients with documented SDoH needs who received notification or outreach about the event(s) |

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| St. James Hospital | Implement routine screening for social needs (including food insecurity) and provide proactive, assisted referrals to appropriate community resources to support financial and housing stability. | % of patients screened for social determinants of health, including food insecurity, housing, language and literacy issues<br><br>% of screened patients who screen positive for at least one social need<br><br>% of patients with identified needs who receive a completed referral to community resources. |
| Institue for Human Services (IHS) | Provide referrals to utility assistance programs and disaster relief services to support housing stability and prevent service shutoffs or displacement. | # of contacts referred to utility support services<br><br># of contacts referred to disaster relief services |

Priority: **Poverty**

Goal: **Identify, promote, and implement programs that address poverty.**

Objective: **1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Arnot Health - Ira Davenport Memorial Hospital | Provide routine screening for social needs (including food insecurity) and provide proactive, assisted referrals to appropriate community resources to support financial and housing stability. | % of patients screened for social determinants of health, including food insecurity, housing, language and literacy<br><br>% of patients who screen positive for one or more SDoH needs<br><br>% of patients with identified needs who receive a completed referral to an appropriate resource |
| Cornell Cooperative Extention / SNAP - Ed | Provide school-based nutrition education using the CATCH curriculum. | # of classes<br><br># of schools implementing nutrition education<br><br>% of students reporting increased likelihood of engaging in healthy nutrition behaviors |
| Cornell Cooperative Extention / SNAP Ed | Increase availability and use of fruit and vegetable incentive programs (FVRx) | # of participants<br><br>Total dollar amount of vouchers distributed<br><br>% of vouchers redeemed |

Priority: **Poverty**

Goal: **Identify, promote, and implement programs that address poverty.**

Objective: **1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.**

| Partner Organization | Intervention | Performance Measures | Disparities Addressed |
|---|---|---|---|
| Corning Wegmans | Collaborate with the regional Food Bank to coordinate the annual “Fill the Bus” community-wide food drive to collect non-perishable items for children who are at risk of hunger. | Total monetary value of donations collected<br><br># of individual food donations | Low SES |
| Corning Wegmans | Engage local employers and their workforce in United Way campaigns, including employee pledges and internal fundraising efforts, to strengthen the safety net of community services that benefit low-income families. | Total monetary value raised through employee campaigns | Low SES |
| Corning Wegmans | Promote the Food Bank’s “Check Out Hunger” campaign, which encourages shoppers to donate at checkout to support food access programs for families experiencing food insecurity. | Total monetary value raised<br><br># of individual donations | Low SES |
| Corning Wegmans | Support United Way’s Scan Campaign by encouraging patrons in participating retailers to contribute via simple point-of-sale options that fund local poverty-alleviation programs. | Total monetary value raised<br><br># of individual donations | Low SES |

Priority: **Poverty**

Goal: **Identify, promote, and implement programs that address poverty.**

Objective: **1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Institue for Human Services (IHS) | Provide referrals for employment services, food assistance, income supports, and related social services to help individuals and families improve economic stability. | Total monetary value of donations collected<br><br># of individual food donations |
| Institue for Human Services (IHS) | Distribute gas cards and transportation tokens to support travel to medical appointments, human services appointments, Veterans Affairs, and DSS services. | Total monetary value raised through employee campaigns |
| Institue for Human Services (IHS) | Provide travel training to educate residents on how to effectively use Steuben County's public transportation system. | Total monetary value raised<br><br># of individual donations |

Priority: **Poverty**

Goal: **Identify, promote, and implement programs that address poverty.**

Objective: **1.1 Reduce the percentage of people aged 65 years and older living in poverty from 12.2% to 11%.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Steuben County Public Health | Develop and disseminate a comprehensive resource guide for adults aged 65+ that highlights available community services—including financial assistance, food support, transportation, healthcare access, and housing resources. | # resource guides distributed<br><br># of facilitaties and organizations receiving electronic or physical copies |
| St. James Hospital | Establish an outpatient care management liaison process to ensure timely internal referrals and coordinated support services for patients with identified socioeconomic needs. | # of patients referred through the outpatient care management liaison process.<br><br>% of referrals completed within the established timeframe.<br><br># of outreach opportunities initiated or supported by the liaison.<br><br>% of patients who engage with recommended socioeconomic support services. |
| Cornell Cooperative Extention / SNAP - Ed | Expand Veggie Van sites serving older adult populations. | # of Veggie Van sites serving older adults<br><br>% of FMNP (Farmers Market Nutrition Program) checks redeemed<br><br>% of SNAP benefits utilized at Veggie Van sites |
| Cornell Cooperative Extention / SNAP - Ed | Implement Veggie Van Voucher program to increase access to affordable produce for older adults. | # of participants<br><br>Total dollar value of vouchers distributed<br><br>% of vouchers redeemed<br><br>% of participants reporting improved access to healthy foods (post-survey) |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **11.0 Increase the crude rate of patients per 100,000 population who received at least one buprenorphine prescription for opioid use disorder from 446.0 to 490.6.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| SCASAS | Expand access to Medication-Assisted Treatment (MAT) by enrolling eligible individuals in buprenorphine or other approved medications for opioid use disorder. | # of people enrolled on MAT during treatment<br><br>% of MAT participants retained in treatment for 30, 60, or 90 days (recommended if data available) |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Steuben County Public Health | Update and maintain a publicly accessible data dashboard displaying timely opioid-related indicators to increase transparency, inform community response efforts, and support data-driven decision-making. | # of updates to the dashboard (reviewed quarterly) |
| St. James Hospital | Provide MyChart-based education and training for healthcare providers on evidence-based prescribing practices, opioid stewardship, and patient communication regarding medication risks. | # of providers trained (first time)<br><br># of providers completing annual refresher training<br><br>% of trained providers reporting increased knowledge of safe prescribing practices<br><br>% of providers implementing recommended prescribing guidelines |
| St. James Hospital | Distribute evidence-based educational materials to healthcare providers and patients focused on safe post-operative pain management and opioid-use risk reduction. | # of educational matierals distributed |
| Arnot Health - Ira Davenport Memorial Hospital | Maintain permanent safe disposal sites for prescription drugs and organized take-back days | # pounds of medication disposed of yearly |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Arnot Health - Ira Davenport Memorial Hospital | Screen all patients using the Columbia-Suicide Severity Rating Scale (C-SSRS) to identify individuals at elevated risk and ensure that all patients with positive or high-risk results receive timely, supported referrals to appropriate behavioral health or crisis intervention services. | # of patients that received the C-SSRS Assesment<br><br>% of screened patients with a positive CSSRA result<br><br>% of patients with a positive C-SSRS result who received follow-up plan |
| NAMI Steuben | Promote and facilitate "Family to Family" signature program to engage residents in support services | # of participants<br><br>% of participants reporting an increased knowledge of support services in post-survey<br><br># of referrals to "Family to Family" |
| NAMI Steuben | Provide educational sessions and materials related to preventative factors such as mental wellness, drug use, and access to care/support services | # of trainings hosted<br><br># of total participants across all educational programming<br><br># of trainings with commhnity partners |
| NAMI Steuben | Partner with Helpline to collect and report data for OMH requirements | # of calls receieved<br><br>% of callers requesting support relating to substance use and overdose related experiences |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Steuben Prevention Coalition | Provide substance misuse and abuse prevention across Steuben County school districts, incorporating EBIs. | # students educated about substance use, misuse & prevention<br><br>% students indicated an increase in knowledge about substance use, life skills and/or prevention factors<br><br># of students counseled who are at risk for substance abuse<br><br>% students showing an increase in protective factors after counseling |
| Institue for Human Services (IHS) | Implement Teen Mental Health First Aid (tMHFA) to equip youth with skills to recognize signs of mental health challenges and substance misuse risk in themselves and peers | # of participants served<br><br># of instructors trained<br><br>% of participants reporting increased confidence, knowledge, and skills |
| Institue for Human Services (IHS) | Strengthen referral pathways for individuals using opioids or at risk of overdose by promoting and enhancing access to 2-1-1 and GetHelpNYY | # contacts referred to mental health / substance abuse services in Steuben County<br><br># of referrals made through GetHelpNY |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Institue for Human Services (IHS) | Implement the Living Healthy chronic disease and pain self-management curriculum to support individuals with chronic pain who may be at increased risk for opioid misuse by improving their coping strategies, communication skills, and confidence in managing their condition. | # total participants served<br><br>% of participants completing the program via toolkit<br><br>% of participants completing in-person classes<br><br># of peer leaders trained<br><br>% of participants reporting increased knowledge of self-management skills |
| Steuben Prevention Coalition | Provide substance misuse and abuse prevention across Steuben County school districts, incorporating EBIs. | # students educated about substance use, misuse & prevention<br><br>% students indicated an increase in knowledge about substance use, life skills and/or prevention factors<br><br>#students counseled who are at risk for substance abuse<br><br>% students showing an increase in protective factors after counseling |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **12.1 Reduce the crude rate of overdose deaths for Black, non-Hispanic residents, per 100,000 population, from 59.2 to 35.5.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Steuben County Public Health | Implement Narcan training programs for incarcerated individuals in Steuben County, ensuring access to overdose-prevention knowledge and skills prior to release. | # of incarcerated individuals enrolled in Narcan training<br><br># of certified trainers delivering the program<br><br># of trainings administered<br><br>% of participants reporting high confidence in administering Narcan (score 4–5)<br><br>% of incarcerated individuals with a drug-related offense |

Priority: **Primary Prevention, Substance Use, and Overdose Prevention**

Goal: **Reduce substance use, misuse, overdose and/or associated harms.**

Objective: **13.0 Increase the number of naloxone kits distributed from 397,620 to 596,430.**

| Partner Organization | Intervention | Performance Measures |
|---|---|---|
| Steuben County Public Health | Provide accessible in-person and online naloxone (Narcan) trainings for community members and health professionals | # of trainings admisitered<br><br># of participants<br><br># of participants reporting confidence in administering Narcan (score of 4-5) |
| SCASAS | Partner with the Opioid Committee to ensure wall-mounted naloxone boxes remain stocked at key community sites for clients, visitors, and the public. | # of Narcan boxes distributed to wall box units |
| Institute for Human Services (IHS) | Deliver American Heart Association (AHA) CPR and emergency response trainings that integrate updated Narcan administration guidelines | # of participants served<br><br># of instructors trained (general)<br><br># trainers certified specifically for Narcan instruction<br><br># of Narcan kits distributed<br><br>% of participants reporting increased confidence, knowledge, and skill |
| Steuben Prevention Coalition - Opioid Committee | Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers | # Narcan trainings provided by Opioid Committee |

# Steuben County Community Health Improvement Plan (CHIP)
# 2025-2030 Progress Reporting and Revision Plan

In order to continually evaluate the relevance and effectiveness of the CHIP throughout the cycle, the following progress reporting and revision plan will be followed by Steuben County Public Health and the SMART Steuben group. Doing so will ensure that interventions outlined in the CHIP will continue to meet the evolving needs of the Steuben County community.

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| April 2026 | Submit tracking metrics for Q1 2026 to SCPH | Reporting Partners |
| Quarter 2 2026 (June) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q1 2026<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben members |
| August 2026 | Submit tracking metrics for Q2 2026 to SCPH | Reporting Partners |
| Quarter 3 2026 (September) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q2 2026<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben members |
| November 2026 | Submit tracking metrics for Q3 2026 to SCPH | Reporting Partners |
| Quarter 4 2026 (December) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q2 2026<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| December 2026 | Submit Y1 CHIP/CSP progress report by December 2026. | Steuben County Public Health<br>Arnot Health<br>St. James Hospital |
| January 2027 | Submit tracking metrics for Q4 2026 to SCPH<br>Complete the Annual Review Form and submit to SCPH | Reporting Partners<br>Appropriate SMART Steuben members |
| Quarter 1 2027 (March) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q4 2026<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| April 2027 | Submit tracking metrics for Q1 2027 to SCPH | Reporting Partners |
| Quarter 2 2027 (June) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q1 2027<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| August 2027 | Submit tracking metrics for Q2 2027 to SCPH | Reporting Partners |
| Quarter 3 2027 (Septmeber) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q2 2027<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| November 2027 | Submit tracking metrics for Q3 2027 to SCPH | Reporting Partners |
| Quarter 4 2027 (December) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q3 2027<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| December 2027 | Submit Y3 CHIP/CSP progress report by December 2027. | Steuben County Public Health<br>Arnot Health<br>St. James Hospital |
| January 2028 | Submit tracking metrics for Q4 2027 to SCPH<br>Complete the Annual Review Form and submit to SCPH | Reporting Partners<br>Appropriate SMART Steuben members |
| Quarter 1 2028 (March) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q4 2027<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| April 2028 | Submit tracking metrics for Q1 2028 to SCPH | Reporting Partners |
| Quarter 2 2028 (June) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q1 2028<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| August 2028 | Submit tracking metrics for Q2 2028 to SCPH | Reporting Partners |

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| Quarter 3 2028 (Septmeber) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q2 2028<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| November 2028 | Submit tracking metrics for Q3 2028 to SCPH | Reporting Partners |
| Quarter 4 2028 (December) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q3 2028<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| December 2028 | Submit the mid-cycle CHA update to assist hospitals with their IRS-required CSP, if applicable<br>Submit Y4 CHIP/CSP progress report by December 2028.<br>Submit the 2028-2030 CHA/CSP by December 2028 (Hospitals) | Steuben County Public Health<br>Arnot Health<br>St. James Hospital |
| January 2029 | Submit tracking metrics for Q4 2028 to SCPH<br>Complete the Annual Review Form and submit to SCPH | Reporting Partners<br>Appropriate SMART Steuben members |
| Quarter 1 2029 (March) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q4 2028<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| April 2029 | Submit tracking metrics for Q1 2029 to SCPH | Reporting Partners |
| Quarter 2 2029 (June) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q1 2029<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| August 2029 | Submit tracking metrics for Q2 2029 to SCPH | Reporting Partners |
| Quarter 3 2029 (Septmeber) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q2 2029<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| November 2029 | Submit tracking metrics for Q3 2029 to SCPH | Reporting Partners |
| Quarter 4 2029 (December) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q3 2029<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| December 2029 | Submit Y5 CHIP/CSP progress report by December 2029. | Steuben County Public Health<br>Arnot Health<br>St. James Hospital |

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| January 2030 | Submit tracking metrics for Q4 2029 to SCPH<br>Complete the Annual Review Form and submit to SCPH | Reporting Partners<br>Appropriate SMART Steuben members |
| Quarter 1 2030 (March) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q4 2029<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| April 2030 | Submit tracking metrics for Q1 2030 to SCPH | Reporting Partners |
| Quarter 2 2030 (June) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q1 2030<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| August 2030 | Submit tracking metrics for Q2 2030 to SCPH | Reporting Partners |
| Quarter 3 2030 (Septmeber) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q2 2030<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| November 2030 | Submit tracking metrics for Q3 2030 to SCPH | Reporting Partners |

| Timeframe | Activities | Responsible Agencies |
|---|---|---|
| Quarter 4 2030 (December) | Attend SMART Steuben meeting and discuss the following:<br>• Progress towards interventions<br>• Successes and barriers in Q3 2030<br>• Review of recently available data<br>• Changes in resources | All SMART Steuben Members |
| December 2030 | Submit End of Cycle CHIP/CSP progress report by December 2030. | Steuben County Public Health<br>Arnot Health<br>St. James Hospital |
| Ongoing | Comply with all CHA/CHIP reporting requirements as outlined by the NYSDOH | All SMART Steuben Members |

In addition to the timelines laid out above, Steuben County Public health will schedule and host meetings as appropriate whenever there is a need to discuss challenges, successes, and/or possible revisions to the CHIP.

Revisions to the CHIP will be made if one or more of the following conditions are met:

- Significant barriers to feasibility of proposed activities
- Changes in agency resources (i.e. funding, staffing)
- Changes in legislation
- Capitalizing on an emerging opportunity
- Response to emerging health issues

Proposed revisions to the CHIP will consider the following:

- Newly available data sources
- Availability of data for performance measures
- Existence of evidence based or promising practices to support desired outcomes
- Agency readiness to pursue proposed projects
- Current assets and resources in the community

**Appendix 1: Steuben County 2025 - 2030 Community Health Improvement Plan , Annual Review Form**

Please complete the following questions in regards to activities completed by your agency in the last 12 months as part of the Steuben County Community Health Improvement Plan.

Completion date: _____
Completed by: _____
Reporting agency: _____

1. Please provide any relevant updates related to activities and strategies included in your agency's CHIP that were not already reported in the NYSDOH CHIP Workplan.

2. Have there been any changes in your agency's resources that will affect the completion of activities outlined in your agency's CHIP? If yes, please explain.

3. Please identify any new community partnership opportunities relevant to the priority areas of Housing Stability and Affordability, Poverty, and Primary Prevention, Substance Misuse, and Overdose Prevention.

4. Are you aware of any newly available data sources or updated indicators within the priority areas of Housing Stability and Affordability, Poverty, and Primary Prevention, Substance Misuse, and Overdose Prevention? If yes, please explain.

5. Please describe the emerging health issues that your agency believes should be given priority in the current or future CHIP cycle(s).

6. Please use the space below to provide any recommendations for changes to the work outlined in your agency's CHIP. Recommendations may include changes to planned activities, actions, target dates, responsible parties, or process measures.

7. Please provide any additional feedback below.

Thank you!

Public Health
Prevent. Promote. Protect.
Steuben County NY

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# Appendix 2: 2025 - 2030 CHIP Intervention Amendment Form

**If you would like to change existing interventions and/or measures, or you would like to add an intervention to report, please use the template below to indicate the approriate information for each area.**

**Agency name: _____**
**Reporting period:_____**
**Completion date:_____**
**Completed by: _____**

**Priority Area: _____** **Objective: _____**

| Intervention | Performance Measures | Disparities Addressed | Partner Agencies and Resources |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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Steuben County NY

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

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