

Community Health Needs Assessment (CHNA)

FY 2023-2025 Implementation Strategy

Corning Hospital
1 Guthrie Drive, Corning, NY 14830

General Information

Contact Person: Felissa Koernig, President

Date of Written Plan: June 15, 2022

Date Written Plan Was Adopted by Organization's Authorized Governing Body: June 15, 2022

Date Written Plan Was Required to Be Adopted: November 15, 2022

Authorizing Governing Body that Adopted the Written Plan: Corning Hospital Board of Directors

Name and EIN of Hospital Organization Operating Hospital Facility: Corning Hospital 16-0393490

Address of Hospital Organization: One Guthrie Drive, Corning, NY 14830

I. Purpose of Implementation Strategy

This Implementation Strategy has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy annually to meet the community health needs identified through the community health needs assessment. This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in proposed regulations released April 2013.

II. Health Needs Planned to Be Addressed by Facility

List of Significant Health Needs the Facility Plans to Address include:

- Prevent Chronic Diseases
 - Healthy Eating and Food Security
- Promote Wellbeing and Prevent Mental Health and Substance Use Disorder
 - Mental and Substance Use Disorder Prevention

Please refer to the attached tables which provide a detailed description of intervention actions (including collaborative efforts), population description, and evaluation tools by measurable effectiveness criteria. These tables are stratified by priority health need. While other lower priority needs were identified in the Community Health Needs Assessment posted in a separate document, due to available resources these needs will not be addressed through an implementation strategy in the subsequent fiscal years.

FY2023-2025 Corning Hospital Implementation Strategy

Priority: Prevent Chronic Diseases

Focus Area: Healthy Eating and Food Security

Goals: Increase skills and knowledge to support healthy food and beverage choices. Increase food security

Objective: Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	<p>Intervention #1: Screen for food insecurity, facilitate and actively support referrals to community-based resources to address patient needs</p> <p>Utilize Community Health Workers from Care Compass Network Social Impact Pilot to facilitate increased screening and referrals</p> <p>Community Resources: Food Bank of the Southern Tier WIC, SNAP The Institute for Human Services, Inc. Cornell Cooperative Extension</p>	<p>Population: Children and adults presenting to Guthrie Medical Group Internal Medicine, Family Medicine or Pediatric Practices in Steuben County</p>	<p>Percent of patients screened for SDOH</p> <p>Percent of patients who indicate financial strain or food insecurity</p> <p>Number of referrals made to community resources to address food security or financial strain</p>	<p>Meet quarterly with community partners to improve referral pathways</p> <p>Evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance.</p>	<p>Annually</p>
Intervention #2	<p>Intervention #2: Continue offering age-appropriate health curriculum to children in the surrounding area schools through collaborative curriculum development and events.</p> <p>Examples: a. Healthy Kids Day b. Childhood Healthy Lifestyle Program c. Wellness Fairs</p>	<p>Population: Elementary age children from Steuben County, NY</p>	<p>Number of participants in each program or initiative</p> <p>Number of teachers incorporating healthy eating curriculum</p>	<p>Number of community events relative to previous years</p>	<p>Annually – Ongoing</p>

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Intervention #3	<p>Intervention #3: Promote community exercise programs for children by offering families referrals from pediatric providers</p> <p>Community Resources:</p> <p>Girls on the Run Youth Running Club- SOAR YMCA</p>	<p>Population: Guthrie Family Medicine and Pediatric patients in Steuben County, NY</p>	<p>Number of referrals to community based physical activity programs</p>	<p>Meet quarterly with community partners to improve referral pathways</p> <p>Evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance.</p>	<p>Annually – Ongoing</p>

FY2023- 2025 Corning Hospital Implementation Strategy

Priority: Promote Wellbeing and Prevent Substance Use Disorders

Focus Area: Mental and Substance use Disorder Prevention

Goal: Prevent opioid and other substance misuse and deaths

Objective: Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Intervention #1: Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers. Corning Hospital will register as NYS Opioid Overdose Prevention program to distribute Naloxone from the emergency department to patients at risk of overdose	Population: Emergency department patients served by Corning Hospital	Percent of staff who completed naloxone administration training Number of Naloxone kits distributed	Percent of patients seen in the emergency department for an opioid related visit who receive Naloxone	Annually
Intervention #2	Intervention #2: Build support systems to care for opioid users or those at risk of an overdose Continue collaboration with CASA- Trinity to provide education to Guthrie Social Workers, Crisis Workers and Care Coordinators on local resources and other drug and alcohol topics as identified. Explore NY Matters and other closed loop referral systems to increase patient access to medication assisted treatment and other supportive services for substance use disorder	Population: Guthrie patients accessing care in Steuben County	Number of emergency department, inpatient and primary care patients referred to CASA-Trinity Number of patients connected with substance use disorder services within 30 days	Meet quarterly with CASA Trinity to improve referral process	Annually

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	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #3	<p>Intervention #3: Continue promoting safe drug disposal using safe disposal units and community events</p> <p>MedSafe® drug disposal units are installed for community use in two Guthrie locations in Steuben County:</p> <ul style="list-style-type: none"> • Guthrie Medical Group Centerway Site at 130 Centerway, Corning NY 14830 in the 1st Floor Lobby area • Corning Hospital, 1 Guthrie Drive, Corning NY 14830 in the Corning Hospital Outpatient Pharmacy. <p>MedSafe® drug disposal units allow for safe and anonymous disposal of unused or expired medications by community members. The units are available for the community during pharmacy hours.</p>	<p>Population: Community members in Chemung, NY, Schuyler, NY, and Steuben, NY counties</p>	<p>Pounds of medication disposed of (quarterly)</p>	<p>The frequency in which the MedSafe® drug disposal units need to be emptied will be evaluated to determine what other resources are warranted</p>	<p>Annually-Ongoing</p>

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Priority: Promote Wellbeing and Prevent Substance Use Disorders

Focus Area: Mental and Substance use Disorder Prevention

Goal: Reduce the prevalence of major depressive disorders

Objective: Reduce the past year prevalence of major depressive episode among adults age 18 and older

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	<p>Intervention #1: Strengthen economic supports and household financial security by screening for financial strain and housing needs in primary care settings and referring patient to community-based organizations to address identified needs.</p> <p>Community Resources: Arbor Housing and Development The Institute for Human Services, Inc. Catholic Charities</p>	Population: All Guthrie primary care patients in Steuben County, NY	<p>Percent of patients screened for social determinants of health</p> <p>Percent of patients who indicate need for financial/housing assistance</p> <p>Number of referrals to community resources for financial strain or housing needs</p>	<p>Meet quarterly with community partners to improve referral pathways</p> <p>Evaluate closed-loop referral systems to ensure patients receive social determinant of health assistance.</p>	Annually-Ongoing
Intervention #2	<p>Intervention #2: Increase access to mental health providers by hiring psychologist to support Corning service area.</p> <p>Increase depression screening in primary care and refer to treatment when indicated.</p>	Population: Steuben County, NY	<p>Percent of adults screened with PHQ-2</p> <p>Number of patients seen by psychologist</p>	Review and adjust workflows to utilize additional psychology support	Annually-Ongoing