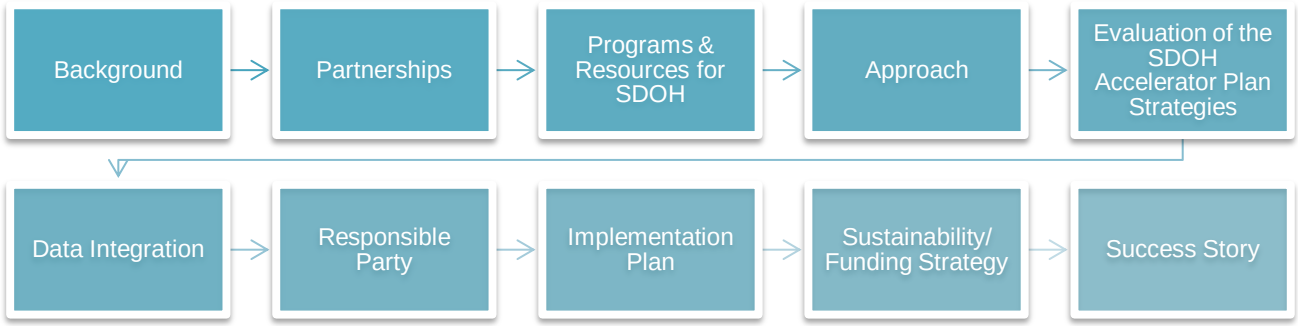
SDOH Accelerator Plan Template

Name: The Healthy Cattaraugus NY Partnership **Date:** August 30, 2023

The recipient is required to include the following components in the SDOH Accelerator Plan.



BACKGROUND

Community Background

☐		**Describe and define the tribe, community, or catchment area that the SDOH Accelerator Plan will address. Include any relevant background or historical information that contributes to current health and social community context.** Cattaraugus County is a 1,300 square mile, primarily rural county in southwestern New York State consisting of two cities, nine villages, and 32 towns populated by more than 76,000 people in nearly 32,000 households. The population is declining, largely white (92%), and concentrated in the southeast quadrant of the county. Most of the county contains fewer than 51 people per square mile. The median age is nearly 42. Almost 17% of the county's population lives below the poverty level and more than 5,800 households receive SNAP benefits. The percentage of individuals living in poverty breaks down as follows: White, 15%, African American, 48%, Native American or Alaska Native, 37%, and Asian, 16%. A community needs assessment conducted by Connecting Communities in Action found that the leading conditions of poverty were lack of employment, substance abuse, lack of education, low wages, and an unwillingness or inability to relocate for better resources. Five-year unemployment rates have been lower than state and national rates. Major employers include government, education, and health care. The median household income is $52,470, compared to a statewide median income of $74,430. There are 13 public school districts in the county. Nearly 64% of students are eligible for free-or-reduced lunches. Graduation rates, at 87%, are higher than the state's rate of 83%; nearly 40% of high school graduates choose not to pursue further education. Safe and affordable housing is a pressing need and housing costs typically account for 45% of median income.

Community Health Issues

BACKGROUND

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Identify primary health issues in the community and describe how the recipient used data to determine primary health issues in the community including information about the Community Health Needs Assessment (CHA) if relevant.

Cattaraugus County ranks 61 among 62 counties in the State for health outcomes and health factors. The most current Community Health Assessment (CHA-CHIP), conducted by the County Health Department in 2021, found that diabetes, cancer, and heart disease had the highest rates of prevalence.

The area has a shortage of physicians, and the lack of transportation makes it difficult to access care. The unavailability and high cost of nutritious foods contributes to levels of high obesity. Drug abuse continues to be prevalent, and pain management programs, methadone clinics, or drug prevention programs are limited. Mental health issues are also on the rise and psychiatric care, behavioral health programs, and providers are also limited. Vision and dental services are limited, as are programs for new and expectant mothers.

Selected Population(s)

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Describe the population(s) selected and the process by which this population was identified. Include description of data used to identify selected population(s) (e.g., demographic, geographic, political boundaries, size of population).

Our target populations are county residents with low income and low or limited access to available services.

Catchment areas were created using a data-driven conceptual framework which included a population density/poverty index map based on U.S. Census block groups.

The variables considered in the poverty index map included the median household income in the past 12 months (in 2021 inflation adjusted dollars); poverty status in the past 12 months of people in housing units; proportion of population with income below 200% of poverty level; and the proportion of households receiving public assistance income or food stamps/SNAP in the past 12 months. The data used was from the US Census Bureau's 2021 American Community Survey and are estimates only.

The population density map was created by dividing the block group population (based on 2020 census data) by the area of the block group in square miles.

These data, representing the "poverty canvas" of the county, can be viewed at: Low Income Map (arcgis.com). To better understand the spatial distribution of food access points, the five-mile and one- mile service areas of full-service supermarkets (source: NYS Agriculture and Markets) and food pantries (source: various internet sites) have been mapped on the "poverty canvas" and can be viewed at Food Pantry / Supermarket Catchment Areas (arcgis.com).

The 'poverty canvas' was then used to identify contiguous census block groups that were determined to have relatively high population density with high poverty. Catchment areas for these target block groups were created by determining the five-mile driving distance from the center of the contiguous block groups. These catchment areas became the geographic areas used as basis for subsequent decision-making by the leadership team.

Two of the catchment areas have been selected to demonstrate "proof of concept" by introducing evidence-based interventions to reduce food insecurity and increase access to care, beginning in 2024.

PARTNERSHIPS

Leadership Team

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Describe the Leadership Team, including the organizational affiliation of each team member, the community and/or population that each member represents, and the role they will serve in developing and reviewing the SDOH Accelerator Plan.

The leadership team consisted of 13 community leaders, representing health care, government, community-based organizations, and Indigenous territories. Organizations represented include CCA: Connecting Communities in Action, the Southern Tier West Center for Regional Excellence, the Cattaraugus County Department of Aging/NY Connects, the Seneca Nation of Indians, the Cattaraugus County Health Department, Universal Primary Care, the Southern Tier Health Care System, CASA/Trinity, the NYS Public Health Corps Fellows, and Canticle Farm. All committee members either work or reside in Cattaraugus County or the Indigenous territories.

Team members met monthly from January through August, both virtually and in person; developed the key components of the Accelerator Plan; and approved the final version of the plan. Besides attending the regularly

		scheduled meetings, team members routinely were called upon by the facilitator to complete specific tasks related to the plan's creation, subject to the entire team's review and approval.
Multisectoral Partners		
☐		**Describe multisectoral partner roles, responsibilities, and goals.** The primary multisector partners are CCA: Connecting Communities in Action (CCA) and the Cattaraugus County Health Department (CCHD). CCA is a private, nonprofit organization formed in 1965 in response to the War on Poverty. Headquartered on the Seneca Nation of Indians' Territory in Salamanca, NY, CCA works closely with territory leaders and local community-based organizations to provide strengths-based opportunities for vulnerable people to achieve economic, physical, and emotional security. CCA's services and opportunities for low-income and disenfranchised people fall into eight categories: energy conservation; emergency and homeless services; housing, nutrition, and victim services; youth programs; parent support; and mental health. The agency has an annual budget of nearly $11 million and a history of successfully managing a variety of funds from multiple federal, state, local, and private sources. The Cattaraugus County Health Department (CCHD), headquartered in Olean, NY (Cattaraugus County), has had a long-standing partnership with CCA. The Health Department's mission is to engage and empower the public to live healthier lifestyles through education, prevention, testing, diagnosis, and treatment. Other partners include the Cattaraugus County Department of Aging/NY Connects, Universal Primary Care, the Southern Tier Health Care System, the Seneca Nation, several community-based organizations, and the New York State Public Health Corps Fellows.
☐		**Identify potential missing partners that may contribute to improving SDOH.** Partners who were not part of the leadership team but who have been kept informed of the Accelerator Plan's development and will be assisting with the implementation phase include FeedMore WNY, local school superintendents, and local food pantries. FeedMore WNY currently operates two mobile farm trucks that serve Buffalo and Erie County NY. A third truck will serve residents in Chautauqua and Cattaraugus Counties, as well as local food pantries in the area. FeedMore offers a backpack program in the West Valley, Olean, and Franklinville School Districts in Cattaraugus County. The agency also operates a school pantry program; however, no Cattaraugus County schools are participating currently, given the lack of staff that would be required to run the program. Moving forward, the support of local school superintendents will be critical to the expansion of the school pantries and backpack program. The local food pantries have been surveyed by a member of the NYS Public Health Corps Fellows to determine hours of operation, number of staff and volunteers, estimated number of individuals and families served weekly, the availability of space to provide additional services, and the availability of internet connectivity.
☐		**Describe method used to engage diverse and inclusive new and existing partners in program planning and implementation efforts.** Among the leadership team's first tasks was to develop a stakeholder communication and engagement plan. Eight stakeholder groups were identified including funders, health insurers, political leaders, county officials, and city officials, as well as representatives from the Seneca Nation, faith communities, and community-based organizations. Periodic written updates were sent to nearly 90 leaders and influencers within these groups to keep them apprised of the process, the plan, and the team's progress. Stakeholders were encouraged to provide feedback throughout the process and given the project coordinator's name so they could contact her directly. In addition, personal visits are being and will continue to be made to the current and new partners within the targeted catchment areas to enlist their support.
☐		**Describe new partner linkages and how duplication of services across partners was minimized or avoided.** The leadership team will maximize the use of available resources and avoid duplication of services through collaboration. We plan to work closely with FeedMore WNY to secure funding for the additional vehicles, food, and staff that will be required to serve the targeted catchments. We also will draw upon FeedMore's expertise in running school pantries and backpack programs. The new partnerships being formed with local food banks will be critical in determining the effectiveness of food prescriptions, pantry co-locations at clinics, and food drop-offs to reduce food insecurity.

PARTNERSHIPS

		The partnerships with the Southern Tier Health Care System, Universal Primary Care, and the Upper Allegheny Health System will be critical to the implementation of the strategies selected to increase access to care.

Shared Mission and Goal Statement

☐		**The Leadership Team will articulate a shared mission statement that represents the purpose of the SDOH Accelerator Plan, with mutually agreed upon goals.** The following Statement of Intent was developed and approved by the leadership team early in the process: *The Healthy Cattaraugus NY Partnership is a collaborative of organizations working to improve the physical and emotional health of Cattaraugus County residents, particularly those living in poverty. We have two goals: reduce food insecurity and improve access to care.* *We're focused on people who do not have enough to eat because we know that poor nutrition contributes to poor health and that, even if residents can afford food, the options available too often are not the best.* *We're committed to improving access to health care, both physical and mental, because people should be able to get the help they need when they need it and because access can reduce more serious injuries and illnesses.* *Education and increased public awareness will be critical to our success, as will our ability to develop an effective collaborative that can connect people to what they need.* *We will reach out to people where they live and gather -- in the schools, houses of worship, and community meeting spaces within our towns and villages, Indigenous territories, and rural areas.* *Finally, we will measure and evaluate everything we do, recognizing that, if we can demonstrate improved outcomes, we will attract the public and private funding that will sustain our work.* *Our mission is to improve the health of all Cattaraugus County residents, especially for those living on the margins.*

PROGRAMS AND RESOURCES FOR SDOH

Existing Resources and Programs

☐		**Describe the existing resources and programs available for the selected population(s). If multisectoral intake and referral systems exist, include a description of how the various programs currently work together.** The two catchment areas in which the interventions to reduce food insecurity and increase access to care will be introduced have limited resources. Combined, the catchments are home to nearly 13,000 residents. Salamanca has two municipal centers, eight churches, two food pantries, two full-service supermarkets, three libraries, four schools, three fire stations, more than two dozen physicians, and a Federally Qualified Health Center. Little Valley/ Cattaraugus Valley has 11 churches, four food pantries, three fire stations, one municipal center, two libraries, two schools, and one physician. Although the area still lacks a full-service supermarket, a food market recently opened there. Besides the assets already available in the targeted catchment areas, Connecting Communities in Action offers a food pantry five days a week, as well as a soup kitchen that offers hot meals on site or to go. Each year, CCA provides 16,000 food boxes through its food pantry and 8,700 hot meals through its soup kitchen. CCA regularly receives food donations from local businesses, restaurants, and grocery stores and relies upon the local food bank for shelf-stable food items. Fresh produce, bread, and milk are obtained through local food recovery efforts. The Cattaraugus County Department of the Aging provides more than 34,000 congregate meals and 139,000 home-delivered meals annually and the other partners on the planning team offer a range of additional services and programs. CCA and the County Health Department routinely share data. CCA collects information within an agency-wide database that cross references referrals between agencies, allows for linkages to services, and tracks client activities and progress. This long-standing partnership between CCA and the Health Department ensures the tracking of all services, provides progress reports, and minimizes the duplication of services.

APPROACH

SDOH Priority Areas

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Describe the selected SDOH priority areas (a minimum of two (2)) and provide justification for selecting the priority areas.

Our SDOH priorities are to reduce food insecurity and improve access to care. These priorities were selected based on the CCA's triennial community needs assessment and the County Health Department's CHA-CHIP which found that residents' primary concerns included lack of nutritious foods, the increase in chronic disease, and the lack of access and clinical linkages.

The Little Valley/Cattaraugus catchment area is considered a "food desert," given residents' low incomes and low access to fresh, nutritious foods. The area lacks health care providers and access to nearby health care facilities is hampered by limited transportation. While the Salamanca catchment offers more options for food and health care, access remains an issue. The County's social vulnerability index score of .73 (out of 1.0) indicates a moderately-high level of vulnerability.

Outcomes

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Describe the short-, intermediate, and long-term outcomes that will result from the planned SDOH strategies and activities.

Short-term outcomes have included increased collaboration between and among members of the leadership team and the creation of a data-driven model to inform current and future decision making.

Intermediate outcomes will include increased collaboration between and among community partners, particularly those within the catchment areas selected to demonstrate proof of concept, and residents' increased awareness of available resources.

Long-term outcomes will include a measurable reduction in food insecurity and increased access to care, both of which should contribute to improved population health and the reduction or improved management of chronic disease.

Activities

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Describe the process for identifying and tailoring approaches to the selected tribe, community, or catchment area.

Under the direction of one of the leadership team members, four New York State Public Health Corps Fellows researched and identified 12 evidence-based or best practice interventions to reduce food insecurity and 12 interventions to increase access to care, specifically in rural settings where residents had low income and low access.

Leadership team members then reviewed, discussed, and prioritized the interventions they felt could best demonstrate proof of concept in the selected catchment areas noted above. Five interventions were selected to reduce food insecurity and three interventions were chosen to increase access to care.

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Describe the activities required to improve SDOH for the selected population(s).

The five strategies/tactics to reduce food insecurity include:

1. Using mobile food pantries and pop-up pantries to improve access to healthy foods.
2. Co-locating food pantries at clinics.
3. Issuing healthy food prescriptions.
4. Offering food drop-offs, ideally using community health workers.
5. Expanding the school backpack program.

The three strategies/tactics to increase access to care include:

1. Using telehealth interventions.
2. Introducing community paramedicine.
3. Piloting school-based health services.

Specific action steps for implementing these strategies/tactics are outlined below in the "Implementation Plan."

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Describe the number and types of evidence-based practices identified and tailored to improve SDOH for the selected population(s).

The following evidence-based and best practice interventions were selected to reduce food insecurity:

1) Mobile Food Pantry/Pop-up Pantry

General Audience Links:
Talawanda Oxford Pantry and Social Services goes mobile (spectrumnews1.com)

Pop-Up Pantries - Foodlink Inc (foodlinkny.org)

Academic Citation Links:
Perceived Advantages of and Concerns About Mobile Food Pantries Among Mothers Who Utilized Food Pantries Before or During the COVID-19 Pandemic: Journal of Hunger & Environmental Nutrition: Vol 0, No 0 (tandfonline.com)
Nutrients | Free Full-Text | Feasibility of Food FARMacia: Mobile Food Pantry to Reduce Household Food Insecurity in Pediatric Primary Care (mdpi.com)

2) ***Health Clinic/Food Pantry Co-locations***

General Audience Links:
'Food Pharmacies' In Clinics: When The Diagnosis Is Chronic Hunger : The Salt : NPR
Community Food Shelf | NorthPoint (northpointhealth.org)

Academic Citation Links:
An In-Clinic Food Pharmacy Addresses Very Low Food Security | Annals of Family Medicine (annfammed.org)
Food as Medicine Clinic: Early Results and Lessons Learned - PubMed (nih.gov)

3) ***Healthy Food Prescriptions/Vouchers***

General Audience Links:
Food assistance programs across state expand healthy food options for low-income families | by Governor Jay Inslee | Washington State Governor's Office | Medium

Academic Citation Links:
The food pharmacy: Theory, implementation, and opportunities - ScienceDirect
Fresh Food Farmacy - Allison Hess, Michelle Passaretti, Stacy Coolbaugh, 2019 (sagepub.com)
Implementation of an On-Site Food Prescription Project to Address Food Insecurity in Multiple Free Clinic Sites Serving an Adult Latinx Population: Journal of Hunger & Environmental Nutrition: Vol 0, No 0 (tandfonline.com)

4) ***Food drop-offs (potentially using community health workers)***

General Audience Links:
How community health workers are alleviating food insecurity during the pandemic - Scrubbing In
DoorDash, InstaCart Are Working With Food Banks to Deliver Groceries to People in Need (verywellhealth.com)

Academic Citation Links:
Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries | Health Affairs
Food to Overcome Outcomes Disparities: A Randomized Controlled Trial of Food Insecurity Interventions to Improve Cancer Outcomes | Journal of Clinical Oncology (ascopubs.org)

5) ***School backpack program***

General Audience Links:
FeedMore WNY – Backpack Program – Enrollment and Implementation Guide

Academic Citation Links:
Eating on schooldays and non-schooldays among children at risk for food insecurity: Implications for weekend food backpack programs: Journal of Hunger & Environmental Nutrition: Vol 13, No 3 (tandfonline.com)
“BackPack” Food Programs Linked to Higher Test Scores for School Children | Carsey School of Public Policy | UNH

The following interventions were selected to increase access to care:

1. ***Community Paramedicine (Mobile Integrated Health Care)***

General Audience Links:
Community Paramedicine Overview - Rural Health Information Hub

Academic Citation Links:
Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program

2. ***Telehealth Interventions***

General Audience Links:

APPROACH		
		Expansion of Telehealth Across the Rural–Urban Continuum - Ann D. Bagchi, 2019 (sagepub.com) Academic Citation Links: Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review - PMC (nih.gov) ***3. School-based Health Services*** General Audience Links: School Based Health Centers - One Pager Community School / Health & Wellness (genvalley.org) Academic Citation Links: Twenty Years of School-Based Health Care Growth and Expansion | Health Affairs
☐		**Describe the types of community and systemic barriers encountered and addressed during the plan development process.** No barriers were encountered during the planning process. The community and systemic barriers that will need to be addressed during the implementation phase will include issues of low income, low access, unwillingness of some partners to partner and collaborate, unwillingness of residents to avail themselves of services, and insufficient human and financial resources to support and sustain the implementation plan.
☐		**Describe how policy, systems, environmental, programmatic and infrastructure activities build on each other to sustain health improvements and the achievement of selected outcomes.** Focusing initially on a few catchment areas to demonstrate proof of concept will result in a more strategic, intentional, and collaborative approach to reducing food insecurity and increasing access to care. We plan to inform and engage all available assets in the catchment area, including municipal centers, schools, fire stations, food pantries, farmers' markets, libraries, and health care providers. Once completed, the Accelerator Plan will be shared with Federal, State, and local government officials to enlist their support of the public policy changes and funding that will be required. The plan also will be shared with major donors, local employers, and foundations that have the capacity to provide private philanthropic support to ensure the sustainability of this work.
Anticipated Reach of the Activities		
☐		**Describe the potential reach of the activities for the selected population(s).** Efforts will focus initially on two catchment areas comprised of nearly 13,000 residents. Over time, the strategies and tactics will be expanded into the remaining three catchments, which represent a combined population of nearly 34,500 (based on 2020 census data).
Anticipated Policy, Systems, Environmental, Programmatic, and Infrastructure Outcomes		
☐		**Describe sustainable outcomes that will result from implementation of the SDOH Accelerator Plan strategies and activities.** The anticipated sustainable outcomes will be food security and access to care. Food security is achieved when all people within a household have enough food all the time for an active, healthy life. Access to care is achieved when there are adequate health care services available, and people can use those services to achieve the best possible health outcomes.

EVALUATION OF THE SDOH ACCELERATOR PLAN STRATEGIES		
☐		**Describe how the SDOH Accelerator Plan strategies and outcomes will be measured, with particular focus on the social and public health impact on the selected population(s).** Strategies for reducing food insecurity include mobile food pantries, pop-up pantries, co-location of food pantries at clinics, food prescriptions, food drop-offs, and school backpack program expansion. These strategies could be measured as follows: • # of mobile food pantries and pop-up pantries available on a monthly and quarterly basis • # of new mobile food pantries in catchment area • # of individuals and families (unduplicated) accessing the mobile or pop-up pantries on a monthly and quarterly basis

EVALUATION OF THE SDOH ACCELERATOR PLAN STRATEGIES

- # of pantries that are co-located with clinics
- # of individuals and families (unduplicated) accessing co-located pantries
- # of food prescriptions written and # of food prescriptions filled on a quarterly basis
- # of school districts participating in school backpack programs
- # of children in each participating school who utilize the backpack programs

Outcomes will be measured as follows:

1. A still-to-be-developed self-reporting assessment tool, based on a Likert Scale, will enable residents to rate their access to healthy foods as improving over time.
2. A similar self-reporting assessment will measure the perceived decrease in food insecurity over time.
3. County-wide community health needs data will be reviewed pre- and post-intervention and documented by the Health Department.

Strategies for increasing access to care include telehealth interventions, community paramedicine, and school-based health services. These strategies could be measured as follows:

- # telehealth providers willing to serve the catchment area
- # individuals (unduplicated) accessing telehealth on a quarterly basis
- # of community paramedicine providers available in the catchment area
- # individuals (unduplicated) accessing community paramedics on a quarterly basis.
- # schools in the catchment area willing to offer school-based health services
- # students (unduplicated) accessing care in school-based health clinics on a quarterly basis
- # families (unduplicated) accessing care in school-based health clinics on a quarterly basis

Outcomes will be measured as follows:

1. A still-to-be developed self-reporting assessment tool, based on a Likert Scale, will enable residents to rate their access to health care.
2. A health screening form will be used to identify asymptomatic individuals for chronic health disorders and to refer individuals to licensed sources of care when indicated. The County Health Department will be notified of, and/or participate in, those events. This could also include changes in the number of insured individuals.
3. The triennial Community Health Needs Assessment will illustrate gaps and additional points of access still needed for the community.

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Describe the evaluation purpose, goals, evaluation questions, data collection and methods.

The purpose of evaluation in any system is to measure the effectiveness of the strategies and interventions chosen to address the problem. The community providers selected to address any given strategy would develop, with the assistance of the Leadership Team, the goals and evaluation techniques specific to their interventions. Methods would vary by approach and expected outcome. For example, if Connecting Communities in Action were to secure funding for a mobile food pantry, that agency would draft realistic goals and outcomes, tools for measuring access to the pantries, etc. for approval by the team. Similarly, if the Federally Qualified Health Center secured a grant for school-based health services, many of those outcomes would be dictated by the Health Services and Resources Administration at Health and Human Services.

DATA INTEGRATION

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Describe the existing data sources across partners.

Existing data sources across partners include:

- Health Department's Community Needs Assessment: This assessment, conducted triennially, convenes a diverse group of community partners and stakeholders to collect, analyze, and interpret county data and identify the most pressing health related needs among county residents.
- Connecting Communities in Action's Community Needs Assessment: This assessment, conducted triennially, reviews quantitative and qualitative data across several domains that include income and poverty; employment; education and cognitive development; housing; health; and social/behavioral development including nutrition, civic engagement, support services and linkages.
- County GIS, Maps, and Data: A plethora of information can be found directly associated with the county, including, but not limited to, demographic data, labor statistics, and property GIS data.

DATA INTEGRATION

- NYS County Health Rankings: Provides County-level data in terms of health outcomes and health factors. The database allows public health professionals to understand where the county stands on key health indicators.
- Internal data across partners: The agencies represented by members of the SDOH Leadership Team have current internal data that can be used to develop baselines.
- Finally, the New York State Community Action Association (NYSCAA) offers specific data on poverty levels, needs assessments, and County data.

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Describe the process for monitoring and integrating data elements to create a comprehensive system for tracking selected population(s) resource utilization.

Due to the sensitive nature of some of the health data collected, it may not be possible to fully integrate data systems that protect privacy and are compliant with HIPAA regulations. It may be more reasonable to expect that there will be a repository for data related to food security and another related to access to care. The data for those repositories will be provided by the champions for the respective interventions, assuming the resources necessary for implementation have been secured.

RESPONSIBLE PARTY

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Describe how each partner will participate in the planning, implementation, and reporting process.

Each member of the Leadership Team has fully participated in the process of creating the Accelerator Plan.

As stated above, how each partner will participate in implementation and reporting will depend on which agency or agencies are able to secure funding for implementation. The implementors would be responsible for reporting.

IMPLEMENTATION PLAN

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Provide a budget for implementing the strategies and activities.

The ***estimated annual budget*** for implementing the proposed strategic interventions for each of the next three years is $1,332,925 broken down as follows:

- Salaries, wages, benefits: $645,000
- Equipment: $180,000
- Technology & software: $39,500
- Marketing: $40,000
- Training: $29,000
- Operating expenses: $253,750
- Office expenses: $24,500
- Admin. Overhead: $121,175

The total estimated annual budget is a compilation of the estimated budgets for the implementation workplans below.

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Provide a work plan with a timeline to complete proposed strategies and activities.

Following are the ***high-level*** implementation workplans for each of the proposed strategic interventions. The designated champions for each intervention will be responsible for forming time-limited working groups which will be tasked for completing the required action steps, identifying additional activities that may be required, tracking metrics, and monitoring progress towards established outcomes.

Objective: Reduce food insecurity
Target Catchment: Little Valley/Cattaraugus and Salamanca

Strategic Intervention: Mobile Pantry/Pop-ups

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Specialized vehicle with refrigeration • Driver • Food • Community partners for primary access/distribution

	• Marketing plan, materials, messaging • Budget (salaries, insurance, vehicle maintenance, fuel)
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Data collection, analysis, management system • Secondary access/distribution points • Supplies and/or additional equipment • Nutrition education • Non-food supplies, personal care items • Tablets and software for data collection • Outside expertise to create the marketing plan.
Key Action Steps	• Identify and secure cooperation of critical partners to provide access/distribution sites. • Prepare operating budget. • Secure required funding. • Purchase vehicle; hire and train staff; secure food; develop marketing plan, materials, and messaging; develop route schedule. • Prepare operations manual and policies. • Reinstitute Cattaraugus County Food and Agriculture Policy Network
Critical Partners	• FeedMore WNY • Cornell Cooperative Extension • Local schools • Municipal centers • Fire departments • Clinics • Selected community-based organizations • Food pantries
Estimated Budget *(Letters of Intent are being sent to private and public funding sources)* *(*	• Salaries, wages, benefits: $45,000 • Equipment: (vehicle): $100,000 • Technology & software: $2,500 • Marketing: $5,000 • Training: $1,000 • Operating expenses: $5,000 • Office expenses: $4,000 • Admin. Overhead: 16,250 • ***Total: $178,750***
Metrics	• # of mobile food pantries and pop-up pantries available on a monthly and quarterly basis • # of new mobile food pantries in catchment area • # of individuals and families (unduplicated) accessing the mobile or pop-up pantries on a monthly and quarterly basis
Champions	• CCA: Connecting Communities in Action • FeedMore WNY • NYS Sustainable Agriculture Working Group
Anticipated Implementation Date	April 2025

Objective: Reduce food insecurity
Target Catchment: Little Valley/Cattaraugus

Strategic Intervention: Food Drop-offs

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Program coordinator (note: program coordinator would be responsible for food drop-offs, school backpack program, scheduling of mobile pantry, and oversight of the food prescription program.) • Food • Part-time driver • Community partners for primary access/distribution • Marketing plan, materials, messaging • Budget (including mileage reimbursements)

Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Data collection, analysis, management system • Nutrition education • Supplies and/or additional equipment • Non-food supplies, personal care items • Tablets and software for data collection • Outside expertise to create the marketing plan.
Key Action Steps	• Identify and secure cooperation of critical partners who would serve as access/distribution sites. • Prepare operating budget. • Secure funding for program coordinator and part-time driver, food, marketing. • Hire and train staff; secure food; develop marketing plan, materials, and messaging; develop route schedule. • Prepare program operations manual and policies.
Critical Partners	• FeedMore WNY • Local schools • Municipal centers • Fire departments • Selected community-based organizations • Food pantries
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $75,000 for program coordinator (ideally LPN, Registered Dietician); $25,000 for the driver • Equipment: • Technology & software: $5,000 • Marketing: $5,000 • Training: $1,000 • Operating expenses: (50,000 miles @.655) $32,750 • Office expenses: $4,000 • Admin. Overhead: $14,775 • ***Total: $162,525***
Metrics	• # of participating drop off sites • # of food drop offs on a quarterly basis
Champions	• CCA: Connecting Communities in Action • FeedMore WNY
Anticipated implementation Date	February 2025

Objective: Reduce food insecurity
Target Catchment: Little Valley/Cattaraugus

Strategic Intervention: School Backpack Program

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Partner school(s) • Program coordinator • Food and backpacks • Marketing plan, materials, messaging • Budget and funding
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Community partners to provide alternate access/distribution sites • Data collection, analysis, management system • Nutrition education • Personal care items • Tablets and software for data collection • Outside expertise to create marketing plan.
Key Action Steps	• Secure commitment from school superintendent, local school(s) principal(s) • Identify and secure cooperation of critical partners to serve as additional access/distribution sites. • Prepare operating budget. • Secure required funding. • Prepare program operations manual and policies.
Critical Partners	• Local schools

	• FeedMore WNY • Municipal centers • Fire departments • Selected community-based organizations • Food pantries
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $10,000 • Equipment: (backpacks): $5,000 • Technology & software: $1,500 • Marketing: $5,000 • Training: $1,000 • Operating expenses: $100,000 • Office expenses: $4,000 • Admin. Overhead: $12,650 • ***Total: $139,150***
Metrics	• # of children served • # of backpacks distributed
Champions	• CCA: Connecting Communities in Action • FeedMore WNY
Anticipated implementation Date	March 2024

Objective: Reduce food insecurity
Target Catchment: Salamanca

Strategic Intervention: Food Prescriptions

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Program Coordinator • Relationships with clinics and practitioners • Primary distribution points; food pantries • Provider and clinical support team education/training • Marketing plan, materials, messaging • Budget and funding
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Data collection, analysis, management system • Nutrition education • Tablets and software for data collection • Outside expertise to create marketing plan.
Key Action Steps	• Secure cooperation of health care providers/clinical support teams • Secure cooperation of local food pantries, distribution sites • Prepare operating budget. • Secure required funding.
Critical Partners	• Local health care providers/clinical support teams • Local health insurance providers • Community-based organizations • Local food pantries • Local farms
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $50,000 • Equipment: • Technology & software: $15,000 • Marketing: $5,000 • Training: $5,000 • Operating expenses: $5,000 • Office expenses: $2,500 • Admin. Overhead: $8,250 • ***Total: $90,750***
Metrics	• # of food prescriptions written • # of food prescriptions filled on a quarterly basis
Champions	• Universal Primary Care • FeedMore WNY
Anticipated implementation Date	• July 2024

Objective: Reduce food insecurity
Target Catchment: Salamanca

Strategic Intervention: Clinic/Pantry Co-location

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Site locations • Staffing • Food and supplies • Marketing plan, materials, messaging • Budget and funding (particularly for perishables)
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Data collection, analysis, management system • Nutrition education materials • Tablets and software for data collection • Outside expertise to create marketing plan.
Key Action Steps	• Secure cooperation of clinics/providers • Secure cooperation of local food pantries, distribution sites • Prepare operating budget. • Secure required funding. • Implement marketing.
Critical Partners	• FeedMore WNY • Local clinics • CCA
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $50,000 • Equipment: • Technology & software: $3,000 • Marketing: $5,000 • Training: $5,000 • Operating expenses: $50,000 • Office expenses: $3,000 • Admin. Overhead: $11,600 • ***Total: $127,600***
Metrics	• # of pantries that are co-located with clinics • # of individuals and families (unduplicated) accessing co-located pantries
Champions	• Universal Primary Care • CCA
Anticipated implementation Date	• April 2025

Objective: Increase Access to Care
Target Catchment: Little Valley/Cattaraugus and Salamanca

Strategic Intervention: Telehealth Interventions

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Telehealth Navigator/Care Coordinator (to work with providers and patients to coordinate telehealth and community paramedicine) • Marketing/education plan, materials, messaging • Budget and funding
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Data collection, analysis, management system • Outside expertise to create marketing plan.
Key Action Steps	• Secure cooperation of health care providers to use existing telehealth sites for primary and secondary visits

	• Identify additional sites (municipal centers, libraries, schools, including patients' homes) • Prepare operating budget. • Secure required funding. • Implement marketing. • Provide training on access for health care interfaces.
Critical Partners	• Southern Tier Health Care System • Universal Primary Care • Olean Hospital/Upper Allegheny Health System • Trinity/CASA • Insurance companies
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $90,000 (tech savvy RNs, LPNs) • Equipment: • Hardware & software: $10,000 (laptops, cell phones, cell phone plan) • Marketing: $5,000 • Training: $5,000 • Operating expenses: $5,000 (travel reimbursement) • Office expenses: $2,000 • Admin. Overhead: $11,700 • ***Total: $128,700***
Metrics	• # telehealth providers willing to serve the catchment area • # individuals (unduplicated) accessing telehealth on a quarterly basis
Champions	• Southern Tier Health Care System • Universal Primary Care
Anticipated implementation Date	• October 2024

Objective: Increase Access to Care
Target Catchment: Little Valley/Cattaraugus and Salamanca

Strategic Intervention: Community Paramedicine

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Willing partners • Training • Data collection, analysis, management system • Tablets and software for data collection • Marketing plan, materials, messaging • Budget and funding
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Outside expertise to create marketing plan.
Key Action Steps	• Secure cooperation of providers • Develop training program. • Prepare operating budget. • Secure funding. • Implement marketing.
Critical Partners	• Southern Tier Health Care System • Universal Primary Care • Olean Hospital/Upper Allegheny Health System • County Health Department
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $90,000 • Equipment: $25,000 • Technology & software: $2,500 • Marketing: $5,000 • Training: $5,000 • Operating expenses: $50,000 • Office expenses: $5,000

	• Admin. Overhead: $18,250 • ***Total: $200,750***
Metrics	• # of community paramedicine providers available in the catchment area • # individuals (unduplicated) accessing community paramedics on a quarterly basis.
Champions	• Southern Tier Health Care System
Anticipated implementation Date	• December 2024

Objective: Increase Access to Care
Target Catchment: Little Valley/Cattaraugus and Salamanca

Strategic Intervention: School-based Health Services

Essential Resources *(Essential resources are critical to the implementation of the intervention. Without them, the intervention cannot be implemented.)*	• Site location • Staffing/Dedicated clinician • Supplies • Data collection, analysis, management system • Marketing plan, materials, messaging • Budget and funding
Secondary Resources *(Secondary resources contribute to a successful implementation but, if not available, the intervention still can be implemented.)*	• Tablets and software for data collection
Key Action Steps	• Secure cooperation of local school(s) • Secure cooperation of health care providers • Prepare operating budget. • Secure required funding. • Implement marketing.
Critical Partners	• Schools • Southern Tier Health Care System • Universal Primary Care • Olean Hospital/Upper Allegheny Health System • County Health Department
Estimated Annual Budget *(Letters of Intent are being sent to private and public funding sources)*	• Salaries, wages, benefits: $70,000 for program coordinator/assistant; $140,000 for nurse practitioner or physician's assistant • Equipment: $50,000 • Technology & software: Telehealth • Marketing: $5,000 • Training: $6,000 • Operating expenses: $6,000 • Office expenses: • Admin. Overhead: $27,700 • ***Total: $304,700***
Metrics	• # schools in the catchment area willing to offer school-based health services • # students (unduplicated) accessing care in school-based health clinics on a quarterly basis • # families (unduplicated) accessing care in school-based health clinics on a quarterly basis
Champions	• Universal Primary Care
Anticipated implementation Date	• September 2025

SUSTAINABILITY/ FUNDING STRATEGY

☐

Describe strategies to expand, diversify, and sustain implementation efforts, including funding.

The proposed interventions constitute a multi-year strategy which initially will be introduced in the two targeted catchments, and then expanded to the remaining three catchments, over the next 36-to-48 months. We will "learn as we go," and make whatever improvements are necessary to ensure that our efforts are intentional, focused, and achieving the desired, measurable outcomes.

Our approach to securing sustainable funding will be multi-pronged.

First, comprehensive "cases for support" will be created for each of the proposed interventions for review and consideration by potential public and private funders. Each case for support will outline the public health issue to be addressed and the specific intervention for which funding is being sought.

Second, we will research, cultivate, and solicit public and private short-term support for specific interventions.

Third, we will aggressively pursue longer-term funding through New York State's 1115 waiver.

Fourth, we will develop a comprehensive relationship-based stewardship program to ensure that funders are kept apprised of the progress being made and the outcomes achieved because of their investments. An effective stewardship program will be critical to securing future commitments and support.

Finally, we will advocate for changes in policy that will allow reimbursement for community paramedicine.

SUCCESS STORY

☐

Complete a success story on establishing, expanding, and coordinating multisector partners. The success story is required to include the following components.

Title: ***Doubling Down on Food Insecurity in Cattaraugus County NY***

Problem/Issue:
Nestled in the southwestern corner of New York State, Cattaraugus County is part of the Appalachia region. The county ranks 61 among 62 counties in the State for health outcomes and health factors. The most current Community Health Assessment (CHA-CHIP), conducted by the County Health Department in 2021, found that diabetes, cancer, and heart disease had the highest rates of prevalence. Obesity levels are high and chronic disease management is hampered by the unavailability and high cost of nutritious food.

Approach:
Reducing food insecurity was one of two priorities (increasing access to care was the other) identified by the Healthy Cattaraugus NY Partnership, based on community needs assessments conducted by Connecting Communities in Action and the County Health Department. Using GIS maps, five catchment areas were created using a combination of high poverty, low access, and population density. The partnership's leadership team -- 13 community leaders representing health care, government, community-based organizations, and Indigenous territories -- selected two of the catchment areas in which to focus evidence-based interventions for reducing food insecurity and increasing access to care, beginning in 2024.

One of the catchment areas is a 23-mile stretch in the western region of the County, between Salamanca and Gowanda. This area, which is considered a "food desert," is a well-commuted passageway for the Indigenous Seneca Nation territories of Allegany and Cattaraugus and includes the villages of Little Valley and Cattaraugus Valley (combined population: 2,200). The town of Salamanca, which borders Little Valley and Cattaraugus Valley and has 5,000 residents, was selected as the second catchment.

Under the direction of one of the leadership team members, four New York State Public Health Corps Fellows researched and identified 12 evidence-based or best practice interventions to reduce food insecurity and 12 interventions to increase access to care.

Leadership team members then selected five interventions to reduce food insecurity: mobile pantry/pop-ups, food drop-offs, food prescriptions, clinic/pantry co-locations, and school backpack programs. Three other interventions were chosen to increase access to care.

Achievements and Impact:
New partnerships are being formed to successfully implement the interventions, make the best use of existing resources, and avoid duplication of services.

SUCCESS STORY

One of the new partners in reducing food insecurity will be FeedMore WNY, whose food bank program has distributed more than 17 million pounds of nutritious fresh and shelf-stable foods to nearly 300 pantries, soup kitchens, emergency shelters and other hunger-relief agencies throughout Western New York.

FeedMore WNY currently operates two mobile farm trucks that serve Buffalo and Erie County NY. A third truck will serve Chautauqua and Cattaraugus Counties, as well as the local food pantries in the area.

FeedMore offers a school backpack program in the West Valley, Olean, and Franklinville School Districts in Cattaraugus County. The agency also operates a school pantry program; however, no Cattaraugus County schools are participating currently given the lack of staff required to run the program.

New partnerships are being formed as well with local food pantries. A member of the NYS Public Health Fellows surveyed the pantries to determine hours of operation, number of staff and volunteers, estimated number of individuals and families served weekly, the availability of space to provide additional services, and the availability of internet connectivity.

Challenges:

To date, there have been no challenges in working with the partners. Moving forward, the primary challenge will be to secure the additional financial resources required to bring the interventions to fruition and maintain those interventions long-term.

Lessons Learned:
Going through the planning process has underscored the importance of collaboration, data-driven decision making, program scalability and sustainability, and community engagement.

Collaboration: The planning team's success exemplifies its ability to collaborate effectively with various stakeholders, including local healthcare providers, community organizations, and government agencies. This collaborative approach has identified community needs and developed targeted interventions.

Data-driven decision-making: The planning team has consistently relied on data analysis to identify priority areas for intervention and has focused on evidence-based models.

Program scalability and sustainability: The planning team's process has emphasized scalability and sustainability, ensuring that the proposed interventions will be viable in the long term.

Community engagement: Community leaders and influencers have been kept informed of the planning process and invited to help inform the decision-making.

Future Direction:

Moving forward, the Healthy Cattaraugus NY Partnership will work closely with FeedMore WNY to secure funding for the additional vehicles, food, and staff that will be required to serve the targeted catchments. We also will draw upon FeedMore's expertise in running school pantries and backpack programs and will help food pantries better leverage their assets. Taken together, the proposed interventions offer a realistic and achievable multi-year strategy for reducing food insecurity, managing chronic disease, and improving population health.