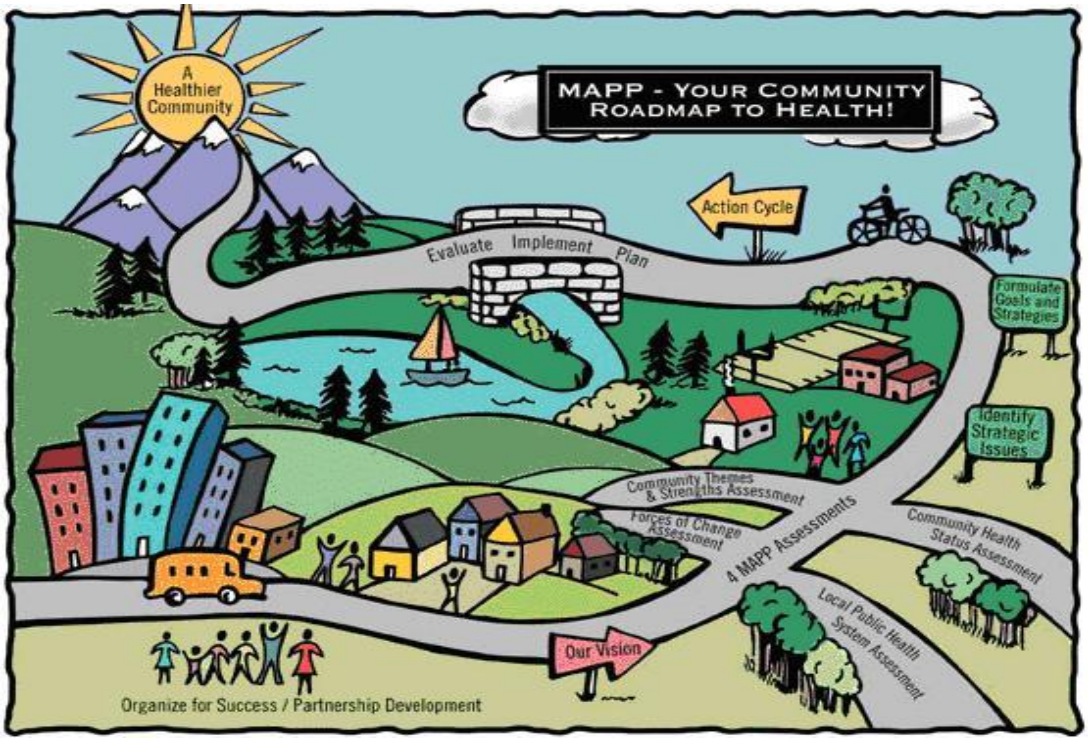
YATES COUNTY

Public Health
Prevent. Promote. Protect.

Yates County Community Health Improvement Plan

November 2013



1.

Executive Summary

What are the health priorities for Yates County?

This was the question facing the Yates County Public Health Department as they delved into a comprehensive process that involved health care organizations, hospitals, business and community leaders, academia, government agencies, non-profit organizations and county residents. Key partner agencies (Yates County Public Health, Finger Lakes Health (Soldiers and Sailors Memorial Hospital), Cornell Cooperative Extension, and other community partners), engaged in a process facilitated by the S2AY Rural Health Network over a 22 month period to collect data, solicit opinions, facilitate a process and guide a discussion to determine not only what are the most pressing problems facing our residents, but also what we can effectively and efficiently address.

In the end, the partner agencies decided to tackle two tough priorities and one disparity:

Prevent Chronic Disease:

1. **Obesity**
2. **Hypertension**

Disparity - Access to specialty care for the low-income population

Additionally, Yates County Public Health chose to focus on a third priority - promoting a healthy and safe environment, particularly reducing falls for vulnerable populations and occupational injuries.

Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State (NYS). Specifically, they account for approximately 70% of all deaths in NYS, and affect the quality of life for millions of other residents, causing major limitations in daily living for about 10% of the population. Costs associated with chronic disease and their major risk factors account for more than 75% of our nation's health care spending[1]. Obesity is a major contributor to chronic disease.

Obesity Prevalence

- The percentage of New York State adults who are overweight or obese increased from 42% in 1997 to about 60% in 2008.
- The percentage of obese adults in New York State more than doubled from 10% in 1997 to 25% in 2008.
- Obesity among children and adolescents has tripled over the past three decades. Currently, a third of New York's children are obese or overweight.
- Health care to treat obesity-related illnesses and conditions cost the United States an estimated $150 billion and New York State more than $7.6 billion every year.

According to the data available when the CHA was completed (2008-09 EBRFSS data), Yates County had a high age-adjusted percentage of adults who are obese or overweight (BMI 25 or above): 65.7% of Yates County residents are obese or overweight vs. State average of 59.3%. According to our survey, the ***AVERAGE*** BMI= 30.7. Public health officials across the state and the nation must take steps to address this rising epidemic.

Additionally, NYS has the second highest mortality rate in the U.S. from cardiovascular disease (CVD). CVD was responsible for 31% of deaths in NYS in 2010 and accounted for a substantial proportion of the estimated $50 billion in direct medical costs spent on chronic disease in the state. Heart disease, and hypertension in particular as a major contributor to heart disease (and cerebrovascular disease) must also be prioritized.

Yates County Public Health also chose to address the priority of unintentional injury/fall risk within the county. According to 2008-2009 EBRFSS data, the age adjusted number of adults in Yates County who experienced a fall within the last three months was 21.1% as compared to the NYS average of 17.3%, nearly 22% higher. When considering occupational health indicators from the NYS Department of Health from 2009-2011, the number of fatal work-related injuries per 100,000 employed persons aged 16 years and older Yates County rate is astonishingly higher than the NYS rate at 24.4 and 2.3, respectively. The Yates County rate is more than ten times higher than the NYS rate.

[1] CDC Chronic diseases: The Power to Prevent, the Call to Control
http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm

2.

Background and Process

Community Health Improvement Plan

The Yates County partners; Yates Community Health Planning Council, utilized the Mobilizing for Action through Planning and Partnership (MAPP) process to determine two priorities from the 2013 Prevention Agenda. The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is: *"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action".* The MAPP process encompasses several steps.

Organize for Success- Partner Development
The goal of this step is to bring together key partners and familiarize them with the MAPP process and determine key local questions. To accomplish this, the partners Department invited participants from a wide range of the organizations throughout the county. Organizations that participated in the community health assessment process included:

- Yates County Public Health Department
- Soldiers and Sailors Memorial Hospital of Yates County, Inc.
- S2AY Rural Health Network
- Yates County Youth Bureau
- ProAction/Yates County Office for the Aging
- Yates County Department of Social Services

- Yates County Sheriff's Office
- Yates County Community Services
- Yates County Workforce Development
- Courts of Yates County
- Red Cross
- Rushville Health Center (RPCN)
- Finger Lakes Community Health
- ARC of Yates
- Cornell Cooperative Extension
- Council on Alcoholism & Addictions in the Finger Lakes
- Finger Lakes WIC Program
- Tobacco Coalition of the Finger Lakes
- Finger Lakes Health
- Child and Family Resources, Inc.
- Penn Yan and Dundee Central School Districts

Assessments

Four Assessments inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of four different assessments is a unique feature of the MAPP process. Most planning processes look only at quantitative statistics and anecdotal data. MAPP provides tools to help communities analyze health issues through multiple lenses.

The first assessment examined the Community Health Status Indicators. Two methods were used to examine indicators. The first was to collect relevant statistical data using the NYSDOH Community Health Indicator Reports and a variety of other secondary sources. This was completed by our technical assistance provider, the S2AY Rural Health Network. The second method was to collect primary data by conducting a comprehensive survey among a random sample of community residents to determine their opinions, health-related behaviors and health needs. A total of 158 completed surveys were returned in Yates County. Surveys were conducted electronically through a Survey Monkey link, along with paper copies which were distributed to the public through employers, health, educational and human services agencies and through other community groups. The survey was designed to encompass questions in the five Prevention Agenda areas that the New York State Department of Health (NYSDOH) has identified as high priority issues on a statewide basis.

The second assessment evaluated the effectiveness of the Public Health System and the role of the Yates County Public Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was also conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. The assessment was completed through the use of a more user-

friendly version of the CDC and NACCHO tool, Local Public Health System Assessment (LPHSA). Each of the ten essential public health services was rated by the group by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System.

The third assessment was the "Community Themes and Strengths" Assessment that was conducted through focus groups that were held throughout the County. This assessment looked at the issues that affect the quality of life among community residents and the assets the County has available to address health needs. These were held in conjunction with the fourth assessment that looked at the "Forces of Change" that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes. The focus groups conducted in Yates County included a coffee club at St. Paul Lutheran Church, a Workforce Development Job Readiness Group, a Dundee Champions meeting, a TB & Health Assoc. Board meeting, Youth Board meeting and a Tier One Meeting. These groups also helped to ensure that adequate representation of the public was included in the assessments.

Identification of Strategic Issues

Once these results were tallied, a finalized list of the top issues from all components of the assessment process was compiled, and the data was presented at a meeting of community representatives including the local hospital, Public Health staff and partners from a variety of the agencies listed above. They were charged with ranking the priorities based on their knowledge of health needs and available services, along with the data presented, to select two priorities and one disparity. In order to accomplish this, the Hanlon Method was used. This method of ranking focuses most heavily on how effective any interventions might be. The Hanlon Method utilizes the following formula to rank priorities:

$$\mathbf{(A \ \& \ 2B) \ X \ C}$$

where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. As the multiplier, the effectiveness of the solution is given a lot more weight than the size or seriousness of the problem, with the hope of making wise use of limited resources by targeting solutions that are known to be effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores.

It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution) individually using a paper ranking form, the rankings were not heavily influenced by group dynamics. Based upon the ranking through the

Hanlon Method, Yates County's scores on the top health related issues in the county were:

Issues	Hanlon	PEARL
Obesity	**152.56**	**5.71**
Unintentional Injury	**143.88**	**5.71**
Hypertension/Stroke	**135.75**	**5.71**
Well Child/Lead	129.63	5.57
Transportation	124.13	5.43
Access to Specialty Health Care	122.75	**5.86**
COPD/CLRD	112.25	4.71
Behavioral Problems in Young Children	101.25	4.57
Depression/Other Mental Illness	92.50	5.14
Dental Health	85.13	4.71
Alcohol/Substance Abuse	83.13	4.86

Community partners then narrowed their focus to discuss the top ranked issues (bolded above). Obesity, Unintentional Injury and Hypertension/Stroke were the top ranked issues by Hanlon score. All three were also top-ranked issues by PEARL factors (a three way tie), with only Access to Specialty Health Care having a higher PEARL factor (with a much lower Hanlon score). After all of the above discussion and data review, Yates County chose to focus on the top two priorities of:

1. Obesity
2. Hypertension

And the following disparity:

Access to specialty health care for the low-income population

As noted above, Yates County also chose an additional focus on unintentional injury/preventing falls in vulnerable populations and occupational injury.

Formulate Goals and Strategies

During this stage research and evidence-based best practices were considered by the Yates Community Health Planning Council (YCHPC) from many different sources including the state's Prevention Agenda 2013 – 2017 material, and national guidance, such as the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020. The Health Impact Pyramid developed by Thomas R. Frieden, MD, MPH was extensively utilized. This is a pyramid approach to describe the impact of different types of public health interventions and provides a framework to improve health. The base of the pyramid indicates interventions with the greatest potential impact and in ascending order are interventions that change the context to

make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, on-going direct clinical care, and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort.

For each focus area under the selected Prevention Agenda "Prevent Chronic Disease" priority objectives and goals were identified that included improvement strategies and performance measures with measurable and time-framed targets over the next five years. Strategies proposed are evidence-based or promising practices. They include activities currently underway by partners and new strategies to be implemented.

These strategies are supported and will be implemented in multiple sectors, including at local schools, worksites, businesses, community organizations, and with providers, to make the easy choice also the healthy choice. We will create an environment that is conducive to physical activity and good nutrition through our network of partnerships with these diverse organizations.

Over a several month period, our partnership worked to develop a broad based plan to address our chosen priorities of obesity, hypertension and unintentional injury and our disparity of access to specialty care for the low-income population. Priorities were ranked on May 24, 2013, and the YCHPC met again on June 28, July 26, August 23, and September 27, 2013 to develop our Community Health Improvement Plan to address these priorities.

The Yates Community Health Planning Council "CHIP Chart" places emphasis on three key areas: 1) interventions that make individual's default decisions healthier (Tier 4 of Frieden's Pyramid); 2) successful management strategies for existing diseases and related complications, including clinical interventions (Tiers 2 and 3) including early detection opportunities that include screening populations at risk; and 3) Additional activities such as continuing some existing initiatives, focusing on easier health promotion activities to encourage healthy living and limit the onset of chronic diseases. As noted above, the new funding granted by the Greater Rochester Health Foundation will also allow us to work at Level 5 of the Pyramid over the next five years, having a large potential impact for a portion of the County. These strategies recommended by the Health Impact Pyramid are based on the interventions' evidence base, potential to address health inequities, ability to measure success, potential reach, potential for broad partner support and collaboration, and political feasibility. This is based on findings from such organizations as the Institute of Medicine of the National Academies and their report, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation* or the CDC's, *Recommended Community Strategies and Measurements to Prevent Obesity in the United States.*

Activities at the Tier 5 level of Frieden's Pyramid will be in the Dundee area with the Dundee Neighborhood Health Improvement project. Initiated in 2008 and funded by the

Greater Rochester Health Foundation (GRHF), this project is one of three in NY State (soon to be one of six) that is broadly focused on improving the social determinants of health to improve the community and improve health outcomes over the long term. The project serves the Towns of Barrington, Starkey and the Village of Dundee in rural Yates County, and includes both technical assistance (from Asset Based Community Development of Northwestern University) and evaluation consultants who are monitoring the long term changes in health outcomes. Unique aspects of the initiative include a resident-driven, asset-based approach to addressing community problems and improving health outcomes. This allows the Dundee community to focus on the lowest level of Frieden's Pyramid, ultimately having the most direct effect on improving health outcomes. This project may well become a model of national significance, (along with the two urban projects, both located in the City of Rochester, and the three new projects, one in Seneca County, one in Wayne County and another one in Rochester). The S2AY Rural Health Network is the lead agency for the project.

Obesity and hypertension leading to other chronic diseases, including diabetes, cancer, heart disease, stroke, arthritis and others. We have included many interventions to encourage increased physical activity and better nutrition thus reducing our obesity and hypertension rates leading to lower chronic disease rates. These initiatives include many suggested activities from the State's "Prevent Chronic Disease Plan" such as creating community environments to support physical activity and improved nutrition and breastfeeding, and involving the clinical community in solutions. While many "program activities" are included, environmental and policy changes are also included to change the context of decision making to make the healthy choice the easier choice.

The CHIP Chart that follows in a few pages outlines the workplan to address both hypertension, obesity and unintentional injury in Yates County.

One exciting aspect of the CHIP Chart is the unlimited possibilities offered by technological advances. Finger Lakes Health, Finger Lakes Community Health, the Regional Primary Care Network and other local providers are beginning to implement Electronic Health Records (EHR). These EHR’s will create a sea of change in how providers manage their patients. When fully functional the benefits of EHRs include improved quality and convenience of patient care, accuracy of diagnoses, health outcomes, care coordination, increased patient participation in their care and increased practice efficiencies and cost savings. We will utilize this technology to give our residents one more, vital tool to improve their health outcomes. EHR’s will give providers decision support tools and available resources at their fingertips leading to disease management discussions with patients and better chronic disease case management.

Primary care providers will be trained to talk to their patients about their weight, physical activity, diet and tobacco use. Professional training programs in prevention, screening, diagnosis and treatment of overweight, obesity and diabetes will be provided and reach across the spectrum of health care providers. Initially, the updated resources mentioned above will be made available to providers via a comprehensive referral guide with the

goal of having it available through a link in the EHR in the future. Through the use of this new technology follow-up calls will be able to be made to check on patient compliance. Additionally, the EHR's will provide the opportunity and documentation necessary to evaluate and measure their use. EHR's provide one more important connection in the network to support residents to fight obesity and diabetes.

As we pursue our CHIP we will continue to identify emerging best practices to reduce obesity and hypertension. We will evaluate our own programs and develop data measures to assess their impact. Promising cases for return on investment will be shared with policymakers. Our continued and developing partnerships in the development of this plan have allowed us to strengthen the connection between public health, local hospitals and providers. Specifics are outlined in the CHIP Chart below.

Maintenance of Engagement

The Yates Community Health Planning Council's CHIP Chart designates the organizations that have accepted responsibility for implementing each of the activities outlined in the work plan. Measurements and evaluation techniques are provided for each activity with starting target dates provided. As mentioned above the members of the Yates Community Health Planning Council have agreed to continue to meet on a regular basis to ensure that the initiatives outlined in this plan are implemented, monitored and evaluated. Progress will also be reported quarterly to the Yates County Human Services Committee of the Legislature, the Finger Lakes Health Board and the S2AY Rural Health Network Board of Directors. Additionally, several activities will be worked on jointly though the S2AY Rural Health Network. Activities on the work plan will be assessed and modified as needed to address barriers and duplicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives.

Take Action

WORK TOGETHER

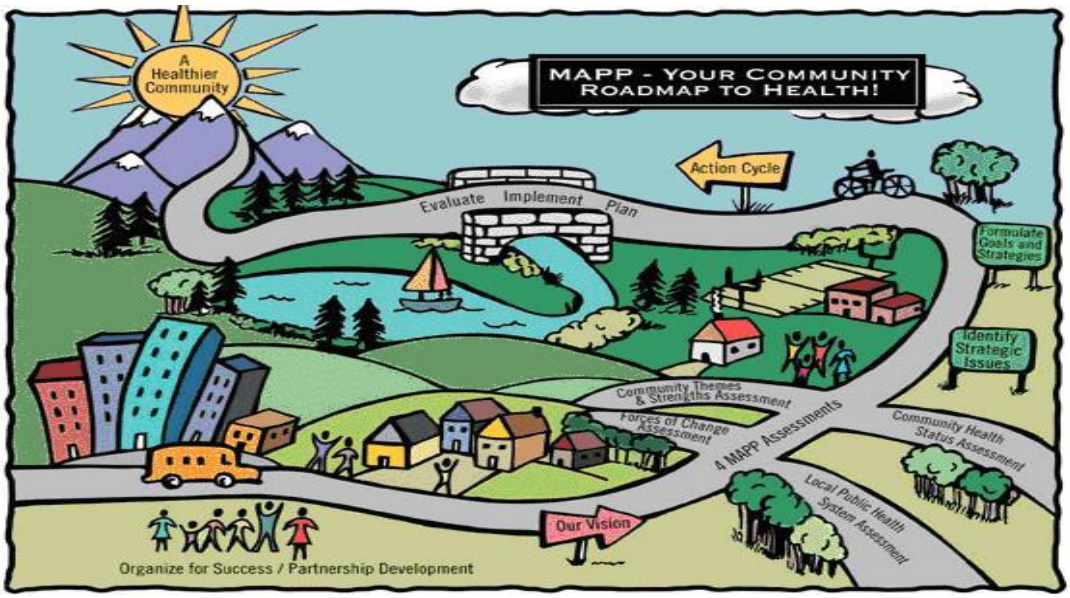
3.

Community Health Improvement Plan

The Yates Community Health Planning Council spent several meetings developing and refining the attached CHIP Chart, the overall workplan for community health improvement. While many objectives will only focus on program-related measures, we have made sure to include three measures that will specifically lead to improved health outcomes and help to achieve our goals of reducing heart disease and reducing obesity in a very measurable way. These include:

- 10% increase of WIC mothers breastfeeding at 6 months - annually for 3 years
- Reduce sodium content in hospitals/nursing homes/provided senior meals by 30% over 3 years
- Increase percentage of people in enrolled practices who are managing their hypertension to 75% by December 2017.

We fully expect that our continued efforts will lead to a healthier Yates County:



Prevention Agenda Focus Area: *Prevent Chronic Disease* **Goal 1:** *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
1. Reduce Obesity in Children and Adults	*A. Create community environments that promote and support healthy food and beverage choices and physical activity*	1A - 1. Work with local food programs to increase use of local food produce (www.ampleharvest.org) and provide education to clients.	Choose Health Yates (CHY)	June 2014 – On-going	# Food pantries using local produce # Clients educated
		1A - 2. Contact county restaurants to mark healthy choices on menus.	CHY	January 2014 and on-going	# Restaurants participating # Contacted
		1A - 3. Encourage CHY members, YCHPC members, non-profits and local businesses to adopt healthy meetings guidelines.	CHY/Chamber/YCHPC	January 2014 and on-going	# Organizations that adopt healthy meeting guidelines # Contacted
		1A - 4. Encourage CHY and YCHPC members, non-profits and local businesses to adopt sugar sweetened beverage policies.	CHY/Chamber/YCHPC	January 2015 and on-going	# Organizations that adopt policy # Contacted
		1A - 5. Work together to increase breastfeeding in Yates County. Encourage CHY members, YCHPC members , non-profits and local businesses to adopt breast feeding policies.	Breastfeeding coalition/Chamber/WIC physicians/CHY/YCHPC	June 2014 and on-going	EHR documentation of education, document # of all referrals made to breast feeding specialist, % increase of WIC mothers breastfeeding at 6 months # Contacted # Organizations that choose to implement a policy
		1A - 6. Investigate further initiatives to support breastfeeding within the county.	Breastfeeding Coalition CHY	January 2016 and on-going	10% increase of WIC mothers breastfeeding at 6 months - annually for 3 years

Prevention Agenda Focus Area: *Prevent Chronic Disease* **Goal 1:** *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
1. Reduce Obesity in Children and Adults	*A. Create community environments that promote and support healthy food and beverage choices and physical activity*				
		1A - 7. Advocate for the implementation of healthy vending policy in County facilities, hospitals and among YCHPC and CHY members.	CHY/Chamber/ YCHPC	January 2016 and on-going	# Organizations that adopt policy # Contacted
		1A - 8. Promote use of Farmer's Markets (and EBT use for) at WIC Clinics.	CHY/WIC/DSS/Office of the Aging	June 2014	Measure increased use of EBTs at Farmer's Markets # Contacted
		1A - 9. Encourage use of walking programs and other physical activity competitions, including county 5ks/races, triathlons, bike races etc .	FLH/CHY/libraries/ Community Center/Our Town Rocks	Spring 2014 and on-going	# of participants # of miles walked
		1A - 10. Implement Girls on the Run program in Penn Yan and Dundee for grades 3-5.	CHY/Youth Bureau	Spring 2014	Minimum of 8 girls per team (one team in Penn Yan, one team in Dundee)
	B. Prevent childhood obesity through early-care and schools	1B - 1. Partner with child care centers, Head Start programs, local schools and after school programs to promote reducing screen time, healthy living, eating and physical activity.	CHY/Child and Family Resources	June 2014 and on-going	Track changes in nutrition, physical activity and reduced screen time # Contacted # That report implementing a change
		1B - 2. Work with school cafeterias encouraging use of local produce and farms.	CHY/Schools/Local Farmers	Spring 2015	# relationships established Quantity produce purchased
		1B - 3. Continue to develop, expand and publicize joint use agreements with schools.	CHY/Schools	Fall 2015	# of contacts made/ encouraged # of joint use agreements
		1B - 4. Ensure that women enrolled in MOMS program are getting adequate education and referrals for diet, physical activity and breastfeeding education.	YCPH	March 2014 and annual check-ins thereafter	% of patients educated # and type of referrals made

Prevention Agenda Focus Area: *Prevent Chronic Disease* **Goal 1:** *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
	C. Expand the role of health care, health service providers, and insurers in obesity prevention	1C - 1. Encourage that providers use their EHRs to trigger them to speak to their patients about their weight, diet and exercise and refer them to community resources.	FHL/CHY/YCHPC	January 2015	% of providers who use decision support software in the EHRs to help them discuss diet and exercise with their patients (if available) % referring to community resources # Contacted/educated # of providers who have EHR

Prevention Agenda Focus Area: *Prevent Chronic Disease* **Goal 1:** *Reduce Obesity in Children and Adults*					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
1. Reduce Obesity in Children and Adults	*D. Expand the role of public and private employers in obesity prevention*	1D - 1. Develop list of free resources available to support worksite wellness efforts.	CHY	January 2015	Resource list developed
		1D - 2. Disseminate resources to worksites.	CHY/Chamber	March 2015-June 2015	Distribute to at least 40 worksites
		1D - 3. Continue to seek grants to implement worksite wellness programs.	CHY/S2AY	As grant opportunities arise	Attempt to apply for at least 2 grants annually
	E. Develop and implement community-led, place-based interventions targeted to address the social determinants of health in high-priority vulnerable communities.	1E - 1. Engage Dundee area residents to use the assets of their neighborhood to carry out activities that will impact the physical, social and economic health of the community. Including: - Make healthy eating and being active easier choices by offering healthy foods, providing pedometers, creating walking trails, improving parks. - Improve social connections by residents working together to create programs, events that bring other residents together- community events, youth trips and activities. - Enable children to become proficient readers by providing age-appropriate books birth-Grade 3 and creating a community culture that supports reading. - Encourage small business growth by providing Micro-enterprise loans. - Encourage business and tourism by working to beautify the environment	OTR/S2AY/YCHPC	Private Foundation funding through 1/2016. May be renewed.	Quarterly and annual reports to the Foundation. Participant and community-level outcomes.

Prevention Agenda Focus Area: *Prevent Chronic Disease* **Goal 2:** *Reduce Hypertension*					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
2. Increase access to high quality chronic disease preventive care and management in clinical and community settings	*A. Prevent chronic disease*	2A - 1. ***Disparity:*** Utilize alternative methods of care, including telehealth, tele-dentistry and rural rotations (cardiology and nephrology services) to meet the needs of low-income rural residents.	FLH and FLCH	11/13 and on-going	# of low-income and rural patients using alternative methods of care
	B. Decrease hypertension rates	2B - 1. Work to prevent hypertension by assisting hospitals, nursing homes and senior meal providers in reducing sodium content in all meals served including to patients, visitors, staff and public.	YCPH/Hospitals/ Nursing Homes/ Office for the Aging/S2AY/CHY	January 2014 and on-going	Reduce sodium content by 30% over 3 years, by November 2017
		2B - 2. Work with the FLHSA to bring the hypertension reduction program down to Yates County. Work with/seek other funding sources as applicable.	FLHSA/S2AY RHN/CHY	January 2014 and on-going	Implementation of program and at least 75 people enrolled by December 2015. Increase percentage of people managing their hypertension to 75% by December 2017.
		2B - 3. Encourage and educate 2 dental offices (FQHC's) to take blood pressure of adults and refer to primary care provider if appropriate.	RPCN/FLCH/CHY	January 2014 and on-going	85% of dental patients receiving preventive care at FQHCs will have their blood pressures assessed, and 90% of those with high blood pressure will be transitioned into appropriate follow-up (seen immediately, referred to their own PCP or scheduled for an appointment depending on the reading)

Prevention Agenda Focus Area: *Promote a Healthy and Safe Environment* **Goal 3 (additional Yates County Goal):** *Reduce Fall Risk in Vulnerable Populations, Reduce Occupational Injuries*					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce fall risks among vulnerable populations	*Promote Bone Builders Program*	Distribute letter to local businesses to focus on fall prevention, what they can do to help their customers and make them aware of the Bone Builders program	YCHPC, Yates County Injury Prevention Coalition	Sept. 2013	Increased number of participants in Bone Builders. Ultimate decrease in number of falls among 60+ population
	Conduct safety assessment and provide night lights	When called into homes, as possible, conduct a safety assessment and when appropriate, provide nights lights to residents. Encourage access of other appropriate resources to make homes safer	Ambulance, Yates County Emergency Services, Yates County Injury Prevention Coalition	2013-2014 – Ongoing as need arises	Survey home-delivered meals participants and Emergency Response System participants regarding fall prevention strategies.
Reduce occupational injuries and illnesses	*Focus on reducing injuries among Mennonite population*	Provide educational sessions to Mennonite population on farm injury prevention and water safety	Yates County Emergency Services, Yates County Injury Prevention Coalition	2013-2014 Mennonite School Year and 8/2014- - Farm Safety Day	Survey families of school children and attendees at Farm Safety Day
	Provide resources to providers	Provide injury prevention materials to providers that they can distribute to and discuss with their patients	YCHPC, Yates County Injury Prevention Coalition	Sept. 2013- Falls Assessment Tool Kit (from CDC)	Annually survey health care providers on use of tool kit distributed in 9/2013.