| Priority: Prevent Chronic Diseases | | | | | |
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| Focus Area 1: Reduce Obesity in Children and Adults | | | | | |
| Timeframe: To be completed by December 31, 2018 (Ongoing) | | | | | |
| Do the suggested interventions address a disparity? ☐ Yes ☒ No | | | | | |
| Goal | Outcome Objectives | Interventions/Strategies/Activities | Process Measures | Partner Role | Partner Resources |
| #1.3 Expand the role of health care, health services providers and insurers in obesity prevention. | **Objective 1.3.2:** by 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%. Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH) (Also, see: Focus Area – Maternal and Infant Health) | Link health care-based efforts with community prevention activities such as comprehensive school-based obesity prevention programs; community-based, nationally recognized diabetes prevention programs; and breastfeeding counseling and support systems. (IOM Obesity Prevention) | Number of primary care practices that are designated as NYS Breastfeeding Friendly<br><br>Number and demographics of women reached by policies and practices to support breastfeeding | Public Health and Finger Lakes Breastfeeding Partnership to increase number of CLC's trained and integrated into the community of Seneca County. Increase support for breastfeeding (i.e. develop baby café, education etc.) Work in partnership with Finger Lakes Community Health (FQHC) on designation to become NYS Breastfeeding Friendly.<br><br>Finger Lakes Health to provide breastfeeding educational materials at affiliated family doctors. | - Public Health commits .10 FTE/year ($4,795.00)<br>- Finger Lakes Health commits .01 FTE/year.<br><u>Additional Community Partners</u><br>- Primary Care Physicians<br>- Finger Lakes Breastfeeding Partnership/S2AY RHN: $3,300 for CHIP Cycle<br>- Finger Lakes Community Health |

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| Timeframe: To be completed by December 31, 2018 (Ongoing) | | | | | |
| Do the suggested interventions address a disparity? ☐ Yes ☒ No | | | | | |
| Goal | Outcome Objectives | Interventions/Strategies/Activities | Process Measures | Partner Role | Partner Resources |
| #1.4 Expand the role of public and private employers in obesity prevention. | **Objective 1.4.1:** By December 31, 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities. Baseline to be determined.) (Data Source: NYSDOH Healthy Heart Program Worksite Survey) | Implement nutrition and beverage standards in public institutions, worksite s and other key locations such as hospitals. | Number and type of key community locations that adopt and/or implement nutrition and beverage standards<br><br>Number of adults that have access to locations. | Public Health to work towards Healthy Vending efforts at County Locations.<br><br>Finger Lakes Health continues to use standards identified in the NYS DOH Cutting the Salt: Addressing Sodium Reduction.<br><br>S2AY RHN/Regional Worksite Wellness Committee to assist PH and partners in worksite wellness efforts. | - Public Health commits .07 FTE PH Educators/year ($ 3,000.00)<br>- Finger Lakes Health commits .05 FTE/year.<br><u>Additional Community Partners</u><br>- Vendors<br>- Human Resource Departments<br>- Risk Management Departments<br>- Worksite Wellness Committee/S2AY RHN: $2,475 for CHIP Cycle |
| | **Objective 1.4.2:** By December 31, 2018, increase the percentage of employers with supports for breastfeeding at the worksite by 10%. Baseline to be determined. (Data Source: NYSDOH Healthy Heart Program Worksite Survey) (Also, see: Focus Area – Maternal and Infant Health) | Use the Business Case for Breastfeeding to encourage employers to implement breastfeeding-friendly policies. | Number of employers that have implemented lactation support programs.<br>&<br>Number and demo of women reached by policies and practices to support breastfeeding. | PH in partnership with Finger Lakes Breastfeeding Partnership to train additional and retrain existing CLCs. Support and implement breastfeeding friendly policies.<br><br>Finger Lakes Health to distribute Business Case for Breastfeeding and CLC referral materials to practices who see new mothers.<br><br>PH and FLBP/S2AY RHN/Regional Worksite Wellness Committee to reach out to and provide support to worksites in adopting breastfeeding friendly policies. | - Public Health commits .10 Public Health Nurse/year ($4,795.00)<br>- Finger Lakes Health commits .01 FTE/year.<br><u>Additional Community Partners</u><br>- Finger Lakes Breastfeeding Partnership/Worksite Wellness Committee/S2AY RHN: $3,300 for CHIP Cycle |

| Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings. | | | | | |
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| Timeframe: To be completed by December 31, 2018 (Ongoing) | | | | | |
| Do the suggested interventions address a disparity? ☐ Yes ☒ No | | | | | |
| Goal | Outcome Objectives | Interventions/Strategies/ Activities | Process Measures | Partner Role | Partner Resources |
| #3.2: Promote use of evidence-based care to manage chronic diseases. | **Objective 3.2.4:** By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90) | Participation in regional blood pressure registry.<br><br>"My Reminder Campaign" to assist with hypertension medication adherence. | Number of primary care practices that submit patient numbers to registry.<br><br>Number of materials distributed for "My Reminder Campaign." | FLHSA to provide hypertension registry data to partners every 6 months. Supply PH and FLH with "My Reminder Campaign" materials for distribution.<br><br>Participating registry partners to send registry data to FLHSA.<br><br>PH and S2AY to follow up with providers bi-annually after publication of registry data to offer education and blood pressure screening training. | - Public Health: $1,750 for CHIP Cycle. Additional cost for PH .08% FTE/year ($3,500.00)<br>- Finger Lakes Health commits .02 FTE/year.<br><u>Additional Community Partners</u><br>- Primary Care Physicians<br>- Finger Lakes Health System Agency – In kind contribution.<br>- S2AY Rural Health Network: $2,475 for CHIP Cycle<br>-Finger Lakes Community Health |

| Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings. | | | | | |
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| Timeframe: To be completed by December 31, 2018 (Ongoing) | | | | | |
| Do the suggested interventions address a disparity? ☒ Yes ☐ No<br>*Disparity is addressed through CDSMP classes being offered to Behavioral Health Clients, low income populations and elderly. | | | | | |
| Goal | Outcome Objectives | Interventions/Strategies/ Activities | Process Measures | Partner Role | Partner Resources |
| #3.3 Promote culturally relevant chronic disease self-management education. | **Objective 3.3.1:** By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. (Data Source: BRFSS; annual measure, beginning 2013) | Promote the use of evidence-based interventions to prevent or manage chronic diseases. | Percent of adults with one or more chronic diseases who have attended a self-management program.<br><br>Number and percent of adults among population(s) of focus (E.g., communities of color, persons with disability, low-income neighborhoods) who have attended EBIs | PH and Wayne CAP to offer and conduct CDSMP classes. Promote and enroll members in classes. Identify additional partners that can be trained in CDSMP and hold classes within the county.<br><br>PH to provide detailing to physicians to encourage referral to and knowledge of EBI to manage chronic disease (i.e. CDSMP).<br><br>Finger Lakes Health to provide care managers information to facilitate referral into CDSMP.<br><br>Office for the Aging to provide data for number of adults who attend CDSMP.<br><br>S2AY RHN / Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes. | - Public Health .08%FTE for implementation and promotion of CDSM Programs/year ($3,500.00)<br>- Finger Lakes Health commits .01 FTE/year.<br><u>Additional Community Partners</u><br>- Wayne CAP: $10,211.00/year<br>- Office for the Aging (referral and data source)<br>- S2AY RHN / Regional Living Healthy Group: $1,886 |

| Priority: Promote Mental Health and Prevent Substance Abuse | | | | | |
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| Focus Area 2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders | | | | | |
| Timeframe: To be completed by December 31, 2018 (Ongoing) | | | | | |
| Do the suggested interventions address a disparity? ☐ Yes ☒ No | | | | | |
| Goal | Outcome Objectives | Interventions/Strategies/ Activities | Process Measures | Partner Role | Partner Resources |
| #2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults. | **Objective 2.1.1:** December 31, 2018, reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days to no more than 34.6%. (Baseline: 38.4 per 100, 2011 YRBS) - Tracking Indicator | **School-based programs: Project towards No Drug Abuse**, and **Project Success** target social and psychological factors that promote the initiation of substance use, and build student resiliency by teaching social competency, autonomous problem-solving, developing self-control and communication skills, improving decision-making strategies, and acquiring resources to resist drug use. | Number of students that participate in program.<br><br>Percent of youth below age 21 who report drug use in the last 30 days.<br><br>Number of public awareness, outreach, and educational efforts to change attitudes, beliefs, and norms towards underage and excessive adult alcohol use, prescription opiates. | COA to conduct SPORT – Evidence Based Intervention in Romulus and South Seneca.<br><br>Seneca Substance Abuse Coalition to provide data for percent of youth below age 21 who report drug use in last 30 days.<br><br>Seneca Addictions to conduct Project Success intervention in Waterloo, South Seneca and Seneca Falls Schools.<br><br>PH and Finger Lakes Health support and education around the efforts of the partners to reduce underage drinking and non-medical use of prescription pain relievers.<br><br>FLHSA to provide data around substance abuse.<br><br>Additional partners to work to create universal referral system to substance abuse and mental health services. | - Public Health commits .02% FTE ($ 1,750.00)<br>- Finger Lakes Health commits .02 FTE/year.<br><u>Additional Community Partners</u><br>- Council on Alcoholism and Addictions of the Finger Lakes<br>- Waterloo School<br>- Romulus School<br>- Seneca Falls School<br>- South Seneca School<br>- Seneca Substance Abuse Coalition<br>- Seneca Addictions<br>- FLHSA<br>-Seneca County Community Counseling |