Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1A**: *Reduce Obesity in Children and Adults*					
Strategy Area	*Objectives*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Create community environments that promote and support healthy food and beverage choices and physical activity	A. By December 31, 2017, reduce the percentage of children who are obese by 2% and reduce the percentage of adults who are obese by 2%.	A1. Maternal Infant Child Health Collaborative has two initiatives: community organization through Maternal Child Health Care and Access to Health Care Committee/CHIP will promote healthy lifestyles and increase access to health care among disparate population and direct outreach to the disparate population which includes healthy weight before and during pregnancy and promoting breastfeeding (Disparity - reduce obesity rates among low-income population)	Maternal Child Health Coalition (which includes Livingston County Department of Health (LCDOH), WIC, Noyes Health, various community partners), Access to HealthCare Committee (which includes LCDOH, Noyes Hospital, Excellus, and various community partners)	January 2014 and annually thereafter	Documentation of education Increase by 2% the number of women exclusively breastfeeding upon hospital discharge by 2017, (Baseline 64% - 2012) 1% increase of WIC mothers breastfeeding at 6 months by 2017 (Baseline 28% of WIC mothers breastfeeding at 6 months, 2008-2010) 1% decrease of the number of pregnant women in WIC who were pre pregnancy overweight (Baseline: pregnant women in WIC who were pre pregnancy overweight 24.4, 2008-2010) 1% decrease in the number of pregnant women in WIC who were pre pregnancy obese (Baseline: 29.1, 2008-2010)
		A2. Increase the number of local restaurants which identify healthy menu choices for adults and children	LCDOH, Cornell Cooperative Extension (CCE), local restaurants	January 2014 and annually thereafter	Monitor number of participating restaurants A minimum of two additional restaurants per year with have health choices identified (Baseline: 9) A minimum of two restaurants to track healthy choices purchased for a two month time period
		A3. Increase the number of food retailers which identify healthy food and beverage options	LCDOH, Office for the Aging	January 2014 and annually thereafter	Monitor number of participating food retailers A minimum of two additional food retailers per year with have health choices identified (Baseline 2)
		A4. Promote the benefits of Farmer's Market (and SNAP/EBT use for) to low income population (WIC, DSS) (Disparity - reduce obesity rates among low-income population)	LCDOH, CCE, Livingston County DSS, local farmers	October 2014 and annually thereafter	Measure increased use of EBTs at Farmer's Markets Baseline 2014, increase by 1% per year thereafter Reduce the percentage of children who are obese by 2% and Reduce the percentage of adults who are obese by 2%. (Baseline: 22.7 %, 2009) Reduce the percentage of adults with annual household income of <25,000 who are obese by 2% (Baseline 29%, 2009)

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Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Create community environments that promote and support healthy food and beverage choices and physical activity	A. By December 31, 2017, reduce the percentage of children who are obese by 2% and reduce the percentage of adults who are obese by 2%.	A5. Promote use of farmer's market vouchers among low-income senior population (Disparity - reduce obesity rates among low-income population)	Livingston County Office for the Aging, Farmers Markets	Annually June-October	Number of vouchers actually redeemed Baseline 2014, increase by 1% per year thereafter Reduce the percentage of adults with annual household income of <25,000 who are obese by 2% (Baseline 29%, 2009)
		A6. Increase the use of local physical activity opportunities (i.e. school exercise facilities and municipality owned parks, paths and trails) (Disparity - reduce obesity rates among low-income population)	LCDOH, Noyes Health, local schools, local municipalities, LC Planning Department, Genesee Valley Health Partnership, and LC Chamber of Commerce	Baseline April 2014 and annually thereafter	Number of facilities and parks/paths/trail offering physical activity opportunities to the public including disabled population Resource Guide with physical activity opportunities developed and distributed to community A minimum of 1 additional municipality having improved access to parks, shared-use paths and trails or open spaces by 2017 (Baseline 3)
Prevent childhood obesity through early-care and schools	B. By December 31, 2017, reduce the percentage of children who are obese by 2%	B1. Reestablish HIP HOP (Healthy Input, Health Output) initiative to provide research based obesity prevention for local schools to increase activity levels, improve nutrition and improve overall health status among students • Provide technical support to schools regarding wellness policies and ongoing committees • Complete School Health Index (SHI) with a minimum of one school per year • Provide resources to improve nutrition and physical activity areas of improvement as identified by the SHI	Cornell Cooperative Extension (CCE), LCDOH, Noyes Health, Student Support Services Center at GVEP, Local Schools, Kidstart	April 2014 and annually thereafter	Documentation of education/outreach Number of schools that completed SHI Number of Policies Developed Decrease overweight rate among local students by 2% by 2017 (Baseline 10.4% overweight all students- 2008-2010) Decrease obese rate among local students by 2% by 2017 (Baseline 14.7% obese all students- 2008-2010)
		B2. Increase access and use of vegetable gardens at local daycare centers	Noyes Health, local daycare centers, Kidstart	October 2014 baseline established, and annually thereafter	Number of adults and youth involvement in gardens Pre and post survey regarding number of servings consumed

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Expand the role of health care and health service providers and insurers in obesity prevention	C. By December 2015, garner information from insurers regarding obesity prevention to increase HCP obesity prevention practices	C1. Collaborate with insurers regarding local obesity data and prevention education opportunities via meetings, reports, etc.	LCDOH, Noyes Health, local insurers, GVHP	Fall 2014 to 2015	Data and prevention education opportunities gathered and analyzed to share with GVHP and community stakeholders
Expand the role of public and private employers in obesity prevention	D. By December 2017, increase by 5% the percentage of worksites that offer a comprehensive worksite wellness (CWW) program for all employees and is fully accessible to people with disabilities	D1. Livingston Wellness Partnership to provide CHANGE assessment, health fairs, health screenings, education and support policy/practice change regarding nutrition and physical activity such as, healthy food and beverage options policy	Livingston Wellness Partnership, ACHIEVE	April 2014 and annually thereafter	Increase number of worksites with CWW program. Baseline 2014 Minimum of one worksite complete CHANGE assessment Minimum of 1 policy at one worksite implemented per year.
		D2. Develop list of free resources available to support worksite wellness efforts.	Livingston Wellness Partnership	List developed by March 2014; distribute annually thereafter	Inventory list of available resources annually Dissemination of list/resources to a minimum of 30 worksites.
		D3. Continue to seek grants to implement worksite wellness programs	Livingston Wellness Partnership, GVHP	Ongoing	Discussion of grant opportunities a minimum of one time per year Discussion regarding sustainability

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1B:** *Reduce Diabetes and Prediabetes*					
Strategy Area	*Objectives*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Prevention, screening, early detection, treatment, and self-management support. Foster collaboration among CBOs, the education and FBOs, independent living centers, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive services	A. By December 31, 2017, increase patient compliance with educational programs and appropriate diabetes screenings by 2%	A1. Use media and health communication including email, mailings, social media and educational materials such as, Chronic Disease Prevention and Screening Tool	Chronic Disease CHIP Committee (Noyes Health, LCDOH, LCOFA, Literacy Volunteers, CCE) GVHP	April 2014 and on-going	Number of media and outreach
		A2. Establish and support Chronic Disease Self-Management Education Programs and Pre Diabetes Self Management Program	Noyes Health, LCDOH, LCOFA,	Implement starting June 2014 and conduct a minimum of two classes per year thereafter	Stanford Chronic Disease: 2 classes year one, 3 classes in each of year 2 & 3 -goal for each class is 8-10 participants CDC Diabetes prevention: one class year one and 2 classes in each of year 2 & 3, goal for each class is 10 - 16 participants Minimum of 60% will report increased ability to self-manage their health condition each year. This will be measured by attendance sheets, pre-workshop surveys and post-workshop evaluations.
		A3. Increase patient compliance with educational programs via HCP offices and Care Managers	HCP office staff, Noyes Diabetes Education Program, LCDOH support groups	Establish baseline April 2014 and ongoing	Number of individual counseling visits Attendance records Number of physical referrals and patient compliance
		A4. Gather, analyze and share four screening tests for Diabetes (HbA1c, lipid profile, dilated eye exam and nephropathy monitoring)	Noyes Diabetes Education Program, LCDOH, HCP providers and staff	Establish baseline April 2014 and annually thereafter	Comparative Annual report shared with all partners
	B. By December 31, 2017, decrease diabetes hospitalization by 2%	B1. Establish Continuum of Care Coalition to improve population health, prevent readmissions and improve collaborations	Noyes Health, LCDOH, LCOFA, Nursing Homes, Healthcare providers/staff, FBOs	March 2014 and ongoing quarterly meeting	Number of partners, meeting minutes, readmission rate to Noyes Hospital
		B2. Maintain HelpSource and NYConnects healthcare resource available to the community	Noyes Health, LCDOH, LCOFA, GVHP	June 2014 and annually thereafter	Inventory list of resources and availability to community.

Prevention Agenda Focus Area: **Promote Mental Health and Prevent Substance Abuse** **Goal 2:** Prevent Substance Abuse and other Mental Emotional Behavioral Disorders					
Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Promote mental health and prevent substance abuse	A. By December 31, 2017, reduce the percentage of Livingston County adults reporting 14 or more days with poor mental health in the last month by 3%	A1. Increase capacity to meet the community needs regarding mental health and substance abuse	Council on Alcohol and Substance Abuse (CASA), Livingston County Mental Health and Noyes Mental Health	January 2014 establish baseline and annually thereafter	Number of Chemical Dependency visits, number of mental health visits Number of individuals served Number of FTEs on staff Reduce the percentage of Livingston County adults reporting 14 or more days with poor mental health in the last month by 3% (Baseline: 8.5, 2009)
		A2. Increase the range of services available to specialized population ie. older population *prescription drug abuse. Co occurring SA/MH, developmentally disabled, Hispanic population	CASA, LC Mental Health and Noyes Mental Health, Community Outreach Services Noyes, Office for the Aging, Migrant Center	January 2015 and annually thereafter	Assess available services Plan created to increase services to address needs of the specialized population Services established Monitor number of clients of services
		A3. Decrease stigma regarding mental health by integrating mental services into primary care and other medical settings	LC Mental Health and Noyes Mental Health, local healthcare providers	June 2015	Assessment of mental health service locations in the community Increase the number of mental health services which are integrated into primary care or other medical settings
		A3. Assess and address transportation service barriers to Mental Health and Substance Abuse services	CASA, Liv Co Mental Health and Noyes Mental Health, Livingston Area Transportation Services (LATS), LCDSS, Livingston County Planning Dept.	January 2015 and annually thereafter	Conduct assessment among residents regarding transportation services Plan created to address barriers Conduct assessment among residents after plan implemented to ensure decrease in barriers
	B. By December 31, 2017, reduce percent of underage drinking, non-medical use of prescription drugs, and marijuana use by youth by 2%	B1. Maintain Health Communities That Care initiative (county based coalition which brings the community together to access youth and family needs and resources to implement effective strategies, activities (such as Family Day, Project Sticker Shock) and programs to address the needs including risk and protective factors)	CASA/ Healthy Communities That Care (HCTC), CBOs, FBOs, local schools, PTA/PTOs	January 2014 and ongoing	Conduct Health Communities That Care PNA survey every two years Analyze PNA data Research and implement evidence based interventions to address PNA data results
		B2. Continue to implement and evaluate violence prevention initiatives such as, Second Step, Peace Circle, PBIS	LCDOH, GVHP, local schools	January 2014 and ongoing	Review of LCDOH Violence Prevention Coordinator's annual report
		B3. Continue to pursue passage of a Social Host Law in Livingston County	HCTC, elected officials	January 2014	Review of Board of Supervisors' meeting minutes regarding status of law

Prevention Agenda Focus Area: Promote Mental Health and Prevent Substance Abuse **Goal 2:** Prevent Substance Abuse and other Mental Emotional Behavioral Disorders					
Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Promote Mental Health and Prevent Substance Abuse	C. By December 31, 2017, reduce suicide rate among use among youth and adults by 2%	C1 Create and maintain a suicide prevention task force	Strengthening Social and Emotional Health CHIP Subcommittee (LC Mental Health, Noyes Mental Health, LCDOH, Veterans Office, Mental Health Association, Compeer, Livingston County Sheriff Department, Office for the Aging, LC Workforce Development and Youth Bureau)	April 2014	Number of participants Number of meetings
		C2. Collaborate with key stakeholders to integrate, implement and coordinate suicide prevention initiatives	Strengthening Social and Emotional Health CHIP Subcommittee	April 2014 and annually thereafter	Number of events Review of suicide data
	D. By December 31, 2017, increase collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders	D1. Increase school based services i.e. clinic satellites and Substance Abuse prevention services	CASA, Liv Co Mental Health and Noyes Mental Health, local schools	June 2014 and annually thereafter	Number of school districts participating Number of school based visits Baseline established in 2014