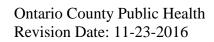
Ontario County Public Health Revision Date: 11-23-2016







	Priority: Prevent Chronic Diseases							
Focus Area 1: Reduce Obesity in Children and Adults								
Timefram	<b>Timeframe:</b> To be completed by December 31, 2018 (Ongoing)							
	<b>Do the suggested intervention(s) address a disparity?</b> ⊠ Yes □ No							
	*Objective 1.0.1 – Targeting Geneva area (low income) and Objective 1.3.2 – Targeting FQHCs for Breastfeeding Friendly Certification (low income population).							
Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources			
#1.1	Overarching Objective 1.0.1:	Implementation of evidence based	Number of programs/	FF Thompson (FFT) to provide	-FFT: 0.25 FTE/			
Create	By December 31, 2018, reduce	programs including "Get Up Fuel	presentations offered.	"Get Up Fuel Up" program.	Grant Dollars=			
communi	the percentage of children who	Up" and "Food, Fun, and Fitness".			\$6,800.00 per year			
ty	are obese:		Number of	Finger Lakes Health (FLH) to				
environm	• By 5% from 13.1%	Implementation of evidence based	participants.	provide "Food, Fun, and Fitness"	-FLH: 0.03 FTE			
ents that	(2010) to 12.4%	programs such as "Rethink Your		program. (CHAT)	per year			
promote	among WIC children	Drink" (group workshops).	Pre/post test data					
and	(ages 2-4 years). (Data	www.cdph.ca.gov/programs/cpn	from programs.	Public Health (PH) and Ontario	-PH: \$14,739.86 (2			
support	Source: NYS Pediatric	s/Pages/RethinkYourDrinkCurri		County Health Collaborative	years)			
healthy	and Pregnancy	culum.aspx	Participant feedback.	(OCHC) – led by PH, to provide				
food and	Nutrition Surveillance	<u> </u>		support through promotion and	Additional partners			
beverage	System [PedNSS])	Provide food demos, classroom		networking.	include FL Eat			
choices	• By 5% from 17.6%	based lessons, afterschool			Smart NY/CCE and			
and	(2010-12) to 16.7%	workshops, presentations at school		FL Eat Smart NY (Cornell	OCHC.			
physical	among public school	assemblies and fairs, and family and		Cooperative Extension (CCE)) to				
activity.	children Statewide	parent events.		Provide programming,				
	reported to the Student			presentations, and support to				
	Weight Status	Assist schools in high need		Geneva.				
	Category Reporting	communities in implementing						
	system. (Data Source:	policies, systems, and practices that						
	NYS Student Weight	improve access to nutrition						
	Status Category	education, healthy foods, and						
	Reporting [SWSCR])	physical activity.						
	(Prevention Agenda	F7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1						
	[PA] Tracking							
	Indicator)							

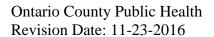








#1.3	Objective 1.3.2:	Recruit hospitals to participate in	Number of	CSH, FFT, and Finger Lakes	-CSH: 200 staff
Expand	By 2018, increase the	quality improvement efforts to	breastfeeding classes	Community Health (FLCH) to	hours/year
the role	percentage of infants born in	increase breastfeeding exclusivity at	offered.	participate in quality improvement	
of health	NYS hospitals who are	discharge.		efforts to increase breastfeeding	-FFT: 0.02 FTE per
care	exclusively breastfed during		Data from	exclusivity at discharge. Encourage	year
health	the birth hospitalization by	Encourage and recruit pediatricians,	breastfeeding classes.	affiliated practices to become BF	
services	10% from 43.7% (2010) to	obstetricians and gynecologists,		Friendly Certified.	-FLH: 0.01 FTE
providers	48.1%.	Federally Qualified Health Centers	Number of primary		per year
and	Data Source: Bureau of	(FQHCs), and other primary care	care practices that are	Finger Lakes Health to provide	
insurers	Biometrics and Biostatistics,	provider practices and clinical	designated as NYS	breastfeeding educational materials	-PH: \$13,475.02 (2
in obesity	NYSDOH; NYC Office of	offices to become New York State	Breastfeeding	at affiliated family doctors.	years)
preventio	Vital Records, NYC DOHMH)	Breastfeeding Friendly Practices.	Friendly.		
n.	(Also, see: Focus Area –	Specifically target FQHCs first, to		PH, S2AY Rural Health Network	-WIC: 0.40 FTE
	Maternal and Infant Health)	reach low income population	Number of women	(RHN), WIC, Child & Family	per year
		(disparity).	reached by policies	Resources (CFR), and Finger Lakes	
			and practices to	Breastfeeding Partnership (FLBP)	-FLBP/S2AY
		Encourage and recruit CACFP	support	to provide training, education, and	RHN: \$3,300 (2
		participating daycare centers/homes	breastfeeding.	assistance to practices and daycare	years)
		to become New York State		centers/homes to become BF	
		Breastfeeding Friendly Certified.	Develop a second	Friendly Certified.	Additional partners
			Baby Café in the		include FLCH and
		Identify location for Baby Café.	County.		CFR.
	Objective 1.4.2:	Use the <i>Business Case for</i>	Number of employers	FFT and CSH to work internally to	-FFT: 0.01 FTE per
	By December 31, 2018,	Breastfeeding to encourage	that have	implement breast feeding worksite	year
	increase the percentage of	employers to implement	implemented	strategies.	
	employers with supports for	breastfeeding-friendly policies.	lactation support		-CSH: 100 staff
	breastfeeding at the worksite		programs.	FLH to distribute Business Case for	hours per year
	by 10%.			Breastfeeding and CLC referral	
	Baseline to be determined.		Number and	materials to practices who see new	-FLH: 0.01 FTE
	(Data Source: NYSDOH		demographics of	mothers.	per year
	Healthy Heart Program		women reached by		
	Worksite Survey)		policies and practices	PH and FLBP/S2AY	-PH: \$6,209.08 (2
	(Also, see: Focus Area –		to support	RHN/Regional Worksite Wellness	years)
	Maternal and Infant Health)		breastfeeding.	Committee to reach out to and	
				provide support to worksites in	-FLBP/S2AY
					RHN/Regional







		adopting breastfeeding friendly policies.	Worksite Wellness Committee: \$3,300
			(2 years)

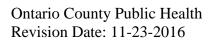
	Priority: Prevent Chronic Disease							
	Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.							
Timeframe:	Timeframe: To be completed by December 31, 2018 (Ongoing)							
Do the sugge	ested intervention(s) add	ress a disparity? 🗵 🗀	Yes □ No					
*Objective 2	.1.3 – Low income popula	ation and youth.						
Goal	<b>Outcome Objectives</b>	Interventions/	Process Measures	Partner Role	Partner Resources			
	Č	Strategies/Activities						
#2.1	Objective 2.1.3:	Encourage	Number of municipalities that restrict tobacco	Tobacco Action	Efforts to be led by			
Prevent	By December 31,	municipalities to	marketing in stores, including:	Coalition of the Finger	TACFL. Additional			
initiation of	2018, increase the	implement policies	o Tobacco display restrictions	Lakes (TACFL) to	partners include OCHC.			
tobacco use	number of	that protect youth	o Prohibiting the use of coupons and multi-	provide programming,				
by youth	municipalities that	from tobacco	pack discounts	outreach to elected	-PH: \$661.02 (2 years)			
and young	restrict tobacco	marketing in the		officials, attendance at				
adults,	marketing (including	retail environment,	Number of elected officials communicated	public hearings, and				
especially	banning store displays,	also known as the	with about the impact of retail tobacco	education/media				
among low	limiting the density of	point-of-sale (POS).	marketing on youth.	outreach.				
socioecono	tobacco vendors and							
mic status	their proximity to		Number of public hearings attended. Number	OCHC – led by PH, to				
(SES)	schools) from zero		of organizations/key community leaders	provide support				
populations	(2011) to 10. (Data		engaged in efforts.	through promotion and				
	Source: Community			networking.				
	Activity Tracking,		Information, advertisements, and media					
	CAT)		utilized to educate and promote efforts.					

Ontario County Public Health Revision Date: 11-23-2016





## **Priority:** Prevent Chronic Disease Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings. **Timeframe:** To be completed by December 31, 2018 (Ongoing) $\boxtimes$ Do the suggested intervention(s) address a disparity? $\Box$ Yes No **Outcome Objectives** Interventions/Strategies/ Process Measures Partner Role Partner Resources Goal **Activities** #3.2: Objective 3.2.4: Participation in regional Number of primary care PH, FLH, CSH, FFT, and S2AY RHN to -PH: \$1,303.62 (2 By December 31, 2018, blood pressure registry. practices that submit patient provide assistance in recruiting practices Promote vears) increase the percentage numbers to registry. to participate in registry. use of of health plan members, -FLH: 0.02 FTE evidenceages 18-85 years, with based care FLH and FFT to provide Data to Finger per year Lakes Health Systems Agency (FLHSA) hypertension who have to manage chronic controlled their blood through EHR transfer. -CSH: 200 staff diseases. pressure (below 140/90) hours per year FLHSA to provide programming, reports, and technical assistance to practices and -FFT: 0.02 FTE per partners. vear -S2AY RHN: \$2,475 (2 years) -FLHSA: in kind #3.3 Objective 3.3.1: Promote the use of Percent of adults with one or FFT and Wayne CAP to offer and -Wavne CAP: By December 31, 2018, Promote conduct CDSMP classes. Promote and \$10,211 per year evidence-based more chronic diseases who increase by at least 5% culturally interventions to prevent or have attended a selfenroll members in classes. the percentage of adults manage chronic diseases. -FFT: 0.04 FTE/ relevant management program. chronic with arthritis, asthma, PH to coordinate training for additional Grant Dollars= cardiovascular disease. Number of providers that CDSMP trainers. \$7,000.00 per year disease or diabetes who have selfuse their EHRs to trigger OCHC to identify additional partners that manageme taken a course or class to -PH: \$3,668.04 (2 them to speak to their can be trained in CDSMP, promote learn how to manage years) patients about their their condition. (Data classes and support as a county wide education. weight, diet and exercise, Source: BRFSS; annual initiative. -S2AY and refer them to EBIs. RHN/Regional









measure, beginni	ng	S2AY RHN / Regional Living Healthy	Living Healthy
2013)		Group to assist with coordination of	Group: \$1,886 (2
		evidence based programs and provide	years)
		back-up peer leaders for classes.	
			Additional partners
			include OCHC.

Priority: Promote Mental Health and Prevent Substance Abuse							
Focus Area 2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders							
Timeframe: To	be completed by D	December 31, 2018 (Ongoing)					
Do the suggeste	Oo the suggested intervention(s) address a disparity?   Yes   No						
Goal	Outcome	Interventions/Strategies/	<b>Process Measures</b>	Partner Role	Partner Resources		
	Objectives	Activities					
#2.1 Prevent underage drinking, non- medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.	Objective 2.1.2: December 31, 2018, reduce the percentage of youth ages 12- 17 years reporting the use of non-medical use of painkillers. (Baseline: 5.26% 2009- 2010, NSDUH, Target: 4.73%) - Tracking Indicator	Implement strategies to prevent overdose including  Engaging the community and coalition building  Educating prescribers  Reducing supply and diversion control through "lock your meds" campaigns, placing prescription drop boxes, and facilitating drug take back days  Harm reduction through Narcan trainings  Community based prevention education  Continued evaluation of project components/success	Number of members engaged in coalition.  Number of schools and student participants.  Number of trainings held for prescribers.  Number of medication drop boxes placed (and drug take back days).  Number of educational trainings, workshops, and forums held (number of participants).	Substance Abuse Prevention Coalition (Partnership for Ontario County) to provide programming, trainings, educational sessions, facilitate coalition, and work with law enforcement to place drop boxes (and drug take back days).  PH, CSH, FLH, FFT, Ontario County Mental Health (OCMH), OCHC, and law enforcement to provide support through promotion, networking, and sending staff to trainings (NARCAN, Mental Health First Aid, etc.).  CSH houses a psyche unit and providers numerous in/outpatient services for psyche and substance abuse, and case management.	-PH: \$2,372.13 (2 years) -CSH: 6,240 staff hours per year -FLH: 0.01 FTE per year -FFT: 0.01 FTE per year Additional partners include the Substance Abuse Prevention Coalition, OCHC, law enforcement, and OCMH.		
				PH, FLH, FFT, and CSH to provide NARCAN trainings and/or education.			