Wayne County Public Health
Revision Date: 11.23.2016

Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 1.3.2 – targeting the low income population (very high Medicaid rates)					
Goal	**Outcome Objectives**	**Interventions/Strategies / Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.1 Create community environments that promote and support healthy food and beverage choices and physical activity.	**Objective 1.1.1:** By December 31, 2018, decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day: • By 5% from 20.5% (2009) to 19.5% among all adults. (Data source: NYS BRFSS) (Health Disparities Indicator)	Increase the number of institutions with nutrition standards for healthy food and beverage procurement.	Number of municipalities, community-based organizations (CBOs), worksites, and hospitals that develop and adopt policies or practices to implement nutrition standards (cafeterias, snack bars, vending, etc.) Number of individuals potentially accessing settings that have adopted policies to implement nutrition standards for health food and beverage procurement.	Public Health (PH), Cornell Cooperative Extension (CCE), and Regional Worksite Wellness Committee/S2AY Rural Health Network (RHN) to reach out to worksites, CBOs, etc. to implement healthy policies or practices (vending, meeting guidelines, etc.). Newark Wayne Community Hospital (NWCH) and PH to work internally to adopt healthy policies and practices.	-PH – facilitation, education and coordination - $6,672 (2 years) -NWCH – 100 hours (2 years) – internal policy and execution. -Regional Worksite Wellness Committee/ S2AY RHN=$2,475 (2 years) Additional Partners: -CCE
#1.3 Expand the role of health care, health service providers, and insurers in obesity prevention.	**Objective 1.3.2:** 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%.	Recruit hospitals to participate in quality improvement efforts to increase breastfeeding exclusivity at discharge.	Number of hospitals that have joined NYS BQIH, NYC BHC, Great Beginnings NY, Latch on NYC, WHO Baby Friendly Designation, or Excellus Maternity Care Excellence Designation.	NWCH to implement efforts and maintain WHO Baby Friendly status. PH, Finger Lakes Breastfeeding Partnership (FLBP), Finger Lakes Community Health (FLCH), Wayne County Rural Health Network (WCRHN), and S2AY Rural Health Network (RHN) to support efforts of the hospital through promotion, etc. WCRHN to fund Breastfeeding Summit Activities.	-NWCH – 3,600 hours (2 years) PH – education - $12,119 (2 years) -FLBP/S2AY RHN=$3,300 (2 years) -WCRHN=$7,084.37 per year Additional Partners: -FLCH

		Encourage and recruit pediatricians, obstetricians and gynecologists, and other primary care provider practices and clinical offices to become New York State Breastfeeding Friendly Practices.	Number of primary care practices that are designated as NYS Breastfeeding Friendly Number and demographics of women reached by policies and practices to support breastfeeding.	FLBP, PH, S2AY RHN to work with FLCH to certify practices as Breastfeeding Friendly. NWCH to support/encourage breastfeeding during delivery and at discharge.	-PH –education - $12,119 (2 years) -FLBP/S2AY RHN=$3,300 (2 years) -NWCH – 200 hours (2 years) Additional Partners: -FLCH

Priority: Prevent Chronic Diseases					
Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke exposure					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 2.2.2 – targeting the low income population (Medicaid)					
Goal	Outcome Objectives	Interventions/Strategies / Activities	Process Measures	Partner Role	Partner Resources
#2.2 Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	**Objective 2.2.2:** By December 31, 2018, decrease the prevalence of cigarette smoking by adults ages 18 years and older: • By 17% from 18.1% to 15.0% among all adults. (Data Source: NYS BRFSS) (PA Tracking Indicator) • By 28% from 27.8% (2011) to 20.0% among adults with income less than $25,000. (Data Source: NYS BRFSS) (PA Tracking Indicator; Health Disparities Indicator)	Increase awareness of Medicaid benefits for smoking cessation including counseling and medication.	Number of Medicaid enrollees who smoke and utilize the cessation benefit.	Wayne County Cancer Services Program (CSP), PH, NWCH, and Wayne County Rural Health Network (WCRHN) to offer cessation classes. Wayne Health Improvement Partnership (WHIP) and Tobacco Action Coalition of the Finger Lakes (TACFL) to promote benefit through promotion and networking.	-PH – Education - $67,553 (2 years) -NWCH – 1 FTE dedicated + 1,000 hours (2 years) Additional Partners: -WHIP -TACFL -WCRHN
		Promote use of evidence-based tobacco dependence treatments among those who use tobacco.	Number of providers who deliver evidence based assistance to their patients who smoke including brief	NWCH to identify providers using Opti-Quit and Baby and Me Tobacco Free, promote the use of Opti-Quit and Baby and	-NWCH – 1 FTE dedicated (2 years) PH – see above

	• By 17% from 29% (2011) to 24% among adults who report poor mental health. (Data source: NY Adult Tobacco Survey) (PA Tracking Indicator; Health Disparities Indicator)	• Opti-Quit (EMR Referral) • Baby and Me Tobacco Free	counseling, medications, and arrange for follow up. Tracking referrals to Opti-Quit and Baby and Me Tobacco Free through EMR.	Me Tobacco Free, and provide referral/ utilization data. WHIP and partners to promote the use of referral systems.	Additional Partners: -WHIP
Priority: Prevent Chronic Diseases					
Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) 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.	Number of primary care practices that submit patient numbers to registry.	Finger Lakes Health Systems Agency (FLHSA) to provide technical support and data/reports. FLHSA, PH, and S2AY RHN to work to recruit additional practices. NWCH to provide data to FLHSA. PH to follow up with practices with information and trainings to increase control rates.	-NWCH – 100 hours (2 years) -PH – coordination, education - $4,897 (2 years) -FLHSA – in kind -S2AY RHN=$2,475 (2 years)
#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	Promote the use of evidence based interventions to prevent or manage chronic diseases.	Number and type of evidence based self-management programs offered by partners. Number of participants at EBIs offered by partners. Number of providers that use their EHRs to trigger them to speak to their patients about their weight,	Wayne CAP, Aging and Youth, and PH to offer classes (CDSMP and NDPP). Wayne CAP and Aging and Youth to offer CSDMP training. WCRHN to provide funds for Wayne CAP to promote and deliver CSDMP. WHIP and partners to promote trainings and send staff to trainings.	-Wayne CAP=$10,211 per year -PH – education, facilitation, coordination - $3,550 (2 years) -NWCH – 200 hours (2 years) -WCRHN=$5,000 per year

	measure, beginning 2013)		diet and exercise, and refer them to EBIs.	WHIP and partners working to increase referrals and the use of EHR to refer patients. S2AY RHN/Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes. NWCH to encourage providers to refer to programs and use EHR to trigger referrals.	-S2AY RHN/Living Healthy=$1,886 (2 years) Additional Partners: -Aging and Youth -WHIP

Priority: Promote Healthy women, Infants, and Children					
Focus Area 2: Child Health					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#2.2 Reduce prevalence of dental caries among children.	**Objective 5-3:** By December 31, 2018, increase the proportion of NYS children who receive regular dental care by at least 10%.	Link children and families to dental services. Offer Fluoride Varnish Training to practices.	Number of providers trained and offering fluoride varnish at pediatric visits. Number of and data from school based dental health sites. Investigate opportunities to increase school-based dental and health sites/ services.	PH to offer trainings to providers. NWCH and FLCH to encourage practices to utilize trainings and offer fluoride varnish at pediatric visits. WHIP to work with RPCN to promote school-based dental health sites and identify and remedy barriers to use of sites. Schools and WHIP to investigate opportunities to increase school-based dental and health services. WHIP and partners to promote dental health for children and families.	-PH – education, facilitation, coordination - $9,170 (2 years) -NWCH – 100 hours (2 years) -WCRHN=$2,000 per year Additional Partners: -FLCH -WHIP -RPCN -Schools

				WCRHN to provide funds for FLCH to provide dental hygiene education in schools.	

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 1: Promote Mental, Emotional and Behavioral Well-Being					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) 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.	Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	**Overdose Prevention** Project Lazarus is a public health model that asserts drug overdose deaths are preventable and communities are ultimately responsible for their own health. The model components include: 1) community activation and coalition building; 2) prescriber education and behavior; 3) supply reduction and diversion control; 4) pain patient services and drug safety; 5) drug treatment and demand reduction; 6) harm reduction including Naloxone training; 7) community-based prevention education;	Percent and/or number participating in Naloxone trainings Percent participation in safe prescription opiate disposal programs, take-back events, drop boxes, safe storage education, and law enforcement diversion efforts Investigate, coordinate, and build partnerships to develop a comprehensive approach to prevent substance abuse, overdose deaths, etc. Number of public awareness, outreach, and educational efforts to change attitudes, beliefs, and norms towards underage and excessive adult alcohol use, prescription opiates.	PH, Mental Health, and Trillium to provide Naloxone trainings. NWCH to work to place a prescription drop box at the hospital. WHIP and partners to promote take back days, drop box placement, etc. PH, WHIP, and partners to identify opportunities to partner with coalitions/ groups (Wayne Wellness Coalition, etc.) to coordinate efforts. PH and WHIP to work with schools to identify EBIs to implement. WHIP and partners to provide education and promotion of prevention efforts.	-PH – coordination, facilitation, education - $10,517 (2 years) -NWCH – 200 hours (2 years) Additional Partners: -Mental Health -Trillium -WHIP -Schools