Wayne County Community Health Improvement Plan

November 2013

1.

Executive Summary

What are the health priorities for Wayne County?

This was the question facing well over 1,000 people in 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 (Wayne County Public Health, Newark-Wayne Hospital, Wayne County Rural Health Network, 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 can we 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. **Heart Disease**

Disparity - reduce obesity rates among low-income population

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.

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

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), Wayne County had the highest age-adjusted percentage of adults who are obese or overweight (BMI 25 or above) in New York State: 71.7% of Wayne County residents are obese or overweight vs. State average of 59.3%. According to our survey, the AVERAGE BMI= 28.25. 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.

2.

Background and Process

Community Health Improvement Plan

The Wayne County Prevention Agenda Team 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 Department invited participants from a wide range of the organizations throughout the county. Organizations that participated in the community health assessment process were:

- **Wayne County Public Health**
- **Newark-Wayne Community Hospital**
- **Wayne County Rural Health Network**
- **Cornell Cooperative Extension of Wayne County**
- **Wayne County Community Action Program**
- **Wayne ARC**

- **schools**
- **Wayne County Department of Social Services**
- **Wayne County Aging & Youth**
- **Representatives from the Wayne County Board of Supervisors**
- **Finger Lakes Community Health Centers**

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 674 completed surveys were returned in Wayne 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 Wayne 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 Wayne County included the Wayne County Rural Health Network Board of Directors, Wayne County Public Health's Health Services Advisory Board, Newark Wayne Community Hospital physician's group, Wayne County Fire Chiefs and the Head Start Health & Nutrition Advisory Board. 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:

$$(A \,\&\, 2B) \times C$$

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, Wayne County's scores on the top health related issues in the county were:

	Hanlon	PEARL
Obesity	**175.50**	**4.60**
Alcohol abuse/Substance abuse	119.21	4.40
Mental health	**134.07**	4.07
Access to urgent care	109.64	3.53
Access to health care	**131.07**	3.67
Behavioral problems in young children	107.07	3.73
smoking/tobacco use	100.14	**4.67**
Cancer	**127.87**	**4.80**
Heart disease	**152.40**	**4.93**
Unintentional Injury	76.40	2.67
CLRD	112.80	3.80
Teen pregnancy	94.27	4.07

Community partners then narrowed their focus to discuss the top ranked issues (bolded above). Obesity and heart disease were the top ranked issues by Hanlon score, while heart disease was also the top-ranked issue by PEARL factors, and obesity was fourth in PEARL rankings. Although ranking high in PEARL, smoking/tobacco use and cancer ranked lower in Hanlon, so the group decided that, after all of the above discussion and data review, Wayne County would focus on the top two priorities of:

1. Obesity
2. Heart Disease

And the following disparity:

Obesity among the low-income population

Formulate Goals and Strategies

During this stage research and evidence-based best practices were considered by the Wayne County Prevention Agenda Team 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.

Additionally, we are extremely excited to report that as of October 22, 2013, we will be able to add some objectives under the lowest level of Freiden's pyramid, Socio-economic factors. Through the largesse of the Greater Rochester Health Foundation, our Clyde-Savannah community was awarded a Neighborhood Health Improvement grant that the Dundee community in Yates County has had since 2008. This is a long term community building program, designed to influence the social determinants of health over a long period (anticipated 10 years or more) to improve health outcomes. While the grant will not start until December 1, 2013 and we do not know all the details and cannot yet plug detailed objectives into the CHIP, we know that it will enable us to make huge strides in improving health outcomes for at least one part of our community as part of our CHIP. We are thrilled with this opportunity. This is one of the few opportunities available to actually influence health outcomes by working at the bottom level of "Freidan's Pyramid."

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 and heart disease (July 11, 2013, August 21, 2013, September 25, 2013 and October 30, 2013). The Wayne County Prevention

Agenda Team "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.*

Obesity is one of the leading causes of preventable deaths 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 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.

The CHIP Chart that follows in a few pages outlines the workplan to address both heart disease and obesity in Wayne County.

One exciting aspect of the CHIP Chart is the unlimited possibilities offered by technological advances. Newark-Wayne Community Hospital 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 finger tips 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 tobacco use. 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 Wayne County Prevention Agenda Team 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 Wayne County Prevention Agenda Team have agreed 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 Wayne County Board of Supervisor's Health & Medical Committee, Newark-Wayne Community Hospital Board and the Wayne County 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
Assess Needs
& Resources
Pick Priorities
Find Programs &
Policies that Work
Implement
Strategies
Evaluate Efforts
Employers and
Businesses
Health Care
Professionals
Community
Leaders
Government
Officials
Public Health
Professionals

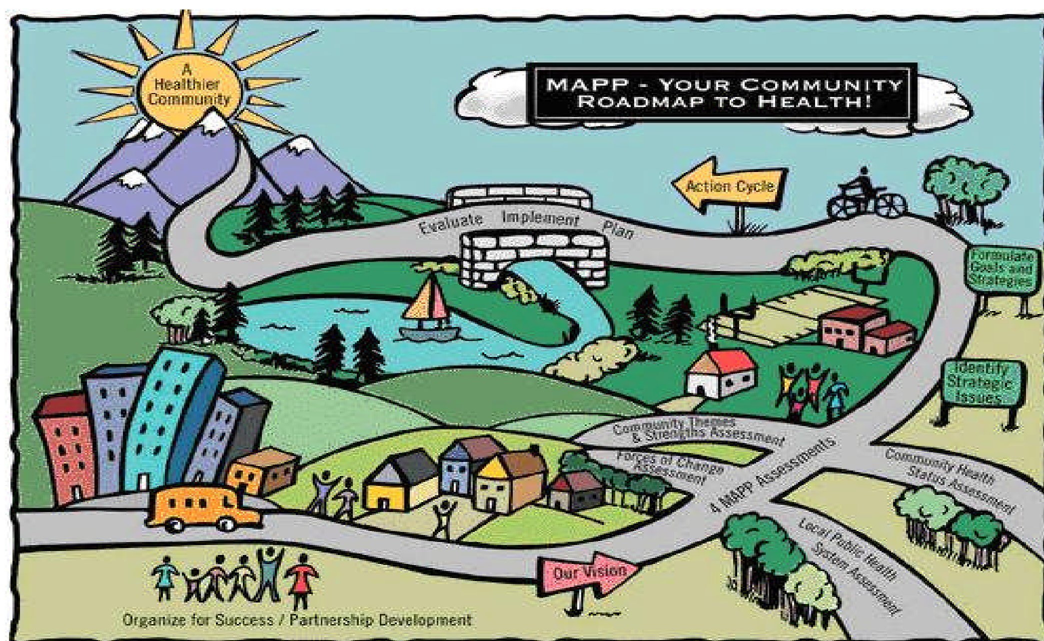
3.

Community Health Improvement Plan

The Wayne County Prevention Agenda Team 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 in women exclusively breastfeeding and breastfeeding at 6 months (obesity)
- 10 % increase of WIC mothers breastfeeding at 6 months (obesity disparity)
- Increase percentage of people managing their hypertension to 75% by December 2017.

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



Prevention Agenda Focus Area: Prevent Chronic Disease
Goal 1: *Reduce Obesity in Children and Adults*

Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Reduce Obesity in Children and Adults	A. Create community environments that promote and support healthy food and beverage choices and physical activity	A1. Support Newark Wayne Community Hospital in becoming baby- friendly under WHO guidelines. Work with the hospital to ensure support for Spanish speaking population.	Newark Wayne Community Hospital (NWCH) and Breastfeeding Coalition	January 2015	EHR documentation of education, 10 % increase in women exclusively breastfeeding and breastfeeding at 6 months, 10 % increase of WIC mothers breastfeeding at 6 months
		A2. Work together to increase breastfeeding in Wayne County. Increase access to breastfeeding information and encourage continued breastfeeding after delivery.	NWCH, Wayne County Prevention Agenda Committee, Breastfeeding Coalition	January 2015 Annual Breastfeeding Summit - August 2013 and ongoing	EHR documentation of education, 10 % of women exclusively breastfeeding and breastfeeding at 6 months, 10 % increase of WIC mothers breastfeeding at 6 months
		A3. Investigate further support of breastfeeding for employees working for county government.	Public Health, NWCH and Breastfeeding Coalition	January 2015	Policy Developed
		A4. Advocate for the implementation of Wayne County Healthy vending policy	Public Health, Wayne County Prevention Agenda Committee	January 2016	Policy implemented. Track healthy choices made. Increase healthy choices by 100% over 3 years
		A5. Promote use of Farmer's Markets and at CSAs (and SNAP/EBT use for) at WIC Clinics (Disparity - reduce obesity rates among low-income population)	Public Health, CCE, Wayne County Prevention Agenda Committee, Wayne County DSS, WIC	December 2014	Measure increased use of EBTs at Farmer's Markets

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1**: *Reduce Obesity in Children and Adults*					
Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Reduce Obesity in Children and Adults	A. Create community environments that promote and support healthy food and beverage choices and physical activity	A6. Promote use of farmer's market vouchers among low-income senior population (Disparity)	WCOFA, Farmers Markets, CCE, WCPH	Annually June-October	Increase the percentage of vouchers actually redeemed from 70.21% in 2012 to 85% by 2017
		A7. Increase access and use of new and existing community gardens at summer/school based programs (encourage adults to participate)	CCE, Wayne County Prevention Agenda Committee, Wayne County RHN, Wayne County School Districts, Trailworks	October 2014 baseline established, Oct 2015 and possibly annually thereafter	Number of adults and youth involvement in gardens (can communicate with partners).(Sample measurement of baseline harvested ,compared with year 2 harvest weight)
		A8. Support WCRHN "The Good Life Program" (Disparity - reduce obesity rates among low-income population)	WCRNH, CCE, Prevention Coalition, schools, NWCH	November 2013, quarterly BMI/blood pressure measurements	35 families per year. Baseline BMIs
	B. Prevent childhood obesity through early-care and schools	B1. Support CCE in getting additional healthy local foods purchased and consumed in schools (including calcium-rich products)	CCE, Cornell Food and Brand Lab, Wayne County Prevention Agenda Committee, Creating Healthy Places, Food Link	September 2014-June 2015	Measure increase in local healthy foods purchased by schools. Plate waste observation on random basis
		B2. Continue to support, promote and expand joint use agreements with schools and CCE	CCE, Trailworks, Public Health, Towns	March 2015	Increase resources available to the community members (parks, basketball courts, etc.)
		B3. Provide support to the Child Care Council in reducing screen time, improving nutrition (including calcium-rich products) and increasing physical activity in child care settings.	CCE, Child Care Council	March 2015	# of policies developed or revised that are adopt in accordance with best practice

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 1**: *Reduce Obesity in Children and Adults*					
Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Reduce Obesity in Children and Adults	B. Prevent childhood obesity through early-care and schools	B4. Implement the "I'm moving, I'm learning" and/or the CATCH curriculum, which infuses physical movement and healthy nutrition within their daily classroom routines	Head Start, Wayne County Prevention Agenda Committee, CCE, WCPH	Minimum of 6 workshops offered during the year - 2014	Children attending full day classes receive 2/3 of nutritional needs in program, following CACFP guidelines. Staff track height and weight three times per year. Number of schools trained and implement curriculum for CATCH.

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: *Reduce Obesity in Children and Adults*					
Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Reduce Obesity in Children and Adults	C. Expand the role of health care and health service providers and insurers in obesity prevention (and see Goal 2 below)	C1. Institute Good Life and support existing Eat Smart NY educational programs around obesity.	NWCH, Wayne RHN, WCPH, CCE-Eat Smart NY	Nov 2013 and on-going	10 classes conducted and 300 participants reached annually.
		C2. Encourage that health care providers and collaborating organizations refer to and make maximum use of obesity prevention programs, including the Good Life program and Eat Smart NY (Disparity - reduce obesity rates among low-income population)	NWCH, Wayne RHN, WCPH, CCE-Eat Smart NY, participating school districts	Nov 2013 and on-going	Increase adults reporting improvement in at least one healthy behavior from baseline: one of four food resources management practices, one of four nutrition practices and one food safety practice. Increase in youth reporting trying a variety of foods.
	D. Expand the role of public and private employers in obesity prevention	D1. Include nutrition/physical activity (and tobacco) module in workforce orientations	Public Health, CCE, Wayne CAP	November 2013	Component developed. Number of times presented/number of people reached
		D2. Develop list of free resources available to support worksite wellness efforts.	Wayne RHN, Wayne County Worksite Wellness Collaborative, Wayne Wellness Coalition/WCPH	List developed by June 2014; distribute annually thereafter	Inventory list of available resources. Dissemination of list/resources to at least 40 worksites.
		D3. Continue to seek grants to implement worksite wellness programs	Wayne RHN, Wayne County Worksite Wellness Collaborative, Wayne Wellness Coalition, S2AY, WCPH	As grant opportunities arise	Attempt to apply for at least 2 grants annually.

Prevention Agenda Focus Area: Prevent Chronic Disease **Goal 2:** *Reduce Heart Disease and Hypertension*					
Strategy Area	*Objectives*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Increase access to high quality chronic disease preventive care and management in clinical and community settings	A. Prevention, screening, early detection, treatment, and self-management support.	A1. Work to prevent heart disease and hypertension by assisting NWCH in reducing sodium content in all meals served in hospital (patients, visitors and public), DeMay Nursing Home, and senior meals	S2AY Rural Health Network, WCPH, CCE, WCOFA, NWCH	Implement starting Nov 2013 for 3 years	Reduce sodium content by 30% over 3 years, by November 2016. Meet recommended guidelines
		A2. Work with the FLHSA to bring the hypertension reduction program to Wayne County	FLHSA, S2AY Rural Health Network, WCPH, Wegmans	January 2014 and on-going	Implementation of program and at least 300 people enrolled by December 2015. Increase percentage of people managing their hypertension to 75% by December 2017.
		A3. Expand the Chronic Disease Self-Management Programs, "Living Healthy."	Wayne County Action Program, Wayne County Rural Health Network, Office for Youth and Aging	Minimum of 6 workshops offered during the year - 2014	Goal- at least 50 people will report increased ability to self-manage their health condition each year. This is measured by attendance sheets, pre-workshop surveys and post-workshop evaluations.
	B. Train primary care providers (PCPs) to talk with their patients about their weight (including physical activity and diet) and their tobacco use, as appropriate. Ensure that such discussions include dividing goals into manageable milestones and that PCPs can easily link their patients with available community resources simply, through the EHR	B1. Encourage participation in Center for Medicare and Medicaid Innovation (CMMI) model, including motivational interviewing model	NWCH, Dr. Stephen Cook (pediatric), Wayne County Prevention Agenda Committee	July 2016	Number of participants trained. Number of participants using model
		B2. Develop list of community resources and make sure that they are available to the PCPs	NWCH, Dr. Stephen Cook, Wayne County Prevention Agenda Committee, FLCH	July 2016	Inventory list of resources availability

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: *Reduce Heart Disease and Hypertension*					
Strategy Area	*Objective*	*Activities*	*Partners*	*Timeframe*	*Measurement/Evaluation*
Increase access to high quality chronic disease preventive care and management in clinical and community settings	B. Train primary care providers (PCPs) to talk with their patients about their weight (including physical activity and diet) and their tobacco use, as appropriate. Ensure that such discussions include dividing goals into manageable milestones and that PCPs can easily link their patients with available community resources.	B4. Ensure that decision support/reminder tools of EHR s are being used Continue calls by nurses to follow-up with patients on follow-through/compliance. Provide a comprehensive list of resources for PCPs.	NWCH, Wayne County Prevention Agenda Committee	July 2016	Implementation of decision support/reminder tools in EHR, documentations of use and documentation of calls by the nurse via EHR.
Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	C. Eliminate exposure to secondhand smoke	C1. Renew efforts to create smoke-free environments, especially encouraging Wayne County government to lead by example	Public Health, TACFL, Wayne Wellness Coalition, Municipalities - Lyons	January 2017	Policy developed/implemented.
		C2. Train primary care providers (PCPs) to talk with their patients about their tobacco use (see below). Train care coordinators/health coaches to address patient needs – RGMG and GRIPA for NWCH, GRATCC for FLCH.	Public Health, RGMG, Finger Lakes Migrant Health, PCPs, GRIPA, GRATCC	December 2014	xx number of care coordinators/health coaches being trained/used. Number of PCPs trained and/or given information about cessation counseling.