Wayne County 2019-2021
Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP)

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Public Health
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Wayne County, NY

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

Common Ground Health

Wayne County Executive Summary

The Wayne County Health Department, in partnership with Newark Wayne Community Hospital, has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

County	Priority Areas & Disparity
Wayne County	**Prevent Chronic Disease** 1. Tobacco prevention 2. Chronic disease preventative care and management **Promote Well-Being and Prevent Mental and Substance Use Disorders** 3. Promote well-being 4. Prevent mental and substance use disorders **Disparity: low income**

Selection of the 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP) priority and disparity areas was a joint process which began in the summer of 2018 with assistance from the S2AY Rural Health Network and Common Ground Health. A variety of partners were engaged throughout the process including the public health departments and hospital staff, Community Based Organizations (CBOs), school district representatives, local federally qualified health centers (FQHCs), Aging and Youth, the S2AY Rural Health Network, Common Ground Health, and more. The community at large was engaged throughout the assessment period via a regional health survey in 2018 (*My Health Story 2018*) and focus groups. Partners' role in the assessment were to help inform and select the 2019-2021 priority areas by

sharing any pertinent data or concerns and actively participating in planning meetings.

On May 17, 2019, the health department engaged key stakeholders in a prioritization meeting facilitated by the S2AY Rural Health Network. Key partners and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail, news media and newsletters were utilized to help stimulate participation. Common Ground Health provided group members copies of county specific pre-read documents in advance of the meetings. The documents included information on current priority areas and progress made to date, as well as a mix of updated quantitative, qualitative, primary and secondary data on each of the five priority areas outlined in the New York State Prevention Agenda. Data were collected from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from the *My Health Story 2018* Survey and local data sources such as Wayne County's school student survey. A copy of the pre-read document, prioritization meeting materials and meeting attendees are available upon request.

Using the above referenced data and group discussions, participants utilized Hanlon and PEARL methods[2] to rank a list of group identified priorities. To address the previously mentioned priorities and disparities, the health department facilitated

[2] Hanlon and Pearl are methods which rate items based on size and seriousness of the problem as well as effectiveness of interventions.

CHIP planning meetings where partners discussed opportunities to leverage existing work. Existing work efforts were then compared to intervention options (primarily selected from the New York State Prevention Agenda Refresh Chart) and were informally voted on and selected.

Regionally[3], Wayne County aligns with nearby counties on several interventions including the following:

Focus Area	Intervention* & # of Counties Selected
Tobacco prevention	**3.1.2** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties) **3.2.3** Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence based quitting, increasing awareness of available cessation benefits (especially Medicaid) and removing barriers to treatment (selected by three counties) **3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Prevent mental and substance use disorders	**2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties)
*Interventions shown are those where three or more counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix A.	

Tobacco prevention was a widely selected focus area by several regional counties (five out of eight counties). Many counties, including Wayne, have selected goals which revolve around prevention of initiation of tobacco use as well as tobacco cessation efforts. The complete list of Wayne County's selected interventions, process measures and partner roles in implementation processes can be found in the county's Community Health Improvement Plan grid (Appendix A).

[3] The region includes eight of the nine Finger Lakes counties: Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties.

The CHIP's designated overseeing body, Wayne Health Improvement Partnership (WHIP), meets on a monthly basis. The group has historically reviewed and updated the Community Health Improvement Plan and will continue to fulfill that role. During meetings, group members will identify any mid-course actions that need to be taken and modify the implementation plan accordingly. Progress will be tracked during meetings via partner report outs and will be recorded in meeting minutes and a CHIP progress chart. Partners and the community will continue to be engaged and apprised of progress via website postings, email notification, presentations, and social media postings.

Wayne County Community Health Improvement Plan 2019-2021

Glossary of Acronyms:

CCE – Cornell Cooperative Extension (of Wayne)
CDSM – Chronic Disease Self-Management
CHIP – Community Health Improvement Plan
CTFFL – Center for a Tobacco-Free Finger Lakes
FLESNY – Finger Lakes Eat Smart New York
FQHC – Federally Qualified Health Center
N-O-T – Not-On-Tobacco (evidence-based program)
NWCH – Newark-Wayne Community Hospital
TACFL – Tobacco Action Coalition of the Finger Lakes
TFO – Tobacco-Free Outdoors
Wayne CAP – Wayne Community Action Program
WCRHN – Wayne County Rural Health Network
WHIP – Wayne Health Improvement Partnership

Priority Area: Prevent Chronic Disease

Focus Area 3 Tobacco Prevention, Goal 3.1 Prevent initiation of tobacco use

INTERVENTION 3.1.2: USE MEDIA AND HEALTH COMMUNICATIONS TO HIGHLIGHT THE DANGERS OF TOBACCO, PROMOTE EFFECTIVE TOBACCO CONTROL POLICIES AND RESHAPE SOCIAL NORMS

Corresponding PA objective(s): 3.1.2 Decrease the prevalence of combustible cigarette use by high school students; 3.1.3 Decrease the prevalence of vaping product use by high school students

This intervention addresses a disparity: low SES

Note: We can also collect data on vaping and tobacco use/attitudes through the school surveys, over time.

2019	SHARE UNIFIED MESSAGES AROUND TOBACCO AND VAPING PREVENTION AND CESSATION. Tobacco Action Coalition of the Finger Lakes (TACFL) will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies. Center for a Tobacco-Free Finger Lakes (CTFFL) will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies. CTTFL specializes in educating professionals, including mental health professionals, about tobacco cessation. • **Resources**: Messages, media connections, sharing platforms • **Metrics/Goals**: o 2+ unified messages from WHIP agencies o For agencies using Facebook and Instagram, please share your analytics for how your post performed (these are provided by the platforms). We may identify patterns in types of posts that get more engagement.
	PROMOTE TOBACCO-FREE OUTDOOR SPACES. TACFL will provide Tobacco-Free Outdoor toolkits to Public Health to share with service provider agencies serving **low SES** mothers involved with Head Start type programs, and to NWCH to share in communications to health care providers, within a year. • **Resources:** toolkits

	• **Metrics/Goals:** 4+ total documented interactions per year educating providers and health/human service entities on TFO
	INCREASE TOBACCO CESSATION REFERRALS THROUGH COMMUNICATION WITH HEALTH PROVIDERS. NWCH to continue to encourage providers to consistently refer smoking patients to evidence-based tobacco cessation programs, such as Public Health's tobacco cessation program and Baby & Me Tobacco Free, available through both NWCH and Public Health.
2020	SHARE UNIFIED MESSAGES AROUND TOBACCO AND VAPING PREVENTION AND CESSATION. TACFL will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies. CTFFL will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies. CTTFL specializes in educating professionals, including mental health professionals, about tobacco cessation. • **Resources**: Messages, media connections, sharing platforms • **Metrics/Goals**: o 4+ unified messages from WHIP agencies o For agencies using Facebook and Instagram, please share your analytics for how your post performed (these are provided by the platforms). We may identify patterns in types of posts that get more engagement.
	INCREASE TOBACCO CESSATION REFERRALS THROUGH COMMUNICATION WITH HEALTH PROVIDERS. NWCH and CTFFL, with the support of WHIP, will create a "prescription pad" for providers to use with their smoking patients who are interested in quitting. This may be part of the same prescription pad in Intervention 1.1.5 for increasing referrals to CDSM courses. The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly. • **Resources:** coordination, access to providers, prescription pads • **Metrics/Goals:** o Number of referrals made to Chronic Disease Self-Management Courses (CDSM, NDP, Etc.) using the Prescription Pads; goal is 100 for 2020. o Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently
	PROMOTE TOBACCO-FREE OUTDOOR SPACES TO LOCAL DECISION MAKERS. Public Health and partners will support TACFL's initiatives to present to local level decision makers at least once on the benefits of Tobacco-Free Outdoor (TFO) public spaces, **targeting low SES communities.** This may include letters of support, other correspondence, compiling data in support of TFO, or in-person attendance with TACFL at their presentation. • **Resources:** Letters of support, data • **Metrics/Goals:** o Number of agencies providing letters of support (goal of 2+) o Number of instances where technical assistance was provided (goal 1+) o Number of local level decision makers reached (goal 4+) o Number or percent of decision makers reached who expressed support for TFO (goal 2+)
2021	SHARE UNIFIED MESSAGES AROUND TOBACCO AND VAPING PREVENTION AND CESSATION.

	Tobacco Action Coalition of the Finger Lakes (TACFL) will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies. Center for a Tobacco-Free Finger Lakes (CTFFL) will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies. CTTFL specializes in educating professionals, including mental health professionals, about tobacco cessation. • **Resources**: Messages, media connections, sharing platforms • **Metrics/Goals**: o 4+ unified messages from WHIP agencies o For agencies using Facebook and Instagram, please share your analytics for how your post performed (these are provided by the platforms). We may identify patterns in types of posts that get more engagement.
	NWCH, CTTFL, AND WHIP AGENCIES WITH ACCESS TO HEALTH CARE PROVIDERS TO CONTINUE PROMOTING THE "PRESCRIPTION PAD"; and address barriers to its use identified in 2020. The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly. • **Resources:** coordination, access to providers, prescription pads • **Metrics/Goals:** o Number of provider offices in NWCH's network consistently using the prescription pad (target TBD pending 2020 findings) o Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently

Focus Area 3 Tobacco Prevention, Goal 3.2 Promote tobacco use cessation

INTERVENTION 3.2.3: USE HEALTH COMMUNICATIONS TARGETING HEALTH CARE PROVIDERS TO ENCOURAGE THEIR INVOLVEMENT IN THEIR PATIENTS' QUIT ATTEMPTS ENCOURAGING USE OF EVIDENCE-BASED QUITTING, INCREASING AWARENESS OF AVAILABLE CESSATION BENEFITS (ESPECIALLY MEDICAID), AND REMOVING BARRIERS TO TREATMENT.

Corresponding PA objective(s): 3.2.8 Increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers enrolled in any Medicaid program

2019	CONTINUE TO PROMOTE TOBACCO CESSATION REFERRALS TO HEALTH CARE PROVIDERS TO INCREASE THE NUMBER OF PERSONS WHO ARE CONNECTED TO QUITTING RESOURCES THROUGH THEIR HEALTH CARE PROVIDER. NWCH to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby & Me Tobacco Free (available through NWCH and Public Health), and Public Health's tobacco cessation program. CTFFL to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services. • **Resources**: baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL • **Metrics/Goals**: o Number of Quit Line callers who heard about the Quit Line from their provider o Number of Quit Line callers with Medicaid, number of referrals to Public Health's tobacco cessation program resulting from a provider recommendation o Number of referrals to Baby & Me Tobacco Free resulting from a provider recommendation o Note: Baseline data will be available soon.
2020	CONTINUE TO PROMOTE TOBACCO CESSATION REFERRALS TO HEALTH CARE PROVIDERS TO INCREASE THE NUMBER OF PERSONS WHO ARE CONNECTED TO QUITTING RESOURCES THROUGH THEIR HEALTH CARE PROVIDER. NWCH to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby & Me Tobacco Free (available through NWCH and Public Health), and Public Health's tobacco cessation program. CTFFL to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services. • **Resources**: baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL • **Metrics/Goals**: o Number of Quit Line callers who heard about the Quit Line from their provider o Number of Quit Line callers with Medicaid, number of referrals to Public Health's tobacco cessation program resulting from a provider recommendation o Number of referrals to Baby & Me Tobacco Free resulting from a provider recommendation
2021	CONTINUE TO PROMOTE TOBACCO CESSATION REFERRALS TO HEALTH CARE PROVIDERS TO INCREASE THE NUMBER OF PERSONS WHO ARE CONNECTED TO QUITTING RESOURCES THROUGH THEIR HEALTH CARE PROVIDER. NWCH to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby & Me Tobacco Free (available through NWCH and Public Health), and Public Health's tobacco cessation program. CTFFL to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services.

	• **Resources**: baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL • **Metrics/Goals**: o Number of Quit Line callers who heard about the Quit Line from their provider o Number of Quit Line callers with Medicaid, number of referrals to Public Health's tobacco cessation program resulting from a provider recommendation o Number of referrals to Baby & Me Tobacco Free resulting from a provider recommendation

- **NOTE: Prevention Agenda does not provide an intervention for assisting youth with tobacco/vaping cessation under the Tobacco Prevention section; but please see an evidence-based tobacco/vaping cessation intervention under Intervention 1.1.4 in Promote Mental Health and Prevent Substance Use Disorders, Focus Area 1 Promote Well-Being.**

Focus Area 3 Tobacco Prevention, Goal 3.3 Eliminate exposure to secondhand smoke

INTERVENTION 3.3.1: PROMOTE SMOKE-FREE AND AEROSOL-FREE (FROM ELECTRONIC VAPOR PRODUCTS) POLICIES IN MULTI-UNIT HOUSING, INCLUDING APARTMENT COMPLEXES, CONDOMINIUMS AND CO-OPS, ESPECIALLY AMONG THOSE THAT HOUSE LOW-SES RESIDENTS.

Corresponding PA objective: 3.3.1 Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes

This intervention addresses a disparity: low SES

2019	SHARE UNIFIED MESSAGES AROUND SMOKE-FREE HOUSING. TACFL will produce messages around smoke-free housing which will be shared by Public Health and partners. • **Resources:** Messages • **Metrics/Goals:** o 1+ Letter to the editor o 1+ Local media articles on smoke-free housing
	COMPILE INFORMATION AND PREPARE TO ASSIST HOUSING UNITS WITH IMPLEMENTING AND/OR UPHOLDING SMOKE-FREE POLICIES. TACFL and Public Health will collaboratively survey tenants and landlords in housing units without smoke-free policies to learn barriers to implementing such policies. TACFL and Public Health will collaboratively survey tenants and landlords in housing units with smoke-free policies to identify strengths and challenges in upholding smoke-free policies. • **Resources:** Surveys • **Metrics/Goals:** o 1+ housing entity without a smoke-free policy surveyed (include number of units) o 1+ housing entity with existing smoke-free policies surveyed (include number of units)
2020	SHARE UNIFIED MESSAGES AROUND SMOKE-FREE HOUSING. TACFL will produce messages around smoke-free housing which will be shared by Public Health and partners. • **Resources:** Messages • **Metrics/Goals:** o 1+ Letter to the editor o 1+ Local media articles on smoke-free housing
	ASSIST HOUSING UNITS IN IMPLEMENTING AND/OR UPHOLDING SMOKE-FREE POLICIES. TACFL and Public Health to collaboratively assist housing units in implementing new smoke-free policies and/or upholding existing smoke-free policies. • **Resources:** Policy development guidance (TACFL Resources) • **Metrics/Goals:** o 1+ housing entity assisted with implementation of smoke-free policies (include number of units) o Number of housing entities assisted with upholding existing smoke-free policies (include number of units)
2021	SHARE UNIFIED MESSAGES AROUND SMOKE-FREE HOUSING.

	TACFL will produce messages around smoke-free housing which will be shared by Public Health and partners. • **Resources:** Messages • **Metrics/Goals:** o 1+ Letter to the editor o 1+ Local media articles on smoke-free housing

Focus Area 4 Chronic Disease Preventive Care and Management, Goal 4.1 Increase cancer screening rates.

INTERVENTION 4.1.3: USE SMALL MEDIA SUCH AS VIDEOS, PRINTED MATERIALS (LETTERS, BROCHURES, NEWSLETTERS) AND HEALTH COMMUNICATIONS TO BUILD PUBLIC AWARENESS AND DEMAND.

Corresponding PA objectives: 4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on the most recent guidelines; 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening based on the most recent guidelines; 4.1.5 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines

This intervention addresses a disparity: un/under-insured

2019	USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF BREAST, CERVICAL, AND COLORECTAL CANCER SCREENINGS THROUGH CANCER SERVICES PROGRAM (for the uninsured and underinsured). • **Resources:** Messages and promotional materials • **Metrics/Goals:** 1+ unified message for Breast Cancer Awareness Month in October
	USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF LUNG CANCER SCREENING SERVICES AVAILABLE AT NWCH. Note: Some messages may overlap with unified messages for tobacco/vaping prevention/cessation. • **Resources:** Messages and promotional materials • **Metrics/Goals:** o Increase participation by 10% by end of 2020; January-June 2019 baseline = 288 patients (155 program, 133 non-program) o 4+ unified messages
2020	USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF BREAST, CERVICAL, AND COLORECTAL CANCER SCREENINGS THROUGH CANCER SERVICES PROGRAM (for the uninsured and underinsured). • **Resources:** Messages and promotional materials • **Metrics/Goals:** o 1+ unified message for per awareness month (cervical cancer – January, colorectal cancer – March, breast cancer – October) o 1+ unified message per public screening event
	USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF LUNG CANCER SCREENING SERVICES AVAILABLE AT NWCH. Note: Some messages may overlap with unified messages for tobacco/vaping prevention/cessation.

	• **Resources:** Messages and promotional materials • **Metrics/Goals:** o Increase participation by 10% from January-June baseline data shown above o 4+ unified messages
2021	USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF BREAST, CERVICAL, AND COLORECTAL CANCER SCREENINGS THROUGH CANCER SERVICES PROGRAM (for the uninsured and underinsured). • **Resources:** Messages and promotional materials • **Metrics/Goals:** o 1+ unified message for per awareness month (cervical cancer – January, colorectal cancer – March, breast cancer – October) o 1+ unified message per public screening event
	USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF LUNG CANCER SCREENING SERVICES AVAILABLE AT NWCH. Note: Some messages may overlap with unified messages for tobacco/vaping prevention/cessation. • **Resources:** Messages and promotional materials • **Metrics/Goals:** o Increase participation, set goal based on 2020 data o 4+ unified messages

Focus Area 4 Chronic Disease Preventive Care and Management, Goal 4.1 Increase cancer screening rates.

INTERVENTION 4.1.5: REMOVE STRUCTURAL BARRIERS TO CANCER SCREENING SUCH AS PROVIDING FLEXIBLE CLINIC HOURS, OFFERING CANCER SCREENING IN NON-CLINICAL SETTINGS (MOBILE MAMMOGRAPHY VANS, FLU CLINICS), OFFERING ON-SITE TRANSLATION, TRANSPORTATION, PATIENT NAVIGATION AND OTHER ADMINISTRATIVE SERVICES AND WORKING WITH EMPLOYERS TO PROVIDE EMPLOYEES WITH PAID LEAVE OR THE OPTION TO USE FLEX TIME FOR CANCER SCREENINGS.

Corresponding PA objective: 4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on the most recent guidelines

This intervention addresses a disparity: Transportation

2019	INCREASE ACCESS TO MAMMOGRAPHY by coordinating with RRH's Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events. • **Resources:** Availability, messages and promotional materials, relationships with businesses/networks • **Metrics/Goals:** o 1+ unified message promoting Mobile Mammography unit o 1+ unified message per public Mobile Mammo screening event with openings left
2020	INCREASE ACCESS TO MAMMOGRAPHY by coordinating with RRH's Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events. • **Resources:** Availability, messages and promotional materials, relationships with businesses/networks • **Metrics/Goals:** o 2+ unified messages promoting Mobile Mammography unit o 1+ unified message per public Mobile Mammo screening event
2021	INCREASE ACCESS TO MAMMOGRAPHY by coordinating with RRH's Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events. • **Resources:** Availability, messages and promotional materials, relationships with businesses/networks • **Metrics/Goals:** o 2+ unified messages promoting Mobile Mammography unit o 1+ unified message per public Mobile Mammo screening event

Priority Area: Promote Well-Being and Prevent Mental Health and Substance Use Disorders

Focus Area 1 Promote Well-Being, Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan

INTERVENTION 1.1.3: CREATE AND SUSTAIN INCLUSIVE, HEALTHY PUBLIC SPACES: ENSURE SPACE FOR PHYSICAL ACTIVITY, FOOD ACCESS, SLEEP; CIVIC AND COMMUNITY ENGAGEMENT ACROSS THE LIFESPAN

Corresponding PA objective(s): 1.1.1 Increase Wayne County's Opportunity Index Score; 1.1.3 Reduce the number of youth grades 9-12 who felt sad or hopeless
Note: The opportunity index score includes a "community score" in the more detailed data, and the community score considers availability of healthy foods (among several other factors).

This intervention addresses a disparity: Low SES families (food insecurity)

2019	PROMOTE FOOD SECURITY FOR CHILDREN AND THEIR FAMILIES THROUGH THE SCHOOLS. Assist Community Schools Director, serving 4 districts (Sodus, North Rose-Wolcott, Lyons, Clyde-Savannah), in making the impact of the evidence-based Community Schools program sustainable beyond the grant period and replicable in other Wayne County school districts by assisting in developing a food pantry toolkit to create a path for schools to improve food security for students. WHIP agencies (including Public Health, Aging & Youth, CCE, Wayne CAP, school districts) to assist with promotion of food drives to stock the pantry as requested. Note: Multiple types of unified messages may be appropriate to go home in student backpacks; school food pantries may eventually serve as referral access points for other services. • **Resources**: food pantry toolkit • **Metrics/Goals**: successful creation of a food pantry toolkit within 2019
	IMPLEMENT EVIDENCE-BASED/PROMISING PRACTICE SOLUTION TO ENSURE SCHOOL FOOD PANTRIES ARE STOCKED WITH NUTRITIONAL FOODS. Public Health is seeking to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: schools, CCE/FLESNY, and WCRHN. • **Resources:** NYN or similar framework, advertising budget/promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time • **Metrics/Goals:** o 1 plan, formal or informal, showing how these agencies will roll out this initiative o 1+ community with a school receiving nutritious donations as a result of NYN/similar initiative o Baseline of need established for each of the 4 schools with food pantries
	ROCHESTER REGIONAL HEALTH (NWCH) PILOTING A PRESCRIPTION FOOD PROGRAM WITH FOODLINK AS OF JULY 1, serving patients at Canal Park Family Medicine (Macedon), Newark Internal Medicine, Sodus Internal Medicine, and ElderOne (Newark). Patients will be given $30/month to use at Foodlink's mobile unit to purchase fresh fruit and vegetables. Education to the patients will be provided by Care Managers at the practices. CCE/FLESNY to do demonstrations and education at sites when FoodLink comes. o **Resources**: Funding o **Metrics/Goals:** 50 participants completing program

2020	CONTINUE TO IMPLEMENT EVIDENCE-BASED/PROMISING PRACTICE SOLUTION TO ENSURE SCHOOL FOOD PANTRIES ARE STOCKED WITH NUTRITIONAL FOODS. Public Health will continue to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: schools, CCE/FLESNY, and WCRHN. • **Resources:** NYN or similar framework, advertising budget/promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time • **Metrics/Goals:** o 4+ communities with a school receiving nutritious donations as a result of NYN/similar initiative o Assessment of pantry inventories versus need (are they fully stocked, is anyone going without)
	SUPPORT CCE IN THEIR 2020 GOAL TO TRAIN ONE NEW ELEMENTARY OR MIDDLE SCHOOL WITH AT LEAST 50% OF STUDENTS QUALIFYING FOR FREE/REDUCED MEALS IN CATCH. Promote the effectiveness of the evidence-based physical activity program, CATCH, to increase demand for the program beyond the 2 school districts which have already implemented it with targeted, unified messaging to school district decision-makers and the public. At least one unified letter to schools within the year and at least 2 unified messages around the effectiveness of CATCH to the public per year. Gather data on any barriers preventing schools from adopting this curriculum. Agencies: CCE, participating school districts, Public Health, agencies sharing unified messages • **Resources**: personnel, time, unified messages • **Metrics/Goals**: o 1 unified letter (or form letter sent by multiple agencies) sent to each district not participating in CATCH within 2020 (likely 9 districts) o A compilation of any barriers identified by schools as a result of these letters o 2 unified messages shared within 2020 – those of us who can get analytics data from social media posts, please report engagement statistics so we can see which types of posts have the best performance and reach.
	CONTINUE TO SUPPORT ELEMENTS OF COMMUNITY SCHOOLS WHICH ADDRESS FOOD INSECURITY, by providing unified messaging around food drives and letters of support for continued funding, as applicable. At least 4 unified messages per year, letters of support as requested. Agencies: Public Health, Aging & Youth, WCRHN, CCE, participating school districts, Wayne CAP • **Resources**: unified messages, letters of support • **Metrics/Goals**: 4+ unified messages per year, letters of support as requested. Those of us sharing unified messages on social media, please provide post reach and engagement stats.
	IMPROVE ACCESS TO NUTRITIONAL FOODS THROUGH THE FRUIT & VEGETABLE PRESCRIPTION PROGRAM. FLESNY collaborating with Finger Lakes Community Health (FLCH, a network of FQHCs) to provide Fruit & Vegetable Prescription Program through 2 sites. The pilot of this program produced promising results. Providers at these sites write produce "prescriptions" to qualifying patients. • **Resources**: funding, vouchers, participating retailers (farmers markets) • **Metrics/Goals**: o 60%+ redemption rate of prescription vouchers, number of vouchers distributed per site
	ROCHESTER REGIONAL HEALTH (NWCH) PILOTING A PRESCRIPTION FOOD PROGRAM WITH FOODLINK AS OF JULY 1, serving patients at Canal Park Family Medicine (Macedon), Newark Internal Medicine, Sodus Internal Medicine, and ElderOne (Newark). Patients will be given $30/month to use at Foodlink's mobile unit to purchase fresh fruit and vegetables. Education to the patients will be provided by Care Managers at the practices. CCE/FLESNY to do demonstrations and education at sites when FoodLink comes. Ends June 30, 2020.
2021	CONTINUE TO IMPLEMENT EVIDENCE-BASED/PROMISING PRACTICE SOLUTION TO ENSURE SCHOOL FOOD PANTRIES ARE STOCKED WITH NUTRITIONAL FOODS.

	Public Health will continue to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: schools, CCE/FLESNY, and WCRHN. • **Resources:** NYN or similar framework, advertising budget/promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time • **Metrics/Goals:** o 1 plan, formal or informal, showing how these agencies will roll out this initiative o 4+ communities with a school receiving nutritious donations as a result of NYN/similar initiative o 100% of pantries receiving 100% of the donations needed to meet needs of students and their families
	CONTINUE TO PROMOTE THE EFFECTIVENESS OF CATCH THROUGH TARGETED, UNIFIED MESSAGING TO SCHOOL DISTRICT DECISION-MAKERS AND THE PUBLIC, AND ATTEMPT TO ADDRESS ANY BARRIERS TO IMPLEMENTATION WHICH HAVE BEEN IDENTIFIED BY THE SCHOOL DISTRICTS. At least one unified letter to schools within the year and at least 2 unified messages around the effectiveness of CATCH to the public per year. Agencies: Public Health, CCE, participating school districts • **Resources**: unified messages, collaborative problem-solving • **Metrics/Goals**: o 1 unified letter (or form letter sent by multiple agencies) sent to each district not participating in CATCH within 2021 (number of districts TBD) o Discussion about school-identified barriers and plans to address them recorded in WHIP minutes 2 unified messages shared within 2020 – those of us who can get analytics data from social media posts, please report engagement statistics so we can see which types of posts have the best performance and reach.
	CONTINUE TO SUPPORT ELEMENTS OF COMMUNITY SCHOOLS WHICH ADDRESS FOOD INSECURITY, by providing unified messaging around food drives and letters of support for continued funding, as applicable. At least 4 unified messages per year, letters of support as requested. Agencies: Schools, Public Health, WCRHN, Aging & Youth, Wayne CAP, CCE • **Resources**: unified messages, letters of support • **Metrics/Goals**: 4+ unified messages per year, letters of support as requested. Those of us sharing unified messages on social media, please provide post reach and engagement stats.

INTERVENTION 1.1.4: INTEGRATE SOCIAL AND EMOTIONAL APPROACHES ACROSS THE LIFESPAN. SUPPORT PROGRAMS THAT ESTABLISH CARING AND TRUSTING RELATIONSHIPS WITH OLDER PEOPLE. EXAMPLES INCLUDE THE VILLAGE MODEL, INTERGENERATIONAL COMMUNITY, INTEGRATING SOCIAL EMOTIONAL LEARNING IN SCHOOLS, COMMUNITY SCHOOLS, PARENTING EDUCATION.

Corresponding PA objective(s): 1.1.1 (Modified from State to County) Increase Wayne County's Opportunity Index Score
This intervention does not address a disparity.

2019	PROMOTE THE IMPACT OF LIFESKILLS (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year. • **Resources**: Unified messages • **Metrics/Goals**: 2+ unified messages within 2019

	PROMOTE THE IMPACT OF COMMUNITY SCHOOLS IN THE 4 COMMUNITY SCHOOLS DISTRICTS to increase awareness of and support for Community Schools through unified messaging at least twice within the year. • **Resources**: Unified messages • **Metrics/Goals**: 2+ unified messages within 2019
	APPROPRIATE PARTNERS TO PROVIDE LETTERS OF SUPPORT AND/OR TECHNICAL ASSISTANCE TO OPTIMIZE LIKELIHOOD OF CONTINUED FUNDING FOR COMMUNITY SCHOOLS AND/OR LIFESKILLS, OR OTHER EVIDENCE-BASED PROGRAMMING, AS REQUESTED BY PROGRAM DIRECTOR(S). • **Resources**: collaboration, staff time • **Metrics/Goals:** Assistance provided as requested
	IMPLEMENT N-O-T AND INDEPTH IN SCHOOLS TO IMPROVE STUDENT ACCESS TO TOBACCO/VAPING CESSATION. Public Health and school districts will receive training on August 27th allowing them to implement an evidence-based program, Not On Tobacco (N-O-T) and INDEPTH in the schools to help students stop smoking/vaping. Per the American Lung Association, it is much more expansive than cessation – covering lifestyle behaviors in physical activity and nutrition, self-control, stress management and decision-making. • **Resources**: funding for training (PH), school staff time • **Metrics/Goals**: Percentage of school districts participating (ideal 100%, but initial 8 of 11 districts (~73%))
2020	PROMOTE THE IMPACT OF LIFESKILLS (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year. • **Resources**: Unified messages • **Metrics/Goals**: 2+ unified messages within 2019
	PROMOTE THE IMPACT OF COMMUNITY SCHOOLS IN THE 4 COMMUNITY SCHOOLS DISTRICTS to increase awareness of and support for Community Schools through unified messaging at least twice within the year. • **Resources**: Unified messages • **Metrics/Goals**: 2+ unified messages within 2019

	PROMOTE N-O-T WITHIN THE SCHOOLS BY DISTRIBUTING UNIFIED MESSAGES INCREASING FAMILY AWARENESS OF AND DEMAND FOR THIS SERVICE. Evaluate reach of N-O-T in the schools and possible funding for more districts to have staff trained in N-O-T.
	• **Resources:** Staff time, funding, data
	• **Metrics/Goals**:
	  o 100% of trained schools successfully implement N-O-T. If not, identify barriers 100% of schools without successful implementation.
	  o WHIP minutes showing discussion of potential funding sources for an additional training, if needed.
	  o Percentage of N-O-T facilitators saying they are able to accommodate all students interested in the program, number of students enrolled in the academic year per district. Target: 100%. If less than 100%, identify barriers for 100% of schools unable to accommodate all interested students.

2021	Same as 2020

INTERVENTION 1.1.5: ENABLE RESILIENCE FOR PEOPLE LIVING WITH CHRONIC ILLNESS: STRENGTHENING PROTECTIVE FACTORS INCLUDE INDEPENDENCE, SOCIAL SUPPORT, POSITIVE EXPLANATORY STYLES, SELF-CARE, SELF-ESTEEM, AND REDUCED ANXIETY.

Corresponding PA objective(s): 1.1.2.1 Reduce the percentage of adults 65+ New Yorkers reporting 14 or more days with poor mental health in the last month
This intervention addresses a disparity: transportation

2019	RE-EVALUATE PREVIOUSLY IDENTIFIED BARRIERS TO IMPLEMENTATION OF CERTAIN CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS TO SEE WHICH ARE STILL IN EFFECT AND WHICH ARE RESOLVED; UPDATE 2020 WORK UNDER THIS INITIATIVE TO ADDRESS THOSE BARRIERS TO EXTENT POSSIBLE. Agencies: Public Health, Aging & Youth, Wayne CAP, WCRHN, FLCH, any agency offering any type of evidence-based CDSM course • **Resources**: collaboration • **Metrics/Goals**: WHIP minutes showing compilation of barriers and plans to address
	Begin developing a directory of wellness classes so that Wayne County residents and their health care providers have a comprehensive list of everything available to them. This directory will include courses such as Chronic Disease Self-Management, National Diabetes Prevention Program, and more. Agencies: all | Note: WCRHN has a similar task in their work plan • **Resources**: collaboration • **Metrics/Goals**: draft of directory within 2019
	USE UNIFIED MESSAGING TO PROMOTE UPCOMING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS, especially home-based and work place programs which alleviate the transportation barrier experienced by many Wayne County residents. At least once within the year. In 2019, WHIP can, at a minimum, promote the remaining 2019 Aging & Youth and Wayne CAP CDSMP class. One has already occurred, taught by both Aging & Youth and Wayne CAP. • **Resources: U**nified message(s) • **Metrics/Goals**: o Wayne CAP goal: 100 people completing course per year o 1+ unified message within 2019, depending on course availability o Aging & Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging o Percent of classes hitting their attendance goal (for CDSMP via WCAP, A&Y, 8 persons per class)
2020	COMPLETE THE DIRECTORY OF WELLNESS CLASSES, INCLUDING AT-HOME CLASSES, AND PROMOTE IT TO THE PUBLIC AND HEALTH CARE PROVIDERS TO INCREASE WAYNE COUNTY PARTICIPATION IN CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS. • **Resources**: Unified messages, distribution lists • **Metrics/Goals**: o Quarterly emails to distribution list of providers promoting the directory o Unified messaging to public 4+ times per year
	USE UNIFIED MESSAGING TO PROMOTE UPCOMING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS, especially home-based programs which alleviate the transportation barrier experienced by many Wayne County residents. 4+ times per year, depending on courses. In 2020, WHIP can, at a minimum, promote Aging & Youth's 2 CDSMP classes. • **Resources**: unified messages, distribution lists • **Metrics/Goals**:

	o Unified messaging to public 4+ times per year o Percent of classes hitting their attendance goal (for CDSMP via A&Y, 8 persons per class) o Wayne CAP goal: 100 people completing course per year o 1+ unified message within 2019, depending on course availability o Aging & Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging
	INCREASE PROVIDER REFERRALS TO CDSM COURSES THROUGHOUT THE COUNTY. NWCH to collaborate with all WHIP agencies offering evidence-based CDSM courses to revamp and promote the "prescription pad". The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly. • **Resources:** coordination, access to providers, prescription pads • **Metrics/Goals:** o Number of provider offices in NWCH's network consistently using the prescription pad o Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently
2021	CONTINUE TO BOOST AWARENESS OF THE WELLNESS CLASS DIRECTORY AMONG THE PUBLIC AND PROVIDERS THROUGH UNIFIED MESSAGING. Increase awareness of any chronic disease self-management programs which are covered by insurance. • **Resources**: unified messaging, insurance plan information • **Metrics/Goals**: o Quarterly emails to distribution list of providers promoting the directory o Unified messaging to public 4+ times per year
	CONTINUE TO INCREASE PROVIDER REFERRALS TO CDSM COURSES THROUGHOUT THE COUNTY. NWCH to collaborate with all WHIP agencies offering evidence-based CDSM courses to continue promoting the "prescription pad"; and address barriers to its use identified in 2020. The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly. • **Resources:** coordination, access to providers, prescription pads • **Metrics/Goals:** o Number of provider offices in NWCH's network consistently using the prescription pad (target TBD pending 2020 findings) o Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently
	USE UNIFIED MESSAGING TO PROMOTE UPCOMING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS, especially home-based programs which alleviate the transportation barrier experienced by many Wayne County residents. 4+ times per year, depending on courses. In 2021, WHIP can, at a minimum, promote Aging & Youth's 2 CDSMP classes. • **Resources:** Unified message(s) • **Metrics/Goals**: o Unified messaging to public 4+ times per year o Percent of classes hitting their attendance goal (for CDSMP via A&Y, 8 persons per class)

	o Wayne CAP goal: 100 people completing course per year o 1+ unified message within 2019, depending on course availability o Aging & Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging

Focus Area 2 Mental and Substance Use Disorders Prevention, Goal 2.3 Prevent and address adverse childhood experiences (ACEs)

INTERVENTION 2.3.3: GROW RESILIENT COMMUNITIES THROUGH EDUCATION, ENGAGEMENT, ACTIVATION/MOBILIZATION AND CELEBRATION

Corresponding PA objective(s): 2.3.3 Increase communities reached by opportunities to build resilience
Community Schools also fits under this intervention but is reported under other CHIP interventions already. We can revise the CHIP down the line to better reflect the work of Finger Lakes Resiliency Network.

2019	PUBLIC HEALTH AND PARTNERS TO SUPPORT SCHOOL APPLICATION FOR A TIER 3 WRAP AND RENEW GRANT IMPACTING CHILDREN IN 5TH-8TH GRADE. "RENEW focuses specifically on increasing effective school engagement, employment, post-secondary education and high school completion. RENEW has shown success in reducing school dropout and school push out, while increasing high school participation and completion for students with emotional and behavioral challenges." – midwestpbis.org Support may include letters of support and/or technical assistance on the grant application. • **Resources**: collaboration, data • **Metrics/Goals**: assistance provided, funding awarded
2020	INCREASE PUBLIC AWARENESS OF AND SUPPORT FOR TRAUMA-INFORMED CARE IN THE SCHOOLS by highlighting effectiveness of Community Schools, 4 unified messages per year. • **Resources:** unified messages • **Metrics/Goals:** 4+ unified messages per year
	CONTINUE TO SUPPORT EVIDENCE-BASED OR PROMISING PRACTICE TRAUMA-INFORMED CARE IN THE SCHOOLS by providing letters of support and/or technical assistance for funding applications, such as helping to map programs. • **Resources**: information • **Metrics/Goals**: WHIP minutes or emails showing discussion of initiatives
	IDENTIFY OPPORTUNITIES TO INCREASE PUBLIC AWARENESS OF AND DEMAND FOR RESILIENCE INITIATIVES, such as the Finger Lakes Resiliency Network, within the overall community. • **Resources**: information • **Metrics/Goals**: WHIP minutes or emails showing discussion of opportunities
	INCREASE PROVIDER AND COMMUNITY AWARENESS OF MENTAL HEALTH'S MOBILE RESPONSE TEAM(S) THROUGH UNIFIED MESSAGING. • **Resources:** unified messages • **Metrics/Goals**: 2+ unified messages
	USE UNIFIED MESSAGING TO PROMOTE AGING & YOUTH'S EVIDENCE-BASED POWERFUL TOOLS FOR CAREGIVERS COURSE. • **Resources:** unified messages, promotional materials • **Metrics/Goals:**

	○ 1+ unified message per course offered ○ Generate enough enrollment to maintain course offering
2021	INCREASE PUBLIC AWARENESS OF AND SUPPORT FOR TRAUMA-INFORMED CARE IN THE SCHOOLS by highlighting effectiveness of Community Schools, 4 unified messages per year. • **Resources:** unified messages • **Metrics/Goals:** 4+ unified messages per year
	CONTINUE TO SUPPORT EVIDENCE-BASED OR PROMISING PRACTICE TRAUMA-INFORMED CARE IN THE SCHOOLS by providing letters of support and/or technical assistance for funding applications, such as helping to map programs. • **Resources**: information • **Metrics/Goals**: WHIP minutes or emails showing discussion of initiatives
	IDENTIFY OPPORTUNITIES TO INCREASE PUBLIC AWARENESS OF AND DEMAND FOR RESILIENCE INITIATIVES, such as the Finger Lakes Resiliency Network, within the overall community. • **Resources**: information • **Metrics/Goals**: WHIP minutes or emails showing discussion of opportunities
	INCREASE PROVIDER AND COMMUNITY AWARENESS OF MENTAL HEALTH'S MOBILE RESPONSE TEAM(S) THROUGH UNIFIED MESSAGING. • **Resources:** unified messages • **Metrics/Goals**: 2+ unified messages
	USE UNIFIED MESSAGING TO PROMOTE AGING & YOUTH'S EVIDENCE-BASED POWERFUL TOOLS FOR CAREGIVERS COURSE. • **Resources:** unified messages, promotional materials • **Metrics/Goals:** ○ 1+ unified message per course offered ○ Generate enough enrollment to maintain course offering