<table>
<tr><td colspan="2">Priority Area: Prevent Chronic Disease</td><td colspan="2">Focus Area: Healthy Eating And Food Security</td></tr>
<tr><td colspan="2">Goal: 1.2 Increase Skills And Knowledge To Support Healthy Food And Beverage Choices</td><td colspan="2">Disparity: Low Income</td></tr>
<tr><td colspan="4">Objective: 1.1 Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC])</td></tr>
<tr><td colspan="2">Implementation Partner: Local Health Dept.</td><td colspan="2">Partner Role(s) and Resources: CCHD/WIC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.</td></tr>
<tr><td colspan="4">Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings</td></tr>
<tr><td colspan="2" rowspan="3">Family of Measures: WIC provides nutrition education at every appointment. Secondary nutrition education contact also made. Education provided at annual breastfeeding and community baby shower events. Refers to Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Nutrition and breastfeeding assessments conducted. Education on reducing sugar sweetened beverages included.</td><td colspan="2">Projected (or completed) Year 1 Intervention:
Obesity NYS 10.1 Chemung 9.7
High Maternal Weight Gain NYS 35.0% Chemung 41.8%</td></tr>
<tr><td colspan="2">Projected Year 2: Obesity NYS 10.1 Chemung 9.7, High Maternal Weight Gain NYS 35.0% Chemung 41.8%, and Fruits/Veggies NYS 82.8 Chemung 78.5%</td></tr>
<tr><td colspan="2">Projected Year 3: Obesity NYS 10.1 Chemung 9.7, High Maternal Weight Gain NYS 35.0% Chemung 41.8%, and Fruits/Veggies NYS 82.8 Chemung 78.5%</td></tr>
<tr><td colspan="4">Objective 1.2 Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])</td></tr>
<tr><td colspan="2">Implementation Partner: Headstart</td><td colspan="2">Partner Role(s) and Resources: EOP Headstart responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.</td></tr>
<tr><td colspan="4">Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings</td></tr>
<tr><td colspan="2">Family of Measures: Economic Opportunity Program (EOP) Birth to Five School Readiness supports five locations as well as a Home Based Program. They utilize the I am Moving, I am Learning (IMIL) Program. The goals of IMIL are:
1) Increase Physical Activity in the Classroom
2) Improve the Quality of Nutrition Provided
3) Improve Staff Wellness
4) Improve Family Engagement
Nutrition education is provided daily to the children, quarterly in a newsletter to families, and monthly to families at meetings at their site.
The Eat Well Play Hard curriculum will be added to three sites in October and two others in the spring of 2020. It includes these initiatives:
1) Make nutrition and movement lessons part of a child’s daily routine</td><td colspan="2">Projected (or completed) Year 1 Intervention:
Five Head Start sites and a home based program serving 204 center based Head Start children, 27 center based Early Head Start children, 50 Early Head Start home based children and 12 pregnant mothers in the home based program for a total of 293 students and their families. 40-60 minutes of active indoor or outdoor play, as well as several 15 minute sessions of movement throughout the day such as circle time dance & songs, and Zumba Kids Jr. for 30 minutes 1-2 times per week provided. In year one children’s BMI was reduced by 3% and the number of children in the obese category was decreased by 2%. Children participated in a “Food Experience” monthly learning about and cooking a healthy food. Child and Adult Care Food Program (CACFP) guidelines followed. In addition, we have done away with all canned foods and the children only receive fresh vegetables and as much local organic produce as possible. We do serve fresh-frozen, but we try not to. In addition, children are taught how to self-serve in specialty portioned cups and scoops. They learn what a serving is, and what it should look like. The children eat whole grains, vegetables, fruits, protein, and dairy at each meal. Allergies are always accommodated. Families receive a quarterly newsletter with fresh healthy recipes on a budget. They are invited to education events surrounding nutrition & health. We recently hosted Dr. Zama with Arnot Health who discussed Heart Health. Our Health Educator also attends monthly meetings with the parents and delivers health information that is current and addresses issues they may have (for example changes with immunizations).</td></tr>
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2) Provide nutrition and physical activity education to families 3) Offer fruits, vegetables, and low-fat dairy more often 4) Create or enhance nutrition and physical activity policies 5) Make family-style dining an everyday practice 6) Provides education workshops/trainings for families	**Projected Year 2:** We would like to increase the physical activity to 1.5 hours per day and increase Zumba Kids Jr. to 2 times per week as well as explore other options such as children's YOGA and Mindfulness
	Projected Year 3: We would like to increase the physical activity to 1.5 hours per day and increase Zumba Kids Jr. to 3 times per week as well as explore other options such as children's YOGA and Mindfulness
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** Comprehensive Interdisciplinary Developmental Services (CIDS) responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings	
Family of Measures: Comprehensive Interdisciplinary Developmental Services (CIDS) encourages healthy eating and breastfeeding during home visits.	**Projected (or completed) Year 1 Intervention:** # of home visits
	Projected Year 2: # of home visits
	Projected Year 3: # of home visits
Implementation Partner: Local Health Dept., Hospital, Community Based Organizations	**Partner Role(s) and Resources:** CCHD, Arnot Health, and HP2 members responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.2 Quality Nutrition (And Physical Activity) In Early Learning And Child Care Settings	
Family of Measures: Chemung County Health Department (CCHD), Arnot Health, and community partners provide education at free summer meal sites.	**Projected (or completed) Year 1 Intervention:** CCHD tabled at 7 meal sites. Arnot Health was at 7 locations serving 107 children.
	Projected Year 2: # of sites # reached
	Projected Year 3: # of sites # reached
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** SRHN responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.4 Multi-component school-based obesity prevention interventions	
Family of Measures: Steuben Rural Health Network; Girls on the Run of the Southern Tier: • 80% of participants in Girls on the Run of the Southern Tier will show an increase of physical activity outside of participating in the program during the weekday and weekend. • 80% of participants in Girls on the Run of the Southern Tier will show a decrease in screen time after participating in the program (These measured	**Projected (or completed) Year 1 Intervention:** 80% of participants will show an increase of physical activity outside of the program. 80% of participants will show a decrease in screen time after participating in the program (completion of pre and post survey asking 2 questions on physical activity) 90% of participants will complete a 5K Open rate of 35 % for the nutrition fact email
	Projected Year 2: 85% of participants will show an increase of physical activity outside of participating in the program during the weekday and weekend. 85% of participants will show a decrease in screen time after participating in the program, 90% of participants will complete a 5K, and open rate of 40 % for the nutrition fact email.

by completion of pre and post survey asking 2 questions on physical activity) • 90% of participants will complete a 5K Open rate for "Nutrition tips and tricks" sent weekly to families via email and posted on social media.	**Projected Year 3:** 90% of participants will show an increase of physical activity outside of participating in the program during the weekday and weekend. 90% of participants will show a decrease in screen time after participating in the program 90% of participants will complete a 5K, and open rate of 45% for the nutrition fact email
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** FLESNY responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.4 Multi-component school-based obesity prevention interventions	
Family of Measures: Finger Lakes Eat Smart NY (FLESNY) and Cornell Cooperative Extension (CCE) work with local elementary and middle schools to implement the Coordinated Approach To Child Health (CATCH) program. Quality nutrition and physical activity is provided in seven area schools serving 2,851 students. The Elmira City School District (ECSD) adopted CATCH in their wellness policy for all elementary schools, CATCH is used school wide (classroom, PE, brain breaks, MBE minutes, cafeteria).	**Projected (or completed) Year 1 Intervention:** 7 schools trained in CATCH with 2,851 students impacted. ECSD adopted CATCH in their wellness policy for all elementary schools, CATCH is used school wide (classroom, PE, brain breaks, MBE minutes, cafeteria)
	Projected Year 2: 8 schools trained in CATCH 3,157 students impacted in CATCH schools
	Projected Year 3: 8 schools trained in CATCH 3,157 students impacted in CATCH schools
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources: CHSC** responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.4 Multi-component school-based obesity prevention interventions	
Family of Measures: Creating Healthy Schools and Communities (CHSC) works with Elmira School District staff and partners to build capacity for assessing, developing and implementing Local Wellness Policy (LWP) aligned with USDA Healthy, Hunger-Free Kids Act	**Projected (or completed) Year 1 Intervention:** Providing ongoing support to assist with implementation of 2017 updated LWP, impacting the 6,000+ students. Support provided for using the 2017 School Health Index, self-assessment planning tool as a the school level to guide: Daily recess for elementary students, Access to physical activity facilities outside of school day, Prohibit using physical activity as punishment and taking away physical activity as punishment, Using food as reward or punishment, Access to drinking water, All foods/beverage sold and served during the school day meet USDA's Smart Snacks in Schools nutrition standards, implicitly addresses SSB
	Projected Year 2: Ongoing support to assist with assessing and enhancing 2017 LWP in 2020. As well as ongoing support to assist with implementation of 2017 LWP and 2020 updated LWP, impacting the 6,000+ students
	Projected Year 3:
Objective 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults)	
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources: CHSC** responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results.	

Family of Measures: Creating Healthy Schools and Communities (CHSC) # of engaged worksites # of engaged small retailers # of policies adopted Education provided and distributed	**Projected (or completed) Year 1 Intervention:** Arnot Health: new Community Supported Agriculture program. CIDS: new Healthy Vending Machine. EOP: new Healthy Vending, Wellness Newsletter, & Employee Wellness Activities. Perry & Carrol: new Healthy Snack options being offered to employees. Riverside Elementary: Smoothie blenders purchased for staff break rooms; indoor walking path floor decals with motivational posters. Parley Coburn: Yoga materials to offer classes for staff. Able2: Community Garden and Produce Cart, distribution of educational materials to all work sites. 3 small retail locations adding fresh fruit stand to their stores. 2 small retailers signing up to accept Fruit & Vegetable Prescription Program vouchers which will increase access to healthy options in low income neighborhoods. CHSC signage outside location advertising that Fruit is now being sold here.
	Projected Year 2: # of engaged worksites, # of engaged small retailers, # of policies adopted, Education provided and distributed
	Projected Year 3:
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** CCHD and partners responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results.	
Family of Measures: Creating Healthy Schools and Communities (CHSC) - EOP, CCHD, Arnot Health, and other partners participate in the CHSC program.	**Projected (or completed) Year 1 Intervention:** EOP recently put in a "healthy vending" machine that offers more healthy choices, and promotes health. They have instituted a Wellness Program for staff educating and encouraging them to make healthier choices. They provide healthy snacks at meetings and gatherings. CCHD provides monthly wellness tips and provides activities to encourage physical activity. Arnot Health started a Community Supported Agriculture program and holds a weekly farmers market. Many others listed above.
	Projected Year 2: Continue to provide education and opportunities. Increase education to families and employees. Implement Healthy food Policies.
	Projected Year 3:

Priority Area: Prevent Chronic Disease	**Focus Area:** Physical Activity
Goal: 2.2 Promote school, child care and worksite environments that increase physical activity	
Objective: 1.1 Decrease the percentage of children with obesity (among WIC children ages 2-4 years)	
Implementation Partner: Local Health Dept.	**Partner Role(s) and Resources:** CCHD/WIC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.2 Promote school, child care and worksite environments that increase physical activity	
Family of Measures: WIC - Increase the percentage of TV and Screen Time to less than 2 Hours daily (currently 83%)	**Projected (or completed) Year 1 Intervention:** 1 earned media activity, 3 social media posts, 2 community outreach disseminating information on reducing screen time

	Projected Year 2: 1 earned media activity, 3 social media posts, 2 community outreach disseminating information on reducing screen time
	Projected Year 3: 1 earned media activity, 3 social media posts, 2 community outreach disseminating information on reducing screen time
Implementation Partner: Community Based Organization	**Partner Role(s) and Resources:** EOP responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.2 Promote school, child care and worksite environments that increase physical activity	
Family of Measures: Economic Opportunity Program (EOP) - Head Start provides structured physical activity opportunities every day. In the Family Support Services program the monthly events offered occasionally offer opportunities for physical activity which may include swimming, walking in a park or at the YMCA, going to the Zoo, bowling, etc.	**Projected (or completed) Year 1 Intervention:** EOP provides 40-60 minutes per day of structured indoor-outdoor play, as well as 30 minutes of Zumba Kids Jr. and movement/dance breaks throughout the day of 15 minutes or so.
	Projected Year 2: Continue to provide
	Projected Year 3: Continue to provide
Goal 2.1 Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	
Objective: 1.15 Increase the percentage of adults age 18 and over who walk or bike to get from one place to another (among all adults)	
Implementation Partner: Community Based Partner	**Partner Role(s) and Resources:** CHSC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.1.1 Implement a combination of one or more new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes)	
Family of Measures: Creating Health Schools and Communities (CHSC) and Chemung County Planning - # Complete Streets policies adopted	**Projected (or completed) Year 1 Intervention:** Town of Elmira: Complete Streets Traffic Calming Signage. Town of Southport: Complete Street Implementation Project to increase community physical fitness -- fit stations. Walking College - planning a Complete Streets implementation project to increase community physical fitness and boost economic development.
	Projected Year 2: # Complete Streets policies adopted
	Projected Year 3: # Complete Streets policies adopted
Objective: 1.7 Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among all adults))	
Implementation Partner: Local Health Dept., Hospital, Community Based Organizations	**Partner Role(s) and Resources:** CCHD, Arnot Health, and HP2 members responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities, new or upgraded park or facility amenities or universal design features; supervised activities or programs combined with onsite marketing, community outreach, and safety education.	
Family of Measures: Chemung County Health Department (CCHD), Arnot Health, and community partners: #	**Projected (or completed) Year 1 Intervention:** 278 people at final event for Gold Shoe. 65 screenings done by Arnot Health. 95% visited one or more parks for the first time, 84% said

participating in Gold Shoe# participating in Park Prize Pursuit # social media posts # reached thru newsletter	they felt healthier, and 82 participated in scheduled walks. CCHD newsletter goes out to 593 people.
	Projected Year 2: # participating in Gold Shoe# participating in Park Prize Pursuit # social media posts # reached thru newsletter
	Projected Year 3: # participating in Gold Shoe# participating in Park Prize Pursuit # social media posts # reached thru newsletter

Priority Area: Prevent Chronic Disease	**Focus Area:** Tobacco Prevention
Goal: Prevent initiation of tobacco use	
Objective: 3.1.1: Decrease the prevalence of any tobacco use by high school students.	
Implementation Partner: Local Health Dept.	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.	
Family of Measures: Southern Tier Tobacco Awareness Coalition (STTAC) - # of media outreaches (radio, TV, newspapers), # of paid ads in Chemung County, # of educational presentations provided to youth focused organizations, # of Reality Check activities in Chemung County	**Projected (or completed) Year 1 Intervention:** YTD - 57 earned media outreaches (March - Kick Butts Day, May - World No Tobacco Day, November - Great American Smokeout) 4 –paid ads completed - April -Newspaper?, May - Radio, June – Tobacco-free pharmacies, June – Reality Check recruitment 3 – presentations to youth focused organizations completed 3 – Reality Check activities in Chemung County
	Projected Year 2: 6 – earned media outreaches, 1 - paid ad, 5-presentations to youth focused organizations completed, 3 -Reality Check activities in Chemung County
	Projected Year 3: 6 – earned media outreaches, 1 - paid ad, 5-presentations to youth focused organizations completed, 3 -Reality Check activities in Chemung County
Objective: 3.1.6 Increase the number of municipalities that adopt retail environment policies, including those that restrict the density of tobacco retailers, keep the price of tobacco products high, and prohibit the sale of flavored tobacco products areas. **Disparity:** Low income, minorities, rural	
Implementation Partner: Local Health Dept.	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.1.3: Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas.	
Family of Measures: Southern Tier Tobacco Awareness Coalition - # of community events hosted or attended in Chemung County, # of stakeholders educated # of retail observations completed, # of community members mobilized to write or spread about tobacco marketing	**Projected (or completed) Year 1 Intervention:** 5 - community events hosted or attended (March – Kick Butts Day and Neighborhood Conversations , April – Earth Day and Neighborhood Conversations, May – World No Tobacco Day), 19 - stakeholders were educated - (Feb – Legislative Education Day (2), March – Neighborhood Conversations (1), May – World No Tobacco Day (15)) 2 - retail observations completed , (June – Dollar General, AA Mart)

	4 - community members wrote or spoke about tobacco marketing
	Projected Year 2: 5 - community events hosted or attended, 3 - stakeholders were educated, 2 - retail observations completed , 5 - community members wrote or spoke about tobacco marketing
	Projected Year 3: 5 - community events hosted or attended, 3 - stakeholders were educated, 2 - retail observations completed , 5 - community members wrote or spoke about tobacco marketing
Goal: 3.2 Promote tobacco use cessation	
Objective: 3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%	
Implementation Partner: Hospital	**Partner Role(s) and Resources:** Arnot responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
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.	
Family of Measures: Arnot Health –Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure). # of referrals to NYS Quitline, and # of prescriptions to address tobacco dependency.	**Projected (or completed) Year 1 Intervention:** Currently all PCP show a rate of 91% compliance of screening for tobacco use. Jan. – July 2019 3,842 unique patients (19,000 scripts) receiving prescription and non-prescription medications (Nicotrol, Nicorette, Nicoderm, RA Gum, Chantix, Buproprion, etc.). Approximately 1,211 referrals to NYS Quitline during this time.
	Projected Year 2: Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure). # of referrals to NYS Quitline and # of prescriptions to address tobacco dependency.
	Projected Year 3: Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure). # of referrals to NYS Quitline and # of prescriptions to address tobacco dependency.
Objective: 3.2.3: Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among adults with income less than $25,000) **Disparity:** Pregnant mothers	
Implementation Partner: Community Based Organizations	**Partner Role(s) and Resources:** Mothers & Babies, CCHD, CIDS, STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline. (among all adults focusing on pregnant moms)	
Family of Measures: Mothers & Babies Perinatal Network, CCHD, CIDS, and community partners - # of referrals to Quit	**Projected (or completed) Year 1 Intervention:** Increase referrals to Quit Kit smoking program by 10%, 2 tobacco free outdoor policies by 6/30/20, and increase # referrals to NYS Quitline.

Kit Program's phone based, smoking cessation program for pregnant and parenting women & family members or anyone caring for young children based on American Lung Association materials. URMC Center for Community Health & Prevention Stop Smoking program available for others, in addition to the NYS Quitline. # of social media posts, outreach, etc. promoting these programs. STTAC – concentrate on policies for those serving pregnant moms.	**Projected Year 2:** Increase referrals to Quit Kit smoking program by 10%, 2 tobacco free outdoor policies by 6/30/20, and increase # referrals to NYS Quitline.
	Projected Year 3: Increase referrals to Quit Kit smoking program by 10% and increase # referrals to NYS Quitline.
Goal: Goal 3.3 Eliminate exposure to secondhand smoke	
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. **Disparity:** Low income	
Implementation Partner: Local Health Department	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
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 those that house low-SES residents.	
Family of Measures: STTAC - # of earned media outreaches# venues/events information disseminated# stakeholders educated# new units covered by policies	**Projected (or completed) Year 1 Intervention:** 3 earned media outreaches (February - Legislative Education Day, June - grant renewal, July - HUD anniversary), # venues /events stakeholders educated (February - St. Joseph's and St. Patrick's, April & June - Libertad), and 107 new units covered by smoke free policies - (St. Joseph's, St. Patrick's, and Skip Mills)
	Projected Year 2: 3 earned media outreaches # venues/events information disseminated, 1 stakeholder educated, and 15 new units covered by policies.
	Projected Year 3: 3 earned media outreaches # venues/events information disseminated, 1 stakeholder educated, and 15 new units covered by policies.
Objective: Decrease the percentage of residents (non-smokers) exposed to secondhand smoke in the community.	
Implementation Partner: Local Health Department	**Partner Role(s) and Resources:** CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed.
Intervention: 3.3.2: Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces.	
Family of Measures: STTAC - # of earned media outreaches, # venues/events information disseminated, # stakeholders educated, and # tobacco free major employer or municipal policies adopted.	**Projected (or completed) Year 1 Intervention:** 8 earned media outreaches, # venues/events information disseminated, 6 stakeholders educated, and 3 tobacco free policies adopted.
	Projected Year 2: 6 earned media outreaches, # venues/events information disseminated, 3 stakeholders educated, and 2 tobacco free major employer or municipal policies adopted.
	Projected Year 3: 6 earned media outreaches, # venues/events information disseminated, 3 stakeholders educated, and 2 tobacco free major employer or municipal policies adopted.